West Hertfordshire Hospitals NHS Trust

Watford General Hospital

Quality Report

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Date of inspection visit: 14 to 17 April, 1 and 17 May 2015.
Date of publication: 10/09/2015

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	**Inadequate**
Urgent and emergency services	Inadequate
Medical care	Inadequate
Surgery	Requires improvement
Critical care	Inadequate
Maternity and gynaecology	Inadequate
Services for children and young people	Good
End of life care	Requires improvement
Outpatients and diagnostic imaging	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

West Hertfordshire 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.

West Hertfordshire NHS Trust provides services from 3 sites Watford Hospital, St Albans Hospital and Hemel Hempstead Hospital

We carried out this inspection as part of our comprehensive inspection programme. We undertook an announced inspection of Watford Hospital St Albans Hospital and Hemel Hempstead Hospital between 14 and 17 April 2015.

We also undertook an unannounced inspection on 1 and 17 May at Watford General Hospital

Overall, we rated Watford General hospital as inadequate with 2 of the 5 key questions which we always rate being inadequate (safe and well led).

The main concerns were particularly where five of the eight core services we inspected were rated as inadequate. Only one service was rated as good – the children's and young people's service. This service was rated as outstanding for caring.

Overall we have judged the services at the hospital as good for caring. Patients were treated with dignity and respect and were provided with appropriate emotional support. We found caring in children's and young people's services to be outstanding. However caring required improvement in two areas - maternity and outpatient services where patients were not always treated with dignity and respect.

Improvements were needed to ensure that services were safe, effective, responsive to people's needs and well-led.

We saw several areas of outstanding practice including:

- The children's and young people's service was rated as outstanding for caring.
- For world sepsis day, the sepsis team launched a 'sing-along' video called 'Stamp Out Sepsis' (SOS), sung in time to a well-known song. This was an innovative method that aimed to raise awareness of sepsis and encouraged staff to remember six actions that could improve patient outcome.
- The dementia care team had implemented a delirium recovery programme which aimed to reduce length of stay, readmissions, antipsychotic prescribing and promoted cognitive and physical functioning by cognitive enablement and health and wellbeing for patients. This allowed patient's the opportunity to return home with up to three weeks of 24 hour live in care. The outcomes clearly demonstrated that the majority of patients with delirium went home with the programme in place when usual care would have predicted placement from hospital directly. Most patients recovered to a sufficient level to stay at home.
- Starfish ward staff had supported a parent whose child was frequently admitted to the ward to obtain funding to set up a carers support team. The team was subject to the same governance and recruitment checks as the ward's staff. The carers support team offered sitting services, information and signposting, and befriending services for parents whose children were in-patients at Starfish ward. However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- The trust must ensure medicines are always administered in accordance with trust policy.
- The trust must review the governance structure for Emergency Department (ED) to have systems in place to report, monitor and investigate incidents and to share learning from incidents as well as complaints.
- The trust must ensure there is an effective clinical audit plan in place in ED and End of life care (EoLC).

Summary of findings

- The trust must ensure that major incident arrangements are suitable to ensure patients, staff and the public are adequately protected and that patients were cared for appropriately in the event that a major incident occurred.
- The trust must ensure that all premises are secure
- The trust must ensure that all equipment is maintained and for safe use.
- The trust must ensure all surgical areas are fit for purpose and present no patient or staff safety risks.
- The trust must ensure that all equipment has safety and service checks in accordance with policy and that the identified frequency is adhered to in respect of emergency equipment requiring daily checks.
- The trust must review the provision of the continuous piped oxygen and suction issue on Letchmore Ward.
- Action must be taken to ensure difficult airway management equipment is adequate and checked to ensure it is fit for purpose.
- The trust must ensure staff are able to attend and carry out mandatory training, to care for and treat patients effectively, particularly regarding annual resuscitation training.
- The trust must ensure that staffing levels within adult ED meet patient demand.
- Action must be taken to ensure medical staff are suitably trained to manage the safe transfer of patients from critical care to other hospitals and services.
- The trust must ensure that all staff are effectively supported with formal supervision and appraisals systems.
- The trust must ensure that staff delivering information to bereaved people receive training in communication and bereavement.
- The trust must ensure that all records are accurate and reflective of patients' assessed needs. The trust must ensure that all patient records are accurate to ensure a full chronology of their care has been recorded.
- The trust must ensure that all confidential computerised patient records in the Emergency Surgical Assessment Unit and outpatients are securely stored to minimise the risk of unauthorised access.
- The trust must ensure that all patients' records are kept up to date and appropriately maintained to ensure that patients receive appropriate and timely treatment.
- The trust must ensure that at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff to ensure people who use the service are safe and their health and welfare needs are met.
- The trust must ensure that where a person lacks capacity to make an informed decision or given consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- The trust must ensure all patients have appropriate care plans to meet their assessed needs.
- The trust must review the elective surgery cancellation rates and review the elective surgery service demand.
- The trust must review the cancellation of outpatient appointments and take the necessary steps to ensure that issues identified are addressed and cancellations are kept to a minimum.
- The trust must review waiting times in outpatients' clinics and take the necessary steps to ensure that issues identified are addressed.
- The trust must review the environment within ED to meet patient demand effectively
- The trust must have systems to robustly manage risk and governance.
- The trust must ensure that there are robust governance and risk management systems in place that reflect level of risks and are fully understood by all staff
- The trust must ensure that all incidents are investigated in a timely manner and lessons learning cased to all staff
- The trust must review the elective surgery cancellation rates and review the elective surgery service demand.
- The trust must review the cancellation of outpatient appointments and take the necessary steps to ensure that issues identified are addressed and cancellations are kept to a minimum.
- The trust must review waiting times in outpatients' clinics and take the necessary steps to ensure that issues identified are addressed.
- The trust must ensure that all patients' records are kept up to date and appropriately maintained to ensure that patients receive appropriate and timely treatment.

The trust should also:

Summary of findings

- The trust should review the hospital bed capacity process to ensure appropriate flow through the ED.
- The trust should review clinical pathways to ensure they are consistently followed
- The trust should ensure that staff understand their responsibilities to report all incidents.
- The trust should ensure suitable arrangements are in place to ensure staff receive appropriate clinical supervision to enable them to deliver care and treatment to people who use the services.
- The trust should ensure that all clinical single use equipment is stored safely and appropriately; and disposed of when it has expired.
- The trust should ensure that all medication is stored safely and appropriately.
- The trust should ensure that all food products are disposed of when they have expired used by dates.
- The trust should review the risk register to identify all risks across medical inpatient services.
- The trust should ensure they take the required actions to meet the 18 week refer to treatment national target in surgery
- The trust should take actions to ensure patients are discharged from the unit within four hours of the decision to discharge to improve the access and flow of patients within the critical care unit.
- The critical care service should take actions to reduce the incidence of re admission of patients to critical care within 48 hours.
- The trust should take action to review staffing arrangements to ensure it is able to provide a seven day 24 hour critical care outreach service.
- The trust should take action to ensure referrals of critical care patients are managed in accordance with the trust's operational critical care policy.
- The trust should take action to ensure there is sufficient medical cover for weekends and out of hours for the critical care service
- The trust should ensure that mandatory training for staff in children and young people's services is updated.
- Patients should receive individual risk assessments for the journey to the theatre from children and young people's wards.
- The trust should ensure patients' names are not visible to people visiting the ward to ensure patient confidentiality is not compromised.
- The trust should ensure records of actions taken to address risks on the risk register are completed in a timely way.
- The trust should ensure an effective, personalised care planning process is in place to meet the needs of all patients receiving end of life care.
- The trust should provide education for all staff on care of dying patients.
- Ensure that information on how to complain is accessible to patients in all patient areas within the hospital.
- Put in place a clear strategy for leadership development at all levels.
- Review issues identified and associated with transport problems when accessing outpatient appointments.

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 	The Emergency Department (ED) at Watford General Hospital was inadequate overall. The department was not consistently meeting national targets, which meant that patients remained in the department much longer than they should; the primary cause of this was due to lack of hospital beds. The environment within ED was not adequate to meet patient demand. Staffing levels within adult ED were not always managed well, some shifts fell short and there was a high level of agency usage; recruitment arrangements were ongoing. Consultant cover was provided from 8am to 12 midnight, 16 hours per day, with a consultant on-call from 12 midnight to 8am, seven days a week. Patients felt well cared for and staff told us they felt supported by their peers and management. Paediatric ED had adequate staffing levels to meet the needs of the patients. Patient records lacked sufficient detail to ensure a full chronology of their care had been recorded. Pathways were not consistently followed and there was a lack of care provided for patients who may be at risk of developing a pressure sore. Medicines in adult ED were not always stored in accordance with requirements. Safeguarding arrangements were in place although we found a small number of examples where trust policy had not been followed. The governance structure did not work well and meetings lacked detail and routine agenda items were not consistently discussed in a meaningful way. Systems in place to report, monitor and investigate incidents were not working effectively and there was a lack of shared learning from incidents as well as complaints. There was no clinical audit plan in place and very few audits had taken place the previous year, with a lack of structure going forward.

Summary of findings

Major incident arrangements were not suitable to ensure patients, staff and the public were adequately protected or that patients were cared for appropriately in the event that a major incident occurred.

Medical care

Inadequate

Overall, we found that the service was inadequate. There were staff shortages and an over reliance of agency and locum staff throughout medicine.
Induction processes for temporary staff were not robust at the time of our inspection.
Adult basic life support training compliance was 53% for medical staff and 65% for nursing staff. This placed patients at risk because there were not enough suitably skilled staff to provide care if they needed life support.
Staff did not always report incidents and feedback was not always provided on incidents reported.
There were inadequate plans in place to manage risks identified to prevent future incidents, for example to prevent patient falls. Opportunities to prevent or minimize harm were missed; for example, we could not be assured that safety checks with nasogastric tube feeds were consistently used and that this information was documented.
We found out-of-date single use equipment; We also found equipment that was not tested in line with trust policy and equipment not stored safely and securely to prevent theft, damage or misuse.
We found risks regarding the safety of the environment and safe storage of equipment and chemicals in some a number of wards.
Medicines were not always stored appropriately and we found the clinic room temperature levels on one ward to be over the acceptable level. We found gaps on the administration records and the reasons for not giving patients prescribed medicines were not recorded. This meant that we were not assured that patients were receiving their medicines as prescribed.
Care plans were not always complete and reflective of patient's care and treatment.
Effective infection control precautions were in place in general, although not all staff followed trust policy.

Summary of findings

The arrangements for governance and performance management did not always operate effectively. Staff satisfaction was mixed. Most staff enjoyed working at the trust whereas others felt under pressure. There was staff shortages and an over reliance of agency and locum staff throughout medicine with almost 200 whole time equivalent vacancies in March 2015.
Staff were not always appropriately trained to deliver the care and treatment they were employed for. Most staff understood the concept of Deprivation of Liberty Safeguards (DoLS). However, we found one example where a patient had been unlawfully restrained without a mental capacity assessment or DoLS in place.
Most patients spoke positively about the staff and the care they received. They told us that they received good quality care and that they were treated with respect and dignity.

Surgery **Requires improvement**

Improvements were required to ensure safe, responsive and well-led care and treatment for patients.
We had concerns about the operating theatres at the trust. One of the hospital's five main operating theatres was a converted plaster room without an anaesthetic room where most emergencies took place if elective work was happening. A further two theatres had issues with the ventilation system. The ventilation system should provide clean air movement within the theatres and ensure the filtration of air to prevent transfer of bacteria between procedures. This meant that there was an increased risk of surgical infections. Another theatre was poorly maintained. The walls were cracked, the floor was uneven and lighting was poor. There was also no separate anaesthetic room for children. Children were therefore anaesthetised in theatre with their parents present, which increased the risk of infection. The post-operative recovery area was very small and there were no separate recovery areas for adults and children.
We found senior staff each had a vision for the service at local level; however there was a lack of combined objectives and strategy to achieve an

Summary of findings

improved service. There had been a number of changes in management in the previous 12 months and there were aspects of the service which were not being effectively monitored.
We had concerns about medicines management in some areas. We found intravenous fluids and medication stored on an emergency trolley which were openly accessible and could therefore be tampered with. This meant that medicines were not stored safely and securely to prevent theft, damage and misuse.
Emergency equipment was available on each ward and theatre areas and included medication, oxygen and a defibrillator. We saw that equipment checks had not always been carried out regularly in a minor operating theatre.
The surgical services provided effective care and treatment that followed national clinical guidelines. Staff used care pathways effectively. The services participated in national and local clinical audits. The service performed in line with services in similar-sized hospitals and performed in line with the England average for most safety and clinical performance measures. The service was taking action to reduce new pressure ulcers and slips, trips and falls. Infections following fractured neck of femur and following hip replacement were lower than the national average.
Staff working in surgery services were passionate about the care they gave patients. Staff at all levels had a desire to provide safe, effective, caring and responsive care. Multidisciplinary working was evident. Staff had access to training and had received regular supervision and annual appraisal. We saw that staff were caring and compassionate to patients. Patients we spoke with told us that they had been treated with dignity and respect.

Critical care **Inadequate**

Overall we judged that Critical Care services as inadequate.
Arrangements for the safe care of patients and the trust's vision to provide this were not met. The service lacked a systematic approach to the reporting and analysis of incidents. There was minimal evidence of action plans following incidents, or staff receiving regular feedback so that there was learning from incidents, such as device

Summary of findings

related pressure ulcers of which there was a high level. Although equipment was clean and well maintained the Difficult Airway trolley provided in the Critical care Unit (CCU) did not conform to current professional standards.
Staff shortages were shown to have had an impact services such as the outreach team who provided a link between the CCU and other wards who had 'at risk' patients. There were occasions when they were required to work in the CCU to cover unplanned staff absences. Anaesthetic staffing cover for weekends and out of hours was on the trusts risk register as there was only one CCU resident and one consultant which did not meet the Intensive care Society standards.
There were no consultants in intensive care medicine employed as recommended by the Core Standards for Intensive Care. Referrals to critical care were not managed in accordance with the trusts operational policy. Governance arrangements for auditing and monitoring clinical services were ineffective, although there was some evidence of nursing audit and learning.

Maternity and gynaecology — **Inadequate**

We rated the service as requiring improvement for effectiveness, caring and responsiveness and inadequate for safety and being well led.
Safety was not a sufficient priority. There was limited measurement and monitoring of safety performance. Staff recognized concerns, incidents or near misses, but there were too few permanent staff to attend to the mitigation required to reduce the risk for patients. We found that the service routinely reported never events and safety incidents; however, we found that the service had a number of outstanding investigations. There was a backlog of incident investigations and colleagues were unable to learn lessons from incidents and improve safety in a timely way.
Substantial and frequent staff shortages and poor management of agency or locum staff increased risks to patients. Vacancy levels for permanent midwives, nurses and health care assistants were at 25% and had been at high levels for a significant period of nearly a year. We found that this was

Summary of findings

affecting the permanent staff and many were under pressure to fill gaps, support less experienced staff and those unfamiliar with the working environment.
Patient care records were not always completed in accordance with trust policy.
Daily checks of the maternal resuscitation equipment had not been carried out and the compliance with these checks against trust policy had not been monitored.
The maternity service was not meeting the trust target for compliance with level 3 safeguarding children trained staff.
Medication storage fridges did not always have daily temperature checks recorded which was not in accordance with trust policy.
There were security risks regarding access to Katherine ward found during the inspection, which were immediately raised as a concern.
The maternity and gynaecology services used national evidence based guidelines to establish and deliver the care and treatment they provided but there was not an effective system to ensure polices and guidelines were reviewed to reflect current national guidance.
The staff participated in national and local audits but outcomes from audits had not helped to make improvements in care.
Performance outcomes for maternity were generally in line with trust and commissioners' targets.
There was a multidisciplinary approach to care and treatment, which involved a range of staff in order to enable services to respond to the needs of women.
Consent was appropriately obtained and women were supported to make decisions about their care and treatment. Some staff did not demonstrate a full understanding of consent and mental capacity.
Some staff had not had a performance appraisal in the preceding 12 months.
Maternity and gynaecology staff were generally caring. We observed most staff interacting with women and their partners in a respectful compassionate way. However, we observed two interactions where patients were not treated with respect and dignity in the maternity service.

Summary of findings

Most patients and women spoke positively about their treatment by clinical staff and the standard of care they had received.
Women were involved in their birth plans and had a named midwife for their pregnancy.
Senior staff members who spoke with us were aware of the increasing demands of the local and wider community, and the impact this had on other maternity services. There were occasions when capacity and staffing affected the clinic arrangements and interrupted the provision of services in antenatal care. This meant that women experienced longer waiting times.
Referral to treatment times for patients were generally in line with other NHS trusts.
Bed pressures affected the patients' experience and journey.
The service responded to the needs of women who needed extra support. There was a range of specialist midwives in post.
Elizabeth ward was accommodating outliers from other specialties and as a result gynaecological patients were cancelled frequently.
The service's ability to respond and learn lessons from complaints was not effective.
The service did not have a defined strategy in place that staff could describe.
There was a lack of overall direction and leadership of the service.
There was a lack of managerial and senior clinical ownership in the investigation of serious incidents.
Recommendations from independent reviews of the service had not been owned or actioned by managers.
The service did not have an effective governance framework to support the delivery of good quality care.
There were not effective arrangements for identifying, recording and managing risks, issues and mitigating actions.
The risk register was not current or reflective of the level of risks in the service.
Staff morale was poor and staff did not feel engaged to help shape the service with a focus on care and quality.

Summary of findings

Services for children and young people

Good

Children and young people's services provided safe care. There were arrangements in place to monitor incidents, and staff were clear on their responsibilities. Staffing levels were appropriate at the time of our visit although we were aware there were pressure points in some areas. The service had introduced a policy of staff rotation around the service. This meant staff could gain skills in more than one area of practice, and could provide emergency staffing cover across the service if required. Staff received effective mandatory training in the trust's safety systems, processes and practices.

Good standards of hygiene and cleanliness were maintained across children and young people's services. The environment and equipment was fit for purpose.

There were appropriate arrangements for the management of medicines. Children and young people's individual care records were written and managed in a way that kept them safe. There were arrangements for fluctuations in demand and major incidents.

Children and young people's care, treatment and support achieved good outcomes, promoted a good quality of life and was based on the best available evidence. Children and young people were treated in accordance with legislation, standards and national guidance. Children and young people's care and treatment outcomes were monitored. Staff had good skills, knowledge and experience to deliver effective care and treatment. Staff had the information they need to deliver effective care and treatment to children and young people.

Children and young people were treated with kindness, dignity, respect and compassion when they received care and treatment. We observed many examples of kindness and compassion shown by staff across all the wards and department areas. Children, young people, and their carers were involved in, and supported emotionally to cope with, their care and treatment.

Services were organised so that they met children and young people's needs. Services took account of children and young people's individual needs and circumstances. Care and treatment was accessed in

a timely way. Children, young people, and their carers concerns and complaints were listened and responded to and used to improve the quality of care.
Services were planned and delivered to take into account local need. There was a clear vision and strategy to deliver good quality care for children and young people. Services were well-led at a local level. The governance arrangements ensured that responsibilities were clear and that quality, performance and risks were understood and managed.

End of life care

Requires improvement

We rated this service as good for caring, requires improvement for safety, effectiveness and responsiveness and as inadequate for being well led.
Patients we spoke to were very happy with the care that had been provided to them. Relatives told us that they recommended the care that their relative received by staff at Watford General Hospital.
Facilities overall were in a poor state of repair and potentially caused risk to staff and visitors. Where these issues were mentioned on the trust's risk register no action had been taken to mitigate risk or repair problems. Outcomes on the risk register were out of date and not reviewed or updated within the trust's stipulated timeframe.
We saw that naloxone was prescribed for a patient that had been using long-term opiates prior to their admission despite this being a recent medical alert produced by the trust.
Medical staffing was below that recommended in the National Institute of Clinical Excellence (NICE) guidelines.
The trust took part in the National Care of the Dying Adult (NCADH) in 2013 to 2014 and achieved three out of seven of the organisational key performance indicators (KPIs) and met six of 10 clinical KPIs. The trust had an action plan in place to improve some aspects of end of life care, but this did not cover the items not met in the above audit.
The trust had developed a care planning tool to replace the Liverpool Care Pathway which had been removed however this had not yet been implemented.

Summary of findings

Pain assessments were not always completed in accordance to trust policy. This meant that pain records were incomplete and that patients' pain levels were not effectively monitored.
The trust did not provide effective bereavement services and staff delivering information to bereaved people did not receive training in communication or bereavement.
There was no clear vision for the service that staff could describe consistently.
Palliative care services had been understaffed, moved from directorate to directorate, and offices and interim managers had changed regularly over the previous two years. This impacted on the leadership and direction of the service.
We saw that the trust 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.

Outpatients and diagnostic imaging

Inadequate

We found this service overall to be inadequate.
Incidents were not always reported in line with trust policy, which meant that there was not a reliable oversight of incidents occurring in the outpatients and diagnostic imaging services.
We saw evidence that some incidents were reported and that the service had learned from some incidents. The service had carried out reviews of minor incidents and sharing of these and learning had taken place although this was inconsistent.
Records in the cardiology and ophthalmology outpatients department were not stored securely. This meant that there was a risk of patient records and personal details being seen or removed by unauthorised people in the department.
The organisation of some the outpatients departments were not always responsive to patients' needs. The layout and size of the department was insufficient to provide an adequate environment for patients using the cardiac and ophthalmology clinic. There were no action plans to address this and procedures had not been put in place to mitigate any risk this presented.
Equipment had not always been maintained in line with manufacturers' recommendations.

Summary of findings

We found intravenous fluids and medication stored on an emergency trolley which were openly accessible and could therefore be tampered with. This meant that medicines were not stored safely and securely to prevent theft, damage and misuse.
We found out of date clinical equipment, such as sterile needles and sterile sodium chloride solution.
Clinics were often cancelled and patients experienced delays when waiting for their appointments.
Risk management and quality measurement systems were reactive and not proactive.
Outpatients and diagnostic imaging services had not identified all the risks to service users, and not all identified risks were being managed effectively.
Emergency equipment was available in each centre, and included medication, oxygen and a defibrillator. However we saw that equipment checks had not always been carried out regularly.
We saw written information about the complaints procedure and the Patient Advice and Liaison Service (PALS), but many of the patients we asked had not been given any information about complaints or knew how to make a complaint.
We received consistently negative feedback from patients and staff about, patient waiting times and parking.
We found senior staff each had visions for the service at local-level, yet there seemed to be a lack of combined objectives and strategy to achieve an improved service. Some of the information given to us by senior managers was not found to be what was happening at local level.
Staff we spoke with were aware of key performance indicator targets that required appointments to be made within the 18 week referral to treat target (RTT) but there was no process in place for managing the patient impact when appointments were double or triple booked and therefore they were not proactively managing the situation at clinic-level.
The processes for decontamination and sterilisation of instruments complied with Department of Health (DH) guidance. There was evidence that the service focussed on the needs of patients. There were some systems in place to audit both clinical practice and the overall service.

Summary of findings

There was evidence of multidisciplinary working in the outpatients and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together. We found that staff were approachable and witnessed them being polite, welcoming helpful and friendly.
We found the service required improvement for caring as staff focussed on the task and not the person. Most patients spoke positively about the care and treatment they received and felt they were involved in their care plan.

Watford General Hospital

Detailed findings

Services we looked at
Urgent and 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 and diagnostic imaging

Detailed findings

Contents

Detailed findings from this inspection	Page
Background to Watford General Hospital	18
Our inspection team	18
How we carried out this inspection	19
Our ratings for this hospital	19
Findings by main service	21
Action we have told the provider to take	170

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 local theatre).

Watford is also the focus of the Trust's Women's and Children's services, including neonatal care. In 2011/12 the Trust increased capacity on the Watford site with a new Clinical Decision Unit (CDU) and an eighteen bed 'surge' ward.

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 the town centre.

Our inspection team

Our inspection team was led by:

Chair: Tony Berendt, Medical Director, Oxford University Hospitals NHS Trust

Head of Hospital Inspections: Helen Richardson

The team included 12 CQC inspectors and a variety of specialists including junior doctors, medical consultants, senior managers, child and adult safeguarding leads, trauma and orthopaedic nurses, paediatric nurses, an obstetrician, midwives, surgeons, an end of life care specialist and experts by experience who had experience of using services.

Detailed findings

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before visiting, we reviewed a range of information we held about West Hertfordshire NHS Trust asked other organisations to share what they knew about the hospitals. These included the clinical commissioning groups, the trust development authority, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

We held a listening event in the week leading up to the inspection where people shared their views and experiences of services provided by West Hertfordshire NHS Trust. Some people also shared their experiences by email or telephone.

We carried out this inspection as part of our comprehensive inspection programme. We undertook an unannounced inspection of Watford Hospital on two occasions on the 1 and the 17 May.

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, health visitors, trainee doctors, consultants, midwives, healthcare assistants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

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

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at West Hertfordshire NHS Trust.

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	Inadequate	Good	Inadequate	Requires improvement	Inadequate
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Inadequate	Good	Good	Requires improvement	Inadequate	Inadequate
Maternity and gynaecology	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Services for children and young people	Good	Good	☆ Outstanding	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Outpatients and diagnostic imaging	Inadequate	Not rated	Requires improvement	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

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

Information about the service

The emergency department (ED) provides a 24 hour service, seven days per week to the local population. The department sees around 87,000 patients per year, including 22,000 paediatric patients.

Patients present to the department either by walking into the reception area or arriving by ambulance via a dedicated ambulance only entrance. Patients transporting themselves to the department report to the reception area where they are booked in and streamed to the minor injury unit (minors) or the majors' area.

The department consists of cubicles for patients within majors and minors as well as resuscitation area for up to nine patients and a clinical decision unit (CDU) where patients can be admitted for up to 24 hours if an immediate decision about their care and treatment cannot be reached immediately.

The department has its own paediatric ED with a separate waiting area for children, cubicles, observation area as well as its own resuscitation bay. Patients who attended the ED should be expected to be assessed and admitted, transferred or discharged within a four hour period in line with the national target.

Summary of findings

The Emergency Department (ED) at Watford General Hospital was rated as inadequate.

The department was not consistently meeting national targets, which meant that patients remained in the department much longer than they should; the primary cause of this was due to lack of hospital beds.

The environment within adult ED was not adequate to meet patient demand. Staffing levels within adult ED were not always managed well, some shifts fell short and there was a high level of agency usage; recruitment arrangements were ongoing.

Consultant cover was provided from 8am to 12 midnight, 16 hours per day, with a consultant on-call from 12 midnight to 8am, seven days a week. Patients felt well cared for and staff told us they felt supported by their peers and management.

Paediatrics ED had adequate staffing levels to meet the needs of the patients.

Patient records lacked sufficient detail to ensure a full chronology of their care had been recorded. Pathways were not consistently followed and there was a lack of care provided for patients who may be at risk of developing a pressure sore.

Medicines in adult ED were not always stored in accordance with requirements.

Urgent and emergency services

Safeguarding arrangements were in place although we found a small number of examples where trust policy had not been followed.

Staff mandatory training attendance was below the target of 90% at just under 80%.

The governance structure did not work well and meetings lacked detail and routine agenda items were not consistently discussed in a meaningful way.

Systems in place to report, monitor and investigate incidents were not working effectively and there was a lack of shared learning from incidents as well as complaints.

There was no clinical audit plan in place and very few audits had taken place the previous year, with a lack of structure going forward.

Major incidents arrangements were not suitable to ensure patients, staff and the public were adequately protected or that patients were cared for appropriately in the event that a major incident occurred.

Are urgent and emergency services safe?

Inadequate

The adult emergency department (ED) at Watford General Hospital did not adequately protect patients from avoidable harm. Paediatric ED was safe and, if rated separately, would have been rated as good.

The environment was not suitable for the number of patients attending the department and coupled with delays in accessing beds in ward areas, this meant patient's had long waits to be assessed and paramedics often waited with the patient in corridors for long periods of time.

Arrangements for streaming patients to the relevant part of ED were not adequate, patients who self-presented were streamed by a non-clinical member of staff and it could be some time before they were assessed by a nurse or doctor.

Staffing arrangements were not adequate. There were set numbers of staff working each shift, however, a staffing needs analysis had not been undertaken for nursing staff which meant that baseline nurse staffing arrangements had not been formally considered when deciding on the number of staff required to work per shift. Shifts were often short of the agreed minimum numbers of staff. Some of the staff told us that the department could become busy and there were not always enough staff to ensure patient needs had been met.

Incidents were not always reported and incidents which were reported were not always investigated in a timely manner, the investigation process was not followed consistently and shared learning did not always take place.

The department appeared visibly clean during our inspection, although the trust's infection control audits identified issues with cleanliness, action plans did not fully address the concerns raised.

Medicines were not always stored appropriately and controlled drugs could not be ordered as required which meant other departments had to be approached if supplies in ED ran low outside of agreed ordering times.

Urgent and emergency services

Patient records lacked detail and pathways had not always been consistently followed. Nursing notes were not completed in many patient files and pressure area needs were not assessed. Pressure area care was not always documented or provided.

Safeguarding arrangements were in place and had been followed in the examples we reviewed.

Staff mandatory training attendance was below the target of 90% at just under 80%.

Major incident arrangements at the trust were inadequate. Equipment specifically for major incidents or Chemical, Biological, Radiological or Nuclear (CBRN) were not easily accessible and not all staff with assigned responsibilities were able to locate the equipment if required. Arrangements for directing or supporting patients to a designated isolation/ decontamination area for patients who may have been exposed to a (CBRN) or who may have contracted an infectious disease had not been documented and staff had conflicting views of how to manage such patients.

Incidents

- Between October 2014 and January 2015 a total of 320 incidents were reported by staff working in Watford General Hospital emergency department. From the report provided, immediate action taken had not been recorded for any of the reported incidents. Action taken (investigation) column was either blank, recorded as 'information only', staff spoken to, 'action plan for ED' or to be investigated; only a very small percentage of incidents had details of action subsequently taken and only four incidents had lessons learned recorded.
- We saw that 14 of these incidents were awaiting investigation, three of which had initially been categorised as major.
- We also noted that incidents were not consistently reported, for example, during this inspection we identified that there had been a sewage leak through the ED ceiling had not been reported as an incident. We also saw examples of staffing shortages which had not been reported as incidents. As well as patients who were in the department for long periods of time without being provided with a bed were not reported as incident, or patients who spent the night on one of the minor injury couches for example.
- Between October 2014 and March 2015 a total of four Serious Incidents (SIs) had been reported. Investigations had been completed for two of the incidents, one was in progress and one had not commenced. The Clinical Commissioning Group (CCG) gave deadlines of between one and three months to complete the investigations. There were extensive delays for all investigations to commence and be completed, for example, one of the incidents occurred at the beginning of October, the CCG had given a deadline of just over two months; it took almost six months for the investigation to be sent to the CCG. For the two completed investigations, there was a clear chronology of events, with recommendations and action plans although we found that the action plans lacked detail and did not address all issues identified in the investigations. We also saw that some of the agreed deadlines for recommendations to be completed were not proportionate to the action needed.
- We were told that Serious Incidents were discussed at the ED Clinical Governance. However, even though serious incidents had occurred in October, January and March, from review of minutes for January and March 2015, there was no evidence in the minutes that serious incidents including any preliminary findings had been discussed.
- Serious incidents had been discussed at the September 2014 ED Clinical Governance meeting. There was one learning point related to an incident regarding a child being discharged and it was recorded in the minutes that all children under the age of one should be reviewed by a consultant or paediatric registrar before discharge. The investigation was conducted promptly and agreed actions had short timescales, although there was no action detailing how lessons learned would be shared with staff. And during our inspection we saw examples in files of children under the age of one where this process had not been followed.
- Serious incidents and trends for all incidents form part of the monthly Quality and Safety report presented to the AMCD Divisional Governance and Quality Group. Data within the report is at divisional level and so includes other departments, data is not summarised for ED separately and therefore it is not possible to monitor trends with any accuracy.
- The March Quality and Safety report included data up until and including 13 March 2015. At this time there were 116 incidents outstanding, 104 of which had not been subject to any form of review. This poses a risk,

because suitable and prompt action may not have been taken and incidents could have been incorrectly graded therefore delays may occur in initiating a formal investigation. There was also no data on how long the incidents had been outstanding for.

- The report highlighted that incidents were being incorrectly categorised by type of incident which meant trends could not be analysed accurately.
- Serious incidents were summarised within the report but the summary information lacked detail. It was unclear, for some whether these incidents related to ED or another department whether this included all serious incidents which had occurred, timeliness of investigations of serious incidents.
- The Quality and Safety report was discussed at the March AMCD Clinical Governance Group, in relation to incidents and serious incidents, the minutes stated, 'clinical leads to share this with their teams at governance meetings'. We did not see evidence in the ED Governance action notes for April (the next meeting) that clinical leads had shared information about incidents at the meeting.
- The staff we spoke with told us that feedback from serious incident investigations were shared with those involved.
- A folder, 'team readings' was kept in the ED staff room and within the majors' area. The folder was used to communicate lessons from incidents as well as other information of interest to staff. Staff were expected to read all updates and sign to confirm they had done so.
- Review of the team readings folder showed that 22 information items had been circulated. Information items included diary dates for clinical governance meetings, updates to policies as well as some changes to practice, however these were not always dated and did not always explain why the update had been shared for example, one update reminded staff that all children under the age of one must be discussed with the consultant from 8am until midnight and the paediatric registrar after midnight before discharging them. The email stated that there had been a couple of incidents where this had not been followed which had put children at risk. There was no explanation regarding the incidents which had occurred or how the children had been placed at risk which demonstrated that shared learning did not take place effectively.
- The signing sheet for team readings for the most recent three information items had not been signed by any of the consultants or junior doctors, two middle grade doctors had signed to confirm they had read them, less than 10% of nurses had signed as confirmed they had read and one nurse had signed to confirm they had read information items which had not yet been written.
- The ED did not have a separate Mortality and Morbidity committee. We were told that discussions around Mortality and Morbidity took place at the AMCD Divisional Governance Committee as well as at the Clinical Governance Committee for ED.
- The March 2015 minutes for the AMCD Divisional Governance Committee included a section on mortality and morbidity. It was not clear from the minutes whether a report had been presented. The minutes stated, "ED to review patients who have died within 24 hours of attending ED to identify learning/education issues". There was no further discussion around mortality or morbidity. The January 2015 minutes recorded that mortality rates had dropped in the past months although there had been a spike in December in Medicine. There were no specific discussions around Mortality in ED.
- Review of the Clinical Governance Committee for ED found no evidence that mortality and morbidity had been discussed.
- We were provided with table summaries for all mortalities which had occurred in the ED during February and March. The majority of deaths were concluded as end of life events and it was unclear how these conclusions had been reached due to the lack of information within the summary. For deaths which were not due to the patient being categorised as end of life, it was unclear from the detail in the summary what learning had taken place, what actions were required or how this was shared. For example, the learning point following the death of one patient was, 'Daughter had contacted 111 services at 01:00 and had been told of a 6 hour wait', there was no further information and it was unclear what the learning point was. Another learning point recorded, 'NOK not informed by staff, daughter told but not wife initially. Apologised to family and staff aware now'.
- Staff were aware of the duty of candour principles.

Cleanliness, infection control and hygiene

- There were policies and procedures in place to reduce the risk of cross-infection. Staff knew how to access these via the intranet.

- We observed that the department appeared visibly clean during our inspection and the staff we spoke with did not report any infection control issues.
- We saw staff wash their hands and use hand gel between attending to patients 'Bare below the elbow' policies were adhered to. Staff wore minimal jewellery in line with the trust policy.
- We were provided with the infection control audit summaries for April and February 2015. In February overall compliance for the department was 64% with minimal improvement observed for April at 69%. Issues identified in April included, equipment not tagged as cleaned, dusty resuscitation trolley, commodes not cleaned. An action plan was developed to improve infection control arrangements; however, the action plan did not include all issues identified and we were not provided with evidence of where this was being monitored to ensure improvements were made.
- Staff were aware of the trust's aseptic non-touch technique guidance which aimed to reduce infection, although we did observe that this was not consistently followed.
- The overall completion rate for infection control training was 82% of all staff working within medicines. Data for ED staff was requested separately but not provided.

Environment and equipment

- The minors' area within ED was compact with individual cubicles which had curtains to ensure patients' privacy was maintained during assessment.
- The majors' area had eight cubicles and two side rooms for monitoring and treating patients as well as two assessment cubicles. The nursing station was central to the cubicles although not all of the cubicles and side rooms could be visibly observed from the nurses' station which placed patients at increased risk of not being seen if their condition deteriorated quickly. There was no risk assessment process in place to decide which patients should be placed in each cubicle. We were told that one of the side rooms was not visible to staff and was often used for patients with dementia who attended ED.
- There was one cubicle which was used for mental health patients, although it was noted that it did not fully comply with the Royal Society of Psychiatrist guidance, for example a panic alarm had not been fitted. We were told that all staff had been given a personal panic alarm which could be attached to their ID badge, although we observed that a number of staff chose not to wear these.
- Most of the staff we spoke with told us that equipment needs were adequate although they were frequently short of blood pressure machines and monitors and could spend a lot of time searching for them.
- The resuscitation area had nine bays; eight had monitors, five of which were new. We were told that older machines were less reliable and regularly required repair. We observed that the monitors in resuscitation were five minutes slow and therefore downloads of any observations made would be inaccurate and therefore unreliable.
- During our inspection we also made an observation that five of the monitors in resuscitation area were alarming for over one hour. Staff did not respond to the monitors alarming. When we questioned this, we were told that the monitors needed resetting.
- There was no equipment to monitor patient's heart rhythms outside of the resuscitation area. The staff we spoke with told us that this led to the resuscitation area being very busy during periods of high activity.

Medicines

- Medicines were not always stored appropriately. We found that the refrigerator used to store medicines in the "minors" area was not locked and was in a patient accessible area. The room used to store intravenous fluids was not locked and was also in a patient accessible area. We were therefore not assured that suitable arrangements were in place to prevent medicines being tampered with.
- We found that the storage temperatures of the rooms used to store medicines were not being monitored or recorded. Although when we measured the temperature it was within acceptable limits. The temperature of the refrigerator in the "majors" area had been recorded outside the recommended range for the safe storage of medicines. Nursing staff could not tell us what action had been taken. We were therefore not fully assured that medicines were always stored in a way which maintained their quality.
- We saw controlled drugs were stored and recorded appropriately but we found that they were not being disposed of safely. We were also told that new procedures had been introduced which meant that

controlled drugs could only be ordered on Mondays and Wednesdays. The staff we spoke with told us that if they ran out in-between these days, they had to phone around other wards to obtain controlled drugs.
- Emergency medicines were available for use and there was evidence that these were regularly checked.
- In children's ED staff were able to dispense simple pain relief, within a framework without the child waiting to be seen by a doctor this was under a commonly used system called patient group directive. This shortened delays in children receiving pain relief.
- Medication in children's ED was stored in line with manufacturer's recommendations and controlled drugs were stored in line with legislation.

Records

- We reviewed patient records and found that some of the records were incomplete. A significant proportion of records did not include the time a patient arrived in the department or when they received their initial assessment. Initial observations were not always recorded. Trust policy states that a waterlow score (waterlow scores are used to risk assess the likelihood of pressure area breakdown) should commence at the beginning of each episode of care and be completed with a documented formal risk assessment within six hours and that patients in an A&E, Minor Injury Unit or Outpatient setting with an actual or planned length of stay of below 4 hours should also have a formal risk assessment undertaken. From review of records of patients who may have been at risk of developing a pressure sore and had been in the department for more than six hours did not always have a documented risk assessment and nursing notes were not always completed. There were no records for recording the turning of patients who had a pressure sore or who were at risk of developing a pressure sore, some patients remained in the department for long periods of time on a hospital trolley.
- We also identified that there were differences between the time of arrival recorded on the patient's hard copy record compared to the electronic record. The time differences we observed ranged from five to 24 minutes. This meant that there may not have been accurate recording of performance of the time in which patients were seen and assessed and the organisation performance against the four hour target. The trust told us that the time recorded on the system is the accurate time as patient notes are written in retrospect.
- We observed some examples of differences in the time a decision to admit was made in the notes compared to the time recorded on the computer system, in one case this was 35 minutes which may have meant there was inaccurate recording of the organisations performance against the 12 hour target. The trust told us that the time recorded on the system is the accurate time as patient notes are written in retrospect.

Safeguarding

- Checks were made for all children attending the department to determine whether or not they currently had a child protection plan in place, and from the files we reviewed, we saw that checks had been made in all cases. Staff were also required to record whether there were any safeguarding concerns, this box was ticked for the majority of records, although we noted a small number where this was not the case. The health visitor liaison officer checked the files of all children who had attended ED to ensure safeguarding checks and referrals had been made and we saw evidence of this in patient files, although in one case it had taken five days.
- There were systems in place to make safeguarding referrals if staff had concerns about a child or vulnerable adult. The staff we spoke with talked confidently about the types of concerns they would look for and what action they would take.
- All staff were required to complete safeguarding training. There were three different levels of training most staff were required to complete training at level one and two, with some staff required to complete level three training, for example all paediatric medics and nurses. Within the medical division, 67% of all medical staff had completed safeguarding training according to the level required and 85% of nursing staff.

Mandatory training

- Statutory and mandatory training requirements were listed in the training manual.
- We were provided with a summary of the percentage of staff who had completed their statutory and mandatory training. Data provided was summarised at division level and therefore included staff who worked within ED as

well as other departments within the division. Overall, staff within the division had completed 79% for statutory and mandatory training for the year to date against a target of 90%.

- Compliance with some training sessions was much higher than others, for example, conflict resolution had been well attended by nursing staff at 81.8% but not well attended by medical staff at 0% or administrative staff at 33%. Adult basic life support training was much lower than the target for nursing staff 64.9%.

Assessing and responding to patient risk

- Patients who self-presented to ED were required to report to the main ED reception. Paediatric patients were directed to the paediatric ED. The receptionist then made a decision to direct adult patient to minor injuries or to the majors' area using a list of presenting conditions; receptionists were not clinically trained nor had they been provided with any competency based training to undertake this role.
- If patients were sent to majors they had an initial assessment by a nurse or consultant in the 'pitstop' cubicle, the patient may be referred back to minors, remain in the majors waiting area for a full assessment or sent straight through the resuscitation area if clinically appropriate.
- Patients who were referred to minors waited in the main reception area for a nurse, who was an Emergency Nurse Practitioner (ENP).
- There was no initial clinical assessment system in place in place for patients who self-presented to the department.
- From review of a sample of patient notes who had self-presented we saw that some patients waited in excess of one hour to be assessed by a clinician. We saw that one patient had been incorrectly sent to minors when they should have been referred immediately to majors. This meant that patients may have been at risk of harm due to delays in clinical assessment and treatment.
- We brought this to the trust attention at the time of the inspection.
- We returned unannounced two weeks later and found that the trust was in the process of implementing a new triage model and nursing staff were at varying stages of completing the required training. The IT systems had also been updated to record the level of urgency with which a patient required review, which was determined at triage; although this was not fully operational and was still work in progress.
- We saw that a triage system had been set up in minors, and patients were expected to be triaged within 15 minutes. However, receptionists continued to make decisions about which area of ED patients should be sent to, which placed them at risk because these decisions were being made by staff that were not competent to do so. We found this had been addressed when we returned for a further unannounced visit 17 May 2015.
- We were told and observed that patients were not always triaged within 15 minutes as this was dependent on space within the minors area of ED, and during our unannounced inspection on 1st May 2015, one patient waited approximately 40 minutes because there was no space to assess them.
- Patients who arrived by ambulance were taken directly to the 'pitstop', this was a cubicle used to make an initial assessment and record initial observations. The ambulance pitstop was consultant led during the day and run by a senior nurse at night.
- All patients arriving by ambulance were expected to have an initial assessment and be handed over to a clinician in ED within 15 minutes of arrival. The trust reported that data for ambulance arrivals was recorded and reported on by East of England Ambulance service and told us that this was not always accurate and the trust did not have a system in place to validate the data. This had also been discussed in the April taskforce meeting. We saw that data collected by the trust on the patient's paper record often differed to the trust's own electronic data and that this was between five and twenty five minutes; the time recorded on the IT system being later than the paper record.
- Some of the paramedics we spoke with told us that there were often delays but staff did their best, but they often waited in the corridor for long periods of time and we observed this happening on our first visit. On the unannounced visits, we did not see any patients being cared for in corridor areas.
- The paediatric area of ED had its own triage system. All children were assessed on arrival by a qualified children's nurse and this worked well.

- We were told that the ED did not have a dashboard to report on performance over time. A performance report had recently been developed, although each report only included data for the preceding week and did not measure the performance of all key targets or over time.
- In absence of a dashboard it was difficult to assess the trust's performance over a long period. For the week ending 5 April 85 % of patients who arrive by ambulance should be handed over within 15 minutes and 95% within 30 minutes, for the week ending 5th April 49% of patients took more than 30 minutes to be handed over and 21% took more than 60 minutes.
- We were provided with the number of handover delays which exceeded 60 minutes between April 2014 and January 2015 inclusive, the total number was 648, with 395 of these occurring in December 2014 and January 2015.
- There was a Clinical Decision Unit (CDU) which formed part of the ED. The CDU accepted patients who met specific criteria and were expected to stay no longer than 24 hours. There was set criteria for patients who could be admitted to CDU and an option for 'other' if the patient's condition or needs were outside the set criteria. 'Other' conditions required consultant sign off; from the files we reviewed the proforma had not been signed by the consultant in most cases.
- During our inspection we observed that some patients remained in the ED for long periods of time. Patients could remain in the department for up to 12 hours once a decision to admit had been made. We observed that the time recorded as decision to admit on the system sometimes differed to the time recorded on the patient's notes. We also noted that in March 2015 that one patient had exceeded 12 hours.
- Patients who had long waits in the department were not always transferred to a bed and we were told that when the department was extremely busy some patients spent the night on a couch in minor injuries, we also saw evidence recorded in patient notes that this had happened.
- We saw that the ED had a suitable system in place to monitor adult patients to ensure timely escalation if their condition deteriorated. For adult patients, observations were recorded on the national early warning score (NEWS) a tool produced to monitor signs of deterioration.
- Systems for identifying patients with a pressure ulcer or patients at risk of developing a pressure sore and acting on it were not being followed. Staff were good at reporting incidents when patient's arrived in ED with a pressure sore but there was no evidence they were providing the necessary care and treatment.
- We observed some elderly frail patients who may have been at risk of developing a pressure ulcer and who had been in the department for a long period of time. These patients had not had a hospital bed ordered and their skin integrity had not been assessed.
- There were no intentional rounding checks for patients to ensure their needs had been met. For example providing toileting assistance or to ensure patients were positioned comfortably. We were told that the allocated nurses would regularly check on patients but that this was not documented and frequency of checks had not been agreed.

Nursing staffing

- Staff told us a staffing needs assessment had not been undertaken, therefore the trust had not assessed whether staffing levels were sufficient to meet patient needs. The trust told us following the inspection that the staffing ratio in the ED had been reviewed based on the draft National Institute of Clinical Excellence (NICE) guidance for ED and that a full, formal review was to be carried out once the NICE guidance had been published. The trust told us following the inspection that the ED nursing staffing establishment had been increased above the funded budget by 4.5 whole time equivalent (wte) registered nurses and 5.46 wte untrained staff to meet the current levels of activity.
- We were told that during the winter months it had been excessively busy and that the number of nurses had been increased by one per shift as well as one healthcare assistant who worked across ED for the day shift.
- The nursing vacancy rate within ED was 10 wte; the vacancy rate had reduced slightly compared to recent months, although this had fluctuated throughout the year. From information provided by the trust following the inspection, there were 17 wte registered nurse vacancies and 4.5 untrained staff wte vacancies.
- It was the perception of most of the nursing staff we spoke with that there were not enough nurses to meet the needs of patients and that they were regularly short of staff and there was a high usage of agency nurses which all impacted on the care they were able to provide and meant they were not able to spend much

time with each patient. The nursing staff we spoke with told us that this had been raised in the past, but management were aware and no action had been taken, although there had been an increase in staffing to meet the winter pressures.

- Review of a sample of rotas confirmed the department regularly worked with less than the required number of nurses and that bank or agency nurses were also regularly used which affected the continuity of care.
- There was a local induction process in place for bank and agency nurses, the induction consisted of a checklist used to ensure temporary staff who had no worked in the ED previously were familiar with the environment and policies used by the trust.
- We requested a copy of the unfilled shift reports for February and March; this demonstrated that in February the percentage of unfilled shift was 15% and 20% for March.
- We observed some multidisciplinary handovers and found these to be effective. Each patient in the department was discussed to ensure staff taking over the next shift had a clear insight into the patient's condition, tests undertaken and plan of care.
- The staff we spoke within paediatrics ED told us the department was well staffed and that staffing levels were adequate to meet patient's needs.

Medical staffing

- There were three vacant posts in the department at the time of inspection. Consultant cover was provided between the hours of 08:00 – 24:00 with a consultant on-call between 24:00 and 08:00. . Two consultants worked between the hours of 8am and 4pm with one consultant until midnight. An additional consultant occasionally worked between the hours of 11am and 7pm but because there were not enough consultants these hours were rarely covered. We were told that the department ran better when there was cover during these hours but it rarely happened.
- We saw evidence of in meeting minutes and supporting documents that medical staffing needs were regularly assessed and discussed.
- There was a high vacancy rate amongst middle grade doctors and a significant proportion of shifts were covered by locums. There were standard shifts each week which were covered by permanent and locum staff; one person also worked a shift pattern, which varied each week so there was a difference in the level of cover provided when this doctor formed part of the rota.
- The staff we spoke with told us that there were a number of unfilled shifts per week and that cover could not always be provided, this was supported by our review of the rotas. It was the perception of some staff that there were not enough consultants or middle grade doctors. Particularly as there was only one consultant on duty between the hours of 4pm and midnight, this consultant was responsible for assessing patients at pitstop.
- We requested details of unfilled shifts for medical staff but were not provided with this.
- The Children's Emergency department was staffed mainly with medical staff from the adult ED. Staff said that this was an effective mix; however the department did not have a dedicated paediatric emergency consultant.
- There was no process in place to induct temporary medical staff to the ED.

Major incident awareness and training

- The trust had a major incident plan which was last updated in September 2013. The plan set out the command structure and roles and responsibilities for some departments as well as specific individuals. The plan set out the process for receiving details of a major incident via the switchboard and an action card had been developed to follow. Example scenarios had not been included and the plan had not considered the possibility of mass casualties arriving without the switchboard first being notified. There is a football stadium located within five minutes walking distance of the hospital and no special consideration had been given to this.
- There was a trust wide continuity policy aimed at minimising disruption to patients. The policy included a section for emergency medicine which reiterated the importance having adequate staff, clinical support, cleaning and catering but it did not state how this would be achieved.
- We were told that regular major incident training took place and that CRBN exercises took place regularly where staff would practice erecting the tent and putting on CRBN protective suits.

- During 2014 one consultant had received training on CRBN, training had not been provided to other medical staff and 75% wte nursing staff had completed the training. We were provided with training for nursing staff according to wte as opposed to actual numbers.
- In line with requirements from the Civil Contingencies Act 2004 the trust are required to undertake annual table top major incident exercises as well as a practical exercise once every three years. We requested summary findings from these events. A practical exercise had been undertaken approximately two weeks prior to the visit and we saw evidence of this, although a full report had not yet been written. We were not provided with evidence that a table top exercise had taken place.
- We reviewed the major incident equipment which was stored in a container outside. Most of the equipment inside the container was out of date and CBRN suits which were in date were not within easy access. Suits were obstructed by out of date and heavy equipment. There were additional out of date suits stored in the ED training room.
- We asked one of the shift leaders to show us where CBRN suits were stored; they showed us the expired suits in the training room and were unaware that additional suits were stored inside the container.
- The container did not have a light inside, if equipment was needed at night time, lighting arrangements would be required and these did not form part of the equipment items. We were told that if an incident occurred at night a risk assessment was needed to decide whether equipment should be used or not due to accessibility issues.
- The major incident policy included an action card for processes to be followed once the switchboard had been alerted. However, there were no clear processes for patients who self-presented due to a major incident or patients who may be infectious, for example with Ebola. The staff we spoke with had differing views of where to send patients and who would accompany the patient. There was no designated area for patients to wait until accompanied.
- We were told that if a patient presented with suspected Ebola, once isolated in a side-room, the consultant on duty would assess and treat the patient. This meant that the most senior member of staff would be taken out to assess and care for one patient until clearance had been given.
- Major sporting events regularly take place next to the hospital site, with a capacity for just over 20,000 people to attend. The trust were aware in advance of when such events took place, however, there was no evidence that suitable arrangements were in place to deal with a major incident if one occurred.

Are urgent and emergency services effective?

(for example, treatment is effective)

Inadequate 

The ED was rated as inadequate for effectiveness.

The ED had not developed a clinical audit plan for the current or previous year and many national audits including audits required by the College of Emergency Medicine (CEM) had not taken place during 2013/14. Some audits had taken place in 2014/15. Completed audit reports did not consistently state the aims and objectives and analysis and learning did not always address the weaknesses identified. Audits were presented to the ED Clinical Governance Group but there was minimal evidence of discussion.

The service was not carrying out the trust's intentional rounding checks on all patients.

Patient pathways and national guidance for care and treatment had been followed for some patients but not all. For example we saw that documentation for patients with head injuries or a suspected stroke had been completed well, but for some patients with suspected sepsis the relevant pathway had not been followed consistently.

Pain assessments were not always completed and evidence of pain relief given was not always recorded.

The department did not use a dashboard to monitor performance and although re-attendance rates were reported on externally, these were not specifically reviewed within the committee structure and therefore not discussed or acted on.

We saw that staff did not always understand the training which had been provided and it was their perception that they had not received training on caring for patients with dementia, nursing staff lacked knowledge about mental capacity.

Appraisal arrangements were in place and approximately 70% of non-medical staff had received an appraisal. We were subsequently provided with evidence that almost 100% of medical staff eligible to receive an appraisal had done so. There were arrangements for referring patients to mental health colleagues.

Evidence-based care and treatment

- We requested a copy of the clinical audit plan for 2013/ 14 and 2014/15. This was not provided, and we were given a written statement that there had been difficulty completing the 2013/14 audit plan, some audits had been completed but CEM audits had not due to difficulties with using the CEM website and accessing records. We were told that CEM audits for 2014/15 were either completed, in progress or due to start.
- We noted the March 2015 AMCD Divisional Governance minutes stated the need for a spreadsheet of clinical audits and that a template would be circulated for completion by end of April 2015.
- The ED report on audit findings as part of their ED clinical governance meeting. In March 2015 we saw that a number of audits had been presented at this meeting. Although audits had been presented, there was no discussion recorded in the minutes and the minutes did not record evidence of action taken to improve weaknesses identified.
- We reviewed two complete audit reports/ presentations, Urinary Tract Infection (UTI) and the Older People Audit.
- The UTI audit had been presented at the March 2015 ED Governance Group. The audit was not dated and did not state the aims or objectives. Findings reported included poor documentation of whether urine tests had been sent off for testing and that the antibiotic policy had not been followed consistently with overall non-compliance at less than 50%. The audit prompted questions but conclusions were not drawn and, recommendations had not been documented and there was no action plan.
- Presentation at the ED Clinical Governance committee in March simply stated, to only treat if patient has symptoms, do not use dipstick test in catheterised patients as well as a reminder of which antibiotics to use.
- The CEM 'Older People Audit '2014/15 set out clear objectives, inclusion and exclusion criteria. Recommendations had been drawn from the findings, although these were not all clear, for example, one recommendation was, "Part of ED induction". Presentation at the ED Clinical Governance committee in March stated, '75 yrs (cognitive impairment assessment) and only 7% assessed.' There was no evidence of further discussion.
- For some patients with suspected sepsis, the Roya College of Physicians "Acute care toolkit 9: Sepsis September 2014" had not been followed consistently.

Pain relief

- The ED had a scoring tool to record patients' pain levels. Pain was scored from 0-10. Adult patients were asked (where possible) what their pain rating was. From review of files we noted that pain scores had not been consistently recorded and patients were not always offered pain relief in line with policy.
- The patients we spoke with told us that they had received pain relief if necessary.
- Staff within the children's ED used a number of different techniques including distraction therapy and strong medication administered without the use of needles. One child we spoke to told us that this had been very effective.
- Staff in children's ED told us that they sometimes couldn't provide effective distraction therapy due to the lack of a play therapist. We saw a number of patient notes that demonstrated that a play therapist would have been very beneficial but was unavailable.
- We also saw some examples in patient notes where they had not been offered pain relief in line with policy.

Nutrition and hydration

- We were told that there was no protocols for intentional rounding for patients including to ensure whether patients had been offered something to eat and / or drink. Nurses were allocated to a set number of patients and were responsible for making sure that their nutrition and hydration needs had been met.

- All of the patients we spoke with told us that they had been offered food and drink but in the absence of a formal process there is an increased risk that some patients may be missed and could remain in the department for long periods without receiving adequate nourishment.

Patient outcomes

- Clinical pathways had been developed for a number of conditions; they made reference to national guidance as appropriate and were available on the intranet which staff could access as required.
- We reviewed a sample of patient notes who had attended the ED and found that most patients had received care in line with national guidance, although we observed through review of some patient notes that this was not always the case. We saw some good examples of guidance having been followed for patients with a head injury or a suspected stroke had been treated in line with the relevant National Institute of Clinical Excellence (NICE) guidance. However, guidance for patients with suspected sepsis was not always followed and relevant paperwork not consistently completed. We also saw through review of notes that most patients who required a Venous Thromboembolism (VTE) assessment had not had an assessment completed. Initial assessments and/ or observations had not always been recorded in all patient files.
- We observed that one patient had been sent home after receiving treatment for a wound, the patient also had a high heart rate which had not been followed up before discharge.
- The re-attendance rates to ED within seven days ranged between 6.9% to 8.7%, with two thirds of the months being over 8%. The England average was around 7.5% for the same reporting period. The trust does not maintain a dashboard and therefore we were unable to easily access more recent data, but for January 2015 re-attendance was 7.5%.

Competent staff

- We were told that dementia training and mental capacity act formed part of the trust's safeguarding training module, mandatory training did not include details on how to support or care for patients with a learning disability. Most of the staff we spoke with lacked knowledge about how to support these patients and told us that they had not received training in these areas.
- Some healthcare assistants had responsibility for providing basic patient care, for example, dressing wounds and plastering patients who had a simple fracture or break. We were told that training had been provided on plastering, but formal training for some other aspects of care, for example dressing wounds had not. We saw that the dressing for one patient applied by a healthcare assistant did not conform to guidance. The wound had not been dressed 'joint to joint' which may be uncomfortable for the patient as well as increasing the risk of issues with blood flow.
- The trust had systems in place to ensure professional registration of permanent employees was maintained and up to date and we were told that 100% of all staff employed within ED were up to date with their registration.
- The staff we spoke with told us that they had received an appraisal within the last year and had found this process helpful.
- We were provided with a summary of the percentage of non-medical staff who had received an appraisal. Data provided was summarised at division level and therefore included staff who worked within ED as well as other departments within the division.
- We saw that 70% of all staff excluding medical staff and those on long term leave had received an appraisal. Data provided was trust wide data and therefore it was not possible to determine the number of staff within ED who had been appraised. Data for medical staff was not provided.

Multidisciplinary working

- The staff we spoke with told us that multidisciplinary arrangements worked well most of the time although there were delays in patients being allocated beds due to delays from other speciality teams coming to see patients.
- There was effective multidisciplinary working with therapists.
- Patients who presented at ED with mental health needs were treated for their immediate clinical needs and a referral was also made immediately to the Rapid Assessment, Interface and Discharge (RAID) team for adult patients. Children and adolescents were referred

to the Children's and Adolescent Mental Health (CAMH) team during office hours. Out of hours, advice was sought from the paediatric registrar. Children were admitted and referred to the CAMH team during office hours if there were mental health concerns.

Seven-day services

- There was a physiotherapy and occupational therapy team who worked seven days per week and who assessed patients in ED for their suitability to go home, for example by testing their mobility capabilities.
- Staff told us access to and support from the hospital's pharmacy service was effective.

Access to information

- The information needed to deliver effective care and treatment was generally available to relevant staff in a timely and accessible way.
- We reviewed a sample of adult and paediatric files and saw evidence that patients had been referred to the on-site psychiatric team provided by Hertfordshire Partnership NHS Trust or CAMH also provided by Hertfordshire Partnership NHS Trust within a reasonable timeframe. We also saw evidence of advice being sought and documented when a child with mental health needs attended ED out of hours.
- Some patient records needed to be accessed electronically, using a smart card, for example x-rays. Locum doctors were not issued with smart cards which meant they have to access PACS reports using another doctor's smart card. We were told that the system is often slow and doctors sometimes left their smartcard inserted to minimise delay by logging out and back in; we observed this happening during our inspection'.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was no specific training provision for Mental Capacity Act (MCA) 2005 or Deprivation of Liberties (DoLS). There was also no mandatory training on how to support people with a learning disability or for patients who lived with dementia.
- We talked to staff about the Mental Capacity Act (MCA)2005,
- All of the medical staff we spoke with had a good understanding of the mental capacity act and knew where to seek further information from if required.
- Most of the nursing staff we spoke with did not have an understanding of the MCA or DoLS and were unable to describe what action they would take if they needed to restrain a patient.
- Staff in the paediatric ED were fully aware of how to assess consent for children.

Are urgent and emergency services caring?

Care provided to patients at Watford General Hospital was good.

All of patients and relatives we spoke with told us that they were satisfied with the care they received and felt that staff listened to them and were compassionate; and this was supported by our observations.

Compassionate care

- All of the patients we spoke with told us that staff were kind and caring and that they felt well looked after. One patient told us, "I was brought round very quickly, the receptionist was very helpful. I was assessed quickly and now I'm waiting to see the doctor".
- We observed staff supporting and treating patients in a kind and caring manner, all of the patients we spoke with and observed had access to water and had been offered hot drinks.
- The 'Friends and Family' test is a method used to gauge patient's perceptions of the care they received and how likely patients would be to recommend the service to their friends and family. Feedback from patients through the friends and family test was above the England average towards the end of 2014 but had declined during the first three months of 2015.
- The response rate was much lower than the England average and was significantly lower in January 2015 at 3.2% of all patients completing the survey; this had slightly increased again in February and March at 5.5% and 6.3% respectively.
- Feedback received in 2014 had fluctuated but was largely positive with most patients who completed the survey opting to recommend the service to their friends and family; this had declined by approximately 10% for the first three months of 2015.

Urgent and emergency services

- The trust also performed the same or better than other trusts in the ED survey 2014 for questions which related to caring.

Understanding and involvement of patients and those close to them

- All of the patients we spoke with told us that they were satisfied with the level of involvement and communication from staff.
- We saw that communication issues featured as an item in the complaints summary, however, because data was not provided at a speciality level and a significant proportion of complaints were uncategorised by type, it was not possible to deduce any meaningful information.

Emotional support

- We were told by staff that they provided regular updates to relatives who were in a critical condition and that they were taken to a private room if staff needed to discuss 'bad news'.

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

Inadequate

The ED was inadequate for its responsiveness to patients' needs; the department did not always flow well.

There were frequently delays in patients being handed over from ambulance crews and some patients had long waits in ED with the primary causes were due to lack of beds available across the hospital as well as waiting specialities to assess patients. Most patients who remained within the department for long periods were on trolleys and were not transferred onto hospital beds.

There was a lack of evidence around pressure area care, nursing staff did not routinely specialist mattresses for patients who remained in the department overnight there was minimal documentation around care provided such as offering patients a drink or making them comfortable.

There was a lack of toilets suitable for people in wheelchairs within ED. Translation services were available although staff did not use these services if relatives were available to translate, which meant there was a lack of privacy for patients who may not have wished for their relative to translate information about their condition. There were no facilities within the department to support adult patients with learning difficulties who may struggle to communicate information about their ailment or basic needs.

The service was reliant on using family members to translate for their relative.

There was a complaints system in place, we were not provided with all data requested regarding complaints, but from the information provided it was apparent that complaints were not always responded to in a timely manner.

Service planning and delivery to meet the needs of local people

- The ED was built in 1984 when the annual attendance was 32,000 patients per year. During 2014/15, a total of 86,700 patients attended ED, of which, 22,000 were children.
- An Emergency Care Reconfiguration Project Team in February 2015 to consider proposals to improve flow within the department and monitor progress.
- A project initiation document for improving unscheduled care was first drafted in March 2015. The initial focus was on unscheduled care. Due to an increase in ED attendances and non-elective admissions as well as a downward trend in ED performance the aim was changed to consider the patient pathway to ensure the causes of delays and blockages are being addressed as well as creating capacity.
- Objectives and outcomes had been defined along with the delivery and governance structure. Work streams and key milestones had been outlined for the ED transformation and were supported by a plan for continuous ward improvement. The reconfiguration element of the project made reference to testing the new design against current and future demand.
- Concerns had been shared and documented at the February meeting, that there were improvements required in the streaming process (although the improvements required were not stated) and whether this could be improved by having an Urgent Care Centre at Watford. As well as considering whether the department would benefit from co-locating the Surgical

Assessment Unit and Minors not working when ENPs were pulled to work in the Majors area. The physical layout of the department was also identified as a weakness.

- Most areas within ED supported single sex facilities, there were individual cubicle areas and male and female toilets. Although we noted that toilets in the majors and minors area of ED were not fully accessible for patients with a physical disability. Patients who required a disabled toilet needed to access the toilet in CDU.

Access and maintaining flow through the department

- The national target for patients attending ED to be admitted, discharged or transferred within four hours is 95% of all patients. The trust did not use a dashboard to report on performance therefore it was not possible for us to review performance for the year to date. For the week ending 5 April 2015 the 72% of category 1 patients were seen within four hours and 82% of all attendances. The baseline for 2014/15 was 77%.
- The performance report for the same week reported that the 30 minute handover from ambulances was only achieved 51% against a target of 15 % of the time and the 60 minute handover target had not been achieved for 21% of patients against a target of 0%.
- The number of ambulance handovers which exceeded 60 minutes, between April 2014 and January 2015 inclusive, was 587 with 331 of these occurring in December 2014 and January 2015.
- Once a decision to admit has been made, patients should be transferred to a ward or another hospital as appropriate. Patients should not remain within the department for more than 12 hours once this decision has been reached. From data provided we saw that the longest wait time in ED before being admitted, transferred or discharged, for the year to date was 11:28 hours. On average for the year to date 5% of patients waited more than 8 hours in the department. We also saw that in March 2015, four patients had waited in the department for more than 12 hours once a decision to admit had been made. The reconfiguration task force had been established to review and improve patient flow through the department but there was no evidence of discussion in the minutes about how this could be improved.
- Data sourced externally reported that in January 2015 3.6% of patients left the department without being seen, which was much higher than the national average of 2.1%. There was no discussion in the reconfiguration minutes about how this could be improved.
- The staff we spoke with told us that the department was frequently very busy but that they worked as a team to ensure the best care was provided. Some staff told us that care could be rushed at times.
- We were told that the main cause for patients remaining in the department for too long or waiting for a decision to be made about their care was due to a lack of beds and delays in specialists from other departments coming to assess patients.
- The department was not consistently meeting national targets, which meant that the patients remained in the department much longer than they should; the primary cause of this was due to the lack of beds in both the Acute trust and the community'.
- We were told that performance in children's ED was much better staff told us that when delays did occur it was often because children were waiting to be reviewed by a doctor from a specialty other than paediatrics. We saw a number of notes where children had waited for more than three hours to be reviewed by, amongst others, the surgical and orthopaedic team. On the whole children's ED was meeting the four hour target.
- The trust had arrangements in place for attendance and admission avoidance. There was a team of navigators whose role it was to reduce admissions and length of stays for patients who were medically fit to return home to do so as soon as possible, by ensuring care packages and / or the environment was a safe.

Meeting people's individual needs

- Patients who self-presented at the ED reception, reported their illness or injury to the receptionist. Reception staff worked behind a desk located in the main waiting area; this was not private and information reported by patients could be overheard by patients in the waiting area. Which meant patient's privacy and dignity could not be respected.
- We reviewed patient records and found that the majority of patients did not have any documentation regarding their skin integrity or risk of developing a pressure sore. We also observed that patients who had

remained in the department for long periods were not always ordered a bed. And for those patients who a bed was obtained for, details were not recorded in their nursing notes.

- Some of the staff we spoke with had a basic understanding of how to care for patients living with dementia. Some staff told us that patients with dementia would need to be spoken with calmly and cared for in a quiet area. We were told there was one side-room which was quieter and used for patients with dementia. However, this side-room could not be directly observed from the nursing station and patients were not risk assessed before being placed in there.
- The staff we spoke with told us that patients with a learning disability had a 'passport' which they carried with them and this provided useful information regarding their physical health and relevant contacts. We were told that most people with a learning disability were accompanied by a carer who was able to communicate on their behalf. If the patient was unable to communicate and was unaccompanied, the member of staff would contact the learning disability team during office hours, although there were no specific arrangements out of hours.
- We were told that the department had a picture book to assist people with a learning disability or other communication difficulties in expressing their needs or where they may be feeling pain. However, when we requested to see this book, it could not be located.
- A translation telephone service (Language Line) could be accessed for patients who were unable to communicate adequately in English. However, we were told by all of the staff we spoke with that if the patient attended the department with a relative who was able to speak English that they would use their relative to translate on their behalf. This meant that patients who were unable to speak English were not offered the option of a translation service and they may not want to discuss personal or medical issues via a relative.
- There were information leaflets about specific accidents / injuries / emergency conditions within the department. However, leaflets were only available in English.
- The paediatric area of ED had toys for children to play with. Children up to the age of 16 could be admitted to Paediatric ED, although the design of the department was geared to younger children and did not cater specifically for teenagers.

Complaints handling (for this service) and learning from feedback

- There was a central Patient Advice and Liaison Service (PALS). Patients had the opportunity to contact PALS via the telephone, by email or in person.
- We requested details of all complaints received regarding Adult ED within the previous six months. The report provided by the trust, listed a total of seven complaints between November 2014 and February 2015 which did not fulfil the request. We saw from review of the March 2015 Quality and Safety report that 10 complaints had been reported in January 2015 and a further 13 in February.
- The seven complaints within the report had been either upheld or partially upheld, it had taken between four and eight weeks for a response to be sent and the response for one complaint was still outstanding.
- We were told that complaints were communicated to staff at their daily handover meeting and / or to individual staff members as appropriate.
- We requested evidence of examples of learning from complaints. We were provided with learning points for the A&E Governance meeting held in January, these included issues identified from three complaints, although the lessons learned were not recorded for two of the three complaints and for the third complaint, lessons learned were considered but necessary action had not been agreed.

Are urgent and emergency services well-led?

Requires improvement

The emergency department was not well led and was rated as requiring improvement.

A project plan had been developed which aimed to improve the flow and service provided within ED. The plan was in its infancy and therefore it was not possible to determine its effectiveness.

A committee structure was in place, but, minutes for the ED Governance committee lacked detail and were not always recorded.

Patient safety data, audit updates presented at the committees lacked detail and discussion and the purpose of information items was not always clear and decisions made were not always acted on.

Performance reports lacked detail, and only provided data for the preceding week which made it difficult to analyse performance over time. There was no discussion recorded in meeting minutes around performance against the target or actions needed to improve this in the short term.

The risk register was not used sufficiently well to ensure all risks had been identified, for example, findings from serious incidents were not considered for their level of risk of the incident reoccurring and therefore its inclusion on the risk register and those risks which had been identified were not monitored effectively.

Local leadership worked well and staff reported that they felt well supported by management who were approachable. Patients and staff were given the opportunity to provide feedback about the service, although it was not clear how feedback was acted on.

Vision and strategy for this service

- The trust wide annual plan included a summary of the main priorities for ED (as part of unscheduled care) was to reduced attendances, through developing alternative care pathways as well as reducing admissions and improving flow throughout the hospital. Some of the staff we spoke with were aware of the plans.
- The plan reported that the review and redesign of ED has begun, by including ambulatory care and the GP admission process to better match demand.
- The plan also talked of expanding the physical facilities within ED, by developing a GP-led urgent care centre, expanding the 'pit stop', expanding ambulatory care; strengthen patient tracking system as well as improving recruitment and retention and monitoring attendance data against the staffing profile.
- A project initiation document for improving unscheduled care was first drafted in March 2015. The initial focus was on unscheduled care. Due to an increase in ED attendances and non-elective admissions as well as a downward trend in ED performance, the aim was changed to consider the patient pathway to ensure the causes of delays and blockages are being addressed as well as creating capacity. Objectives and outcomes had been defined along with the delivery and governance structure. Work streams and key milestones had been set out for ED transformation as well as continuous ward improvement. The reconfiguration element of the project made reference to testing the new design against current and future demand.

Governance, risk management and quality measurement

- We requested a committee structure chart but this was not provided and we were given conflicting information regarding reporting lines for committees and groups.
- The ED held a monthly Clinical Governance meeting which was the main forum to discuss complaints, mortality, audits, incidents as well as the departments risk register.
- The committee was named, 'ED Clinical Governance Committee, the department had been rebranded as an Emergency Department although this was not reflected in its governance structure nor how staff described it. We were told that the committee reports to the ACMD Divisional Governance and Quality Group, although its Terms of Reference, which were not dated, stated the Committee reported to the Patient Safety and Quality Panel.
- The ACMD Divisional Governance and Quality Group also received information on patient safety, audits, mortality and morbidity, new and changing guidance and policy updates.
- There was a separate weekly task force meeting whose focus was to review performance although there were no reporting lines for the task force.
- We were also told that other meeting groups were established to monitor and discuss specific projects, for example the reconfiguration of ED.
- There were also monthly meetings for nurses; however we were told that these were not held regularly and not always minuted. Most of the staff we spoke with reported that they did not always have time to attend.
- From review of the ED Clinical Governance minutes for March 2015, we saw that minutes were brief and were recorded on one single page of A4. The previous meeting minutes had not been recorded as discussed, nor were any outstanding actions brought forward and actions were not taken forward to the next meeting. There was also no evidence recorded in the minutes of items which needed to be reported upwards to the AMCD Divisional Governance committee or Patient Safety and Quality Panel.

- We saw that some recent audits had been discussed at the ED Clinical Governance meeting held in March as well as a set of guidelines and the impending CQC inspection, there were no other items recorded as discussed in the minutes of this meeting.
- The audits presented did not prompt discussion; key points were listed for each audit, although there was no action agreed as to how to improve the care for patients based on findings. For example, the committee received an audit on Older people, which listed two bullet points; '75 yrs (cognitive impairment assessment) and Only 7% assessed' There was no additional information or discussion recorded, therefore it was unclear how this would be improved on or immediate actions required.
- The Paediatric Burns Guidelines were discussed at the meeting and four bullet points summarised the discussion; 'Minor Burns to be reviewed at 48 hrs by senior ED doctor; TSS Toxic Shock Syndrome (typically 3-4 days); Burn can look fine; Fever, diarrhoea, lethargy, rash.' There was no further discussion and it was unclear from the information recorded in the minutes how this helped staff to ensure guidance was followed.
- A meeting had not been held in February, the January meeting had not been minuted although 'learning points' had been documented, these included; access to records, learning from complaints as well as HIV testing. It was unclear how the learning points were shared with other staff.
- We were provided with minutes of the AMCD Divisional Governance and Quality Group for December 2014 and January and March 2015. A meeting had not been held in February.
- Each month the Group received a Quality and Safety report which included an update on incidents, mortality and morbidity, complaints, risk register update, patient safety alerts and progress made with audits.
- We reviewed the March report, information reported on incidents lacked detail as was complaints, and for example, the report simply listed the number of complaints received for ED during the previous two months and the categories at divisional level. A significant proportion of complaints had not been categorised, therefore there was no data on trends. The number of outstanding complaints were not reported, nor were details of the numbers of complaints upheld. There was no further analysis or information on complaints within the report.
- Neither the ED Governance Committee nor the ACMD Governance Group received information on departmental performance against key targets, for example the ED four hour wait target.
- The risk register was presented to the AMCD Divisional Governance Group at each meeting.
- The risk register which included risks for the unscheduled care directorate contained eleven risks, four of which had a risk rating of 15 or above (meaning significant risk) after mitigating controls had been considered. Most of the risks identified related to staffing or capacity. Each risk had a description, details of the controls in place, gaps in assurance, risk owner, the date it was opened and the next review date. Ten of the risks had been opened in 2014, one in 2015 and all had a review date of May 2015. The register did not record when the risks had last been reviewed. One of the risks related to the mental health room in ED not complying with the Royal Society of Psychiatrists guidelines, the control was for one to one specialising to be put in place and for the alarm system to be addressed. We did not see one to one specialising in place during our inspection and the staff we spoke with told us that one nurse is responsible for this room along with four other cubicles.
- The risk register had failed to consider risks which had occurred as a result of serious incidents or current practice. During our inspection we identified and observed concerns which had not been included on the risk register, for example, the lack of ward rounds on CDU, the environment in the majors area which meant that not all patients could be observed from the nursing station, the streaming process being run by non-clinical staff, the possibility of a major incident.
- The Quality and Safety report for March 2015 provided a summary of risks with a score of higher than 20, new risks and closed risks. Emergency care had added two new risks and closed two. It was unclear where decisions had been made to open or close risks; there had been no discussion at the group meeting.
- One of the risks recorded as closed in the March 2015 report was, 'There are potential security issues for staff especially around unsocial hours when they are working alone. This is a trust wide risk'. The justification for closing this risk was, 'Risk closed as lone working not in place anywhere on any site'. This meant that the risk was discounted as a local risk because it was a risk across the hospital.

- We also noted from the January 2015 minutes that it had been recorded that the risk register should be updated with the risk that patients are placed on ambulatory care overnight as there had been reports of this happening. It was unclear from the information available, whether these patients were ED patients or not. There was no evidence in the March 2015 minutes that this risk had been taken forward and added to the risk register for unscheduled care.
- A clinical audit plan had not been prepared for 2013/14 or 2014/15. We noted the March 2015 AMCD Divisional Governance minutes stated the need for a spreadsheet of clinical audits and that a template would be circulated for completion by end of April 2015.
- The Quality and Safety report included a summary update on progress of local and national audits for medicine. A total of 39 audits were reported on with a brief sentence about them. Information was listed rather than in a table format, which made it cumbersome and difficult to see at a glance the progress made with audits and it was unclear whether this included all audits for ED. The summary information for audits within the report mostly lacked meaningful information, for example, summary information for the Neutropenic sepsis audit simply stated that 'staff member A suggested sending to staff member B an email'. There was no further information and it was unclear what this meant.
- The January 2015 AMCD Divisional Governance minutes recorded a reminder for clinical leads to submit their speciality minutes along with dates of meetings with an agreed deadline in February. There was no evidence in the March 2015 AMCD Divisional Governance minutes that speciality minutes had been circulated or presented.
- We were told that a taskforce had been established which met weekly and received and reviewed performance reports. The meetings were not minuted, but action logs were recorded. The performance reports included activity and performance for the preceding week only and therefore comparisons could not be made over time. The report did not include data on performance for all targets. Weekly figures were provided for, the four hour target, 12 hour trolley waits, unplanned attendances and patients who left without being seen. The table included a section to report on decision to admit times, as well as thrombolysis within three hours although data was not recorded in the table. Other targets such as ambulance handover and time to initial assessment were not included within the report.
- Review of the action logs for the task force meetings evidenced that achievement against target was not taken forward as an action if targets had not been met. The action log was used to suggest additional targets which could be monitored as well as maintenance and staffing issues.

Leadership of service

- Day to day leadership in the ED worked well but there little evidence that higher management were effective. The clinical management for medical and nursing was well established and the staff we spoke with reported that they had good relationships with their immediate manager and that they would feel comfortable in talking to more senior management within ED if they needed to.
- ED were piloting a new structure for the majors area with a new band 7 role who were responsible for making quality checks, this was in addition to the band 6 who led the shift. When we spoke with staff about this role, including staff who were allocated as the band 7 quality lead they were unclear what was expected of them. We were also told that due to staff shortages, the band 7 quality role was frequently not happening in practice because they needed to work clinically.
- Medical staff reported to the on duty consultant or a senior registrar.

Culture within the department.

- The junior staff we spoke with told us that this was a wonderful place to work and that they felt supported by their peers and management. We observed positive interaction between all staff groups.
- We were told that staff were able to raise issues as part of the daily handover or as part of their annual appraisal.
- Most of the staff we spoke with told us that they felt confident in raising concerns with management. However, some staff told us that they had raised concerns about the triage process and that it was their perception that this was unsafe by they felt unable to voice their concerns.

Public engagement

- Patients are given the opportunity to provide feedback via the friends and family test. The response rate for friends and family was lower than the England average, but feedback received had been positive.

Staff engagement

- An annual staff survey takes place each year to gauge staff perception on a range of matters. We saw that staff within ED had raised concerns and we were told that an action plan was in the process of being developed.
- We were told that staff were able to raise issues as part of the daily handover or as part of their annual appraisal.
- Most of the staff we spoke with told us that they felt confident in raising concerns with management.

However, some staff told us that they had raised concerns about the triage process and that it was their perception that this was unsafe by they felt unable to voice their concerns.

Innovation, improvement and sustainability

- There was a structured learning programme in the Emergency Department plus a weekly sector-wide Emergency resilience group. The Trust was commended by ECIST and had won a national innovation award for its Ambulatory Care service.
- Staff told us they aspired to continually improve the quality of care but current staffing pressures impacted on the longer term planning for the ED.

Medical care (including older people's care)

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

Information about the service

West Hertfordshire Hospitals NHS Trust provides inpatient medical services. There are 12 medical wards, an acute admissions unit and a medical day care unit at Watford General Hospital. There are 408 medical beds in total.

We visited the following areas at Watford General Hospital: the acute admissions unit, ambulatory care, Bluebell ward, Croxley ward, Oxhey ward, Sarratt ward, Winyard ward, Cassio ward (gastroenterology), the stroke ward, Heronsgate ward (medical), Aldenham ward (respiratory medicine), Gade ward (rheumatology and clinical haematology), Tudor ward (a winter pressures ward), Letchmore ward (surgical), the cardiac care unit, the discharge lounge, Helen Donald Unit (a nurse led medical day unit) and the endoscopy unit.

We spoke with over 50 members of staff including: nurses, doctors, pharmacists, therapists, administrators, and housekeepers. We spoke with over 40 patients and six relatives. We observed interactions between patients and staff, considered the environment and looked at care records. We also reviewed the trust's medical performance data.

Summary of findings

Overall, we found that the service was inadequate.

There were staff shortages and an over reliance of agency and locum staff throughout medicine. Induction processes for temporary staff were not robust at the time of our inspection.

Adult basic life support training compliance was 53% for medical staff and 65% for nursing staff. This placed patients at risk because there were not enough suitably skilled staff to provide care if they needed life support.

Staff did not always report incidents and feedback was not always provided on incidents reported. There were inadequate plans in place to manage risks identified to prevent future incidents, for example to prevent patient falls. Opportunities to prevent or minimize harm were missed; for example, we could not be assured that safety checks with nasogastric tube feeds were consistently used and that this information was documented.

We found out-of-date single use equipment, equipment that was not tested in line with trust policy and equipment not stored safely and securely to prevent theft, damage or misuse. We found risks regarding the safety of the environment and safe storage of equipment and chemicals in some a number of wards.

Medicines were not always stored appropriately and we found the temperature levels on one ward to be over the acceptable level. We found gaps on the administration

Medical care (including older people's care)

records and the reasons for not giving patients prescribed medicines were not recorded. This meant that we were not assured that patients were receiving their medicines as prescribed.

Care plans were not always complete and reflective of patient's care and treatment.

Effective infection control precautions were in place in general, although not all staff followed trust policy.

The arrangements for governance and performance management did not always operate effectively.

Staff satisfaction was mixed. Most staff enjoyed working at the trust whereas others felt under pressure. There was staff shortages and an over reliance of agency and locum staff throughout medicine with almost 200 whole time equivalent vacancies in March 2015.

Staff were not always appropriately trained to deliver the care and treatment they were employed for. Most staff understood the concept of Deprivation of Liberty Safeguards (DoLS). However, we found one example where a patient had been unlawfully restrained without a mental capacity assessment and DoLS in place.

Most patients spoke positively about the staff and the care they received. They told us that they received good quality care and that they were treated with respect and dignity.

Are medical care services safe?

Inadequate

We found the safety of the service was inadequate.

There were staff shortages and an over reliance of agency and locum staff throughout medicine. Induction processes for temporary staff were not robust at the time of our inspection.

Adult basic life support training compliance was 53% for medical staff and 65% for nursing staff. This placed patients at risk because there were not enough suitably skilled staff to provide care if they needed life support.

Staff did not always report incidents and feedback was not always provided on incidents reported. There were inadequate plans in place to manage risks identified to prevent future incidents, for example to prevent patient falls. Opportunities to prevent or minimize harm were missed; for example, we could not be assured that safety checks with nasogastric tube feeds were consistently used and that this information was documented.

We found out-of-date single use equipment; we also found equipment that was not tested in line with trust policy and equipment not stored safely and securely to prevent theft, damage or misuse. We found risks regarding the safety of the environment and safe storage of equipment and chemicals in some a number of wards.

Medicines were not always stored appropriately and we found the temperature levels on one ward to be over the acceptable level. We found gaps on the administration records and the reasons for not giving patients prescribed medicines were not recorded. This meant that we were not assured that patients were receiving their medicines as prescribed.

Care plans were not always complete and reflective of patient's care and treatment.

Effective infection control precautions were in place in general, although not all staff followed trust policy.

Incidents

- Staff told us that they were encouraged to complete incident reports on the electronic reporting system. Most staff told us that they had feedback from the

reports. However, some staff told us that they did not always complete incident reports because they did not feel that they made a difference or that incidents would be addressed. For example, staff in the discharge lounge told us that they did not always know what to report and instead reported incidents informally to their manager, however they never received feedback. This meant that data provided in relation to incidents may not have provided a reliable oversight of incidents occurring in medicine.

- Strategic Executive Information System (STEIS) data showed that between February 2014 and January 2015 there had been 90 serious incidents requiring investigation. Grade three pressure ulcers accounted for 34 of these; slips, trips and falls accounted for eight of the incidents.
- We saw some learning from incidents. For example, the trust tissue viability team told us that since January 2015 they were notified on the electronic reporting system of all pressure ulcer incidents in the trust. This enabled them to target wards across the trust that needed additional support to reduce pressure ulcers. In March 2015 they introduced care plan documentation to help guide staff to prevent and treat pressure ulcers, called 'Best Shot'. The team had seen a 10% improvement in the trust Test Your Care patient experience results in March 2015 compared to the previous month, since the documentation was implemented. There were root cause analysis reports completed for all pressure ulcers grade three and above, that were reviewed by the pressure ulcer group which included the chief nurse. The tissue viability team told us that learning should be disseminated locally at ward level, however, they could not provide evidence that this happened.
- The September 2014 minutes of the bone health and falls group showed that 229 falls had been reported from April to June 2014. This had improved compared to 253 the previous year. However, the data showed that only 62% of assessed patients at risk of falls had care plans in place and that all patients that had fallen did not have care plans in place. We also found evidence of patients not having care plans completed in incident reports. There was no action documented within the bone health and falls group minutes to demonstrate how care was going to be improved. This meant that the bone health and falls group were not putting actions into place and that care plans were not always completed to prevent patients falling.
- We reviewed cardiology morbidity and mortality meeting minutes which demonstrated patient cases were discussed with associated actions recommended for practice improvement. However, there was no documentation on the minutes to evidence the progression of the actions or if actions had been completed and implemented.
- NHS Safety Thermometer information was displayed outside each ward. This included information about falls and new pressure ulcers.
- NHS Safety Thermometer information showed that between December 2013 and December 2014 there were 51 grade two or three pressure ulcers, 44 falls with harm and 66 catheter acquired urinary tract infections. Prevalence rates varied during the months with no sustained improvement.
- Some wards, such as Gade, had a daily 'safety huddle', to highlight safety issues such as patients at risk of falls or pressure ulcers. All ward staff were encouraged to attend
- Senior staff we spoke with were aware of the Duty of Candour legislation and able to describe the responsibilities involved.

Cleanliness, infection control and hygiene

- Areas we visited were visibly clean and wards had cleaning schedules in place.
- Schedules were generally signed in accordance with trust policy. However we found on Sarratt ward that two toilets had not been recorded as cleaned for a day and a half, which was not in accordance with trust policy.
- Equipment had green "I am clean" stickers on them so staff would know which equipment was safe to use.
- Staff had access to personal protective equipment such as gloves and aprons.
- We observed staff adhering to the trust's '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.
- On Sarratt ward, we observed two staff walk onto the ward without using the antiseptic hand gel located by the entrance.
- Sixteen of the 24 acquired C.difficile infections between December 2013 and November 2014 were within

medicine. These had been investigated. For example, there had been an incident meeting to discuss the six cases that occurred in August 2014. The findings concluded that there was no evidence of transmission. Staff said learning from these incidents was cascaded to staff teams.

Environment and equipment

- We inspected six resuscitation trolleys that were centrally located on wards. They were visibly clean and defibrillators had been serviced in line with trust policy. We found that staff had documented daily equipment testing for the resuscitation trolley to ensure equipment was fit-for-purpose.
- Two out of five doctors on Acute Admission Unit (AAU) did not know the location of the nearest resuscitation trolley. This meant that not all doctors would be able to locate the trolley in an emergency.
- On AAU we found out-of-date equipment including an arterial blood collection syringe that expired in 2012 and a suprapubic catheterisation set that expired in 2014. We reported these to nursing staff, who disposed of the equipment. Staff informed us that regular checks should be carried out on this equipment.
- We found an open equipment store and procedure rooms in AAU. This meant that equipment, such as biopsy needles, enteral syringes and dressing packs, were not stored safely and securely to prevent theft, damage or misuse.
- We saw a single-use enteral syringe (a syringe used to administer nourishment and medication through a feeding tube) that had been used and left on a patient's bedside table on the stroke ward. We reported this to a registered nurse who told us that enteral syringes could be used more than once if using water. However, according to the trust's enteral feeding policy, single-use enteral syringes should only be used once and then discarded.
- We found a blood pressure monitor on the stroke ward that required portable appliance testing (PAT) in August 2014. We found an oxygen cylinder and a cardiac monitor on Sarratt ward that required testing in October and December 2014, respectively. The trust assured us that the process and procedures required to meet its statutory obligations are in place, however, this meant that on the ground it was not clear if all equipment was tested in line with trust policy.
- On Sarratt ward workmen were painting. The fire extinguishers had been detached from walls and left on the corridor floor, there were also mattresses propped up against the wall. This caused a potential trip hazard, especially in a ward for elderly people, some of whom may have been living with dementia.
- The fire exit doors in Bluebell ward garden were blocked by flower pots to prevent patients wondering beyond the garden through the doors. The flower pots posed a risk to the evacuation procedure and there had been no risk assessment until we requested this information. The risk was assessed on the 07 May 2015 and the fire safety officer advised that the pots were removed.
- There was no piped oxygen and suction for each bed space on Aldenham ward. Portable oxygen cylinders were however available on the ward. This was on the risk register since March 2010 and staff told us that there had been no action to address this risk.
- On Sarratt ward, we found chemicals that posed a risk to patients' and visitors were in unlocked storage rooms. We also found that the dirty utility room had been propped open with a builder's tool. This room contained chemicals that were harmful to health as well as an unlocked clinical sharps bin, This was not in accordance with trust policy, which was that this room should be kept locked at all times. This ward catered for people living with dementia. We raised these concerns to the senior nurse in charge, who took action to address the concern.
- On Tudor ward, we found that the main electrical cupboard on the ward was not locked and this posed a risk that any patient, some of whom were living with dementia, could have accessed electrical circuit boards. We raised this immediately with the nurse in charge, who locked the door.
- On the unannounced inspection on 17 May 2015, we found significant health and safety concerns in Schrodells Unit with building materials, tools, oxygen cylinders, containers of chemicals hazardous to health in full public access areas (namely the internal corridor from the unit to the emergency department). The door to the main electrical cupboard was unlocked allowing access to the main electrical circuit board. We found numerous oxygen cylinders that were not securely stored in accordance with trust policy. The external door to the sub-contractors compound was not locked, allowing full access to all the equipment, builder's tools and chemicals being stored in this area. This was

escalated to the on-site supervisor team and the on call director, who arranged for the director of estates to attend the site to make the area safe. The trust subsequently confirmed that the area had been made safe and that appropriate locks had been fixed to the maintenance rooms and the sub-contractors compound. However, the trust was not able to provide a copy of the fire risk assessment, including safe storage of chemical hazardous to health and storage of oxygen cylinders, that had been competed prior to the commencement of the building works.

- On the unannounced inspection on 17 May 2015 in Tudor ward, we found clinical storerooms left unlocked, allowing access to clinical supplies and cleaning materials. We found door wedges being used on fire doors as staff told us they had reported the fire doors were defective and had not been repaired. The fire doors to the bay areas did not have working automatic door retractors so staff had used door wedges to keep these doors open. The clinical site supervisor removed the door wedges from all these doors on the ward when we brought this to their attention as they stated the use of door wedges on fire doors was not in accordance with trust policy.
- We also found a lack of appropriate security systems as visitors identity was not checked when the door was opened by staff via the door intercom. This was brought to the attention of the nurse in charge. When we returned to the ward half an hour later with one of the site supervisors, we again found that the door to the staff kitchen area was open with a door wedge. We found cleaning materials potentially hazardous to health were in an unlocked cupboard in this area. The trust subsequently informed that all maintenance issues had been addressed and all staff working on the ward had been informed of the need to maintain ward and storage room security.

Medicines

- We looked at the prescription and medicine administration records for 25 patients on five wards. We saw arrangements were in place for recording the administration of medicines and a coding system indicated any reasons why medicines were not administered. We found 13 medication gaps on the administration records and the reasons for not giving patients prescribed medicines were not recorded. This meant that we were not assured that patients were receiving their medicines as prescribed.
- If patients were allergic to any medicines this was recorded on their prescription chart.
- Staff generally administered patients' medication according to trust policy. However, we observed one nurse handling medicines without using gloves on Sarratt ward on 14 April 2015. We brought this to the attention of the nurse in charge who agreed it was not accepted good practice to do this and planned to review that nurse's training.
- We found medicine unattended on top of the medication trolley on Sarratt ward and raised this immediately to the senior nurse, who locked the medicine away.
- We saw controlled drugs (medicines subject to additional controls as they are liable to be misused) were stored and recorded appropriately. However, we found that they were not disposed of safely or in line with the Department of Health's 2007 Safer Management of Controlled Drugs.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. Nursing staff told us that they were only permitted to order controlled drugs from the pharmacy on fixed allocated days. If controlled drugs were needed at other times they were borrowed from another ward. Nurses told us that this caused delays in patients receiving medication.
- We saw records that showed the medicine fridges were checked daily to ensure they were at the recommended storage temperature. However, on Gade ward we saw two dates in April 2015 that had not been checked for the chemotherapy fridge and pharmacy fridge.
- On Gade ward we found the treatment room door open. This meant that medicines, such as fondaparinux injections (an anticoagulant medication) and adrenaline syringes (a medication to relieve the symptoms of anaphylaxis) found on top of medication cupboards, were not stored safely and securely to prevent theft, damage or misuse. We reported this to the ward sister who took action to address this concern.
- The treatment room on the Helen Donald Unit where medications including intravenous fluids and anti-sickness tablets were stored was 27°C. This was above the National Pharmacy Associations

recommended storage temperature of 25°C or less and the trust policy of a maximum 25°C. We reported this to the sister. They reported that pharmacy had ordered a thermometer for the room but it had not yet arrived and therefore room temperature was not monitored. Staff told us that the air conditioning worked intermittently and therefore they had opened the window to cool the room. The treatment room was on the ground floor. There was a chain to prevent unauthorised access to the path that passed outside the treatment room. However, there was a risk that the room could be accessed from outside the building from unauthorised personnel. This meant that medicines were not stored safely and securely to prevent theft, damage or misuse and not stored within correct temperature ranges.

- We visited the Helen Donald Unit treatment room the following day. The window was closed and the air conditioning was active. The sister told us that they had contacted pharmacy and actions were planned to ensure medication was stored appropriately in the future.

Records

- All healthcare professionals used the medical notes to record patient care. Medical notes were up to date.
- Most patient care plans were up to date. However, we found examples were care plans were not accurate. For example, on Sarratt ward, we found two out of five patients' care plans we looked at, that food and fluid intake had not been recorded in accordance with trust policy. There was a risk that incomplete record keeping could have meant the patients were not receiving the required level of care and support.
- On the stroke ward we looked at five care plans of patients who had nasogastric tubes in place for artificial feeding. Three of the care plans had no pH documented for that day despite artificial feed running through the tube. More information on this incident can be found in the 'assessing and responding to patient risk' part of this report.
- On Sarratt ward, we found one computer terminal, at the unmanned reception desk, had not been "screen locked" and the full, confidential details of a patient were clearly visible. We raised this with the nurse in charge who took action to address this concern.
- Patients' first and surnames were displayed on a white board in view of visitors on each ward. This meant that anyone entering the ward could view all the names of patients and confidential information on the ward.
- We saw staff handover sheets contained information such as patients first and surnames, presenting complaint, past medical history and discharge plans. Staff told us that they disposed of handover sheets in confidential waste bags at the end of each shift. However, the bags were left open on the floor of wards next to nurses' stations and did not securely store all confidential waste.

Safeguarding

- Nursing staff were aware of what to do if they had a safeguarding concern and were able to tell us what constituted such a concern. There was a safeguarding team and staff on the ward knew how to contact the team when they required support.
- Within the medicine division, medical staff had a 62% compliance with safeguarding adult's level 1 training and a 54% compliance with level 2 training. Nursing staff had an 87% compliance for both safeguarding adults level 1 and 2 training. This placed patients at risk because there was not enough suitably skilled clinical staff to identify and raise safeguarding alerts.
- Compliance for all levels of safeguarding children's training (one, two and three) was between 63% and 77% for medical staff, and 67% to 91% for nursing staff. Staff told us that training was only one hour which did not meet the intercollegiate safeguarding children and young people guidance 2014.

Mandatory training

- Mandatory training included fire awareness, safeguarding, information governance and health and safety training. Overall there was a 79% compliance with mandatory training for staff in the medicine division at the time of the inspection. In the Board Performance report for March 2015, there was not a target for staff compliance with this training set.
- At the time of the inspection, 53% medical staff and 65% nursing staff in the medical division had received adult basic life support training. This meant that a significant number of staff had not received any life support training in the last 12 months. This placed patients at risk because there were not enough suitably skilled staff to provide care if they needed life support.

Medical care (including older people's care)

Assessing and responding to patient risk

- On the respiratory medicine ward (Aldenham ward), we found that consultant-led ward rounds were inconsistent. Patients transferred from the Critical Care Unit (CCU) with non-invasive ventilation (NIV) were not seen within 12-24 hours or regularly by a consultant respiratory physician.
- We were informed that that every respiratory patient had a daily consultant review five days a week we looked at seven sets of notes and found that none of these patients had a record of having received a daily consultant review. Most patients had been seen by a consultant three times over seven days.
- There was no respiratory review of patients receiving NIV over a weekend or bank holiday as this was delivered by the on call medical team who may not have the required specialist knowledge, a concern that was expressed by junior doctors who told that not infrequently advice was sort from other hospitals. The trust told us a process was in place for support to be received from the CCU (ITU) Outreach team. We saw no evidence of this being used in practice.
- The trust policy for management of NIV was found to be past its review date of October 2013 at the time of the inspection.
- Patients receiving NIV had prior to the inspection been cared for together in a designated high dependency unit area on the respiratory ward as referenced in the trust policy for management of NIV and joint guidance published by the British Thoracic Society and the Royal College of Physicians. However this had ceased prior to the inspection and patients receiving NIV were now being cared for in general locations on the ward area.
- The signage for the HDU remained in place but was no longer in use. We were informed that there had been no discussion or consultation with the ward sister or the ward nursing team regarding this change. Staff informed us the changes had made providing care for NIV patients more challenging in ensuring the correct level of staffing and equipment was maintained to meet patient need.
- We were informed that the ward also often cared for sick patients from other areas who needed to be transferred out from critical care. There was no evidence of any risk assessment being undertaken regarding this. We observed that during our inspection staff were frequently moved from this ward to cover shortfalls elsewhere.
- The trust subsequently informed us that a new clinical lead for respiratory medicine had been appointed and that an external review of the respiratory service was underway.
- The trust's enteral feeding policy stated that prior to commencing a nasogastric tube (a tube passed into stomach through the nose) feed the nasogastric tube tip position must be confirmed using pH indicator paper to test human gastric aspirate. A pH between 1 and 5.5 indicated the tube was within the stomach and it was safe to feed.
- On the stroke ward we looked at five care plans of patients who had nasogastric tubes in place for artificial feeding. Three of the care plans had no pH documented for that day despite artificial feed running through the tube. We highlighted this to a registered nurse and the sister who told us that two of the patients had had their pHs tested by night staff which had been handed over to them but that this had not been documented. The sister was unsure if the third patient had their pH tested and planned to investigate. This meant that we could not be assured that safety checks with nasogastric tube feeds were consistently used and that this information was documented.
- Most patient care plans and clinical risk assessments were up to date. These included assessments for pressure ulcers, nutrition and National Early Warning Score (NEWS).
- The divisional governance and quality group reviewed all cardiac arrests. The December 2014, January 2015 and March 2015 meeting minutes showed that a total of 13 of the 23 patients that went into cardiac arrest had incorrect NEWS and a further five patients on cardiac care ward areas had no NEWS because the area did not use the tool. A discussion with the cardiac care unit sister was planned with the aim of implementing the NEWS. The March 2015 meeting also noted that a NEWS audit completed on Aldenham ward showed that 17 out of 20 NEWS were correct. This meant that NEWS score were not always completed correctly and therefore patient risk was not always determined. This was not recognised on the divisions risk register.
- During our inspection, we had to highlight a patient on AAU with cardiac arrhythmia (a heartbeat that is irregular) to the nurse caring for the patient, who could not interpret the monitor.
- Tudor ward was located in the Schrodells Unit, a short walk from the main hospital building. The operational

policy for Tudor ward was in draft form and not fully completed, yet the ward was open. Staff told us that they would call 999 if a patient needed emergency medical treatment. However, this was not the process documented in the draft operational policy, this demonstrated an inconsistent message. This was not highlighted on the risk register.

- On Sarratt ward, we found one instance (out of five patients' records reviewed) of where a patient had triggered a score of four on their NEWS chart, which trust policy states "requires medical review", yet there was no evidence in the nursing or medical notes that this patient had been seen by a doctor. We raised this with the nurse in charge, who requested a doctor's assessment,

Nursing staffing

- Between January 2015 and March 2015, no wards managed to achieve the registered nursing establishment, with an average of 5% shifts not filled. The wards with the highest percentage of unfilled shifts were AAU triage that failed to fill 10% of shifts, and Aldenham, Croxley (February 2015 to March 2015), Heronsgate and Gade wards that failed to fill 8% of shifts.
- During our inspection we found evidence of short staffing. For example, on the stroke ward on the 15 and 16 April 2015, the ward was a registered nurse short each day, in addition on the 16 April 2015 the ward was also a health care assistant short. The service had a staffing escalation procedure to alter senior managers of areas of risk due to short staffing.
- On Gade ward we found the ward was two registered nurses short on the 16 April 2015. The sister, who was meant to be supernumerary, was caring for patients and an agency nurse was also working.
- On Sarratt ward, we found that there were 14.9 whole time equivalent (WTE) registered nurse vacancies. Senior staff reported the staff turnover was 18% and the Board's Performance Report for March 2015 reported the staff turnover figure was 17%. Senior staff reported it was a daily "struggle" to ensure the nursing rota was covered.
- On our unannounced inspection on 17 May 2015, senior staff reported that seven out of 12 medical care wards were understaffed. Sarratt ward had been understaffed eight days out of the previous 17 days. The service followed trust policy for assessing risk due to staffing concerns, "rag rated" (red, amber, and green) and followed escalation procedures, which included flexing staff from other wards to minimise risk. Whilst on this ward, we had to alert nurses to attend to a patient in a side room who was trying to get out of bed. Their call bell was not within reach. A nurse attended to this patient once we had raised the concern.
- The trust provided data that showed between January 2014 and November 2014 agency nurses formed an average 21% of the nursing workforce in the medicine division. There was a plan in place to recruit registered nurses from other areas of the UK.
- We found incidents reported where agency nurses had not always delivered appropriate care to patients. For example, on Tudor ward where 21 of the 25 registered nurses were agency, there was an incident where an agency nurse failed to complete clinical care plans and basic patient care had not been provided. Another incident showed that a nurse who spoke limited English did not understand that she needed to care for additional patients and therefore three patients were not given medication during the shift.
- We found evidence that transferring registered nurses between wards where they did not always know the clinical protocols resulted in patients receiving delayed assessments. For example, a nurse who had been transferred to Gade ward for a shift was not aware that there was a haematology doctor on call. When a haematology patient deteriorated the nurse called the junior doctor for medicine rather than the specialist doctor. This meant that the patient had a delay in specialist care. The ward sister told us that they now tried where possible to get staff familiar with the ward or completed a local induction with staff.
- In some medical wards, we found extensive use of bank and agency staff, with some wards, for example Tudor ward, having a quarter of all shifts filled by temporary staff. We looked at the staff rota and staff told us that for all seven night shifts up to the inspection on 15 April 2015 there had been no permanent nursing staff on duty at nights. The trust provided further information that showed that for these seven nights, two shifts had one permanently employed nurse on duty, four nights were covered by bank nurses and one night was covered by agency nurses.
- Trust had a process for ensuring agency staff had an induction process. However, we checked staff induction

records at the unannounced inspection on 1 May 2015 and found six out of eight temporary staff working on Tudor and Sarratt wards did not have a competed trust agency induction checklist on file.

- During our unannounced inspection on 1 May 2015, we found staffing pressures on Sarratt ward (despite the trust having taken action to address the staffing pressures on this ward by closing six beds) and Croxley wards; with a high use of agency with no evidence of written induction. We raised this as a concern on the day of this visit. On our unannounced visit on 17 May 2015 we found evidence of agency staff inductions on file but these did not include ward security procedures and safe storage of clinical equipment. The trust subsequently informed us that a new temporary staff induction process was now in place and that frequent audits had been carried out to ensure this process had been followed and recorded. According to trust audits, only 39% of temporary staff in the service had evidence of an induction on 15 May 2015 and this had improved to 81% on 26 June 2015.
- In some areas staff were being constantly moved on a day by day basis to address shortfalls elsewhere staff found this unsettling to the continuity of teams and the care provided to patients.
- The trust informed us that there was focus on targeted nursing recruitment campaigns including overseas recruitment. As a result of the recruitment campaign they were anticipating 172 new nurses to join from September 2015. The latest nursing vacancy rate was 15% in May 2015.

Medical staffing

- Locum doctors formed a significant proportion of the medical workforce. Between March 2014 and January 2015 locums accounted for 36% to 50% of consultants working in care of the elderly; 20% to 29% of acute care physicians; and 6% to 14% of junior doctors working within general medicine.
- Out of hours there was one registrar and two junior doctors for medicine. On Saturdays and Sundays there were three consultants covering AAU and ambulatory care. At night there was an on call consultant.
- There was a doctor available to care for the medical patients on non-medical wards.
- Doctors used an electronic handover system. They told us that this had improved communication between medical teams as doctors all used a single record.
- At the time of the inspection, there was no dedicated hospital at night team, but we found on a later unannounced inspection on 1st May 2015, that this team had been set up. We observed the handover from day doctors to the hospital at night team and saw that is focused on patients at risk across specialities.
- The NHS Deanery, a regional organisation responsible for postgraduate medical and dental training, had provided information that it had removed educationally approved registrar training due to their workload and lack of consultant supervision and reported a lack of consultant cover on Fridays. Consultant support was generally perceived by junior doctors to be variable. At weekends, junior doctors not infrequently sought advice from other hospitals.

Major incident awareness and training

- Staff could describe the major incidents policy and there was a link to the policy on the trust intranet home page.
- Flexible medical capacity wards, such as Tudor ward, opened during periods of high bed occupancy to provide additional patient beds.

Are medical care services effective?

Requires improvement

We found the effectiveness of the service required improvement.

Most staff understood the concept of Deprivation of Liberty Safeguards (DoLS). However, we found one example where a patient had been unlawfully restrained without a mental capacity assessment and DoLS in place.

There were insufficient competencies to ensure staff had the right skills to complete tasks, especially within cardiology and respiratory services.

Nursing care plans were not generally reflective of patients' assessed needs.

We saw evidence based care and treatment within the trust. Although the division was unable to provide a local audit plan and details of local audits undertaken in the

previous six months. Outcomes of patient care and treatment were variable. We saw evidence of local audits where national guidance was compared to trust practices and associated action recommended.

In the main we saw good multidisciplinary working. However, there was a lack of urgency for some services to move to seven day working.

Evidence-based care and treatment

- The tissue viability team told us that the 'Best Shot' pressure ulcer care plans were based upon the NHS 'stop the pressure' campaign and April 2014 NICE guidelines (CG179). The team told us that the care plans had been peer reviewed by clinical nurse specialists (CNS) and dieticians to ensure best practice across multiple disciplines. Ward staff told us that they had felt engaged with the implementation of the care plan.
- In cardiology we saw evidence of NICE guideline updates and local audits that compared national guidance with trust practices. For example, there had been an audit of 40 inpatients that required direct current cardioversion (a corrective procedure where an electrical shock is delivered to the heart to convert, or change, an abnormal heart rhythm back to normal sinus rhythm). This concluded current practises did not need to change but polices and pathways were to be reviewed to ensure early identification of patients requiring direct current cardioversion. However, we saw no evidence that policies and pathways were reviewed.
- Endoscopy services were Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accredited in January 2014. JAG found the service met the accreditation standards framework such as policies, practices and procedures.
- The medicine division was unable to provide a local audit plan and details of local audits undertaken in the previous six months.
- We found trust policies and guidelines available on the intranet, such as medicines management and insulin pump therapy guidelines. We asked two ward nurses to locate these on the intranet which they were able to do.

Pain relief

- We saw nurses asked patients if they were in pain, identify the location of the pain and deliver pain relief medication where necessary.
- None of the patients we spoke with told us that they were in pain.
- In the National Cancer Patient Experience Survey 2014, the trust scored in the top 20% of trusts nationally for patients feeling that hospital staff did everything to help control pain all of the time.

Nutrition and hydration

- One patient commented, "The food is excellent". Whereas another patient told us, "You never get what you ask for".
- On the stroke ward, we found patient food such as cheese, tuna and double cream that had expired best before dates. We reported this to a registered nurse who disposed of the food. The nurse told us that it was the housekeepers' responsibility to check the food.
- There was a nutrition support worker who worked weekdays on the stroke ward. They told us that they liaised closely with nurses, Speech and Language Therapists (SLT) and dieticians to help patients meet their nutritional requirements in a safe way. All of the ward staff commented about the essential role of the nutrition support worker on the ward and the difference they made to patients.
- Patients who were nil by mouth had signs above their bed to alert staff not to offer the patient any food or drink.
- On Sarratt ward, we found two out of five patients' records that we looked at, Malnutrition Universal Screening Tool (MUST) risk assessment had not been recorded correctly, as the patient had not been weighed. This meant that their nutritional status had not been assessed correctly. We raised this concern with the senior nurse on duty, who took action to ensure these risk assessments were completed accurately.

Patient outcomes

- The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than expected. There had been a focus on understanding and reducing the trust mortality. According to the Board's Performance Report for March 2015, the HSMR was 83.6, which was much better than the national target of 100. The HSMR had reduced from 85.8 to 83.6 over the previous three months. It was acknowledged an element of this reduction was due to better reporting

and data management. The trust had taken a series of actions that had led to substantial improvements to mortality over the past three years that put the trust as one of the best 15% nationally.

- The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. According to the Board's Performance Report for March 2015, the SHMI was 90.3, which was better than the national target of 100. The SHMI had reduced from 97.6 over the previous three months. It was acknowledged an element of this reduction was due to better reporting and data management. The trust had taken a series of actions that had led to substantial improvements to mortality over the past three years that put the trust as one of the best 15% nationally.
- The overall trust score for the Sentinel Stroke National Audit Programme (SSNAP) between July 2014 and September 2014 was a 'D'; the score relates to 'A' being the best and 'E' being the worst. The trust performed better than the national average for patients having thrombolysis treatment (to remove blood clots) within one hour of admission. The trust performed better than the national average for the proportion of patients directly admitted to a stroke unit within four hours of clock start despite staff informing us that the beds were not always available. However, the trust was not meeting its own 90% target for patients being admitted to the ward within four hours, instead achieving 81% between April 2014 and March 2015. The trust was unable to provide data to demonstrate when stroke beds were required but unavailable.
- The trust was worse than the national average for having rehabilitation goals agreed within five days, and for the proportion of patients assessed by a physiotherapist, SLT and occupational therapist within 72 hours. We saw the April 2015 action plan for stroke services. There were clear improvements to the service completed, for example all emergency department consultants had been trained in thrombolysis which had improved the audit results. However, the action plan made no reference to improve therapy assessments within 72 hours to improve patient outcome.
- The trust performance in the September 2013 National Diabetes Inpatient Audit (NaDIA) was variable with some results better than the England average, such as foot risk assessments within 24 hours of admission; and other results worse than the England average, such as medication errors. We saw evidence of the service undertaking further local audits to identify key issues regarding medication. Recommendations from audits were made, such as improved staff education. We saw evidence that the diabetes team offered multiple training sessions for nurses, midwives, doctors and presented at the grand round to update and teach staff about diabetes care.
- The Myocardial Ischaemia National Audit Project (MINAP), MINAP 2013/14 showed the trust performed better than the England average for non-ST-elevation infarction (nSTEMI) patients seeing a cardiologist or team member and for patients being referred for or receiving an angiography (a medical imaging technique used to visualise the inside of blood vessels and organs). However, the trust performed worse than the England average for nSTEMI patients being admitted to a cardiac unit or ward. The trust had not submitted any data for the thrombolytic door to needle time.
- Therapy services were in the process of developing clinical key performance indicators for patient outcomes. At the time of our inspection there was no inpatient outcome data to review.
- The length of stay for elective medical patients was longer than the England average between June 2013 and July 2014. For example, average length of stay within clinical haematology was 14 days compared to the England average of 6 days. The trust highlighted that elective haematology admissions would have been for patients undergoing treatment for acute leukaemia and a higher chemotherapy dose prior to stem cell collection, therefore, felt that this accounted for the higher length of stay.
- The length of stay for non-elective patients was almost a day shorter than the England average across medicine. For instance, within general medicine patients stayed 5 days compared to the England average of 6 days.
- Nursing care planning was variable across the service. On Sarratt ward, we found one patient who was living with a dementia did not have a completed "This is me" information document or a defined nursing care plan as to how to manage this patient's physical and mental health needs.

- We found for all patient records that we looked at that there were not always defined nursing care plans in place for staff to follow to be able to meet the assessed needs of the patients. There were not clear moving and handling plans for staff to follow, aside from the initial risk assessment. Care plans were not generally person centred and did not give clear guidance for staff to follow. Senior staff told us there was a care plan working group to look at the whole assessment and care planning systems in the service, but that as yet, there was no defined timescale for the completion of this review.
- We saw that 81% of patients had their symptoms discussed at the multi-disciplinary meetings, against the England and Wales average of 96% in the lung cancer audit.

Competent staff

- Staff in the discharge lounge told us that they had no clinical supervision. We spoke with their non-clinical manager who admitted that they did not know what clinical supervision was. There was no local induction for new staff in the discharge lounge.
- Staff on Aldenham ward told us that the non-invasive ventilation (NIV) nurse practitioner had left the trust and the post had not been replaced. This meant that since 2012 no staff had completed NIV competencies, been assessed to ensure their practice was correct or had any ongoing review of their competencies. A study day had been planned for May 2015 to address this.
- The lack of cardiac skilled nurses on AAU was highlighted on the risk register, which did not reference training staff in cardiac competencies to resolve this concern. After the inspection the trust provided the progress report following the cardiac move into AAU in October 2014 that reported a staff skills gap analysis had been completed and identified nursing staff required training in managing cardiac patients. It reported that a training programme was implemented, that all staff had been trained and no issues had been raised since January 2015. However, during the inspection two senior nurses told us that the current situation was unsafe and there was no confidence in the nursing staff to do the job properly.
- The tissue viability team told us that they offered monthly study days for registered nurses and that they were planned to introduce 'skin champions' in the trust to provide ward level advice. They provided micro teaching sessions on request to staff groups such as physiotherapy and midwives. However, there were no competencies in place for staff regarding tissue viability.
- The tissue viability team told us that they received regular one to ones and that some staff within the team were being supported to complete a degree course with tissue viability elements. They told us that they were able to attend study days such as Wound UK.
- There was monthly in-service training for therapy services to update staff on new guidance. The process of therapy supervision was being reviewed. We were told this was part of the trust workforce efficiency programme. Some therapists told us that they felt this would result in reduced supervision.
- Physiotherapy and occupational therapy had band five competencies in place. However, there were no competencies in dietetics.

Multidisciplinary working

- The majority of staff reported good multidisciplinary team working. There were good ward links with specialist services and we saw patients being referred to services such as tissue viability and diabetes.
- However, some staff told us that a small number of consultants did not always listen to therapists about patient care. For example, we saw evidence where a consultant had discharged a patient where a therapist had felt the patient was not safe for discharge. This had been reported as an incident.
- There was partnership working between Macmillan Cancer Support and trust cancer services. The lead cancer nurse told us about team leader clinical nurse specialist posts and a planned team building day that had been funded by Macmillan Cancer Support.
- There was a nutrition team that included a pharmacist, consultant, dietitian and nutrition nurse. They worked together to treat patients that required specialist nutritional management, such as total parental nutrition (a method of administering nutrition into the body through the veins).

Seven-day services

- There was a transient ischaemic attack (TIA) service four days a week. If patients had symptom onset during service times, staff were able to see patients within 24 hours for specialist assessments and investigations, this

was in line with National Institute for Health and Care Excellence (NICE) stroke guidance 2008. However, outside of service provision, patients would have to either be admitted or go to another local acute hospital.
- There was a stroke clinical nurse specialist on call 24 hours seven day a week.
- The cancer clinical nurse specialists and the tissue viability team worked Monday to Friday, with some extended late night practices. There were no plans to implement seven day working for either team.
- Physiotherapy provided an out of hours on call service for urgent patients, for example patients requiring urgent chest physiotherapy. Physiotherapists and occupational therapists could volunteer to provide a weekend service in AAU to help facilitate discharge but this was not essential practice.
- Therapy services had been recently (April 2015) been successful in gaining additional investment to support seven day working following a business case in 2014/15. However, this had not been implemented, the model for service delivery had not been developed and no staff consultation had happened.
- The discharge lounge was open Monday to Friday 8am to 8pm, then Saturday and Sunday 10am to 5pm.

Access to information

- Staff could access further clinical guidelines and pathways on the trust intranet.
- The tissue viability team told us that they had updated the tissue viability policy in March 2015 but that the incorrect version had been uploaded onto the intranet. They reported that this had been raised with the information technology department but it had not yet been resolved. This meant that staff did not have access to the most up to date policy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff obtained verbal consent before carrying out patient interventions.
- Most staff understood the concept of Deprivation of Liberty Safeguards (DoLS) and could give examples of where the safeguards should be applied or considered.
- We looked at the notes of a patient on AAU. Staff had called the police as the patient was at risk of endangering themselves and others. The patient had been physically restrained by the police and chemically restrained by staff with no mental capacity assessment or DoLS completed. An incident report had been completed the following day that stated the action taken was that doctors had been advised to complete a mental capacity assessment. The incident outcome had been marked as a 'near miss'.
- The day following the incident, the patient was seen by the adult safeguarding lead nurse who documented, "concerned as patient has been unlawfully restrained overnight", "and sedated with no mental capacity assessment taken place and DoLS applied for". The adult safeguarding lead nurse then completed the DoLS application. This meant that the patient had been restrained without appropriate assessments in place.
- We saw another mental capacity assessment and DoLS application in place for a patient on coronary care unit that was promptly and correctly completed.

Are medical care services caring?

Good

We found that the service was good for caring overall.

Most patients spoke positively about the staff and the care they received. They told us that they received good quality care and that they were treated with respect and dignity.

The NHS Friends and Family Test in March 2015 showed that 93% of the medicine inpatient respondents said that they were either likely or extremely likely to recommend the trust to friends and family.

However, not all patients had drinks within reach and we found examples where privacy was not always respected.

Compassionate care

- We saw staff speak with patients in a respectful way, engaging and laughing with patients. Patients felt that their privacy and dignity was respected by staff.
- On Croxley ward staff demonstrated a sensitive approach when assisting people who were confused and upset due to living with dementia.
- We carried out a Short Framework for Inspection Observation (SOFI) on Sarratt ward and found that the majority of staff interactions with the six patients' we observed were positive and respectful. However, we did see two instances where staff put items in the patient's

bedside drawer without speaking to the patient, who was looking at them, We also saw once example when a nurse entered the bay are a and shouted across the bay to other staff, ignoring the six patients in the bay.

- Most patients and carers we spoke with told us that they were happy with the care they received. One patient commented, "I cannot fault the care in anyway"; another said, "Staff are extremely kind and very patient"; and another commented, "Staff are incredible and wonderful people". One patient on Croxley ward told us that they had difficulty getting a bottle to urinate in and that if they had a pad this would be left wet. The patient blamed this on poor staffing levels.
- The NHS Friends and Family Test had a 41% response rate for medical inpatients. The March 2015 results showed that 93% of the medicine 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%.
- All patients that responded on behalf of Gade, Cassio, AAU and the stroke ward all recommended the trust to friends and family. However, 9% of patient respondents on the red suite within AAU were either unlikely or extremely unlikely to recommend the wards.
- We audited if patients could reach their call bell on Gade and the stroke ward. We found five out of five patients on Gade; and 11 out of 14 patients on the stroke ward were able to reach their call bell. This meant that 84% of the patients we observed were able to alert staff using the call bell system if they needed help.
- We audited if patients had a drink within reach on Gade and the stroke ward. We found four out of five patients on Gade; and 6 out of 14 patients on the stroke ward had a drink within reach. This meant that 53% of the patients we observed were able to reach a drink.

Understanding and involvement of patients and those close to them

- On entering each ward there was staff uniform information to inform patients and visitors of each staff member's role so patients and relatives could identify the roles of staff.
- We saw staff explaining to patients the treatment and care they were delivering.
- We saw evidence of families being involved in patient care and discharge. For example, within the stroke services there were planning meetings involving family members.
- Most relatives told us that they understood the treatment plans of their loved ones. One relative told us that, "Staff are too busy to communicate with visitors".

Emotional support

- We saw thank you cards, expressing the gratitude of patients and relatives for the kindness and support they had received.
- In the National Cancer Patient Experience Survey 2014, the trust scored in the bottom 20% of trusts nationally for patients feeling that their CNS definitely listened carefully the last time they had spoken; that they got understandable answers from their CNS to important questions most of the time; and that they were able to discuss worries or fears with staff. The cancer patient survey action plan noted that all established CNSs had now attended an advanced communication course and new staff had booked onto the course, with the aim to improve their communication skills. The trust scored in the top 20% for patients knowing their CNSs name and for being given written information about the type of cancer they had.

Are medical care services responsive?

Requires improvement

Overall, we found the service required improvement for responsiveness.

There were high levels of bed occupancy due to pressures on patient flow within the hospital. We found medically fit patients across medicine awaiting social care packages. We saw some evidence of the trust working with the local health economy to promote patient flow.

Medical patients on non-medical wards had a dedicated medical team caring for them and there were admission checklists for medical patients being transferred to non-medical wards. We found evidence that checklists were not always followed and clinically inappropriate patients were transferred. We found evidence that patients were discharged home and transferred to wards after 8pm and in some case after 10.30pm.

The trust failed to collect data to demonstrate how responsive or effective the Helen Donald Unit was to patient needs or how responsive therapy services were to inpatient referrals.

Bluebell ward organised activities for patients. However, we found a lack of activities for patients on other wards.

Service planning and delivery to meet the needs of local people

- The trust alongside the wider local health economy partners had piloted a 'super discharge week' in March 2015. The week was based on the Emergency Care Intensive Support Team concept of a "perfect week". The aim was to implement small changes, system wide, to improve patient flow within the system. Therapy services increased the workforce of two care of the elderly wards (red suite and Oxhey ward). The outcome showed that there were an increased number of discharges, Elizabeth ward (a gynaecology ward) had a reduced number of medical patients and length of stay across the trust was reduced. Recommendations were made from the pilot to facilitate discharge during usual practice.
- The diabetes team told us that they had regional strategic review meetings with the community services to ensure that diabetes patient pathways met patient need throughout the local health economy.
- Inpatient chemotherapy had been suspended in 2014 due to insufficient numbers of trained nurses. The chemotherapy training and development nurse told us that they had a plan in place to provide chemotherapy training and annual updates for staff. The aim was that inpatient chemotherapy would be re-implemented once enough nurses were competent. This risk had been highlighted on the risk register.
- The dementia care team had implemented a delirium recovery programme which aimed to reduce length of stay, readmissions, antipsychotic prescribing and promoted cognitive and physical functioning by cognitive enablement and health and wellbeing for patients. This allowed patient's the opportunity to return home with up to three weeks of 24 hour live in care. The outcomes clearly demonstrated that the majority of patients with delirium went home with the programme in place when usual care would have predicted placement from hospital directly. Most patients recovered to a sufficient level to stay at home. The team were writing a report of the programme in the hope that this would be published.

Access and flow

- Between January 2015 and March 2015 the average number of medical patients admitted each day was 79. This had increased month upon month.
- During the week ending 05 April 2015 the trust's bed occupancy was 97%, above the trust target of 90%. There had been no significant change in bed occupancy compared to the previous week. The Dr Foster Hospital Guide 2012 identified that occupancy rates above 85% could start to affect the quality of care given to patients and the running of the hospital more generally.
- There were more medical inpatients than there were medical beds. This was managed by using beds on the surgical wards, usually Letchmore ward. This had changed in the last year to enable medical patients to be grouped together on Letchmore ward rather than spread throughout the hospital. Staff reported that this had improved patient care. We found three medical patients on Letchmore ward all under the same consultant. This meant that the ward surgical team knew which medical team to contact for all medical patients.
- Between September 2014 and December 2014 there was an average of 33 medical patients outlying in general surgery and six in trauma and orthopaedics. Medical patients on non-medical wards were cared for by a medical outlier doctor, but nursing care varied between medical and surgical nursing staff.
- There was an admission checklist for medical patients being transferred to Elizabeth ward and Tudor ward. The checklists aimed to identify medically stable patients suitable for transfer. However, we found evidence that checklists were not always followed. For example, the incident reports on Tudor ward showed that four patients had been transferred between 20 January 2014 and 23 March 2014 that did not meet the admission criteria. In addition to these patients, six other reported incidents demonstrated that there were patients on Tudor ward that did not meet the wards criteria, for example patients with diarrhoea, and patients who were aggressive or wondering.
- The trust recognised that there were some delays in discharge. Nurses told us that some wards had a dedicated social worker to facilitate discharges, such as Gade ward. However, other wards, such as Heronsgate did not.
- On Gade ward we found seven patients and on Sarratt ward we found eight patients medically fit for discharge awaiting social care packages. On Croxley ward nurses

told us that the social worker was on holiday for five weeks and no full-time cover was in place. Therefore, discharges were arranged by other social workers if they had capacity. Of the 28 beds on Croxley, 10 were occupied by patients medically fit for discharge.

- Clinical nurse specialists (CNS) told us that there were limited rooms available and suitable on wards to break bad news to patients. This meant that providing confidential emotional support for patients and their family was difficult.
- The Helen Donald Unit was a nurse led medical day unit that provided six couches and 12 chairs for patients that were fit enough to avoid admission yet required intravenous treatments such as chemotherapy and blood transfusions. However, data to show the responsiveness of the service or how the service benefited patient flow within the trust was not collected.
- The trust provided data that showed between April 2014 and December 2014, 75% of patients experienced no ward moves during their admission. Nineteen percent of patients experienced one move, 5% two moves and 1% three or more moves.
- We found evidence in the admission and discharge book on the coronary care unit that between 01 March 2015 and 14 April 2015 nine patients had been discharged home after 8pm. Six patients had been transferred to other wards after 8pm and a further three patients had been transferred after 10.30pm with the latest being 11.20pm. Bed managers told us that the trust policy was not to move patients after 8pm.
- Staff in the discharge lounge told us that patients often waited eight hours in the lounge until they were discharged. We saw an example of a patient the week prior to our inspection who was admitted to the lounge at midday and their discharge was delayed due to no discharge summary being completed and no take home medication arranged. The patient was discharged at 8.30pm.
- The trust did not collect referral to treat times for therapy inpatient services, except for SLT which was provided by a service level agreement. Between April 2014 and March 2015, SLT met the Royal College of Speech and Language Therapists national standard target of assessing all patients referred within two working days. However, for all other therapy services, the trust could not evaluate how responsive the services were.
- The standard was for patients to receive five treatment sessions per week for SLT, occupational therapy and physiotherapy. This information was collated on a paper system. The aim was to establish the gap between service need and service delivery. The trust provided data for the month of December 2014 that showed SLT were meeting 50% of patient need, occupational therapy were meeting 35% of patient need, and physiotherapy were meeting 37% of patient need. The trust was unable to provide more recent data as there was a delay in inputting the data in to the electronic spreadsheet due to poor administrative capacity.
- On AAU, the occupational therapy and physiotherapy service worked at an integrated team that endeavoured to see all patients referred who were medically stable on the day of discharge to ensure that they had all the necessary support in place. The March 2015 results showed that they met this target for 99% of patients, 84% of those were seen within one hour of referral.
- The report states that In the Board's Performance Report for April 2015, the percentage of patients treated within 62 days of GP urgent referral for suspected cancer was 76.4% against the trust target of 85%. The trust cancer committee meeting minutes showed that risk, governance and clinical pathways were regular agenda items. On the cancer survey action plan, there were no agreed performance indicators for the 17 actions identified. This meant that actions could not be easily evaluated to establish if they had resulted in improvements.

Meeting people's individual needs

- The trust had a dementia awareness team. We saw initiatives by the Alzheimer's Society were in place such as the 'This is me' booklet and signs behind patient's beds to identify and meet the needs of patients living with dementia. However, on the stroke ward we saw the 'This is me' booklet in place for a patient living with dementia was not completed.
- Bluebell ward was the hospital's designed dementia care ward and organised activities for patients to participate in, such as gardening or bingo. However, we found a lack of activities for patients on other wards.
- 'Look good, feel good' events were being planned for October 2015 to help support patients living with cancer.
- Bariatric equipment was available.
- A translations service was available for non-English speakers. Staff reported that this service was effective.

- Patients had a choice of meals. Meals to meet cultural and clinical requirements were available, 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.
- We saw examples where privacy could be compromised. For example, a toilet door lock on the stroke ward was missing leaving a hole. This meant that patients could not lock the door and that people could peer from the ward into the toilet compromising patient privacy. The sister told us that this had been reported to estates but was unable to produce the risk assessment for the toilets use when we asked.

Learning from complaints and concerns

- We saw patients were given a welcome pack on some wards to provide information about the ward including the complaints process.
- We saw literature about the complaints procedure and information about the patient advice and liaison service (PALS) on display on most wards.
- We asked for but were not able to see evidence of complaints received by the trust. Staff explained that they would always try to resolve informal complaints on the ward. Formal complaints were directed to PALS who initiated an acknowledgment. The complaint was then passed to the relevant person in the unit to respond fully.

Are medical care services well-led?

Inadequate

Overall, we found the service was not well-led and was rated inadequate.

Trust vision and values were not well embedded at local level. We were not provided with or assured that the medical division had a local vision or strategy for the service. There was a lack of strategic and succession planning.

Staff satisfaction was mixed. Most staff enjoyed working at the trust whereas others felt under pressure due to staff shortages. There were recruitment issues across medicine, with almost 200 whole time equivalent vacancies in March 2015.

The arrangements for governance and performance management did not always operate effectively. Risks were not always identified and robust risk management and actions were not always recognised or implemented where performance could be improved.

We found examples of innovation within medicine. In most services patient feedback was sourced and actions taken where areas could be improved.

Vision and strategy for this service.

- Some staff were aware of the trust's vision and values, whereas others could not describe what these were.
- We were unable to speak to all the medical leaders of the division due to staff being on leave. We were not provided with or assured that the medical division had a local vision or strategy for the service.
- Therapy managers told us that they had team objectives for the year based upon the trust's strategic plan. We requested a copy of the objectives but the trust did not provide this. Therapy services had no annual plan.
- There was no strategic plan or succession plan in place for the tissue viability team.
- The diabetes teams had documented aspirations to improve patient care. However, these had no timelines for completion associated.

Governance, risk management and quality measurement

- We found that not all risks had been identified on the risk register, for example, incorrectly completed NEWS, the emergency procedure at the Schrodells Unit, or staff in cardiac competencies. Other risks such as no piped oxygen of the respiratory ward had been opened for five years despite estates being due to install outlets in December 2014.
- Lack of nursing competencies in NIV and cardiology threaten the delivery of safe and effective care, there had not been adequate action to manage this.
- Minutes of the monthly medical divisional governance and quality group meetings showed that there were discussions and actions planned around safety and quality improvements, clinical effectiveness and patient experience. The minutes of the meetings did not always state the outcomes from discussions. For example, when the incorrect NEWS relating to cardiac arrests were discussed at three consecutive meetings there were no actions documented from this.

- We saw two meeting minutes of bi-monthly bone health and falls group attended by local service managers, which discussed falls data and policies. It was noted that since the previous risk lead for medical division had left the trust, files had been deleted and therefore the group had been unable to obtain the minutes of the previous bone health and falls group meetings. Hence, the group could not refer to previous actions required. The minutes showed inconsistent agenda items and there was a lack of attendance at meetings. For example, the minutes in September 2014 demonstrated falls data had been reviewed, however, there was no detailed outcome documented of themes or root caused analysis of falls. At the February 2015 meeting there was no documented discussion of falls data. The February 2015 minutes indicated that only five staff attended the meeting compared to 15 at the September 2014 meeting. The November 2014 meeting had been cancelled due lack of participation. This demonstrated variable ability of staff to attend.
- The trust cancer committee meeting minutes showed that risk, governance and clinical pathways were regular agenda items.
- On the cancer survey action plan there were no agreed performance indicators for the 17 actions identified. This meant that actions could not be easily evaluated to establish if they had resulted in improvements.
- The lead cancer nurse told us that they could not access and analyse data immediately and would have to request data from the system administrators which took over 24 hours to respond. In the November 2014 trust cancer committee meeting minutes it is noted that, "there is no method of achieving an accurate position for cancer submissions, COSD (cancer outcomes and service dataset) data and cancer audit data, as very often information is unreliable". This meant that managers did not have immediate access to their services own current data and that data may not be accurate. The limitation of information systems was rated amber on the January 2015 cancer improvement action plan and a plan was in place to address this, although the delivery date for this was January 2015.
- 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. The existing area for providing stroke rehabilitation was displaced and three inpatient beds were established. This resulted in a smaller area available for therapists to undertake inpatients therapy, not enough equipment for all patients, such as oxygen facilities and risked poorer patient outcome. This had been highlighted on the risk register. Therapists and matrons told us that they had appealed against the decision to use the area for inpatient beds but felt their voices were not heard. One staff member commented that they felt: "bullied" by an executive to implement the plans.
- Therapy managers could not measure the effectiveness or responsiveness of the service. They did not always collect required data or had access to the most recent data due to lack of administrative support. Data was not added to the electronic system in chronological order and the last data available was from December 2014. Therapy managers had noted that the system was not ideal however; they did not feel this was a risk to their service and had no plan in place to address this issue. This meant that the service had poor quality measures four months out of date.
- Therapy managers and the chief pharmacist who was accountable for the service admitted that governance, risk management and quality measures could be scrutinised and challenged better within the service.

Leadership of service

- All managers told us that they were proud of their teams and recognised that staff worked hard within their roles.
- Some staff told us that they did not know the structure of the organisation.
- Ward sisters were meant to work in a supervisory manner. However, due to staff shortages three sisters told us that this rarely happened. This meant that local leadership was compromised.
- There was a week day ONION meeting were staff could take concerns and get a response, or share changes within services. Most staff reported that this was a positive forum where changes could be quickly implemented.
- Leadership in respiratory, especially NIV support, for both nursing and medics had been compromised due to unfilled posts. However, a new clinical lead for respiratory medicine had been appointed.

Culture within the service

- Most staff reported that they were happy working at the trust.
- Staff told us that recruitment and retention was a problem within the trust. Some staff believed that

nurses had left the trust due to increased work pressures. Nurses in some areas expressed low levels of satisfaction, high levels of stress and work overload and in some cases were clearly distressed and tearful.

- In March 2015 there were 198 whole time equivalent (WTE) staff vacancies within the division of medicine. Of these, nursing staff accounted for 171 WTEs and medical staff accounted for 14 WTEs. Vacancies had risen since January 2015 from 183 WTE. Recruitment from other countries was underway for nurses but senior nurses admitted this was slow. There was a lack of urgency to reduce vacancy rates within medicine.
- Staff within therapy, tissue viability, diabetes and cancer services reported a lack of clerical and administrative support.
- The 2014 staff survey showed that the number of staff who had experienced harassment, bullying or abuse from colleagues in the previous 12 months was 26%, worse than the England average of 24%. This was most noticeable on Croxley, stroke and Sarratt wards where 36%, 30% and 29% of staff reported they had experienced harassment, bullying or abuse from colleagues in the previous 12 months respectively.
- The survey showed that 4% of staff reported that they had experienced physical violence from colleagues in previous 12 months. This was 1% worse than the England average. Survey results showed this was most evident on Cassio and Sarratt wards with 23% and 29%, respectively. None of the staff that we spoke with told us that they had experienced physical violence in the workplace.
- The trust's workforce committee considered the key findings of the report alongside an overview action plan to reflect divisional ownership for local action plans. Actions to address specific issues, in particular to bullying and harassment, and staff feeling uncomfortable to report incidents, were planned.
- Some band five and six staff did not feel supported by their managers. Some told us that they had personally experienced or had witnesses bullying or aggressive receptions from consultants. They told us that this had been reported to their seniors. Some managers told us that they were aware of some conflict between staff and consultants earlier in the year, but they had not checked the outcome or ensured the current health and wellbeing of staff concerned.

Public and staff engagement

- There were 'You said, we did' comments on display boards on each ward. For example, on Gade ward one comment from a patient stated that the ward was too hot. In response the ward purchased 17 fans to cool patients.
- Each ward board displayed their 'I want great care' score. For example, Sarratt ward scored 4.69 out of 5 for March 2015. Patient comments included, "Care was excellent, staff were considerate".
- There were memory trees on wards that encouraged patients to feedback their inpatient experience. AAU tree comments included, "Very calm friendly staff"; "Excellent professional care".
- The trust webpage stated that in 2012 "the discharge lounge has been given a facelift, in line with the trust's target to improve the overall patient experience". Staff on the discharge lounge told us that they had developed questions for a patient satisfaction survey which had been given to their manager to complete. However, they had received no response which meant that they had no patient feedback measure to evaluate the overall patient experience.

Innovation, improvement and sustainability

- We saw evidence of the trust promoting health with lanyards and pens promoting the avoidance of sepsis and pressure ulcers.
- For world sepsis day (13 September 2014), the sepsis team launched a 'sing-along' video called 'Stamp Out Sepsis' (SOS), sung in time to a well-known song. This was an innovative method that aimed to raise awareness of sepsis and encouraged staff to remember six actions that could improve patient outcome. The video was accessible on the internet.

Surgery

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

Information about the service

Surgical services provided by West Herefordshire Hospitals NHS Foundation 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. Watford General Hospital had eight operating theatres, three of which were used for women's and children's services. There were also five surgical inpatient wards.

The hospital provided a range of elective and unplanned surgical services for the communities it served. This included trauma and orthopaedics, ophthalmology, urology and general surgery. On the days of our visit all of the theatres were in use. The service had a day surgery unit which enabled people to have minor procedures without having overnight stays in hospital.

Watford hospital undertook 28,774 surgical spells for the period July 2013 to June 2014. Information provided to us by the trust stated that the activity level was 42% day-case, 29% elective, and 29% emergency patients.

We visited five surgical wards, four theatres, the recovery area and the emergency surgical assessment unit. We spoke with 22 patients and seven relatives. We observed care and treatment and looked at 12 care records. We spoke with 52 staff which included nurses, doctors, consultants, ward managers and therapists. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the hospital. We observed patient handovers, ward rounds and multidisciplinary team meetings.

Summary of findings

Improvements were required to ensure safe, responsive and well-led care and treatment for patients.

We found senior staff each had a vision for the service at local level; however there was a lack of combined objectives and strategy to achieve an improved service. There had been a number of changes in management in the previous 12 months and there were aspects of the service which were not being effectively monitored.

The hospital had five main operating theatres; however, one theatre was a converted plaster room which was a very small facility that was not of an adequate size. There was no anaesthetic room available and it was practice that parents accompanying children into this facility accessed the theatre directly in their street clothes. There was no procedure in place to address any risks for infection prevention and control regarding this practice.

Theatre five was poorly maintained. The walls were cracked, the floor was uneven and lighting was poor.

A further two theatres had issues with the ventilation system. The ventilation system should provide clean air movement within the theatres and ensure the filtration of air to prevent transfer of bacteria between procedures. This meant that there was an increased risk of surgical infections. An audit undertaken by the trust for the period April 2014 to March 2015 indicated that there had been no reported increase in surgical infections.

Surgery

The post-operative recovery area was very small and there were no separate recovery areas for adults and children.

We witnessed a disagreement between two staff that had the potential to affect patient care, as a doctor had asked a nurse to rush through their pre-operative assessment checks. The nurse refused and continued to ensure patient safety was not put at risk.

We had concerns about medicines management in some areas. We found intravenous fluids and medication stored on an emergency trolley which were openly accessible and could therefore be tampered with. This meant that medicines were not stored safely and securely to prevent theft, damage and misuse.

Emergency equipment was available on each ward and theatre areas and included medication, oxygen and a defibrillator. We saw that equipment checks had not always been carried out regularly in a minor operating theatre.

The surgical services provided effective care and treatment that followed national clinical guidelines. Staff used care pathways effectively. The services participated in national and local clinical audits. The service performed in line with services in similar-sized hospitals and performed in line with the England average for most safety and clinical performance measures. The service was taking action to reduce new pressure ulcers and slips, trips and falls. Infections following fractured neck of femur and following hip replacements were lower than national average.

Staff working in surgery services were passionate about the care they gave patients. Staff at all levels had a desire to provide safe, effective, caring and responsive care. Multidisciplinary working was evident. Staff had access to training and had received regular supervision and annual appraisal. We saw that staff were caring and compassionate to patients. Patients we spoke with told us that they had been treated with dignity and respect.

Are surgery services safe?

Requires improvement

The safety of surgery services was found to be requiring improvement

Patients were not always protected from the risk of avoidable harm and unsafe care and there was limited assurance about safety.

The hospital had five main operating theatres; however, one theatre was a converted plaster room which was a very small facility that was not of an adequate size. There was no anaesthetic room available and it was practice that parents accompanying children into this facility accessed the theatre directly in their street clothes. There was no procedure in place to address any risks for infection prevention and control regarding this practice.

Another theatre was poorly maintained. The walls were cracked, the floor was uneven and lighting was poor.

A further two theatres had issues with the ventilation system. The ventilation system should provide clean air movement within the theatres and ensure the filtration of air to prevent transfer of bacteria between procedures. This meant that there was an increased risk of surgical infections.

There was also no separate anaesthetic room for children. Children were therefore anaesthetised in theatre with their parents present, which increased the risk of infection.

The post-operative recovery area was very small and there were no separate recovery areas for adults and children.

The resuscitation trolleys, and medication stored on these, were not secure which meant unauthorised people had access to them as they were stored in public areas.

Staff told us they were encouraged to report incidents, and these were discussed at ward meetings and monthly quality meetings. A root cause analysis (RCA) was completed following incidents and robust action plans were developed.

The hospital's surgical safety checklist was fully completed for all patients. Patients were appropriately escalated if their condition deteriorated. Medical and nursing handovers were well structured.

Surgery

Infections following fractured neck of femur and following hip replacement were lower than national average.

We saw that nursing and medical staffing levels were good, and recognised tools were used to determine staffing levels. Systems were in place to ensure continuity of services.

Incidents

- Between February 2014 and January 2015, the Strategic Executive Information System (STEIS) data showed that there had been 46 serious incidents reported in relation to surgical services across the trust. During the inspection, we saw evidence that these incidents had been investigated and remedial actions implemented to improve patient care. The most frequently reported incident type was Grade 3 pressure ulcers. Other reported incidents included drug incidents and Clostridium Difficile and health care acquired infections.
- Staff in all surgical areas demonstrated their knowledge of the incident reporting process. We were told staff had direct access to the electronic system to enable prompt reporting. We saw a number of the surgical wards had developed newsletters to provide information about incidents and included reminders to staff about safety checks.
- The trust used a standard template to record and report incidents to ensure consistency of investigation and reporting of incidents. We saw examples of investigations undertaken by ward managers on Flaundon, Langley and Cleeves wards.
- We reviewed the minutes of care group governance minutes that discussed incidents and the actions required. These meetings occurred at specialty level within the care groups as well as at the care group level itself. Both senior managers and clinicians attended these meetings.
- We saw evidence of feedback to ward and theatre staff. Information was shared at handover, newsletters or through bulletin boards in staff areas.
- We spoke with four nurses and two health care assistants on Letchmore and Langley wards. They told us that they knew how to report incidents using the electronic reporting system. We found that RCAs of incidents and action plans were posted on notice boards in staff areas.
- Staff were able to tell us about the principles of the Duty of Candour regulations. They told us it was about being open and transparent with patients following incidents.
- Mortality and morbidity meetings were undertaken monthly and were well attended by all staff groups. Minutes of meetings were seen, cases reviewed and any learning points were identified and documented.
- NHS Safety Thermometer information was prominently displayed in the ward areas. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. This tool enabled wards and units to measure harm and the proportion of patients that were harm-free from pressure ulcers, falls with harm, urinary tract infection with catheters and venous thromboembolism (VTE or blood clots). The results related to the individual ward or area and showed results compared with the previous month.
- For surgical services, frequency rates of catheter urinary tract infections (C.UTIs) had remained low throughout December 2013 to December 2014. We saw there were five recorded C.UTIs during this period. The records showed that there had been no falls recorded from July 2014 and December 2014.
- The number of pressure ulcers had increased slightly over the services. There were 18 recorded incidents from February 2014 to January 2015. Care and treatment records showed that appropriate risk assessments were carried out upon admission to the wards and patients identified as being at risk had the appropriate care plans and supporting equipment (e.g. pressure-relieving mattresses) in place to minimise the risk of acquiring a pressure ulcer.
- The surgical service had a performance dashboard that it used to monitor the quality of care provided. Nursing care standards were measured by a system called Test Your Care which is a collection of nursing care indicators that monitor and improve the standard of patient care. There were nine groups of questions and each month 76 checks were made by two members of the nursing team. The overall percentage was displayed on the board on each ward. For example, we saw that for March 2015, Flaundon Ward had 85% and Langley Ward had 89% overall compliance with nursing care standards. The trust target was for wards to score 90% or higher to achieve 'green' status.

Cleanliness, infection control and hygiene

Surgery

- All of the wards we visited were visibly clean and cleaning schedules were clearly displayed on the wards. Equipment was cleaned and was marked as ready for use.
- Staff followed the trust infection control policy. We observed that staff regularly washed their hands in between patients, used personal protective equipment (PPE) such as gloves and aprons and adhered to the trust's 'bare below the elbows' policy in clinical areas.
- There was hand gel available throughout the wards and assessment units. A prompting system was found at every door entrance, which reminded everybody to decontaminate their hands prior to entry. All units undertook various infection control audits at local level. Wards openly displayed these findings on boards at entrances. Audits reflected good infection control practices, for example, Cleeves and Langley Wards had achieved 100% hand hygiene for the previous six weeks.
- The surgical wards, day surgery unit and theatres visited were visibly clean with the appropriate green 'I am clean' sticker on the equipment being used.
- All patients admitted to hospital were routinely screened for Methicillin Resistant Staphylococcus Aureus (MRSA) so that anyone who was found to be carrying the bacteria could be treated and, when required, isolated.
- There had been no recent incidences of MRSA and Clostridium difficile (C.difficle) reported within the surgery division. For example, we saw it had been over 12 months since a reported case of MRSA and 276 days since a reported case of C.difficle on Cleeves Ward.
- Managers and staff completed audits to check that bacteriological screening of patients had been completed prior to admission. All patients prior to elective surgery had been fully screened for hospital acquired infections.
- The day case surgery unit was very small. The unit had three cubicles with beds close together. The floor space between each bed was 80cm. This posed an infection control risk, as, for example, staff members would not be able to assist a patient to use a commode which measured 60cm in width. A theatre sister told us that trust policy stated that two staff members should assist a patient when they were in the cubicle.
- Effective decontamination of surgical instruments is critical in the management of healthcare associated infection and patient safety. Staff said they had no issues or concerns regarding the sterility of equipment.
- Cleaning staff described the process for dealing with contaminated waste. Numbered tag seals were allocated to individual staff who used these to seal the contaminated waste sacks before placing them in trolley skips that were collected by porters. The tags meant that any contamination from incorrectly bagged waste could be tracked.
- The information provided by Public Health England indicated that trust's surgical site infection rates from April 2013 to June 2013 for total knee replacement surgery was 0% which was better than the England average of 2%.
- Sharps bins were readily available and all other waste bins were clearly labelled and adequately located in clinical areas.

Environment and equipment

- The hospital had five main operating theatres; however, one theatre was a converted plaster room which was a very small facility that was not of an adequate size. There was no procedure in place to address any risks for infection prevention and control regarding this practice. This was accepted practice and we found no entry on the service risk register to address this risk.
- There was a further minor theatre close to the surgical admissions unit. We were told that this theatre was used one morning a week for lithotripsy treatment. Lithotripsy is a procedure used to treat kidney stones,
- Theatre five was poorly maintained. The walls were cracked and the floor was ripped and repaired in places. The floor was uneven and unable to support a large load. Lighting was also poor in this theatre.
- We were concerned about the ventilation in theatres one and two. The ventilation system should provide clean air movement within the theatres and ensure the filtration of air to prevent transfer of bacteria between procedures. The ventilation also regulates temperature. This meant that there was an increased risk of surgical infections. The trust's microbiology department had inspected the theatres and advised that surgery could continue as the airflow was, in fact, over-ventilating.
- The staff changing rooms and toilet facilities were poor. There was an exposed breeze block wall in the changing area and missing ceiling panels. There were no shower facilities. A shower cubicle was acting as a storage area. We noted that the missing ceiling panels were stored with clean scrub suits.

- The post-operative recovery area was very cramped. There were seven recovery bays for the five theatres, however, this reduced to five recovery bays if there was no room for patients to transfer to intensive care.
- There was also no separate children's recovery area which meant they were treated with adults. The Royal College of Surgeons guidelines recommend that there should be a separate recovery area for children. The divisional director for surgery told us that plans to convert theatre five into a paediatric recovery room had been approved by the board. This meant that the hospital would have separate adult and paediatric recovery areas.
- Changing facilities were very limited in the day case unit for patients preparing for surgery. We observed a patient being told to change into a surgical gown and put on compression stockings in the only available patient toilet in this area. The patient had difficulty putting on the stockings and came back across the corridor without shoes to ask nursing staff for help.
- The Emergency Surgical Assessment Unit (ESAU) had four bays and eight chairs for patients. There was a medical and nursing station behind a screened off area. There was very little privacy as the unit was small. When the unit was busy, patients and partners/carers had to sit by lift along the corridor as insufficient room. We were told there had been discussions to expand the ESAU, but a date had not been identified.
- An enclosed corridor, known as the 'tunnel' by staff, was built to transfer patients to and from theatre and the gynaecology wards, which are situated in a different part of the hospital site. We saw that the transfer took place along a corridor and two passenger lifts. One of the lifts was very narrow and not designed for an electric bed as staff could not stand alongside the bed. The lift had broken down on the afternoon of our visit and a member of staff advised that they had been trapped in the lift for 45 minutes. The trust reported that the lift has been measured and complied with the regulations at the time of installation. They advised that there was space for a standard hospital bed and two staff members.
- Staff said that there was a steep slope, described as 'difficult', when they exited the lift to return to Elizabeth ward in the gynaecology unit of the hospital.
- Two paramedics from the local ambulance service told us that they spend "a lot of their day" taking patients from the surgical wards to Castle Ward, a delayed transfer of care unit in another part of the hospital They said the tunnel was too narrow to take beds through and therefore they had to transfer patients between wards by transport ambulance.
- The trust told us that a tunnel currently under construction to move patients between buildings and was due to open in May 2015.
- The service commissioned regular safety checks for equipment. We found that equipment was in good working order and had been safety checked.
- Emergency resuscitation equipment was available in all the areas we inspected and this was checked on a daily basis by staff except for the resuscitation trolley in the minor theatre. This emergency equipment was the designated equipment for the day case surgery unit.
- Not all of the resuscitation trolleys were maintained securely in line with trust policy. Resuscitation trolleys in theatres and wards were all found to be appropriately stocked. However, trolleys were not locked to prevent tampering or loss of equipment. The trust did not use plastic tab locking systems which enabled staff to see that trolleys had not been used or tampered with, without having to check every individual item.
- Two of the patient bays on Letchmore Ward did not have piped suction or oxygen. Staff told us work to install this had commenced, but had been stopped and they were not aware of when the work would re-commence. We saw that portable suction and oxygen was available on the ward.
- Patients' notes had records of the surgical equipment or prosthesis used to enable them to be tracked and traced. This meant that any issues with patients or the equipment after surgery were identified in order that they could be followed up.
- Sharps bins were readily available and all other waste bins were clearly labelled and adequately located in clinical areas.

Medicines

- Patients told us they were usually given their medicines on time. They also said medicines were explained to them and they were told about risks associated with taking medication.
- A pharmacist visited all wards each week day. We saw that pharmacy staff checked that the medicines

patients were taking when they were admitted were correct and that records were up to date. Pharmacy staff were also available on the wards to provide medicines to patients on discharge.
- We observed staff administer medicines safely. Records demonstrated that medicines were prescribed and administered correctly.
- We saw controlled drugs were stored and recorded appropriately but we found that they were not always being disposed of safely as trust policy was not always followed.
- Emergency medicines were available for use and there was evidence that these were regularly checked. We found intravenous fluids stored in unlocked areas and on emergency trolleys which were openly accessible and could therefore be tampered with.

Records

- Patient's medical records were stored securely behind nursing desks. Nursing notes, such as patient drug charts and risk assessments, were kept by bedsides in folders. Medical records accompanied patients to and from theatre.
- Records included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. Preoperative records were seen, including completed preoperative assessment forms.
- The trust had a standardised care pathway for elective surgery which was started at the pre-admission clinic. This documented the patients' journey from admission to discharge.
- Comfort rounds, known as 'intentional rounding' were undertaken every two hours, this included change of position and pressure area care as required. We saw these were clearly documented in the records.
- We found that the Emergency Surgical Assessment Unit (ESAU) had very little privacy as the unit was small and we noted that patients waiting on chairs could see the computer screens which contained confident patient details.

Safeguarding

- Staff were knowledgeable about their role in safeguarding, and confirmed that they had received safeguarding training in the past year. Staff were able to describe the different types of abuse, and correctly tell us what they would do if they thought someone was being abused.
- Information about the trust's safeguarding arrangements, including a safeguarding policy and key contact and referral details, were readily available to staff.
- The wards and theatres also had safeguarding link nurses in place. Staff told us that they could contact the hospital-wide safeguarding lead if they required additional guidance or support.
- The ward manager on Cleeves Ward told us about a safeguarding incident a member of staff dealt with and the procedure that was followed.

Mandatory training

- All new employees received a corporate and local induction that welcomed them to the trust and introduced them to their respective departments. All staff received mandatory training as part of their induction programme. The surgical team had designed their own induction programme.
- The mandatory training covered key topics such as infection control, information governance, manual handling and resuscitation training. We saw the training figures for nursing staff for mandatory and statutory training was 63% for the surgical wards and 80% for theatre staff. In the Board performance report for March 2015, there was no set targets for staff compliance with mandatory training.
- Staff confirmed that their mandatory training included infection control, resuscitation and manual handling. E-learning courses were also available in a number of subjects including safeguarding and equalities and diversity.

Assessing and responding to patient risk

- Staff were aware of how to escalate key risks that could impact on patient safety, such as staffing and bed capacity issues. There was daily involvement by ward managers and bed co-ordinators to address these risks.
- Upon admission to the surgical ward and prior to undergoing surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for VTE, pressure ulcers, nutritional needs, risk of falls and infection control risks.

Patients identified as being at high risk were placed on care pathways. Care plans were in place to ensure that risks were mitigated and patients received the right level of care.

- The surgical wards used the national early warning score (NEWS) to identify if a patient was deteriorating. There were clear directions for actions to take when patients' scores increased, and staff were aware of these.
- Staff carried out 'intentional rounding' observations every two hours and this increased to hourly checks if there was a deterioration in the patient's medical condition.
- We spoke with staff in anaesthetic and recovery areas, and found that they were competent in recognising deteriorating patients. In addition to the early warning score, observation chart and procedures, pathways and protocols for different conditions or operations were used.
- The trust assessed the appropriateness of patients for surgery using the ASA physical status classification. This is a nationally recognised system for assessing the fitness of cases before surgery. For example; ASA1 meant the patient was healthy and ASA2 for mild systemic disease. We saw that patients with a classification of ASA3 (severe systemic disease) were reviewed on the morning of surgery. This meant that patients were appropriately assessed to ensure their safety prior to surgery.
- The resuscitation trolley for the day case unit was stored in the minor operations theatre. Staff would need to go through three doors before accessing the trolley if it was needed in an emergency. We also found that the trolley was not checked by staff on a daily basis.
- We observed a doctor speaking aggressively to nursing staff asking them to rush through their pre-operative assessment checks in the day case unit. Staff refused to do this and continued to ensure all checks were completed appropriately. We informed trust senior managers of this incident on the day of our inspection.
- We saw theatre staff completed checklists based on the World Health Organisation (WHO) safety procedures to safely manage each stage of a patient's journey from ward through anaesthetic, operating room and recovery. We observed a comprehensive debrief at the end of the operating list that considered what went well and any areas for improvement.
- The trust carried out an audit to monitor adherence to the WHO checklist by reviewing the completed checklist record. We saw that the trust had achieved 94% compliance across all surgical specialties in the completion of the checklist for month of January 2015.

Nursing staffing

- The trust used the nationally recognised Safer Nursing Care Tool along with The National Institute for Health and Care Excellence (NICE) guidance to assess required nursing staff levels. This included surgical areas.
- The required and actual staffing numbers were displayed in the areas visited. For example, on Letchmore ward we saw that the planned and actual staffing levels of four nurses and three healthcare assistants was met.
- Information provided by the trust showed that in March 2015 the division of surgery recorded 2.3% (58 shifts) red/amber shifts alerts. This is where the actual staffing level falls below the planned level.
- We were told that any red/amber shift alerts were responded to with a senior nurse review at the time of raising the alert. They were also discussed at daily meetings and mitigations put in place to ensure patient safety. For example, cover provided by another clinical area or a supervisory nurse working as part of the staffing numbers.
- Staffing for the surgical team were in accordance with the Association of Perioperative Practice (AfPP) guidelines. Staff within the surgical team cross-covered both the Watford and St Alban sites. This meant that staff could be seconded when shortages occurred.
- The wards and theatres we inspected had sufficient numbers of trained nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care at the time of our inspection.
- Staff in both surgical wards and theatre said they recognised recruitment as a major safety risk to the service. It was captured on the directorate risk register. We were told that there were 26 nursing vacancies and four healthcare assistant vacancies across the surgical wards.
- The management team told of various measures they had undertaken, such as open recruitment days and overseas recruitment initiatives to decrease the vacancy

factor. We were told that managers had recently recruited 20 nurses from Scotland. There was general agreement that recruitment and retention of nursing staff was seen as a priority by the trust.

- Agency staff had an induction process to follow if they were new to the ward or theatres. We spoke with one agency nurse who confirmed that they had completed an induction programme. We saw a copy of the induction paperwork, which was comprehensive.
- Ward staff said they had formal patient handover in between shift changes, with discussion as a team and then bed side handover. Healthcare support staff said they were given direction as to what patients required for the shift, such as assistance with hygiene or eating. Patients told us that the staff and the wards were busy but the nursing staff looked after them well and they did not have to wait long for help or care.
- We observed nursing handovers on two wards. We saw nursing handover sheets that contained information about care needs, past medical history and plans for discharge. There was a thorough discussion of each patient, which included information about their progress and potential concerns.
- Patients were collected from wards by theatre support staff prior to surgery and following surgery the support or recovery staff returned patients to the ward and handed over relevant information. We observed a handover between theatres and the ward staff. We saw all the relevant information was communicated to the ward staff. For example, the last time the patient had pain relief, how the operation had gone and whether the recovery time had been satisfactory

Surgical staffing

- The wards and theatres we inspected had a sufficient number of medical staff with an appropriate skill mix to ensure that patients were safe and received the right level of care at the time of inspection.
- The Health and Social Care Information Centre's (HSCIC) statistic data from September 2013 showed that the proportion of middle-career doctors within the surgical services was 21% compared with the England average of 11%. The ratio of junior doctors was also greater than the England average (19% compared with an average of 13%). The ratio of consultants was 33% compared with the England average of 40%. The ratio of registrars was also below the England average (26% compared with an average of 37%).
- Locum doctors were used to cover for existing vacancies and to provide cover for staff during leave. Where locum doctors were used, they underwent recruitment checks and induction training to ensure that they understood the hospital's policies and procedures.
- Consultant ward rounds took place twice a day during the working week. There was one ward consultant ward round at weekends. During the day all new patients were seen by a consultant within one hour following their admission.
- Staff told us there were no issues with the staffing levels within theatre.
- Handovers were consistently formalised and structured. During our visit we attended two medical handovers. The handovers were very detailed. For example, at the early morning trauma handover we saw that two consultants and 11 junior doctors were part of the handover. They discussed admissions and plans were made for the day. We observed good teaching being delivered by consultants to junior doctors during the handover.
- We found there was sufficient on-call consultant cover over a 24-hour period and there was sufficient medical cover on-site outside of normal working hours and at weekends.

Major incident awareness and training

- We saw that there were clear major incident plans and business continuity arrangements in place for the trust and surgical division.
- Staff were aware of the procedure for managing major incidents, winter pressure and fire safety incidents.
- There was a bed management system that aimed to ensure patients' needs were met when there was an increased demand on beds. Some medical patients were placed and cared for on the surgical wards.
- Protocols for deferring elective activity to prioritise unscheduled emergency procedures were in place.

Are surgery services effective?

Good

We found that this service was good for effectiveness.

Surgery

We saw that treatment given was evidence based and, where appropriate, was underpinned and guided by National Institute for Health and Care Excellence (NICE) guidance.

Patients were given adequate pain relief in a timely way. The nutritional needs of patients were assessed and patients were supported to eat and drink according to their needs. There was access to the dietetic and speech and language therapy teams.

Patient surgical outcomes were monitored and reviewed through formal national and local audit.

Patients received care and treatment by trained, competent staff who worked well as part of a multi-disciplinary team.

Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards.

Evidence-based care and treatment

- Patients received care according to national guidelines. National Institute for Health and Care Excellence (NICE) guidance was routinely followed including, CG124 for fractured neck of femur patients, CG177 care and treatment of patients with osteoarthritis and CG92 reducing the risk of blood clots in surgery.
- Staff in the surgical wards used enhanced care and rapid recovery pathways, in line with national guidance. We saw a copy of the orthopaedics and spinal pathway which identified the procedures to take. For example, referral to the spinal assessment service and the use of the STarT back screening tool for lower back pain. The aim of the STarT back screening tool was to classify back pain patients according to their risk of persistent pain and then to refer them for the appropriate treatments.
- We saw that pre-operative investigations and assessments were carried out in accordance with NICE clinical guidelines. This included guidance regarding the contraception pill and hormone replacement therapy.
- Local policies, such as the pressure ulcer prevention and management policies were written in line with national guidelines and staff we spoke with were aware of these policies. Staff had been allocated training dates for "BEST SHOT" pressure care awareness days.
- Enhanced recovery pathways were used to improve outcomes for patients in general surgery, urology, orthopaedics and ear nose and throat (ENT). This focused on thorough pre-assessment, less invasive surgical techniques, pain relief and the management of fluids and diet, which helped patients to recover quickly post-operatively.
- Findings from clinical audits conducted in the surgery services were reviewed at monthly clinical audit meetings and any changes to guidance along with the impact these would have on staff practice were discussed.
- We saw a number of audits undertaken by the surgery services. For example, we were shown an audit of the Royal College of Surgeons (RCS) Emergency Surgery Standards, which had helped to ensure that all emergency surgical patients received correct and timely venous thromboembolism (VTE) assessment.
- We saw local completed audits for surgery service. These included weekly pressure sores, legionella and hand hygiene audit and monthly weight audits.
- Nursing and medical staff told us that policies and procedures reflected current guidelines and were easily accessible on the hospital's intranet.

Pain relief

- Pain relief was well managed. We saw that patients' initial pain assessment and pain relief plan was discussed at pre-operative assessment clinic.
- A pain assessment tool was used and we saw ongoing pain management to assess the level of pain relief was appropriate in meeting the patients pain.
- The vast majority of patients we spoke with about their pain told us it was well-controlled and they would ask the nurses if they needed more pain relief.
- Staff had access to the trust pain control team when required.

Nutrition and hydration

- Patients received a malnutrition universal screening tool (MUST) assessment on admission, and those with complex dietary needs were referred to and seen by dieticians. We saw evidence of the MUST assessments and dieticians' comments in two patients' notes we examined. Care plans had been developed as a result of these assessments.
- We saw meals being served to patients for breakfast and lunch. Patients had choices and were able to select from a range of items.

- The trust had a rotational menu offering a wide variety of hot and cold choices.
- The majority of patients we spoke with told us that they were offered a choice of food and spoke positively about the quality and portion size of the food offered.
- Patients told us they had access to water and hot drinks were brought round at frequent intervals throughout the day.
- Patients who needed assistance with eating were identified during the admission process and red trays were used to help staff identify those requiring support. Assistance with meals was provided by relatives, healthcare workers and nurses.
- We saw regimes were in place for patients who were receiving nutrition intravenously. These had been set up by the dieticians and reviewed by them.
- The management of patients' fluid balance was good. Fluid charts were being used. Those we reviewed for patients who had undergone surgery were very detailed and had totals for input and output. These also included measurements from any drains that they had in place.
- Staff at the pre admission clinic told us there was guidance for patients about when they should be nil by mouth from, depending on their operation time. Patients were able to have water up to two hours prior to surgery. Information about fasting was also included on the trust's website.

Patient outcomes

- The bowel cancer audit data showed that 99% of patients were seen by a clinical nurse specialist and 100% for discussion by the multi-disciplinary team. However, the records showed that the length of stay above five days was at 74%, worse than the England average of 69%.
- We saw the neck of femur (NOF) minutes for March 2015 which discussed the National Hip Fracture Data (NHFD) for January 2014 to December 2014. We saw that 438 patients had been entered onto the database. Mortality data showed the analysis for the trust was 8% for the year which was better than 2013 at 12%. We saw the Blue Book average times and indicators. The Blue Book forms a part of the NHFD results by identifying the evidence with regard to best practice. The trust was better than the national figures for average times and indicators. For example, length of stay was 14 days compared to the national average of 20 days and pre-operative assessments were 98% against the national average of 70%.
- Theatre staff attended monthly mortality and morbidity meetings across the surgical specialities. The information was reported through the governance structure to ensure early intervention. The data reported to the trust board between April 2013 and June 2013, the hospital standardised mortality ratio (HSMR) for the trust was 108. By the end of September 2014, it had dropped to 85. We saw the mortality rate at the trust had dropped by more than 21%. This was compared to a national decrease of 3%.
- The standardised relative risk readmission figures showed that Watford General Hospital was similar to the England average for non-elective surgery.
- The standardised relative risk of readmission for all elective admissions was slightly worse than the England average.
- The trusts' hospital episode statistic (HES) for July 2013 to June 2014 data showed that 28,774 patients were admitted for surgery at the hospital.
- The trust performed similar to the England average in three of the four Patient Reported Outcomes Measure (PROMs). These were in groin hernia repairs, hip replacement and knee replacement. It was higher than the England average for varicose vein surgery.

Competent staff

- Nursing and clinical staff we spoke with were knowledgeable and understood their role within the organisation. Nurses and healthcare workers described the induction process and support they had received when they first started at the trust.
- All new staff undertook competency tests to ensure they had the necessary skills to carry out their role. Examples of areas covered included anaesthetics and care of deteriorating patients.
- The matron and a number of staff spoken with told us they had received dementia care and learning disability training. This was confirmed by a member of the learning disability support team based at the hospital.
- Agency and locum staff underwent recruitment checks and induction training prior to commencing employment. We reviewed the record for an agency staff member which had been completed and signed by senior staff.

- Trust data that showed completed appraisal rates across different departments was not available. Records showed 65% of nursing staff and 94% of healthcare assistants across the trust had completed their annual appraisals during the year ending March 2015.
- We saw data which showed that most staff on the surgical wards and theatres had received an appraisal in the last 12 months. For example, on Flaundon Ward only two staff had not had an appraisal; however, these were due to be completed by the end of May 2015.
- Staff told us that whilst they had effective informal "ad hoc" supervision, they did not receive formal clinical supervisions sessions.
- Staff we spoke with during the inspection confirmed that they had received an annual appraisal. Staff told us that appraisals were linked to the trust's vision and values and they thought the process was effective. They confirmed that the process included professional development, the enhancement of clinical skills and encouragement to attend courses.
- The General Medical Council (GMC) National training Scheme Survey for junior doctors for 2014 had a response rate of 98%. The average indicator score for five key indicators namely; adequate training, induction, handover, educational supervision and clinical supervision. The responses for the question about handover showed the worst score at 62% with clinical supervision being the highest at 92%.
- Consultants underwent peer appraisals and were overseen by the associate medical director. The medical staff we spoke with did not highlight any concerns relating to appraisal and revalidation.

Multidisciplinary working

- There was daily communication between the multi-disciplinary teams (MDT) within the surgical ward and theatres.
- We observed two daily ward rounds. Medical and nursing staff were involved in these together with physiotherapists or occupational therapists as required.
- We observed a good working relationship between theatre and ward staff during our visit.
- Nursing staff said that they could access medical staff when needed to support patients' medical needs.
- Doctors and nursing staff told us they worked well together within the surgical specialities. We saw evidence of this on the surgical ward and the day surgery unit.
- Patients' records showed they were referred, assessed and reviewed by a multi-disciplinary team such as dieticians, speech and language therapists and the pain management team when required.
- There was good interaction with the learning disability lead, who was able to provide advice and support to surgical teams.
- The records viewed identified family involvement at admission to encourage effective discharge.
- Staff described the multidisciplinary team as being very supportive of each other. Health professionals told us they felt supported, and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe and effective.

Seven-day services

- Staff rotas showed that nursing staff levels on the wards were sufficiently maintained outside normal working hours and at weekends.
- Sufficient out-of-hours medical cover was provided to patients in the surgical wards by doctors as well as by on-site and on-call consultant cover. Newly admitted patients were seen by a consultant at the weekends. Existing patients on the surgical wards were seen by the doctor on duty during the weekends.
- Theatres, which included anaesthetics and recovery, had staff on duty out of hours and at weekends to cover any emergencies.
- The dedicated pain team did not work weekends. Any support required was provided by the on call anaesthetist.
- The ward staff were aware of medical availability and of out-of-hours imaging and pharmacy services. Occupational therapy had a five-day service and physiotherapy was available five days with acute and on-call cover in the hospital at weekends.
- The pharmacy department was open seven days a week but with limited hours on Saturday and Sunday and there were pharmacists on call out of hours. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis.
- Nursing staff told us that there was a delay in obtaining medicines for people to take home with them when they were discharged, particularly at weekends. This meant that patients were sometimes kept waiting unduly for their medicines.

- Nursing staff were permitted to order controlled drugs (CDs) from the pharmacy on fixed allocated days. The trust told us that if these were needed at other times the nursing staff contacted the pharmacy department to place the order and agree delivery. If there was any delay in the receiving the CDs the required CDs were borrowed from another ward, ensuring that there was not any delay to the patient receiving their prescribed medication.

Access to information

- The hospital used paper-based patient records. The twelve sets of patient records we looked at were complete, up to date and easy to follow. The records we looked at contained detailed patient information from admission and surgery through to discharge. This meant that staff could access all the information needed about the patient at any time during the patient journey.
- Discharge letters given to patients and sent to GPs were written by the responsible medical staff and included all the relevant clinical information relating to the patient's stay.
- Staff told us that information about patients was easily accessible.
- Staff told us they had access to the intranet to complete eLearning and to keep updated with trust policies and procedures. Newly implemented documents were highlighted on the home page.
- We saw that information such as staffing levels, performance information and internal correspondence was displayed in all the areas we inspected.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff provided appropriate information to patients about procedures. Patients who were able to, had provided written consent to procedures. There were supporting patient information leaflets for consent, which were given to patients pre-operatively.
- We saw training records that evidenced that staff had undertaken training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff demonstrated knowledge and understanding of MCA and DoLS when we asked them to describe what they would do in different scenarios. Staff were able to explain benefits and risks in a way that patients understood.
- Patient records showed that verbal or written consent had been obtained from patients or their representatives and that planned care was delivered with their agreement. We observed consent being obtained prior to surgery.
- Patients confirmed they had received clear explanations and guidance about the surgery and said they understood what they were consenting to.
- For patients who did not have capacity to consent to their procedure, staff applied the principles of the Mental Capacity Act 2005 and maintained records according to trust policy.

Are surgery services caring?

Good

We found the service was good for caring.

Patients and their families spoke positively about the staff. They said they were attentive and caring.

Staff supported people to make informed decisions. There was a wide range of information available for visitors.

Staff provided patients, and those close to them, with the support they needed to cope emotionally with their care and treatment.

Compassionate care

- The NHS Friends and Family Test (FTT) results were displayed within the wards. We saw posters encouraging patients to provide feedback so they could improve the care provided. For example, on Flaundon Ward we saw that they had 15 responses for March 2015 with 100% likely to recommend the service.
- In the CQC 2014 inpatient survey relating to operations and procedures, the trust was similar to other trusts but was worse for questions around information. For example, for receiving an explanation they could understand from the anaesthetist or another member of staff about how they would be put to sleep or their controlled. Patient feedback during the inspection was very positive. All the patients we spoke with commended staff saying they were friendly and caring.

- Care observed was positive and maintained patient privacy and dignity. Staff were friendly with patients. Patient's curtains were drawn or doors were kept closed during treatment to ensure privacy and dignity.
- During handover on one of the wards, we witnessed the nurse delivering the handover had 'talked over' patients. For example, we overheard them say about patients, "she can eat and drink," and "they want him to keep his NG tube in," rather than passing the information to the incoming staff in a more person centred manner. We brought this to the attention of the matron on the day of the inspection.
- We noted that the sluice door to the sluice room was open on Langley Ward. We observed bed pans being taken into the room and placed in the macerator for cleaning. The macerator was very loud when it was switched on and a patient in a side room close by asked for the door to be shut as they said it was "noisy and smelly." A nurse attempted to shut the door, but did not notice that it has swung open again. We drew this to the attention of the nurse in charge of the shift before we left the ward.
- We saw doctors introducing themselves to patients at the start of conversations during ward rounds. Patients spoke highly about their consultant.
- There was obvious rapport between staff and patients. Staff clearly knew the preferences for patients who had stayed longer on the ward. For example, we observed a nurse chatting with a patient about their family while assisting them with their medication.

Understanding and involvement of patients and those close to them

- Patients told us they were kept up to date regarding their care including explanations about their procedure and the risks and benefits and we saw this was recorded in their notes.
- In theatres we saw patients were given information about the procedure and how they would recover in the ward and they were asked about preferences they had.
- We spoke with one relative on Langley ward whose family member had a procedure the previous day. They told us they had been kept fully involved and updated as to the patient's condition and future care plans.
- A patient on Letchmore ward told us that that the "doctor had been very thorough" in explaining their condition and proposed treatment to them.

Emotional support

- We asked staff what external or internal people they had accessed to provide emotional support such as counsellors. Staff spoken with were unable to tell us what they offered other than Macmillan Nurses for those patients with cancer. Staff told us they were not aware of any counselling or group support sessions available to patients.
- Staff had good awareness of patients with complex needs and those people who may require additional support should they display anxious or challenging behaviour during their treatment at the hospital.
- On Flaundon ward we saw a patient with confusion calling out and asking for their medication. We were aware that the patient had received their medication and we saw a member of staff approach them and sit at their level and engage the patient in conversation for some time until the patient was settled.
- In theatres we saw theatre staff welcoming patients into the admission area and putting patients at ease, discussing their procedure and answering any questions.

Are surgery services responsive?

Requires improvement

The service was not always responsive to patients' needs and required improvement.

Many theatre lists frequently over-ran and patients' surgery were sometimes cancelled at short notice. This led to patients having appointments cancelled and re-scheduled. This was having an impact on the service's ability to perform and meet its own targets. In the four weeks before our inspection, 125 operations had been cancelled on the day of surgery. Of the cancelled operations, 71% were cancelled for non-clinical reasons. For example, operations were postponed because of a lack of surgical beds, or the operating lists had run over the allocated time.

The surgery services had failed to meet the national targets for 18-week referral to treatment times for all specialties.

Patients experienced delayed transfers of care to other providers, such as community intermediate care or nursing homes. On the day of our visit there were delayed transfers of 15 patients because of a lack of suitable accommodation

for them to move on to, or funding for specialist placements. We saw the service worked closely with the local authority and social workers attended ward meetings when required.

The learning disability liaison team provided a good service for surgical inpatients. Dementia specialist nurses also provided support when patients living with dementia were admitted for surgery Staff told us they attended the wards when patients were admitted to provide them with advice and support.

Complaints were effectively managed and learning was identified and acted upon.

Service planning and delivery to meet the needs of local people.

- NHS England data for April 2013 to November 2014 showed that national targets for 18- week referral to treatment (RTT) standards for general surgery, oral surgery, ENT, urology, ophthalmology, and trauma and orthopaedics ranged between 69% and 87% during this period, which meant that the hospital was not meeting the waiting time target of 90% for these specialties. The trust told us that since January 2015 they had taken significant improvement actions regarding RTT and at the time of the inspection they were on trajectory to meet the standards.
- On the day of their surgery, patients with elective (planned) surgery were admitted to the surgical admissions lounge, for example, they were seen by the nurse and prepared for surgery and the post-operative ward.
- The surgical management team were working weekends to improve referral to treatmenttimes. We were told by the Divisional Director that in recent months, the waiting list for surgery had reduced from approximately 2,500 patients to 1,000. The Trust had undertaken significant work to improve performance against RTT standards and as at the time of the Inspection there was evidence to show that progress was being made.
- A member of staff told us they were unable to deliver an effective service to patients requiring interventional radiology treatment. This was because the equipment in theatres was unsuitable for many processes. This risk was not on the risk register at the time of the inspection.
- We had concerns about the privacy discussions taking place in the cubicles on the day case/surgical admissions unit. This unit had three bays which did not provide any privacy for discussions between the patient and medical and nursing staff. Other patients were able to hear what was being said. If the department was busy, as it was on the morning of our visit, it could be difficult for patients to hear what was being said. There was a small room where patients could go with a doctor if they needed to have more privacy. Staff said the area was too small but it was not included in the service's risk register.

Access and flow

- Surgical admissions were based on elective or emergency surgical pathways through the emergency department.
- The trust had recently opened an emergency surgical admission unit (ESAU), adjacent to Letchmore Ward. This unit was for patients who were referred from General Practitioners (GPs), the emergency department and outpatient clinics.
- Bed capacity meetings took place four times a day, when hospital activity and flow was reviewed. There were no surgical patients in outlying beds at the time of inspection.
- The average length of stay for both elective and emergency surgery was lower than the England average.
- Discharge was sometimes delayed because of a lack of suitable accommodation for people to move on to, or funding for specialist placements. For example, we were told 15 patients across the surgical wards were fit for discharge as at 15 April 2015, but did not have an established package of care. The trust was engaged with partner organisations in managing these delays to minimise the impact on individual patients and the service overall.
- There was an integrated discharge team within the trust to help facilitate patient discharges. The team consisted of nurses, physiotherapists, occupational therapists and social workers. Members of the team attended daily ward rounds to ascertain which patients were ready for discharge.
- Enhanced recovery pathways were used in a number of surgical specialities. Enhanced recovery is a modern, evidence-based approach that helps people recover more quickly after having major surgery. Areas covered included hips, knees, gynaecological, spinal and ear nose and throat. There was however no on-call process in place for the enhanced recovery team. We were told

that the trust was looking to develop a high dependency unit (HDU) so an on-call service may be required in the future due to more complex/demanding surgery being performed.
- Capacity to balance the demands of both elective and non-elective activity meant that the cancellation of operations had become almost routine. This had been first identified as a high risk on the risk register in January 2014. It identified that surgery were often cancelled without clinical advice or input. The divisional director told us that lists could now be cancelled by the theatre manager to accommodate trauma cases.
- There were 125 cancelled operations for the four-week period 16 March 2015 to 12 April 2015. Lack of theatre time was highlighted as the main reason for cancellation in 12 of the cases and 47 cases had their operation postponed for the next day. It was not clear if dates for surgery had been made available for those patients whose procedures had been cancelled.
- One patient on the day surgical unit told us their surgery had been cancelled the previous day at 8:50pm although they had been in the unit since 10am. The patient felt communication was poor, as they were only told it was cancelled when they asked how much longer they would have to wait. The patient reported that they had not been given a reason for the cancellation.
- The percentage of patients whose operation was cancelled and were not treated within 28 days was consistently worse than the England average of 5%. We noted that 16% of cancelled operations for the period January 2014 to March 2014 were not completed within 28 days. In the trust's April 2015 Board performance report, there were 37 cases were patients had had their operation cancelled and not treated within 28 days in the year to February 2015, which was significantly above the trust target of zero cases.
- Hip fracture audit information indicated that that 89% of patients with a fractured neck of femur were operated on within 48 hours which was better than the England average.

Meeting people's individual needs

- Information leaflets about the services were readily available in all the areas we visited. Staff told us that they could provide leaflets in different languages or other formats, such as braille, if requested.
- Staff told us they had access to translation services in person or by using the telephone system. Some staff said they used other staff who were able to speak the language of the patient to help them explain about the care and support the patient required.
- The trust had a named dementia lead and learning disability lead. Staff confirmed they were able to readily access the leads to discuss any concerns and receive advice.
- We saw staff were supported by specialist nurses when caring for patients living with dementia and made use of 'This is me' documentation. This is information about the person living with dementia that lets health and social care professionals know about their needs, interests, preferences, likes and dislikes.
- The learning disability liaison team provided a good service for surgical inpatients. Staff told us they attended the wards when patients were admitted to provide them with advice and support. Staff in the pre admission clinics told us they were encouraging patients to bring in their hospital passports. These were documents that provided staff with individual details about the patients care and support needs.
- Where staff were unable to communicate with patients, they could access communication cards that included easy-to-follow visual prompts. Ward staff also discussed patient needs with relatives or carers and these discussions were documented in the patient records we looked at.
- Discharge planning commenced at the pre-operative admission clinic when a patients expected discharge date was discussed and agreed so patients could make plans for their discharge.

Learning from complaints and concerns

- Ward and theatre areas had information leaflets displayed for patients and their representatives on how to raise complaints. We saw this was in an easy to read format. These included information on how to contact the customer care team, which included the Patient Advice and Liaison Service (PALS).
- The patients we spoke with were aware of the process for raising their concerns with the hospital.
- We saw that noticeboards on each ward included information such as the number of complaints and compliments received during the current month. The staff we spoke with understood the process for receiving and handling complaints.

Surgery

- Formal complaints were recorded on the hospital's incident-reporting system and managed by the customer care team. The ward and theatre managers were responsible for investigating complaints within their areas.
- Staff told us that information about complaints was discussed during routine team meetings to raise staff awareness and aid future learning. We saw evidence of this in the meeting minutes reviewed. For example, following complaints about the noise level on wards at night, patients were issued with ear plugs to use at night. The matron for surgery kept a record of all informal complaints. We saw how these complaints were investigated and the action taken to resolve the complaint. The matron told us that there had been three formal complaints. Two of the complaints had been investigated and resolved. The investigation for the third complaint was in progress.
- The matron also said that they telephoned all complainants within two days to discuss their concerns and assure them that their concerns had been taken seriously.
- The wards also displayed patient feedback from the previous month and what changes had been implemented as a result of that feedback. For example, patients had complained that the wards were sometimes noisy at night. Patients were now supplied with soft ear plugs to help lessen the noise and assist them to sleep better at night.

Are surgery services well-led?

Requires improvement

We rated this service as requires improvement for being well led.

Senior leaders understood their roles and responsibilities to oversee the standards of service provision in all surgical areas. However, there had been a number of changes in management in the previous 12 months and there were aspects of the service which were not being effectively monitored. There was a new and impressive management team in place which were now in the process of addressing these concerns.

There was a clinical governance system in place that allowed risks to be escalated to divisional and trust board level through various committees and steering groups. There were action plans in place to address the identified risks. However, we found that, when issues were identified, timely action was not always taken to address those risks. For example, issues with the fabric and ventilation of the theatres had been identified on the risk register in 2013 and had not been addressed.

There was effective teamwork and visible leadership at ward and theatre level within the surgery services. The majority of staff were positive about the culture and support available across the surgical services. The trust had a number of changes in management over the past year and this included senior management of surgery services.

Staff we spoke with told us that the managers were approachable and the culture within the service was seen as open and transparent.

Vision and strategy for this service

- The trust's quality strategy for 2014 to 2019 included performance targets relating to patient experience, effectiveness of services and patient safety.
- The trust vision and values were visibly displayed across the wards and theatre areas we inspected and most staff had a good understanding of the vision and values. We saw that a new staff appraisal system had been introduced which was linked to the trust's values.
- The trust's values included providing consistently good, safe care in a friendly, listening and informative way and always with dignity and respect. Staff were able to discuss the trust's values and objectives across the surgical wards and they were clearly displayed on ward areas.
- Staff were passionate about improving the service for patients to ensure they provided a quality service.

Governance, risk management and quality measurement

- The service used a risk register to itemise risks. We reviewed the risk register for surgical services based at Watford which contained 38 risks. The list included a description of the risk and the actions that had been taken to mitigate the risk.
- We noted that some of the risks had been identified as far back as 2012. There was no evidence that the controls put in place to mitigate the risks were having a positive effect.

- We identified that a 'tunnel' had been built to transport patients from one area of the hospital to another, for example, from theatres to the gynaecology unit. The tunnel was narrow in places and one of the lifts could only accommodate a patient's bed and staff member. The risk of a patient needing emergency assistance while being transported through the tunnel was not identified on the risk register.
- The surgical division did not have an effective governance team in place. There was no governance lead, although one had recently been appointed, nor were there any risk surgeries (meetings) or reviews of risks.
- We saw that surgical team meetings took place weekly when group managers, matrons, human resources and business managers came together to discuss issues. For example, complaints, incidents and staffing levels.
- There was a clear structure for the escalation and investigation of never events and serious incidents.
- We saw the theatres' team brief which was printed and circulated to staff. This included a resume of the recorded/documented theatre list.
- In each area we inspected, there were staff meetings to discuss day-to-day issues and to share information on complaints and audit results.
- The service had quality dashboards on display on the wards and the day surgery unit. This showed performances against quality and performance targets. Members of staff told us that these were discussed at team meetings.
- The trust had completed local as well as national audits, for example regular audits to ensure staff record keeping and accuracy were compliant with national standards.

Leadership of service

- The surgical services were divided into specific surgical specialties and each specialty had a clinical lead in place. The surgical specialties were consultant-led and medical staff spoke positively about the support they received.
- Management on the surgical wards and in theatres told us that the senior management for the surgical division was supportive. However, some staff raised concerns that senior management had a wide portfolio, for example, at St Alban's Hospital, and they were not always seen regularly in some areas, particularly theatres.
- We were told that it was difficult to arrange team meetings in ward areas so some wards were having a 'huddle' at the beginning of the shift to give feedback to staff and inform them of any changes. This also allowed effective allocation of staff and resources.
- Junior doctors felt well supported by consultants and senior colleagues. Medical staff felt supported by the medical leadership in the division and the trust.

Culture within the service

- We observed that staff were positive about working for the trust, and understood the contribution they made personally to the care and treatment of patients.
- The Clinical Director described the culture of the new surgical division management team as positive, collaborative and pro-active with increasing involvement in clinical leadership and in quality and governance initiatives.
- 'The staff sickness rate across the trust was better than the England average of 4.5%. The average sickness rate within the surgical division was 3.5%.
- Some staff told us that there was a 'bullying' culture by some consultants, particularly in theatres. Staff said that it has "always been like that" and that "you get used to it." The surgery divisional director advised that focus meetings had been held with staff and the trust's whistleblowing policy had been circulated to all staff.
- The matron for surgery inpatient care told us that she had an open door policy and had set aside a weekly one hour session where staff could come and discuss in private any concerns they may have. We saw these 'Meet with Matron' sessions advertised throughout all the inpatient wards.
- We witnessed a doctor shouting at a nurse in the corridor outside of the day case surgery unit. Nursing staff told us this often happened as the medical staff wanted to start the theatre list as soon as possible.

Public and staff engagement

- The trust held monthly care group engagement session for all staff. These sessions had a different focus every month, for example training updates.
- The surgical divisional leads held monthly clinics whereby staff could raise any concern or share an experience.
- Staff said they received good support and regular communication from their line managers.

- Each ward displayed clearly key performance data, for example hand hygiene audit and infection rates, and staffing numbers so that patients and their visitors as well as staff could see how well the ward was performing. There were also examples displayed of how the ward had responded to both positive and negative feedback.
- The theatre and ward-based staff we spoke with told us that they routinely engaged with patients and their relatives to gain feedback from them. Information on the number of compliments and complaints was displayed on noticeboards in each of the wards we inspected.
- Patients were engaged through feedback from the NHS Friends and Family test. The survey showed that of 151 responses 98% said they would be extremely likely to recommend the hospital as a place to be treated.
- The staff survey showed that from 800 responses trust-wide, 63% would recommend the trust to family and friends if they needed care and treatment and 54% said they would recommend the trust as a good place to work.
- We found that wards and clinical areas held meetings and produced newsletters to enable staff to be informed and to contribute to the development of services. We found through our discussions with all grades of staff that staff felt informed and involved with the day to day running of the service, and its strategic direction.

Innovation, improvement and sustainability

- The trust used a comprehensive system of metrics, called 'Test your Care' presented as dashboards to ensure that quality issues and trends could be readily identified. When an effective governance team was in place, the divisional management team should be well placed to ensure that improvements needed were identified and that performance across a wide range of metrics was sustained.
- The surgery division was in the process of introducing a further method of obtaining patient's experience of their care at the hospital. We saw 'I Want Great Care' comment leaflets were available in ESAU. This patient feedback system is an independent service which works with providers to provide detailed, accurate and timely monitoring of patient experience. The system had already been trialed in other services across the trust.
- A ward manager had developed a pressure ulcer prevention and treatment pack called 'Best Shot.' This pressure ulcer pathway was approved by the board and was now used throughout the trust.
- The trust operated a 'Celebrating Excellence Staff Award.' This was an initiative whereby a patient, a colleague, a carer or volunteer had the chance to celebrate and reward staff who go that 'extra mile in delivering care or treatment.' We were told a staff member on one of the wards had recently been nominated to receive this award.

Critical care

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

Information about the service

The 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. 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, two of which had ante rooms for the safe management of patients who require isolation for infection control purposes. Level one patients, meaning those at risk of their condition deteriorating, or those recently relocated from higher levels of care, were also managed within the unit when beds on general wards are not available. The main source of referrals was received from the acute admissions unit at Watford Hospital.

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

As part of our inspection we spoke with six patients, three relatives and 24 staff. We spoke with a range of staff including nursing staff, junior and senior doctors, administrative staff, and physiotherapists working within CCU and other doctors and nurses admitting patients to or receiving patients from CCU. We observed care and the treatment patients were receiving and viewed all or part of 10 care records. We sought feedback from staff and patients at our focus groups and listening events.

Summary of findings

Overall, we found that the service was inadequate.

The trust's vision to provide safe care was not met. The service lacked a systematic approach to the reporting and analysis of incidents. This meant safety concerns were not consistently identified or addressed quickly enough. Necessary improvements were not always made when things went wrong such as the prevention of pressure ulcers. Governance arrangements for auditing and monitoring clinical services were ineffective although there was some evidence of nursing audits and learning from these audits being shared.

Although equipment was visibly clean and well maintained the Difficult Airway equipment provided in CCU did not conform to current guidance by the Association of Anaesthetists. Not all staff had received training regarding its use.

Staff shortages were shown to have had an impact on services such as the outreach team who provided a link between CCU and other wards who had 'at risk' patients. Anaesthetic staffing cover for weekends and out of hours was on the trust's risk register as there was only one CCU doctor and one consultant which did not meet the Core Standards for Intensive Care Units 2013.

An audit of compliance against service specifications for adult critical care, and core standards for intensive care and rehabilitation standards, had been completed. Six of the 49 standards were reported in July 2014 as not being met and 12 were only partially being met.

Critical care

Although there was evidence most recommendations had subsequently been met, one classed as urgent had not been addressed. This related to providing training for medical staff to manage the transfer of critically ill patients to another service.

It was commented that those patient's awaiting discharge from the unit to the wards were not always as closely observed as they could be and that this may attribute to the higher than national average incidence of 1.65%of patients compared to the national average of 1.2% of patients being readmitted to the unit, within 48 hours of discharge. However there was no evidence to show any preventative actions were being taken to reduce this readmission rate. Doctors reported difficulty accessing CCU beds for medical patients.

Referrals to critical care were not managed in accordance with the trust's operational policy in that where there was a difference of opinion the referring consultant did not speak directly to the CCU consultant. Also, patients who were ready to be discharged to a ward environment were often delayed for up to a week due to lack of ward beds, and in some instances were discharged home directly from CCU.

We also found that: staff cared for patients in a compassionate manner ensuring dignity and respect. Both patients and their relatives were very satisfied with the care provided.

There were effective arrangements in place to safeguard adults from abuse. Medicines management systems were found to be safe. Results from infection prevention and control audits had been responded to appropriately to ensure patient safety.

Staff were up to date with the trust's mandatory training requirements.

Patient's needs were assessed and care and treatment was delivered in line with legislation, standards and evidence based guidance. Nursing and medical staff were appraised to judge their competency and professional development. There was effective multidisciplinary working, with support provided to the unit by a range of professionals.

Are critical care services safe?

Inadequate

Overall, we found that the service was rated as inadequate for safety.

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.

The standard of reports of incidents was variable and incidents were not always reported promptly.

There was evidence staff did not respond appropriately to changes in risks to patients. CCU had a high incidence of device related pressure ulcers but there was little evidence that prompt learning from these had taken place. Only recently had steps had been taken to minimise this risk through the introduction of new risk assessments and the use of a device to prevent pressure ulcers caused by nasogastric tubes.

Although equipment was visibly clean and well maintained the Difficult Airway trolley in CCU did not contain an appropriate emergency tracheostomy kit and therefore did not conform to current professional standards. The Association of Anaesthetists AAGBI SAFETY GUIDELINE 2012 for Checking Anaesthetic Equipment 2012 recommends 'Equipment for the management of the anticipated or unexpected difficult airway must be available and checked regularly in accordance with departmental policies. A named consultant anaesthetist must be responsible for difficult airway equipment and the location of this equipment should be known. This meant staff could not effectively respond in an emergency situation.

Staff in some departments did not have easy access to the contact details of consultants on call for critical care and the trust's operational policy for critical care was not followed by medical staff when referring a patient for admission to CCU. This resulted in delays to treatment. Doctors reported they experienced difficulty with obtaining agreement for the admission of medical patients to CCU which meant the critical care service was not meeting the needs of the hospital.

Critical care

The unit followed the nurse staffing standards from the Core Standards for Intensive Care Units 2013 and the British Association of Critical Care Nurses guidance for the staffing of critical care units. However due to difficulties with recruitment of band 6 nurses with intensive care qualifications, the unit had to rely on a high use of temporary staff who did not always receive an orientation to the unit before commencing their duties. This had an impact on other services such as the outreach team who provided a link between CCU and other wards who had 'at risk' patients.

There was only one CCU doctor and one consultant for up to 19 patients which did not meet the Core Standards for Intensive Care Units 2013 which recommends 'In general, the Consultant patient ratio should not exceed a range between 1:8 to 1:15 and the ICU resident/patient ratio should not exceed 1:8.'

Arrangements for medicines, including recording, handling, storage and administration, kept people safe. Records were legible, up to date and information within the records was easily accessible to staff.

There were arrangements in place to safeguard adults from abuse. Staff received safeguarding training and understood their responsibilities. Staff were up to date with the trust's mandatory training requirements**.**

Not all staff were compliant with the trusts infection control policy in being bare below the elbow.

The unit was found to be visibly clean.

Incidents

- Nursing and medical staff told us they understood how to use the hospital's electronic incident reporting system and were aware of their responsibility to raise concerns and report near misses and safety incidents. When checking the incident reports we noted no action had been taken to enter a near miss incident relating to the lack of a tracheostomy kit on the difficult airway trolley that had been identified and reported to staff by an inspector the previous day. An incident report was requested and completed. This meant the trust and some of the CCU team would be unaware a near miss had occurred and would not be able to learn from the incident.
- It was noted that from intelligence data available, for the period February 2014 to January 2015, the trust reported fewer incidents per hundred admissions than the England Average.
- Staff told us they received feedback about incidents at unit meetings to allow them to learn, but we did not find recent evidence to support this. We looked at three sets of minutes of critical care meetings including meetings of band 7 nurses and there was no evidence of discussion of reported incidents and planned actions to minimise reoccurrence. Clinical incidents did not appear as a standing agenda item for CCU staff meetings.
- The service was part of the East of England critical care network. Incidents were reviewed at network meetings and changes agreed to prevent further incidents. We saw evidence the matron attended these meetings.
- There had not been any serious incidents requiring investigation reported by CCU for the previous year.
- During our inspection we were made aware of an incident that occurred that involved a lack of response to a request to admit a patient to CCU which had not been promptly recorded as a Serious Incident.
- To manage serious incidents, the hospital held Serious Incident Decision meetings. Incidents were reviewed to determine if the trust's criteria for dealing with them as a serious incident were met and what type of investigation would be required. We attended the meeting and the team, led by the clinical director, confirmed the incident was classified as a serious incident, which would require an internal investigation.
- The trust used a standard template to record and report incidents to ensure consistency of reporting and investigation of incidents. We saw examples of investigations undertaken by the trust.
- We reviewed all 195 incidents reported in CCU between October 2014 and January 2015.These incidents related primarily to pressure ulcer incidents and delayed discharges. Delayed discharges are patients who no longer require critical care but use a bed in CCU whilst waiting for a bed on a ward. There had been 108 incidents.
- The 18 incidents of pressure ulcers were mostly device related (caused by medical devices such as nasogastric tubes or catheters). There was little evidence of any analysis of this trend or timely actions taken to minimise the risk. A nationally recognised grading system was

used to determine the severity of these ulcers; Grade 3 indicated full thickness skin loss and Grade 2 partial skin loss. Three ulcers were assessed and reported as Grade 3 and the remainder as Grade 2.

Safety thermometer

- The NHS safety thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. Information was displayed in CCU for patient's relatives and staff. This included information on falls, pressure ulcers and infections. Staff were aware of the data and used this as an indicator of the safety of the care they provided and where risks had been minimised. For example recent actions had been taken trust wide to minimise the risk of pressure ulcers through the introduction and use of a set of risk assessment and care planning tools for skin care which met CCU needs
- At the time of the inspection, there had not been any reported incidents of falls in the past month, no new Methicillin-Resistant Staphylococcus Aureus (MRSA) infection for 311 days and no pressure ulcers acquired in CCU had been reported for the previous 11 days.

Cleanliness, infection control and hygiene

- The CCU was visibly clean and odour-free.
- 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 training. Records showed the few staff members whose training was not complete dates had been set for them to complete this training.
- There was a specific cleaning schedule in place. Staff told us that the standard of cleanliness and compliance with the schedule were checked by their supervisor 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.
- We observed that staff followed the trust's policy regarding infection prevention and control. This included most staff being 'bare below the elbow', hand washing and the correct wearing of disposable aprons and gloves. We did not observe any procedures where eyewear was used; however, it was available. However during the inspection we noted a member of the medical staff was not compliant with the trust's infection prevention and control policy by wearing metal rings with stones and gel nails. This not only posed an infection control risk to patients but also meant patients were at risk of sustaining injuries to their skin. The matter was escalated to the matron of CCU who advised they had previously verbally raised this concern with the individual and their line manager but no further action had been taken nor had the matter been recorded as an incident. The matron requested the rings and nails were removed immediately. The incident was reported on the hospital's incident reporting system.
- Hand washing facilities and hand wash gels were readily available for patients, staff and visitors in all areas and were being used consistently.
- The March 2015 audit of compliance with the trust's hand washing protocol showed there had been a 3% increase resulting in a 90% compliance rate for nursing staff and a 6% decrease resulting in a 79% compliance rate for doctors. The noncompliance had been discussed at the clinical governance meeting and doctors had been written to, reminding them of the importance of good hand hygiene.
- Infection control audits completed in December 2014 found environmental aspects of CCU to be non-compliant. This mainly related to the fabric of the premises such as flaking paint on the walls. Maintenance staff were observed repairing some of the paintwork during the inspection.
- We reviewed other detailed infection control audits between December 2014 and March 2015 and found an average compliance rate of 97%. These audits related to the cleaning and decontamination of equipment. The main non-compliance for these audits related to the fact that patients with infections in side rooms did not have disposable blood pressure cuffs for their use only. To address this, the cuffs were cleaned with the recommended solution used for the decontamination of equipment in accordance with the infection prevention and control policy.
- There was a dedicated information board for staff, relatives and visitors which included infection prevention and control protocols, results of audits and detailed cleaning schedules displayed in the relatives' room. This meant there was openness about the trust's performance in relation to infection prevention in that information was available to relatives and visitors as well as staff.

Critical care

Environment and equipment

- The environment was spacious and well lit and corridors were free from obstruction to allow prompt access.
- The security of the unit was good. The entry to the CCU was controlled by an intercom 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 although nursing staff could not recall an occasion where all ventilators had been in use at one time. This meant there was always spare equipment if an item was not functioning correctly. 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 due to delayed discharges. Staff explained this situation usually arose at least once a month but at times more frequently.
- Physiotherapists treating patients in CCU felt they had sufficient and appropriate equipment to provide appropriate care.
- We saw there was a place to store faulty equipment and that equipment awaiting repair had been decontaminated and was labelled unsafe for use.
- The manufacturer's instructions regarding the safe and correct use of equipment such as ventilators was easily accessible to staff.
- Control of Substances Hazardous to Health (COSHH) risk assessments had been completed and the policy and risk assessments were up to date.
- During the handover between nurses, the nurse in charge allocated responsibility for checking essential equipment such as emergency and transfer trolleys to a nurse who did not have direct patient responsibilities to ensure these duties were not compromised. These duties were listed and actions recorded in the nursing handover sheet.
- Equipment at vacant bed areas plus resuscitation equipment was found to be in good order and had been checked to ensure it was complete and fit for use. Once beds had been vacated and cleaned, a comprehensive check list was completed by nurses to ensure all equipment in the immediate bed area such as suction, monitoring and ventilation equipment was ready and in place.
- The Difficult Airway trolley in CCU did not contain an appropriate emergency tracheostomy kit as recommended by 4th National Audit Project of The Royal College of Anaesthetists and The Difficult Airway Society. There was a handwritten sticker on top of the trolley dated 10 November 2014 ''No emergency kit available, go to theatre if needed''. There was a mini tracheostomy kit but it was not suitable for emergency tracheostomies. This matter was reported to the clinical director of CCU and the situation was immediately addressed. This matter had not been previously reported as a risk. The National Audit Project IV/Royal College of Anaesthetists report recommends, 'The maintenance of a clear airway in patients admitted to ICU requires continuous preparedness for insertion of a tracheal tube or tracheostomy in difficult circumstances. The airway trolley needs regular checking, maintenance and replacement of equipment after use which should be appropriately documented.'
- There was no evidence to show the Difficult Airway trolley contents were checked regularly. The clinical director told us that they assumed the nursing staff managed this; however it is usual practice for anaesthetists to check and be familiar with the contents of this trolley as it would be the anaesthetists who would use the equipment. We spoke with the junior doctors who confirmed they had not had training about the use and maintenance of the difficult airway trolley and could not specify its contents.

Medicines

- 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.
- Medicines were observed being received by a registered nurse and delivered in a secure sealed container in accordance with the trust's medicine management policy. There was a system in place to alert staff if items delivered required immediate refrigeration.
- Medicines requiring refrigerated storage were stored appropriately. We saw that the temperatures of the refrigerators were checked and recorded each day. Staff were aware of what action to take if the fridge temperature was outside safe parameters. We saw one incident had been recorded on the trust's incident reporting system where the temperature had been found to be outside the acceptable parameters. This

was found to be due to the fridge being unplugged. Notices were displayed to alert staff not to remove fridge plugs. The pharmacist had been notified and appropriate actions were taken regarding the fridge contents.

- Controlled drugs were stored in a locked unit and the keys held separately from the main keys by the nurse in charge. The other medicines were in specific locked cupboards. For example, all potassium related medicines and infusions were stored separately from other infusions to minimise the risk of the incorrect fluid being selected and administered.
- 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. We saw records that staff had completed their competencies in medicines administration and management.
- Staff had access to up to date medicines information such as British National Formularies. These were managed by the pharmacy team to ensure staff only used the most recent version of the formulary to ensure patient safety.
- 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.
- Prescription drug charts were clear and complete. Medicines were signed for appropriately; if medicines were discontinued, the charts were signed and dated on the date of discontinuation and crossed through.
- There had been four incidents reported by CCU relating to the management of medicines in the period October 2014 to January 2015. Three related to incorrect calculations of drugs administered. The standard of reporting was variable especially in relation to preventative actions taken. One incident on the incident reporting system stated this was in part due to the legibility of the prescription. The action was to emphasise the importance of not administering a medicine if unsure of the prescription. However, there was no mention of requiring the prescriber to improve their standard of writing when prescribing medicines. There was no evidence of planned training provided for staff administering medicines to ensure they could safely calculate and prepare infusions as prescribed to prevent further incidents.
- Nursing staff explained there was a sepsis protocol the doctors worked to when prescribing antibiotics and that the microbiologist visited the unit daily to review patients. There was access to an on call microbiologist out of hours if further advice was required.

Records

- The patient notes and all associated clinical work, such as medicine administration, were all completed on paper records.
- We reviewed five sets of nursing and medical records. Risk assessments were documented and evaluated although with the number of pressure ulcers reported it was indicated that risk assessments were not always effective and acted upon in a timely manner. Most of the pressure sores were device related and mostly preventable. For example there were three incidents of sores caused due to the incorrect positioning of the urinary catheter.
- 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 but in a folder to ensure patient confidentiality.
- Medical notes were in good order and information was easy to access through the use of colour coded sheets. For example, physiotherapists used blue documents specifically designed to record the assessment and treatment of patients and evaluate their care. Other examples included yellow forms used by speech and language therapists.
- We looked at samples of records which were fully completed, legible with entries timed, dated and signed for.
- Vital signs were well documented 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.
- 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.

Critical care

Safeguarding

- Nursing and medical staff had been trained to recognise and respond to safeguarding concerns in order to protect vulnerable patients. Overall there was a reported 94% compliance with safeguarding training level 1 and 100% Level two for adults and children within the trust. We spoke with five staff including nurses, doctors and administrative staff regarding their role in ensuring patients were safeguarded from abuse. All were clear about their responsibilities, as well as how to escalate concerns both internally and externally.
- We saw two examples of safeguarding concerns raised by staff in CCU that had been reported on the trust's incident report system. These showed the concerns had been escalated in a correct and timely manner and had involved the multi-disciplinary team including the safeguarding team.

Mandatory training

- Nursing and administrative staff described the mandatory training they attended. This included for example safeguarding training for adults (levels one and two), information governance, fire safety and infection control.
- Mandatory training records showed 91% of staff were up to date with the trust's mandatory training requirements. To maintain this status staff received emails to remind them of their current compliance level with their mandatory training.

Assessing and responding to patient risk

- 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, infections identified, 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.
- During the inspection a patient received in the accident and emergency unit was referred to the duty critical care consultant for admission and treatment in CCU. The patient was considered to not require admission to CCU and it was advised the prescribed treatment be provided in the acute admissions ward. A further request to admit the patient to CCU was made but the trusts critical care operational policy admission referral process was not followed resulting in delays to the treatment of the patient. This incident was reported as a serious incident and referred to and accepted by the serious incident decision team for an internal investigation.
- During this same episode, we observed staff in the accident and emergency department attempting to contact the critical care consultant on duty. The contact details were not available to staff. They tried contacting the consultant through the outreach team and also contacted switchboard who could not say who the CCU consultant on call was. This was because they did not have access to the duty rota which was in electronic format. This meant staff were not able to effectively respond to patient's needs to ensure their safety by obtaining the appropriate clinician's support in a timely manner.
- We spoke with eight 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. Some doctors explained they felt the referral process was not effective and described how they experienced difficulty with getting medical patient referrals to the CCU accepted. We spoke with CCU consultants about this concern who expressed frustration about the lack of engagement they experienced with consultant Physicians.
- 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. The report recommended, 'the service establish transfer training internally within the trust and/or seek collaboration with another trust as a matter of urgency.
- 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. The purpose of this service was to support all aspects of the acutely and critically ill patient including early identification of patient deterioration, timely admission to a critical care bed and delivery of effective follow up of patients post discharge. The outreach team provided educational support to enhance skills and knowledge of

the multi-disciplinary team in general ward areas when caring for at risk and deteriorating patients. This was in accordance with National Institute of Clinical Excellence (NICE) guidelines.

- To aid early identification of deteriorating patients the trust used the National Early Warning scoring observation tool (NEWS). To ensure the tool was correctly used, training was provided to staff and completed NEWS documents were audited. This meant that staff could use the observations to alert doctors or the outreach team of a patient's potential deteriorating condition to ensure early intervention and treatment.
- Unplanned readmission rate of 1.2% to the critical care unit within 48 hours of discharge to the ward was the same as the national average rate of 1.2%. This was discussed with medical staff who reported that those awaiting discharge from the unit to the wards may not always be as closely observed as they could be and felt this may attribute to patients being readmitted to the unit within 48 hours of discharge. There was no evidence that there was an effective plan in place to address this.
- The acquired pressure ulcer incidents in critical care were mostly device related. Nursing staff in CCU had recently introduced the use of a small device to minimise the risk of development of skin damage caused by long term use of nasogastric tubes. Staff had found these to be effective. Patients were monitored using recognised observational tools and monitors. Alarms were set on monitoring equipment to alert staff to any changes in a patient's condition. This meant deteriorating patients would be identified and action taken such as escalation to the appropriate team without delay.
- The clinical director of CCU told us they attended weekly mortality meetings but we did not see evidence of these meetings. We saw evidence of Morbidity meetings held within the trust but these did not contain details of who attended the meetings.
- 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.
- The outreach team maintained their own list of sick 'at risk patients' but they were not aware of any similar list held by the trust for example by the bed bureau at the time of the inspection. However they were aware the trust did have arrangements in place to commence providing a Hospital at Night service on 20 April 2015. The programme aims to enhance patient safety through having a multi-professional team who have the full range of skills and competences to meet the immediate needs of patients during out of hours.

Nursing staffing

- The unit followed the staffing standards from the Core Standards for Intensive Care 2013 and the British Association of Critical Care Nurses guidance for the staffing of critical care units. There was one nurse for each patient needing intensive care (level three) and one nurse for two patients needing high dependency care (level two). In addition, the nurse in charge was supernumerary. The staffing rota was planned and staff worked on a rotational basis on days and nights. Any changes to the rota were crossed through and initialled so that approved changes to shifts could be evidenced and tracked if required.
- There was a high level of temporary staff usage due to the fact there were more than 13 whole time equivalent nursing vacancies in CCU at the time of the inspection. On the day of the inspection there were five agency staff on duty. Overall the trust has a higher share of bank and agency staff of 13.9% compared with the England average of 6.1%. However this agency figure was influenced by staff preferring to join an agency to work extra shifts because they received a better rate of pay rather than working overtime for the trust.
- There were occasions where staffing cover was insufficient to meet the dependency levels of the patients. These episodes had been escalated and reported as clinical incidents. The shortfall was due to the non-attendance of a booked agency nurse. There were no other incidents reported or evidence of any negative impact to patients reported on this date. Nursing staff confirmed that permission to request agency staff was well supported and not problematic.
- Although there was a nurse in charge who was supernumerary to effectively manage the service during the day time this was not always possible at night. For example, there were six occasions during February 2015 where a supernumerary nurse in charge had to manage a low dependency patient.
- Agency staff were, when booked, provided by an agency who were known to the trust and had given evidence and assurances that the staff they supplied were qualified and had current registration with the Nursing and Midwifery Council.

- Agency staff new to the CCU were given an induction to the unit and provided with a leaflet to use during their shift which included information such as useful bleep numbers of key services such as x-ray, pharmacy and portering plus names of the senior medical team. However data supplied by the trust showed agency staff in CCU did not always receive an induction. On occasion as few as 35% of agency staff received an induction to the unit. The induction records were retained by the manager when signed by the staff member for reference.
- The outreach team consisted of one band 7 and 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 (for example 8% of their shifts in the past month) 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 proposed action was to call the fourth on call doctor to attend requests for outreach support for deteriorating patients.
- At the time of the inspection, there were 23 band 6, seven band 7 nurses and four band 5 nurses with an intensive care qualification in post. Five nurses were currently undertaking the intensive care course and we saw evidence that staff had had training to provide mentorship to these nurses. The matron explained the number of places on the course had been increased from two to five to attract and sustain staffing numbers with the appropriate skills.
- There was a good handover between nursing staff when shifts changed and we saw this had recently been reviewed for its effectiveness and planned actions implemented. A formal handover session for half an hour at the start of each new shift took place in the patient's bed space to the nurse coming on duty in addition to a one to one documented handover between the senior nurses in charge. The majority of nurses worked the trust-standard 12 hour long shifts, unless a different flexible arrangement was agreed.
- Ward receptionists were employed for non-clinical duties such as obtaining medical records, arranging appointments and responding to visitors to the unit.

Medical staffing

- Care in CCU was consultant led and delivered. There were a total of 11 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 jurisdiction of the consultant.
- We saw continuity of care at consultant level was provided by the use of an on call rota. 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 Core Standards for Intensive Care Units 2013 and the British Association of Critical Care Nurses recommends that a ratio of one consultant to 14 patients should not be exceeded. The ratio at the time of the inspection was one consultant and one resident doctor to 19 patients however six of these patients were Level 1 patients who had been discharged from CCU and waiting for beds elsewhere.
- Anaesthetic staffing cover for weekends and out of hours was entered on the trust's risk register in April 2014. There was only one CCU doctor and one consultant on duty which did not meet the Intensive Care Society standards.
- There was a standardised handover between shifts each day which we observed. Ward rounds were led by the consultant with input from other relevant staff, including junior doctors, nurses, and allied healthcare professionals.

Major incident awareness and training

- There were contingency and hospital wide major incident plans, which included critical care and anaesthetic response.
- We spoke with two nursing staff that were clear with regards to what a major incident was and about their role in responding to it. The matron described two examples of desk top exercises they had completed, the most recent being for preparedness due to the potential receipt of patients with the Ebola virus.

Critical care

Are critical care services effective?

Good

Overall, we rated the service to be good for effectiveness.

There was participation in local and national audits, including clinical audits.

Patients were assessed regularly for pain, nutrition, hydration and effective care or treatment. Patient's needs were assessed and care and treatment was delivered in line with legislation, standards and evidence based guidance. Nursing and medical staff were appraised to judge their competency and professional development.

There was multidisciplinary work, with support provided to the unit by a range of professionals. The hospital did support a critical care outreach team, although this was at times compromised when the team were required to work in CCU due to staff shortages. Out of hours medical support did not meet national standards. There were suitable arrangements for out of hours support from other services, such as physiotherapy, imaging and pharmacy.

Evidence-based care and treatment

- Recognised clinical guidance was used to deliver care, for example National Institute for Clinical Excellence (NICE) guideline CG83, 2009 – rehabilitation after critical illness. Research shows that up to 70% of patients who have an admission to a critical care unit (CCU), have some degree of post-traumatic stress (PTS) following their discharge. To minimise this, a post discharge clinic was provided and patients received a leaflet with a discharge leaflet about their care and support following discharge from the unit.
- Physiotherapists worked towards evidence based goals of mobilising patients within five days of an admission to critical care to ensure length of stay was minimised. Physiotherapists had recently reduced the number of ward rounds attended to two from three rounds a week to focus more on providing one to one care immediately following nurse handover.
- There was an enhanced recovery project for upper Gastro Intestinal patients. These patients required a period of care post operatively in CCU. Pre-operative visits to the unit were arranged to help the patient understand what to expect and not be alarmed when they found themselves in the unit. This had been found to be effective in reducing a patient's length of stay at the hospital.
- The use of ''Fresh Eyes'' stickers had been adopted. This was a system adopted from the maternity service 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 mostly found this to be beneficial except when it was very busy and difficult to swap patients.
- Some local CCU policies had no dates of expiry or ratification. These documents could not be accessed on the intranet similar to trust wide policies.
- Audits of certain aspects of care were used and compared both internally with other departments and externally with the critical care network. For example, internal audits of infection control compliance and audits of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) management which were forwarded to the NHS East of England critical care network. The NHS East of England DNARCPR policy was in use. The observational tool National Early Warning Score (NEWS) was in use. Compliance with the use of NEWS in other areas such as wards had been audited since its introduction. There was evidence of improvement from October 2012 (30% compliance) with an increase in compliance to 74% in December 2014 against the trust's target of 85%.

Care plans and care pathways

- Central venous catheter care bundles were used and audited. A bundle is a nationally recognised structured way of improving the processes of care and patient outcomes using a small, straightforward set of evidence-based practices for nursing staff to follow.
- The unit used a gold standard chart to record care including a range of recognised assessment tools including the Glasgow Coma Score and the Richmond Agitation Sedation scale for sedation assessment. In addition there were other assessments and intervention guidance, for example oral care and pain management. In summary the facility to record and monitor all aspects of a dependent person's needs were provided and we observed these were utilised correctly.

Pain relief

- Pain relief was well managed. Pain scores were documented in patient records, using recognised techniques and measures. We observed that patients who were awake were regularly checked for pain. 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 unit used the Malnutrition Universal Screening Tool (MUST) to assess the nutritional needs of patients. Nutrition and hydration was managed effectively. We observed a doctor requesting a dietician's advice for a patient receiving treatment for burns. Records of nutritional advice requested and provided were documented. The unit also had a link nurse to promote nutrition and hydration needs of patients and ensure needs were met.
- Fluid intake and output was measured, recorded and analysed. The method of nutritional intake was recorded and evaluated each day. Energy drinks and food supplements were used for patients who needed them.
- Access to dietician support was available Monday to Friday as was access to speech and language therapists (SALTs).

Patient outcomes

- The critical care outreach team audited cardiac arrests to identify if treatment and processes had been followed in accordance with the trust's protocols and identify any issues for escalation. If any issues were found these were reported as an incident. For example, if equipment was found to be faulty or staff attending did not have the skills to appropriately respond. These were then followed up by the outreach team.

ICNARC

- The unit fully participated and submitted a complete set of data for the audit undertaken by the Intensive Care National Audit and Research Centre (ICNARC). The Annual Quality Report 2013/14 for adult, general critical care showed the unit had a higher than national average re-admission rate within 48 hours. This was 1.65% against a threshold of 1.2%.
- We spoke with two doctors in CCU who did not have an understanding or awareness of ICNARC and its significance. They told us they did not receive feedback about the data. This meant the team were unable to utilise the data to effectively review and improve the quality of care provided.

Competent staff

- There was a comprehensive induction for new staff. This included both a trust wide induction and local induction. There was one designed for permanent staff and students and another for temporary staff, such as bank and agency staff.
- Medical, nursing and physiotherapy staff we spoke with reported they had appraisals where they could discuss their work. Staff said they found the appraisal process useful and were given objectives to achieve the department and trust wide goals. The trust had six core values; these were part of the appraisal document and performance was reviewed and objectives planned to meet these values. We asked for evidence of the number of appraisals completed but this information was not available.
- A peer review by the East of England Critical Care Operational Delivery Network had been completed on 07 July 2014. This was an audit of compliance against service specifications for adult critical care, and core standards for intensive care and rehabilitation standards. Six of the 49 standards were not being met and 12 were only partially met. We reviewed the recommendations produced to address the shortfalls and were able to see the majority had been subsequently met or work was in progress to ensure compliance. For example, the standard for discharges from CCU from decision to discharge to actual discharge should not exceed four hours. The unit were continuing to audit this and report reasons to the trust executive team. There was no evidence that there was an effective plan in place to address this, the non-compliance with the recommendations was not included on the unit or trust risk register.
- Staff were given the opportunity for specialist training such as leadership training and training to achieve a post-registration critical care qualification. The Core Standards for Intensive Care Units recommends that 50% of nursing staff should have this qualification. The CCU met and exceeded this standard. All intensive care unit staff were trained in adult intermediate life support.
- Staff had access to a training room to complete mandatory eLearning courses and other training. The

room was equipped with spare equipment such as syringe drives and cardiac monitors used solely for training purposes. There were also resources provided about caring and supporting people with learning difficulties.
- We saw evidence of staff having completed various competencies such as use of the observational tool NEWS, medicines and intravenous therapy. Nursing staff were provided with a booklet to record competencies and the stages they had achieved. We saw examples of these in use.
- The unit used a rotational programme to help staff from other departments develop their skills in caring for patients with a high level of dependency. Staff from both the maternity and recovery departments were working in CCU under supervision during the inspection.
- We observed informal bedside training incorporated to bedside care delivery and saw that staff had received mentorship training to support students and new staff in accordance with professional guidelines.

Multidisciplinary working

- There was a multidisciplinary team (MDT) that supported patients and staff in the unit. For example, there was a dedicated critical care pharmacist who provided advice and support to clinical staff in the unit and a microbiologist who attended the unit on a daily basis. During the MDT meetings issues such as admissions (including patients scheduled for elective surgery), discharges from the unit, patient dependency levels (for example level two or level three) and any specific issues such as infections were discussed.
- There were physiotherapists attached to CCU, who joined the ward rounds to discuss, for example, weaning plans, mobilisation and rehabilitation for patients. The physiotherapists worked closely with the outreach team to prepare people for discharge and minimise the incidence of re-admissions to CCU.
- There was access to a psychiatric liaison service and requests for this service were responded to and patients seen within 24 hours of a request.
- Staff had access to a tissue viability nurse to provide guidance and advise staff about appropriate wound care such as the management of pressure ulcers.
- For organ transplants there was an NHS England Blood and Transplant service lead nurse employed as well as trained link nurses to support this service. There was also a board on the ward with information about organ donations for staff and relatives.

Seven-day services

- There was a consultant on call to the service out of hours. However, they were not necessarily a specialist in intensive care medicine, but were general anaesthetists.
- Consultants worked on rotation and were responsible for ensuring the unit had adequate clinical cover from junior doctors at all times when a consultant was not on duty on the unit.
- Most facilities were available out of hours, this included physiotherapists, radiographers and radiologists and pharmacists all available at night and weekends.
- There was consultant cover for patients in the unit from 8am to 5pm and an on call service out of hours and weekends when consultants visited patients

Access to information

- Staff had easy access to medical records when required. The CCU employed reception staff who coordinated the provision and requests for medical records.
- Staff had access to useful information such as the manufacturer's guidance about the equipment they used and how to communicate effectively with people living with dementia. There was also text books about critical care nursing for staff to refer to.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked by nurses, physiotherapists and doctors to give their consent when they were mentally and physically able. Staff acted in accordance with the trust's policy when treating an unconscious patient, or in an emergency. Staff we spoke with understood and acted in accordance with the Mental Capacity Act 2005 if it was decided to temporarily deprive a patient of their liberty. Staff had received training in aspects of the Mental Capacity Act 2005, including provisions for depriving someone of their liberty in their best interests.
- There was a sedation protocol that took account of the potential need to use restraints if a patient became delirious, this included guidance for staff about how this was to be managed. The guidance advised use of

restraint 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.

- During the inspection we observed patients being cared for with delirium. Deprivation of Liberty Safeguards (DoLS) had been authorised and these had been correctly completed and included a date for when they expired.
- Care and treatment was given to patients who could not give valid informed consent in their best interests. General day-to-day care and treatment decisions, such as giving medications, giving personal care, nutrition and hydration and performing tests were made by the clinical teams. If more serious decisions were needed, there was evidence that staff held best interest meetings with those people who could speak for the patient to hear all the views and opinions on future decisions. The assessment form for mental capacity and best interests was thorough. These were completed by the patient's consultant.
- For patients on clinical trials there was evidence in the medical records that there had been a discussion about this with the patient and their consent had been recorded.

Are critical care services caring?

Good

We rated the service good for caring.

Comments from patients and relatives about the care they had received in the critical care unit (CCU) were positive.

Patients were cared for by dedicated, kind and caring staff.

We saw and overheard sensitive and considerate interactions between staff and their patients. Patients were treated with privacy and dignity.

Patients and relatives were involved in decisions about care and treatment and, where able, gave informed consent.

Compassionate care

- Staff practiced and understood the principles of delivering compassionate care to patients receiving intensive care. This included supporting patients who were confused or anxious. Staff explained they would talk to a patient and tell them their name, smile, reassure the patient and try to help them relax. Nurses and doctors talked to patients and their relatives with kindness and compassion.
- We spoke with six patients and three relatives in CCU. All the patients we met told us their care had been good. Relatives we spoke with said staff had met with them soon after they arrived the first time, and they had received updates on each subsequent visit. All visitors we met 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.
- Although the Patient Led Assessment of the Care Environment (PLACE) trust wide score of 78 for privacy and dignity fell below the national average of 88, we observed care being delivered in CCU where patients' privacy and dignity was preserved. 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 being drawn or door being closed when any patient received personal care.
- The Friends and Family Test (FFT) is used to evaluate if they would recommend the service to others. The trust wide results fell below the England average score of 95% during the period June 2014 to October 2014 but had increased in November 2014 to 93%. There was a higher response rate to the FFT at Watford General Hospital compared to England average.
- A calm quiet relaxed atmosphere was maintained by staff for patients and relatives through the staff being discreet and quietly spoken. Telephones and entry phones were answered promptly. 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.

Patient understanding and involvement

- We observed nursing staff introducing themselves by name and helped orientate patients by providing the date and time of day. They then explained what they were going to do, where possible, with the patient's

agreement and why. They explained, for example, when medicines were due to be given, when staff changed at handover, or if the patient was going to be moved to another department for a test.

- One patient said, ''Staff responded quickly and sorted me out. They explained what was going on. I would normally have been admitted to a different hospital but it is so much better here.''
- Another patient told us they had been asked for their consent for treatment and their opinions before decisions were made. Relatives told us staff had given them the advantages and disadvantages of any proposed treatment options.
- There was a system in place for pre-operative visits, for some specialities such as patients undergoing major gastro intestinal operations. One patient described how they had been told that they would wake up in critical care unit and knew what to expect. They said, ''the staff are brilliant and so kind, they saved my life.''

Emotional support

- The receptionists managed telephone calls and visitors requesting access to the unit. They greeted patients and their relatives in a quiet, warm and friendly manner
- Patients who were restless and confused were observed to be provided with one to one support and relatives were given appropriate information and reassurance by staff.
- The unit was using 'patient diaries.' These were used for staff to record patient progress and for friends and family to record their visits or significant events. The system for commencing diaries was not well-developed; this system had been in use previously but had only recently been re started.
- During the inspection a minister for Jehovah Witnesses visited the ward. They were able to describe their involvement in the development of a protocol for the management of patients regarding the use of blood and blood related products to ensure people's beliefs were respected.
- There was a hospital bereavement group and staff had access to attend bereavement training. The ward receptionist in CCU described that they had been supported to attend a compassionate communication course to help respond and support distressed and anxious relatives.
- Access to counselling services for staff were available. To access this service there was a confidential 'Employee Assistance' dedicated telephone line.

Are critical care services responsive?

Requires improvement

We found that the service required improvement for responsiveness.

Services are not always planned in conjunction with other local services. Services were delivered in a way that is inconvenient and disruptive to people's lives. The Critical Care Unit (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.

The core critical care standard for discharges from CCU from decision to discharge to actual discharge was not met. However this matter was outside the control of the CCU team and staff were continuing to audit this and report reasons to the trust executive team.

CCU had a quiet room for relatives to have discussions in private or stay overnight if required. The unit was able to meet the individual needs of patients and provided personalised nursing care. 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 and were encouraged to do so. Complaints from patients were infrequent, but staff were aware of how to respond appropriately.

Service planning and delivery to meet the needs of the local people

- Certain categories of patients who needed specialist services were transferred to appropriate units in London. However, the unit did take medical patients directly from the accident and emergency department as well as elective surgical patients who required close monitoring post operatively. The CCU operational policy had a patient pathway which describes the different patient flows into and out of CCU. Such as admissions through accident and emergency, admissions from theatres and criteria for admission to CCU.

- 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. 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.
- The CCU had a visitor's room for relatives to have discussions in private. This room was used for relatives if they needed to stay overnight, if for example, their loved one was very unwell or was unstable. There were no arrangements for provision of food and drink. Although staff provided tea and toast when possible, there were vending machines available for people to use. Feedback surveys had shown there were suggestions for the provision of a hot drinks machine and there was information displayed in CCU to let people know this request was being responded to.

Access and flow

- The trust provides acute healthcare services to a population of approximately half a million people living in west Hertfordshire and the surrounding area. There were a total of 19 critical care beds for the care and treatment of people 16 years and above to meet the needs of this population.
- Adult critical care bed occupancy was largely consistent with the England average occupancy rate. It fluctuated around the England average throughout the reporting period of 2014 with no trends identified.
- With the exception of readmissions within 48 hours to CCU, Intensive Care Nursing Audit and Research Centre (ICNARC) quality indicators were within the expected range, this included out of hours discharges to wards and non-clinical transfers, of which there were none reported.
- Patients who were ready to go to a ward often remained in the CCU from one to six days until a ward bed was available. From October 2014 to January 2015, there had been 108 occasions when this had occurred. These were reported as incidents and this risk was recorded on the CCU risk register. During the inspection, there were at times up to six patients who had been clinically discharged from CCU were still on CCU and were awaiting beds on other wards. We saw that the trust's Clinical Strategy for 2015 included plans for redesigning and continuously improving the unscheduled care pathway and model of care to drive improvements in non-elective length of stay and improve patient flow.

Discharge and transfer

- There was a system of an optional post discharge follow up for patients who had been a patient in CCU for 48 hours or more. Follow up after discharge is a recommendation from Core Standards for Intensive Care Units 2013 and the National Institute of Clinical Excellence (NICE) CG83 2009. There was a leaflet describing this service, its benefits and how it could be accessed. This leaflet also included information about what patients and relatives upon discharge from CCU could expect for example, problems they may encounter such as difficulty concentrating.
- Doctors reported that those awaiting discharge from the unit to the wards were not always as closely observed as they could be and felt this may attribute to patients being readmitted to the unit within 48 hours of discharge.
- For inter hospital transfers, CCU used the East of England Critical Care Network (EECCN) standard transfer multiple copy document. We saw this used during the inspection. The back of the pro forma included a risk assessment to be completed prior to transfer using the NEWS observational tool and other indicators to evaluate the level of risk. Staff explained the consultant had the final say regarding the team and skills required to safely transfer a patient to another hospital or service.
- When patients were discharged directly home from CCU, (staff reported this occurred about once a month) they worked with the integrated discharge team to ensure the patient's needs were met.

Meeting people's individual needs

- Staff were able to describe the areas of equality and diversity they had experience of supporting. They were knowledgeable about the strands of equality and diversity and what made each person an individual. Staff would respect different cultures and religious needs by, for example, providing only male or female staff if this was important to the patient. Staff we spoke with said all patients would be treated and cared for as individuals and adjustments would be made to ensure the outcomes for patients were as good as they could be.

- There were translation services available. The reception staff explained that they contacted the Patient Advisory Liaison Service (PALS) if an interpreter was required. They described the service as being responsive and their experience had been that they could usually provide an interpreter within half an hour if urgent. An example given was of a patient who had been repatriated and doctors required the medical notes to be interpreted to fully understand the patient's needs and treatment that had been provided.
- When preparing for a patient to be discharged from the unit, the receptionists ensured patients were asked where appropriate about their preference of transport, for example to use a wheelchair or stretcher.
- Staff had access to a network of support for patients' spiritual needs, both within the hospital and from the local community. The chaplaincy for the hospital visited the hospital regularly. In addition specific visits could be arranged.
- There was good access to a range of information for families and friends displayed in the visitor's room on topics such as how patient diaries were used and their benefits, what research was being undertaken and how consent for this was obtained. There was also information about access to the patient advice liaison service (PALS) should relatives have a concern about the service.
- There was an overnight room for relatives to use and access to a multi-faith room and ministers to provide spiritual support when required.

Learning from complaints and concerns

- The staff received feedback about the care provided through the use of comment cards. We saw evidence of how this information had been used to improve the quality of the service such as the introduction of wall clocks so that patients could orientate themselves.
- A patient's relative described a series of communication problems they had experienced which had resulted in their next of kin being re admitted to CCU. They told us the doctor offered to assist them to access PALS and explained they could make a formal complaint if they wished. They declined as they were happy with the care provided in CCU.
- We asked for but were not able to see evidence of complaints received by the trust or feedback about complaints to staff. Staff explained the unit received few complaints or concerns. Informal concerns or complaints were dealt with by staff on duty and the Matron either took responsibility to address these, or was informed about how they had been managed. Formal complaints were redirected to PALS who initiated an acknowledgment. The complaint was then passed to the relevant person in the unit to respond fully.

Are critical care services well-led?

Inadequate

Overall, we rated the service as inadequate for well led.

The leadership and governance did not always support the delivery of high quality person-centred care. This meant that the trust's vision was not being met to provide consistently good safe care. The arrangements for governance and performance management were not cascaded through the critical care service.

The arrangements within the CCU for governance did not operate effectively. There has been no recent review of the governance arrangements. Although delayed discharges were recorded on the risk register and each delay recorded as a clinical incident there was no evidence of a local strategy being initiated or requested by the trust board to minimise this risk.

Governance arrangements for auditing and monitoring clinical services were ineffective and unclear. Although there was some evidence of nursing audit and learning, information and analysis were not used proactively to identify opportunities to drive improvements in care. Risks identified were not always responded to in a timely manner.

There was lack of recognition of risk and where risks were recognised action was not always taken to address them in an effective or timely manner.

Recommendations from a peer review by the East of England Critical Care Operational Delivery Network completed on 07 July 2014 had not been addressed effectively.

Junior medical staff were unaware of the latest Intensive Care National Audit and Research Centre (ICNARC) data results and the unit's participation in these audits.

Critical care

The critical care nursing team was well motivated and supported at local level. The local nursing leadership were well respected because of their clinical skills and knowledge.

Feedback from relatives was responded to and there was participation in the local critical care network to identify and share best practice.

Vision and strategy for this service

- The trust's vision was to embody in its hospitals all the principles, values and the sense of service that created the NHS by providing consistently good, safe care in a friendly, listening and informative way, as and when people needed and wanted it and always with dignity and respect. The trust values were used and embedded within the appraisal documents used to evaluate staff performance.
- There was no evidence of a local critical care strategy or of one being requested by the trust board.
- We saw evidence that there were recent plans to increase the number of consultant posts in critical care. However the risk had been on the register since April 2014.
- The trust performed better than other trusts in the General Medical Council (GMC) National Survey of Trainees for seven out of 12 indicators and the same as other trusts in the other five indicators.

Governance, risk management and quality measurement

- There was a Critical Care risk register in use in addition to the trust risk register. However not all key risks were identified and therefore there were not effective plans in place to address them.
- Staff were aware of the items that were on the CCU risk register such as delayed discharges and use of temporary staff. Some items had been on the register since 2009 such as delayed discharges and were due to capacity issues. Actions taken included continued monitoring, working closely with bed managers but there was no plan formulated or requested to reduce the risk or number of incidents.
- We were told there were clinical governance meetings, which were attended by the CCU team but there was no evidence available to support this. The minutes of these meetings were not distributed to the nursing team.
- Junior medical staff were unaware of the latest Intensive Care National Audit and Research Centre (ICNARC) data results and the unit's participation in these audits.
- The outreach service had a policy that reflected national and local critical care network guidelines. The policy specified the team's role in participating in audit activities and identifying further learning needs as required. However on occasions where the outreach staff were used to staff the unit potentially leaving the hospital without an outreach service These situations were not reported as incidents
- Nursing and medical staff were aware of the CCU risk register and the risks recorded. This included delayed discharges from CCU due to lack of beds available on the wards, the quality and number of temporary staff employed and the failure to meet recognised standards of out of hour's medical cover. The risk register reflected what staff told us.
- The matron of CCU explained the main staffing challenge was the recruitment of band 6 nurses with an intensive care qualification. This matter was recorded on the CCU risk register as the matter had been long term (on going for 12 months) and resulted in continued use of agency staff. Measures had been taken to minimise the risks and potential impact on patient safety such as ensuring where possible agency staff not familiar with the unit were allocated patients with a low dependency level however these staff did not always receive an orientation prior to commencing their duties.
- A shortfall in out of hours medical staff (anaesthetists) had been recorded on the CCU risk register in April 2014 and subsequently reviewed in January 2015. Actions taken were that incidents in CCU were monitored to ensure there was no increase of which may indicate a shortage of medical staff had an impact on patient safety nor had the shortfall resulted in cancellation of operating lists with patients requiring care in CCU post operatively. A business case had been submitted in February 2015 for the appointment of an additional 1.5 whole time equivalents (WTE) consultants. There had also been some recruitment activity for CCU resident doctors and eight applications had been received but applicants were found to be inexperienced and not appointed. There were no posts advertised at the time of the inspection.

Leadership of service

Critical care

- The unit was led by a consultant clinical director and an interim band 8 matron.
- Senior clinical staff had access to and were participating in leadership programmes provided by the trust.
- Only recently had there been a trust wide initiative to minimise the level of pressure ulcer incidents, This was through the introduction of a specific set of skin care prevention and treatment documentation called 'Best Shot'. There was no local action plan specific to critical care to reduce the number of incidents.
- 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. We were unable to establish if this had been escalated by those who had concerns.
- There was a mixed response from medical staff about clinical leadership. Junior doctors felt very well supported by the CCU consultant when on call. However, some stated when issues were raised they were not responded to. Examples given were the recommendations not being responded to that featured in the East of England Critical Care peer review, such as training to manage patients during transfer to other services or hospitals.
- Physiotherapists described the CCU team as receptive to their input and that they were involved in decision making about patients planned care.
- Nursing staff reported they felt well supported by their line manager. Staff spoke positively about the appraisals they had received. They described and we saw the trust's values were used as the framework for reviewing performance and setting objectives. Ninety nine percent of CCU staff had received a recent appraisal. Nurses described how they had met the director of nursing when she came and spent a day working on the unit which was valued by staff. One nurse said, "I thought this was excellent, they knew what our challenges were. They were easy to approach; I could go and talk to them."

Culture within the service

- Administration staff described how they felt respected and that their contribution was valued by the team.
- We observed good team working, and there was a pleasant atmosphere. Staff said the matron knew how to get the best out of staff. They felt supported and allowed to use their own initiative within reason and described that CCU had a positive learning environment**.**
- The staff sickness absence rate for the trust was lower than the England average, for the CCU the sickness rate was 13.6%
- A staff member explained they had required a long-term absence from work but felt they had been well supported on their return to work and were complimentary of their colleagues and manager in the support they had received.
- There was a strong culture of teamwork and commitment from the nursing staff in CCU. All the staff we spoke with said the strength of the unit was a friendly and cohesive team. Patients and relatives also commented on the positive nature of the staff they met.
- Staff in CCU told us they felt supported by their line manager and were encouraged to raise and report concerns.

Public and staff engagement

- Due to the nature of critical care there was no general public involvement with how the service was run, but patients and their relatives were asked to comment on their care. Staff and patient surveys were completed. The results for 2014 showed staff felt feedback from people using the service was actively used to make improvements. We saw examples of feedback received from relatives and actions taken to improve the environment such as the purchase and use of clocks for patients. The relatives and patients we spoke with were all complimentary of staff and the service provided.
- Most staff we met felt they had a voice and their opinions were valued. There was a degree of flexible working, which the staff appreciated.

Innovation, improvement and sustainability

- There were approved research programmes which were well promoted and documented. Information was displayed for relatives to raise awareness.
- There was a practice development nurse for the critical care service. They described how they ensured staff were supported to complete their induction programmes when new to the unit and comply with

mandatory training requirements in addition to helping staff achieve and maintain clinical competencies required for provision of effective care in a critical care environment.

- Clinical governance was ineffective and therefore reviews of critical care procedures and ensuring best practice was slow. For example local CCU protocols were not dated or referenced to national guidance therefore staff using this information could not be sure they were using the most recent best practice.
- There was active participation and involvement with the local Critical care network.

Maternity and gynaecology

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

Information about the service

The maternity service provides antenatal, labour and postnatal care for women.

Between July 2013 and June 2014 there were 5,456 babies born across the trust. The year before, 2012/13, there were 5,696 deliveries. This level of activity puts the trust in the top 30% of trusts for the number of deliveries.

The trust had a higher percentage of births to mothers aged 35 to 39 (22% compared to England average of 16%).

At Watford General Hospital there is a consultant led delivery suite with 12 delivery rooms (including one bereavement room) and two obstetric theatres. There is also a three-bedded recovery bay for women returning from theatre and a two-bedded obstetric observation bay. Two of the delivery rooms have en-suite facilities.

The Alexandra Birthing Centre (ABC) provides midwife led birthing services for women with uncomplicated pregnancies and who are anticipating a normal birth. There are seven birthing rooms in this centre and they all have en-suite toilet and shower facilities. There are two pools and a sensory room. There are approximately 1100 births a year in the ABC and this unit has one of the highest levels of pool births in the country.

There is a 14 bedded antenatal ward at Watford General Hospital and a maternity day assessment unit and screening services. There was also a 26 bedded postnatal ward with an additional six transitional care beds.

There is a dedicated operating theatre for gynaecology at Watford General Hospital and women who have elective and emergency inpatient surgery are treated on Elizabeth ward. At the time of the inspection the 28 bedded ward was providing care for both gynaecology patients and for other female medical patients and some patients requiring care for the elderly.

The service also carries out termination of pregnancies at Watford General Hospital.

We visited all clinical areas in the service and spoke with 30 staff, 15 patients and looked at the records for 13 patients.

Maternity and gynaecology

Summary of findings

We rated the service as requiring improvement for effectiveness, caring and responsiveness and inadequate for safety and being well led.

Safety was not a sufficient priority. There was limited measurement and monitoring of safety performance.

Staff recognized concerns, incidents or near misses, but effective action was not always taken to investigate or address these. We found that the service routinely reported never events and safety incidents; however, we found that the service had a number of outstanding investigations. This meant that the service was not reviewing incidents in a timely way in order that lessons could be learned when things went wrong and was not improving the safety of the services for patients.

Substantial and frequent staff shortages and poor management of agency or locum staff increased risks to patients. Vacancy levels for permanent midwives, nurses and health care assistants were at 25% and had been at high levels for a significant period of nearly a year. We found that this was affecting the permanent staff and many were under pressure to fill gaps, support less experienced staff and those unfamiliar with the working environment.

The mix of patients and staffing levels on Elizabeth Ward was of concern. The staff on this ward were unable to provide the care required by the dependency levels of patients on the ward and, although highly professional, were struggling to cope with the workload.

Patient care records were not always completed in accordance with trust policy.

Daily checks of the maternal resuscitation equipment had not been carried out and the compliance with these checks against trust policy had not been monitored.

The maternity service was not meeting the trust target for compliance with level 3 safeguarding children trained staff at the time of the inspection.

Medication storage fridges did not always have daily temperature checks recorded which was not in accordance with trust policy.

There were security risks regarding access to Katherine ward found during the inspection, which were immediately raised as a concern.

The maternity and gynaecology services used national evidence based guidelines to establish and deliver the care and treatment they provided but there was not an effective system to ensure polices and guidelines were reviewed to reflect current national guidance.

Performance outcomes for maternity were generally in line with trust and commissioners' targets.

The staff participated in national and local audits but outcomes from audits had not helped to make improvements in care.

There was a multidisciplinary approach to care and treatment, which involved a range of staff in order to enable services to respond to the needs of women. Although staff told us that that working relationships between the professional groups could be improved.

Consent was appropriately obtained and women were supported to make decisions about their care and treatment. However some staff did not demonstrate a full understanding of consent and mental capacity.

Some staff had not had a performance appraisal in the preceding 12 months.

We found this service required improved for caring. We observed most staff interacting with women and their partners in a respectful compassionate way. However, we observed two interactions where patients were not treated with respect and dignity in the maternity service.

Women were involved in their birth plans and had a named midwife for their pregnancy.

Senior staff members who spoke with us were aware of the increasing demands of the local and wider community, and the impact this had on other maternity services.

There were occasions when capacity and staffing affected the clinic arrangements and interrupted the provision of services in antenatal care. This meant that women experienced longer waiting times.

Bed pressures affected the patients' experience and journey.

Maternity and gynaecology

Referral to treatment times for patients were generally in line with other NHS trusts.

The service responded to the needs of women who needed extra support. There was a range of specialist midwives in post.

The gynaecology ward took a high number of outlier patients from other specialities. This impacted on the response the service gave to gynaecology patients. Gynaecological elective patients were cancelled frequently and nurses on the gynaecology ward told us that elective patients often had to wait for several hours in a 'holding' area for a bed to become available.

The service's ability to respond and learn lessons from complaints was not effective.

The service did not have a defined strategy in place that staff could describe.

There was a lack of overall direction and leadership of the service.

There was a lack of managerial and senior clinical ownership in the investigation of serious incidents.

Recommendations from independent reviews of the service had not been owned or actioned by managers.

The service did not have an effective governance framework to support the delivery of good quality care.

There were not effective arrangements for identifying, recording and managing risks, issues and mitigating actions.

The risk register was not current or reflective of the level of risks in the service.

Staff morale was poor and staff did not feel engaged to help shape the service with a focus on care and quality.

Are maternity and gynaecology services safe?

Inadequate

We rated this service inadequate for safety.

Safety was not a sufficient priority. There was limited measurement and monitoring of safety performance. Staff recognised concerns, incidents or near misses. However, effective action was not always taken to investigate or address these in a timely manner.

We found that the service routinely reported never events and safety incidents; however, we found that the service had a number of outstanding investigations. There was a backlog of incident investigations included deaths of babies. This meant that the service was not reviewing incidents in a timely way in order that lessons could be learned when things went wrong and was not improving the safety of the services for patients.

Substantial and frequent staff shortages and poor management of agency or locum staff increased risks to patients. Vacancy levels for permanent midwives, nurses and health care assistants were at 25% and had been at high levels for a significant period of nearly a year. We found that this was affecting the permanent staff and many were under pressure to fill gaps, support less experienced staff and those unfamiliar with the working environment.

The mix of patients and staffing levels on Elizabeth Ward was of concern. The staff on this ward were unable to provide the care required by the mix of patients on the ward and, although highly professional, were struggling to cope with the workload.

Patient care records were not always completed in accordance with trust policy.

Daily checks of the maternal resuscitation equipment had not been carried out and the compliance with these checks against trust policy had not been monitored.

The maternity service was not meeting the trust target for compliance with level 3 safeguarding children trained staff.

Medication storage fridges did not always have daily temperature checks recorded which was not in accordance with trust policy.

Maternity and gynaecology

There were security risks regarding access to Katherine ward found during the inspection, which were immediately raised as a concern with senior staff within the department.

Incidents

- Between 2013 and 2015 there had been four "never events" in the division, of which three occurred within gynaecological surgery and one in obstetrics at Watford hospital. A Never Event is defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures are implemented. Each never event was reviewed by the surgical quality group which included a full root cause analysis (RCA) of the incidents and learning from these incidents was disseminated to staff.
- Escalation of risk was identified through the trust's electronic incident reporting system. The ward manager or supervisor of midwives on call was contacted when a serious incident occurred.
- Nineteen serious incidents had been reported since April 2014. The trust told us that each underwent an initial local multidisciplinary review, and then was escalated to executive level before a comprehensive investigation was undertaken.
- The Women and Children's Services patient safety group dashboard, dated January 2015, reported that there were 172 incidents in maternity and 200 incidents in gynaecological services in a holding area and awaiting review. The same dashboard, for February 2015, showed that the number outstanding for maternity had increased to 184 and in gynaecology it had risen to 204. This meant that the service was not reviewing incidents in a timely way in order that lessons could be learned when things went wrong and was not improving the safety of the services for patients.
- From February 2014 to January 2015, 16 serious incidents were reported by the service. These incidents included a maternal death, three babies transferred unexpectedly to the neonatal intensive care unit (NICU), a ward closure, a uterine rupture leading to a caesarean section, a gynaecology patient inappropriately operated on in a maternity theatre and one case of a hospital acquired infection Clostridium Difficile (C. Difficile). A number of these investigations from November and December 2014 had not been completed at the time of the inspection in April 2015.
- The integrated performance report for Women and Children's services for January 2015 indicated that the service was below the 95% target for conducting Venous Thromboembolism (VTE) assessments as only 30% had been completed. At the end of April 2015, this performance had improved to 92.5%, against the trust target of 95%.
- The trust's target of 95% for harm-free care had been consistently achieved over the previous year for all harms in maternity and gynaecology.

Maternity

- In the past year, one 'never event' occurred in the maternity service. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. The never event occurred in November 2014 and involved a swab being retained following an operation. This concern was not identified until one month after the original operation and the patient had returned home. The investigation of this never event had not been completed at the time of our inspection. There was no evidence that senior managers had actively monitored the progress of this investigation.
- We reviewed a trust board meeting report with an update on serious incidents dated 6 March 2015. We found that seven of the reports listed were for maternity services. The reasons given for the delay in completing these investigations and reports were staff leaving and having to pass the work on to another individual and workload pressures.
- We reviewed the reports on the root cause analysis investigation for three of these serious incidents that had been completed. All three included detailed information, lessons learned and recommendations. There was also a section of the report entitled: 'Being Open Process'. This reflected the duty of candour and demonstrated how the investigation team had been in touch with the patient to discuss the progress and findings of the investigation. However staff were not aware of the findings of all these reports or the recommendations.
- We were informed that the maternity service had suspended admitting further women on one occasion in 2014 due to staffing and bed capacity issues. This was in line with the Maternity Escalation policy and was investigated as a serious incident. This had been recorded on the trust's electronic incident reporting system. The investigation had been completed in

February 2015 and learning had been identified relating to access and flow, escalation and decision making. Staff at the time of the inspection were not aware of the findings of this report.

Gynaecology

- The root cause analysis investigation report for the gynaecology patient inappropriately operated on in a maternity theatre said there were different views between the surgical team and maternity teams about the appropriate use of Maternity Theatres. The report concluded that there was no operational policy or guidance on this and recommended that a theatres' operational policy, which included escalation plans, was to be completed and developed. The target date for this was January 2015 but had not been completed by the time of our inspection
- In gynaecology, the most reported incidents related to slips, trips and falls. After robust nursing interventions, this trend reduced on this ward with no serious injuries reported in February 2015. However, eight of the 28 beds were being used for gynaecology patients. The rest were occupied by medical patients who were managed by a separate medical team. Slips, trips and falls were attributed to this group of patients rather than the gynaecological ones.
- The safety data on Elizabeth ward said it had been 13 days since the last fall on the ward. However, the nurse in charge said that there had been a fall recently but they had not had time to update the notice board.
- The integrated performance report for Women and Children's services for January 2015 indicated that the service was below the 95% target for conducting Venous Thromboembolism (VTE) assessments as only 30% had been completed.
- The trust's target of 95% for harm-free care had been consistently achieved over the previous year for all harms in maternity and gynaecology.

Cleanliness, infection control and hygiene

- The trust's infection control dashboard for January 2015 indicated that 100% of staff working on the ABC were compliant with infection control training.
- This was lower on Victoria ward (ante-natal) at 92%, and the delivery suite at 91%. Katherine ward (post-natal) was below the Trust's target at 81% as was Elizabeth ward (gynaecology, medical and elderly care) at 75%.
- The dashboard also included scores, based on observation, for hand hygiene with doctors falling well below the target on Elizabeth ward at just 45%, 50% on the ABC and 80% on the Delivery suite and 81% on Katherine ward. Victoria and Katherine wards achieved 100% compliance with hand hygiene for doctors and midwives.
- Overall cleaning scores were at least 96% compliant on all the maternity and gynaecology wards with Elizabeth ward with 100% compliance.
- Environment audits were completed according to the trust's infection control policy. Most areas achieved above 88%. In January 2015, the labour ward theatre scored 53%, the labour ward 68% and the antenatal clinic 79%. To address these poor results, domestic staff had been retrained and ward staff reminded of their responsibilities.
- Availability of hand wipes at mealtimes, hand gel and hand hygiene posters were areas identified for improvement. Hand gel was placed throughout the ward areas but not in all bed spaces, and hand hygiene posters were not widely displayed.
- According to the CQC maternity survey for 2013, the service scored about the same as other trusts for the cleanliness of the hospital room or ward. However, the trust scored worse than others for cleanliness of toilets and bathrooms.
- We saw that the environment in which women were receiving care was cleaned daily. We also saw staff cleaning equipment after use and applying stickers to indicate the equipment was clean and ready for use.

Maternity

- We saw midwives and nurses using the hand disinfectant gel and encouraging visitors to do the same. We observed staff to be complying with the trust's dress code, which included having bare arms below the elbow to facilitate full hand washing. Staff were seen using appropriate personal protective equipment such as gloves and aprons.
- On the final day of our visit there were two patients on the delivery suite who had tested positive for MRSA and were due to undergo elective caesarean sections. We saw how the midwife in charge of the delivery suite made appropriate arrangements for isolating these to patients and advised all staff to use barrier nursing. The infection control nurse attended the ward and gave clear advice, supported by a copy of the written

guidance, on the cleaning of the maternity theatres between and after these procedures. A thorough clean and change of the curtains in the recovery room was to be carried out in accordance with trust policy.
- The integrated performance report for January 2015 demonstrated that Women and Children's services were meeting the targets for Methicillin Resistant Staphylococcus Aureus (MRSA) screening for both elective and emergency surgery.
- However we identified from maternal medical notes, three women undergoing planned caesarean sections had not been screened for MRSA before surgery.
- We discussed this screening with midwives and reviewed the database, which confirmed that women were not being routinely screened. We found no evidence that the trust's policy and procedure were being followed in these cases.
- The trust told us that their data showed that in February and April 2015 there was only one patient in each month that was not screened. Also in 2013/14 and up to the time of the inspection there were no hospital acquired MRSA infections in Maternity which demonstrated that policies were being followed.

Environment and equipment

- There was a trust-wide equipment library for syringe drivers and pressure-relieving mattresses. We saw that the trust had invested in some bariatric equipment and further equipment was hired as necessary. Ward staff requested items from the library 'in hours' and the helpdesk for mattresses and feed pumps 'out of hours'; the clinical site supervisor was contacted for syringe drivers out of hours.
- The resuscitation trolley on the postnatal ward was old and the lock no longer worked. We were informed that a new trolley was being purchased by the League of Friends.
- Two ultrasound machines were broken and identified as a risk on the risk register in March and June 2014 but there were no mitigating actions on the register or updates on the risks this posed to the operation of the service.
- The service risk register detailed a significant risk in June 2012 as key equipment in antenatal care did not have a maintenance contract. The service had therefore made appropriate arrangements for local maintenance of equipment to be carried out.
- On the labour ward, we found that on 10 occasions since November 2014, the daily checks of the maternal resuscitation equipment had not been carried out and the compliance with these checks against trust policy had not been monitored. The defibrillator had not been checked on 57 occasions since August 2014, and the neonatal trolley on two occasions during March 2015. We raised this concern immediately with the ward manager who took action to ensure this concern was addressed.
- We discussed the evacuation procedures from the birthing pool in the case of an emergency. Midwives practised these within their 'skills and drills' programme. Skills drills are the accepted format by which healthcare professionals gain and maintain the skills to manage a range of obstetric emergencies.

Medicines

- Medication was stored in locked cupboards within clinical rooms. The medicines cupboard on the wards had appropriate stock control systems and the cabinet was locked.
- The service was introducing a new system for management of 'sharps' (e.g. needles) 'but was not yet fully compliant. The system had only been introduced in the last two weeks but staff informed us that they had training.
- We observed nurses and midwifes wearing the correct tabard advising that they should not be disturbed during a drugs round. We also saw midwives checking each other's medication before they gave it to the patient.
- Ward staff were supported during weekdays by a pharmacist and a pharmacy technician, whose key roles included chart review, medicines reconciliation and supply, patient counselling and review of patients' medicines.

Maternity

- We checked the resuscitation trolley and the drugs kept on the ABC. All the medication was in-date and appropriately stored.
- We reviewed the records for the two fridges on the postnatal ward and found that one had temperature checks missing for 13 days between 1 March and 17 April 2015 and the fridge containing MMR vaccine had temperature checks missing for 11 days in the same

period. We spoke with staff and found that there was limited awareness of the importance of temperature checks. All the medicines in these two fridges were in date.
- We saw that community midwives were carrying medication without proper storage facilities, and we raised this with the pharmacist during our inspection. On the labour ward, we saw that epidural drugs were overstocked and had been stored not only in an 'epidural-only cupboard' but also in a neighbouring cupboard.

Records

- The maternity service used hand held maternity records for the recording the majority of care. Part of the pathway was recording using an electronic system. The service did not use the 'National Maternity Record' template but a locally produced format.
- Nursing and medical records were kept secure.
- We reviewed five sets of notes on the Victoria ward. There were several items missing in the five sets of notes we reviewed, including missing signatures and items left undated.
- Each of the notes contained a bed cleaning pro-forma which was to indicate whether the patients' bed had been cleaned before admission. Of the five forms we reviewed, two did not contain the specific bed numbers.
- We looked at two sets of records that were fully and accurately completed on the postnatal ward. We noted that the maternity early warning charts had been correctly completed as had the records for catheter insertion, daily postnatal reviews and VTE risk assessments.
- Perinatal Institute's pregnancy care records for all pregnant women and their babies were kept by the women during their care
- Child health records, known as 'Red Books', were distributed to mothers for each new born baby.
- Three sets of records were reviewed on Elizabeth ward. Two were for gynaecology patients and one was a medical patient.
- Two out of three contained a falls risk assessment and two had a completed prescription sheet and a completed Malnutrition Universal Screening Tool (MUST) risk assessment**.** All three had a Waterlow score which is a risk assessment for skin integrity. In all three sets of notes there were signatures and the designation of staff missing.

Safeguarding

- Staff we spoke with were aware of the trust's safeguarding policy and the reporting procedure. Staff followed the trust's procedure for reporting concerns.
- There was an effective data base that could be accessed by health visitors and social workers.
- The Maternity service was reporting that 83% of staff were trained at level 3 in safeguarding in March 2015 against a trust target of 90%. There was an action plan in place to improve compliance with this training.
- We observed the midwives on the labour ward identify a child protection issue. They acted quickly and made contact with colleagues in social services and took appropriate action.

Mandatory training

- The service risk register showed a significant risk in January 2015 for staff compliance with mandatory training which was at 74% against the trust target of 90%. An action plan was being developed to address this risk.
- Staff said operational pressures limited opportunities for training and development.

Assessing and responding to patient risk

Maternity

- During our inspection we found that a door on the postnatal Katherine ward, which should have been secured with swipe card entry only, was broken and left open. This door was next to the area for 'transitional care' babies. We reported it to the midwife in charge and were informed that it had not worked for some time but it was not an external door.
- However, we found that the external fire door at the top of the stairs was propped open because there was painting in progress and so the whole area was accessible. This meant that babies and mothers were potentially at risk from unauthorised visitors to the ward and it also presented a fire safety risk. We escalated this issue and we were informed that the painting work had

stopped and would not recommence until a security plan was in place. The trust took immediate action to address this risk on the day we raised it. No security incidents had been reported regarding this issue.

- Terminations of pregnancy for foetal abnormalities were carried out at the hospital. These were generally carried out on Elizabeth Ward. These were usually scheduled to take place at weekends when there is less pressure on beds from elective surgical work. However should there be an increased clinical risk that warrants the procedure to be carried out during weekdays, this would be organised by senior staff.
- The modified early obstetric warning score (MEOWS) system was used to record and document women's vital signs. This helped staff to recognise any change in a woman's condition.
- One set of notes detailed a patient on Victoria ward who had had complex medical conditions during antenatal and postnatal care that required urgent medical interventions. This patient was incorrectly categorised as 'low risk' despite the need for staff to be alerted to this patient's complex medical history.

Midwifery staffing

- The trust had used a nursing acuity assessment tool since 2006, after participating in the original research programme with Leeds University.
- The Safer Nursing Care Tool (SNCT) had been used since January 2014 and an assessment of all wards undertaken; this also took account of professional judgement and guidance from the National Institute for Health and Care Excellence (NICE).

Maternity

- Safe staffing levels were a concern across the service. There was a high use of agency and bank staff, coupled with an intense workload and a number of inexperienced staff. The vacancy rate in December 2014 was 15.6% and in April 2015 was approximately 25% for midwives.
- The midwife to birth ratio was on average 1:29, including back and agency staff. The service was mostly able to provide 1:1 support for mothers in labour but were reliant on moving staff from the ABC and post-natal ward. Midwives were not well supervised as the supervisor to midwife ratio was 1:23 which was above the service target of 1:15 as of December 2014.
- The trust provided additional information that from May 2015, there were 11 supervisors and 254 midwives so the ratio therefore was now 1:13.
- For May 2015, the number of substantive staff was 80%, which was below the trust target of 90%. 12% of staff were agency and 8% bank staff.
- On the labour ward during our inspection we saw how the midwife in charge coped with the staffing shortages. There should have been eight midwifes on duty on the ward but there were only five available. One midwife had been deployed from the Alexandra Birthing Centre (ABC), one recalled from a training day and the other vacancy was to be filled by an agency midwife who would be arriving mid-morning. The band 7 midwife acted in accordance with the maternity staffing escalation policy.
- The midwife in charge informed us that two of the other midwives were only scheduled to work an 'early' shift and would be leaving in mid-afternoon. The midwife in charge had escalated this as a concern with the senior managers but there was no resolution at the time of the inspection.
- The midwife in charge said that all this was normal and they were short of midwives two or three times a week. They had to borrow from less busy units and if they got busier, they escalated again and brought in midwives from the community and the on-call midwife.
- All the staff and managers we spoke with raised staffing levels as an issue both for safety and continuity of care.
- The speciality midwife for teenage pregnancy was a bank member of staff as the trust did not have the role filled on a permanent basis.
- The staff vacancies were covered, in the main, by temporary bank and agency staff. However these staff were not always available and the gaps in the rota were not always filled. We found that agency induction processes were not comprehensive.
- The trust promoted one-to-one care in active labour. However, midwives told us that this was unlikely to be provided because of demand on the ward (for example, at times they could have up to three women in active labour in their care). One-to-one care was recorded as 87 to 90% on the labour ward.
- Staffing levels on the 28 bedded Elizabeth ward were based on it being a gynaecology ward with a staffing establishment for each shift of four nurses and two health care assistants. This did not reflect the higher

patient dependencies on the ward at the time of the inspection as this ward was now providing care for medical patients and those requiring care because they were elderly and frail.

Medical staffing

- Medical staffing was appropriate and there was an effective level of cover.
- The service had similar levels of consultant-level and junior-level staffing compared to other trusts. (35% consultants compared to England average of 34% and 58% junior-level staff compared to England average of 51%).
- There was a two tier junior doctor rota with two registrars and an SHO trainee. From 5pm the junior registrar (ST3-5) allocated to cover delivery suite and a senior trainee (ST 5-7) was allocated to cover gynaecology and obstetrics supporting the junior on the delivery suite. These two people worked very closely together and provided care across both Maternity and Gynaecology as needed. Additionally the obstetric trainees were supported by the resident on site consultant who was present on the Delivery Suite until 10pm and on call from home thereafter.
- We were informed that a consultant was present from 8.00 am to 10.00 pm seven days a week. There was also separate consultant and anaesthetist on call after 10.00 pm. The anaesthetists were from within the trust's overall anaesthetist team. There was dedicated theatre staff who formed part of the maternity medical team.
- There was an additional consultant for elective caesarean sections and a gynaecology on-call consultant Monday to Friday 08.00 to 5.00 pm.
- We were informed that there were 17 consultants with the 18th expected in post shortly. The 18th consultant would be the new labour ward lead. They were providing 98 hours of dedicated cover on the labour ward per week.
- The Clinical Negligence Scheme for Trusts (CNST) had assessed the maternity service at level 2, which required the trust to provide at least 60 hours of direct consultant labour ward cover per week. The average weekly total of consultant hours in May 2015 was 98 hours, which was the trust target.
- The medical staffing mix was similar to the national average,
- Recruitment to current vacancies at consultant and senior registrar levels was underway; however, there had been difficulties in filling the posts. To reduce risk, experienced locum doctors who knew the service and the teams had been booked for 6-month periods, and gaps were filled whenever possible by internal staff working extra shifts.
- The maternity service staffing levels for obstetric anaesthetists and their assistants were in line with Safer Childbirth (RCOG, 2007) recommendations.
- Handovers took place in the morning and evening. We observed several ward rounds and handovers that were informative and well-paced.
- A gynaecology ward round and handover took place at 8.00 am attended by the gynaecology consultant handing over to a senior trainee, a speciality middle career doctor and a more junior trainee. They were also involved in the surgery and ward rounds. The oncology patients were seen by the oncology consultant post-operatively.

Major incident awareness and training

- Staff were aware of the major incident policy released in July 2014, and senior staff were aware of the business continuity plans. The gynaecology service followed the trust-wide major incident policy.
- An annual practical obstetrics multi-professional training (PROMPT) programme was established for the maternity services.
- We discussed the evacuation procedures from the birthing pool in the case of an emergency. Midwives practised these within their 'skills and drills' programme. Skills drills were the accepted format by which healthcare professionals gained and maintained the skills to manage a range of obstetric emergencies.

Are maternity and gynaecology services effective?

Requires improvement

We rated the service as requiring improvement for effectiveness.

Maternity and gynaecology

The maternity and gynaecology services used national evidence based guidelines to establish and deliver the care and treatment they provided but there was not an effective system to ensure polices and guidelines were reviewed to reflect current national guidance.

The service participated in national and local audits.

Performance outcomes for maternity were generally in line with trust and commissioners' targets.

Some staff had not had a performance appraisal in the preceding 12 months.

There was not a robust system in place for clinical and operation formal supervisions and the ratio of supervisors to midwives was significantly higher than the trust target.

Effective pain relief was provided to patients.

Information needed to deliver effective care and treatment was generally available to relevant staff in a timely and accessible way.

There was a generally multidisciplinary approach to care and treatment, which involved a range of staff in order to enable services to respond to the needs of women.

Some women were not always involved in making decisions about their care and treatment.

Some staff did not demonstrate a full understanding of consent and mental capacity.

Evidence-based care and treatment

- The risk register for Women and Children's services indicated that there was no forum to review and update clinical and operational policies within the division
- The National Patient Safety Agency (NPSA) Intrapartum Toolkit was in place. NPSA had developed this to improve safety within maternity by providing guidance and resources to help staff monitor and investigate incidents. Not all staff were aware of this process.
- Five sets of patient notes seen contained information that was recorded using the 2003 version of National Institute for Health and Care Excellence (NICE) guidance, even though this guidance had been subsequently updated. We also noted that old terminology, such as 'Pet Bloods', were used in the notes. This abbreviation used to be used to refer to a medical condition called pre-eclamptic toxemia
- The theatre staff applied the World Health Organization (WHO) surgical safety checklist as part of the '5 steps to safer surgery' procedures at critical time points within a patient's care pathway to ensure their safety.

Pain relief

- Various forms of pain relief were available to women; these ranged from drug free methods, such as the birthing pool or relaxation techniques, to entonox gas, opioids or epidurals.
- There was effective access to epidural pain relief.
- Most women told us their pain relief had been very good.

Nutrition and hydration

- Women had a choice of meals with took account of their individual preferences, respecting cultural and personal preferences.
- The women we spoke to were happy that their fluid and dietary needs had been met.
- Mealtimes were protected, yet there was flexibility to obtain meals for women who were admitted outside of set mealtimes.

Patient outcomes

- Between July 2013 and June 2014 there were 5,456 babies born across the Trust. The year before, 20012/2013, there were 5,696 deliveries. This level of activity puts the Trust in the top 30% of trusts nationally for the number of deliveries.
- The Board Performance report for March 2015 recorded one maternal death in the past year.
- 6.7% of deliveries were 'other forceps' compared to 3.4% nationally in the period July 2013 to June 2014. From the service dashboard in December 2014, the rate of forceps or ventouse deliveries was 17%, which was above the RCOG recommended target of 15%. From the service dashboard in December 2014, the number of home births was 2.35%. In December 2014, the number of emergency deliveries had risen to 19% from 17% in November 2015.
- The total number of deliveries in December 2014 was 444, reduced from 517 in November 2014.
- From the service dashboard in December 2014, the number of failed instrumental deliveries was four, increasing from two in November 2014.

Maternity and gynaecology

- The trust provided additional information that the Maternity performance dashboard had been in progress since January 2015. The content had been negotiated with the Clinical Commissioning Group and was adapted to the trust format.
- From the data provided for May 2015, there had been 466 births with 25% of births being induced, which was above the trust target of less than 20%. 15 were home births. The rate of forceps or ventouse deliveries was 13%, which was better than the RCOG recommended target of 15%. The number of caesarean deliveries (both planned and emergency) was 30% which was above the trust target of 24%. 2% of deliveries had resulted in third or fourth degree tears which was better than the trust target of 3%.
- There had been two cases of eclampsia in the three months to May 2015, and no incidences of post-partum hysterectomies being carried out. The number of failed instrument deliveries in May 2015 was five, which was worse than the trust target of three or less.
- From the CQC intelligence Monitoring report for December 2014, there was no evidence of risk in any of the maternity outlier indicators.
- The maternity service planned to adopt the maternity-specific safety thermometer by April 2015. The national recommended maternity clinical outcomes were measured in line with the Maternity Dashboard: Clinical Performance and Governance Score Card (Good Practice No. 7) Royal College Obstetricians and Gynaecologists 2008. Between April 2014 and November 2014, there were no failed instrument deliveries and 456 emergency caesarean sections.

Competent staff

- The majority of staff we spoke with had not had a performance appraisal in the preceding 12 months. This included staff on the gynaecology ward.
- There was not a robust system in place for clinical and operation formal supervisions and the ratio of supervisors to midwives was significantly higher than the trust target.
- A number of recommendations from the Morecombe Bay report related to supervision and were not actioned
- Staff said opportunities for development were limited due to rota pressures and the need to focus on operational demands.
- Medical staff told us that they were satisfied with the trust and that it was a friendly, cooperative and enthusiastic team.
- Trainees were part of the East of England deanery. They said that they got good surgical experience at Watford General but teaching appeared to be less well organised.
- Consultant-led teaching had just recommenced when we visited.

Multidisciplinary working

- Generally care was delivered in a coordinated way with different teams and services involved.
- Staff work together to assess and plan ongoing care and treatment in a timely way when people were due to move between teams or services.
- Handovers involved a range of professionals to focus on a multi-disciplinary approach to care and treatment. This included community midwives and general practitioners when arranging for discharges.

Seven-day services

- '24 hour on call' processes were in place on the labour ward for both midwives and doctors.
- The band 7 maternity bleep holder was called in initially and then the community midwives were called in when necessary. This process had an impact on the community workload, and some clinics had been cancelled because of it. Staff said concerns had arisen when staff had not been released from the birth centre, unoccupied at the time, to support a busy labour ward. Senior staff said that the policy was to be revisited to ensure that support was available when needed.
- There was access to diagnostic services at the weekend.
- Therapy services were available in both maternity and gynaecology wards on a weekend.
- There was access to urgent care, for example, if a woman deteriorated and needed level 3 care.

Access to information

- Information needed to deliver effective care and treatment was generally available to relevant staff in a timely and accessible way.
- Care summaries were sent to the patient's GP on discharge to ensure continuity of care within the community and the patients also received a copy.

Maternity and gynaecology

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most midwives understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004.
- Women were not always consulted about their choice of birth.
- The midwives on the labour ward were expecting a woman to attend for an elective caesarean. However, when she arrived the midwife said that she had 'refused' the caesarean. In fact, it became clear that no one had spoken to her about her choices. She had a previous caesarean delivery and so it had been assumed she would have a second. The midwife in charge said that this had been a misunderstanding and the arrangements for this elective caesarean were cancelled. The midwife said, 'We should be sorting this out much earlier in the process.'
- There was a general lack of awareness of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS) on the gynaecology ward. Staff said they had not received comprehensive training and were unable to describe how they would act to ensure the proper steps were taken to protect someone who did not have capacity.
- They were unable to confirm how capacity could be determined. They told us they would refer to the safeguarding team between Monday and Friday, but were not aware of how to seek authorisation from deprivation of liberty, how to make a best interest decision for someone or the difference between lawful and unlawful restraint.

Are maternity and gynaecology services caring?

Requires improvement

We rated this service as requiring improvement for caring.

We observed most staff interacting with women and their partners in a respectful compassionate way. However, we observed two interactions where patients were not treated with respect and dignity in the maternity service.

Maternity and gynaecology staff were generally caring although there was lack of consistency in how well people were supported.

Feedback received from those using the service at the time of the inspection was mixed.

Results from patient surveys were variable.

Most women were involved in their birth plans and had a named midwife for their pregnancy.

The service did not have a bereavement midwife in post so specialist advice and support was not provided to families.

Compassionate care

- Most staff understood and respected people's personal, cultural, social and religious needs, and took these into account.
- We heard from two women who had experienced some difficulties in triage. One woman said that the midwives were unresponsive.
- We observed two interactions with patients where staff were not compassionate or respectful causing distress to the patients and their relatives.
- Staff ignored requests for help and a relative said they were, "overwhelmed by the situation"
- A relative heard staff swearing in front of a patient as an ultrasound machine was broken. A patient described the midwives as "utterly shocking, incompetent and dithering".
- During a confidential interview with a patient, inspectors were interrupted 14 times by staff, in a half hour period, who did not acknowledge the patient's right to privacy. We raised this concern with senior managers at the time of the inspection.
- Staff did not always keep patients well informed when they were waiting or respond when they needed assistance. Some patients told us they thought they had been forgotten.
- For antenatal care, the Friends and Family Test (FFT) showed that between May 2014 and Oct 2014 the Trust scored worse than the England average, with the lowest score recorded in July when only 70% of patients would have recommended the Trust to friends and family for antenatal care (compared to England average of 94%). The score improved with 98% of patients recommending the antenatal care at the trust in January 2015.

Maternity and gynaecology

- In the Friends and Family Test (FFT) for December 2013 to November 2014, the labour and birth, staff and care in hospital after birth results showed that the trust had generally scored similar to the England average for percentage of patients who would recommend the trust to family and friends.
- In the FFT for post-natal care, the results showed between December 2013 and May 2014 the trust generally performed above the England average for percentage of patients who would recommend the postnatal ward, but between June 2014 and November 2014 the percentage dropped to well below the England average (between 75% and 84% compared to England averaged of between 91% and 94%).
- In May 2015, the overall FFT score for maternity service was 93% positive.
- In the CQC's Survey of Women's Experiences of Maternity Services in 2013, the service performed about the same as other trusts for questions relating to labour and birth and staff during labour and birth. The trust performed about the same as other trusts for questions relating to care in hospital after birth.
- Between December 2013 and May 2014, 100% of patients who responded said they would recommend the postnatal community service.

Understanding and involvement of patients and those close to them

- The women we spoke with told us they were involved in developing their birth plans and had received sufficient information to enable them to make choices about their care and treatment during labour.
- Women in the maternity unit told us their partners had been encouraged to stay with them.
- We observed some difficulties in patients being able to have someone stay with them in the waiting area on the gynaecology ward. At the time the ward had outlier medical and surgical patients.
- Patient notes contained information pages for mothers that had prescriptive statements rather than information offering choice, such as 'Your midwife will give you information on where you will give birth'.

Emotional support

- There was not a specialist bereavement midwife in post to support parents in cases of stillbirth or neonatal death. Staff said they would provide that support as and when required but not all had had specific training in this area.
- Some medical staff told us they thought the overall bereavement service was poor and could be improved.
- Chaplaincy support was available for bereaved parents.
- Chaplaincy support was available 24 hours a day, on an on call basis.
- Staff told us they could access a 24 hour counselling line; they said this helped them to talk about their feelings and to continue caring.

Are maternity and gynaecology services responsive?

Requires improvement

We rated that this service as requiring improvement for responsiveness.

Senior staff members who spoke with us were aware of the increasing demands of the local and wider community, and the impact this had on other maternity services

In maternity, bed pressures affected the patients' experience and journey.

There were occasions when capacity and staffing affected the antenatal arrangements and interrupted the provision of services in antenatal care. This meant that women experienced longer waiting times in the clinic.

Referral to treatment times for gynaecology patients were generally in line with other NHS trusts.

There were occasions when capacity and staffing affected the antenatal arrangements and interrupted the provision of services in antenatal care. This meant that women experienced longer waiting times in the clinic.

The gynaecology ward took a high number of outlier patients from other specialities. This impacted on the response the service gave to gynaecology patients.

Nurses on the gynaecology ward told us that elective patients often had to wait for several hours in a 'holding' area for a bed to become available.

Maternity and gynaecology

The service's ability to respond and learn lessons from complaints was not effective.

Service planning and delivery to meet the needs of local people

- In the East of England Local Supervising Authority (LSA) audit report the supervisors of midwifes said that they regularly attended local pregnancy clubs to gain women's views of the services during pregnancy. However, they concluded that, although women's views are sought 'there is a lack of action on the results'.
- The LSA audit also reported that 'service users who are harder to reach are not well represented'.
- However the LSA audit found that the supervisors of midwifes were effective in supporting women to exercise choice about their place of birth. The report found that some environments in the hospital were 'woman-centred' and others less so.
- The trust had invested in a plan for the obstetric theatres, providing dedicated scrub teams and freeing up midwives for labour ward-related duties. This was introduced following a Never Event in 2014, to be implemented from April 2015 and completed by April 2016.
- Bed occupancy data that was originally provided to us by the trust was very low, ranging between 7% and 13% each quarter (compared to England averages of between 55% to 60%). The trust provided further information that showed for the period November 2014 to January 2015, bed occupancy data for Maternity was on average 82.1%."The trust had calculated its bed occupancy as around 89% as reported to the NHS England Bed Occupancy report for 2014 to 2015.

Access and flow

Maternity

- We attended Victoria the antenatal ward on the second floor of the building. We saw that there was an early pregnancy unit, a maternity day assessment unit, antenatal clinics, dating scan service and triage all along the same corridor. There was also a small private room that was used to give sensitive or difficult information to women and their families. Through these units women had access to early assessment and antenatal clinics.
- When we visited there was a combined diabetic clinic taking place with a diabetic nurse specialist present and a dietician. The names of the doctors in charge of the clinics were displayed on a notice board.
- There were a number of women waiting to be seen and we asked the health care assistants about the waiting time. They said that it was 40 minutes. The waiting time was not displayed.
- Several midwives told us about delays in transferring women from the antenatal, Victoria ward to the labour ward. The delays were the result of a shortage of midwifes to provide one-to-one care in labour. One midwife said, 'Sometimes we hold women on the antenatal ward longer than we want because of the pressures on the labour ward.'
- We observed this process whilst we were with the senior midwife in charge on the labour ward. The senior midwife said, 'It is a juggling act all day so that we can time the electives and inductions for when we have midwives available.'
- When we attended theatre to observe two caesarean sections, the consultant informed us that, although they were performing the procedure, there were no beds allocated for the patients post recovery.
- When we visited the labour ward there was a woman in the bereavement room who had given birth the day before and was anticipating the death of her baby with foetal abnormalities. There were no available beds on an appropriate ward so it was planned, therefore, to move the woman to the private Knutsford suite as this was the only area with any beds available. Staff said that sometimes they used rooms in the Knutsford suite but the decision would be taken by a more senior member of staff. The midwife said that Knutsford Suite could cause problems because patients who have paid in advance take priority and sometimes they have to move a patient who has paid on a 'room only' basis. The midwife told us that the women were informed in advance that this might happen but said, 'The difficulty then occurs if there are no beds elsewhere'.
- We were also informed that, between July 2013 and December 2014, the maternity service was closed once. This was due to demand and capacity issues. The service was closed for a total of 12 ½ hours in December 2014. We spoke to the matron in charge of the delivery suite about this and to one of the senior midwives. They both said that it had been a very busy day and that the service had to close to ambulances but women were

still admitted. The matron said that the closure was reported as an incident on the electronic reporting system. We asked about lessons learnt and recommendations about improving access and flow. They said that they had not seen the report yet at the time of the inspection. We saw that the lessons identified from the closure were in the report submitted to the Trust Board on 16 April. The lessons included escalating issues so that members of the management team were briefed about emerging situations and a reinvigoration of the maternity bleep holder role.
- On two occasions we observed that the caesarean section list in theatre was disorganised with the start time delayed by staffing issues and late (day of surgery) pre-assessment care of the mother.

Gynaecology

- The review by the Royal College of Obstetrics and Gynaecology (RCOG) in October 2013 also included comments about the pressure on the service at Watford General and particularly on the Elizabeth ward. They noted that Elizabeth ward was accommodating outliers from other specialties and that gynaecological patients due to undergo elective surgery were cancelled frequently. This meant that patients did not have timely access to treatment. All elective surgery was cancelled on the Elizabeth ward on the final day of our inspection.
- The number of patients treated within 18 weeks (for patients admitted to a ward) was 89% in May 2015 with an average waiting time of 14 weeks.
- The number of patients treated within 18 weeks (for patients not admitted to a ward) was 95% in May 2015 with an average waiting time of 5 and a half weeks.
- In the Operational Recovery plan presented to the trust board in May 2105, additional diagnostic equipment for Gynaecology (Urodynamics) had been provided to deliver an increase in capacity for the service where there was a challenge in meeting the six week diagnostic standard.
- Staff said that patients were left waiting in the day room, from 7.30 am, for elective surgery. These patients may not have been taken into theatre for several hours if beds were not available or if emergencies occurred, which took priority. We saw a patient in the day room, who said, 'We thought we had been forgotten".
- On the final day of our visit, staff told us all elective surgery was cancelled on Elizabeth ward because of a shortage of available beds. The trust informed us that on that day there were four patients booked on the morning list and two patients booked on the afternoon list. Two patients were cancelled from the morning list. The other elective surgery cases went ahead as planned.
- We saw at the time of our visit, 12 of the 23 patients on Elizabeth ward were non gynaecology patients.

Meeting people's individual needs

- A small multi-faith chapel was available for all patients and their families to use.

Gynaecology

- We spoke with the nurse and interim director with responsibility for Elizabeth ward. This was a 28 bedded ward that had originally been for gynaecology and gynaecology oncology patients. However, the ward was also being used to treat medical patients and those requiring elderly care. The interim head of quality and risk acknowledged that this was a concern. Staff said this issue had been raised at 'onion' meetings (which were daily meetings were ward leaders discussed ward performance and escalation issues, including staffing levels) over a period of time but had not been actioned.
- Some of the patients were elderly and confused and needed a significant level of support, including regular turning in bed, support with meals and getting to the toilet. We asked about falls on the ward and the nurse said, 'They are inevitable as there are too few of us to offer the nursing care they need'. We noted that the risk register for Women's and Children's services reported an increase in slips, trips and falls in June 2014 on Elizabeth ward. Patients were assessed for falls risks.
- Not all staff had had specific training for care for patient living with dementia on this ward.

Maternity

- We spoke with two health care assistants in the antenatal clinic. We asked about interpreters for mothers whose first language was not English. They said that interpreters were available and could be booked in advanced for planned appointments via the patient advice and liaison service. We saw a poster and leaflet in the clinic that provided information about this service. Staff said it was more difficult if the interpreter could not be booked in advance, and in emergencies.

- The environment on the delivery suite was old and most of the delivery rooms were small and in need of refurbishment. One of the midwives we spoke with said, 'We need a new maternity unit. We have are using every inch of space and every cupboard.
- The ABC had been refurbished and was spacious and light. The seven delivery rooms were large and comfortable and there were seats that would recline for partners to sleep. There was also a sensory room. One of the birthing pools on the ABC unit was in need of repair and had been out of action for four weeks.

Learning from complaints and concerns

- A midwife responsible for complaints and quality said that there were delays sometimes in getting people up from antenatal to the delivery suite.
- The response to a recent complaint, in the report dated 6 March 2015, indicated that the service was planning a new design of clinical record for the maternity service.
- The findings of the investigation conducted in response to the complaint raised questions about the accuracy of record keeping and the independent team noted: 'issues with the standard and completeness of record-keeping'. Staff were not able to demonstrate an awareness of the learning from this complaint.
- From the service dashboard in December 2014, there were no formal complaints recorded and in November 2014, there had been 11. Six were regarding obstetrics and five regarding anaesthetics.
- In May 2015, there had been 23 complaints within the maternity service, with seven relating to midwives.

Are maternity and gynaecology services well-led?

Inadequate

The service was rated as inadequate for being well-led.

The service did not have a defined strategy in place that staff could describe.

There was a lack of overall direction and leadership of the service.

There was a lack of managerial and senior clinical ownership in the investigation of serious incidents.

Recommendations from independent audits of the service had not been actioned by managers.

Recommendations in an independent review by the Royal College of Obstetricians and Gynaecologists of the service in October 2013 had not been owned or actioned.

The service did not have an effective governance framework to support the delivery of good quality care.

There were not effective arrangements for identifying, recording and managing risks, issues and mitigating actions.

The risk register was not current or reflective of the level of risks in the service.

Staff morale was poor and staff did not feel engaged to help shape the service with a focus on care and quality.

Vision and strategy for this service

- The service did not have a clear vision and a set of values, with quality and safety the top priority.
- Staff reported significant pressures within the service that had not been addressed for a number of years and that this was not in accord with the trust's overall vision to provide high quality, safe care.
- Staff said the service had no sense of direction and was "Rudderless"

Governance, risk management and quality measurement

- The service did not have an effective governance framework to support the delivery of good quality care. There were not robust arrangements for identifying, recording and managing risks, issues and mitigating actions.
- In 2014, one 'never event' occurred in the maternity service. The investigation of the maternity never event was due to be completed by 24 March 2015 but had not been completed at the time of our inspection.
- There was no evidence that the progress of this investigation had been actively monitored. However, we later noted, from an April 2015 board paper, that an extension had been requested to allow more time to complete the investigation.
- The service risk register showed 53 defined risks to the safety and quality of care and treatment delivered. 26 of these risks had not been completed in full on the risk

register as mitigating actions were not recorded and no further actions required were recorded. This meant the risk register was not current or reflective of the level of risks in the service.

- We noted that risks were identified and placed on the risk register however, it was not clear if action had been taken to reduce or remove the risk. For example, the risk register noted, in June 2014, that the ultrasound scan for nuchal translucency scanning was six years old. Foetal Anomaly Screening: Ultrasound Practitioners' Handbook guidance dated 1 January 2015 states it should be less than five years old.
- The risk register for Women's and Children's services included a risk, opened in June 2014, for Elizabeth ward. This had not been regularly reviewed and updated to show actions required. Members of the nursing, midwifery and medical staff had all raised concerns regarding non gynaecology patients to Elizabeth ward
- The East of England Local Supervising Authority (LSA) completed an annual audit report for West Hertfordshire maternity services in May 2014. The audit included a review of the examination of the service against the Morecambe Bay benchmarking undertaken by the trust's supervisor of midwives. This assessment found that the service was fully compliant for 12 of the recommendations, partially compliant for two and non-compliant for five of the criteria. The LSA audit said, 'This is of concern as the benchmarking tool has now been in place for three years and the Trust does not seem to have moved any further forward since year one'.
- The East of England Local Supervising Authority (LSA) audited the service in May 2014. The audit revealed that the senior staff were not involved in escalating safety concerns to the trust.
- We were informed that in January 2015, a higher number of babies born in the birthing pool in the ABC experienced respiratory difficulties immediately after birth. A change in cleaning fluids was suspected to be the cause and an audit had been conducted locally, but remained inconclusive in March 2015. The ABC had reverted to the cleaning fluids used earlier. This concern had not been escalated and was not on the service risk register. This was escalated to senior managers at the time of the inspection who took action to minimise potential risks. The trust told us that four babies born in the ABC in early January 2015 required resuscitation and admission to NICU. These cases were audited and a review was undertaken with infection control regarding cleaning regimes.An ongoing prospective audit of all pool births was in progress and any incidents related to babies requiring sustained resuscitation or addition to NICU were reviewed by the risk and governance team.
- The service participated in national and local audits but outcomes from audits had not been used to make improvements in care.
- We reviewed two independent reports on the provision of private maternity services at West Hertfordshire including the private service offered by the Knutsford Suite. Staff told us the provision of Knutsford Suite private maternity unit was challenging because all the wards depended on the same staff. Staff were aware there had been an independent review making recommendations but told us nothing had changed.
- The first review took place in January and February 2013. In was commissioned in response to a formal complaint that that had been raised in 2012 and coincided with internal concerns about the private maternity services. This report identified a number of themes including unacceptable behaviours from consultants to staff, for example, and that private practice took precedence over NHS patients. The report made eight recommendations finalised in March 2013 with the expectation, as set out in the terms of reference, that it would be presented first to the Division Board and then to the Trust Board.
- A second independent review was commissioned by the Trust's Medical Director from the Royal College of Obstetricians and Gynaecologists in October 2013 and finalised in February 2014. In summary, this review covered the provision of gynaecology services at Watford General and an assessment of trust guidelines and advised the trust that to review the service as a whole 'if the provision of private obstetric care interferes with the provision of obstetric care to NHS patients. The second reported referenced the first report and concluded that the first report had not been ratified by either the Divisional or Trust Board and that, as a result, the 8 recommendations had not been implemented. The second review encountered the same themes reported in the first and stated "We heard examples of prioritisation of private patients over NHS patients with 'queue jumping' both for induction of labour and for elective caesarean section. Private elective caesarean sections are prioritised over NHS elective work resulting in instances of NHS caesarean sections being deferred unit the afternoon emergency list." The second report

endorsed that all the recommendations of the first report should be implemented. In addition, further recommendations were added by the second report to ensure proper governance arrangements for the private maternity services and that these arrangements should not interfere the provisions made for NHS patients.
- We were not able to find any evidence that the recommendations from either report had been implemented and that the issues that gave rise to the two reviews were continuing.
- We did find a document entitled 'Position Paper for Private Maternity Services' dated March 2015. This position paper commented on the practice of using the 'Knutsford Suite as part of the trust surge policy' and included a request for an 'open and transparent discussion with the Trust Executive' about the issues.
- The divisional clinical director said that the choice offered by the Knutsford Suite might be good but that it represented, 'A conflict of interest'. The clinical director said that not everyone agreed but, with current staffing levels, it was a conflict of interest if NHS patients were delayed or disadvantaged.
- We raised this concern with senior leaders in the trust, who took action following the inspection to suspend the private maternity service offered by the Knutsford Suite.

Leadership of service

- The leadership of the service did not encourage openness and the promotion of good quality care. Medical leadership did not take ownership for the level of risk in the service.
- We were informed that the Head of Midwifery had been absent and on extended leave since January 2015. This was contributing to the lack of overall direction and leadership of the service.
- In the absence of the Head of Midwifery, four senior members of the team were sharing the responsibility of leadership and decision making for the service with the divisional manager.
- The divisional manager said that, after careful consideration, it had been decided not to invite a senior member of staff to 'act' as Head of Midwifery. However, the trust informed us that a new Head of Midwifery was being engaged temporarily from another trust and would be in post by the end of April 2015 to support the service.
- Many managerial staff were in interim positions. We were informed this was because of a restructuring process that had not been completed. There were also staff who were interim in specialist posts such as the midwives for safeguarding and for vulnerable adults.
- One midwife said, 'The service feels precarious with so many colleagues in interim roles'. Another said, 'There is a lack of direction and focus and it seems there is no end in sight.'
- We found no evidence of action being taken in response to a number external reports and audits

Culture within the service

- Staff told us morale was low due to staffing concerns and how this long standing concern had affected the quality of care and increased our sickness levels'.
- We spoke with a senior staff member on the labour ward who informed us about some concerns they had with the performance and competence of a locum doctor who was working on the ward. However, we heard later that the matter had not been dealt with appropriately causing distress to the staff involved.
- The midwives also spoke about their frustrations with booking of bank nurses process and the difficulty of getting vacant shifts covered. One midwife said, 'It is not fit for purpose'. Another midwife, and one of the supervisors of midwives, told us: 'The bank is an utter shambles. The system does not work and it is very difficult to register with the bank'.
- Staff said: 'The pressure of work and the stress of the busy working environment results in high levels of sickness and high turnover. It is a vicious circle.' Another midwife said, 'We have held two open days and we have a third coming up. But we are losing midwives as fast as we can recruit them.'
- Staff said staffing pressures were 'totally unacceptable' we feel 'demoralised' and 'broken'. Our manager does all they can to raise the issues on our behalf but, 'It feels like nobody is listening'.

Public and staff engagement

- People's views and experiences were not effectively gathered and acted on to shape and improve the services and culture.
- Staff did not feel actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture.

- Leaders did not prioritise the participation and involvement of patients and staff.
- We saw some written feedback from women who had attended Katherine Ward. This feedback was displayed on a 'Quality Tree' on the wall of the 1st floor corridor. One read: "Very attentive and caring staff. Very helpful and attended to every need". Another made the following comment about the delivery suite: "Not enough beds at first, but midwife did well considering".
- Staff also said 'We have third year students doing projects and they could get involved with guidelines. The Head of Midwives was not interested and we missed an opportunity.' The students were keen to get involved but this was not taken up.

Innovation, improvement and sustainability

- There was a lack of innovation and sustained, continual improvement across the service.

Services for children and young people

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

Information about the service

The children and young people's service is part of Watford General Hospital main site but has its own entrance and reception area. Services for children and young people consisted of an inpatient ward, day ward, outpatient services, local neonatal unit and transitional care unit.

Starfish ward and the Safari day unit are located on level one, Women's and Children's building, Watford General Hospital. Starfish is a 20-bed general in-patient paediatric ward caring for children and young people up to the age of 16 years. The ward cares for children with both medical and surgical conditions and also has two high dependency beds. The Safari day unit provides day care for children and young people up to the age of 16 years. The Safari unit provides care for children for treatments and investigations, and following surgery. The purpose of the Safari day unit is to provide children and young people with planned hospital care in an appropriate environment, which does not require an overnight stay. Safari day unit operates between hours of 07.00 to 19.00 hours. Both Starfish and Safari ward staff discuss with in-patients over the age of 16 whether an adult ward would be a more appropriate care setting for their care and treatment, and patients are given a choice.

The children's and young people's service has a neonatal intensive care unit (NICU) and a special care baby unit (SCBU), as well as a children's emergency department (the children's emergency department was inspected as part of our review of urgent and emergency services).

The NICU is a level 2 neonatal unit providing care for infants who require high dependency care, short-term intensive care, and special care to premature and sick infants. This unit has 30 cots; these consist of six transitional care cots, three ITU cots, five HDU cots, and 16 special care cots. The unit accepts babies delivered 27 weeks upwards and weighing greater than 800 grams. The NICU is located on level 3 of the maternity unit at Watford General Hospital, adjacent to the delivery suite.

There is a neonatal unit on site. This is described as a 'level two' unit and provides high dependency care and some short-term intensive care. Babies who are very sick or premature are usually transferred to another local acute hospital or to another special care baby unit.

The children's outpatient service is run from Watford General Hospital. Most outpatient clinics at Watford are classed as general paediatric clinics but the service also provides subspecialty clinics such as diabetes, cystic fibrosis, oncology and gastroenterology. In Watford General Hospital the outpatient's clinic is on the ground floor of the Women's and Children's Building. Children and young people's outpatient clinics run Monday to Friday.

Services for children and young people

Summary of findings

We found that people were protected from abuse and avoidable harm. Staff were clear on their responsibilities to raise concerns and report incidents. There were arrangements in place to monitor incidents.

Children were safeguarded as risks to children were assessed and monitored on a day to day basis. Staff responded appropriately to changes in children's needs. There were systems in place to manage changes in demand and disruptions to services.

Children had good outcomes because they received effective care and treatment that met their needs. We found that children's care and treatment was regularly reviewed and records were updated. Information about children's care was routinely collected and used to improve services for children and young people. We found children's rights were protected and consent to care and treatment was obtained in line with the current legislative framework. Staff were aware of the legal principles of Gillick competence, in decisions about whether a child (16 years or younger) was able to consent to their own medical treatment, without the need for parental permission or knowledge. Staff were also aware of and procedures were in place to support staff in the principles of the Mental Capacity Act 2005. Whereby if staff held a reasonable belief that a young person lacked the capacity to consent to their care and treatment, decisions could be made in the young person's best interests.

Children and family services participated in local and national audits, such as the National Neonatal Audit Programme (NNAP) and the National Paediatric Diabetes Audit (NPDA). Information from audits and other monitoring activities was shared internally and externally and understood by staff. Monitoring information was used to improve services.

Staff were qualified to do their jobs and supported to deliver effective care and treatment through training, supervision and appraisal. Staffing levels were appropriate at the time of our visit although we were aware there were pressure points in some areas. The service had introduced a policy of staff rotation around the service. This meant staff could gain skills in more than one area of practice, and could provide emergency staffing cover across the service if required.

Children and young people were supported and treated with dignity and respect and were involved as partners in their care. Children were treated in accordance with national guidance. We observed many examples of compassion and kindness shown by staff across all the wards and department areas. The trust had a parents' room on Starfish ward to enable parents and children to maintain their relationships.

Children and young people's needs were met through the way services were organised and delivered. Services were planned and delivered to take into account local need. The premises were appropriate for children with Starfish and Safari wards having been redecorated in child friendly décor. Complaints and compliments information was displayed in the ward areas. The trust monitored complaints. Complaints were responded to in a timely way and improvements were made to children and young people's care and treatment as a result of complaints or concerns.

The leadership, governance, and culture promoted the delivery of high quality person-centred care for children and young people. Services were well-led at a local level. There were clear governance arrangements in place. Staff were aware of the trust's vision and values and the strategic goals of the trust. The children's and young people's service had a risk register in place to monitor and address current and future risks.

Services for children and young people

Are services for children and young people safe?

Good

We rated the service as good for safety.

We found when something went wrong; children and families received a sincere and timely apology and were told about any actions taken to improve processes to prevent the same happening again.

Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses; they were fully supported when they did so. Monitoring and review activities enabled staff to understand risks and gave a clear and accurate picture of safety.

Children and young people's safety performance showed a good track record and steady improvements. When something went wrong, there was an appropriate thorough review or investigation. Lessons were learned and communicated widely to support improvement in other areas as well as services that were directly affected. A root cause analysis (RCA) was completed as part of the investigation of incidents. RCAs identified learning from incidents and lessons learned from incidents were shared across teams. Opportunities to learn from external safety events were also identified. Improvements to safety were made and the resulting changes were monitored. There were clearly defined and embedded systems, processes and standard operating procedures to keep children and young people safe and safeguarded from abuse. These:

- Were reliable and minimised the potential for error
- Reflected national, professional guidance and legislation
- Were appropriate for the care setting
- Were understood by all staff and implemented consistently
- Were reviewed regularly and improved when needed.

Staff received up-to-date training in safety systems. Safeguarding children and young people was given sufficient priority. Staff took a proactive approach to safeguarding and focused on early identification. They took steps to prevent abuse from occurring, responded appropriately to any signs or allegations of abuse and worked effectively with others to implement protection plans. There was active and appropriate engagement in local safeguarding procedures and effective working with other relevant organisations.

Staffing levels and skill mix were planned, implemented and reviewed to keep children and young people safe at all times. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff could manage risks to children and young people who used services.

Risks to children and young people were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies or behaviour that challenged. Children, young people and their carers were involved in managing risks; and risk assessments were child-centred, proportionate and reviewed regularly.

Staff recognised and responded appropriately to changes in risks to children and young people who use services.

Risks to safety from service developments, anticipated changes in demand and disruption were assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations.

Incidents

- The service had systems in place to ensure that incidents were reported and investigated appropriately. We reviewed a sample of two investigation reports during our inspection. Root cause analysis (RCA was completed as part of the investigation of incidents. RCAs identified learning from incidents and lessons learned from incidents were shared across teams. An action plan was developed as a result of RCAs. For example, as a result of one incident involving confidential information, procedures had been changed and doctors were required to shred confidential information prior to their leaving the ward at the end of their shift.
- All the nursing and medical staff we spoke to stated that they were encouraged to report incidents via the electronic incident data management system.
- Reports provided by the trust showed that a total of six serious incidents had been reported between February 2014 and January 2015 to the Strategic Executive

Information System (STEIS). Incidents were monitored by the chief nurse for trends. Incidents were standard agenda items at children's and neonatal quarterly departmental governance and quality group meetings.

- The service held monthly 'paediatric and neonatal departmental governance and quality group meetings' and 'children's and neonatal quarterly departmental governance and quality group meetings'. These were safety and risk meetings which were attended by a staff representative from each service area. The minutes of these meetings showed that a record of every reported incident was circulated as a standing agenda item and discussed at the meetings. Where incidents had been reported a full investigation had been carried out and steps were taken to ensure lessons were learnt. Action plans were produced following investigations. These were monitored and tracked to completion at subsequent meetings. Staff told us that learning from incidents was cascaded to ward staff at team meetings, as well as handovers.
- Staff told us they understood their responsibilities to report incidents using the electronic reporting system, and knew how to raise concerns. Staff confirmed that they received feedback on incidents that took place in other areas of the service as well as their own. Staff and managers told us they were satisfied there was a culture of reporting incidents promptly within children's and young people's services. Incidents were audited on the trust's electronic reporting system.
- The NICU used the safety thermometer to monitor pressure ulcer care. This is a nationally recognised tool that monitors how the service performs in providing harm free care. The trust undertook the adult safety thermometer and applied it to neonates. Staff recognised this had limitations with regards to neonatal care, but used it to record episodes of harm. In March 2015, neonates reported that they had no pressure ulcers, and that care had been 100% harm free. These results were displayed on wards for staff, patients and visitors to see. Staff on Starfish ward told us that children and young people's services were being responsive in preparation for the introduction of the new children's safety thermometer.
- Staff would be alerted to patient safety alerts by email. Staff told us children and young people's services would take action to respond to relevant alerts. Alerts were a standard item on by the children's and neonatal quarterly departmental governance and quality group meeting. Staff described how completed actions would be reported to the Department of Health's (DOH) central alerting system, (CAS). We did not see any completed actions during our visit.
- Staff and managers we spoke with were aware of and able to explain the duty of candour. Staff explained the duty of candour in terms of being open, honest and transparent with people. There is also a contractual duty of candour imposed on all NHS providers of services to 'provide to the service user and any other relevant person all necessary support and all relevant information' in the event that a 'reportable patient safety incident' occurs. Staff said they had not had reason to use the duty of candour since its implementation in November 2014.

Cleanliness, infection control and hygiene

- All the areas we visited were clean and free from clutter. We saw housekeeping staff cleaning on the wards and in the departments throughout our visit.
- Monthly infection control audits were undertaken. For the year to date children and young people's services were fully compliant with NICE standards for infection control.
- We saw staff regularly washing their hands between treating patients. Hand washing facilities and hand sanitising gels were readily available. 'Bare below the elbow' policies were adhered to. Staff told us they actively challenged anyone who did not follow this policy in the clinical area.
- At the time of our visit, children's and young people's services were achieving trust compliance standards for hand hygiene. The service was achieving 100% compliance with the national institute for clinical excellence (NICE) national specifications for cleaning. We saw that gloves, aprons, and other personal protective equipment (PPE) were readily available to staff.
- The importance of all visitors cleaning their hands was publicised and we observed parents and other visitors using hand gels and washing their hands.
- The ward areas had an ample supply of appropriate toys that could be cleaned safely. Play specialist staff told us that toys in the children's ward were cleaned by them as part of their role. Toys in the outpatients department were cleaned by housekeeping staff. We viewed toy cleaning records on Starfish ward and these were up to date.

- There were no reported cases of methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C. diff) for children's and young people's services in the past 12 months.
- A programme of training and assessment was in place for 'aseptic no touch technique' (ANTT). During our visit we observed staff undertaking ANTT correctly.
- There was no separate anaesthetic room for children. Children were therefore anaesthetised in theatre with their parents present. Parents did not wear gowns or overshoes which increased the risk of infection.

Environment and equipment

- Starfish and Safari wards had been refurbished with children in mind. The ward areas provided a safe environment for children and families which were effective for cleaning and maintenance. Staff had access to age appropriate recovery equipment for children following surgery.
- Entrances to all children's ward areas were secure, entry was granted by a member of staff via an intercom for visitors during the day and at night. On Starfish and Safari ward access was granted by a ward clerk at reception during the day and by ward staff at night. CCTV was used to monitor entrances at all children's wards.
- All staff reported adequate access to equipment. However, staff raised concerns about timely access to maintenance. We reviewed a number of items on the wards, the NICU and special care baby SCBU, and saw they had been recently inspected. We viewed records that equipment was checked on a weekly basis and further checks were in place on the special care baby SCBU.
- Age-appropriate resuscitation and emergency equipment was available for staff across children's and young people's services. Daily safety check protocols for emergency equipment were in place and up to date.
- We saw that a bedside buzzer on Safari ward was not working when a band 7 nurse tested it. The nurse referred this to hospital estates for repair. We saw a member of the hospital estates team visit the ward promptly to repair the buzzer.
- An established audit programme was in place for reviewing infection control and cleanliness in clinical areas. Starfish ward and Safari ward received a comprehensive environmental and infection control audit in October 2014 and November 2014, respectively. The results of the audit indicated that the children's wards needed refurbishment. We saw that improvement actions identified by the audits had been followed up and implemented. For example, as a result of the audits Starfish and Safari wards had been refurbished in child friendly decor. Staff told us that NICU had agreement from the trust for it to be refurbished in the near future; a date had not been arranged for the work on NICU to commence.
- NICU unit had received an environmental audit in December 2014. We saw that action had been taken to address environmental and infection control risks. For example, the audit identified that three breast milk fridges were not at the required temperatures; following and investigation three new breast milk fridges were purchased in December 2014 to replace the faulty fridges. We noted the new breast milk fridges were storing breast milk at the required temperatures.
- In hot weather, it was necessary to open some windows in the neonatal unit to prevent overheating. This was identified as a significant risk on the risk register July 2014 and the service was awaiting a feasibility study to consider installing air conditioning

- The trust had a paediatric lead pharmacist for children and young people's services who staff could liaise with and ask for advice. The pharmacist worked across all the ward and department areas; and attended the children's ward and NICU daily, reviewing prescriptions and making recommendations.
- The paediatric pharmacy was in the process of moving to e-prescribing. E-prescribing is the computer-based electronic generation and writing of a medical prescription, it takes the place of paper and faxed prescriptions. Staff told us the transition to E-prescribing had run smoothly overall.
- Up to date copies of the British National Formulary for Children were available on all wards and departments.
- Medicines were stored safely with room and fridge temperatures checked regularly and recorded. We viewed records medicines were being stored at the required temperatures. All the drug store cupboards were locked and controlled medicines were stored in separate locked cupboards. Where medicines required refrigeration, fridge temperatures were checked daily.
- Prescriptions were prescribed daily by the registrar and checked by the consultant of the day.

- Ward rounds on Starfish ward were accompanied by the paediatric lead pharmacist. Medicines reconciliation rounds occurred on children and young people's wards. Medicines were restocked through a 'top up' system, ensuring a continued supply. Out of hours, the hospital had an on-call pharmacist. Staff we spoke with described the access to out-of-hours pharmacist advice as good.
- Children's weight was clearly documented and prescriptions were appropriate for the child's weight. We viewed nine children's medicine administration records (MAR). Children and young people's allergies were clearly recorded in their medical records.
- Nursing staff' training in medicines administration was up to date. Nursing staff were aware of policies on the administration of controlled drugs and the Nursing and Midwifery Council's Standards for Medicine Management.
- All medication errors were reported as incidents, recorded on the electronic system, investigated and reviewed at the monthly 'paediatric and neonatal departmental governance and quality group'. Staff were open and reported medication incidents. We saw evidence that these were investigated, and staff involved in incidents were seen on an individual basis, during which they were asked to reflect on the incident. Where the incident was a prescribing error, senior medical staff were informed and the error was followed up with the doctor concerned.
- There had been 16 medicines errors in the previous 12 months on NICU/SCBU. Starfish ward had 31 medicines errors in the previous 12 month period. Medicines incidents were reviewed by the medicines use and safety panel (MUSP) on a monthly and quarterly basis. The paediatric lead pharmacists also reviewed medication incidents and flagged up any concerns regarding themes. Action plans were in place to address themes identified. For example, the trust identified some staff were not double checking intravenous (IV) medications in accordance with the trust's policy. As a result all band 6 nurses were retrained on the administration of IV medicines. All staff received clear guidance on the procedures for administering and checking IV medicines, and were instructed to follow the trust policy at all times when checking IV medicines. Staff were informed that non adherence to the trust's policy would result in the trust taking performance management action against the member of staff concerned.
- Across the children and young people's wards we found that access to controlled drugs (CD's) was restricted to appropriate designated staff and CD's were secured inside a double locked cupboard. Medicines requiring refrigeration were stored in a lockable fridge. A compliant CD register was in place. This is a bonded book used to record CD medicines. We found no discrepancies between the stock, controlled drugs in the cupboard, and the CD register.

Records

- Patients' records were managed in accordance with the Data Protection Act 1998. Records were kept confidential on the wards in lockable trolleys by the nurses' station.
- Patients were identified on whiteboards in the nurses' station on Starfish and Safari wards. However, this was visible to people visiting the ward and could have compromised patient confidentiality.
- We looked at 11 sets of notes on the wards, the neo-natal unit, and SCBU; we found them to be accurate and legible. Patient Information was easy to find.
- Documentation for admitting patients and assessing needs and risks was child-centred.
- We viewed staff training records and found that most staff training in information governance was up to date.
- Leaflets explaining patients' rights to access their medical records was available on the ward. The trust's website carried information on people's rights under the Freedom of Information Act 2000.

Safeguarding

- Safeguarding policies and procedures were in place. Staff we spoke with understood their safeguarding responsibilities and knew what to do if they had concerns. 95% of staff had completed standard level two safeguarding training. 90% of clinical staff had completed level three enhanced safeguarding training. Staff told us that the trust's target was 100% staff trained at the appropriate level in safeguarding, but this would be difficult to reach due to figures being skewed by new staff who were on inductions or staff waiting for training updates.

- The trust employed children's safeguarding liaison nurses who worked with wards and departments, raising awareness and offering support, advice and resources where necessary. Each liaison nurse also managed complex safeguarding cases and worked collaboratively with other health and social care organisations.
- We spoke with the trust's safeguarding nurse specialist who confirmed that staff were trained to appropriate level set out in the intercollegiate document 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff, 2014'. The trust had an action plan in place to ensure compliance with the 'Working together to safeguard children, 2015' recommendations and to ensure changes in practice would be embedded.
- The trust had a named consultant for children's safeguarding as well as a children's safeguarding nurse specialist. Staff told us they would liaise with the safeguarding nurse specialist if they had concerns. Staff on the wards had access to the contact details of the local authority safeguarding team for out of hours safeguarding advice or to report concerns. The trust had information sharing protocols in place and a shared information system with the local authority social services.
- Multi-agency safeguarding meetings were held weekly. In addition, a Child Protection panel was held three times a year, at which all complex child protection cases and recent evidence were discussed.
- The trust had a draft policy awaiting ratification to safeguard women or children with, or at risk of, Female Genital Mutilation (FGM).
- Children and young people's services had parents support volunteers. They offer practical and emotional support to parents who have a child in hospital. The volunteers are subject to the same pre-employment checks as trust employees, and are required to have completed mandatory training, induction, and regular supervision.

Mandatory training

- Staff we spoke with confirmed that they were up to date with training, or had dates to attend scheduled training.
- All the wards areas displayed information about training for staff. For example, we saw posters informing staff of dates for level three safeguarding training updates displayed in staff areas.
- The trust had recently introduced an electronic system of training and appraisal in the months prior to our visit. This enabled managers and staff to access information on training so they could see when updates were needed and ensure action plans were in place for wards or units that did not achieve mandatory training targets. The trust had introduced a new annual appraisal system in 2014. 90% of nursing staff had received an annual appraisal in the past 12 months.
- We viewed the women and children's staff training spreadsheet. This indicated that across women and children's services there were a number of staff' that had not completed the required mandatory training updates. Senior staff assured us that mandatory training updates for staff in children and young people's services were either completed or arranged. The administration manager told us there was a time lag between training being completed and it showing up on the trust's electronic system.

Assessing and responding to patient risk

- The service used a paediatric early warning score (PEWS) system on the children's wards, this was based on the NHS institute for innovation and improvement PEWS system. This tool supported early identification of children at risk of deterioration. There were clear directions for escalation within each child's file on the wards. We spoke with staff, who were aware of the appropriate action to be taken if patients scored higher than expected. We reviewed notes and saw that where higher scores had been recorded, action had been taken to escalate concerns, or the rationale for not escalating had been documented.
- In case of an emergency within the children and young people's inpatient area, the paediatric resuscitation team would attend. All band 6 and band 5 nurses on Starfish ward were trained in paediatric life support (PILS). The Starfish ward manager and some band 6 nurses were trained in European paediatric life support (EPLS). All qualified staff on the NICU had received new born life support (NBLS) training.
- We accompanied a patient who was going to theatre from the Safari ward. We timed the journey at 10 minutes. The journey involved the patient in using three lifts. Staff told us that patients were not risk assessed for the journey; but, staff carried cardiopulmonary resuscitation (CRASH) equipment during the journey. We discussed this with the head of nursing, who told us that

the service would take immediate action to add the journey to the service's risk register. We noted that patients were not individually risk assessed for the journey to theatre.

- Staff on Safari ward told us the ward stayed open until 20.00 on occasion to facilitate discharge and avoid the need for overnight transfers of patients to Starfish ward. This meant that some children could be discharged home, rather than staying overnight in hospital.

Nursing staffing

- The trust had introduced a 'Paediatric Nurse Rotation Scheme'. The scheme was set up for all newly qualified paediatric nurses and allowed them to gain experience in all areas and specialties within paediatrics. Staff told us the scheme had resulted in nurses gaining a better understanding of how the children and young people's department worked. A matron told us the scheme had led to increased staff retention as staff felt more valued and motivated.
- There were 128 WTE nursing staff working in paediatric services. The safe staffing dashboard was displayed in the neonatal unit and children's wards. This showed details of the required levels of staffing, and actual levels present on each shift. Staffing levels were adequate, as was the required skill mix at the time of our visit. Staffing levels conformed to the Royal College of Nursing (RCN) guidance 'defining staffing levels for children and young people's services' 2013. There was a minimum of two registered children's nurses at all times in all children and young people's inpatient and day care areas. Staff had access to a band 7 nurse at all times in any 24 hour period. We viewed staffing rotas for the previous month that confirmed this.
- Staff we spoke with reported that there were sufficient nursing staff to ensure that shifts were filled in line with their agreed staffing numbers.
- During our inspection staff were very visible, particularly on Starfish ward. Staff and managers told us they met surges in activity by being flexible and creative with staff planning. Where there were shortfalls in staff due to sickness or annual leave, staff across the ward areas would be flexible and would cover shifts. Where this was not possible, bank staff that were familiar with the wards areas were used. As a last resort, agency staff would be used. Procedures were in place to request agency staff. Staff told us that if agency staff were required they would request agency nurses who were familiar to the service.
- The trust informed us that temporary staff must have relevant and appropriate training and experience and provide evidence of being a registered paediatric nurse (RN60) or a registered nurse who was adult trained but had paediatric experience (RN00). The trust added that nurses without the relevant training would not be employed. The service kept records of temporary staff inductions. There were no temporary staff on shift at the time of our visit.
- The service had conducted an establishment review which verified the findings of the East of England Neonatal Operational Delivery Network appraisal and designation visit in July 2015; this indicated that the NICU was 18 WTE nurses short in order to meet the British Association of Perinatal Medicine (BAPM) guidelines. Staff told us that the number of staff required had been agreed by an interim divisional manager. However, when the permanent divisional manager returned to work, a further review had been arranged into the numbers of WTE staff required to meet BAPM guidelines. Ward staff were unsure why a further review was required.
- Staff told us that staffing levels in the NICU were safe. The head of nursing told us that flexible staffing meant that staffing was managed on the NICU. Staff told us that the service had taken steps to mitigate risk; this included the use of bank staff and on-call cover. Neonatal on-call support was provided by a matron, band 7 nurses, as well as telephone support. Staff told us that paediatric nurses were rotated around children and young people's services. This meant staff from other wards and areas of the service were familiar with neonatal care and could be redeployed to provide support across the service at times of staff shortages. We viewed the staffing roster for NICU in the previous three months and found there was sufficient nursing staff to ensure that shifts were filled in line with agreed staffing numbers. However, staff pointed out that this was due to nursing staff working flexibly across children and young people's services.
- The trust used the Keith Hurst 'safer nursing tool' to estimate the number of nursing staff and skill mix required to maintain safe staffing numbers on wards. Activity based on the age of the children was reviewed

daily by the ward managers to ensure compliance with the RCN guidance on staffing. RAG ratings were used to assess safe staffing levels. The RAG ratings indicated that overall staffing levels across children and young people's services were generally good across all shifts.

- Staff told us staffing red flag events were closely monitored and reported through daily children's and young people's situational report (sitrep) meetings and 'Onion' meetings. Onion meetings were daily meetings that both medical and non-medical staff could attend to raise issues about hospital operational issues or services with senior managers. We viewed records that confirmed this.
- Starfish ward had three nursing vacancies at the time of our inspection. We saw that the service was actively recruiting by advertising the vacancies both internally to staff who work at the trust and externally to potential new recruits.
- On the NICU the trust employed 1.8 WTE advanced neonatal nurse practitioners (ANNPs). These are very experienced nurses with additional training which enabled them to work autonomously to the equivalent of up to a registrar level doctor. The NICU were looking to send another member of staff for ANNP training. Staff at NICU told us that the service was pro-active in recruitment and training for its staff. The usual NICU staffing level was three qualified in speciality (QIS) nurses on each shift. Staff said that occasionally the unit only had two QIS on shift. However, staff added that this was mitigated by the staff rotation policy, whereby qualified nursing staff from other children and young people's teams could be redeployed to assist in specialist care.
- Nursing staff on Starfish ward told us they had a twice daily hand over; staff were not to be disturbed during hand overs as this was classed as protected time. In outpatients, nursing staff told us they were briefed by the children's outpatients' co-ordinator before the start of clinic every day. Nursing handovers occurred at each change of shift. On the paediatric wards the nurse in charge who had the overall co-ordinating role, received a detailed handover from their counterpart. We viewed a Starfish handover sheet and saw that staffing for the shift was discussed, as well as any high risk patients or potential issues.

Medical staffing

- All children were seen by a consultant within 24 hours of admission to the ward.
- There were 41.8 WTE medical staff working in paediatric services. This included 13.25 WTE consultants, 15.2 specialists/registrars, and 13.35 junior doctors. The children and young people's service had a lower proportion of consultants to other medical staff than the England average. The divisional director said this had not lead to consistent under filling of allocated consultants on the roster, due to medical staff offering to work extra shifts. Rostering records we viewed confirmed this. The trust were actively recruiting three further consultants by advertising the posts.
- The trust were meeting BAPM 2014 guidelines for medical staffing on NICU. A neonatal consultant was on-call at all times and none of the staff reported any difficulties or delays in receiving attention from a consultant. Nurses told us that when they were concerned about a patient, they were encouraged to call the consultant.
- Consultants undertook ward rounds daily, including at weekends.
- Starfish and Safari had two registrars during the day and one registrar during the night. At night the registrar also covered the children's emergency department. However, there was an on-call consultant at night who would attend in the case of a medical emergency.
- Junior doctors across Children and young people's services reported that they had very good training and support from their senior consultants.
- There were two handover sessions per day for the medical teams. A consultant was present at all handovers.

Major incident awareness and training

- Staff were aware of the trust's major incident and business continuity policy; senior staff understood their roles and responsibilities within a major incident. However, some junior nursing staff were unsure about their role in a major incident. Staff told us they had not been involved in a rehearsal for a major incident.
- Staff were aware of the trust's policy on the reporting procedures for escalating incidents.

Are services for children and young people effective?

Services for children and young people

Good

We rated this service as good for effectiveness.

Children and young people had good outcomes because they receive effective care and treatment that met their needs.

Children and young people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.

Children and young people had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. The expected outcomes were identified and care and treatment was regularly reviewed and updated.

Information about children and young people's care and treatment, and their outcomes, was routinely collected and monitored. This information was used to improve care. Outcomes for people who used services were positive, consistent and met expectations.

There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services and service accreditation. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff, and used to improve care and treatment and children and young people's outcomes.

Children were cared for by a multidisciplinary team of dedicated and skilled staff. Staff felt supported and had access to training. Consultant support and presence was provided over seven days.

Evidence-based care and treatment

- Children and young people's services had a band 7 nurse who acted as a clinical practice facilitator responsible for ensuring that practice was based on national best practice guidance.
- We viewed the NICU Bliss family accreditation certificate for its pledge to the Bliss family charter. The Bliss family friendly accreditation scheme (BFFAS) recognises and rewards neonatal units across the country caring for premature and sick babies, where they deliver consistent high quality family-centred care.
- The Trust was working towards the UNICEF Baby Friendly accreditation. The Baby Friendly Initiative is based on a global accreditation programme of UNICEF and the World Health Organization. It is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care.
- Children were treated according to national guidance, including guidance from the National Institute for Health and Care Excellence (NICE), and the Royal College of Paediatrics and Child Health (RCPCH). We saw appropriate care pathways were in use and were in keeping with the relevant clinical or nursing guidance. For example, we viewed the care pathway for perinatal nutrition and saw that the documentation clearly recorded that the pathway was based on an award winning model pioneered by the east of England perinatal network in 2014. We also viewed 'the guidelines for single checking medication by a registered paediatric nurse'; these had been ratified by the trust's drugs and therapeutics committee in January 2014 and were due to be reviewed in January 2017.
- Policies, procedures and guidelines were available to all staff, including temporary staff, via the trust intranet. Staff we spoke to knew how to access them when necessary. We were unable to find some policy information on the system due to the IT system developing a glitch during our visit. Staff told us the trust's IT system was occasionally slow and unreliable, and the IT department had been informed.
- The children and young people's policies we saw were up to date. For example, the trust's 'policy for safeguarding children, young people, and unborn babies had been issued in December 2014 and was due to be reviewed in December 2016. The policy was informed by the Hertfordshire safeguarding children's multi-agency procedures.
- The service was involved in a range of local and national audits. Staff told us that a meeting had been planned to review and monitor the progress of clinical audits. For example, we viewed the children and young people's audit planner for 2015-16. Work was in progress to audit the service's implementation of a range of national guidance including, NICE CG160, 'feverish illness in

children: assessment and initial management in children younger than 5 years'; and NICE CG149, 'antibiotics for the prevention and treatment of early-onset neonatal infection'.

- The service met or exceeded three out of five of the indicators for the National Neonatal Audit Programme (NNAP) 2013. The three that were met or exceed related to babies having temperature taken within one hour of birth, mothers receiving antenatal steroids and babies receiving mother's milk on discharge from a neonatal unit.
- The service did not meet the standards for indicators relating to eligible babies receiving retinopathy of prematurity screening (to screen for a visual impairment) and documented consultation with parents and a senior member of neonatal team within 24 hours of admission.

Pain relief

- Pain was assessed and managed appropriately. We observed age-specific tools in use in the neo-natal unit (NICU) and the appropriate national guidance was followed.
- Patients were given analgesia, as required, and staff monitored whether the analgesia had adequately relieved the child's pain.
- Appropriate equipment was available including equipment for patient-controlled analgesia (PCA). The lead anaesthetist for children was involved with the children's pain service and pain strategy.
- The play specialist team were available in each ward and department, and provided distraction technique therapy for children undergoing a variety of procedures. Play specialists described numerous distraction therapies and techniques they used to help reduce patients' pain and distract them from painful procedures.
- Two of the parents we spoke with confirmed that staff ensured their children were not in pain.

Nutrition and hydration

- The ward areas had a protected mealtime's policy, which meant that children and young people could eat without being disturbed, except for parents and siblings. We saw that this was observed by staff on the ward.
- Children's and young people's wards used a nationally recognised screening tool for the assessment of malnutrition in paediatrics to determine if patients were at risk of malnutrition. We noted that there were plans of care for any children at risk, with input from speciality teams as required. Children and babies were frequently weighed, and there were records relating to their fluid, nutritional intake and output.
- Support was available from dieticians for specialist advice and support with special diets and feeds. The staff were also aware of how to order specialist menu choices, such as halal food or gluten-free meals.
- There were adequate facilities for the management of bottle-feeding.
- The records we reviewed during our inspection showed that fluid or dietary intake was monitored and recorded where required.

Patient outcomes

- The service took part in all the national clinical audits that they were eligible for. For example, the trust took part in the NNAP. The annual report showed that, for the period of January to December 2013, the trust achieved three out of five intended outcomes for people were being achieved. The trust achieved the standard that all (100%) of babies of less than 28 weeks gestation have their temperature taken within one hour of delivery: mothers of premature babies received antenatal steroids (87% against a target of 85%): babies that received mother's milk when discharged from a neonatal unit (79% against a target of 59%) other key standards were babies that received retinopathy of prematurity screening (98% against a target of 100%); babies received a documented consultation with parents within 24 hours of admission to the neo-natal unit (95% against a target of 100%).
- The trust also took part in the NPDA, published in 2013. The audit showed that the trust had mixed results for paediatric diabetes. NICE guidance states that an HbA1c level below 7.5% indicates that diabetes is well managed. The trust had 9.4% proportion of children with a glycated haemoglobin (HbA1c). This was better than the England and Wales average of 15.8%.
- The service had a slightly lower readmission rate than the England average in all categories except general surgery. Readmission rates for children and young people with asthma were better than the England average and about the same as the national average for diabetes and epilepsy. The service had comprehensive discharge planning to reduce the likelihood of patients being readmitted.

- The average length of stay for emergency admissions that were 1-17 years old was in line with England average. The service provided in patient care for children up to the age of 16. Staff told us 16-17 year olds would be given the choice of admission to an adult or a paediatric area according to bed availability, providing they did not display behaviour unsuitable for a children's ward environment. Staff said this would always be decided in consultation with the young person and their family. Staff told us young people who chose to stay on the wards would be offered a bed in a secluded area of the ward. There was an adolescent's room available on Starfish ward to young people. This contained a TV, sofa, and games console.
- Children's and young people's services did not have a specific end of life care policy for children's services. However, the service had processes in place to undertake mortality and morbidity case reviews should this be required as part of the service's governance arrangements.

Competent staff

- Information we saw on the wards and in the departments showed that most staff had received an appraisal in the last 12 months. Staff we spoke with during the inspection confirmed that they had received an annual appraisal. All of the 19 staff nursing staff we spoke to told us they felt well supported by their ward teams and the senior nursing and managerial staff.
- Junior medical staff reported good access to teaching opportunities and said that they were encouraged to attend education events.
- We saw that staff had the right qualifications and had access to further development. For example, the trust employed two ANNPs who were highly skilled members of staff.
- The nursing staff in the NICU had access to in-house training and the neonatal life support course. The junior doctors in the unit reported that they received good educational supervision' and said that the consultant staff took an active interest in their teaching.
- Children and family services had recently employed 3.8 WTE emergency nurse practitioners (ENP's) who were trained in child and adolescent life support.
- On Starfish ward, staff were routinely required to care for young people who required support from and external provider of child and adolescent mental health services (CAMHS). Staff told us they were not trained to care for patients with these specialist needs and they found it challenging to cope with at times. Staff said discussions with CAMHS were on-going in regards to CAMHS providing appropriate placements for these young people. The trust's health and safety department carried out anti-ligature assessment of Starfish wars in 2014, and all young people with identified mental health needs were risk assessed by CAMHS.
- The medical staff we spoke to all confirmed that they had received an appropriate induction when they started work and had an appraisal to identify training needs. Staff said they received access to clinical supervision and good training opportunities.
- Nursing staff told us the practice learning facilitator or ward manager regularly assessed their competence in medicines management and drug insertion.

Multidisciplinary working

- There was strong evidence of multi-disciplinary team working in all departments, within and outside services. There were regular weekly multi-disciplinary team meetings. We also saw evidence of engagement with external agencies such as social services and networking with other children's services to share specialist expertise. For example, Starfish ward had a psycho-social ward round every Friday. This was a multi-disciplinary ward round that looked at children's and young people's psychological and emotional wellbeing. The ward round included clinical psychologists, as well as CAMHS and safeguarding staff.
- Medical and nursing staff worked closely with the clinical psychology team for children with complex needs throughout the referral, discharge and transition processes.
- The pharmacy, dietetic and physiotherapy teams were children and young people's specialists and joined ward rounds. The service had support from 1.8 WTE children and young people's physiotherapists.
- The trust employed 1.8 WTE play specialists. Play specialists were an integral part of the children and young people's ward and department teams. Play specialists work with children to make the hospital environment welcoming and fun. They answer questions children may have about what will happen on the ward and reassure children. The trust had one full-time diploma qualified play specialist and another who was about to qualify. The play team were informed

of all planned admissions at handover, and were involved in multidisciplinary ward rounds, as necessary. The play team were available Monday to Friday 07.30 – 16.30.

- The neonatal unit had an outreach service, where babies discharged from the unit were supported by the neonatal team in the community. The neo-natal team worked closely with community based services such as health visitors and GPs to ensure care was transferred effectively to community services.
- We spoke with two parents on the medical ward and they told us that they felt the multidisciplinary team was "very good". They said that their child's specialist team gave holistic care and all visited them together in one session.
- There were qualified play specialists available on Starfish and Safari wards Monday to Friday. The outpatient clinics employed a qualified nursery nurse during the week. Play specialists attended the wards weekly psycho-social meetings.
- We noted that young people up until the age of 16 were cared for within the service. Staff told us that young people over the age of 16 would be consulted about whether to remain on a children's ward or whether an adult ward would be more suitable.
- The staff we spoke with said that there were good working relations with the social work department and children were seen and assessed in a timely manner.
- Surgery services included: general surgery and neurology from six months of age, with a dedicated paediatric consultant and paediatric anaesthetist. Other services included: ear, nose and throat (ENT) surgery and dental surgery from two years of age. Surgery staff told us they had very good working relationships with staff on the children and young people's wards and communication was effective.

Seven-day services

- There were consultant ward rounds seven days a week on the wards, and they were available out of hours through on-call arrangements.
- Starfish ward operated a 24-hour service. Safari ward was used mostly for day case surgery and would close at weekends. Safari would stay open in the early evening if a child required an overnight stay following their surgery and then would be transferred to Starfish ward, which was directly next to Safari ward.
- The pharmacy department was open seven days a week but with limited hours on Saturday and Sunday. There were pharmacists on call out of hours.
- Physiotherapy services were available seven days a week. Out-of-hours support was available through an on-call system.

Access to information

- Senior staff were aware of the Caldicott Guardian; this is a position whereby the holder has responsibility to ensure the protection of patient confidentiality. This meant patients could be sure that their confidential records would only be shared appropriately.
- GP's were informed of patients discharge on the day of discharge. Care summaries were sent to patient's GP on discharge to ensure continuity of care within the community. GP's could telephone consultants and registrars for advice following discharge.

Consent

- Parents were involved in giving consent to examinations, as were children when they were at an age to have a sufficient level of understanding. Staff we spoke with were aware of Gillick competence, this is a decision whether a child 16 years or younger, is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Staff told us they would always speak with a child and encourage them to involve their parents where appropriate; but would respect the rights of a child deemed to be competent to make a decision about their care or treatment.

Are services for children and young people caring?

Outstanding ☆

We rated this service as outstanding for caring.

Feedback from children, young people and their families who use the service was continually positive about the way staff treat people. 'The trust's 'iWantGreatCare' results were consistently high.

There was a strong, visible person-centred culture. Staff we spoke with were motivated and inspired to offer care that

was kind and promoted children, young people, and their families' dignity. Relationships with patients and their families were highly valued by staff and promoted by local leaders.

Staff took patients and their families' personal, cultural, social and religious needs into account.

Patients and their families were active partners in their care. Staff were fully committed to working in partnership with children, young people and their families and making this a reality for each patient. Staff always empowered patients and their families to have a voice and to realise their potential. Staff demonstrated determination and creativity to overcome obstacles to overcome obstacles to delivering care. Children, young people, and their families' preferences and needs were always reflected in how care was delivered.

Children, young people and their families' social needs were highly valued and embedded in their care and treatment.

Compassionate care

- Throughout our inspection, we observed positive interactions between staff, parents and children. We saw staff responding in a considerate manner with children, young people and their families in all of the areas we visited.
- Parents we spoke to told us they had been treated with respect and compassion by the staff and praised staff for their attitude and approach.
- Children and young people's services scored consistently highly on the 'iWantGreatCare' survey. For example, in the week 30 March – 5 April 2015 the Starfish ward and Safari day unit achieved an average score of five out of five in the 'iWantGreatCare' survey.
- The Care Quality Commission (CQC) use national surveys to find out about the experience of patients receiving care and treatment from healthcare organisations. CQC's most recent survey gathered information on the care of 113 children and young people at West Hertfordshire Hospitals NHS Trust. The survey found that the trust was in line with the national average with 9 out of 10 parents and children reporting their experience as good. However, the trust did better than the national average in regards to parents and carers saying staff agreed a plan for their child's care with them.
- All of the parents we spoke with told us they felt involved in planning and making decisions about the care and treatment of their child. For example, one parent told us that a consultant had liaised with another hospital and explained their child's needs to every medical professional who was treating their child. This ensured that other professionals were fully aware of their child's needs.
- We saw that children and young people's privacy and dignity was respected by staff drawing curtains when providing intimate care or treatment. Staff response to buzzers was timely. Play specialists worked with nursing staff on Starfish and Safari wards to ensure that children and young people were not left unsupervised for prolonged periods when they didn't have a parent or carer visiting.
- We observed a carers support volunteer attending Starfish ward and spending time supporting parents with practical tasks. For example, a volunteer assisted a parent by attending to a baby whilst the parent took a shower.
- All the parents we spoke with told us they felt very involved in their child's care. We saw that staff spent time with children, young people and their parents to ensure they understood their care and treatment, and were supported throughout their time in hospital whether as an inpatient or an outpatient. A parent told us, "The staff here really do go the extra mile. They really put themselves out to help."
- We saw staff pulling curtains around patients when providing intimate care or treatment. This ensured patients' privacy and dignity was respected at all times.
- A carers' support volunteer told us how the carers support team were involved in planning and supporting Christmas parties and Easter activities with the play specialists and ward staff.

Understanding and involvement of patients and those close to them

- All of the patients and parents we spoke with said that they had been involved in their care and in making decisions around their treatment.
- Play specialists told us children were asked about the activities they would like to be involved on a daily basis. We saw a play specialist asking a child what they would like to do. The child chose to watch a DVD. The play specialist assisted the child in choosing and playing the DVD.

Services for children and young people

- During our inspection, we observed staff communicating with patients and parents to ensure they understood their care and treatment. Parents we spoke with told us they felt well informed and could ask any questions of the staff if they wished to do so.
- We observed how staff talked and explained procedures to children in a way they could understand. Services for children and young people at the hospital were caring. We observed a number of examples of compassion and kindness shown by staff across all the departments and ward areas. For example, we saw a five year old receiving an allergy test on Safari ward. The nurse explained in accessible language what she was doing, why she was doing it, and what she would do next.
- Staff encouraged parental involvement in ward rounds. Parents were supported by the carer support team to record any questions they had for the multi-disciplinary team on a parents ward round questions form. The forms were used by parents as prompts during ward rounds.
- A parent told us Starfish ward staff had provided a meal for their infant child who was a visiting a sibling who was a patient on the ward. The parent said, "They think about little things that make a big difference." Staff told us they would provide toast and cereals for families in the morning if they had stayed overnight, and would speak to the kitchen staff if parents had specialist diets. This meant parents could stay with their child on the ward and not have to leave the ward to eat or find refreshments.

Emotional support

- It was evident from our discussions with staff that they were very aware of the need for emotional support to help children and families cope with their care and treatment. All the parents and relatives we spoke with confirmed this during our discussions with them.
- Staff were aware of how anxiety can impact the welfare of the child and made provision, where needed, to manage this. For example, play specialists offered support with pre-operative children to alleviate their anxiety.
- Starfish ward had a team of volunteers, the carers support team. The volunteers offered practical and emotional support to parents of children and young people who used services. Parents we spoke with told us the practical and emotional support provided by the volunteers was valued by them.
- Parents we spoke with told us they felt confident in leaving the ward and leaving their children in the care of the staff on the ward.
- Children and young people who were experiencing mental or emotional distress had access to a child psychologist. We observed staff attending babies who cried promptly to offer comfort.
- Staff told us the hospital Chaplaincy would offer support for parents and others close to a child who had received bad news. Nursing staff told us they had received training in breaking bad news during their induction. Staff told us the Chaplaincy team had access to multi-faith support for children, young people, and their families where there was a need.

Are services for children and young people responsive?

Good

We rated this service as good for responsiveness.

Children and young people's needs were met through the way services were organised and delivered**.**

Children and young people's services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services provided.

The needs of different children and young people were taken into account when planning and delivering services.

Children and young people's care and treatment was coordinated with other services and other providers.

Reasonable adjustments were made and actions were taken to remove barriers when children and their carers found it hard to use or access services.

Service planning and delivery to meet the needs of local people

- A parent who had a child on Starfish ward identified the need for parental support. The trust gave its support to the parent creating the parents support volunteers.
- Services were flexible and developed with the needs of local children in mind. For example, the neo-natal unit had developed an outreach service for families who

required support in the community. Discharged babies with complex needs would be supported by staff from the neonatal team prior to being transferred to community nursing services.
- There were no separate areas for children and adolescents on the wards. However, Starfish ward had a room that had been furnished and decorated for adolescents. Young people could watch television or videos in the room. The room also had a gaming console young people could use. Starfish ward also had a play room for younger children with toys and a selection of children's books.
- Children and young people's service had an effective service level agreement in place for diabetes specialist services, where the trust did not directly employ diabetes specialists. This had resulted in reductions in the time between referral and access to diabetes services.
- Information for parents on access to patient records was available in the parents' room on Starfish ward. This explained people's rights to access medical records under the Data Protection Act 1998.

Access and flow

- The neo-natal unit (NICU) discussed planned deliveries of babies with the anti-natal service and delivery suite on a daily basis.
- The overall average occupancy level for NICU in the previous 12 months was 69%. The optimum occupancy level was 70% according to BAPM guidelines. This meant the unit was managing to maintain the availability of emergency cots and providing the optimum safe nursing levels.
- The occupancy rates from April 2014 and March 2015 were: Safari day unit 18%; Starfish ward 56%; special care baby unit 56%. The ward manager told us they rarely had to cancel operations due to bed shortages.
- In out-patients we saw that clinics were busy but provided a flexible service. Parents we spoke with said that there had been no problems with appointments on the whole and that they were seen reasonably promptly in the clinic.
- The current waiting time for an out-patients paediatric appointment was 12 weeks. For most specialties such as cardiology, the waiting times were around eight weeks.
- The longest waiting time was for children's neurology services. The waiting time for a neurology appointment was 14 weeks at the time of inspection.
- Outpatients offered clinical psychology clinics on an ad hoc monthly basis. Staff told us that the clinics were based upon when the outpatients unit had enough patients to run a clinic. The clinics involved a consultant paediatrician and clinical psychologist.
- Children could be admitted from the children's emergency department which was adjacent to but separate from the main emergency department.
- We saw the service had produced a flow chart for patients which would assist them, as well as staff, to map the patients journey through the service.

Meeting people's individual needs

- Each ward and department catered for the needs of individual children. This included ensuring that there was enough space next to each bed or neonatal cot for a parent to visit. There was accommodation available for parents to stay with children overnight.
- There were sufficient play areas on the wards. Staff we spoke with told us that the service was flexible enough to meet the needs of all children admitted to the wards, regardless of the complexity of their physical needs. We observed good facilities for children with disabilities. For example, Starfish ward had a playroom with a sensory area for younger children and children with learning disabilities.
- There were age appropriate leaflets and booklets for children and young people that explained the different procedures they could have, as well as their medical or surgical condition.
- Staff told us that the hospital had access to interpreters if required and information in other languages for people whose first language was not English. We did not observe any interpreters being used during our inspection.
- The trust's play specialist team worked alongside nursing and medical staff to provide support to children and young people. Parents spoke highly of this service and how the play specialists had helped with treatment.
- The décor of the children's outpatient clinics was child themed and had a good range of play equipment for all ages which was kept to a good standard.
- The parents' area provided a good range of written information about treatment and care for a range of conditions.
- Children's likes and dislikes regarding food were identified and recorded as part of their nursing assessment on admission. Children and young people

were able to choose what they wanted to eat from a menu. There was a menu booklet which was distributed by staff on the wards for children and their families to view.

- There were adequate facilities for breastfeeding mothers, throughout the children's services.
- All of the inpatient areas had facilities for a parent to stay overnight and sleep. These included pull-down beds next to the child's bed. There was parental accommodation for parents whose children had to stay in hospital for a long period of time.
- Support was available for children with learning disabilities or physical needs, with access to registered learning disabilities nurses, as required.
- The divisional manager told us that work was on-going with the clinical commissioning group (CCG) to identify a safe place at the trust for children awaiting an appropriate mental health bed. In the interim families were invited to stay with their children on the ward where appropriate. This risk was identified on the trust's risk register.

Learning from complaints and concerns

- Complaints were managed in accordance with trust policy. Staff and managers told us that they preferred to resolve concerns "on the spot." Staff said these were not recorded, but if they could not deal with the concern immediately parents would be directed to make a formal complaint. Parents we spoke with all said that they had not raised any complaints with the service, and they found staff approachable if they wished to raise issues.
- Information regarding complaints and concerns was on display in the parents' room. Leaflets detailing how to make a complaint were freely available. We only saw leaflets in English. This meant non-English speakers would have to request information on how to make a complaint from staff. Staff told us information in all languages could be requested on the same day from the hospitals accessible communications team.
- The service held monthly 'paediatric and neonatal departmental governance and quality group meetings''. The minutes of these meetings showed that complaints to the service were a standing agenda item and would be discussed at the meetings. Staff told us learning from complaints was shared at team meetings and across services where applicable. However, children and young people's services had not received a formal complaint in the previous 12 months.

Are services for children and young people well-led?

Good

We rated this service as good for being well led.

The leadership, governance and culture promoted the delivery of high quality child-centred care.

There was a clear statement of vision and values, driven by quality and safety for children and young people's services. It had been translated into a credible strategy and well-defined objectives that were regularly reviewed to ensure that they remained achievable and relevant. The vision, values and strategy had been developed through a structured planning process with regular engagement from internal and external stakeholders, including people who use the service, staff, commissioners and others

Strategic objectives were supported by quantifiable and measurable outcomes, which were cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, were understood and an action plan was in place.

Staff in all areas knew and understood the vision, values and strategic goals.

The trust board and other levels of governance within children and families services functioned effectively and interacted with other services appropriately. Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, were clearly set out, understood and effective.

Vision and strategy for this service

- The management team for services for children and young people had a clear vision for the service. Safety and quality were clearly the top priorities for the management team. The divisional director was able to tell of the plans in place to develop and enhance the

service to meet the demand for planned services. For example, both Safari and Starfish ward had recently been decorated and renovated as part of the trust's strategy to improve patients' experience.

- The chief nurse was the non-executive lead for children and family services. The chief nurse had regular 'onion' meetings with children and family staff. Staff told us the chief nurse was visible and approachable.
- The nursing and medical management team were aware of how they fitted into the wider management model for the trust. We saw that a new staff appraisal system had been introduced. The system was linked to the trust's values.
- Most of the staff we spoke with understood the vision and strategy for developing the service, and said that they felt they were kept informed. Staff were also aware of the trust's vision and values. Staff told us the trust's vision and values were communicated on the trust's emails. We saw posters displayed on the wards that communicated the trust's vision and values.

Governance, risk management and quality measurement

- There was a governance framework in place and responsibilities were defined. Monthly quality and safety reports were produce which reviewed the quality and safety of services provided to ensure the best outcomes for patients.
- Monthly departmental governance meetings and quarterly departmental governance as well as quality group meetings were held. These meetings contained a number of standing agenda items including reported incidents, complaints and infection control. Staff attending the meetings fed back to children and young people's teams following these meetings to ensure teams were informed of the key issues. The meetings also fed into the wider divisional structure to ensure that trust-wide issues were picked up and any concerns from the children and young people's group were reported. For example, we viewed the meeting minutes from February 2015 and saw that the minutes comprehensively reviewed children and young people's safeguarding information from the previous quarter.
- A risk register was in place which identified the key concerns for the service. There were 21 items on the register. We discussed gaps in recording actions on the risk register's action plan with staff. Staff demonstrated that the service had acted to address all the risks to patients identified on the register. However, recording on the risk register had not been updated to indicate the current status of risks on the register or all the actions the service had taken to minimise risk. Most staff we spoke with were aware of the risk register, but could not explain why the records on the register had not been updated. The chief nurse told us immediate action would be taken to address the gaps in recording on the risk register. The head nurse told us they would take responsibility for updating the risk register and said they would prioritise the updating of information. The head nurse highlighted that actions identified on the register had been completed and the non-recording of actions had not had an impact on patient care.

Leadership of service

- Services for children and young people were well-led. Department and ward level leadership was effective and well managed. Consultants' roles and responsibilities were defined by the trust's job planning process.
- There were governance arrangements in place that monitored the outcome of audits, complaints, incidents and lessons learnt throughout the service. We looked at copies of governance meetings, risk registers, quality monitoring systems, and incident reporting practices. These showed that there were management systems in place that enabled learning and improved performance, and these were continuously reviewed. For example, low staff annual appraisal rates were identified on the children and young people's risk register. The trust had developed a new system of staff appraisal. Staff appraisal rates were monitored on a monthly basis by the divisional manager and reported to the chief nurse.
- We saw that the local clinical leaders and managers encouraged co-operative, supportive relationships among staff and teams, and compassion towards patients. Staff told us that local leaders were very visible and approachable. We observed the head nurse advising managers and staff on the wards on several occasions.
- Senior ward staff we spoke with said that they felt supported by senior management, and if they raised any concerns about the service, they would be listened to. Staff across the service told us the chief nurse was visible and accessible through regular 'onion' meetings.

Culture within the service

- Staff told us that there was a very positive culture within teams, and that staff supported each other well. We saw that staff worked well together in multidisciplinary teams to provide holistic care to children. Staff told us the culture of the service was very focused on meeting the needs of children and young people who use the service.
- Staff described an open culture, where they were encouraged to report incidents, concerns and complaints to their manager. Staff we spoke with told us they felt able to raise any concerns.

Public and staff engagement

- We saw a number of examples as to how children and young people's staff were kept informed by managers of service developments. Staff we spoke with said they felt engaged in services. For example, the chief nurse attended the children and young people's 'onion' meetings monthly. 'Onion' meetings provide managers with the opportunity to regularly engage with front line staff.
- Services used a variety of methods and tools to collect feedback from patients and parents regarding the care and treatment provided. The trust's 'iWantGreatCare' comment leaflets were available and accessible in all children's and young people's ward and outpatient areas. 'iWantGreatCare' is an independent service which works with providers to provide detailed, accurate and timely monitoring of patient experience. For example, we viewed the results of the 'iWantGreatCare' survey for the week commencing 30 March 2015 for the Safari unit. This indicated that 15 people had responded to the survey. The unit had achieved an overall score of five out of five.
- Staff told us that the service regularly held events for local schools to increase local children's engagement and understanding of hospital services.

Innovation, improvement and sustainability

- We saw a range of innovations which helped to provide a flexible and responsive service. For example, the service had a dedicated telephone between surgery recovery and Starfish ward. This was put in place to improve the response to calls for young people who were waiting to be collected from surgery following surgical procedures.

End of life care

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

Information about the service

West Hertfordshire Hospitals NHS Trust serves a population of approximately 600,000 people.

The hospital reported 611 in-hospital deaths between April 2013 and October 2013. The proportion of deaths across the trust that were patients receiving Specialist Palliative Care in 2014 was 31% (448 out of a total of 1456).

The End of Life Services provided consisted of a specialist palliative care team at Watford General Hospital. This consisted of four full time equivalent specialist palliative care nurses, and a lead nurse managing palliative care and oncology. The service has two consultants who worked one day per week each at Watford General Hospital.

We spoke to seven patients at Watford hospital and four sets of relatives and visited the Patient Affairs Office and Mortuary at Watford General Hospital.

Summary of findings

We rated this service as good for caring, requires improvement for safety and responsiveness and as inadequate for effectiveness and for well led.

Patients we spoke to were very happy with the care that had been provided to them. Relatives told us that they recommended the care that their relative received by staff at Watford General Hospital.

We saw staff carry out care to patients in a respectful and careful manner. Staff spoke to people politely and respected their privacy and dignity by knocking on doors and asking for consent to proceed with tasks.

Where concerns were mentioned on the trust's risk register no action had been taken to mitigate risk or repair problems in an effective and timely way. Outcomes on the risk register were out of date and not reviewed or updated within the trust's stipulated timeframe.

Facilities overall in a poor state of repair and caused a potential risk to staff and visitors.

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.

Medical staffing was below that recommended in the National Institute of Clinical Excellence (NICE) guidelines.

End of life care

Not all Do Not Attempt Cardiopulmonary resuscitation forms were completed in accordance with trust procedures.

The trust took part in the National Care of the Dying Adult (NCADH) in 2013 to 2014 and achieved three out of seven of the organisational key performance indicators (KPIs) and met six of 10 clinical KPIs. The trust had an action plan in place to improve some aspects of end of life care, but this did not cover the items not met in the above audit.

The trust had developed a care planning tool to replace the Liverpool Care Pathway (LCP) which had been removed however this had not yet been implemented in nearly two years since the LCP ceased. Staff were not aware of the new plans.

Pain assessments were not always completed in accordance to trust policy. This meant that pain records were incomplete and that patients' pain levels were not effectively monitored.

The trust did not provide effective bereavement services and staff delivering information to bereaved people did not receive training in communication or bereavement.

There was no clear vision for the service that staff could describe consistently.

The trust did not have a formal audit regime for end of life services, and had not conducted research into the needs of local people. We did see an action plan which documented the intention to carry out this research in future, although this had not yet commenced.

Although specialist care planning was in place for some illnesses (for example; heart failure and patients living with a dementia), there were no care planning tools in place for patients with learning disability. However, staff we spoke with were not aware of the care planning tool for patients living with dementia.

Palliative care services had been understaffed, moved from directorate to directorate, and offices and interim managers had changed regularly over the previous two years. This impacted on the leadership and direction of the service.

We saw some evidence of a drive to improve the service and an example project that had taken place to widen knowledge about end of life care with staff in the trust. This was clearly driven by staff working in palliative care services, but it was not clear how senior leaders supported the service.

We saw that the trust 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.

End of life care

Are end of life care services safe?

Requires improvement

We rated this service to be requires improvement for safety.

Not all Do Not Attempt Cardiopulmonary resuscitation forms were completed in accordance with trust procedures.

Medication was not always appropriately prescribed. 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.

Where concerns were mentioned on the trust's risk register no action had been taken to mitigate risk or repair problems in an effective and timely way.

Medical staffing was below that recommended in the Commissioning Guidance for Palliative Care.

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.

Facilities overall where in a poor state of repair and caused a potential risk to staff and visitors.

Serious incidents had occurred where staff had found that the fridges in one of the trust's mortuaries had failed. Checking systems were not put into place to monitor this risk at Watford mortuary.

Incidents

- No serious incidents requiring investigation were reported in the period February 2014 to January 2015.
- Staff understood the process in place for reporting incidents
- Where incidents were reported and risks identified action was not always taken in a timely manner.
- 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. This was brought to the attention of the clinical team at the time of the inspection.
- Items on the risk register had not been updated or acted upon by the date due
- Staff in a multidisciplinary meeting for end of life care discussed issues where end of life patients have had their discharge from hospital delayed due to medications not being ready for them. In the meeting, staff discussed how this can be improved in future to improve the service and learn from previous incidents.
- We spoke to two managers and four nurses about the duty of candour and two managers were able to describe what this meant, but nurses were unsure.

Cleanliness, infection control and hygiene

- We saw in all areas that offices and ward areas were kept visibly clean and free from clutter. Patient areas had adequate space and facilities to enable them to be cleaned properly, and bins and waste areas were emptied regularly.
- Trust infection control guidelines were available in the mortuary.
- Staff used personal protective equipment (PPE) and followed the infection control procedures that were in place in accordance with the trust's policies.
- We saw that facilities were suitable to maintain hygiene standards.
- Hand cleaning wipes were provided to patients at mealtimes so that they could clean their hands before eating.
- Staff in the mortuary showed us the colour coded system for name boards in use to ensure that patients booked in on certain days could be identified at a glance.

Environment and equipment

- Seven patients and one relative told us that they thought the environment was clean and well maintained, and one patient told us that one domestic worker in particular "took real pride in their work "and frequently asked patients if the area was clean enough or if they felt an area required more attention to cleaning or was not satisfactory.
- Equipment was available to meet patient needs such as syringe drivers and pressure relieving equipment.

End of life care

- 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. The offices in use were in better condition; however this environment was not healthy for staff to work in.
- We saw other areas of the mortuary to be clean and tidy, and fire exits were free of obstacles.

Medicines

- The stock of medicines for palliative care patients were stocked in the ward area for patients requiring palliative care.
- We saw that medications were stored in locked cupboards in coded storage rooms in accordance with the trust's policy.
- We saw that a fridge was out of use in the Acute Admission Unit (AAU) which meant that staff had to walk to the other part of AAU on a separate floor to access medications for patients. This meant that medication administration could be delayed, and staff levels may be affected during this time. We were unable to ascertain when the fridge would be fixed as staff told us it had been out of action for months and they were unclear as to who was responsible for its repair.
- We reviewed a document produced by the trust named "risk of distress and death from inappropriate doses of naloxone in patients on long-term opioid treatment" dated December 2014. This document highlighted recent incidents in other trusts and highlighted precautions that should be taken.
- We reviewed medication administration records for patients receiving palliative care on AAU. One person was prescribed suitable medication for anxiety and appropriate clear instructions for staff to follow.
- However the other chart we reviewed had naloxone prescribed for a patient that had been on opiates prior to their admission. We reviewed the trust's policy on prescribing naloxone and saw that this 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.
- We saw nurses in AAU prepare three syringe drivers for patients. They followed correct checking and preparation procedures to ensure the patients were given the right drug at the right time.
- Medication storage cupboards, drug trolleys, and drug fridges in use were locked at the time of our inspection.
- At a multidisciplinary meeting we attended, staff discussed discharge medications for end of life patients.
- During the 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.

Records

- We reviewed two care records of people receiving palliative care in AAU and saw that one person had admission paperwork which did not clearly document the medication they had been prescribed prior to admission. This lack of clarity may have led to the incorrect administration of medicines.
- We saw that admission paperwork included risk assessments for pressure area care, moving and handling, and falls amongst others.
- We saw that the records kept by the palliative care team were stored in an appropriate manner and secure so that patient information was protected.
- In ward areas we saw that paper records were stored securely and were not left unattended on desks. Bedside records did not contain sensitive information, and closing folders were used so that information is only visible once the folder is opened, and not on display for example on a clipboard.
- We reviewed 11 do not attempt cardiopulmonary resuscitation forms (DNA CPR) and saw that the documents were in place where necessary and stored in paper form in the patients notes so that they could be discharged with the patient. All 11 forms were dated, all had reasons for the form being completed, all were signed by the doctor completing it, but four were not countersigned by a consultant. Whilst the trust's policy

stated that it endorsed the use of the NHS East of England Integrated DNACPR Policy for Adults, the trust's policy did not give clear guidance as to who the responsible senior clinician should be to sign the form, not give guidance for a countersignature by a consultant/senior clinician if the form was competed by a junior doctor.

Safeguarding

- The palliative care nurses were able to give examples of safeguarding issues and describe an example of when they had come across a safeguarding concern and how they had dealt with it.
- Palliative care staff had received safeguarding training in line with the trust's policy.
- On ward areas, we saw signs for patients, staff and visitors to inform them of the process to report a safeguarding incident.
- We saw that review systems were in place at monthly meetings to review safeguarding investigations and feedback learning to other areas of the trust.

Mandatory training

- We saw computer records that showed the mandatory training for palliative care nurses was up to date, and we were told that each nurse in the team has a specific palliative care qualification. For example a degree (BSc) in the subject.
- Staff told us that mandatory training for nurses in the palliative care team did not include refresher courses specific to end of life care.
- 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.

Assessing and responding to patient risk

- We saw that the trust used an early warning assessment tool for recording the observations of patients admitted to the hospital. This tool scores each aspect of patient's observations in order to prompt staff to follow clear procedures documented on the form. This meant that there was a system in place to monitor patient risk, including those patients receiving end of life care.
- We saw the early warning tool in place and staff showed us how they used it to monitor the improvement and deterioration of patients. Staff were able to explain the procedure to follow if a patient's condition became worse, and knew that contact details and pager numbers of key staff members were included on the form to save time.
- We saw that risk assessments were in care files relating to moving and handling, risk of falls, pain control and tissue viability. We saw that actions were documented to take place where risks were identified; for example an air mattress requested for a person at risk of tissue breakdown.

Nursing staffing

- The palliative care team consisted of four whole time equivalent registered nurses, and the trust also has specialist nurses to cover all areas of cancer care that worked closely with the palliative care team.
- The team were led by a lead nurse that covers palliative care services and oncology.
- We spoke to nurses in the palliative care team and they told us that they had recently been able to secure funding for a clinical educator. However the funding for this position ended this year and it was not clear if this would be extended.
- We spoke to three nurses working in the palliative care team who told us that staffing levels had been low on their team and nurses had recently been recruited. Further plans were in place to recruit two more specialist palliative care nurses but this would not take place for at least another three months.
- Staff told us that the palliative care team did not have an effective system in place to cover sickness. We were told that the other person working that day would cover the service and see patients on the wards.
- Palliative care nurses handed over cases to each other and held records about the patients they reviewed so that other members of the team could pick up case notes.

Medical staffing

- Medical staffing was below that recommended in the National Institute of Clinical Excellence (NICE) guidelines.
- We spoke to one of the two consultants that oversaw palliative care at the hospital and described the projects they had been involved in developing the provision of palliative care during the last few years. These doctors were covering 3 days per week for patients at the

hospital - 2 clinical and 1 non clinical. 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 recommends 1.0 wte consultant per 850 acute beds. Based on the Trust having 0.7 wte consultants for c. 650 general acute beds this represents a shortfall against the required number of 0.8 wte. However we noted that this was an improvement on the cover two years earlier which equated to 0.4 whole time equivalent doctors covering end of life care.

- The mortuary manager told us that the staffing in the mortuary was at 40% of its full staffing capacity, and there were three newly recruited trainees which could not be left unsupervised. This meant that the trust was using a high number of locum staff to cover the 60% of shifts which were not covered by permanently employed staff. The trust did not have a risk management plan in place for the high level of locum staff use in the mortuary, and this was not documented on the trust's risk register.

Major incident awareness and training

- We saw that the trust had hired a free standing refrigerator unit at the hospital to cover the trust in case of an incident and lack of storage during the winter months. We saw that the fridges in use in the main mortuary were not full, and that the contingency fridges were not required.
- Mortuary staff told us that 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 is storage or other issues relating to the mortuary. Porters had had this training but managers and other staff in the hospital had not been trained in these procedures.

Are end of life care services effective?

Requires improvement

We rated end of life services as requires improvement for effectiveness.

The trust took part in the National Care of the Dying Adult (NCADH) in 2013 to 2014 and achieved three out of seven of the organisational key performance indicators (KPIs) and met six of 10 clinical KPIs. The trust had an action plan in place to improve some aspects of end of life care, but this did not cover the items not met in the above audit.

The service did not have 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 (LCP) which had been removed however this had not yet been implemented in nearly two years since the LCP ceased. Staff were not aware of the new plans.

Pain assessments were not always completed in accordance to trust policy. This meant that pain records were incomplete and that patients' pain levels were not effectively monitored.

We saw that the trust had plans to increase the number of staff in the palliative care team to enable them to improve the effectiveness of the service as it was not providing a comprehensive seven day a week service.

Staff were competent in their roles and were keen to progress services further but the trust needed to develop its training and development process for staff with regards to end of life care.

Multidisciplinary working was effective.

Access to relevant clinical information was not always effective as the trust did not maintain a register of all patients at end of life so that relevant information could be shared with community teams and general practitioners.

Evidence-based care and treatment

- Following the removal of the "Liverpool Care Pathway" nationally the trust had developed the "Individualised Care Plan for the Dying Person" in consultation with ward staff, community health care professionals and two other local NHS trusts. At the time of our inspection the document was not yet in use and was in the process of being approved by the trust. The trust was in the process of undertaking a case note review of the last 30 patients who had died prior to rolling out these Individualised Care Plans for the Dying Person.

End of life care

- Staff we spoke to told us that they were not aware of a care plan being introduced to replace the Liverpool Care Pathway.
- The trust had developed Best Practice Guidelines for Compassion and Dignity at End of Life dated August 2013, and these referenced patients having personalised end of life care plans with the focus on symptom control, pain relief, nutrition and hydration.
- The palliative care team told us that they were recruiting for two full time nurses, one of which would be the lead in implementing the new care planning document and the roll out across the hospital.
- We saw the forms staff used to monitor the use of syringe drivers in use for patients in accordance with the recommended guidelines for use of the specific syringe drivers the trust has in use.

Pain relief

- We looked at medication administration records of three patients in AAU. We saw that pain medication was reviewed by doctors on admission to AAU, and that pain scores were routinely taken from patients.
- We saw that only two out of nine patients' records we reviewed had baseline pain scores documented on their admission to Watford General Hospital. This meant that pain records were incomplete and that patients' pain levels were not effectively assessed.
- We spoke to three trained nurses about pain management and they did not appear confident in doing this.

Nutrition and hydration

- On AAU we saw staff assisting patients to eat and drink at lunch time. Staff sat down with patients to do this and gave appropriate levels of encouragement. They fed people whilst chatting nicely and did not rush them with their food.
- The new 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.
- Individual care plans contained guidance for staff about patients' nutritional needs, including the management of nausea.

Patient outcomes

- The trust took part in the National Care of the Dying Adult Audit in 2013 to 2014 and this audit showed the trust was performing below average compared to other trusts in both the organisational and clinical parts of the audit.
- The trust achieved three out of seven organisational Key Performance Indicators (KPIs), including the palliative care team covering seven days a week, clinical protocols for the prescription of medications for the five key symptoms at the end of life and for formal feedback processes regarding bereaved relatives and friends' views of care delivery.
- The trust did not achieve the following organisational KPIs regarding access to information relating to death and dying, staff education and training, representation at board level and clinical protocols promoting patient privacy, dignity and respect, up to and including after the death of the patient.
- The performance of the service was variable in the clinical case note review part of the audit. Out of the 10 clinical KPIs, the trust met six including discussing the plan of care with dying patients , meeting hydration needs and appropriate medicines being prescribed for pain and symptom control. The four clinical KPIs that were not met included the professional recognition that the patient was dying, discussing spiritual needs with patients and their relatives, meeting nutritional needs, and effective review of interventions in the last 24 hours of life.
- Staff in palliative care services stated that they were working on the results of the National Care of the Dying Adult Audit in order to improve the outcomes in the next audit. However the action plan we were shown called "End of Life Care – Meeting the Challenges" did not cover all of the failed KPI's above and it was therefore unclear how the trust will improve the provision of service.
- It was unclear where the content and delivery of this action plan was being monitored.
- To allow national comparisons, data from the Health and Social Care Information Centre (HSCIC) shows how the trust has performed in relation to the number of patients that have died whilst receiving palliative care. From 1 October 2013 to 30 September 2014, 30% of patients that died in the trust's hospitals received palliative care, which was better than the national average of 25%. It was also better than the previous year's percentage which was 13%.

End of life care

- Two junior doctors carried out an audit into "rescue opioid analgesia" as part of their academic studies; where patients were reviewed as to whether they were on regular opioid medication or not, and if so was an "as required" (PRN) dose prescribed and was the dose appropriate. The result of the audit showed that the hospital did not perform well and that patients were being under dosed with pain medication. Staff told us that this audit provided useful information for them to learn from but no action plans to improve the care or repeat the audit were in place.
- Staff were not able to describe regular audits or quality assurance procedures that took place other than the National Care of the Dying Adult Audit that the trust participated in during 2013, and the results were published in 2014.

Competent staff

- Staff told us that appraisals and supervisions took place and were up to date, although clinical supervision for palliative care nurses took place in four weekly meetings with local hospices.
- Staff told us that staff training and development for end of life care could be improved.
- In the trust document 'National Care of the Dying Audit 2014 Summary of Outcomes for Watford General Hospital' dated June 2014, the service recommended that extra resources were made available for the team to be able to raise the profile of the end of life care service with focus on training and support for staff teams in general. These recommendations were included on the service's action plan dated December 2014, but there were no timescales for these actions to be completed.
- A nurse on AAU told us that the education nurse from the palliative care team had been "extremely supportive and went to great lengths to inform the team to enable them to give the best end of life care".
- A nurse on AAU told us that the trust was funding her to study a palliative care course which they was enjoying and that they planning on pursuing this route in their career.
- Doctors working in the palliative care services maintained their revalidation working in conjunction with the local hospice.
- The mortuary manager told us that they provided practical training for porters so that procedures are followed at all times.
- There were printed policies in the mortuary in place for locums to view while they were working. We saw induction folders in place for each locum demonstrating that each new person employed in the mortuary are made aware of the policies and procedures, and where to find them.
- We spoke to a portering team leader who told us that the mortuary manager ensured that all porters attend training in infection prevention, cleaning procedures, moving and handling, equipment, security, checking patients in, and the procedure for allowing people into the mortuary when mortuary staff were not on site.
- Mortuary staff told us that that they took part in peer supervision and feedback of practical skills where latest research and techniques are discussed.

Multidisciplinary working

- We attended a multidisciplinary meeting where patients' care needs were discussed. We saw that staff interacted well and a high level of knowledge of palliative care, patient's needs, and transfer of care was demonstrated. The hospital caseload was discussed, which consisted of 17 patients on wards at Watford General Hospital. Included in the discussion was a review of seven cases where people had died to raise any points for the team to learn from in future.
- We spoke to nurses on the wards about their links with the palliative care team. They told us that they are able to refer patients to the team for review promptly, and call the nurses for advice on patient care.
- We reviewed five sets of patient records and saw documented evidence of a multidisciplinary approach to care. Doctors acknowledged and acted upon guidance from the specialist palliative care team.
- We saw examples of documented communication of planned care between health care professionals; however it was unclear what systems the trust had in place to ensure physiotherapy recommendations were facilitated with patients.
- The trust had a close relationship with a local hospice that provided training and support for staff calling for advice. Staff on wards told us that they could contact the hospice for advice if they could not access the palliative care team for a reason.

Seven-day services

- The Specialist Palliative Care Team worked from 9am to 5pm on Monday to Friday and 10am to 5pm on

Saturdays and Sundays. 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.

- Consultant palliative care doctors were 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. This meant that currently the trust did not run a full seven day service for end of life care.
- Nurses in the palliative care team told us that they do not currently provide a complete seven day service, although there are plans for this to come into place and the trust were recruiting nurses for the team. Staff told us this was planned to be completed by the end of April 2015. Staff currently worked weekends although there were occasions where some days were not covered by a palliative specialist nurse.
- We saw the "End of Life Care – Meeting the Challenges Action Plan" created to address prominent issues in palliative care and saw that the first item listed was for the trust to be able to provide seven day working for palliative care for complex patients with a life limiting illness. The action plan clearly confirmed the intention of the trust to employ an additional band 8A team leader, two full time band 7 posts, and a band 5 office manager. The delivery date for this action plan was stated to be April 2015, dependent on provision of extra resources. However at the time of the inspection limited progress had been made.
- Mortuary staff did not work weekends, but the mortuary manager had arranged training for porters and other staff providing care while permanent staff were not available.

Access to information

- 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 have access to up to date records. 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, so there may have been some delay in professionals communicating information about people at the end of their life with General Practitioners (GP's) and community palliative care teams.
- The consultant for palliative care at the trust told us that they would call doctors in the hospital to explain plans of care arranged for patients in their care to ensure that messages are passed on and understood. They also told us that they called the patient's GP to pass on this information to ensure effective communication.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us that doctors carried out assessments for mental capacity and told us that they would inform medical staff if they were unsure if a patient had reduced capacity.
- Staff we spoke to understood the deprivation of liberty safeguards and explained the process they would follow if they felt a patient was at risk of harm to themselves or others. Staff told us that patients with bed rails fitted to their bed had risk assessments in place and consent forms to ensure they were used only where absolutely necessary for patient safety reasons..
- We reviewed 11 "do not attempt cardiopulmonary resuscitation" (DNA CPR) forms and found that all were dated and all had reasons for the form being completed. However, five forms did not record a discussion with the patient and four of these did not give a reason for not discussing with the patient. Five forms did not record a discussion with the patient's family or carers, and four did not give a reason as to why this did not take place.

Are end of life care services caring?

Good

We rated end of life services at this hospital to be good for caring.

Patients we spoke to were very happy with the care that had been provided to them. Four sets of relatives told us that they recommended the care that their relative received by staff at Watford General Hospital.

End of life care

Patients had an in depth understanding of their conditions and care plans and clearly been involved in this process. This meant that staff had discussed treatment plans with patients and their relatives and carers.

We saw staff carry out care to patients in a respectful and careful manner. Staff spoke to people politely and respected their privacy and dignity by knocking on doors and asking for consent to proceed with tasks.

The trust did not provide effective bereavement services and staff delivering information to bereaved people did not receive training in this.

Compassionate care

- We spoke to seven patients who told us that they felt safe in the hospital.
- One relative told us that she "felt able to leave her husband and go home knowing he would be looked after".
- We saw staff carry out care to patients in a respectful and careful manner. Staff spoke to people politely and respected their privacy and dignity by knocking on doors and asking for consent to proceed with tasks.
- We saw palliative care nurses speaking with patients and listening to them carefully and talking to them in a respectful manner.
- Patients told us that they found the palliative care team to be caring and supportive towards them.
- Three patients told us that the food was good, and that there was a wide range of choice.
- One person said "the food is smashing", and another said "I would love a bacon sandwich for breakfast, but you only get cornflakes".
- One patient told us "the nurses are very nice but the doctors just stand at the end of my bed and talk to each other".
- A family member told us that they had gone to visit their relative the previous day to our inspection and did not know that they had been moved to another bed as staff had not contacted them.
- Staff said surveys for patient satisfaction did not specifically identify end of life care results, however, the trust provided information to show a bereavement survey had been completed between February and April 2015.

Understanding and involvement of patients and those close to them

- Two patients we spoke to told us that the palliative care team involved their family as they wished in discussions whilst they were staying in the hospital.
- Seven patients we spoke to stated that the care they received was very good, and that they felt well informed about what was happening.
- A patient told us "the doctors have shown me my x-rays of my lungs to help me understand what is happening".
- One patient told us "they have told me I'm having furosemide (a diuretic drug) to get the fluid off my lungs". This meant that staff were explaining care to patients in a way that they understood and retained the information.
- We reviewed the care records of a person at the end of their life and saw comprehensive documentation by a junior doctor around a long discussion with the patient's family around the end of life care for the patient.
- A relative asked to speak to us as they wanted to tell us about the care their relative had received. They told us that the care in general was good but singled out a nurse in particular as being exceptional as they had ensured that they were with their relative when they died, and was able to reassure them that they had passed away peacefully. The nurse that was mentioned in this compliment wanted to make it clear that the care was provided by the ward team and not just her.
- Where patients were at the end of their life and were being cared for in hospital, staff invited relatives to multidisciplinary meetings where appropriate to discuss the planned care for their relative. This meant that the expectations of patients, family and medical staff could be communicated clearly to mitigate misunderstandings.
- Staff in the mortuary told us that there were policies and procedures in place for relatives and carers to access the mortuary when they wished see the patient.

Emotional support

- The trust did not provide effective bereavement services and staff delivering information to bereaved people did not receive training in this.
- We spoke to the staff that provided bereavement information to patients and their carers in the patient affairs office. The staff told us that they were not trained in counselling or bereavement, and that their role was to signpost people to further services. They returned property to family and carers and liaised with them around the issue of death certificates.

End of life care

- Staff said that no training was provided for this bereavement support role but that the staff had "years of experience" and many had taken bereavement and counselling courses in previous roles in their careers.
- The staff in the patient affairs office conducted viewings when mortuary staff were not available, and had contact details for the hospital chaplains to put relatives into contact with them.
- The trust had no counselling service and relied on local hospices for this service. 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.
- Nurses in the palliative care team had all attended communication training in order to provide emotional support to people under their care.

Are end of life care services responsive?

Requires improvement 

We rated end of life services as required improvement for responsiveness.

The trust had not conducted research into the needs of local people. We did see an action plan which documented the intention to carry out this research in future, although this had not yet commenced.

The trust did not have a policy for the rapid discharge of patients to their preferred place of death.

The discharge planning process was not effective which meant palliative care nurses spent significant time with some patients to arrange their discharge appropriately.

There were no care planning tools for end of life care in place for vulnerable groups such as people living with dementia or learning disability.

Not all wards had appropriate rooms for sensitive conversations with patients and their families to take place.

Not all complaints were passed on the end of life services to ensure development of the service.

Service planning and delivery to meet the needs of local people

- The trust aimed to assist 95% of patients under the palliative care team to receive care in their preferred place; at home, in hospital, or in a hospice. We were told that the trust currently meets this target but the trust was not able to provide us with evidence of this.
- The trust did not have rapid discharge policy for patients to their preferred place of death. The trust was not able to tell us how many patients died in their preferred place of death.
- The palliative care team planned to implement further research into the needs of local people when they have recruited the staff to complete the team and enable their resources to allow further audit and implementation of the action plan. We saw that this plan was documented in the action plan for development of the service.
- Staff in AAU that looked after patients at the end of their lives told us that sometimes side rooms were not available and dying patients had to be looked after in bays with other patients.
- There were no palliative care suites or dedicated side rooms in Watford General Hospital.
- The trust was involved with Bedfordshire and Hertfordshire Bereavement Alliance. Meetings were hosted at local mosques and at the hospital, and different religious leaders were invited to attend and contribute so that views from the local community were heard.
- The facilities the staff had for speaking to people in patient affairs were very cramped. We were told that there were plans to improve this facility and reduce the amount of interruptions the location caused when staff were conducting sensitive conversations with family members.

Meeting people's individual needs

- During a multidisciplinary meeting the palliative care team discussed the use of the "heart failure passport" which was a document kept by patients with heart failure approaching end of life. This was implemented due to health records not always being available for people in a timely fashion and enabled staff to meet the care needs of these people without delay. Staff told us that this also meant that medications for these people were not stopped or started inappropriately. This was

currently in draft form being piloted with ten patients. Staff were unable to describe how the slow access of records affected other patient groups and what steps were in place for people with different diagnoses.

- We saw that the hospital had a multi-faith room available for use by staff, patients and visitors. Both rooms held books of a variety of different faiths and notices relating to services and contact details of chaplains so that visits could be arranged with them, or so that other religious people can be contacted via them.
- Staff told us that the trust used to have a discharge planner who was able to arrange discharges from hospital promptly, which was useful for end of life care services as these patients can be in a rush to get home and have complicated discharge requirements and medications. Staff said this post no longer existed at the time of inspection so the palliative care team spent a large amount of time assisting ward staff in these circumstances. However, the trust told us that the palliative care team had two WTE dedicated band 6 palliative care discharge liaison nurses who were providing this service.
- We saw that doctors used an advanced care plan to ensure patient's wishes and preferences were discussed at an early stage. We saw three of these in place for patients receiving palliative care.
- There were no specific care pathways in place for people living with dementia, learning difficulties, or other diagnosis that may inhibit their understanding of their condition.
- The trust had launched the 'Rose Project' in late 2014 which was to establish a more compassionate and respectful environment when a person was dying on a ward.
- We were told that the multi-faith rooms in the hospital were being refurbished with financial support from a local shopping chain and charity following a successful bid. Staff told us that they were planning on improving the family rooms as staff had raised this due to the current rooms being tired. Staff in AAU told us that at times bad news had to be broken to people in an inappropriate setting and the new facilities would resolve this.
- The trust worked with a weekend bereavement service which has been piloted for several months and "appears to be working well", although no formal auditing of the service was available. Staff told us that there were plans to roll this out for all people, not just for those whose faith requires early burial.
- The trust has a MacMillan information centre in the main reception at Watford General Hospital, where volunteer staff take telephone messages between 10am and 4pm and pass on answerphone message from over the weekend to the specialist nurses. This meant that at times people calling the hospital for advice had to leave messages on an answerphone and wait for a call back from the team.
- The mortuary did have procedures in place to allow a streamlined process to meet the needs of people with religious or other wishes.

Access and flow

- The service had an average of 59 referrals to the palliative care team each month in the six months to March 2015. A palliative care consultant told us that Watford General Hospital looked after around 80 patients a month with end of life needs.
- Patients were referred to the palliative care team through faxing a form to the office for review by a palliative care nurse.
- We reviewed the referral forms the palliative care team held in the office. These were faxed from wards and give staff the opportunity to highlight how urgent the referral was. We saw that these forms had sections on them for the palliative care team to complete when they visited the patient to show how long patients waited for a visit from the team but these were not completed. We asked the nurses why this was and they told us that the forms were not used to audit waiting times and therefore were not used although there was no other system in place to measure the time taken for a patient to be reviewed.
- Ward staff told us "the palliative care team are really supportive and always come to the ward the same day I refer to them". However, the trust were not able to give us any evidence to support this.
- The minutes of the Compassionate End of Life Care Panel on 21 October 2014 referred to medicines for discharge completed by pharmacy being delayed causing cancellation of discharge of some dying patients. No figures were available for how many patients may have been affected.
- We were told that when the palliative care team are fully staffed that there would be a nurse triaging the referrals

and was able to give advice about care of patients from an office base. The palliative care nurses held pagers and could be distracted from providing care and advice to others if they were paged whilst on a ward.

Learning from complaints and concerns

- A manager told us how they would deal with complaints, but told us that this rarely happened with palliative care services. They told us that managers investigated complaints and incidents from other departments so that an independent view was taken. However, we were told that verbal complaints are managed at ward level and the findings are documented in the notes of the patient, and not logged on the ward or notified to the trust. There is no auditing system in place for verbal complaints.
- The palliative care consultant told us that they do 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.
- In the minutes of the meeting of the group for implementation of compassionate end of life care on 10 September 2013, there were nine formal complaints about end of life care in the 2013. The common themes included the lack of rooms for breaking bad news conversations with patients and relatives, with these often having to take place in corridors or dingy inappropriate spaces, lack of good symptom control, lack of communication, delays in setting up a care packages, difficulties in completing wills for dying patients, inability of the staff to recognise that a patient is dying, and issues around communication regarding DNACPR.
- The "End of Life Care – Meeting the Challenges Action Plan" we saw from December 2014 stated that "regular audit and continuous improvement of services will provide a reduction in complaints about end of life care and allow the team to learn from them". The target date for the completion of this action was April 2015, but the trust was not able to provide us with evidence to show if this action had been met.

Are end of life care services well-led?

Inadequate

We found that end of life services were not well-led and were rated as inadequate.

There was no clear vision for the service that staff could describe consistently.

Governance within the service was not effective as risks were not always identified or where identified not acted upon in a timely manner. Not all risks were clearly identified on the trust's risk register. The service did not have its own risk register.

We observed risks had not been addressed promptly which put staff and visitors at risk of harm, this meant that systems and quality checking procedures were not adequate.

There were not effective plans in place to address outcomes of audits such as the National Care of the Dying Adult Audit in 2013 to 2014.

The service did not have local audits in place to measure the effectiveness and outcomes of the service.

A care planning tool to replace the Liverpool Care Pathway had not yet been implemented

There was some instability within the service as palliative care services had been moved from directorate to directorate with changes to offices and interim managers regularly over the previous two years. This impacted on the leadership and direction of the service.

We saw good examples of local leadership in the mortuary. Training, policies and procedures were clearly in place to support staff working in the mortuary.

We saw some evidence of drive to improve the service and an example project that had taken place to widen knowledge about end of life care with staff in the trust. This was clearly driven by staff working in palliative care services, but it was not clear how this was supported by senior leaders.

Vision and strategy for this service

- There was no clear vision for the service that staff could describe consistently.

End of life care

- We saw the evidence of a recent project that the trust had jointly funded with the trust, a local hospice and St James Foundation with Help the Hospices to pay for a clinical nurse educator to raise the profile of end of life care on wards in the area and improve multidisciplinary working in the region. This project developed the Rose project ("pink rose" symbol) a sign that was used to alert people on wards that someone was at the end of their life and raise awareness of this. The project supplied a box of notices, curtain and door signs, leaflets for staff and patients and their carers, and canvas bags for storing property to each ward area. We spoke to staff in ward areas who showed us where the equipment was stored and explained how and when it was used, although we were not able to see the system in use. The trust told that staff had implemented a pilot on specific ward areas. No audit had taken place to measure the success of it or receive patient or carers' responses.
- A nurse on AAU told us that there were two end of life care champions and that they attended monthly meetings with the palliative care education nurse. The nurse was unable to tell us what information had come from these meetings so it was not clear what information was passed to the champions and how it was disseminated.

Governance, risk management and quality measurement

- Senior staff working in palliative care told us that there is no risk register specific to palliative care.
- We looked at the risk register the trust held and saw that three issues relating to mortuaries were listed which related to slow air changes reported by the Human Tissue Authority (HTA) which were listed twice, and the risk of the mortuary refrigerator units failing. The risk register did not specify to which mortuary this concern applied to. The trust informed us it related purely to Hemel Hempstead hospital and not Watford.
- Outcomes on the risk register were also out of date and not reviewed or updated within the trust's stipulated timeframe.
- 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.
- We saw that the trust held a meeting called "Compassionate End of Life Care Panel" which meets every six weeks since it was implemented 18 months ago. Present at the meetings were; consultant in palliative care, consultant in intensive care, hospice champion educator, head nurse for cancer and palliative care, pharmacist, and students. We attended one of these meetings where the implementation of the rose project was discussed, which demonstrated plans to improve the service. The team also discussed training opportunities for doctors to attend communication training where they are completing DNA CPR forms.
- The service did not have 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 not yet been implemented.

Leadership of service

- The consultant leading the palliative care services told us that the services have improved substantially over the last two years. However the service was covered by a consultant for two days a week, and one day for meetings and other administration tasks which made up the majority of the role. They said "we have really raised the profile of palliative and end of life care, and the Rose project is something we are really proud of".
- We spoke to the manager in charge of the palliative care team who told us that the service had been managed under different departments of the hospital very recently and work had been stressful for the team. From November 2013 to August 2014, palliative care came under the corporate division, and after August 2014, the palliative care services came under the medicine directorate, and three weeks prior to our inspection this had been moved to come under the surgery directorate. This impacted on the leadership and direction of the service.
- The lead nurse for cancer and palliative care told us that their office had moved three times in the last six months. This meant that they could not concentrate fully on their role.
- There was a cancer and palliative care operational team which dissolved when two senior members of staff left the trust in 2013. This had impacted on the workload and meant that the management team have been managed by different interim managers and lacked prominent leadership.

End of life care

- Staff told us that the executive team had provided support to identify palliative care services as a separate entity, and there are plans for palliative care and cancer care to each have a lead nurse. However, the trust did not have clear timescales for this to take place.

Culture within the service

- Staff in the palliative care team told us that they generally felt listened to as when they have presented cases for improvement of the service by increasing staffing numbers the trust had acted and allowed for recruitment. However staff also said that a lot of changes have happened in a short period of time which did not give them time to fully embed the changes.
- Staff did feel valued they told us. Staff told us that they were able to be open and honest with their colleagues, and that they felt listened to by their line managers.
- At a local level, we saw that managers had some understanding of performance management of the team they led.
- A member of staff told us that it is "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.

Public and staff engagement

- The palliative care team told us that feedback gained from patients did not relate specifically to end of life care. Complaints were collated and we saw that action plans are put in place where members of the public have brought issues to light.
- Staff working on wards gave us mixed feelings about the "rose project" as they disliked the use of a label on curtains identifying where people were at the end of life, and some liked the project and the bags provided for patients. One member of staff told us that they had negative feedback from relatives but they did not pass this information on to the team to respond or learn from the comments. Staff we spoke to working on wards said that they were not aware of any consultation or pilot scheme around the rose project, and as far as they knew no audit had taken place to measure the success.
- The trust used twitter and other social media sites to interact with the public around end of life care.
- The trust carried out surveys for patient and staff satisfaction, although these did not specifically identify end of life care results.
- Patients and their relatives were involved in their care and given the opportunity to meet with the team around care planning, although it was not clear if this meeting was used to document feedback about the service.
- Staff told us that the trust held "bereavement steering group" meetings to improve the services provided to bereaved people. Staff told us that they attend these meetings as well as the trust's "patient experience group" where the team discuss quality of the service in relation to patient experience.

Innovation, improvement and sustainability

- The palliative care team told us that the funding for contract of the clinical educator was ending this year and that they are putting a business case together to keep this member of staff.
- The "rose project" had been implemented and this included a use of a label on curtains identifying where people were at the end of life. However there was mixed feedback from staff regarding this.
- 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.
- The "End of Life Care – Meeting the Challenges Action Plan" had a second point to improve the service by providing strategic leadership. The plan stated that the trust aims to invest more time in educating all levels of health professionals, and the palliative care specialist nurses told us that they planned to facilitate training so that nurses on wards feel confident in their palliative care skills.
- We were told about other planned improvement to the services, for example introducing nurse prescribing qualifications to the specialist palliative care nursing team in order that a more streamlined service can be developed, and anticipatory prescribing developed by nurses. However these improvements were not listed on the improvement action plan for the service.
- The mortuary manager had plans to improve the amount of tissue donation the trust is involved with, and was keen to develop the service further.

Outpatients and diagnostic imaging

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

Information about the service

West Hertfordshire Hospitals NHS Trust has outpatients departments at three hospital sites. Watford General Hospital, Hemel Hempstead Hospital and St Albans Hospital.

They provide outpatient services across a wide range of specialities for example, cardiology, ophthalmology, urology, radiology. The trust had approximately 435,959 appointments across the three hospitals between July 2013 and June 2014: this is within the mid-range compared to all trusts in England.

Outpatients includes all areas where people undergo physiological measurements, diagnostic testing, receive diagnostic test results, are given advice or receive care and treatment without being admitted as an inpatient or day case.

We visited the general outpatient area at Watford General Hospital which included radiology, cardiology, ophthalmology and orthopaedics. We spoke with 26 patients and their relatives and 45 staff, including consultants, radiologists, physiotherapists, matrons, sisters, nurses, healthcare assistants, medical and reception staff. We observed care and treatment, and looked at records.

During our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

We found this service overall to be inadequate.

Incidents were not always reported in line with trust policy, which meant that there was not a reliable oversight of incidents occurring in the outpatients and diagnostic imaging services.

We saw evidence that some incidents were reported and that the service had learned from some incidents. The service had in some areas carried out reviews of minor incidents and sharing of these and learning had taken place. However, this was not consistent across the service as a whole.

Records in the cardiology and ophthalmology outpatients department were not stored securely. This meant that there was a risk of patient records and personal details being seen or removed by unauthorised people in the department.

The organisation of some the outpatients departments were not always responsive to patients' needs. The layout and size of the department was insufficient to provide an adequate environment for patients using the cardiac and ophthalmology clinic. There were no action plans to address this and procedures had not been put in place to mitigate any risk this presented.

Equipment had not always been maintained in line with manufacturers' recommendations.

Outpatients and diagnostic imaging

We found intravenous fluids and medication stored on an emergency trolley which were openly accessible and could therefore be tampered with. This meant that medicines were not stored safely and securely to prevent theft, damage and misuse.

We found out of date clinical equipment, such as sterile needles and sterile sodium chloride solution.

Clinics were often cancelled and patients experienced delays when waiting for their appointments.

Risk management and quality measurement systems were reactive and not proactive. Outpatients and diagnostic imaging services had not identified all the risks to service users, and not all identified risks were being managed effectively.

Emergency equipment was available in each centre, and included medication, oxygen and a defibrillator. Daily and weekly equipment checks had not always been carried out regularly.

We saw written information about the complaints procedure and the Patient Advice and Liaison Service (PALS), but many of the patients we asked had not been given any information about complaints or knew how to make a complaint.

We received consistently negative feedback from patients and staff about patient waiting times and parking.

We found senior staff each had visions for the service at local-level, yet there seemed to be a lack of combined objectives and strategy to achieve an improved service. Some of the information given to us by senior managers was not found to be what was happening at local level.

Staff we spoke with were aware of key performance indicator targets that required appointments to be made within the 18 week referral to treat target (RTT) but there was no process in place for managing the patient impact when appointments were double or triple booked and therefore they were not proactively managing the situation at clinic-level.

The processes for decontamination and sterilisation of instruments complied with Department of Health (DH) guidance. There was evidence that the service focussed on the needs of patients. There were some systems in place to audit both clinical practice and the overall service.

There was evidence of multidisciplinary working in the outpatients and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together.

We found that most staff were approachable and witnessed them being polite, welcoming helpful and friendly. However, the service required improvement for caring as some staff focussed on the task and not the person.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Inadequate

We rated the service as inadequate for safety.

Incidents were not always reported in line with trust policy and staff were not clear about what should be reported as an incident.

Medicines were not well managed or always stored appropriately with some out of date items being found available for use.

Patients in radiology were being routinely being given medication without a prescription or a patient group directive in place. Some staff not aware that a prescription was needed and did not know about the contraindications that meant, for some people it was not safe to give it and they would be at risk of harm.

Care premises, equipment and facilities were not adequate. For example: The accessibility and size of the cardiac clinic rooms on level three were insufficient to provide a safe environment for patients using it. This meant that that it could be difficult to provide resuscitation should there be need to bring in equipment, or remove a patient on a trolley. There were no action plans or procedures that had been put in place to mitigate risk or to change the environment.

Equipment had not been maintained in line with manufacturers' recommendations. For example, we found two of the four plaster couches in the fracture clinic plaster room had tears and tape placed over the tear. On one couch it was peeling off. Risk assessments had not been completed and infection control processes were not being followed by nursing staff.

Staff did not assess, monitor or manage risks to patients.

Records were stored in areas that were not secure. Rooms were unlocked and patient notes were kept on the floor in some areas and on open shelves in others. This meant that records not securely stored could be read or removed by unauthorised people coming into the room.

Incidents

- Staff were familiar with the electronic reporting system to report incidents within the department. However, we spoke with two staff in the outpatients department who told us they did not access the computer to report incidents via the electronic reporting system. One health care assistant told us they were not allowed to complete incident forms and needed to report to nursing staff. Another member of staff told us they were not allowed access to the information system (IT) and would report concerns to their manager who would complete an incident form if needed. We spoke with the manager about an incident staff had told us about and found it had not been reported.
- Staff told us there was no formal training on how to use the electronic incident-reporting system. As a result, it was clear that staff had different opinions on which incidents should be reported.
- Incidents were not always reported in line with trust policy. For example, records were sometimes not available for clinics and concerns were raised with us by staff and patients that said they had to wait to be seen as records had not turned up.
- We were given examples of incident reporting in outpatients by staff which included clinics cancelled at short notice where patients were already in the clinic and long delays for transport. Some staff told us they used to report these issues as incidents but nothing ever changed as a result so they no longer reported these incidents. Another member of staff told us they probably should report incidents when they happened but did not always as they were too busy. This meant that data provided in relation to incidents would not provide a reliable oversight of incidents occurring in outpatients.
- Staff told us the patient referral IT system in radiology had not been accessible and this had not been reported. Data provided by the trust over a twelve month period showed that there had been four incidents in radiology, categorised as low harm.
- Staff told us that they rarely got any feedback unless the incident was really serious and nothing seemed to change as the same incidents continued to occur.
- There was limited understanding of the duty of candour amongst the staff we spoke with. Staff were not clear about the trusts being open policy and what it meant for them

Cleanliness, infection control and hygiene

Outpatients and diagnostic imaging

- We looked at most areas of the outpatients department including: the clinical and office areas in the radiology department, clinic and office areas for cardiology, clinic and office areas for ophthalmology, the orthopaedic and fracture clinic, the plaster room, service user waiting areas and facilities, along with clerical areas and records storage areas. Not all the areas we looked at were clean and tidy. For example:
- The eye clinic optometrist clinic room had carpet on the floor that was not appropriate for clinic rooms. Over 90% patients requiring treatment in the clinic were children, many with complex needs. We saw evidence that the carpet had been inspected and "condemned "by the trust three times since 2013 and had not been replaced. The carpet was stained, dirty and would not be able to be cleaned appropriately.
- The lead nurse took responsibility for monitoring the trust policy on hand washing and took responsibility for training staff. We observed that staff complied with the trust policy of being bare below the elbow and wearing minimal jewellery.
- Hand gel was available in all clinical areas. Notices were displayed regarding hand washing and infection control.
- Regular hand hygiene audits demonstrated high compliance rates throughout the department and infection control guidelines were clearly displayed in the outpatients department.
- There were systems in place for the segregation and correct disposal of waste materials such as x- ray solutions and sharp items. Sharps containers for the safe disposal of used needles were available in each clinical area. These were dated and were not overfilled. Notices were displayed in clinical areas explaining the actions staff should take in the event of an injury from a needle.
- Information leaflets and notices were displayed to remind people of the importance of notifying the radiologist of any the associated risks. For example: were they pregnant.
- Staff told us that they received mandatory training in amongst other things infection prevention and control training.
- Staff we spoke with demonstrated knowledge and understanding of cleanliness and control of infection.
- The outpatients and radiology departments regularly undertook infection control inspections, although we did not see these. Regular physical audits were also undertaken. Trolleys and clinical areas were cleaned down by the staff on a daily basis. Some equipment was in a poor state of repair and presented an infection control risk to patients.
- The trust commissioned an outside provider to manage its cleaning schedules within the hospital.

Environment and equipment

- Staff told us maintenance was a problem. For example: patients in ophthalmology received treatment in the laser room which because of the type of treatment had no windows and equipment that was required to be left switched on was in regular use. The air conditioning system in the room had been broken since August 2013. Staff had requested that it go on the risk register and completed an incident form as the room became very hot. We saw evidence that this had been escalated and saw that no action had been taken to address this risk. This was escalated again in 2014 where the lead nurse informed the manager that a patient had passed out in the laser room because the heat was intolerable and highlighted this as a health and safety risk. We were informed that the system needed replacing and it had been taken off the risk register staff were unclear why. There was no evidence of action being taken to address this.
- In the orthoptists' clinic room staff had a new piece of equipment they have had for a couple of months. Staff were unable to use it as they could not get a bracket put on the wall by maintenance. Requests had gone into maintenance but were not progressed. Staff told us that the impact for patients would be that patients might not get a full and timely diagnosis. Some of the equipment had been broken for a year and not repaired or replaced.
- In the cardiology department on level 3, three rooms that used to be offices were used for clinic appointments. Rooms were small and access to one room was along a narrow corridor. All three rooms had no water or sinks for staff to wash their hands in which meant staff could only use cleaning gel. There was no evidence of an associated risk assessment being in place.
- The corridor to the rooms was narrow and staff told us it would be difficult to get access in all the rooms in an emergency. There was no risk assessment or protocol in place that staff were aware of to highlight the risk to patients using the clinic rooms.

- We saw evidence of daily performance checks of equipment. However we found that not all equipment was consistently checked and on checking resuscitation equipment and consumable clinical products we found some were out of date. Meaning that the checks that were in place were not always carried out effectively.
- · Equipment we looked at was visibly clean and stored appropriately, although some equipment was damaged and presented a risk to patients. For example, we found two of the four plaster couches in the fracture clinic plaster room had tears and tape placed over the tear. On one couch it was peeling off. Risk assessments had not been completed and infection control processes were not being followed by nursing staff.
- The trust's electrical maintenance engineering department were responsible for annual portable appliance testing (PAT) and equipment we looked at complied with regulations.
- Radiographers showed us the procedure for minimising exposure to radiation and the personnel protective equipment in place for staff to use. We were told that patients were asked a series of questions, for example to check if they may be pregnant, to reduce the risk of exposure. We saw signs in the changing area that reminded patients to inform staff of key information.

Medicines

- We found that the trust had carried out audits on the secure storage of medicines and controlled drugs in early 2014. This audit had identified many deficiencies in the safe storage of medicines, but many of the recommendations of the audit remained to be implemented.
- There was a pharmacy on site. They checked and replenished stock medicines in all departments and provided an outpatient dispensing service.

Ophthalmology Outpatients

- The emergency trolley was kept in a clinic room that was used by staff and patients for appointments. The trolley had bags of intravenous fluids, one of which was out of date and medication lying on the open trolley. This meant it was easily accessible to anyone using the clinic room. The sister told us the trolley should be checked daily. Records showed this had not been done.
- Medications in the drug cupboards were checked and replenished weekly by pharmacy. No check list was kept by the clinic so that they could check to see what had been used from the cupboards. This meant staff would not know if anyone had removed any medication from the cupboards. Pharmacy would have assumed they had used it and replaced it.
- The clinic kept a separate plastic container on top of the drug cupboard in the same clinic room as the emergency trolley. This was used for people who come into the clinic with an eye infection. It contained various medications including antibiotics and sterile water, and equipment to deliver the medication directly into the patient's eye. We found sterile water and needles that were out of date. The lead nurse told us staff should check weekly but checks were not recorded anywhere so there was no way for staff to know it had been done. This meant that patients would be at risk of infection as equipment was not sterile as it was out of date.

Radiology outpatients

- The radiology department used patient group direction (PGD) policies to allow staff who were not trained to prescribe medication to give one or two specific medications for certain procedures. We looked at these policies and saw that, although staff had signed to agree with the procedure and instructions in the PGD, there was no authorising signature on any of these documents. This meant that the documents were invalid and therefore staff were administering these medications without authorisation. This is contrary to the guidance provided by the Medicines and Healthcare Products Regulatory Agency (MHRA), which regulates medicines and medical devices, and by the National Institute for Health and Care Excellence (NICE).
- Radiology staff were administering medication (buscopan) prior to treatment with no prescriptions. This was an antispasmodic medication for relieving pain and spasms in the stomach and bowel. For example: medication administered for small bowel studies had no PGD in place. Staff said the medication (buscopan) is not covered by PGD. They had no awareness that a prescription was needed and did not have a written copy of any safety questions being asked.
- In another example we looked at, one patient who was given medication (buscopan) and contrast had no prescription to give the medication. However the contrast was given correctly under the guidance of a PGD. "Buscopan" medication should be prescribed and there were contraindications for some patients. We found, two out of three staff we spoke with had no

understanding of the administration of this medication. Another staff member told us they had refused to give it as did not know how to do it. Staff we spoke with did not check that the patients had any allergies or any reason why it may not be safe for them to receive the medication. However, they did check for glaucoma but this was not recorded anywhere on patient notes. Staff were not aware of the contraindications when patients should not be given the medication.

- Medications that were prescribed were managed safely, and we witnessed staff double-checking the expiry date and content of a flush injection before it was administered. In outpatients, radiology medicines were stored in locked cupboards in the department. Lockable medicines fridges were in place, with daily temperature checks. This meant that the department were following the appropriate guidance on the safe handling and storage of medication.

Records

Ophthalmology

- There was no appropriate place to store records in the orthoptists room. Staff showed us records stacked on the floor in a corner under a table. They said they had repeatedly reported the problem and had major problems in getting them collected and returned to central records. Patients records had stayed on the floor in that room for months, some for as long as a year and they showed us a picture on their phone of records stacked in the corner. Staff told us records were not collected once finished with despite raising it with relevant people and with their line manager nothing was done about it.
- Staff had asked for a filing cabinet to store records securely and had heard nothing back and given up trying to get someone to listen and do something. On the day of our visit staff told us that staff had come in the previous day to remove some of the records but we saw they had about 15-20 files siting on the floor waiting for collection. Every patient who came in the room would see the records stacked in the corner. This room is cleaned every day by outside contract cleaners. This meant that unauthorised people could if they wished read people's personal health files whenever they wanted as they were not stored securely or appropriately.
- Once used in clinic, the notes were not collected promptly. Staff said on a number of occasions patient's clinic appointment has been interrupted by staff trying to find another patients records. The problem has been reported on a number of occasions by staff but nothing had been done about it.
- Staff told us that storage of records in the "eye clinic" used to be on the risk register but was not there anymore. They did not know why it had been taken off.

Cardiology

- Patient notes were on shelves in an unlocked room with no one present. Patient records could easily have removed or viewed and no one would know. Staff told us there was not enough space to store records due to the increase in workload and there had been no additional increase in facilities or admin staffing to manage it.
- This issue had been raised as a risk in the past by management who had now left. It was removed from the risk register when two cupboards were put in place twelve months previously but no one could find any risk assessments relating to his issues.
- In the cardiology department administration office the number of records in the department was so large they were being stored on the administration office floor as storage cupboards were full.

Safeguarding

- Staff were aware of their role and responsibilities and knew how to raise matters of concern appropriately.
- The senior nurse in the radiology outpatients department described a safeguarding incident a member of staff dealt with and the procedure that was followed.
- Staff were aware of how to raise and escalate concerns in relation to abuse or neglect for vulnerable adults and children.
- We saw there were safeguarding policies in place and clear procedures to follow if staff had concerns.
- We saw safeguarding was included in the on-going mandatory training. Senior staff informed us dates were being arranged to capture all outstanding training. Staff confirmed they had received a copy of the safeguarding policy.

Mandatory training

Outpatients and diagnostic imaging

- Staff told us that their mandatory training was up to date. The trust provided information after the inspection that showed outpatient service staff were compliant with mandatory training.

Assessing and responding to patient risk

- Outpatients and diagnostic imaging services had not identified all risks to service users, and those identified were not being managed effectively.
- We saw that the eye test area was situated in an area adjacent to a corridor in sight of other waiting patients. This could have been distracting to the patient having the examination and a potential breach of confidentiality.
- Patients we spoke with told us they felt safe.
- Processes were in place within all the departments to manage patients who deteriorated or became unwell. There was an emergency response team in place who could be summoned rapidly.
- An audit reported on in February 2014 stated that compliance for the World Health Organization (WHO) Checklist Audit for interventional radiology procedures needed to improve from 70% to 100%. The national patient safety agency (NPSA) clearly identified that a WHO adapted checklist should apply to all patients undergoing invasive procedures.
- A review by the trust of the WHO checklist found that of 41 patients reviewed only 61% of records were completed correctly. The name of the radiologist performing the procedure was not recorded in any of the 41 responses from Watford General Hospital.
- The biggest reason for incomplete forms, was the lack of signatures and pre-procedure sections not being completed fully (29%), closely followed by the lack of patient IDs in 25% of cases. These standards were a safety checklist to ensure that the correct procedure was being made on the correct patient to ensure that they avoided any allergic reactions and minimised risks. We saw that incidents had occurred because patient's information was not checked correctly or the wrong information had been given on referral forms.
- A review due to take place in September 2014 did not take place. This was undertaken in February 2015 and March 2015 to assure Radiology of their compliance level with the WHO guidance.
- Staff told us that a new six point check system was in place in response to incidents that had occurred because of inaccurate or missing patient information on referrals. We saw that this had been discussed at staff meetings however staff said the process was reliant on patients being able to discuss with staff and confirm whether it was correct or not. If they could not then they had no other way to check as could not access that part of the trust record system

Nursing staffing

- Temporary staff usage percentages across all outpatients were 12% for agency and 1.5 % for non-medical bank.
- Most nursing staff told us that although they were busy, they felt they provided good and safe patient care in outpatients but raised concerns about nursing staff levels on the wards and thought they were unsafe and patients were at risk.
- Extra clinics were required to meet the needs of the local area and this was often covered by permanent staff working over and above their normal contracted hours.
- Some outpatient nurses felt that staffing was generally sufficient but when clinics were overbooked then they did not have enough staff to manage this.
- Staff felt that the nursing numbers and skill mix did not always meet the needs of patients due to demands for outpatient services.
- In cardiology, receptionists said they were required to chaperone patients as they were not enough nursing staff. One manager said they are waiting to have staff recruitment and for health care assistant (HCA) authorised. They said it had been recognised a year ago that they were not staffed correctly. Reception staff did not have appropriate training to chaperone patients.
- Senior managers told us there were plans to increase the service to cover evenings, nights and weekends shifts and enable the magnetic resonance imaging (MRI) service to be available out of hours. They said they required another two or three radiographers to be able to manage this. Radiography staff we spoke with felt that this would not be possible until new staff were in post and finding people with the right skills and experience was difficult.

Medical staffing

- The individual specialties arranged medical cover for their clinics. Medical cover was managed within the clinical directorates, who agreed the structure of the clinics and patient numbers.

Outpatients and diagnostic imaging

- Consultants were supported by junior colleagues in some clinics where this was appropriate.
- In the ophthalmology unit there had been an increase in consultants from four to five, and an increase in secretaries from two to three.
- In the echo cardiology unit three locum agency clinical physiologists were in post. One had been there over 16 months. Staff were unable to demonstrate or aware of a system for checking locum clinical physiologists in the cardiology echo scanning unit qualifications to see if they were still current and registered. This meant that staff could be in a post where they did not have the correct qualifications and experience and patients could be at risk of harm.

Major incident awareness and training

- The trust had a major incident policy which staff were aware of.
- There were business continuity plans in place to ensure the delivery of the service was maintained.
- Staff said they knew about the trusts lone working policies and adhered to them. No concerns were raised by staff.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

People were at risk of not receiving effective care or treatment. Staff did not always have the complete information they need before providing care and treatment. For example; records were not always available in time for clinics. Consultants were regularly not turning up for some clinics due to other priorities. This meant clinics patients would be added to other clinics and would be seen by junior staff without their medical records.

Care and treatment did not always reflect current evidence-based guidance, standards and best practice. Implementation of evidence-based guidance was variable.

The outcomes of people's care and treatment were not always monitored regularly or robustly. Systems to manage and share care records and information were cumbersome and uncoordinated. For example: radiology staff were unable to access the main IT system to view patient's full medical history and were reliant on information provided by the referrer.

Staff worked well together in a multidisciplinary environment to meet people's needs. Information relating to patient's health and treatment was obtained from relevant sources prior to clinic appointments.

Evidence-based care and treatment

- In the Cardiac Catheter Laboratory we saw the x-ray protocol for action required when patients receive a skin dose greater than 2Gy. (This was the maximum dose level patients should receive). However the trust had reported 21 patients with a skin exposure in cardiology over 2Gy that was higher than comparable trusts within the same timeframe. This was a high skin dose and there was no follow up of the potential effects of high radiation dose on patients after they were discharged from hospital. We saw evidence that staff followed the reporting guidance.
- Radiography staff were not following best practice that required radiographers to check previous images before continuing with a scan or x-ray. Incidents discussed at the "radiation summit meeting" indicated radiologists were not routinely doing this. The outcome from this summit did not suggest any changes to protocols or practice to minimise risks for patients. We observed very few radiographers were routinely checking previous images. This meant that staff were not following the ionising radiation (medical exposure) regulations or (IRMER) trust policy.
- We saw integrated care pathways for cardiac devices, cardiac catheterisation, ablation/electrophysiology studies and day case angiogram. These followed NICE guidelines on best practice.
- Protocols were in place for radiology examinations such as preparation of nephrostomy/stent insertion and orthopaedic x-rays.
- We saw protocols in place to ensure fast tracking where there were significant imaging findings for known or unknown cancer diagnoses, as well as severe abnormalities relating to benign or malignant growths team for review and action. We saw evidence staff were following the guidance.

- We compared the practice we saw with the Society and College of Radiographers' recommendations and saw that the department's practice was in line with professional guidance.
- Staff said they knew about the trust's lone working policies and adhered to them. No concerns were raised by staff.

Pain relief

- Pain relief could be prescribed within the outpatient's department and subsequently dispensed by the pharmacy department.
- Patients could be referred to the pain management clinic if assessed as needing this by their consultant.

Patient outcomes

- There was backlog of patient records waiting for secretaries to type letters to inform patients of their cardiology results. We saw at least 90 patient records on the floor in the cardiology administration office covering a large area. We looked at six records and saw they had been there since March 2015. Administration staff told us this issue has been repeatedly escalated over the last three years.
- There were gaps in management and support arrangements for staff, such as appraisal and supervision.
- For the period June 2013 to June 2014 the trust ratio between new and follow up patient appointments was similar to England average.

Competent staff

- Trust data that showed completed appraisal rates across different departments was not available. Some staff told us that they had received an annual appraisal and that it was a useful process for identifying any training and development needs. One lead clinician told us they had not had an appraisal in four years. However, staff in the radiology department told us they had yearly appraisals.
- There was evidence that staff competency was checked on recruitment and there were opportunities for further training.
- The cardiac echo scanning department employed three locums one of whom had been in post 16 months. Locums were responsible for training junior doctors and band 6 staff. One locum told us that they had not done any trust mandatory training and none of the locums needed to as their agency provided training. We were unable to confirm this was the trust policy as information was not available. Their line manager who had been in there current post since July 2014 was not aware of this.
- An induction process was in place for new staff. We spoke with two new staff members who told us that they found both the trust wide induction and their local induction useful.
- Staff in ophthalmology told us that supervision was not routinely carried out, but there was an 'open door' policy and staff could request supervision at any time. In outpatients one lead nurse told us they had completed appraisals for their staff but not done any one to one supervision. They had no time to do them as they did not have enough staff and needed them to be working in the clinics.

Multidisciplinary working

- There was evidence of multidisciplinary working in the outpatients and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together.

Seven-day services

- The outpatients department was open from 8.30am to 5pm, Monday to Friday. However, extra clinics were also scheduled in the evening and at weekends to meet the needs of the local population. These were staffed by current trust staff working additional hours and bank staff.
- MRI services were available during working hours and some evenings and weekends. The extended lists were required to maintain the diagnostic and Referral To Treatment (RTT) waiting time standards.
- There was access to specialist investigations such as MRI and CT scans and to a Radiologist to interpret scans out of hours. To support this, a radiologist was available in AAU for inpatients from 8am to 8pm weekdays and 9am to 6:30 pm weekends and bank holidays.

Access to information

Outpatients and diagnostic imaging

- We spoke with staff about the process of sending patient records to the outpatients department to ensure that doctors had the correct information available. We were told that, due to a shortage in administration staff, sometimes records were not available.
- We spoke to staff running the clinics in the outpatients department and they told us that on occasion appointments had to be cancelled or delayed if the records were not available. Two patients we spoke with confirmed this.
- Information radiology received about patients was dependant on the referrer including all personal information and relevant information, such as any allergies, health issues that might impact on their treatment. They had their own IT system which did not allow them access to all patient information available to the trust. This meant that when the electronic referral information was not accessible staff would follow the Business Continuity Plan to ensure that patients were not inconvenienced. We saw incidents that had been reported in the trust where the wrong personal information had been included on the referral but no evidence of action being taken to address these incidents.
- Referrals for x-rays and scans were received as either paper or as an electronic referral. Referrals that came in by paper were put onto the system by administration staff. Staff told us the IT system was unreliable and they would have periods without being able to access it. This meant that when the electronic referral information was not accessible patients would arrive for appointments and staff would not have all the information they needed to be able to assess people appropriately. The trust told us that when the electronic referral information was not accessible staff would follow the Business Continuity Plan to ensure that patients were not inconvenienced.
- Administration staff told us about the challenges in their department. We were told that referrals to clinics for example cardiology clinics had grown rapidly. Managing the workload and storage issues was a huge pressure for staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at the radiography department's policy on consent. Radiographers told us that they followed the policy to ensure that patient consent was gained for each scan or procedure. We observed staff following this policy as they gained consent from patients.
- Staffs received training on the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and were confident about seeking consent from patients.
- Staff were able to explain benefits and risks in a way that patients understood.
- We saw training records that evidenced that staff had undertaken training in the Mental Capacity Act (2010) (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff told us that doctors discussed treatment options during the consultation. Where written consent was required, this would often be obtained in the outpatient clinic.

Are outpatient and diagnostic imaging services caring?

Requires improvement

We found the service required improvement for caring.

In some areas staff often focused on the task rather than treating people as individuals.

Patients were not always kept accurately informed of waiting times.

Patients were not always treated with privacy and dignity we observed medical staff sharing clinical rooms in ophthalmology due to lack of consulting space. This meant that patient confidentiality and their privacy and confidentiality were compromised. Staff did not discuss this with patients or include them in any decision making regarding this.

Patients were asked whether they wanted their family or friends to be present during consultation and treatment.

Staff had good awareness of patients with complex needs and those people who may require additional support should they display anxious or challenging behaviour during their visit to outpatients.

Outpatients and diagnostic imaging

In most areas observed staff greeting patients in a friendly, but appropriate manner. Patients praised the staff and told us they were, "very nice and friendly."

Compassionate care

- Two orthoptists shared a clinic room for patient consultations. They saw a large number of children many of whom had special needs, and they had no privacy and patients could hear each other's personal information, for example, birth history, health history, family history. Staff did not discuss this with patients or include them in any decision making regarding this.
- During the inspection we observed patients being assessed in shared clinic rooms. Some patients needed quiet and structured examinations due to their particular needs. This was not possible as the other patient was having a conversation and undergoing an examination. Some patients were distressed during the inspection and the present staff did not respond to them.
- In some areas staff often focused on the task rather than treating people as individuals. Sometimes staff needed to examine patient's eyes in the dark. If this was needed then one patient had to sit in the dark while the other patient's eyes were looked at. There was lack of consideration given to how this impacted on those patients.
- Patients were not kept accurately informed of waiting times. In haematology, we observed information was written on a board but the waiting time rapidly rose from 30 minutes to one hour and half hours within 30 minutes. Patients were not made aware of this. In other areas, for example cardiology there was no information about how long patients might wait.
- In most areas we observed staff greeting patients in a friendly, but appropriate manner. Some patients praised the staff and told us they were, "very nice and friendly."
- We saw that clerical staff in clinics assisted patients promptly and were friendly and efficient in busy clinics.

Understanding and involvement of patients and those close to them

- We observed staff supporting one patient to understand their care and treatment in the radiology department.
- Patients were aware of why they were attending the outpatients department.
- Patients were asked whether they wanted their family or friends to be present during consultation and treatment.
- We spoke with 28 patients about their treatment options. One said they had not been encouraged to be part of the decision making process and were not given any details about what would happen. Another patient told us they had brought family members with them who could interpret for them, most told us they had to wait a long time to be seen and when they did appointments were rushed which did not give them enough time.
- We observed staff did not always inform patients of waiting times. Patients we spoke with told us they had waited two to three hours in some cases and not been told of delays. This caused them anxiety as they had paid for parking. They had to go out to pay for more parking and were worried they would lose their place.
- One inpatient we spoke with said they had been brought down from the wards to the ophthalmology clinic and three hours later they were still waiting to be seen. They did not understand why they had not been left on the ward until they could be seen. They told us it was very hot in the clinic and they were very worried they had missed the ward round and would not see the specialist on the ward. No one had informed them of how long they would have to wait.

Emotional support

- Staff told us they worked together to ensure care was as coordinated as possible. However we were given examples of both co-ordinated and uncoordinated planning by patients and staff.
- Staff had good awareness of patients with complex needs and those people who may require additional support should they display anxious or challenging behaviour during their visit to outpatients.

Are outpatient and diagnostic imaging services responsive?

Requires improvement 

We rated the service as required improvement for responsiveness.

Outpatients and diagnostic imaging

Clinics were sometimes cancelled at short notice. This led to patients having appointments cancelled and re-scheduled often several times.

Clinic cancellation rate as 13% which was worse than the trust target of 8%, however, this figure included planned clinic cancellations in advance, for staff leave.

Some of the facilities and premises used did not meet people's needs.

Patients concerns and complaints did not always lead to improvements in the quality of care. For example: verbal complaints were not recorded so data provided by the trust would not give a true record of the number of issues or concerns raised by patients.

Services were not always planned, organised or delivered in a way that met patient's needs. Over recent months, the service had shown an improvement performance in meeting RTT targets.

At the time of the inspection, clinic do not attend rates were in line with the national average.

Diagnostic waiting times were also compliant with the national standard of 99%.

Some patients were not able to access services in a timely way for an initial assessment, diagnosis or treatment.

Some patients experienced waits for some services. For example; cardiology, and respiratory clinics frequently over-ran and some patients told us they had experienced long delays in their appointment time.

Service planning and delivery to meet the needs of local people

- There was no evidence that service was evaluated to ensure it met the needs of local people.
- There were no regular audits of service delivery or of feedback from patients to ensure the service met the needs of the local population.

Access and flow

- The trust did not meet its 18 week referral to treatment (RTT) standard of 95% from September 2013 onwards. The trust was consistently worse than the England average for that entire period. The trust told us that since January 2015 they had taken significant improvement actions regarding RTT and at the time of the inspection they were on trajectory to meet the standard.
- The trust provided further information to show that 7,010 patients had their first outpatient appointment during April 2015. On average, they waited 47 days (6 weeks and 5 days). By 30th April there were 5,275 patients waiting for their first appointment and the average wait for the first outpatient appointment had reduced to 5 weeks and 4 days demonstrating the focus the trust had on meeting the planned RTT standard.
- The national target for urgent GP referral is two weeks. However, the trust met this target between April 2013 and April 2014 and fell below the target between May 2014 and August 2014. Between September 2014 and January 2015 the trust had performed above the target.
- Staff told us that the trust did not collect full details for waiting times for RTT and follow up appointment timeframes for outpatient's appointments at Watford General Hospital. The trust told us that all patients on an 18 week pathway, including review patients, were tracked and were reviewed weekly at the trust's Access meeting where actions were agreed to ensure all patients had a plan.
- The percentage of patients waiting six or more weeks for diagnostics was worse than the England average between December 2013 and September 2014. There was a large increase in January 2014 with 13.4% waiting over 6 weeks. The trust had performed better than the England average in October 2014 and November 2014.The trust provided further information to show that in April 2015, performance was in line with national performance with less than 1% of patients waiting over 6 weeks.
- The Board performance report for March 2015 showed the clinic cancellation rate as 13% which was worse than the trust target of 8%, the year to date figure for March 2015 was 11% of outpatients clinics cancelled.
- The trust told us that the clinic cancellation figure was the aggregate figure for cancellations including all clinics over six weeks. The figures include planned cancellations, for example, when consultants take leave. The trust agreed the figures reported to the board could be clearer.
- However, staffs told us outpatient clinics were regularly cancelled often with little notice and there was no effective system to deal with it. They told us they did not

always record this information on most of the clinics; however they had information on respiratory clinic cancellations. This showed that between January and March 2015, 510 patient appointments had been cancelled. This meant that patients would need to have new appointments booked. Any treatments they needed would be delayed and they would have to wait longer to be seen. However, the trust told us that some cancellations would have been made in order to bring patients in earlier.

- Staff did not know if anyone was responsible for checking that people might be at risk of their condition worsening because of the wait or cancellation of clinics as nobody monitored it.
- The central booking administration system was responsible for cancelling clinics. The process did not work as all patients did not get told their appointment was cancelled. Staff told us some patients regularly turned up for their appointments. Complaints from people who turned up were that they had not received a letter telling them the clinic was cancelled. Staff told us patients were angry and complained they had taken time off work and paid to park to be told there clinic had been cancelled.
- Overbooking of appointments was evident across all the outpatient clinics and staff told us this was so the trust did not breech the 18 week RTT target. Clinics were regularly overbooked with double and triple booked appointments. Consultants could have two or three patients for the same time slot. These meant patients had to wait for much longer periods than necessary and might not get the same consultation time as they would have if clinics had not been so busy.
- We saw clinic lists confirming overbooking of appointments and were told by staff and patients of frequently cancelled clinics in some specialisms.
- In one respiratory clinic the patient had a scan in November and had an appointment for February. This appointment was then cancelled until July, 54 weeks from the original appointment date. The patient had not had the results of the scan as the consultant had not written to the GP and only did so when the patient made a complaint.
- 16 out of the 21 complaints we looked at for Thoracic respiratory clinics were about cancellation or delayed appointments.
- Staff confirmed that if appointments were double booked and running late then patients were less likely to get enough time with the doctor. One patient said they had waited between "one and two hours to see the doctor for four or five minutes"
- One patient visiting OPD told us they had a number of tests performed in sequence on their visit which meant they did not have to wait and keep coming back and were very happy with the service.
- We found patients' experience was variable dependent on which service they were accessing. The majority of examples were negative with patients waiting in clinic for long periods to be seen. Most patients identified waiting times as an issue.
- In radiology, the number of patients waiting for an examination was less than six weeks. This was better than the England average
- Between July 2013 and June 2014 the trust 'did not attend' (DNA) rates were similar to the England averages.
- Challenges in radiology included an increase in demand for imaging in CT, MRI and ultrasound referrals. There was an on call service and routine requests were accommodated out of hours.

Meeting people's individual needs

- The outpatients and diagnostics services in the main building were all accessible as people could access on foot or use the lift.
- Access to the main outpatient's entrance was via wheelchair friendly door. The main information desk was directly in front of the main entrance doors. Some patients told us they had problems finding the department due to poor signage.
- Outpatients clinic were spread out with some clinics in the main building and others in outlying buildings. Patients and staff told us that signage was not good and people did struggle to find their way around.
- Two orthoptists shared a clinic room for patient consultations. They saw a large number of children many of whom had special needs, including autism, learning disability and attention deficit disorders. We saw that two patients had appointments at the same time in a shared room. This meant they had no privacy and patients could hear each other's personal information.
- Patients told us that it was not easy to access translation services and they were expected to bring a family

member with them who could translate. This is considered poor practice. We saw that information displayed on trust noticeboards said that services were available on request. Feedback from patient's groups highlighted lack of access to translation services was poor.

- In the ophthalmology clinic some patient clinic areas were very close together in booths with open access to the corridor. This area was very narrow and staff told us if they had a patient a wheelchair then this took up all the corridor space and no one could pass until it had reached is destination.
- Staff told us the waiting area was very small for the volume of patients with limited seating. On the day of our visit we saw that patients were standing along the entrance as there was no room to sit down.
- Patients who drove themselves to their appointment told us they found car parking difficult as the demand for spaces was high.
- We observed staff speaking with people about their condition and giving appropriate information.
- The cardiology echo clinic waiting area was in a corridor. There were six chairs and if full patients waiting had to sit on the floor. Staff told us patients regularly sat on the floor and it had been like that a long time. The waiting area was in a corridor with through traffic going to a ward and other areas of the hospital. Staff told us it had been known about and raised as an issue for years. Recently they had been told benches had been ordered and they were awaiting delivery but did not know when this would be. Staff did not know if any risk assessment had taken place and it was not on the risk register.

Learning from complaints and concerns

- Most complaints were about waiting times and cancellations of clinics. Staff and patients told us most were verbal and dealt with at the time. However staff said they highlighted concerns with line managers but said the same situations continued to happen and nothing improved.
- We spoke with patients who raised concerns with regard to waiting times and parking, however patients and staff told us nothing had improved.
- In radiology complaints were discussed in staff meetings. We saw minutes of these and evidence of learning, for example, wrong information on referral that had not been checked with the patient correctly. There was a discussion regarding the correct procedure and signposting to the relevant policy. Changes had been made in the way checks were done using a "6 point test" to ensure the correct personal details were known
- Initial complaints were dealt with by reception staff and if more serious by the outpatient senior staff. If they were unable to deal with the person's concerns satisfactorily, they would be directed to the Patient Advice and Liaison Service (PALS). If the person still had concerns, they would be advised how to make a formal complaint.
- However complaints were not handled in line with the trust's policy. This stated that the patient liaison service (PALS) would "provide advice and support" and that when a "concern needed to be escalated to the clinical team or department to assist resolution.
- Verbal complaints were not recorded or passed onto PALS so data provided by the trust would not give a true record of the number of issues or concerns raised by patients.
- PALS leaflets were available in the waiting areas. These informed patients of the PALS service and invited patients to provide feedback and comments. All those we saw were written in English.
- In all the areas we visited poster information on how to make a complaint was displayed. Most patients we spoke with had seen the posters but were not all clear on what they needed to do next if they had a complaint.
- Staff confirmed that they were aware of complaints and had received feedback via the staff meetings.

Are outpatient and diagnostic imaging services well-led?

Inadequate

We rated the service as inadequate for being well-led.

There was no statement of vision and guiding values for the service that staff could describe. Most staff could not tell us in any detail what the trust's vision and values were.

The governance arrangements were not effective. Risks were not always identified and when identified not always managed effectively or in a timely manner.

Outpatients and diagnostic imaging

There was no effective system for identifying, capturing and managing issues and risks at team, directorate and organisation level. For example, information on waiting times, number of cancellations of clinics, how many patients double and triple booked for appointments.

Risks about storage of records and equipment had been known and were on the risk register but were not managed.

Information on complaints was unreliable as all patient complaints were not recorded. There was minimal engagement with people who used services.

There was a lack of openness and transparency, which resulted in the identification of some risk, issues and concerns being discouraged or repressed. For example: staff were told to not to report every individual missing case record as a patient safety incident as stated in the trust policy. Where staff had repeatedly reported concerns this information had not been shared or identified as a risk.

Significant issues that threatened the delivery of safe and effective care were not identified or adequately actioned and actions to manage them were not always taken. For example: arrangements for managing medicines in radiology, cardiology and ophthalmology and health and safety procedures did not always follow best practice guidance.

Some equipment used in support of patients care and treatment was not installed, checked and maintained in line with the manufacturer's instructions, current best practice guidelines and legislation.

Care premises, equipment and facilities did not always meet patients' needs. Records were not always stored safely and patient's information could be read by unauthorised people.

Communication between senior and middle managers and staff was "poor". Staff told us it was difficult to get concerns discussed and actions taken when they highlighted issues that impacted on patients and staff. Leaders were out of touch with what is happening on the front line. There is a lack of clarity about authority to make decisions and how individuals are held to account.

There were low levels of staff satisfaction, high levels of stress and work overload. Some staff did not feel respected, valued, supported and appreciated.

Vision and strategy for this service

- The trust's vision was to provide consistently good, safe care in a friendly, listening and informative way. As and when people needed and wanted it and always with dignity and respect.
- Some staff said they were aware there was a strategy and it had been discussed during appraisals but were unable to describe this in detail.
- Staff were loyal and keen to support the trust in implementing changes. However other staff said they did not feel there was an overall strategy or vision and everyone in their own specialities was doing their own things.
- Some staff told us they felt supported at local team level and highlighted individual senior managers who were contributing to making change happen.
- Staff raised concerns about the impact of recent re-organisation that had involved changes of job roles. Managers had taken on additional responsibilities without any additional training or support.

Governance, risk management and quality measurement

- Not all staff we spoke with were clear about their roles and understood what they were accountable for. For example, one manager was not aware they had the lead for infection control in their department.
- The service risk register was not effective; very few of the risks appeared to have regular updates on progress. This meant that the trust's board may not have had current oversight of risk or assurance the risk was being managed or minimised.
- For example risks had been raised about the lack of space for storing patient records resulting in patients being seen without their medical records. This had been reported in September 2012 and July and November 2014. It was unclear whether the action plan to ensure there was adequate storage has been completed as it had not been updated since August 2014. These meant risks had been identified in September 2012. Three years later the issues were still the same and there was no credible plan in place to manage it.
- Risks identified by staff and known to the trust were not all on the risk register. There was a difference in what staff raised as concerns and what were recorded as risks.
- We saw evidence that the radiology service reviewed their risks at their monthly multi-disciplinary meeting.

Outpatients and diagnostic imaging

- An audit reported on in February 2014 stated that compliance for the World Health Organization (WHO) Checklist Audit for interventional radiology procedures needed to improve from 70% to 100%.
- A review due to take place in September 2014 did not take place. This meant that the radiology service had no way of knowing whether they were fully complying with WHO guidance.
- There were some structures in place to maintain clinical governance and risk management. However these were not effective.
- Staff told us they were aware of the trust's whistleblowing and safeguarding policy and that they felt able to report incidents and raise concerns through these processes. The training records identified that training for safeguarding had been taken place.

Leadership of service

- Some staff told us they did not feel felt well supported by their managers and that the managers were not always available to assist if they had a concern.
- Other staff said immediate line managers did listen but then nothing happened after that and the issues continued. For example; concerns about patient care raised by staff such as: waiting list appointments being double and triple booked and clinic cancellations.
- Managers we spoke with at both middle and at senior level whilst they understand the challenges could not identify the actions they needed to make to ensure all patients have good quality care.
- Outpatients as a service was managed by the medicine divisional director. Day to day management was the responsibility of each individual division and these management groups meet monthly. Staff told us there were no meetings where issues and concerns could be shared and a joint strategy identified to address the issues around overbooking, cancellation of clinics and long waiting times for patients. However the trust told us that issues relating to clinics and waiting times were discussed at weekly Access Meetings which were minuted. One manager told us they knew there was a problem but were unable to do anything about it and would not give us any further details to explain.
- Staff told us they were unable to get the support at the level that was needed to challenge and change some working practices in outpatients.
- Comments from staff suggested some doctors were often late in, left early and did not turn up for administration days. Concerns were raised about the quality of documentation as illegible by some doctors. For example, incorrect date and alterations not signed which affected the legality of documents. Staff told us they were not reporting on the incident system to highlight but had discussed with their line manager but nothing changed.
- One manager that had been post over nine months was not aware of the trust dashboard and had limited understanding of what audits they needed to do or what had not been done. They were unclear what risk assessments they needed to do or when those that had been done should be reviewed.
- All the managers we spoke with said they were overstretched and had been given a number of different roles and responsibilities in recent re -structure. Many staff were new to management across all levels. Some staff had three or more line managers over the past two years and did not see their managers very often.
- Staff in outpatients were concerned that repairs and maintenance took a long time to get done. Maintenance was reactive and getting them to return after their initial visit to fix anything was difficult and sometimes things never got sorted. In one example staff showed us a hole in the fracture clinic outpatient's corridor above the nurse reception desk. A leak had occurred over two years previously in a pipe in the roof. A flexible hose hung from a hole in the ceiling to a container by the side of the reception desk to collect water when it leaked. Staff told us that if it rained heavily then it would leak onto the corridor floor from the ceiling.
- Communication between senior and middle managers and staff was "poor". Staff told us it was difficult to get concerns discussed and actions taken when they highlighted issues that impacted on patients and staff.
- Over 20% of staff that responded to the staff survey highlighted that they were dissatisfied with the quality of care they gave. This is over double the average for the health service as a whole in the country which is 9%.
- In radiology staff said that it was a good place to work and they felt well supported.
- Managers told us turnover of staff in radiology was 4% which was very low. Many staff had been there for years.

Culture within the service

Outpatients and diagnostic imaging

- Some staff told us they were not consulted and were not clear how decisions were made. In one example extra clinics had been put on to deal with demand but nursing staff had not been told and so did not have enough nursing staff to manage the workload.
- Staff told us they worked well together and there was obvious respect between different roles and responsibilities within the multidisciplinary teams working in the different outpatient departments.
- Throughout the inspection, all staff were welcoming and willing to speak with us.
- Staffs in some departments were proud of their service and felt a strong sense of loyalty within the teams.
- In other areas staffs were unhappy as did not feel the service they gave to patients was good enough and they had no control over what happened.
- Staff moral varied with some staff being very positive whilst others felt that their views were not being listened to.

Public engagement and Staff engagement

- Targeted patient surveys had not been undertaken to measure quality and identify areas for improvement within the services.

Innovation, improvement and sustainability

- Staff told us that financial pressures had compromised care and that repairs and maintenance were not followed through because of budget pressures.
- We were unable to gather enough relevant information to make a view on how the impact on quality and sustainability was assessed and monitored when considering developments to services or efficiency changes.

Outstanding practice and areas for improvement

Outstanding practice

- For world sepsis day, the sepsis team launched a 'sing-along' video called 'Stamp Out Sepsis' (SOS), sung in time to a well-known song. This was an innovative method that aimed to raise awareness of sepsis and encouraged staff to remember six actions that could improve patient outcome.
- The dementia care team had implemented a delirium recovery programme which aimed to reduce length of stay, readmissions, antipsychotic prescribing and promoted cognitive and physical functioning by cognitive enablement and health and wellbeing for patients. This allowed patient's the opportunity to return home with up to three weeks of 24 hour live in care. The outcomes clearly demonstrated that the majority of patients with delirium went home with the programme in place when usual care would have predicted placement from hospital directly. Most patients recovered to a sufficient level to stay at home.
- Starfish ward staff had supported a parent whose child was frequently admitted to the ward to obtain funding to set up a carers support team. The team was subject to the same governance and recruitment checks as the ward's staff. The carers support team offered sitting services, information and signposting, and befriending services for parents whose children were in-patients at Starfish ward.

Areas for improvement

Action the hospital MUST take to improve

- Medicines must always be administered in accordance with trust policy.
- The trust must review the governance structure for ED to have systems in place to report, monitor and investigate incidents and to share learning from incidents as well as complaints.
- The trust must ensure there is an effective clinical audit plan in place in ED and End of life care (EoLC).
- The trust must ensure that major incidents arrangements are suitable to ensure patients, staff and the public are adequately protected and that patients were cared for appropriately in the event that a major incident occurred.
- The trust must ensure that all premises are secure.
- The trust must ensure that all equipment is maintained and for safe use.
- The trust must ensure all surgical areas are fit for purpose and present no patient or staff safety risks.
- The trust must ensure that all equipment has safety and service checks in accordance with policy and that the identified frequency is adhered to in respect of emergency equipment requiring daily checks.
- The trust must review the provision of the continuous piped oxygen and suction issue on Letchmore Ward.
- Action must be taken to ensure difficult airway management equipment is adequate and checked to ensure it is fit for purpose.
- The trust must ensure staff are able to attend and carry out mandatory training, to care for and treat patients effectively, particularly regarding annual resuscitation training.
- The trust must ensure that staffing levels within adult ED meet patient demand.
- Action must be taken to ensure medical staff are suitably trained to manage the safe transfer of patients from critical care to other hospitals and services.
- The trust must ensure that all staff are effectively supported with formal supervision and appraisals systems.
- The trust must ensure that staff delivering information to bereaved people receive training in communication and bereavement.
- The trust must ensure that all records are accurate and reflective of patients' assessed needs. The trust must ensure that all patient records and accurate to ensure a full chronology of their care has been recorded.
- The trust must ensure that all confidential computerised patient records in the Emergency Surgical Assessment Unit are securely stored and outpatients to minimise the risk of unauthorised access.

Outstanding practice and areas for improvement

- Ensure that all patients' records are kept up to date and appropriately maintained to ensure that patients receive appropriate and timely treatment.
- The trust must ensure that at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff to ensure people who use the service are safe and their health and welfare needs are met.
- The trust must ensure that where a person lacks capacity to make an informed decision or given consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- The trust must ensure all patients have appropriate care plans to meet their assessed needs.
- The trust must review the elective surgery cancellation rates and review the elective surgery service demand.
- Review the cancellation of outpatient appointments and take the necessary steps to ensure that issues identified are addressed and cancellations are kept to a minimum.
- Review waiting times in outpatients' clinics and take the necessary steps to ensure that issues identified are addressed.
- The trust must review the environment within ED to meet patient demand effectively
- The trust must have systems to robustly manage risk and governance.
- The trust must ensure that there are robust governance and risk management systems in place that reflect level of risks and are fully understood by all staff
- The trust must ensure that all incidents are investigated in a timely manner and lessons learning cased to all staff
- The trust must review the elective surgery cancellation rates and review the elective surgery service demand.
- Review the cancellation of outpatient appointments and take the necessary steps to ensure that issues identified are addressed and cancellations are kept to a minimum.
- Review waiting times in outpatients' clinics and take the necessary steps to ensure that issues identified are addressed.
- Ensure that all patients' records are kept up to date and appropriately maintained to ensure that patients receive appropriate and timely treatment.

Action the hospital SHOULD take to improve

- The trust should review the hospital bed capacity process to ensure appropriate flow through the ED.
- The trust should review clinical pathways to ensure they are consistently followed
- The trust should ensure that staff understand their responsibilities to report all incidents.
- The trust should ensure suitable arrangements are in place to ensure staff receive appropriate clinical supervision to enable them to deliver care and treatment to people who use the services.
- The trust should ensure that all clinical single use equipment is stored safely and appropriately; and disposed of when it has expired it used by date.
- The trust should ensure that all medication is stored safely and appropriately.
- The trust should ensure that all food products are disposed of when they have expired used by dates.
- The trust should review the risk register to identify all risks across medical inpatient services.
- The trust should ensure they take the required actions to meet the 18 week refer to treatment national target in surgery
- The trust should take actions to ensure patients are discharged from the unit within four hours of the decision to discharge to improve the access and flow of patients within the critical care unit.
- The critical care service should take actions to reduce the incidence of re admission of patients to critical care within 48 hours.
- The trust should take action to review staffing arrangements to ensure it is able to provide a seven day 24 hour critical care outreach service.
- The trust should take action to ensure referrals of critical care patients are managed in accordance with the trust's operational critical care policy.
- The trust should take action to ensure there is sufficient medical cover for weekends and out of hours for the critical care service
- The trust should ensure that mandatory training for staff in children and young people's services is updated.
- Patients should receive individual risk assessments for the journey to the theatre from children and young people's wards.

Outstanding practice and areas for improvement

- The trust should ensure patients' names are not visible to people visiting the ward to ensure patient confidentiality is not compromised.
- The trust should ensure records of actions taken to address risks on the risk register are completed in a timely way.
- The trust should ensure an effective, personalised care planning process is in place to meet the needs of all patients receiving end of life care.
- The trust should provide education for all staff on care of dying patients.
- Ensure that information on how to complain is accessible to patients in all patient areas within the hospital.
- Put in place a clear strategy for leadership development at all levels.
- Review issues identified and associated with transport problems when accessing outpatient appointments.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 (1)(b),(c),(e) HSCA 2008 (Regulated Activities) Regulations 2014 **Premises and equipment** All premises and equipment used by the service provider must be suitable for the purpose for which they are being used. Concerns were found regarding the suitability of the premises in medicine, surgery, maternity, outpatients and end of life care both in terms of suitability, safety and security. Difficult airway management equipment on the Difficult Airway trolley provided in the critical care unit did not contain an appropriate emergency tracheostomy kit and therefore did not conform to professional standards. This meant staff could not effectively respond in an emergency situation.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1)(a),(c),(f),(g) HSCA 2008 (Regulated Activities) Regulations 2014 **Safe care and treatment** Care and treatment must be provided in a safe way for service users ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.

This section is primarily information for the provider

Requirement notices

There were concerns regarding assessing the risks to the health and safety of service users of receiving the care or treatment in ED, and staff had not received training to manage the safe transfer of critically ill patients. Medicines were not stored safely. Patients in radiology were being routinely being given medication without a prescription or a patient group directive in place.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a),(b),(c) HSCA 2008 (Regulated Activities) Regulations 2014 **Good Governance** Systems or processes must be established and operated effectively to ensure compliance with assessing, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity, maintaining and keeping secure appropriate records and evaluating and improve their practice in respect of the processing of the information The regulation was not being met because governance arrangements for auditing and monitoring clinical services were ineffective and unclear. Although there was some evidence of nursing audit and learning, information and analysis were not used proactively to identify opportunities to drive improvements in care. Risks identified were not always responded to in a timely manner. Records were not always completed or stored in accordance with trust procedures.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18,(1), (2),(a) ,(b) HSCA 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Staffing

Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed and receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Staffing levels did not always meet patients' needs in ED, medicine, maternity, EoLC and outpatients. There was not a robust system in place for staff supervision and appraisal across all services. Not all staff had had mandatory training as required by the trust's policies.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Regulation 16, (1), (2) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: **Receiving and acting on complaints** The service should operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. There were not robust systems in place for monitoring and responding to complaints, and implementing actions required as a result of investigation, across all services.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10,(1), (2) HSCA 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Requirement notices

Dignity and respect

Service users must be treated with dignity and respect.

Not all patients in maternity and outpatients were treated with dignity and respect.