West Hertfordshire Hospitals NHS Trust

Watford General Hospital

Quality report

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

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

Letter from the Chief Inspector of Hospitals

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

Part of the inspection was announced taking place from 30 August 2017 to 1 September 2017 during which time Watford Hospital, St Alban's Hospital and Hemel Hempstead Hospital were all inspected. We carried out the unannounced inspection on the 12 September 2017.

This was the third comprehensive inspection of the trust. The trust was rated as inadequate overall and was placed into special measures in September 2015. The last inspection took place in September 2016, where the trust and was rated requires improvement overall. It

remained in special measures.

Urgent and emergency care services was rated inadequate during our last inspection in September 2016. Medical care, surgery, services for children and young people and outpatients and diagnostics were rated as requires improvement in 2016.Critical care, maternity and gynaecology and end of life care were rated as good.

At this inspection we rated Watford General Hospital as requires improvement overall.

During this inspection, medical care and surgery were rated as requires improvement. Critical care, maternity and gynaecology, services for children and young people, end of life care and outpatients and diagnostics have been rated as good. This means all these services, except medical care and surgery, have improved and provide a better service to their patients. However, emergency services were rated inadequate.

We saw several areas of outstanding practice throughout Watford General Hospital. For example:

- There were a number of outstanding innovations in the children's emergency department to support the needs of parents, children and younger people. This included support from voluntary groups charities and volunteers to tackle important issues such as mental health and suicide awareness.
- The set up and design of the children's emergency department as an environment to children was outstanding as it enabled the service to undertake interventions on children quickly. The design and space for a district general hospital was unique and was modelled on the set up of the tertiary children's units.
- We observed outstanding care interactions provided by staff to children in the emergency department and in the children's observation bay.
- The pathways of care in the children's emergency department, their effective use within the department on patients was outstanding.
- Staff kept patients at risk of harming themselves safe without depriving them of their liberty. There was an effective process for prompt senior nurse assessment and the provision of enhanced care for patients at risk. An enhanced care team was receiving training to make sure they provided patient centred care.
- The "iSeeU" initiative provided women who were separated from their babies at birth the opportunity to use face-time technology to see their baby receiving care and treatment on the neonatal care unit.
- The pilot Phoenix team provided a case loading service for women with uncomplicated pregnancies who wanted to give birth at home or at the birth centre. The team sent a congratulations card to every mother who was part of their team once they had delivered their baby.
- An electronic referral pathway had improved the care for infants with prolonged neonatal jaundice. The pathway had been developed in partnership with GPs, health visitors, community midwives and local commissioners. This had resulted in a reduction in the referral to appointment time (under 48 hours) and the overall time for parents to receive their child's results was two weeks from referral.
- The diagnostic imaging service monitored its compliance by auditing best practice relating to patients receiving chest radiography. Guidance from the Royal College of Radiologists (RCR) states that it is best practice to undertake chest radiographs on patients in the poster anterior (AP) upright position, apart from when this is not appropriate due to immobility or ill health. Following an audit performed within the diagnostic imaging department, staff embraced the importance of change in practice especially in difficult casualty situations.

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

Importantly, the trust **MUST:**

- The trust must ensure governance quality systems in ED, including the reporting of incidents, identification of risk and management of risk registers provide assurances that the service runs safely and effectively.
- The trust must ensure that the staffing levels on duty are based on acuity, and ensuring the numbers on duty for nursing, medical and support staff are sufficient to ensure safe care.
- The trust must ensure that appropriate action is taken to improve the culture within the emergency department.
- Ensure that there are processes in place to complete patients' venous thromboembolism risk assessments on admission and repeated assessments 24 hours after admission in line with national guidance.
- Ensure that patient risk assessments are detailed with information to allow an accurate assessment of the patients' clinical condition.
- Ensure that there are processes in place to manage and report mixed sex accommodation as incidents and where possible prevent patients of the opposite sex being cared for in the same clinical area.
- Ensure that patient personal identifiable information is not displayed or discussed openly within earshot of unauthorised persons.
- Ensure that staff working within the DVT clinic are competent at the identification of medicines and contraindications.
- 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. A formal decision specific mental capacity assessment must be undertaken of the patient's ability to understand this decision and to participate in any discussions.
- Ensure that all staff caring for patients under 18 years of age complete safeguarding children level three training.
- Ensure staff in outpatient services are aware of the trust policy and fulfil the mandatory reporting duty for cases of female genital mutilation.
- Ensure that World Health Organisation (WHO) five steps to safer surgery checklists are completed in their entirety.
- Ensure that infection prevention and control standards are maintained in treatment rooms where minor operations are performed.
- Ensure that all risks within the outpatient department are included in the departmental risk register.
- Ensure clinical staff within the radiology department are up-to-date on fire and evacuation training.

The trust **SHOULD:**

- Review the arrangements for the collection of blood samples from the emergency department.
- Review ambulance offload and handover times in the emergency department.
- Consider how to effectively learning from complaints is fully implemented to improve patient experience.
- Develop an integrated governance system for the children's emergency department, ensuring there are effective reporting system, and management of risk processes.
- Ensure that all staff maintain all infection control and prevention practices.
- Patients' nutrition and fluids should be accurately recorded and totalled daily.
- Ensure theatres are compliant with national standards, including the ventilation in the

theatre preparation rooms.

- Take steps to ensure the facilities for day surgery patients are appropriate.
- Patients should not be nursed in recovery or ESAU overnight.
- Ensure patients whose surgery is cancelled are treated within 28 days of the cancellation.
- Ensure all surgical patients have access to timely treatment after referral.
- All relevant staff, including junior doctors, should be trained to recognise and respond to signs of sepsis.
- All patient records should be available at pre-operative assessment clinics.
- The route in which the painkiller Paracetamol is to be administered should always be clearly documented in patients' prescription charts.
- Audits of the WHO Surgical Safety Checklist and five steps to safer surgery are improved to assess how well teams are participating in the checks.
- Surgery services should fully participate fully in implementing the National Local Safety Standards for Invasive Procedures.
- The audit programme should be managed effectively and that actions identified are completed and re-audited. This should include an audit of the recognition of sepsis and the treatment provided to patients with signs of sepsis.
- All staff should comply with the trust's hand hygiene policy.
- Standards of cleanliness and hygiene continue to be monitored on Starfish ward.
- Patients should be discharged from the critical care unit within four hours of the decision to discharge, to improve the access and flow of patients within the critical care unit (CCU).
- Patients requiring admission to CCU should be received in four hours of the decision to admit.
- A microbiologist should have daily input to the ward rounds on CCU to review patients care in line with the Guidance for the Provision of Intensive Care Services 2015 (GPICS).
- Take actions to reduce the incidence of mixed sex breaches in the critical care unit.
- Local mortality and morbidity review meeting minutes should include clear delegated actions and monitoring of these.
- The risk register contains all current risks identified to the provision of the critical care service.
- Ensure the service reviews its processes to provide at least 50% of nursing staff with a post registration critical care qualification in line with GPICS standard (2015) and mitigate for any gaps.
- Medicines should be stored within the recommended temperature range.
- All medicines given are documented in line with national guidance.
- All equipment is safety tested annually.
- Resuscitaires should be checked daily.
- Symphysis-fundal height measurements (maternity) are clearly plotted on growth charts.
- Actions should continue to be taken to reduce the caesarean section rate.
- Actions should be taken to improve the perinatal mortality rate and reduce the number of full term babies admitted to the neonatal care unit.
- All complaints are investigated and closed in a timely manner.
- Reduce the number of medical outliers to the gynaecology ward.
- Take action to reduce staffing vacancies and turnover of staff.
- Consider reconfiguring the neonatal unit as its current configuration meant there was insufficient space, which did not reflect current guidelines.
- Continue to monitor the movement of children from the inpatients' wards to the operating theatre along a corridor that was not fit for that purpose.
- Consider ways of improving the environment for children in the operating and recovery areas of the trust.
- Access to emergency equipment should not be impeded.

- Dietary supplements should be stored securely.
- All staff should receive training in a major incident exercise or undergo major incident training.
- The information system for the diabetes service should meet the needs of the service.
- Consider ways to improve the response to the Friends and Family Test in children's services.
- Continue to monitor the level of cancelled outpatient appointments over six weeks in children's services.
- Consider how to improve the results of the next Picker survey in children's services.
- Review the risk register process to ensure the trust was aware of the risks for the end of life care and mortuary services.
- The main outpatient department should have a dedicated area suitable to care for patients on a stretcher, bed or wheelchair.
- Decontaminate reusable naso-endoscopes in a washer-disinfector at the end of each clinic to meet best practice, as outlined in the Department of Health Technical Memorandum (HTM) 01-06 Decontamination of flexible endoscopes.
- Ensure staff are up-to-date on the mental capacity act and deprivation of liberty safeguards training.

Professor Edward Baker
Chief Inspector of Hospitals

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent & emergency services	Inadequate	• The service was in breach of Regulation 17 and 18 HSCA (Regulated Activities) Regulations 2014 in regard to the emergency department. Regulation 17 HSCA (Regulated Activities) Regulations 2014 (1) (2) (a) (b) (c) • Regulation 18 (1) (a) Staffing • We were not assured that there were sufficient staff on duty to provide safe care. • We were not fully assured that the consultant body within the department was working the hours required to safely staff or manage the emergency department. • Only 66% of nursing staff had received Paediatric Intermediate Life Support Training. • Training rates for safe breakaway was lower than expected for doctors and administration staff.

- There was a lack of middle grade cover on the rota overnight and at weekends.
- On average 65-78% of ambulances attending Watford General Hospital are delayed for more than 30 minutes.
- Between July 2016 and June 2017 the trust reported 3211 “black breaches”.
- Learning and outcomes from complaints were not always effectively implemented to improve care.
- There were differences in opinions between the leaders within the service causing this dysfunctionality and it meant that the directorate leaders relationships in some cases had broken down.
- The culture within the department had not improved to a sufficient level since our last inspection. The concerns with this culture had not been adequately addressed by the trust. This lowered staff morale.
- The children’s emergency department was not part of an integrated governance approach to ensure all aspects of the service were included between the two responsible directorates.
- We were not assured that all risks were being adequately identified, or incidents reported and either placed on the risk register or escalated accordingly.

However:

- Duty of candour was evidenced by the service. The service was able to demonstrate where the duty of candour was applied following incidents.
- Lessons from incidents were being learned.
- We observed good hand hygiene practice, in the majority of cases, during the inspection.
- Safeguarding of vulnerable adults and children training compliance have much improved since the last inspection.
- The service had significantly improved the management and treatment of patients with sepsis.
- Pain was assessed on arrival and levels of pain for children were checked at stages throughout their time in the children’s emergency department.
- Excellent pathways of care were established within the children’s emergency department.
- The leadership, culture and staff satisfaction within the children’s emergency department

		was very positive. • Staff engagement has improved since the last inspection.
Medical care	Requires improvement	We rated this service as requires improvement because: • The service was found to be in breach of Regulation 10; Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, due to patients not always being segregated from members of the opposite sex. • The service was found to be in breach of Regulation 10; Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, due to personal identifiable information being on display on wards and patient sensitive information being discussed within earshot of non-authorised persons. • The service was found to be in breach of Regulation 12; Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, due to inconsistent risk assessment and reassessment of venous thromboembolism medicine risks. • The service was found to be in breach of Regulation 12; Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, due to antibiotic regimes not consistently being assessed after 48 hours of initial treatment. • The service was found to be in breach of Regulation 12; Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, due to a registered nurse not always delivering care and treatment in the deep vein thrombosis clinic. • The service was found to be in breach of Regulation 17; Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to nursing risk assessments not always being fully completed and patient information boards being openly displayed and discussed in sight or earshot of non-authorised persons. This meant that confidential information could be viewed

or overheard.

- There was variable compliance with infection control and prevention practices, with staff not consistently washing their hands at the appropriate points, or using hand sanitiser when exiting or entering clinical areas.
- Flow through the hospital did not appear to always be managed effectively, with escalation areas used frequently, limiting services available and impacting patient journey.
- Clinical specialities did not always meet the national average referral to treatment times.
- Flood and fluid charts were not always completed as details of total input and output were missing.

However:

- The service shared details of incidents and used these to identify any learning, sharing information across the service, through local team meetings, peer support meetings and formal mortality review meetings.
- Safety thermometer data was used to identify areas for improvement and changed the way in which the service provided targeted training.
- Personal protective equipment was used by staff appropriately.
- Equipment used across all clinical areas was clean and ready for use. There was an adequate supply for the management of patient care and welfare.
- Patients nursing and medical notes were stored securely and information was contemporaneous and accurately reflected patient care.
- Staff mandatory training was collectively above the trust target of 90%.
- There were processes in place to escalate patients appropriately when their clinical condition changed or deteriorated. There were support networks in place to provide support out of hours.
- The service ensured adequate staffing levels. Locum doctors and agency nursing staff supplemented staffing numbers and integrated into the trust

using generic templates and checklists.

- Some staff had completed a training exercise in line with the major incident policy.
- National guidance and protocols to manage patient care and treatments were reflected in service policy and procedures.
- Patients' pain and nutritional needs were well managed.
- The service had achieved the highest rating for the Sentinel Stroke National Audit Programme (SSNAP) for one year.
- The Hospital Standardised Mortality Ratio (HSMR) for the twelve-month period from January 2016 to December 2016 the HSMR was better than expected at a value of 93 compared to 100 for England.
- For the twelve-month period from January 2016 to December 2016, the Summary Hospital-level Mortality Indicator (SHMI) was lower than expected at a value of 90 compared to 100 for England.
- Staff training was inclusive of all staff working across the service and focused on staff development and patient safety. Internal and external courses were readily available to all staff.
- Multidisciplinary team working was inclusive of all professions and patient centred.
- The medical service provided over seven days, with some services such as dietetics and clinical investigations requiring a referral out of hours or at weekend.
- There was a clear process in place for the completion of mental capacity assessments and Deprivation of Liberty Safeguards (DoLS) referrals with alignment to specific issues and detail.
- All staff treated patients with respect and in a considerate manner. Discussions were open and inclusive. Patients and their relatives were included in decision making about treatment and care.
- Patients and their relatives felt that they were involved with care and treatment plans.
- The medical division was involved with trust wide development plans to realign

			services to other clinical areas. • Staff were aware of their roles in line with the trust escalation plan. • The service had reduced the number of inpatient moves since our last inspection. • Staff were able to access services to ensure patients with specialist needs were addressed. This included interpreters, patient advocates, specialist equipment such as pressure relieving mattresses and patient passports/ “This is Me” to inform care. • Complaints were managed effectively with responses made to complainants in a timely manner and in line with trust policy. • There was clear leadership across the speciality. • Local managers were enthusiastic about improving their ward, team and sharing knowledge. • Team and clinical leads were accessible and respected by all staff. • Staff were aware of the trust’s vision and aims. • Staff were committed to the trust and had pride in their role. • Locum staff were included in all activities and felt valued and supported.
Surgery	Requires improvement	●	We rated this service as requires improvement because: • Ward staff were not protecting patients’ confidentiality, because identifiable personal information was visible in public areas on the wards and patient sensitive information was discussed within earshot of other patients and members of the public. • Doctors did not routinely record reassessments of patients’ risk of developing a blood clot. • Nearly half of ophthalmology patients were waiting more than 18 weeks for surgery. • When patients’ surgery was cancelled, they were not always treated within the following 28 days in line with expected standards. • The surgery audits on the trust’s audit register were nearly all behind schedule.

- The theatres, recovery area and the day surgery unit needed refurbishment in order to comply with national standards.
- Patients were sometimes cared for on the Emergency Surgical Assessment Unit (ESAU) and in recovery overnight because there were not enough available beds on the wards.
- Surgery services were not fully engaged in the implementation of national standards or checking they were doing everything they could do prevent avoidable harm to people having a surgical procedure.
- We found examples of consultants and doctors undermining teamwork because of their attitude to nursing staff.
- Patients' records were not always available at pre-operative assessment.
- The route to administer a commonly used painkiller was not clearly documented on patients' prescription charts.
- Patients did not always get the written information they needed about their treatment.

However:

- Surgery services had taken action to improve access to unplanned and planned treatment. The emergency surgical assessment unit provided timely review of patients from appropriately skilled medical staff and consultants. Most surgical patients waited less time for planned surgery than when we last inspected.
- Surgery services leaders had a clear understanding of risks and the actions needed to manage these so that patients were kept safe from avoidable harm. They made the case for additional resources so that risks, such as a shortage of consultant staff, were eliminated.
- There was a drive to standardise treatment and care. Examples included ward staff taking action to prevent patients getting pressure ulcers, and consultants managing patient treatment. There were a number of initiatives to improve care and treatment, such as

cross-site meetings to review reasons for cancelled operations.

- Staff followed national guidance in order to provide effective treatment and care. Surgical specialities participated in national audits and used the results to make improvements to treatment. Outcomes for surgical patients were similar to or better than the national average.
- There was a culture that supported the reporting and learning from incidents. There was a shared understanding among all professions of the importance of being open when things did not go well. Patients were kept informed when there was an investigation of a serious incident.
- Staff asked for feedback from patients and relatives to check they were satisfied with their care. There was a timely and responsive investigation of complaints. There was action to improve services based on feedback and complaints.
- Patients were protected from the risk of infection because staff followed infection control practices and the premises and equipment were kept clean. Medicines were stored safely and pharmacists supported ward staff in checking that medicines were prescribed and administered safely.
- Ward staff completed risk assessments to make sure patients were given the care and treatment they needed. However, these were not always followed up.
- When a patient's condition deteriorated, there was action to make sure they received a prompt review. An outreach team was available at all hours to support ward staff with a sick patient.
- Surgery services assessed staffing levels to make sure there were enough staff to keep patients safe from avoidable harm. Locum doctors and bank or agency nurses covered vacancies, sickness or other absences. Physician assistants and the hospital at night team helped junior doctors manage their workload. There was recent recruitment of additional anaesthetists and surgeons.
- There was work to improve the information provided to patients so that

		they had a better understanding of what to expect before they came to hospital. Patients and their relatives told us staff explained their treatment clearly when they were in hospital. • Staff followed national standards when they obtained consent for surgery. • Staff protected the rights of people with a mental health condition. There was an effective and patient centred process to make sure people were kept safe from harming themselves without depriving them of their liberty. • Patients we spoke with commented on the caring, attentive, and compassionate service they received. • There was effective multi-disciplinary working in some surgical specialities, which included close working relations between consultant and nursing staff. • Therapy staff encouraged patients to become mobile by moving around, out of bed, as soon as possible after surgery. An enhanced recovery nurse supported some patients to prepare for and to recover from surgery. • Staff spoke positively about working within the service and felt local and senior managers were approachable. • Nursing and theatre staff told us they had opportunities for professional development. Practice development support was available to all ward and theatre staff. Doctors in training were receiving appropriate training and support.
Critical care	Good ●	We rated this service overall as good because: • Leaders fostered a culture where patient safety was the highest priority. This was supported by an active incident reporting culture, maintenance of healthcare records, medicines management and the appropriate level of monitoring for patients. • Staff attended mandatory training, completed competencies, received annual appraisals of their development needs and received support from the unit's professional development nurse. • The unit contributed to the Intensive Care National Audit and Research

Centre (ICNARC) that monitored patient outcomes and mortality indicators. The annual report for 2016/17 showed the unit was performing as expected (compared to other similar services) in all the indicators, except for two related to delayed discharges.

- Despite the delays encountered with discharges from the unit, patients were not being transferred out to wards in the hospital overnight nor transferred to other units as a result.
- The critical care unit nursing and medical staffing was in line with guidance for the provision of intensive care services (GPICS 2015).
- The unit had an active research and development programme and patients' care and treatment was assessed and delivered according to national and best-practice guidelines.
- There were low infection rates and good adherence to infection prevention and control policies, including use of handwashing and personal protective equipment.
- Patients were treated with dignity, respect and kindness. The critical care team were committed to involving patients and their relatives in care and treatment decisions.
- The service was provided in appropriate facilities to care for critically ill patients and relatives and visitors had access to appropriate areas of the unit.

However:

- Systems and processes related to the maintenance of equipment were not always effective. We found five items of equipment that had not been serviced appropriately. We raised this issue and it was addressed during our inspection.
- Staff were not clear how often the contents of the difficult airway trolley should be checked.
- The unit did not meet the guidance for the provision of intensive care services (GPICS 2015) standard of 50% of nursing staff having a qualification in critical care. This was 42% at the time of the inspection.
- Despite actions being taken in

		conjunction with the trust regarding delayed discharges, this remained an issue for many patients in the critical care service. This also reflected in the increasing number of mixed sex accommodation (MSA) breaches, from June 2016 to May 2017, there were on average 10 each month. • Delayed discharges from critical care appeared to impact the services ability to always admit critically ill patients in a timely manner. • Divisional level mortality and morbidity meetings included critical care services. However, local review minutes were brief and actions to be taken were not always clear. • There were risks to the provision of the critical care service we found were not included in the risk register. For example, the delays with servicing equipment. • The microbiologist was available on call and attended the unit three times a week. This did not meet the daily requirement as stated in GPICS (2015).
Maternity and gynaecology	Good ●	We rated this service as good because: • Staff understood their responsibilities to raise concerns and report patient safety incidents. There was a robust governance and risk management framework in place to ensure incidents were investigated and reviewed in a timely way. Learning from incidents was shared with staff and changes were made to the delivery of care because of lessons learned. • Staff understood their responsibilities for safeguarding vulnerable adults, children and young people and were confident to raise concerns. A dedicated team of midwives provided support, care and treatment to women who were considered to be in vulnerable circumstances. There was effective engagement with other professionals and teams to ensure women in vulnerable circumstances were protected. A female genital mutilation (FGM) clinic had been established, which provided tailored care, treatment and support to women with FGM.

- Staff had the right qualifications, skills, knowledge and experience to do their job. There were systems in place to develop staff, monitor competence and support new staff. Mandatory training compliance figures had improved and generally met the trust target.
- Systems were in place for assessing and responding to risk. Staff received multidisciplinary training to help them manage emergencies.
- Women's care and treatment was planned and delivered in line with current evidence-based practice. National and local audits were carried out and actions were taken to improve care and treatment when needed.
- Performance outcomes and measures were regularly monitored and reviewed. Action was taken to improve performance.
- Woman had access to care and treatment in a timely manner. Gynaecology referral to treatment times were generally better than the England average.
- Women were positive about their care and treatment. They were treated with kindness, dignity and respect. Women felt involved in their care and were given an informed choice of where to give birth. Actions were taken to improve service provision in response to complaints and concerns received.
- Leadership was strong, supportive and visible. The leadership team understood the challenges to service provision and actions needed to address them. Continued improvement had been made to ensure staff and teams worked collaboratively. There was a positive culture, which was focused on improving patient outcomes and experience. Staff were proud to work at the trust.

However:

- The emergency caesarean section rate was significantly higher than the national average. However, the trust had introduced a number of initiatives to address this and the latest delivery figures showed caesarean section rates were declining.
- The trust's perinatal mortality rate was

			worse than trusts of a similar size and complexity and the number of full term babies admitted unexpectedly to the neonatal unit had increased since our previous inspection. A quality improvement plan had been developed to address this. The service was compliant with the majority of recommendations made in the MBRRACE-UK perinatal audit report. • Due to bed pressures, patients from other medical specialities were cared for on the gynaecology ward. This meant there were times when gynaecology patients were cancelled on the day of their planned surgery. The high number of medical outliers had had a detrimental effect on staff morale. • Although staffing levels and skill mix was planned and reviewed so that patients received safe care, staffing levels were generally below planned levels in both maternity and gynaecology. Bank and agency staff were used to meet staffing needs whenever possible. • Medicines were not always documented in line with national guidance. The trust took immediate action to address this concern. However, there had been improvement in the storage and management of medicines. • Not all equipment had evidence of annual safety testing.
Services for children and young people	Good	●	Overall, we rated services for children and young people as good for safe, effective, caring, responsive and well-led because: • Staff were confident to report incidents and staff were encouraged to raise concerns. There was a robust governance and risk management framework in place to ensure incidents were investigated and reviewed in a timely way. Learning from incidents was cascaded to staff and actions were taken to minimise risk and prevent incidents from reoccurring. This was an improvement from our previous inspection in September 2016 where feedback from staff had been mixed as to whether incident reporting was encouraged. • At our previous inspection in September 2016 there had been a significant

division of staff concerning opinion and practice in the neonatal unit. Some staff felt this might have had an impact on patient care. Following a thematic review and implementation of the recommendations there was evidence of good local leadership from clinicians and managers. Consultants in the neonatal unit were working well together.

- There was clear and visible leadership from the divisional clinical lead, clinicians, the lead nurse, matrons and managers who were approachable and fully engaged with providing high quality child centred care.
- All staff were aware of the Duty of Candour Regulation and knew how to apply it which was an improvement from our last inspection in September 2016.
- At our previous inspection in September 2016 staff did not always follow the correct security procedures for entering and exiting the neonatal unit, Starfish and Safari wards. During our inspection we observed it was not possible to enter or leave the ward and unit without being challenged by staff who always followed the correct security procedures.
- At our previous inspection in September 2016 there was no safety thermometer on Starfish ward which was contrary to guidelines issued by the NHS. A safety thermometer was implemented in April 2017 which reported 100% harm free care on Starfish ward for the period April to July 2017.
- At our previous inspection in September 2016, children who showed signs of deterioration were not always escalated to a senior nurse or doctor. During our latest inspection we saw in patient records that patients were appropriately escalated to either the nurse in charge or the doctor, whichever was indicated.
- At our previous inspection in September 2016, there were gaps in management and support arrangements for staff, such as mandatory training and appraisal. During our latest inspection all staff in children's services were achieving 93% for mandatory training and appraisal.
- At our previous inspection in September 2016, there were a high number of

cancellations of outpatient appointments for children. Children's services had reduced cancellation rates for appointments less than six weeks. There was an improving picture for cancellations over six weeks.

- We observed the majority of staff followed best practice guidance for infection control to reduce the risk of infection through staff washing their hands, using personal protective equipment and following sterile techniques.
- Suitable arrangements were in place for the management of medicines which included the safe ordering, prescribing and dispensing, recording handling and storage of medicines. There was a paediatric pharmacist in post.
- Staff treated children with kindness, dignity and respect. All parents and children we spoke with told us how "wonderful" the service was and staff always went the 'extra mile' when caring for children and families. There was a strong child centred culture across the service and staff told us how "proud" they were to work in the children and young people's service.
- Staffing levels were safe for the number and acuity of children. There were effective measures in place to ensure that when there was increased activity, staff numbers increased. There were sufficient medical staff in post to provide 24 hour, seven day a week care for babies, children and young people.
- There were practice nurses in post to identify and deliver individual and service wide training needs. Staff had the relevant experience, knowledge and qualifications to care for and treat patients.
- There was effective multidisciplinary team working. This included, safeguarding services, mental health services, dieticians, physiotherapists and occupational therapist, play specialists and pharmacists. There were effective working relationships with other trusts, tertiary services and external organisations.

However:

- At our previous inspection in September 2016, there was insufficient space, which did not reflect current guidelines, in the neonatal unit. During our inspection we saw there was still insufficient space. A thematic review had been undertaken which had identified the unit to be safe in the interim and mitigating arrangements were in place to manage patient flow and safe staffing levels on a daily basis.
- Children who were moved from inpatient wards to the operating theatre travelled along a corridor that was not fit for that purpose. However, a risk assessment was in place and a health and safety review had been undertaken to mitigate the risks to children and young people.
- Operating theatre and recovery arrangements did not consider adequately the specific needs of children.
- Standards of cleanliness and hygiene were not consistently maintained on Starfish ward. We raised this at the time of the inspection and senior staff immediately addressed the issues.
- The information technology system for the paediatric diabetes service was not fit for purpose and required the clinical team to spend extensive periods of time on non - clinical activities.
- Results from the Picker 2016 national inpatient survey for children's services were worse than the trusts previous survey in 2014. Results were worse than average compared to similar trusts in 2016.
- The children's service took an average of 47 days to investigate and close complaints compared to the trust standard of 25 days.
- Children's services were incorporated into the trust clinical strategy 2015 - 2020 and the children's services strategy 2017. However, not all staff in the service were clear about the longer term development of children's services at the trust.
- Although efforts were being made by the service to engage children and carers in feedback about the service, response rates around the Friends and Family Test were consistently low.

End of life care	Good	We rated the service as good for the safe, caring, responsive and the well-led key questions. End of life services requires improvement across the effective key question: • The service was in breach of Regulation 11: Need for Consent Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: There was no evidence, that decision specific mental capacity assessments were always fulfilled when staff completed DNACPR forms • There were systems in place to protect patients from harm and a good incident reporting culture. • Medicines were provided in line with national guidance. We saw good practice in prescribing anticipatory medicines for patients who were at the end of life. • The trust had a replacement for the Liverpool Care Pathway (LCP) called the 'individualised care plan for the dying patient' (ICPDP). The document was embedded in practice on the wards we visited. • The service had produced a detailed action plan to address the shortfalls and issues raised by the national care of the dying audit of hospitals (NCDAH) 2014 to 2015. Local audits were in place to measure the effectiveness and outcomes of the service. • Do not attempt cardio-pulmonary resuscitation (DNACPR) records we reviewed were signed and dated by appropriate senior medical staff. • Relatives were happy with the care their relatives had received and felt involved in their care planning at the end of their life. Staff demonstrated compassionate patient centred care throughout the inspection. • Care and treatment was coordinated with other services and other providers. The specialist palliative care team had good working relationships with discharge services and their community colleagues. This ensured that when patients were discharged their care was coordinated. • All adult wards had compassionate care champions who were trained in providing end of life care and were a direct link to the SPCT.

		• The SPCT saw 91% of patients within 24 hours of referral. • The trust had an executive and a non-executive director on the trust board with a responsibility for end of life care. • There was a clear vision and strategy for end of life care. However: • We could not find evidence that decision specific mental capacity assessments were always fulfilled when staff completed DNACPR forms. In 11 forms we reviewed, the doctor implied the patient did not have capacity. However, in four (36%) of these cases, we could not see any evidence a formal decision specific mental capacity assessment had been undertaken of the patient's ability to understand this decision and to participate in any discussions. This meant that staff did not act in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and associated code of practice. • The trust had systems in place to identify risks. The trust was aware of the risks for the end of life care and mortuary services.
Outpatients & Diagnostic Imaging	Good ●	Overall, we rated the outpatients and diagnostic imaging service as good because: • Since our previous inspection in September 2016, an outpatient quality improvement plan (QIP) had been implemented. This included all issues raised during the previous inspection and we found that 14 out of 15 had been completed in August 2017. Performance data had improved since the plan was implemented and the service was performing in line with their planned trajectory. • There was a positive incident reporting culture across the services provided. We saw robust departmental learning from a recent never event. • Our last inspection in September 2016 highlighted issues with non-compliance with hand hygiene and lack of hand hygiene audits. We found this had improved during our inspection in August 2017. Good standards of hand hygiene were maintained and the department was compliant with hand hygiene audits. • Patient records were stored securely in

locked rooms and trolleys. This was an improvement since our last inspection.

- Radiation protection in the diagnostic imaging department was robust and supervisors were appointed in each clinical area. Medical physics experts and radiation protection supervisors actively worked with staff to provide advice and ensure compliance with safety standards.
- Nurse staffing levels were appropriate with minimal vacancies and staffing levels met patient needs.
- Staff in all departments were aware of the actions they should take in case of a major incident.
- Risk to patients on the waiting list for outpatient appointments was discussed at weekly meetings. Clinical assessments were conducted if patients waited 30 weeks or more for outpatient services.
- Care and treatment was delivered in line with evidence-based guidance, standards and best practice.
- The diagnostic imaging department was working towards the Imaging Services Accreditation Scheme (ISAS).
- There was a comprehensive clinical audit programme in the radiology department to monitor compliance with trust policy and Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Results showed consistent compliance and actions taken to improve.
- Appraisal rates met the trust target, which was an improvement since the previous inspection.
- Multidisciplinary meetings were held in various specialties so that all necessary staff were involved in assessing, planning and delivering patient care.
- Patients were treated with compassion, kindness, dignity and respect.
- Chaperones were available throughout the outpatient and diagnostic imaging services. Information on the chaperone policy was displayed in clinical rooms and waiting areas.
- Patients we spoke with felt well informed about their care and treatment.
- Our last inspection identified issues with patients being treated in the corridor in dermatology. During this inspection, there

was a dedicated room for wound care. This was an improvement.

- Improvements had been made in the ophthalmology department to maintain patient confidentiality. During our previous inspection, two orthoptists shared a clinic room and saw patients at the same time, which did not maintain confidentiality. At this inspection we found that clinic rooms were no longer shared.
- During our last inspection, we were not assured that patients had timely access to treatment as the trust performed worse than the England average for the percentage of patients receiving an outpatient appointment within 18 weeks of referral. However, this had improved and met the England average from April 2017 onwards.
- The trust had improved its performance for cancer waiting times and was meeting the national standard in four out of five measures.
- Patients had timely access to diagnostic imaging services and the percentage of patients waiting more than six weeks was lower than the England average.
- Diagnostic imaging services were available seven days a week and patients were able to change appointments to suit their needs.
- Outpatient specialties held additional evening and weekend clinics to reduce the length of time patients were waiting.
- Our last inspection identified issues with lack of written information for patients prior to their appointment, for example, what to expect on the day. During this inspection, we saw letters contained detailed information for patients. This was an improvement.
- Poor communication between medical and nursing staff was highlighted at our previous inspection for example, clinics were held that nursing staff were unaware of. During this inspection, staff said this had improved.
- Staff completed a weekly monitoring of waiting lists and clinics flexed to meet any changes in demand or noted increased numbers.
- A new cardiac suite had been opened and magnetic resonance imaging (MRI) was available seven days a week to meet the needs of patients.
- There was good awareness of the needs of

patients with a learning disability and dementia. Twiddle muffs were introduced for patients living with dementia attending the diagnostic imaging department to assist with restlessness as promoted by the dementia society.

- Some departments had developed services, such as one-stop clinics, in order to better meet the needs of patients and improve service provision.
- Staff felt that managers were visible, supportive and approachable.
- All staff we spoke with felt respected and valued. The culture across outpatient and diagnostic imaging services encouraged openness, candour and honesty.
- Patients, relatives and visitors were actively engaged and involved when planning services. Clinical leads led an outpatient user group to gather information on patient experience.
- Leadership of the diagnostic imaging department was focused on driving improvement and delivering high quality care to patients. Radiology governance and risk management processes were robust and effective.
- The service had leadership, governance and a culture, which were used to drive and improve the delivery of quality person-centred care.
- There were high levels of staff satisfaction, and individuals were proud to work for the trust.

However:

- We saw evidence that learning from incidents was shared across Watford General Hospital, Hemel Hempstead Hospital and St Albans City Hospital; however, this learning was predominantly within divisions and did not include services provided by different divisions. For example, staff in the main outpatient department which was run by the medical division were unaware of any learning from the never event that occurred in ophthalmology, which was run by the surgical division.
- The World Health Organisation (WHO) five steps to safer surgery checklists had not been completed consistently for patients who had undergone minor surgery with local anaesthetic. For

example, we looked at five patient records in the dermatology clinic and saw safety checklists had not been completed in three out of five records.

- Not all band 5 nursing staff who had direct contact with children in outpatients had received level three safeguarding children training.
- Compliance with fire safety training in the radiology department was below the trust target of 90%. Non-clinical staff compliance was 78% and clinical staff compliance was 73%.
- Patients attending the clinic for the first time and identified as having a learning disability or living with dementia did not always have their records or referral letter flagged. This meant any adjustments could not be made prior to their attendance to facilitate their journey through the department.
- Risks that were identified during both the previous and most recent inspections, such as missing records were not on the departmental risk register.

Watford General Hospital

Requires improvement

Detailed findings

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

Contents

Background to Watford General Hospital

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

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

The Trust's maternity service is amongst the largest in south-east England, with 4,736 births reported from January 2016 to December 2016.

We carried out an announced comprehensive inspection of Watford General Hospital from 30 August to 1 September 2017. We undertook unannounced inspections at St Albans City Hospital and Watford General Hospital on 12 September 2017.

This was the third comprehensive inspection of the trust, the first taking place in April and May 2015. It was subsequently rated as inadequate overall and went into special measures in September 2015. A further comprehensive inspection took place in September 2016, when the trust, although overall was rated requires improvement, remained in special measures.

Our inspection team

Our inspection team was led by:

Chair: Peter Turkington, Consultant Respiratory Physician and Medical Director, Salford Royal NHS Foundation Trust

Head of Hospital Inspections: Bernadette Hanney, Care Quality Commission.

The team included CQC inspection managers, inspectors and a variety of specialists: consultant neonatologist, consultant in palliative care, consultant in emergency care, consultant anaesthetist two outpatient specialist nurses, a radiographer, a paediatric nurse, three specialist surgical nurses, two consultant surgeons, emergency care specialist nurse and advanced nurse practitioner, two pharmacy inspectors and an expert by experience.

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

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

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

people shared their experience by email, telephone or completing comment cards.

We carried out this inspection as part of our comprehensive programme of re-visiting trusts which are in special measures. We undertook an announced inspection from 30 August to 1 September 2017 and an unannounced inspection on 12 September 2017.

Facts and data about Watford General Hospital

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

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

The trust had 520,693 first and follow-up outpatient appointments from February 2016 to January 2017, with 282,031 of those appointments at Watford General Hospital.

Overview of ratings

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & emergency	Inadequate	Good	Good	Inadequate	Inadequate	Inadequate
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity & Gynaecology	Good	Good	Good	Good	Good	Good
Children & young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients &Diagnostic Imaging	Requires improvement	Inspected but not rated[1]	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

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

Urgent & emergency services

Safe	Inadequate	●
Effective	Good	●
Caring	Good	●
Responsive	Inadequate	●
Well-led	Inadequate	●
Overall	Inadequate	●

Information about the service

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

The adult emergency department at Watford General Hospital saw 94,604 patients in 2016/17, which is an increase of 6.3% on 2015/16. The paediatric emergency department was responsible for seeing and treating approximately 26% of these patients. The emergency department (ED) was originally built for 30,000 attendances but is currently seeing in excess of 88,000 attenders per year. At 23.9%, the trust admits more patients than the England average of 22.2%. Bed occupancy is consistently above 90% making admissions within four hours challenging.

During our inspection, we spoke to 24 members of staff, nine patients and two relatives. We examined the records of care for 20 patients during the inspection. We also spoke with the leaders of the unscheduled care division and members of the executive team about the emergency department.

Summary of findings

We have rated the urgent and emergency services at Watford General Hospital as inadequate overall. Safe, responsive and well led have been rated as inadequate. Caring and effective have been rated as good.

We found:

- We were not assured that there were sufficient staff on duty to provide safe care.
- We were not fully assured that the consultant body within the department was working the hours required to safely staff or manage the emergency department.
- Only 66% of nursing staff in the emergency department and children's emergency department had received Paediatric Intermediate Life Support Training.
- The middle grade ratio of the department was 3% against an England average of 15%. There was a lack of middle grade cover on the rota overnight and at weekends.
- The percentage of patients leaving the department before being seen was higher, at 5%, than the England average of 3%.
- The time to initial assessment for self-presenting patients from March to August 2017 averaged between 31 and 55 minutes. This is significantly outside of the recommendation from the Royal College of Medicine (RCEM) which recommend that patient's initial assessment is undertaken within 15 minutes of arrival.

- On average between July 2016 and June 2017 65-78% of ambulances that attend Watford General Hospital experience delays of more than 30 minutes to offload a patient.
- Between July 2016 and June 2017 the trust reported 3211 “black breaches”. This is worse than the previous year.
- Between June 2016 and May 2017 the trust monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average.
- Complaints were investigated and responded to in line with trust policy. However learning and outcomes from complaints were not always effectively implemented to improve care.
- There were differences in opinions between the leaders within the service causing some dysfunctionality and it meant that the directorate leaders relationships in some cases had broken down.
- The culture within the department had not improved to a sufficient level since our last inspection. Several staff formally raised concerns to us regarding the ongoing poor culture within the service. The concerns with this culture had not been adequately addressed by the trust. This lowered staff morale.
- The children’s emergency department was not clearly included in the vision, strategy or direction for either responsible division. The department was not part of an integrated governance approach to ensure all aspects of the service were included between the two responsible directorates.
- We were not assured that all risks were being adequately identified, placed on the risk register and escalated accordingly.

However:

- Duty of candour was evidenced by the service. The service was able to demonstrate where the duty of candour was applied following incidents.
- Lessons from incidents were being learned.
- We observed good hand hygiene practice, in the majority of cases, during the inspection.
- Safeguarding of vulnerable adults and children training compliance have much improved since the last inspection.
- The service had significantly improved the management and treatment of patients with sepsis.
- Policies and pathways for conditions including stroke and chest pain were in place, which reflected National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines.
- The ‘sepsis six’ pathway was well embedded and audit results demonstrated good outcomes for patients diagnosed with sepsis.
- Pain was assessed on arrival and levels of pain for children were checked at stages throughout their time in the children’s emergency department.
- Excellent pathways of care were established within the children’s emergency department.
- Staff had received training in understanding learning disabilities and patients with complex needs.
- Staff in the children’s department were trained to support those with learning disabilities and complex needs.
- There were a number of outstanding innovations in the children’s emergency department to support the needs of parents, children and younger people.
- The leadership, culture and staff satisfaction within the children’s emergency department was very positive.
- Staff engagement has improved since the last inspection.

Are urgent & emergency services safe?

Inadequate

We rated safe as inadequate because:

- We were not fully assured that there were sufficient staff on duty to provide safe care. There was no formal risk assessment on the impact upon staffing following the with the re-arranging of zones in the department. On the days of our inspection the department was also two nurses down on each shift. This meant that at times of surge there would not be sufficient numbers of nurses to safely staff the corridor area.
- We were not assured that the consultant body within the department was working the hours required to safely staff or manage the emergency department.
- We saw a young patient admitted with a self-inflicted condition, there was no consideration or discussion recorded, that the safeguarding teams needed to be notified to ensure the safety and welfare of the child.
- Only 66% of nursing and medical staff in the emergency department and children's emergency department had received Paediatric Intermediate Life Support Training (PILS).
- It was unclear why out of an establishment of 106 whole time equivalent nursing staff that only three required advanced life support training (ALS). Of the three that were identified for training only one had been trained providing a compliance rate for training of 33.3%.
- The middle grade ratio of the department was 3% against an England average of 15%. There was a lack of middle grade cover on the rota overnight and at weekends.
- The core training refresher session for major incidents was attended by only 54% of staff who required it.
- We were informed that mortality and morbidity meetings took place every month; however minutes of these were not routinely recorded for the emergency department.
- There were ligature points in the toilets near the mental health room.
- The time to initial assessment for self-presenting patients from March to August 2017 averaged between 31 and 55 minutes. This is significantly outside of the recommendation from the Royal College of Medicine (RCEM) which recommend that patient's initial assessment is undertaken within 15 minutes of arrival.

However:

- The set up and design of the children's emergency department as an environment to children was outstanding.
- Duty of candour was evidenced by the service. The service was able to demonstrate where the duty of candour was applied following incidents.
- Lessons from incidents were being learned.
- We observed good hand hygiene practice, in the majority of cases, during the inspection.
- Overall, safeguarding of vulnerable adults and children training compliance had much improved since the last inspection.
- The service had significantly improved the management of and treatment of patients with sepsis.

Incidents

- Staff were aware of their responsibility to report incidents both internally and externally and used the hospital's electronic reporting system.
- The unscheduled care directorate reported 2549 incidents between 1 September 2016 and 31 August 2017 for Watford General Hospital. The top reported incidents related to caseload and capacity within the department (874), community acquired pressure ulcers (309), patient falls (102), and monitoring and assessment of patients (178).

- No never events had been reported. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Three serious incidents had been reported between July 2016 and June 2017. These were related to a diagnostic incident, a neonatal incident and an equipment incident.
- We reviewed the serious incident investigation reports for all three serious incidents. The quality of the paediatric investigation was good with a clear terms of reference, root cause identified and appropriate recommendations and lessons to be learned.
- A second investigation reviewed had a clear terms of reference and identified lessons learned, however the root cause of the incident was not clear. The root causes listed related to equipment factors, human factors, and education and training. These are all contributory factors of an incident and not the root cause.
- The third investigation was detailed and provided a clear list of contributory factors as well as clearly identifying the root cause. The terms of reference were appropriate for the investigation and linked to the learning and recommendations identified.
- Information about incidents and learning from incidents was displayed on the notice board within the main adult department. We spoke with six staff specifically about incidents reported, and any learning from incidents they could share with us. All could recall an incident that had been reported or share any learning from a reported incident.
- Evidence of learning from incidents was disseminated through the local governance meetings. In the June 2017 emergency department governance meeting the root cause analysis investigation of the serious incident involving a baby was discussed. As a result the ED team reviewed the pathway of care for babies under 14 days, presenting with jaundice. We looked at these changes as part of the inspection and found that the new pathways were in use in the paediatric emergency department, and were being used effectively to improve patient safety. This evidenced that lessons from incidents were being learned.
- We were informed that mortality and morbidity meetings took place every month; however minutes of these were not routinely recorded for the emergency department. The trust provided us with the minutes of the mortality and morbidity meetings for the acute assessment unit. We reviewed the minutes of five meetings that took place in 2017 and there was no discussion regarding emergency department cases. The governance meetings for the directorate discussed mortality and morbidity, however these related to the acute assessment only.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Duty of candour was evidenced by the service. The service was able to demonstrate where the duty of candour was applied following incidents. This was monitored through the divisional governance meetings.
- All staff we spoke with about incidents, were able to explain what duty of candour was and when it would be needed.
- We were not assured that the service was reporting all incidents when they happened. During our inspection, we were informed of incidents where the department became short of staff. We were made aware of one incident which we discussed with staff who confirmed they had not reported this as an incident formally via the trust's electronic reporting system, although they did escalate their concerns to managers internally. However, staffing issues, demonstrated by shifts that were rated amber and red, were reported through operational meetings and reviewed throughout each day.

Safety Thermometer

- The emergency department was not required to complete the safety thermometer due to the continual change of patients and time spent by patients in the department.

Cleanliness, infection control and hygiene

- There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained.
- Equipment was visibly clean and had been labelled with 'I am clean' labels, which were dated with when the equipment was cleaned.
- We observed the staff use hand gels between patients and there were gel dispensers in every bed space to allow the staff to sanitise their hands at the point of care. However, we noted that there were a limited number of hand gel dispensers in the main corridors, reception area and thoroughfare areas of the department.
- Staff frequently used the hand gels between patients as an alternative to handwashing and therefore, did not wash their hands as frequently as required.
- The service undertook hand hygiene audits on a monthly basis. The results of these audits showed a compliance rate of 77% and 98%, with the trust target being between 95% and 100%. The audit included observation of hand hygiene, and the cleanliness of commodes and equipment in the department.
- There were cubicles in both the main adult department and in the children's department where patients could be isolated to if they were identified as having a potential infection.
- Personal protective equipment was available for staff to use. This included gloves, aprons and masks for use when required. Staff were observed to use these frequently and appropriately throughout the inspection.

Environment and equipment

- The design, maintenance and use of facilities and premises generally met all patients' needs with risk assessments in place where the environment was challenging to deliver care.
- The main environment was largely unchanged since our last inspection. The waiting area could not be observed due to limited visibility from pillars in the middle of the room. An emergency bell had been installed in the reception area and in the waiting room to enable the reception staff call for help in the event a patient required immediate assistance.
- The resuscitation equipment had been checked daily and was stocked in line with resuscitation council guidelines.
- The blood glucose boxes and anaphylaxis boxes were found to be secure, checked regularly and all items were in date.
- We examined a range of equipment including infusion pumps, syringe drivers, ECG machines, and monitors and found them to have all been serviced and in date.
- The children's emergency department was a separate area within the main emergency department and met the standards for 'Children and young People in Emergency Care Settings 2012' though children did not have their own dedicated entrance to the department.
- The children's emergency department was designed specifically for children and young people. The environment was well designed, large and had separate areas for minor treatments, observation and resuscitation. The children's area had a large waiting area, which could be observed from the nurses station at all times, and the bay areas could also be observed.
- There was a risk associated with the security of the children's emergency department

because there were four entry and exit points. The risk of security in the department had been recognised, and fully risk assessed. Staff clearly understood the mitigation requirements and we observed them monitoring the doors during our inspection. The risk was added to a risk register and security was planned for review in the remodel of the department scheduled to commence in September 2017.

- The children's observation bay was dedicated only for children requiring clinical interventions and some overnight stays. The area was separate to the adult department and well suited to children.
- The set up and design of the children's emergency department as an environment to children was outstanding as it enabled the service to undertake interventions on children quickly. The design and space for a district general hospital was unique and was modelled on the set up of the tertiary children's units.
- The emergency department had approved plans for the remodelling the environment. This included the children's emergency department. Work was scheduled to commence on phase one of this plan in September 2017. The remodel will create additional space for the main emergency department, and improve the flow and design of the service. The children's department would also be upgraded with plans for a separate entrance. The refurbishment and remodel plans will significantly improve the flow and space within the service.
- Waste was segregated and disposed of appropriately. Clinical was disposed of using clinical waste bags. Cytotoxic items were disposed of using an appropriate identifiable secure container. Sharps were disposed of using sharps bins, that were stored at a safe height and not at floor level.

Medicines

- There were effective systems in place regarding the storage and handling of medicines.
- We checked a sample of medicines, including emergency medicines, these were in date and stored at the correct temperature.
- Fridge temperatures for medicines requiring refrigeration were checked daily to ensure these medicines were stored correctly. Fridge temperatures observed were within the expected range.
- Throughout the adult area, of the five fridges we checked all except one were locked. The one that was not locked was stored behind a locked door.
- Although the department does not have a commissioned full time pharmacist the pharmacy team ensure that a pharmacist visits the department daily to liaise with and support staff with medicines.
- Medicines were available out of hours and staff knew how to obtain them if needed.
- Checks were in place to ensure emergency medicines were available and safe to be used as well as being protected from tampering.
- Controlled drugs (CDs) (medicines that require extra checks and special storage arrangements because of their potential for misuse) were reconciled correctly in the register, in line with trust policy.
- The medicines storage and management of medicines in the children's emergency department was excellent. The medicines storage area was very organised and items were frequently stock rotated. The medicines were locked and fridge temperatures regularly monitored.
- Staff reported incidents related to medicines on the trust's reporting system. Feedback and any learning was discussed with the member of staff. A recent serious incident had resulted in changes to practice and shared learning across the department.
- In the main resuscitation area, we observed one incident of blood samples not being sent to the laboratory for testing. We found two samples that had been left for over two hours. This could have compromised the integrity of the blood samples or potentially delay care to

the patient. We escalated this to the nurse in charge who ensured all patients were checked to ensure that they had received the appropriate and required treatments, and to ensure that this practice did not continue. We identified this as a concern within the resuscitation area at the last inspection in 2016.

Records

- Patients' individual care records were well managed and stored appropriately. Records seen were accurate, complete, legible and up to date.
- We examined the records of 20 patients during our inspection. We found the quality of record completion had improved since the previous inspection. The records of care were more comprehensive and clear about the care provided.
- Risk assessments were completed for the majority of patients records we examined. When a patient had been in the department for more than four hours higher level risk assessments such as pressure ulcer care and skin integrity were completed.
- Notes were stored in a lockable trolley located in each area. This trolley had a code on it and was locked after each notes. This meant that notes were stored securely.

Safeguarding

- The trust set a target of 90% for completion of safeguarding training for both adults and children.
- Nursing and support staff training rates were 96% for safeguarding adults level 2 and 95% for safeguarding children level 3. Above the trust target of 90%.
- Doctors training rates were 86% for safeguarding adults level 2, which was below the trust's target but an improvement since the previous inspection.
- For safeguarding children level 3, 97% of all staff had received this training which was a significant improvement on the last inspection.
- We saw positive application of the safeguarding processes within the main emergency department. The nurse practitioner raised safeguarding concerns with the nurse in charge in respect of a young adult. The discussion was clear and provided a clear decision on next steps in the best interest of the patient concerned.
- However we also saw another case of a patient admitted with a self-inflicted condition, there was no consideration or discussion recorded in the records that the safeguarding teams needed to be notified to ensure the safety and welfare of their children.
- We saw positive use of the safeguarding children's alert process by the children's emergency department. The staff had raised concerns for a child with an injury that was not consistent with the reasons for the injury being sustained and took appropriate steps to escalate this. The nurses and doctors discussed with appropriate specialties, discussed with the safeguarding adults lead and completed an appropriate safeguarding referral. They admitted the child in the interest of safety whilst the referral process was completed.
- Staff in the children's and adult department were knowledgeable about female genital mutilation (FGM) and information was displayed in the staff areas on the identification of this, and how to report it.
- The children's emergency department were creating additional innovative ways to improve the management and understanding of mental health in children within the department. The department had established good links with the mental health trust and was able to contact them for advice and support as well as referrals.
- The children's emergency department was working with a charity to improve discussion in the department around mental health in children and young people. The charity will bring young people with experience into the service who will speak to those concerned about wellbeing subjects including mental health, self harm and suicide awareness.
- Leaflets for victims of domestic abuse were available for staff to give to vulnerable patients.

Mandatory training

- Staff received effective mandatory training in the safety systems, processes and practices. Nursing training compliance was provided by the trust. The trust set a target of 90% for completion of mandatory training.
- The majority of nurse training met the trust's target of 90%, with hand hygiene, information governance and fire safety being the exceptions. Compliance for nurse training in patient moving and handling (93%), information governance (79%), health and safety (93%), hand hygiene (86%), fire safety (81%), equality and diversity (97%), conflict resolution (96%), infection control (95%), basic life support (BLS) (90%).
- The overall compliance rate for doctors was 83% across the subjects, which was lower than the trust's target of 90%. Compliance for doctors training in moving and handling (54%) which was the lowest performing subject. Information governance (77%), health and safety (76%), hand hygiene (100%), fire safety (100%), equality and diversity (79%), conflict resolution (100%), infection control (88%), basic life support (BLS) (77%).
- The trust provided us with a combined ratio of nurses and medical staff training in Paediatric Intermediate Life Support Training (PILS). This showed that only 66% of nursing and medical staff in the emergency department and children's emergency department had received this training.
- For advanced life support training (ALS) the trust identified that all 28 medical staff members in the department required training and 100% of these staff had been trained. The department data showed that the trust believed that only three members of nursing staff in the emergency department required ALS training. It was unclear why out of an establishment of 106 whole time equivalent nursing staff that only three required this this training. Of the three that were identified for training only one had been trained providing a compliance rate for training of 33.3%.

Assessing and responding to patient risk

- The general median time to treatment has been higher than the England average between April 2016 and March 2017. The guidance recommends that the service provides treatment to patients within 60 minutes. The service did not meet the standard for seven months over the 12 month period.
- Performance for median time to treatment showed a trend of improvement. In March 2017 the median time to treatment was 62 minutes compared to the England average of 58 minutes. Between April and August 2017 the median time ranged from 59 minutes to 85 minutes.
- The data provided on time to initial assessment for ambulance arrivals was doubtful. June recorded a time of zero minutes and March and May 2017 recorded a time of one minute, which is highly unlikely in an emergency department setting. The department leads believed this was a data issue related to the timeliness of patients being 'clicked' on and off the system. The service was aware of the issues and working to improve the quality of their data.
- Patients received an initial assessment following their arrival in the department if they self-presented. Self-presentation is walking into the department rather than being brought in by ambulance. The time to initial assessment for self-presenting patients from March to August 2017 averaged between 31 and 55 minutes. This is significantly outside of the recommendation from the Royal College of Medicine (RCEM) which recommend that patient's initial assessment is undertaken within 15 minutes of arrival.
- The main department have reorganised their flow through the department since the last inspection. The service has introduced a "streaming" system for the patients who arrive on foot. The "streaming" is a simple streaming process, which is recommended by the Royal College of Emergency Medicine (RCEM). Simple streaming will enable the streamer to direct the patient into the appropriate physical area of the department, in order to match the

patient's needs to departmental capability.

- Streaming was staffed by a senior nurse at either band 6 or band 7 grade. We observed streaming during our inspection and observed that it was appropriately used. The nurse through experience was able to identify those patients who were acutely unwell and take them straight through to ensure they received treatment as soon as possible.
- At the last inspection the service used a process called "pit stop" for triage. This was no longer the system used. The service now uses a triage process called "STARR" which stands for "Senior Team Assessment and Rapid Response (STARR)" this was an improved system for the service. The area where "STARR" occurred contained six bays for assessment and initial treatment by a clinical decision maker. Patients would then move from this area to minors, majors or resuscitation as appropriate.
- However, this system was relatively new and not yet embedded. There remained issues with flow through this area which could have placed patients at risk of harm. For example, during the inspection we observed delays of over one hour for assessment in this area, this included patients attending with chest pain.
- The minors area of the department provided challenge to the achievement of the four hour standard at the last inspection. This area of the service had changed to be nurse led, with emergency nurse practitioners and associate nurse practitioners leading the service. We observed patients referred through to the doctors where appropriate, we also observed doctors attending the department when called. The change to a nurse led function, enabled the nurses to lead care and improved the efficiency and performance of this area of the service. This change also enabled the doctors to focus on the patients who required the most care.
- When escalation protocols were implemented due to crowding within the department the service placed patients in the corridor area of the department. The safe clinical management of patients in this area had been a long standing concern for the service and the patients.
- During the inspection we did not see the corridor in use due to the department not being busy for the duration of our inspection. However, we were assured by the new protocols for the management of patients in these areas. The area would be staffed with one nurse to four patients. The nurses were provided with a clear protocol and checklist to adhere to safely manage patients and escalate concerns to the nurse in charge.
- We were concerned that due to the skill mix of the nurses within the department, being quite inexperienced that there may be occasions when an inexperienced or junior staff member would be unsupervised providing care in the corridor. This concern was corroborated by four ambulance crews we spoke with and the hospital HALO, who were concerned by the junior or inexperienced skill mix meaning that the acutely unwell corridor patients may be cared for by staff not sufficiently skilled.
- Patients arriving on foot were assessed using the Manchester triage system. We saw that this process was followed appropriately in all cases reviewed.
- The clinical decisions unit (CDU) was part of the emergency department but in an area separate to the main area. It was staffed by two nurses. There was a criteria for admission on the CDU, which staff were aware of. All the patients we observed in the CDU all met the safe criteria for admission.
- We examined eight observation charts, where patients' temperature, blood pressure, pulse and respirations were recorded. The trust used the national early warning score (NEWS) system. Of the eight we reviewed all were calculated correctly and patients were mostly appropriately monitored. However, we observed on two sets of records where patients required hourly observations that these did not take place in a timely way. For both patients who required hourly observations undertaken, the observations were undertaken at intervals longer than one hour. This could have placed the patient at risk of deterioration if observations are not undertaken in a timely manner.
- Patients assessed and believed to have sepsis and requiring antibiotics within one hour

was 100% for April, May, and June 2017. This was an improvement from January, February and March 2017 which scored an overall compliance of 92%. These results were above the national average and demonstrated good processes in place for the identification, management and treatment within the department.

- Screening rates for sepsis in the department were also increasing month on month. For April (74%), May (94%) and June (92%), this saw an increase on the average of 87% for the previous three months.
- Sepsis training had been conducted by face to face teaching mainly in ED with the nursing and medical staff. Sepsis has been presented at grand rounds discussing the national changes around definitions and the trust data which was well received by all that attended.
- On the sixth day of each month the department held a sepsis day called 'sepsis 6th' which consists of quizzes, data, presentations and facts shared around the trust to increase awareness.
- The paediatric emergency team submitted an abstract about the sepsis screening project in the trust which was accepted for a poster presentation at the Royal College of Paediatrics and Child Health (RCPCH) annual conference later this year.
- The paediatric emergency department had two dedicated resuscitation bays for children. These were based within the children's emergency area, which was an area separate to the adults. In the event of a child that required intensive care, they would be stabilised in the resuscitation room, or in theatre recovery. The Children's Acute Transfer Service (CATS) would then be requested. The CATS team then stayed with the child and safely transferred them to a specialist children's hospital.
- The emergency department had an escalation policy in place. The department had also added a temperature gage that monitors activity in the department, which when high would change the department positions from green to amber, red or black. This was a supportive indicator for staff to trigger the escalation policy based on activity. The escalation policy based on activity was being used effectively during the course of our inspection.
- The TARN report from June 2017 showed the median time to CT scan at Watford General Hospital was 0.73 hours, which is worse than the England average of 0.53 hours. At the time of the inspection, the time to CT was reaching an average of 100 minutes.

Mental Health

- The mental health room was located in the main area of the department. At the inspection in September 2016, concerns were identified in regards to the safety of patients who stayed in this room. Concerns were also identified with safety and training of staff.
- At this inspection we found that the room had been completely refurbished. There were no identifiable ligature points in the room. However, there was a door hinge on the outside of the exit door that remained a risk.
- The furniture in the room had been changed and was suitable because a patient could not cause themselves harm on the chairs.
- The room echoed as there was no sound masking, and limited furniture in the room. This could be a concern.
- The risk assessment process for patients who were placed in this room had been reviewed and was in use. We reviewed the risk assessments for three patients and observed that risk had been appropriately applied. Where a patient was identified as an amber or red risk they required continual supervision. For two of the patients we observed in the room during our inspection there was a person in the room with the patient at all times in line with the requirement of the risk assessment.
- The toilets for the patients was opposite the mental health room. These rooms had doors that opened outwards, and had locks on the inside of the door. Inside the toilets were a number of ligature points that could be used by a patient. We spoke with the clinical director about this risk, as the risk assessment had not identified the need to supervise

patients who were at risk in the toilet and bathroom areas. We were informed that the form had been revised but had not been uploaded for use. The new form, which included the risks associated with the use of the toilet and bathrooms was put into use following this discussion.

- There was a formal procedure for asking patients or checking their property when they presented after self-harming. This meant that patients who could have items with them, which could place the patient, staff, and others at risk of harm was now being managed in a safe way.
- There was a formal assessment for patients to determine where in the department they would be physically safest until the mental health team arrived to provide them with support, or treatment for their conditions. This meant that the service was considering whether the environment was the most appropriate for adults or children with mental health concerns. We were given an example in the children's emergency department of where they felt the environment within the children's emergency department was not appropriate and they made a decision to care for the patient in the observation area instead for the duration of the patient's stay.
- We reviewed the training records provided by the trust. Training on mental health awareness. Training records provided showed that 96% of nursing staff and 100% of medical staff had been trained in conflict resolution. For safe breakaway 84% of nurses, 50% of doctors and 33% of administration staff have received this training, which was lower than expected for doctors and administration staff. This did also not meet the trust training target of 90%.
- We asked the trust to send us details on safe breakaway training and control and restraint training numbers. However, this request was outstanding at the time of writing the report.
- Staff had systems to request a specialist mental health assessment such as from the local mental health trust and crisis support teams known locally as RAID. We observed staff refer patients into this service during the inspection. Staff found this service to be exceptionally important to the running of the service. The service will be provided 24 hours per day from September 2017.
- The department could access a Section 12 registered doctor through the RAID team between 9am and midnight, with an on call service between midnight and 9am. This will be 24 hours per day from September 2017. A Section 12 approved doctor is a medically qualified doctor who has been recognised under section 12(2) of the Act. They have specific expertise in mental disorder and have additionally received training in the application of the Act.

Nursing staffing

- Nursing staffing levels were not consistently sufficient to provide safe care.
- The children's emergency department was understaffed by 25%, this means that there were 8.9 less WTE staff members in post than what was established by the trust to provide safe care, however the service utilised bank and agency staff to backfill any gaps in the rota. This department was staffed by nurses from the women's and children's division.
- The emergency department had a vacancy rate of 8.4 WTE. There were only two active vacancies at the time of the inspection as all posts within the established exception of one which was currently out to advert.
- Between July 2016 and June 2017, Watford General Hospital reported a bank and agency usage rate of 31% in urgent and emergency care. This was due to a high vacancy rate, which has steadily reduced during that time. Whilst vacancy rates were higher than the trust target of 9% at 11%, the department had reduced this to within the trust target by the time of the inspection but the staff had not yet commenced in their roles.
- The department had recently made an appointment to a nurse consultant position. This role would support further development of the nursing staff and also provide support to the

junior medical staff in the department.

- The emergency department had a turnover rate of 15%, which was higher than the trust average of 12%.
- We were not assured that there were sufficient staff on duty to provide safe care. The addition of zones in the department, and making minors nurse led, depleted the available number of nurses available to work in each area. There was no formal risk or impact assessment on the staffing these additional areas, and the change in systems. On the days of our inspection the department was also two nurses down on each shift. This meant that at times of surge there would not be sufficient numbers of nurses to safely staff the additional capacity area (corridor).
- As at July 2017, the emergency department had a sickness rate of 2.2%, and the children's emergency department had a sickness rate of 2.7%.

Medical staffing

- Medical staffing levels were not consistently sufficient to provide safe care.
- Within the department there were 10.7 full time equivalent consultants employed.
- There were four paediatricians in the emergency department, of which one was a paediatric emergency medicine consultant. A paediatric trained medical staff member would always be available to treat a child in the event on an emergency.
- Medical staff vacancy rate for the department was 23.2% for consultant and 8.6% for other medical staff grades. The department was particularly short of staff at consultant and middle grade level. Though recruitment had been made to two new consultant positions.
- In March 2017, the proportion of consultants working at the trust was lower than the England average and junior (foundation year 1-2) staff reported to be working at the trust were higher than the England average.
- Turnover of medical staff within the unscheduled care directorate was 66.5% for all grades of medical staff.
- Medical Staff sickness rates for June and July 2017 were 5.4% and 4% respectively. This is above the trust average but had was reducing and was being monitored by the clinical lead.
- The ratio of consultant staff was 27% against the England average of 29%. The middle grade ratio of the department was 3% against an England average of 15%. The core trainee registrar level staff ratio for the department was 26% against an England average of 32%.
- The junior doctor ratio for the department was significantly better that England average of 43% at 25%.
- The medical rota at consultant level was supported by locum consultants. This was predominantly to cover the weekends. Medical staff recruitment and retention was one of the top risks identified on the risk register. The risk level was graded at 20, which is considered to be high. The highest risks are graded at 25. This had not changed since the last inspection.
- We spoke with the leads for the directorate who shared with us that they had an ongoing recruitment plan for the recruitment of middle grades and registrar grades; however, the position had not improved since the last inspection and middle grade shortages were a risk to the service. There were shifts frequently taking place over night and at weekends where no middle grade was on shift due to these vacancies. We were therefore not assured how effective the workforce and recruitment plans were.
- The shortages of middle grade doctors was a risk to the service as there were not sufficient numbers of medical staff to support all zones within the emergency department. We observed that there was a shortage of medical staff in the STARR zone during the inspection. This was further corroborated by delays to treatment times by doctors, which went up to 120 minutes during our inspection, when the recommendation is under 60

minutes.

- The shortage of medical staff also meant that there were times where there was not a senior medical staff member leading one of the 'zones'. Whilst there was a consultant in charge of the entire department, there was a risk that not having a senior clinician in charge of each area could leave patients at risk of harm.
- On the day prior to our inspection we looked at the data for time to see a treating doctor in the emergency department. The time increased to almost 180 minutes, which is not line with the requirement to see a doctor or clinical decision maker within 60 minutes.
- The consultant rota met the 16 hours of cover recommended by the Royal College of Emergency Medicine (RCEM). Consultant hours daily were between 8am and 12 midnight Monday to Friday and then 8am to 4pm and 4pm to midnight on Saturday and Sunday. After these hours, consultants were available through an on call rota. The consultants undertook an on call duty one in every eight days.
- However, during the inspection concerns were raised to us that some consultants did not always work the required hours listed on the rota. For example, three staff informed us of how one consultant would routinely leave the department before their shift ended at midnight and asked for staff to call them if any emergencies arrived.
- We observed a consultant to consultant handover which was clear and covered each patient in the department. Medical staff of all levels were included in this handover and clinically appropriate information was shared in most cases. Though we did observe one handover where appropriate patient information was not shared. For example, one consultant commented on how good a patient looked for their age as part of the handover, which was not appropriate.
- The trust provided a selection of days where locum medical staff were used between 16 July 2017 and 20 August 2017. This showed that there was a total of 2275 hours that required locum cover within the emergency department during this period, which demonstrates a substantial deficit in substantive medical staffing. The trust was able to fill many of their shifts with internal staff working additional hours (bank), and were supported by an external agency. However, in:
    - June 2017: 49 shifts remained unfilled. Juniors: 16 shifts out of 373 = 4%, middle grades: 22 shifts out of 182 = 12%
    - July 2017: 45 shifts. Juniors: 13 shifts out of 386 =3%, middle grades: 14 shifts out of 185 = 7.5%
    - August 2017: 21 shifts. Juniors: 1 shift out of 384 = 0.25% middle grades: 11 shifts out of 188 = 6%. This supported the inspection findings that there was a concern regarding the shortage of medical staff.

Major incident awareness and training

- Potential risks to the service were anticipated and planned for in advance.
- The trust had a major incident plan that had been updated in 2017.
- The emergency department took part in six major incident exercises since our last inspection. These ranged from 'live' to 'table top' exercises on outbreaks, mass casualties, and chemical, radiological, biological and nuclear (CBRN), which are exercises based on a scenario. Learning had been identified, which the trust and departmental leaders were aware of and were implementing.
- The service had trained 84% of all staff in chemical, radiological, biological and nuclear (CBRN) core training. CBRN defence or CBRNE defence is protective measures taken in situations in which hazards related to chemical, biological, radiological or nuclear warfare (including terrorism) may be present.
- The core training refresher session for major incidents was attended by only 54% of staff who required it.
- The department was able to implement lock down by securing the main doors at either side

of the department and at the ambulance bay. They held a major incident exercise in September 2016 to ensure lock down was effective.
- The major incident store, which contained items used to support staff in the event of a major incident, was located outside of the department. We noted that the use of this facility had improved since our last inspection. The store was clean, organised and regularly checked by staff.

Are urgent & emergency services effective?

Good

We rated effective as good because:

- Policies and pathways for conditions including stroke and chest pain were in place, which reflected National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines.
- The service took part in all national audits.
- Pain was assessed on arrival and levels of pain for children were checked at stages throughout their time in the children's emergency department.
- Excellent multidisciplinary team working was observed with acute medical services, stroke services, intensive care, children's services and the elderly frail unit.
- There was good understanding in the children's department on Gillick competence.
- There was a good development and education programme in place for staff.
- Excellent pathways of care were established within the children's emergency department.

However:

- The local audit programme for the emergency department had improved since the last inspection. The programme of audits had been reviewed and was still being embedded.

Evidence-based care and treatment

- Patients' needs were assessed and are and treatment delivered in line with standard and evidence based practice.
- There was a clear protocol for staff to follow with regards to the management of sepsis. The department had introduced the 'Sepsis Six' interventions to treat patients. 'Sepsis Six' is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. Bundles were also available for neutropenic sepsis. These pathways were working well in the service who had reported good outcome for patients in a recent national audit.
- We reviewed the notes of four adult patients who were admitted with a potential diagnosis of sepsis. All of those patients had appropriate sepsis pathways followed, and treatment was commenced within one hour as per national recommendations.
- We reviewed the policies and pathways for the admission of patients with stroke, fractures and chest pain. We saw that these were written in line with the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines.
- The trust had developed a revised process for ensuring that head injury observations were undertaken in a timely manner. We reviewed the records of two patients with a head injury during the inspection and both had appropriate observations recorded in a timely manner.
- We observed the care of two stroke patients who had attended the department. They were immediately referred to the stroke team who attended the department to provide care. The care provided to this patient, followed the pathway for stroke in emergency care.

- The children's emergency department had an excellent range of well used pathways to support the care provided to children in the service. This included pathways for head injury, jaundice, sepsis, and asthma.
- The children's emergency department had also implemented guidance for staff on how to support children and young people with mental health concerns, challenging behaviour or anxiety.
- The department took part in all required national audits.
- There was limited local audit activity in the department. The audits undertaken were based on the RCEM standards; however the local audit programme had only recently been revised and was still being embedded.
- Local audits included hand hygiene and the environment, and monitoring of observations. There were no other local clinical audits undertaken.
- Within the children's emergency department a large range of local audits were undertaken to improve the quality of care. These included audits on head injury, sepsis and asthma.

Pain relief

- Patients' pain relief was appropriately assessed and managed.
- The College of Emergency Medicine, Pain in Children audit, for 2014-15 identified that there were improvements the service could make. The children's emergency department further audited pain relief and pain management and has revised their protocols for pain management. The service used 'emoji' magnets to place on a board to act as a reminder to staff to ensure pain was routinely checked when observations were undertaken.
- When a patient entered the department, when they self-presented, the streaming nurse enquired about the patient's level of pain. If pain was recorded the nurse would request for pain relief at the next stage initial assessment.
- Through the initial assessment in either minors or STARRing patients were asked about pain, and where indicated pain relief was provided. This was recorded in the patient's record.
- Patients who arrived by ambulance were asked about pain on arrival in the STARRing area.
- We selected the records of five patients to assess pain scores. All had appropriate pain scores recorded. Of the patients we spoke with we asked two specifically about how their pain was being managed, and both reported that they were routinely asked about their level of pain and received pain relief in a timely way.
- In the CQC A&E Survey 2014, the trust scored 7.18 out of 10 for the question "How many minutes after you requested pain relief medication did it take before you got it? This was better than other trusts.
- The trust scored 8 out of 10 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as than other trusts.

Nutrition and hydration

- Risk assessments on patients were undertaken where required if there was a risk of malnutrition. An initial assessment would be undertaken in the department and a referral sent to the dieticians.
- Comprehensive risk assessments of malnutrition risks were undertaken if a decision was taken to admit the patient to the hospital. This would be undertaken by the department in the event of patient being in the department whilst waiting for a bed on a ward.
- Weight loss, food intake and malnutrition was assessed on children who were seen in the children's emergency department. We examined the records of two babies whose weight was considered for risks associated with weight loss during their initial assessment.

Patient outcomes

- Patient outcomes were monitored regularly, the department took part in national audits and made improvements and changes to practice as a result of audits.
- There were no outliers or mortality outliers linked to the emergency department.
- The department was linked to a declining performance trend for the fractured neck of femur pathway, however this was linked to orthopaedics within surgery and not the emergency department specifically.
- The service contributed to the local trauma network, though was not a receiving service for major trauma. The Trauma Audit and Research Network (TARN) is a national organisation that collects and processes data on moderately and severely injured patients. The TARN report for June 2017 identified no immediate risks. The rate of survival at the hospital has decreased from 1.7 per 100 patients in 2014/2015 to 0.8 per 100 patients in 2016/2017 though this was still above the national average.
- Between April 2016 and May 2017, the trust's unplanned re-attendance rate to emergency department within seven days was generally worse than the national standard of 6% and generally worse than the England average. In latest period, performance was 8% compared to an England average of 6%. The highest reported month was September 2016 with a re-attendance rate of 15%. The senior clinicians reported they were looking at trends to identify reasons for re-attendance rates.
- The service took part in all national audits in 2016/17. The results of these had not yet been published, with the exception of the RCEM audit of Sepsis and Septic Shock 2016/17. This audit showed positive results with the trust performing in the top quartile of England.
- In the 2014/15 RCEM audit of assessing cognitive impairment in older people, Watford General Hospital was in the upper quartile compared to other hospitals for none of the six measures and was in the lower quartile for one of the six measures.
- In the 2014/15 RCEM audit for initial management of the fitting child, Watford General Hospital was in the upper quartile compared to other hospitals for two of the six measures and was in the lower quartile for none of the six measures.
- In the 2014/15 RCEM audit for mental health in the ED, Watford General Hospital was in the upper quartile compared to other hospitals for three of the six measures and was in the lower quartile for one of the six measures.
- In the 2016/17 RCEM audit for consultant sign-off, Watford General Hospital was in the lower quartile for three of the four measures. These were traumatic chest pain in patients aged 30 years and over, patients making an unscheduled return to the ED with the same condition within 72 hours of discharge, and abdominal pain in patients aged 70 years and over. The service did not score in the upper quartile on any measure. The service's performance for patients seen by a specialist grade doctor graded at ST4 or above was worse than the national average.
- The service had an action plan in place to improve these outcomes however due to staff vacancies and sickness improvements had been limited to date. The clinical lead was hopeful that improvements would be made once the two new consultants commenced in their roles.
- The children's department undertook a head injury audit which identified learning around neurological observations. This learning was shared on bulletin, with a plan to review the proforma to make it clearer where to record neuro obs. We saw there was a plan to further re-audit this at regular intervals.
- The local audit programme for the main emergency department and the children's emergency department was based on the RCEM standards of care. The services were in the process of completing a large number of local audits to reflect the main service activity.

Competent staff

- There were systems and processes in place to ensure that staff had the necessary qualifications, skills, knowledge and competencies to do their jobs.
- Appraisal rates for administrative and clerical staff were 94%, nursing staff 70% in the children's emergency department and 94% in the adult department. Appraisal rates have improved for the main department but declined for the children's emergency department since the last inspection.
- Nurse revalidation had commenced, and the trust had appointed a lead nurse on revalidation to ensure all nurses were supported through this. In the department more than 70% of nursing staff had successfully completed their revalidation.
- Medical staff revalidation had taken place with seven medical staff completing medical revalidation in 2017. There were scheduled plans for all medical staff to go through the revalidation process.
- The department had recently appointed a practice development nurse to support nurses in the department. Their role at the time of the inspection was predominantly to support increased skill in the nursing staff, and support overseas nurses go through the English exams. Three staff members had successfully completed their English exams to date in the department. All staff we spoke with were highly complementary of the role of the practice development nurse and their benefit to the department.
- There were opportunities to obtain further education and qualifications for role specific qualifications, for example, advanced nurse practitioners, associate practitioners, and emergency nurse practitioners.

Multidisciplinary working

- Nursing and medical engagement and working had improved slightly since the last inspection, however some disjointed working was still observed between some doctors and nurses.
- There was a lead nurse and doctor assigned to each zone within the department. There were no devices used to aide communication, though this was being explored. This made multidisciplinary working challenging at times with the lead nurse having to frequently leave the main post and go between the zones to establish what was going on in the service.
- There was very good engagement and working with the acute medical team and the emergency department. When the department called for an acute medical staff member, they would attend swiftly. However, there were challenges with orthopaedic surgeons attending to patients in the department in a timely way. Three patients who were referred to the service during the inspection were observed to wait for between one and two hours to be seen. The nurses in charge and medical staff informed us this was an ongoing challenge for the service.
- We spoke with four members of the ambulance service who reported that there continued to be long waits for them to hand over patients to the department's staff. They reported that the changes to the corridor would potentially improve delays by reducing the amount of cohorting required, though they were concerned about the skill mix of staff working on the corridor with high risk patients. This was not something we could corroborate further due to the corridor not being in use during the inspection, though the service leads acknowledged skill mix in the department was a known risk they worked to manage.
- There was a good working relationship between the department and the intensive care unit. The service was supported by the intensive care unit with regards to resuscitation and with high dependency patients where required, and we observed good interactions between both departments when discussing patients in the resuscitation area.
- The department worked well with the paediatric service who were responsible for running the children's emergency department. Both departments reported a good working relationships across adults and children's services which was demonstrated through joint

sharing of workloads where required.

- The service worked well with the local mental health trust. The department were supported when referrals were made and response times, when referrals were made, were kept to a minimum. We observed mental health professional's attendance in the department on several occasions, to support the staff. The service was moving to provide a 24 hour per day service from September 2017.
- The working relationship with the elderly frail unit (EFU) was excellent. This service was run by the medical team and took patients from the acute medical referral and emergency referral pathway. The aim of this service was to support patients to go home, when safe to do so and avoid admissions where possible. We observed this service working well to support quick treatment and care to those who required their services.

Seven-day services

- The emergency department was open seven days per week, 24 hours per day.
- The children's emergency department was open 24 hours per day and has been since 2003. The service was staffed 24 hours per day with registered nurses (child branch). Medical staff were available from 8am to 10pm daily and cover from the adult emergency department and paediatric service was provided out of those hours.
- Radiology services operated seven days per week offering CT and plain imaging services. On call services were provided for emergencies when needed to support the service. There was an on-call radiologist available for advice when there was not a radiologist in the department.
- Physiotherapy and Occupational Therapy services were available and delivered 7 days per week 8 am to 4pm with an additional overnight on-call service.

Access to information

- Concerns were raised to us by staff regarding access to information, associated with the IT systems in the trust. The IT systems were slow and challenging to use when the service was busy. This was a frustration for staff who reported that things had not improved in the last year.
- We observed the challenges during the inspection when a system used by the department failed and the contingency arrangements had to be used. The trust reported that there was a programme of upgrades scheduled to improve the IT across the trust, and that IT was one of the trust's top risks.
- Access to all information systems was undertaken through the use of NHS smart cards. This enabled staff access to online systems, which included pathology and radiology.
- Patients' records were in paper format and were stored in a locked trolley.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient's consent was obtained in line with hospital policy and statutory requirements.
- Nursing and medical staff within the department had a clear understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). This was a significant improvement since the last inspection.
- We observed the department used a triplicate book to complete mental capacity assessments and place the assessment in the patient records. The service kept a copy with the patient's details for the purpose of monitoring. The system enabled the service to know who had a mental capacity assessment and when it was issued, which was effective.
- The knowledge regarding the understanding of the Deprivation of Liberty Safeguards (DoLS) was varied throughout the department. In the majority staff understood the DoLS requirement, meaning and when it would be needed. However, two staff members were

not clear on the meaning of DoLS. One nurse on the clinical decisions unit (CDU) thought a completed dementia assessment was the DoLS.
- Staff training rates for all staff in the department was 89% for Dementia and 85% for MCA & DoLS.
- Staff in the children's department were asked about assessing children as 'Gillick competent'. The staff we spoke with (two nurses and one doctor) were clear when this framework would be used.
- All patients who arrived in the department who were over the age of 65 years should have had dementia screening undertaken as part of good practice. The department undertook screening for over 65 years for dementia routinely.
- We observed staff explain what they were going to do, prior to any procedure taking place and asking for the patient's consent before they proceeded.

Are urgent & emergency services caring?

Good

We rated caring as good because:

- The feedback received from the patients and relatives we spoke with was positive.
- The friends and family test results were consistently above the England average.
- We observed positive and caring interactions between staff and patients throughout the inspection. Staff were observed to use the 'hello my name is' approach to patients, and were polite and kind.
- Nursing staff felt cared for and well supported at times when emotional support was required.

However:

- Whilst the majority of medical staff spoken with felt cared for and supported by the department, two doctors raised concerns about how supportive the environment was to care for doctors.
- The FFT response rate for emergency department is 3.4% against a target of 20%.

Compassionate care

- We spoke to nine patients and two relatives during this inspection in the adult department. We also spoke with two parents in the children's emergency department.
- All we spoke with provided positive comments about the service including, "They are very kind", "I have no complaints", and "They do a good job".
- Throughout the inspection, we observed examples of care where doctors and nurses were kind and compassionate towards patients and treated them with dignity.
- We observed several examples of staff asking for the patient's consent prior to entering their cubicle area, respecting their dignity. The department staff adopted the use of the "Hello, my name is" approach when introducing themselves to patients.
- The trust's Urgent and Emergency Care Friends and Family Test performance (percentage recommended) was generally better than the England average between June 2016 and May 2017. In the latest period, May 2017 trust performance was 92.8% compared to an England average of 86%.
- The FFT response rate for emergency department is 3.4% against a target of 20%.
- We observed outstanding care interactions provided by staff to children in the emergency department and in the children's observation bay. The interactions between the staff and the children was kind, compassionate and provided in a way that they understood. This

calm approach also applied to the parents who were also calm as a result of their children being calm.

Understanding and involvement of patients and those close to them

- During our inspection the department was quiet with low attendance numbers. We spoke with nine patients and two relatives regarding care. The patients that were in the department we spoke with reported no concerns. All felt that they were being kept informed and updated by staff on what was happening, and what they should expect regarding their or their relatives care.
- The complaints received by the service showed a trend of complaints regarding communication. Some of these linked to communication about progress with care and when patients would move through to a ward. The concerns also linked to care in the corridor area and the communication around what would happen next in some cases. This was not possible to assess on the inspection as there were few delays with flow during the inspection and the corridor area was not used.
- The trust scored “better than” other trusts for five of the 35 A&E Survey (2014) questions. The trust scored “about the same” as other trusts for the remaining 30 questions. The trust scored better than other trusts for reassurance when distressed and for feeling reassured by staff if distressed while in A&E.
- The trust also scored “better than” other trusts for the assessment of living and support arrangement, and for feeling staff considered their family and home situation before they left A&E.

Emotional support

- Clinical nurse specialists were available to provide support to patients in the department and we observed the nurse specialists for patients living with dementia and diabetes attend the department at the request of staff. These staff supported the care of the patients who required specialist support.
- Counselling services were available through the local mental health trust.
- The staff had debriefs and huddles where there were difficult or emotionally challenging cases that could affect staff.
- We spoke with five doctors and three nurses about caring for staff. The nursing staff reported that the nursing team were a family, and all rallied to each other to provide support.
- Of the five doctors we spoke with regarding care for staff, two reported that they did not always feel supported when needed by the senior staff in the department. This affected how well cared for they felt by the service.
- Patients and staff had access to the chaplaincy service who offered support to patients and staff seven days per week. In addition, there were multi-faith options available and non-religious ministers who also supported the department.

Are urgent & emergency services responsive?

Inadequate

We rated responsive as inadequate because:

- The percentage of patients leaving the department before being seen was higher, at 5%, than the England average of 3%
- On average between July 2016 and June 2017, 65-78% of ambulances that attended the emergency department (ED) experienced delays of more than 30 minutes to offload a patient.

- Between July 2016 and June 2017 the trust reported 3211 “black breaches”. This was worse than the previous year.
- The trust had not had any patients waiting on trolleys for more than 12 hours. However the number of patients observed to be in the department for more than 12 hours, who were admitted by waiting on an inpatient bed was high.
- Flow through the hospital was challenged as there were limited beds available in the hospital. This meant that flow through the department was impeded.
- The service was observed to be focusing on trying to prevent new breaches, which meant that those who had been waiting in the department or CDU for a longer period of time were not being prioritised for beds in specialty areas.
- Not meeting the four hour standard had been normalised within the service. The performance against the four hour standard was consistently lower than the England average with performance on average between 75% and 88%
- Between June 2016 and May 2017 the trust monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average.
- Complaints were investigated and responded to in line with trust policy. However learning and outcomes from complaints were not always effectively implemented to improve care.

However:

- Staff in both children’s and adult areas had received training in understanding learning disabilities and patients with complex needs.
- Training was provided in dementia awareness, and staff knowledge of dementia and how to support a patient was much improved.
- Food and drink was available to those who were in the department for any length of time.
- There were a number of outstanding innovations in the children’s emergency department to support the needs of parents, children and younger people. This included support from voluntary groups charities and volunteers to tackle important issues such as mental health and suicide awareness.
- The children’s department had a range of distraction methods and sensory items to support children’s individual needs whilst they had treatment. Children could watch films, play with toys or play on a games system during their time in the department.

Service planning and delivery to meet the needs of local people

- The department was originally built to deal with 30,000 patients per year and now sees in excess of 88,000 per year. There were plans in place to increase the layout and foot print of the department to accommodate the increase in attendances. The work was scheduled to commence in September 2017.
- The waiting area for the department was small. The original waiting room was built to accommodate a smaller number of attendances. This meant that there were times where it was standing room only in the waiting room during busy times.
- The waiting area was also affected by its proximity to the fracture service which was next door. During busy periods patients attending this service would sometimes use the seats in the emergency department when no seats were available in the x-ray area. The trust had recognised the lack of space for patients to sit as an issue and there were clear plans to increase this space as part of the redevelopment of the department.
- The redevelopment of the emergency department was planned in part to reduce the number of patients that would need to be boarded in other areas of the department such as the corridor areas. It was recognised by the trust that there had been a historic under

investment in the development and expansion of the service and were working to address this.
- The department had undergone changes to accommodate service users since the last inspection. The clinical decisions unit (CDU) had been moved to another area to accommodate the higher rates of attendances by ambulance. This area was developed into the 'STARR' zone. This increased the assessment and treatment areas for patients from two to eight cubicles.
- There were agreements in place to work cohesively with other trusts to ensure responsive care. This included a London trauma trust, and the mental health trust.

Meeting people's individual needs

- Staff took account the needs of different patients including those in vulnerable circumstances.
- Food and drink was available to those who were in the department for any length of time. There were regular time slots for care 'rounding' which included offering patients drinks.
- Food and drink was also available to relatives who were waiting in the department.
- Since the last inspection the service had amended the processes for patients to access food and drinks. The service had a dedicated house keeper, who would undertake regular rounds of the department offering food and drink to patients.
- In the CQC A&E Survey 2014, the trust scored 7.32 out of 10 for the question "Were you able to get suitable food or drinks when you were in the A&E Department?" This was about the same as than other trusts.
- There was an improved level of awareness in the department for meeting the needs of patients with dementia, learning disabilities and complex needs. Staff had received awareness training to support the needs of these patients.
- In the event a patient with known learning disabilities attended the department, the service contacted the learning disabilities specialist nurse. The service ensured there were 'flags' where possible on the patient's records to enable early identification of the support needs required.
- Within the children's emergency department the service had undertaken an extensive amount of work to improve the care and support available to patients and their parents. The range of support options available was impressive.
- The service worked with a volunteer network of parents who provided voluntary support to parents of children in the department. This service enabled parents who had gone through difficult or challenging times to support others with similar experiences. This service also afforded the opportunity to see what a care environment was like to work in, and if they chose to the volunteers would be supported to go through training in skills for care to work formally as an employee of the service.
- The children's emergency department also worked with a youth organisation which brought youths into the hospital to speak with young people about matters they might require support with such as sexual health awareness, cyber bullying, and mental health awareness.
- The service also worked with another charity which supported suicide awareness and mental health awareness discussions amongst young people in crisis to support them through difficult times.
- Patients had access to leaflets in the waiting area providing information on a variety of health conditions. Further leaflets in other languages were also available.
- Leaflets were available for children and adults in the children's emergency department. Information for children was provided in an easy read format to help them understand their condition.
- Staff had access to translation services, via a telephone service, when there was a need to communicate with a patient whose first language was not English.

Access and flow

- Nationally it is recommended that 95% of patients are admitted, transferred or discharged within four hours. Between June 2016 and May 2017 performance for Watford General Hospital was varied. For the majority of the year the trust performed about the same as other trusts in England on performance, the trust showed particularly poor performance between January and April 2017 with results as low as 75%. They had improved slightly to an average of 81% between April and August 2017.
- Between June 2016 and May 2017 the percentage of patients in the department for more than four hours waiting to be seen was consistently higher than the average. On average between 18% and 39% of patients waited for more than four hours for treatment.
- The flow through the hospital remained challenging with bed occupancy routinely above 90%. On the days of our inspection we observed that all breaches of the four hour guideline were due to beds not being available within the hospital or the breaches were for clinical reasons. A clinical breach is where a patient is not well enough to move and it is in the interest of their safety to stay closely monitored in the department until it is safe to move them to another area.
- On review of the breach data information provided for September 2016 and July 2017 there remains a concern with how responsive the emergency department is to moving patients through in a timely way. On average 50% of all breaches recorded are linked to beds and 50% to emergency department performance.
- The clinical decisions unit (CDU) was affected by the challenging flow in the hospital. The CDU policy is that admissions should be for no more than 24 hours. However, during the inspection the longest patient in the CDU was 72 hours.
- The trust was very focused on trying to achieve the four hour performance objective during the inspection, and this compromised of patients who had been in the department for a longer period of time. For example, a patient whose time was approaching four hours would have been moved before a patient who has been in the CDU for more than 24 hours. We also observed a tolerated approach to breaches.
- We observed some staff very focused and dedicated to improving flow through the department, and we observed some staff who did not try and drive improved flow and this meant that breaches occurred more frequently. For example, there was a patient in the resuscitation area of the department who had been in this zone for four hours without a plan of care fully established. This patient could have had a plan of care created to provide care in a more timely way, and also preventing the breach of the four hours.
- The median total time in emergency department per patient averaged around 150 minutes consistently between May 2016 and June 2017. This was similar to the England average.
- On average between July 2016 and June 2017, 65-78% of ambulances that attended the emergency department experienced delays of more than 30 minutes to offload a patient.
- Between July 2016 and June 2017 there was a downward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In July 2016, 82% of ambulance journeys had turnaround times over 30 minutes; in June 2017 the figure was 57%. From July 2016 to January 2017 turnaround times was consistently between 76% and 82%. However performance between February and June 2017 was between 57% and 66%.
- Between July 2016 and June 2017 the trust reported 3211 “black breaches”. A ‘black breach’ occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. There was a downward trend in the monthly number of “black breaches” reported over the period. The trust reported an average of 267 “black breaches” per month. From January to April 2017, higher than average numbers were consistently reported. Performance improved in May and June 2017 when 130 and 77 “black breaches” were reported respectively.

- The trust informed us that there was a cross organisational improvement plan in place. Work was also on going to ensure that conveyances were 'clicked off' the electronic system in a timely and accurate way. The electronic system required a staff member to click a button when the patient was in the care of the department releasing the ambulance crew back to work.
- The department had four distinct zones called minors, majors, resuscitation and STARR. Each zone was led by a clinical decision maker and a lead nurse. The leads would then communicate with the overall lead nurse for the department regarding the needs of their areas. This new set up enabled full oversight of all areas and patients in the department, which was a significant improvement.
- At the last inspection, the minors area of the department struggled to achieve the four hour standard to admit, transfer or discharge 95% of patients within four hours of arrival at ED. This area of the service was nurse led, a change from the previous inspection, with emergency nurse practitioners and associate nurse practitioners leading the service. Since this change the flow of patients through this service has improved, and linked to a small improvement in the four hour performance.
- The trust informed us that they had not had any 12 hour breaches. They defined this as patients who had been waiting on a trolley for treatment for more than 12 hours. The trust had not had any patients waiting on trolleys for more than 12 hours. However, the number of patients observed to be in the department for more than 12 hours, who were admitted by waiting on an inpatient bed in the department, was higher than we would have expected it to be. For example, on the three days we were on site there were 16 patients in the department for more than 12 hours.
- Between June 2016 and May 2017 the trust monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average. Between June 2016 and May 2017 performance against this metric showed a trend similar to the England average however, the percentage of patients waiting was consistently higher than the average in particular between January and April 2017.
- We observed four operational bed meetings during the inspection. During these meetings, flow, capacity, staffing concerns and operational challenges for escalation are discussed. At each meeting the emergency department was discussed, and concerns were escalated to the team by a representative of the department. This was responded to well by the attendees who offered support to the emergency department to help improve flow or provide staff where required.
- Between April 2016 and March 2017 the monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was worse than to the England average of 3% with an average of 5%. Performance against this metric showed an overall trend of improvement however showed July 2016 as the worst performing month at almost 8%.
- The fracture neck of femur pathway between the emergency department and the orthopaedic service was managed by the orthopaedic service and was commenced following a review by an orthopaedic consultant. Whilst there was meant to be dedicated, ring fenced beds in the hospital, to support fast treatment of patients with a fractured neck of femur. However due to capacity this was not always the case.

Learning from complaints and concerns

- Between July 2016 and July 2017, there were 70 complaints about urgent and emergency care services. The trust took an average of 71 working days to investigate and close complaints; there were 18 open complaints at the time of the inspection. This was not in line with trust policy and was not responsive to patient concerns.
- There were thematic trends with complaints in respect of clinical treatment,

communication, staff attitude and use of the corridor area. Whilst the service was responding to the complaints we were not assured that the service was learning from complaints. For example, the service received several complaints over the last two years in respect of patients being communicated to about what is happening when they spend long periods of time in the department. There were no plans or changes implemented to learn from this trend and improve communication on length of stay to patients.

Are urgent & emergency services well-led?

Inadequate

We rated well-led as inadequate because:

- There were differences in opinions between the leaders within the service causing this dysfunctionality and it meant that the directorate leaders relationships in some cases had broken down. Concerns were raised throughout the inspection regarding the leadership of the service.
- We were not assured that all incidents within the department were being reported, or were not being reported in a timely way.
- The culture within the department had not improved to a sufficient level since our last inspection. Several staff formally raised concerns to us regarding the ongoing poor culture within the service. The concerns with this culture had not yet been adequately addressed by the trust. This lowered staff morale.
- We observed some poor behaviours exhibited by staff during the inspection. This did not demonstrate professional behaviour expected of staff.
- The children's emergency department was not clearly included in the vision, strategy or direction for either responsible division. The department was not part of an integrated governance approach to ensure all aspects of the service were included between the two responsible directorates.
- We were not assured that all risks were being adequately identified, placed on the risk register and escalated accordingly. For example, the addition of zones in the department created a number of risks for the service. However, there was no formal risk assessment on the impact upon staffing with the arranging of zones in the department.

However:

- Staff were aware of the core values of the organisation and could articulate these to us.
- The leadership, culture and staff satisfaction within the children's emergency department was very positive. The local leadership team of the children's emergency department demonstrated good leadership for the service.
- Whilst a poor culture was noted, which linked predominantly to the medical staff, the nursing staff had undertaken a lot of work to drive improvement with the nursing voice and culture amongst nursing staff.
- Staff engagement has improved since the last inspection.

Leadership of service

- The emergency department was part of the unscheduled care directorate. The unscheduled care directorate was led by a divisional director, divisional head nurse and divisional manager.
- At the last inspection the unscheduled care directorate was newly formed and staff were settling into their roles. At this inspection we found the directorate leadership to be dysfunctional. There were differences in opinions between the leaders within the service causing this dysfunctionality and it meant that the directorate leaders relationships in some cases had broken down. These challenges were impacting on the effective leadership of the directorate.

- Locally within the emergency department the service was led by a clinical director and a matron. These leads were also responsible for the urgent care centre and minor injuries unit.
- There was no operational or general management function within the structure of unscheduled care. This meant there was limited operational management oversight of Watford General Hospital, the minor injuries service and urgent care centre. The service leads informed us that this was a recognised shortfall and there were plans to advertise the role for an appointment by December 2017. The lack of a support management function in the service was challenging the speed of change implementation.
- The matron was recognised as the nursing leader within the department; staff spoke highly of the matron and felt supported by them. However the matron's role covered all three sites where emergency care was provided and meant their leadership was very stretched. Whilst the matron was good at their role the scope of their role was vast and meant that the trust should consider the remit of leadership for the Matron and ensure they were well supported to deliver their role.
- The shortage of medical staff also meant that there were times where there was not a senior medical staff member leading one of the 'zones'. Whilst there was a consultant in charge of the entire department, there was a risk that not having a senior clinician in charge of each area could leave patients at risk of harm.
- The band six and seven tier of nurses had not received any leadership development and management training in organising shifts at a senior nursing level. This was an area of development for all middle management and was a recognised risk for the trust.
- The introduction of zones within the department meant that there was a clinical leader and nurse lead for each area, which was an improvement in the leadership structure since the last inspection. However it was recognised that this was challenged with skill mix to ensure the right level of leaders were on duty due to staffing challenges.
- The zone model was relatively new and still being embedded, and improving the communication was a learning point the service was working to improve leadership communication.

Vision and strategy for this service

- The unscheduled care directorate had a clear vision and strategy for the improvement of emergency care within the trust. This was a new development since the last inspection and was displayed in the service.
- The vision for the service was to reorganise the roles, redevelop the buildings and provide improved quality of care through a stable leadership team. All the leaders of the service we spoke with were able to clearly articulate this vision.
- It was unclear in the vision and strategy for unscheduled care where the children's emergency department sat. The children's emergency department was also not a clear part of the women's and children's division vision and strategy. This is a joint service between the two divisions, however there was a lack of integrated vision and strategy between the two divisions to support the service's future strategy.
- Staff were aware of the core values of the organisation and could tell us about these. Staff, when spoken to were more engaged in the values and could articulate examples of what they had done in the service to demonstrate them. Staff were aware of the vision of the trust and the changes that were likely to take place following a change in the executive team.

Governance, risk management and quality measurement

- The department had a risk register, which was part of the unscheduled care directorate. At the last inspection, the identification of risk was a concern and departmental risks were not

reflected on the register. At this inspection, we found that there were 11 items on the register for the unscheduled care directorate, of which five related the emergency department.

- We met with the leaders of the emergency department who could tell us what the risks were for the service. The risk register had been improved since the last inspection. The risks were discussed at twice monthly risk meetings between the senior managers. The risks were appropriately graded and monitored.
- However some of the controls listed did not provide assurances that the risk would reduce. For example there was a risk on the register associated with poor patient flow affecting patient experience and leading potentially to poor clinical outcomes. The assurances include a weekly divisional management team meeting, which was not minuted, review of risks and incidents and performance reviews. There was no assurance process for the auditing of clinical outcomes on specific pathway to demonstrate the level of impact, cause of impact and no method of adequately identifying how to effectively manage this risk.
- We were not assured that all risks were being adequately identified, placed on the risk register and escalated accordingly. For example, the addition of zones in the department created a number of risks for the service. However, there was no formal risk assessment on the impact upon staffing with the arranging of zones in the department. This risk should have been identified, managed and added to the risk register for monitoring at local and trust level.
- We asked to see the risk register in use for the service through two different meetings. Both registers we were shown were different to the one supplied through our original data request. Whilst the divisional leaders were clear on which register is used, it was not clear for others in the division with a governance and risk responsibility.
- The risks associated with the children's emergency department were not on the unscheduled care risk register. There was a risk regarding the security of the children's emergency department. The children's emergency department was operated between the unscheduled care and women's and children's directorate, yet the risk only appeared on one risk register for the women's and children's directorate.We were not assured that the service was reporting all incidents when they happened. During our inspection, we were informed of incidents where the department had raised them informally but not reported them using the incident reporting system. These were mostly related to staffing concerns within the department. However, it was acknowledged that whilst the trust's reporting system could be used as appropriate to report incidents relating to staffing, shortfalls in staffing were discussed as part of operational meetings. Staff levels in all areas including ED were reviewed by the heads of nursing, matrons and overseen by the chief nurse or one of her deputies. Where there were any red or amber rated areas, staff were redeployed to ensure safety of all areas. A daily update was sent out to the organisation detailing staffing status across the trust, this was reviewed several times a day.
- There was no formal process for the reporting of the children's emergency department, and what integrated governance processes should be followed to assure good governance of the service. Work was needed to establish a clear integrated governance system for the children's emergency department to ensure effective reporting.

Culture within the service

- During our last inspection a number of concerns were identified with the culture of the medical staff in the department, and their working relationships with the nurses.
- At this inspection we found the culture of the nursing staff to have improved. Nurses had taken control of the leadership of the department and were now leading each shift. The role of the 'controller' consultant was no longer in use.
- However the culture amongst the medical staff remained a significant concern. During the course of the inspection seven staff approached us to raise concerns about the culture

within the service, specifically in relation to the medical staff and how this was impacting on the safe running of the service.

- We were shown examples of messages that staff had sent to the clinical leads about safety concerns in the department, and the responses they received back were dismissive and not supportive of the concerns.
- We were made aware of concerns regarding some medical staff not working the hours required of their shift, and adopting poor behaviours on shifts. This was a recognised concern by the trust and the chief executive acknowledged that further and swifter action was needed to manage and resolve this.
- When we spoke with the nursing staff about their relationship with the medical staff they were all aware that the service knew it needed to change things, but felt that the service had a long way to go to resolve the culture concerns and challenging behaviour.
- We asked what actions had been taken since our last inspection to improve the culture and behaviour of the medical staff, and their relationship with the nursing staff. We were informed that a diagnostic approach had been taken to understand the issues, which consisted of meetings and away days with the teams. The outcome of this showed the same concerns as highlighted by the last CQC inspection report and the NHS Staff survey.
- Through our inspection we established that the service had only progressed to trying to understand the issues related to culture, however no tangible actions had been taken to improve the problems.
- The problems identified with culture during the last inspection remained at this inspection. We observed some poor behaviours from the medical staff that were not an acceptable standard for senior clinicians. This was supported by evidence provided to us by medical staff that showed a lack of support, openness, and willingness to act in response to concerns.
- The culture regarding Duty of Candour was positive, and being open meetings were taking place where required after incidents. Where an incident met the requirement of the Duty of Candour we saw evidence that the regulatory requirements of these were met. Staff we spoke with about Duty of Candour also understood its meaning.
- Overall the 2017 GMC trainee survey showed that of the 17 overall questions that the since 2016 seven questions had improved, seven had worsened and three results were not counted as they were new to this year's survey.
- GMC 2017 trainee survey showed the following results: overall satisfaction rate (75.7%), clinical supervision (82.4%), clinical supervision out of hours (77.2%), systems (68.7%), workload (25%), local teaching (59.1%), supportive environment (67%), handover (68.8%), study leave (36.8%).
- The trust performed better than other trusts in nine questions, about the same as other trusts in nine questions and worse than other trusts in nine questions.
- The engagement score for this trust was 3.78, which is about the in the bottom 20% of trusts.

Public engagement

- The range of engagement and support options available through the children's emergency department was outstanding. The service worked with a volunteer network of parents who provided voluntary support to parents of children in the department. The department also worked with a youth organisation which brings youths into the hospital to speak with young people about matters they might require support with such as sexual health awareness, cyber bullying, mental health and suicide awareness.
- The department sought comments from the patients. They were engaged through feedback forms, comment cards, the friends and family test.
- Posters were displayed throughout the department asking for their comments in an effort to improve the service.

Staff engagement

- There were regular staff meetings held, which was an improvement since the last inspection. There had been a number of open door sessions and staff meetings, as well as away days to engage the staff in the development of the service. We were informed that the service has been able to meet with more than 150 staff using these processes.

Innovation, improvement and sustainability

- On the sixth day of each month the department held a sepsis day called ‘sepsis 6th’ which consists of quizzes, data, presentations and facts shared around the trust to increase awareness. The trust is also making a video for training purposes featuring two relatives who have personally been touched with sepsis to relate the human factors.
- The paediatric emergency team submitted an abstract about the sepsis screening project in the Trust which was accepted for a poster presentation at the RCPCH Annual Conference later this year.

Medical care (including older people's care)

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

Information about the service

The medical care services at West Hertfordshire Hospitals NHS Trust provide care and treatment for general medicine, geriatric medicine, cardiology, endocrinology, gastroenterology, endoscopy, stroke medicine, respiratory medicine, dietetics, pathology, clinical haematology and physiotherapy.

At Watford General Hospital, there are 407 medical beds located within 30 wards. The medical care service also provides endoscopy services at Hemel Hempstead hospital. The service had 44,546 admissions from February 2016 to January 2017. Emergency admissions accounted for 25.340 (57%), 771 (2%) were elective and the remaining 18,435 (41%) were day cases. The top three specialities were general medicine (19,417), gastroenterology (9,785) and clinical haematology (3,584).

The medical services structure included a divisional director, a divisional manager, and clinical leads for speciality services for example; respiratory, dermatology and diabetes/endocrinology. Medical services are split into two groups, unscheduled care and scheduled care. Unscheduled care consists of all admission areas such as the acute admissions unit, coronary care unit and ambulatory care and scheduled care consists of all speciality inpatient wards.

The service was previously inspected in September 2016 and required improvement for safe and responsive, but was good for effective, caring and well-led.

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

- Acute Admission Unit (AAU) which is on three levels
    - Four wards on level 1 (blue, yellow green and purple) which have 15 beds each. These wards are run by acute physicians and where GP patients are reviewed on call
    - Cardiac catheterisation laboratory (Cath lab) on level 2
    - Four wards on level 3; blue and yellow are both care of the elderly ward, while green and purple are cardiology wards. Attached to the cardiology wards is a six bedded isolation ward.
- Aldenham ward - respiratory medicine
- Ambulatory Care
- Bluebell ward – a 16-bedded ward for patients with cognitive impairment and challenging behaviour.
- Cassio ward- gastroenterology
- Coronary Care
- Croxley ward- care of elderly

- Elizabeth ward - gynaecology
- Endoscopy Unit- Watford General Hospital and Hemel Hempstead Hospital
- Frailty unit (Windsor suite)
- Gade ward – rheumatology and haematology
- Helen Donald Unit - haematology day case and chemotherapy unit
- Heronsgate ward - endocrine
- Letchmore ward - surgical ward
- Oxhey ward – a 11 bedded care of the elderly ward
- Red suite – a 18 bedded acute medical ward (72 hour admissions)
- Stroke Unit
- Sarratt ward – a 36 bedded care of the elderly ward
- Tudor ward – delayed transfer of care
- Winyard ward – a 18 bedded care of the elderly ward which included patients with delirium.

We spoke with 58 members of staff including nurses, doctors, pharmacists, therapists, administrators, and housekeepers. We spoke with 12 patients and staff, considered the environment and looked at 42 care records. We also reviewed the trust's medical performance data.

Summary of findings

We rated this service as requires improvement because:

- The service was found to be in breach of Regulation 10; Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, due to patients not always being segregated from members of the opposite sex.
- The service was found to be in breach of Regulation 10; Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, due to personal identifiable information being on display on wards and patient sensitive information being discussed within earshot of non-authorised persons.
- The service was found to be in breach of Regulation 12; Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, due to inconsistent risk assessment and reassessment of venous thromboembolism medicine risks.
- The service was found to be in breach of Regulation 12; Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, due to antibiotic regimes not consistently being assessed after 48 hours of initial treatment.
- The service was found to be in breach of Regulation 12; Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, due to a registered nurse not always delivering care and treatment in the deep vein thrombosis clinic.
- There was variable compliance with infection control and prevention practices, with staff not consistently washing their hands at the appropriate points, or using hand sanitiser when exiting or entering clinical areas.
- The service was found to be in breach of Regulation 17; Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to nursing risk assessments not always being fully completed and patient information boards being openly displayed and discussed in sight or earshot of non-authorised persons. This meant that confidential information could be viewed or overheard.
- Flow through the hospital did not appear to always be managed effectively, with escalation areas used frequently, limiting services available and impacting patient

journey.
- Clinical specialities did not always meet the national average referral to treatment times.
- Flood and fluid charts were not always completed as details of total input and output were missing.

However:
- The service shared details of incidents and used these to identify any learning, sharing information across the service, through local team meetings, peer support meetings and formal mortality review meetings.
- Safety thermometer data was used to identify areas for improvement and changed the way in which the service provided targeted training.
- Personal protective equipment was used by staff appropriately.
- Equipment used across all clinical areas was clean and ready for use. There was an adequate supply for the management of patient care and welfare.
- Patients nursing and medical notes were stored securely and information was contemporaneous and accurately reflected patient care.
- Staff mandatory training was collectively above the trust target of 90%.
- There were processes in place to escalate patients appropriately when their clinical condition changed or deteriorated. There were support networks in place to provide support out of hours.
- The service ensured adequate staffing levels. Locum doctors and agency nursing staff supplemented staffing numbers and integrated into the trust using generic templates and checklists.
- Some staff had completed a training exercise in line with the major incident policy.
- National guidance and protocols to manage patient care and treatments were reflected in service policy and procedures.
- Patients' pain and nutritional needs were well managed.
- The service had achieved the highest rating for the Sentinel Stroke National Audit Programme (SSNAP) for one year.
- The Hospital Standardised Mortality Ratio (HSMR) for the twelve-month period from January 2016 to December 2016 the HSMR was better than expected at a value of 93 compared to 100 for England.
- For the twelve-month period from January 2016 to December 2016, the Summary Hospital-level Mortality Indicator (SHMI) was lower than expected at a value of 90 compared to 100 for England.
- Staff training was inclusive of all staff working across the service and focused on staff development and patient safety. Internal and external courses were readily available to all staff.
- Multidisciplinary team working was inclusive of all professions and patient centred.
- The medical service provided over seven days, with some services such as dietetics and clinical investigations requiring a referral out of hours or at weekend.
- There was a clear process in place for the completion of mental capacity assessments and Deprivation of Liberty Safeguards (DoLS) referrals with alignment to specific issues and detail.
- All staff treated patients with respect and in a considerate manner. Discussions were open and inclusive. Patients and their relatives were included in decision making about treatment and care.
- Patients and their relatives felt that they were involved with care and treatment plans.
- The medical division was involved with trust wide development plans to realign services to other clinical areas.
- Staff were aware of their roles in line with the trust escalation plan.

- The service had reduced the number of inpatient moves since our last inspection.
- Staff were able to access services to ensure patients with specialist needs were addressed. This included interpreters, patient advocates, specialist equipment such as pressure relieving mattresses and patient passports/ “This is Me” to inform care.
- Complaints were managed effectively with responses made to complainants in a timely manner and in line with trust policy.
- There was clear leadership across the speciality.
- Local managers were enthusiastic about improving their ward, team and sharing knowledge.
- Team and clinical leads were accessible and respected by all staff.
- Staff were aware of the trust’s vision and aims.
- Staff were committed to the trust and had pride in their role.
- Locum staff were included in all activities and felt valued and supported.

Are medical care services safe?

Requires improvement

We rated safe as requires improvement because:

- We found inconsistent patient risk assessments on admission and the reassessment after 24 hours of venous thromboembolism (VTE). This was a breach of Regulation 12; Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Treatment room temperatures were elevated above the recommended temperature range. Staff were not able to assure us that medicines were safe to use. This was in breach of Regulation 12; Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- We found inconsistencies in the review of intravenous antibiotics after the initial 48 hours of administration as per guidance.
- We saw variable compliance with handwashing or sanitising by staff across all clinical areas. This included some staff not washing their hands after the use of personal protective equipment following direct patient care and not using had sanitiser when entering or exiting a ward.

However:

- There were processes in place to enable staff to share learning from incidents, which included simulation exercises, discussion at team meetings and feedback through peer support and mortality groups.
- Collected safety thermometer data identified areas for improvement. The service implemented snapshot training to key areas to improve practice and results.
- The service maintained all equipment used across all clinical areas which was clean and ready for use. There was an adequate supply of equipment that assisted to ensure the management of patient care and welfare.
- Patients nursing and medical notes were stored securely. Information was contemporaneous and accurately reflected patient care.
- Collectively, mandatory training figures showed compliance over the trust target of 90%, although details from some areas showed that compliance was just below the target of 90%.
- The service ensured adequate staffing levels despite challenges to recruitment to maintain patient safety. Locum doctors and agency nursing staff supplemented staffing numbers and integrated into the trust using generic templates and checklists.

Incidents

- The medicine service had systems in place to maintain patient safety, which included an electronic system for recording and monitoring incidents. Staff were aware of their roles and responsibilities in the reporting of incidents both internally and externally.
- One never event was reported between June 2016 and June 2017 in April 2017. Never events are serious incidents that are wholly preventable as guidance, or safety recommendations that provide strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. The never event referred to a medication error which upon investigation had not been administered. We were told that the incident had been shared across the trust and we saw that staff were familiar with the event and the learning.
- The trust medicine service reported 2582 incidents from June 2016 to June 2017 through the National Reporting and Learning System (NRLS). NRLS is a central database of patient safety incident reports. The incidents were RAG (red, amber, green) rated and the records showed that 848 (33%) relating to patient accident were rated red. A number of incidents were rated amber which included, 252 (10%) for medicine, 240 (9%) relating to the implementation of care and ongoing monitoring/review and 233 (9%) for infection control. We saw evidence that incidents were investigated locally and findings shared with staff through team meetings and communication books. Staff confirmed that the service shared learning across all staff groups through individual feedback, team meetings or newsletters.
- Strategic Executive Information System (STEIS) data showed that between June 2016 and June 2017 there were 24 serious incidents at Watford General Hospital requiring investigation. This was a significant increase from the previous inspection data, which reported 12 serious incidents between July 2015 and June 2016. Nineteen of the current serious incidents referred to hospital acquired pressure ulcers, above grade 2. Pressure ulcers affect an area of skin and underlying tissue and are categorised according to severity from one to four. For example, category one identifies the discolouration of skin, with category four being full thickness skin loss with underlying damage to muscle, bone or tendons. To help reduce the number of hospital acquired pressure ulcers the trust had implemented an increased awareness programme, which included improved staff alertness of risks and actions that could be taken to reduce harm.
- The quality account 2016/17 states the trust have done the following regarding pressure ulcer care which was confirmed during our inspection;
    - Ward based training introduced in pressure area care
    - Mr B Harm-free – a doll used as a symbolic patient representing harm free care – used for training and promotional activity with staff
    - Daily safety huddle to discuss pressure area care on each ward
- Staff described their responsibilities regarding the duty of candour requirements. They informed patients when things went wrong, were open and transparent relating to all incidents. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients(or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour policy for the trust was available on the trust's intranet system. We saw the meeting minutes (March 2017) for cardiology where duty of candour and the handling and learning from incidents were presented to staff. We also saw posters across the service reminding staff of their role under the duty of candour.
- We saw that incident investigations included information on duty of candour and showed details of communication with patients and their families when something went wrong. We also saw that apologies were made when necessary.
- The safety and quality committee meeting minutes for February 2017 identified that all patients had been assessed to ensure that the duty of candour process had been applied appropriately.

- The medicine service participated in the multidisciplinary mortality review meetings, we saw minutes from the February and April 2017 meetings. The mortality group reviewed all individual cases and uploaded review documents to the trust's electronic system. However, the data provided from January 2017 to May 2017 identified that of the 297 deaths recorded within the care of the elderly division only 48% had a completed form. We saw the action from the February 2017 meeting minutes, which included the random sampling of notes against the data, entered onto the trust's system.

Safety thermometer

- The wards visited displayed monthly data collected which staff confirmed they used to make improvements to patient care. Examples of data collected included; pressure ulcers, falls and catheter associated urinary tract infections and blood clots (venous thromboembolism or VTE).
- We saw that most patients were assessed on admission for the risk of venous thromboembolism (VTE) as required, however the repeat assessment after 24 hours was not always completed. This is in breach of Regulation 12; Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We saw that 16 out of the 20 VTE assessments that we saw, had not been completed after 24 hours of admission.
- The trust has created the 'stop the pressure' improvement plan for 2017/18 whose aim was to obtain a target of zero grade four and grade three avoidable pressure ulcers and a 50% reduction in grade two pressure ulcers. The NHS safety thermometer data showed the medical service reported 38 pressure ulcers (category two to four) from June 2016 to June 2017.
- We saw that the service had introduced short training sessions on pressure area care, catheter infections and falls. The training was completed by either the clinical specialist, such as tissue viability nurse or the ward manager, and was completed either at board rounds or nursing handover. The idea was to promote awareness and preventative action.
- The NHS safety thermometer identified eight falls (harm levels three to six) and 16 urinary tract infections (UTI) (level 3 only) from May 2016 to May 2017. The falls prevention data continued to be below the national average baseline of 0.49 (March 2017) at 0.32 while the UTIs had improved from the baseline of 25 to 22 for 2016/17.
- The serious incident panel and the ward scorecards reviewed all falls if harm had occurred. As a result, the trust developed the "FALLSTOP" campaign and care pack, which staff used. FALLSTOP is a campaign, which aims to "raise awareness of the common causes of trips and falls, and what you can do to stop them from happening". Wards demonstrating falls with harm or high numbers of falls, present their findings at the falls steering group. This ensured that all staff understood the causes while sharing lessons learnt.

Cleanliness, infection control and hygiene

- The trust had an Infection Prevention and Control Annual Plan 2016 -2017 to ensure it complied with the Health and Social Care Act 2008 (DH 2015). The purpose of the infection prevention and control (IPC) annual plan is to set out the activities the divisions, including the medical division needs to do to ensure that safe quality care is provided. It also provides assurance to the board that the programme of work if delivered would minimise any risks.
- We saw that staff wore appropriate personal protective equipment (PPE) when conducting personal patient tasks such as assisting them to wash or readjust their positions. However, we did not see consistent handwashing at the point of contact. For example, staff should wash their hands after removal of gloves and apron following personal care.
- The trust's target for MRSA bacteraemia was zero avoidable cases. MRSA bacteraemia is an MRSA infection of the bloodstream, which can be serious. From September 2016 to May 2017, there had been one case of MRSA reported. The hospital completed a post infection

review, which involved the patient's care pathway in respect of the identified case. During our inspection, staff informed us of a patient with a diagnosis of MRSA and we observed staff following the correct procedures regarding infection control and hygiene.

- Following two cases of *Clostridium difficile* infection (CDI) on Cassio ward in August 2016, there were no further acquired cases of CDI on Cassio ward or any further CDI outbreaks in the Trust.
- The water supply to a hospital can be a source of infection for patients and staff. The infection and control bi annual report for October 2016 to March 2017 stated that all outlets, that is taps and shower heads, in clinical areas were returning negative results for *pseudomonas aeruginosa* (a bacterium which can affect the lungs) and there were no cases of legionella (a respiratory disease) identified.
- The trust's hand hygiene target was 95%. The infection and prevention control dashboard monitored compliance with hand hygiene. The medicine division showed a compliance rate of between; 93% in May 2016 to 100% in March 2017. Ward notice boards displayed hand hygiene compliance for both staff and visiting relatives to see. On Aldenham ward, the score recorded for July was 75%, which was below the trust target. Ward staff told us that the score related to the increased number of agency staff and specialist visitors who attended the unit on the day of audit. The ward manager confirmed they were expecting the August audit to show a marked improvement due to the challenging of poor practice.
- Adequate hand washing facilities and hand gel were available for use at the entrance to the ward areas, within the wards, at the entrance to bays and side rooms. There was prominent signage and an audio reminder of the importance of hand washing at the entrances to wards and within the toilet and bathroom areas. However, we observed inconsistency amongst staff regarding the washing of their hands on the care of the elderly wards. For example on Sarratt ward, we observed staff moving from patient to patient within the bays without washing their hands or the use of hand gel. We also observed medical staff not cleaning their hands on entrance to the wards.
- The infection and prevention control nurses completed monthly code of practice audits. The areas audited included: safe management of sharps, availability of wipes on all blood pressure (BP) machines and intravenous (IV) trays clean and stored appropriately. The results within the medical wards for quarter four (February 2017) showed a variance of between 72% (Winyard ward) and 97% on the acute assessment unit (AAU) and Red Suite.
- The medical service participates in an antimicrobial (an agent that kills microorganisms or stops their growth) programme which is a key component in the reduction of healthcare associated infections (HCAI). The trust conducted an annual survey of antimicrobial procedures in November 2016. The summary of the report showed that the percentage of patients prescribed antimicrobials was 40% (250 patients) which is in line with the national survey (38%). Most patients 68% (169) had antimicrobials prescribed in the un-scheduled care division (38% in care of the elderly, 12% in admissions and 18% in medicine). Examples of the actions and recommendations included; continuance in the delivery of teaching sessions to medical, nursing and pharmacy staff and ensuring that 72-hour review includes a defined stop/review date if antibiotic treatment was to continue. We saw that the antibiotics prescribed did not always have stop dates and the 72-hour review were not always completed.
- We saw that in order to prevent contamination, patient's food remained covered until they were ready to eat.
- The endoscopy unit had effective processes in place to ensure the cleanliness of equipment and to prevent contamination. This included separate dirty and clean rooms, and the use of designated staff for equipment cleaning. We saw endoscopes were leak tested, manually cleaned, and washed in washers between 45-50 minutes following a full wash cycle.
- The endoscopy team completed weekly water sampling for contamination. We saw evidence of sampling, results and action taken for "rogue" results. Any incident of contamination was managed by resampling and "closing" the unit until confirmed as clear of

contaminants. We saw stringent infection control measures were followed in the endoscope washrooms.

- Decontaminated endoscopy equipment was stored for up to 72 hours in ultraviolet cabinets within the department. Endoscopy staff tracked all equipment to ensure effective decontamination.
- Patients attending endoscopy appointments identified as having suspected communicable infections were placed at the end of treatment lists to allow additional cleaning times between patients.

Environment and equipment

- Watford General Hospital is a varied site with several older buildings and some new purpose built facilities. The location of each ward affected the functioning of the ward area. For example, some wards within the Princess Michael of Kent building had reduced storage facilities, limited staff rooms and office space. The new buildings, such as the acute admissions unit, purple, green and yellow wards had more space.
- During our last inspection, we identified that some ward names were confusing, as they were known as both a colour and a ward name, such as blue ward - cardiology. We saw that ward names had not changed; however, the reception issued written directions for visitors in locating each coloured ward area.
- The medical services had identified systems, processes and practices in place to keep people safe. For example, portable electric equipment, for example, blood pressure machines had been service tested regularly to ensure they were safe for use and had clear dates for the next test date on them. There were systems to maintain and service equipment as required.
- All clinical areas appeared clean and well maintained.
- The trust had a service level agreement with an external company to manage the cleaning of the wards and the Catheterisation laboratory (Cath lab). The company provided a seven-day service up until 11:30pm.
- We saw copies of the control of substances hazardous to health (COSHH) risk assessments within the wards visited which included guidance on the handling and storage of items such as disinfectant. The risk assessments also covered the precautions for safe handling, which included well-ventilated areas and the use of personal protective equipment.
- Most clinical areas had resuscitation equipment readily available. There were systems in place, which included daily checking, to ensure the equipment was fit for purpose. Records indicated that daily checks of the equipment had taken place on all the wards we visited. However, on Sarratt ward we found that the valve on an oxygen cylinder was dated September 2014 with no evidence of a review. This was brought to the attention of senior staff and during a revisit to the ward, we noted there was a notice on the oxygen cylinder not to use it and the issues had been reported.
- Records indicated that equipment such as defibrillators, hoists and infusion pumps were serviced regularly.
- Staff reported that they had access to all equipment required and we saw porters attending wards with requested items. Due to the building environment, staff reported poor storage facilities and we saw that this meant that items were stored in corridors and any available space. For example, we saw that clean commodes were stored in the corridor on Croxley ward. The service had recognised the concern and updated the ward risk register accordingly. Staff had processes in place to prevent trip hazards and maintain patient safety by keeping corridors and bays as clear as possible.
- Staff had access to pressure relieving support surfaces to prevent patients suffering pressure ulcers. For example, staff said they could easily order pressure-relieving mattresses for patients as required.

- There was sufficient capacity in the endoscopy unit at Watford General Hospital to enable emergency and routine surveillance procedures. An endoscopy is a procedure where the inside of the body is examined using a flexible endoscope with high quality video images projected onto a monitor.
- The West Hertfordshire Hospitals NHS Trust had improved access to the endoscopy services at Watford General Hospital since our last inspection. The expansion project was designed with the needs of patients in mind, with increased capacity, an improved environment for patients and enhanced workflow and efficiencies. Patients and staff were kept informed of changes through a regular newsletter. Staff and patients told us they were happy with the changes to the unit.
- There were processes and procedures in place for tracking equipment used for each patients endoscopic investigation, including sterile equipment used for biopsies and details of staff members operating and decontaminating.
- We saw the fire risk assessment for the frailty unit, which identified the persons at risk, the hazards and means of escape in the event of a fire. The risk assessment dated February 2017 identified key areas for improvement, which included; “the escape route is untidy and needs to be reviewed to provide an uninterrupted and clear means of escape”. Also identified were insufficient trained fire marshals to cover sickness, leave and shift patterns. However, during our visit to the frailty unit we found no issues or concerns. The area was visibly clear of clutter and staff knew what procedures to follow in the event of a fire.
- We saw that there were 11 alerts from the National Patient Safety Agency (NPSA) in May 2017 of which five were medical device alerts. Evidence provided showed the acknowledgement of all alerts within 48 hours together with their closure where appropriate.
- The clinical areas used the appropriate coloured disposal bags. General waste and recycling facilities were available to staff, patients and visitors.
- Staff ensured the correct assembly and labelling of sharps disposal bins. This included the name of the ward, assembler and date of assembly. All bins remained closed when not in use.
- In order to maintain the security of patients, visitors were required to use the intercom system outside wards to identify themselves on arrival before they were able to access any of the wards.

Medicines

- During the September 2016 inspection, we identified that the temperatures of treatment rooms where medicines were stored were higher than the recommended levels. This was escalated to the trust during the inspection and a requirement notice issued. During this inspection, we saw that treatment room temperatures were elevated above the recommended maximum temperatures (25ºCelcius) in six treatment rooms. We saw that temperatures were elevated to 34 degrees on one ward and another had exceeded 28 degrees for the month of August. Incidences were reported through the trust’s electronic reporting system and actions taken to mitigate the risks. This included the installation of air conditioning units. However, these were not in working order during the announced inspection. Staff when asked, were unable to assure us how they knew the medicines were safe for use as all were reliant on the pharmacy overseeing the management of medicines. This meant that we could not be assured that there were clear processes or procedures in the storage and administration of medicines.
- The air conditioning units were planned to be in use from the 4 September 2017. We found on our unannounced inspection that the air conditioning units were working and that room temperatures had decreased. Temperatures were recorded between 18 and 25 degrees across all wards.
- The pharmacy team monitored medication stored in areas where the temperatures exceeded expected ranges and removed any potential harmed or affected medicines. We

also saw that ward staff reported the temperature abnormalities using the trust's incident-reporting tool.

- Comprehensive medicine reconciliation arrangements were evident across the medical services. This included the taking of a patient's medicine history, undertaking medicine reconciliation on admission to hospital as well as checking for any contra-indications or unsafe prescribing. The trust rate was 87% (Audit report April 2017). We did not see data relating to medicine reconciliation compliance for medical services.
- Staff recorded medicine fridge temperatures daily. Temperatures were largely within the recommended parameters of 2 to 8 degrees; however, staff did not always record the actions taken when temperatures were outside of the accepted range. We saw that staff reset the fridge temperatures, and occasionally completed an incident form for elevated temperatures, but did not always reset or report when temperatures were lower than 2 degrees.
- Patients admitted to hospital required anticoagulation therapy assessment to prevent hospital-acquired thrombosis (venous thromboembolism). Staff generally completed the initial assessments (on admission); although the repeat assessment after 24 hours was not recorded in the majority of charts, we reviewed. This meant that patients might have received inappropriate anticoagulation therapy.
- The drug chart recorded all antibiotic prescriptions within the antimicrobial sections. They had a highlighted review section after 48 hours of antibiotics. We saw that medical staff did not always complete the review section to confirm that antibiotics should continue after this period. We saw that five patients had been prescribed antibiotics and two did not have a review of antibiotics recorded at 48 hours, with treatment continuing after this period. Trust data referred to antibiotic reviews at 72 hours, however this was not in line with the review pane on the medicine charts used.
- We looked at ten medical administration records (MAR) charts and found the following concerns. These were brought to the attention of the nurse in charge of the wards:
    - Patients prescribed compression stockings by the doctor but no signature by the nurse to indicate these had been given (four of the six MAR charts applicable)
    - No stop dates on intravenous fluids (two of the eight MAR charts)
    - Amoxicillin administered from 25 August 2017 to 31 August 2017. However, there was no evidence of any review during this period.
- Nursing staff administered medicines according to the prescription and checked patients' identity prior to administration. When appropriate two nursing staff completed checks for medicines such as intravenous antibiotics and fluids.
- There were processes in place to ensure patients received their time specific medicines at the correct times, which included insulin and medicines for Parkinson's disease. We reviewed two patient medicine records, which identified these medicines as administered at the correct time.
- The pharmacy report for quarter four (January 2017 to March 2017) identified the number of medicine related incidents across the trust of which there were 216. Unscheduled care had 87 incidents including 30 in the general medicine and sub speciality and nine for the care of the elderly. The report also identified eight incidents for the medicine speciality service, which included gastroenterology and dermatology. The type of medicine incidents included; omitted medicine (52) and wrong storage (44) as well as 23 anticoagulant and 13 controlled drug incidents. We saw copies of the actions which included lessons learnt. Examples included; discussions at safety huddles and ward meetings to ensure staff compliance with the administration of medicines.
- The National Diabetes Inpatient Audit (NaDIA) report also highlighted 42% of patients with diabetes experiencing one or more medication errors, which included prescription errors and medicine management errors. Of the patients on insulin, 16% experienced one or more insulin error, which placed the hospital in quantile 1.
- The patient's medicine chart identified that the ward pharmacists reconciled their medicines

within two days of admission to the hospital
- Medicine trolleys were secure throughout all clinical areas, locked when not in use and stored where possible in the treatment rooms.
- We saw that controlled medicines were stored according to guidance and administration recorded by two nurses. During our September 2016 inspection, we identified that there was a difference in the process of storing patient's own controlled drugs. This inspection showed that patients own medicines were stored and recorded correctly in line with local policy. Patients medicines brought into hospital were recorded in a separate controlled drug book and all administrations recorded by two nurses.
- The administration of contrast intravenous fluid used in the catheterisation laboratory (Cath lab) was carried out in line with trust policy. Staff spoken with knew how to access this policy when required.

Records

- Each patient had two sets of records, a nursing risk assessment and care plan folder and a medical notes folder. Medical notes were stored in locked trolleys located either in the ward corridor or within the patient bay. Some trolleys were secured to the wall to prevent unauthorised removal.
- The trust used trolleys with the same access code to enable all clinicians to access notes in an emergency.
- Nursing risk assessments were stored at the end of each patient's bed. Risk assessments were colour coded and maintained in generic hospital folders. This meant that staff could easily locate specific items such as nutritional assessments, National Early Warning Score charts (clinical observation charts) or falls assessments when working on a different ward.
- Clear written notes and the management of individual care records maintained patient safety. However, we observed many of the pages were loose which had the potential of being lost when in transit.
- Risk assessments were largely "tick box" assessments with sections for additional written information and a nurse signature and date of assessment. We saw that charts were largely completed using a "tick" only with minimal or no detail regarding the assessment. For example, we saw the assessment for bedrails but the assessment lacked any detail to the conversations held with patients, details of the bed or equipment used at home or the rationale for choosing to use them.
- We looked at 42 records across the service and found most charts for example; National Early Warning System (NEWS) and fluid charts completed appropriately. However, where applicable there was a lack of VTE 24 hour re-assessment in 16 of the 20 records seen.
- Staff informed us that nursing documentation was under review by specialist leads, which included some risk assessments. For example, we were told that the tissue viability specialist team were reviewing the pressure area care documentation.
- Nursing staff reported that they felt the documentation was satisfactory for needs and easy to locate (due to being colour coded). Ward sisters reported that additional training and encouragement was required to ensure paperwork reflected nursing activity. We saw that the wards displayed sample documentation and completed record keeping audits.
- Nursing staff recorded daily activities in the medical notes, which meant that there was a record of patients' activity and treatment. We saw that nursing records within the medical notes were a summary of the day's activity.
- Although the recording of notes was clear, we found inconsistencies in the recording of staff grade or registration. However, doctor signatures contained contact details, included their bleep number.
- Patients had paper medical administration records (MAR) drug charts and records seen were legible.
- All patients assessed as having a grade one to two pressure ulcers had their repositioning

recorded on the intentional rounding charts. Intentional rounding is a structured process where nurses on wards in acute hospitals carry out regular checks with individual patients at set intervals. Intentional rounding charts recorded interactions between staff and patients such as toileting, pain assessments, oral hydration and position changes. We saw that all intentional rounding charts were up-to-date at the time of our inspection.

- Detailed information had been clearly recorded on patient records and showed that all patients had been reviewed during a ward round within 14 hours of admission, diagnosis and management plans were identified, and nursing assessments and care plans had been completed.

Safeguarding

- Staff understood their responsibilities and knew how to identify potential abuse and report safeguarding concerns. Staff completed safeguarding training through electronic learning and had a good understanding of their responsibilities in relation to the safeguarding of adults in vulnerable circumstances
- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements.
- Safeguarding adults and children was part of the mandatory training programme for staff and different levels of training provided according to their job role. Nursing staff exceeded the trust target of 90% for all safeguarding modules. Safeguarding children level 3 across the trust had an overall rate of 100% with 97% of staff having completed their training at Watford General Hospital. The service had been issued with a requirement notice regarding poor access to safeguarding level 3 staff following our September 2016 inspection. We did not receive data relating to safeguarding children level 3 training for medical staff.
- Staff received feedback from safeguarding referrals that they made and received learning from other safeguarding referrals at team meetings and in safety huddles.
- Safeguarding information, including contact numbers of the trust leads were kept on display on the wards and staff were aware of how to access the safeguarding team.
- Safeguarding concerns were discussed at handovers and staff showed awareness of any ongoing concerns. For example, we reviewed notes of a patient and found that safeguarding concerns clearly raised and documented.
- We saw children visiting patients on wards during our visit. Staff said they allowed children on the wards under supervision by their relatives or friends.

Mandatory training

- The service had been issued with a requirement notice following our September 2016 inspection relating to the poor compliance with mandatory training. During this inspection, we found that mandatory training compliance had improved considerably. Watford General Hospital had an 89% mandatory training completion rate for medical staff; this was just below the trust target of 90%.
- Nursing and midwifery staffs' completion rate was 93%. Information governance had the lowest completion rate at 89%, which was just below the trust target of 90%.
- All new starters completed e-learning training prior to commencement. Senior staff informed us how they notified staff when they needed to update their training. They stated this enabled them to maintain staff training in a timely way.
- The trust target for infection prevention and control (IPC) mandatory training was 90% for clinical staff. The bimonthly IPC meetings monitored compliance. The data for March 2017 showed that 94% of clinical staff and 84% of non-clinical staff had completed their training. In addition, the IPC nurses undertook additional training in response to root cause analysis (RCA), audits and surveillance results. This is in the form of "power" training where the IPCNs delivered short, quick sessions on clinical concerns. Topics covered in the power

training include hand hygiene, isolation and decontamination procedures. The mandatory training data for the medicine service, provided by the trust, showed this had increased to 96% as of July 2017.

- Nursing staff reported the use of “quick training” sessions across all clinical areas. These sessions occurred at handover, board rounds or quiet periods as able, concentrating on topics relevant to the clinical area such as pressure ulcer prevention, caring for patients with dementia or other clinical conditions.
- We did not see any evidence of sepsis training for nursing or medical staff during this inspection.

Assessing and responding to patient risk

- On admission, the service assessed patients using national assessment tools. This included the malnutrition universal screening tool (MUST), falls assessment, pressure area assessment, manual handling assessment and bed rail assessments. Each completed assessment on admission required either a review weekly or when the patients’ clinical condition changed.
- Admission clerking documents included the templates of clinical pathways, for example, the sepsis bundle. Each clerking document included details of the patients’ admission condition, symptoms, treatment and initial diagnosis. The medical team completed each assessment within 14 hours of admission to the hospital.
- We did not see any medical notes for patients with suspected sepsis. We saw posters across all areas detailing signs of sepsis and actions to be taken if a patient was suspected of having sepsis.
- Wards did not have “sepsis boxes” but held frequently used antibiotics in local treatment rooms. Antibiotics appropriate for the use of suspected sepsis were readily available to facilitate immediate treatment.
- The service used a venous thromboembolism (VTE) risk of bleeding assessment tool. This tool in accordance with the National Institute for Health and Care Excellent (NICE) QS3 is to be completed on admission and repeated after 24 hours. An audit (April 2017) identified the completion of risk assessment as non-compliant although a review of patients showed they had received the appropriate medicines despite incomplete documentation. The audit also highlighted a group of patients who should be exempt from VTE risk assessment but who were previously included for example, patients on anticoagulation treatment.
- The June 2017 integrated performance report for unscheduled care also showed that as of May 2017 82% of patients had a completed risk assessment. This was below the trust target of 95%. We saw the immediate actions highlighted which included; all patients’ charts to be checked during their first doctors ward round (after admission to hospital) and ward to managers to explore changes, which would help improve performance. The trust board meeting minutes for July 2017 identified that VTE risk assessments had improved at 91%. During this inspection, we saw that the service did not always follow the National Institute for Health and Care Excellence (NICE) (QS3 Statement 4) “Reducing VTE risk in hospital patients ‘guidelines on all wards. For example, no VTE reassessments (after 24 hours) had been carried out on 16 out of 20 records. This meant we could not be assured that patients had received the relevant assessment to manage their care and patients’ risk of thrombosis (blood clot) or risk of bleeding could not be determined.
- In order to assess and respond to patients’ needs, the dementia care team had implemented a delirium recovery programme (DRP). The aim of the programme was to reduce length of stay, reduce the number of direct placements from hospital, reduce admissions and improve patient experience and functional outcome through individualised care and cognitive enablement. The DRP also ensured appropriate antipsychotic medicine prescribing through alternative approaches to reduce challenging behaviours. The DRP supported patients in their home by providing a 24-hour live-in carer. The aim of the

programme was to promote independence and reduce the cover provided by the carer over a three-week period. During this period, the person using the service received an occupational therapy review, a visit by a social worker, a physical and mental health review together with a trial of a discharge care package during the last week.

- The service promoted the use of the "This is Me" assessment document produced by the Alzheimer's Society. This assessment helps to highlight to staff the care preferences, and any special considerations relevant to each patient. However, during the inspection we found inconsistencies in the completion of the assessment document. This meant that staff might not have all the necessary information to care for their patient appropriately.
- The service used nationally recognised risk assessment tools such as malnutrition universal screening tool (MUST) and Waterlow score. MUST is a five-step screening tool to identify patients, who are malnourished, at risk of malnutrition (under nutrition) or obese. The Waterlow score gives an estimated risk for the development of a pressure ulcer in a patient. To reduce the risk of harm, identified patients had care plans, which staff monitored more frequently.
- The National Early Warning Score (NEWS) system was a method of identifying and guiding the clinical staff when a deteriorating patient's care should be escalated to a higher level. This system alerted nursing staff to escalate patients for review if routine vital signs were abnormal. During our inspection, we identified no concerns with the completion of the NEWS and the records identified staff had responded appropriately to the needs of deteriorating patients. Staff confirmed they had completed their NEWS training.
- There were systems and processes in place to refer deteriorating patients to the medical team, critical care outreach team or hospital at night team depending on the time of day. We saw records showed the referral and response, with any adjustments to treatment plans.
- The medical service was able to access enhanced care workers who provided specific support for vulnerable patients. The enhanced care worker was able to provide one to one care during the patient's stay in hospital when required. Senior staff confirmed that they found the service they provided invaluable and felt they improved the quality of care for patients. Staff said patients "responded positively" and became "more settled" after their intervention.
- To support patients, who may become agitated, were prone to self-injury, or who disrupt medical treatment by pulling at intravenous tubes or catheters the wards used "posey mitts." These mitts limited the patient's dexterity and prevented patients from harming themselves.
- Where possible, staff placed patients requiring additional supervision in the same area to enable one nurse to supervise a number of patients. Nursing staff told us that staff received additional training to enable them to provide activities and distraction therapy.
- There was a lack of in-patient podiatry service due to the absence of a podiatrist. A business plan submission had been successful but the trust had failed to recruit to the post. However, the service had recognised the risk, which they highlighted on the medical risk register as an area of concern. However, this contravened the National Institute for Health Care Excellence (NICE) Diabetic foot problems: prevention and management of foot problems in people with diabetes guidance.
- All bed spaces had call bells, which sounded different alarms for routine and emergency calls. Patients confirmed staff responded to calls quickly. We saw that nursing staff reported any problems with call system to the estates team for maintenance.

Nursing staffing

- The service had processes in place to maintain safe staffing across all clinical areas. Ward staffing establishments were calculated and reviewed annually, and agreed with the ward manager, head of nursing and chief nurse according to the ward size and activity. On a daily basis, staff were able to flex the number of staff required according to activity on the

day. Where necessary additional healthcare assistants were used to support nursing staff. The nurse/ patient ratios on wards averaged one nurse to six or seven patients, whereas higher dependency areas (such as acute respiratory) had a lower ratio of one nurse to two or three patients. When activity or dependency increased, ward managers were able to negotiate additional support through the nursing medical lead.

- The service used the safer nursing care tool (SNCT) which supported nurses to decide on the safe nurse staffing levels for acute wards. The SNCT took into account patients' level of sickness and dependency. It also included quality indicators linked to nursing care to help ensure staffing levels achieved best patient care.
- The senior nursing team attended the 8am bed management meeting and they discussed hospital wide staffing. They identified areas where staff could be moved to support those under pressure.
- The vacancy rate at Watford General Hospital was 8%, which was just below the trust target of 9%. Nursing vacancies were elevated with some wards reporting a number of vacancies. For example, Sarratt ward reported that there would be 20 nursing vacancies by the end of August as staff had moved to other speciality departments across the trust, for example, critical care.
- Watford General Hospital's medical services turnover rate was 6%, which was better than the trust target rate of 12%. However, their sickness rate was 5%, which was worse than the trust target of 3.5%.
- Nursing staff reported that they regularly used agency staff to supplement ward staffing numbers. The ward manager reviewed the planned and actual staffing numbers and escalated any shortfalls to the matron. The matron would review staffing across their clinical area to identify if staff could be moved from other wards. If cover could not be provided by other wards or by the hospital bank, agency staff were requested. Nursing staff told us that agency staff were always inducted to the wards and where possible the same staff were booked to promote continuity of care.
- Handover between shifts varied according to the ward. Nursing handover on Sarratt ward included a ward overview of every patient's name, age and diagnosis to every member of staff followed by a detailed handover for the allocated patient group. Staff told us that the handover had changed to ensure staff awareness of every patient to promote safety for covering breaks.
- Nursing handovers took place at the end of each patient's bed or in their side rooms. During an observed handover on the care of the elderly ward, we found that nurse handovers included information about the patients' health condition, cognition and social circumstances. For example, patient's diagnosis and treatment plan. However, personal patient information disclosed during the end of bed handover meant that the service could not ensure the patient's privacy and confidentiality.
- Staff attended safety huddles, which reviewed patients' risk assessments, incidents, updates on policies and any other information relevant to the day-to-day care of patients.

Medical staffing

- Medical staffing was appropriate with effective out of hours and weekend cover. Medical staffing within the acute admission unit was in line with national guidance from the Society for Acute Medicine and West Midlands Quality Review Service in the publication "Quality Standards in the AMU" dated June 2012.
- Each clinical area had a designated clinical lead and a supporting medical team, which varied in size according to the number of patients. We saw that additional locum staff were used to support teams where there were vacancies and in areas requiring additional support. For example, we saw that the medical service had improved medical oversight of medical patients cared for on non-medical wards by introducing one consultant responsible for the patients and a designated medical doctor to work on the non-medical wards. For

example, one medical doctor allocated to work on Letchmore (surgical) ward and another allocated to Elizabeth (gynaecology) ward.

- As at July 2017, the trust data reported 242 whole time equivalent (WTE) medical staff in post. This was below the trust target of 273 WTE staff.
- The vacancy rate medical staff at Watford General Hospital was 11%, which was above the trust target of 9%.
- Watford General Hospital medical services' turnover rate was 49%, which reflected the changes in rotational training staff. The turnover rate for permanent staff was 8% which was in line with trust targets.
- Within unscheduled care, there were two consultants from 7am to 9:30pm. There was a duty geriatrician until 9pm and acute physicians until 5pm weekdays and a physician of the day from 5pm to 9pm weekdays. The physician of the day was available on-call overnight.
- A Cardiologist round took place twice daily Monday to Friday, once on Saturdays, Sundays and bank holidays.
- All new patients admitted on the Acute Admissions Unit (AAU) were seen by the on-call consultant prior to the board round at 9am. This meant there was clear oversight of all patients, which included those pending investigations, speciality referrals, therapist input as well as the possibility of patients medically stable for discharge.
- We observed a doctors handover which consultant led and well attended by the medical team. We saw that the handover included the sharing of appropriate information such as new admissions and patients transferred to the wards. The consultant discussed the workload and allocated actions. Doctor's handover ward rounds occurred daily on each ward. There was good interaction between doctors, nursing staff and allied health professionals, which included physiotherapists, occupational therapists and a social worker.
- Doctors confirmed that consultant support was very good and they responded quickly to any calls.
- Doctors confirmed there was a good induction programme overseen by individual consultants and specialist registrars. Areas covered included incident reporting and the importance of following the duty of candour processes, how to manage a difficult diagnosis and the effectiveness of discharge planning.
- We spoke with several locum staff who reported that they felt part of the team, receiving clinical supervision, training and support from substantive staff.
- Most doctors said they felt there was insufficient junior doctors' on-call out of hours and at weekends. During our inspection, the service had two foundation doctors and one specialist registrar covering 15 medical wards. Doctors told us that changes had been made to specialist registrar cover by the deanery, (the regional organisations which is responsible for junior doctor's training) which was out of the trust's control. To address these concerns we were told by the senior team that locum staff were employed to support the service.

Major incident awareness and training

- Staff could describe the trust's major incident policy, which was accessible on the trust's internal website.
- Most staff spoken with said they had not completed major incident training but were able to describe the procedures they would undertake. Some staff said they were due to participate in a simulation at a nearby hospital.
- Some staff told us that they had completed a major incident training exercise attended by volunteers from the fire cadets who acted as patients. The exercise required staff to evacuate a ward using emergency equipment provided from their own wards.
- The trust had appropriate plans in place to respond to emergencies, business continuity such as adverse weather conditions and major incidents.
- Staff described what their responsibilities were in the event of a fire and guided us to the fire safety policy.

Are medical care services effective?

Good

We rated effective as good because:

- The service used national guidance and protocols to manage patient care and treatments.
- Staff completed pain assessments, interventions and monitoring to promote patient comfort.
- Staff assessed and monitored patients for malnutrition and referred to dietetic support if necessary. Staff ensured that patients could access their food and drinks and assisted them to eat and drink appropriately.
- Sentinel Stroke National Audit Programme (SSNAP) data showed that the service had achieved the highest rating (Band A) and maintained this rating for one year.
- The Hospital Standardised Mortality Ratio (HSMR) for the twelve-month period from January 2016 to December 2016 the HSMR was better than expected at a value of 93 compared to 100 for England.
- For the twelve-month period from January 2016 to December 2016, the Summary Hospital-level Mortality Indicator (SHMI) was better than expected at a value of 90 compared to 100 for England.
- Staff maintained training and competencies using internal and external training programmes. These were inclusive of all staff working across the service and focused on staff development and patient safety.
- Multidisciplinary team working was inclusive of all professions and patient centred.
- The medical service was provided over seven days, with some services such as dietetics and clinical investigations requiring a referral out of hours or at weekend.
- There was a clear process in place for the completion of mental capacity assessments and Deprivation of Liberty Safeguards (DoLS) referrals with alignment to specific issues and detail. Ward managers and divisional matrons tracked all DoLS assessments.

However:

- We found inconsistencies in the 24 hour calculation of fluid charts to identify total input and output.
- Trust wide IT issues affected the speed of some IT systems; however, staff did not see this as having a negative impact on patient care.
- A registered nurse was not always responsible for the management of and treatment of patients attending the deep vein thrombosis clinic.

Evidence-based care and treatment

- Policies were relevant and accessible by staff via the trust's intranet system. These policies used national and best practice guidelines to care for and treat patients. The service were monitoring compliance with National Institute for Health and Care Excellence (NICE) guidance and were taking steps to improve compliance where further actions had been identified. Staff understood appropriate NICE guidelines and referred to these regarding patients' care and treatment. When required, staff could refer to national guidance folders, which we saw on some wards.
- There were new computed tomography coronary angiography (CTCA) and magnetic resonance imaging (MRI), in place. The coronary care unit ensured staff were aware of new protocols linked to this equipment. CTCA is the taking of pictures or images of the coronary arteries of the beating heart. An MRI is a type of scan that uses strong magnetic

fields and radio waves to produce detailed images. This ensured that staff had the information to provide evidence-based care and treatment for patients using the service.

- The trust had clear written guidance for the use of sedation during procedures. The guidelines included a transoesophageal echocardiography (TOE) World Health Organisation (WHO) checklist. TOE refers to an ultrasound scan of the heart. A third person to monitor the patient (compliant with immediate life support (ILS) training) also needed to be present during all procedures requiring sedation. Staff carried out a team brief at the beginning of each procedure and a “debrief” at the end of the procedure.
- The service participated in the National Audit of Cardiac Rhythm Management (CRM) Device Audit, which is an official record of CRM device procedures in the United Kingdom. The 2015/16 audit showed that the hospital was performing above minimum standards for both new permanent pacemakers (PPM) and other complex devices. The conclusions of the review showed that: acute procedure outcomes and complication rates were acceptable and comparable to the imperial benchmark set down by the National Institute for Cardiovascular Outcomes Research (NICOR).
- Catheterisation laboratory procedures, for example, the implementation of a pacemaker (a small device placed in the chest or abdomen to help control abnormal heart rhythms) and cardioversion (a procedure that sets the heart beating at a regular and healthy rate) were carried out in line with professional guidance. We reviewed the cardiac catheterisation suite’s integrated care pathway, which included the adaptation of the World Health Organisation (WHO) ‘Five steps to safer surgery ‘checklist.
- The Catheterisation laboratory also had guidance to follow should a patient only have creatinine (a waste product that comes from the normal wear and tear on muscles of the body found in every patient’s bloodstream) levels provided. The catheterisation laboratory integrated care pathway identified this procedure and staff spoken with explained the process.
- Care pathways were in place for managing patients that needed care following a stroke and for patients who received ambulatory care (ambulatory care is medical care provided on an outpatient basis). The care pathways followed NICE guidance.
- The trust had put in place a policy and procedure that identified and supported patients living with dementia to improve their management and care.
- The service used a behaviour-monitoring template to track patients' behaviour. This template supported patients with cognitive impairment or a history of mental health illness. Nursing staff were encouraged to use the template to identify any triggers for behavioural changes and any actions that calmed patients or situations. The templates identified actions and the treatment required prior to patients becoming agitated or aggressive. The template used a national tool template used within mental health for recording behaviour triggers and treatment.
- The ward manager or designated deputies completed local audits. The trust also implemented a “test your care” programme, which involved staff from other clinical areas attending the ward to complete an audit of the environment, documentation and patient feedback. This was in progress when we attended Tudor ward. We saw staff checking equipment for maintenance records, reviewing records for completion and discussing care with patients. The notified nurse in charge responded to any issues identified. The team meetings, divisional meetings and trust boards ward reviewed the results to address any concerns. This ensured that the trust had oversight of individual ward performance and compliance against trust policy and procedure.
- The quarterly audit identified any medicine omissions. The recommendations (April 2017) identified that further ongoing education and training of medical and nursing staff is required to increase awareness of the importance of administering medicines on time and recording a reason if a medicine is not given.

Pain relief

- There were processes in place to monitor and measure patients' pain. Nursing staff used the National Early Warning Score tool to record pain scores and monitor effectiveness of any analgesia given.
- We saw nursing staff ask patients if they were in pain, or whether pain had improved following their medicines.
- A pain specialist service was available for advice and support. We saw patients had been referred to the service for ongoing pain management of long-term conditions.
- Patients told us staff were responsive to complaints of pain, offering analgesia, position changes and diversional therapy as able.
- Staff assisted patients who complained of discomfort to adjust their position and intentional rounding charts recorded any changes.

Nutrition and hydration

- Staff assessed patients' nutritional needs on admission and at regular intervals throughout their inpatient episode.
- We saw the Malnutrition Universal Screening Tool completed on admission and updated weekly or with any changes to the patient's condition. Scores were calculated correctly and care plans reflected any findings, such as weight loss, use of supplements or the referral to dietitian
- There was clear guidance on the referral to dietitian support and identified steps to encourage patients to eat and drink. Staff confirmed they referred patients to a dietitian as required. We saw referrals within the records with no issues or concerns highlighted with the timeliness of access. Senior staff also confirmed patients who may have been obese had access to a dietitian to support their needs.
- Nursing staff were able to access dietetic support at weekends via a telephone call to the on call team.
- We saw that patients across the service had jugs of water on their bedside tables within reach to promote hydration.
- Some wards offered patients living with dementia blue plates to identify them as requiring additional support for meals.
- Food and fluid charts were completed with the amount and type of fluid or food taken. However, there were inconsistencies in the calculation of total volumes of fluids taken or passed over a 24-hour period.
- Nursing staff assisted patients to adjust their position to enable them to eat and drink. We saw staff on Croxley ward assisted patients to sit out of bed in a chair, or upright to enable them to manage their meals themselves.
- We saw breakfast served on Sarratt ward. Food remained covered until the patient was ready to eat.
- Patients visiting the ambulatory care unit service had access to drinks. We saw both hot and cold drinks offered to patients.
- Patients cared for in escalation areas, such as ambulatory care and the frailty unit were able to choose a hot meal from the hospital menu. Staff collected food delivered to the nearest ward at meal times.

Patient outcomes

- The service had processes in place to monitor patient outcomes and report findings through national and local audits and to the trust board. This information was used by the organisation to benchmark practices against similar organisations.
- The latest Sentinel Stroke National Audit Programme (SSNAP) reporting quarter (August to November 16) (published March 2017) showed the trust had an A" rating putting

Watford General Hospital stroke services in the top 16% of hospitals nationally contributing to the audit. The audit considered several domains, which included scanning, implementation of treatments, provision of therapy services and discharge planning. However, performance during May 2017 identified the need to improve on the admission to stroke services within four hours. The data provided by the trust for May 2017 showed a drop to 58% from 67% in March 2017 which is below the trust target of 90%. However, the data is just below the national average of 60% for the period April 2016 to March 2017. The records also showed that 72% of patients spent 90% of their stay on the stroke unit which was above the trust target of 80% for patient stays on the unit. We saw the Integrated Performance Report – Unscheduled care June 2017, which identified immediate actions to take which included the review of capacity at operational meetings. It was however recognised that medical outliers were admitted to the stroke unit at times of peak pressures which impacted on the stroke service. The action taken as a result of the initially poor performance included:

  - Increased consultant workforce/presence
  - The development of an early supportive discharge service to enable stroke patients to be discharged to their homes quickly
  - Support by the therapy team, when appropriate, to provide a much closer scrutiny of the patients' journey.
  - The sharing of the SSNAP results with members of the stroke multi-disciplinary team

- The Hospital Standardised Mortality Ratio (HSMR) is an indicator of trust-wide mortality that measures whether the number of in-hospital deaths is higher or lower than would be expected. For the twelve month period from January 2016 to December 2016, the HSMR was better than expected at a value of 93 (compared to 100 for England) and 1,207 deaths compared to an expected 1,304 deaths. Weekend HSMR was within the expected range for this period.
- The Summary Hospital-level Mortality Indicator (SHMI) is a nationally agreed trust-wide mortality indicator that measures whether the number of deaths both in hospital and within thirty days of discharge is higher or lower than would be expected. For the twelve month period from January 2016 to December 2016, the SHMI was lower (value of 90) than expected and therefore better than the England average of 100 and had been sustained for more than two years.
- There was currently one active mortality outlier (a service that lies outside the expected range of performance) alert for this trust. The alert identified refers to urinary tract infections (UTIs) highlighted by the Care Quality Commission (CQC) outlier panel in February 2017. We saw the February 2017 mortality review group-meeting minutes, which identified there were 81 deaths relating to urinary tract infections (UTI) against an expected death of 60. The actions from the February 2017 included the random sampling of 20 patient records. The April 2017 meeting minutes highlighted the outcome of the sampling, which included the revised changing of five records due to inaccurate recording.
- The National Diabetes Inpatient Audit (NaDIA) 2015/16 (published March 2017) placed Watford General Hospital in quantile 3, (quantile 1 means that the result is in the lowest 25% whereas quantile 4 means the results are in the highest 25%). For example, the data showed that the hospital provided 0.74 diabetic specialist nursing hours per patient compared to the England value of 0.67. The audit identified 80% of inpatients with diabetes at Watford General Hospital were satisfied with the overall care received. The audit also showed that each patient received 0.33 consultant hours per week, which was higher than the England value of 0.19. However, the emergency readmission of patients for the management of their diabetes was higher than the England average (86%) at 92%.
- The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attacks. MINAP provides comparative data to help clinicians and managers to monitor and improve the quality and outcomes of their local services. The MINAP report for 2015/16 published in June 2017 showed that at Watford General Hospital

94% (430 patients) with Non-ST elevation myocardial infraction (nSTEMI) (a type of heart attack) were seen by a cardiologist and 3% were admitted to a cardiac ward. The report also identified that 68% (414 patients) received an angiography (a type of x-ray to check the blood vessels during their admission or before discharge.

- The National Audit of Dementia (care in general hospitals) measures the performance of general hospitals against criteria relating to care delivery known to impact upon patients with dementia while in hospital. One hundred and ninety nine hospitals participated (98%) in the audit. The audit's standards derived from national and professional guidance, including the National Institute for Health and Care Excellence (NICE) Quality Standards and guidance and the Dementia Friendly Hospitals charter. The 2016/17 audit (published July 2017) found that Watford General Hospital scored between 100% for nutrition (ranked 1 of 199) but discharge ranked 129 of 195 participants with an overall score of 69%.
- All trusts in England participate in the lung cancer audit based on the National Institute for Health and Care Excellence (NICE) guideline. Watford General Hospital scored the same as other trusts for; crude proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery (21% against a national aggregate of 24%) and crude proportion of fit patients with advanced Non-Small Cell Lung Cancer (NSCLC) receiving chemotherapy (59% against a national standard of 60%). However, the trust scored worse than the national level for; crude proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy (48% against the national level 69%). We requested a copy of the action plan to address the audit findings, but one was not provided.
- The trust participated in the national falls and fragility fractures audit programme (FFFAP) published in September 2016 for the period January 2015 to December 2015. The audit was created to measure against the National Institute for Health and Care Excellence's (NICE's) guidance on falls assessment and prevention (NICE clinical guideline 161 (CG161)3). The FFFAP audits the care that patients with fragility fractures and inpatient falls receive while in hospital and to facilitate quality improvement initiatives. Areas reviewed included: assessments for the presence or absence of delirium, the measurement of standing and lying blood pressure and an assessment for medication that increases falls risk. The results were RAG (red, amber and green) rated and Watford General Hospital scored red in four of the seven indicators. The quality report for 2016/17 highlighted the actions taken which included: critical reviews of incidents for patient with recurrent falls or falls with a fracture, better communication with GPs and a multidisciplinary falls assessment and intervention to start promptly after admission.
- The trust participated in the British Thoracic Society national audit in asthma 2016 (published February 2017). Asthma is a common lung condition that causes occasional breathing difficulties. As a result of the audit it was found that:
    - A significant number of patients were not being discharged appropriately on a steroid inhaler or with adequate follow up as an outpatient. This was addressed by the introduction of a checklist to ensure clinicians awareness of the discharge procedures.
    - Poor documentation regarding patients being seen by a respiratory specialist nurse. The action taken was to introduce a sticker with a checklist in the notes to confirm the patient is seen by the specialist nurse prior to discharge.
- In order to assess if these changes have improved results a re-audit would be carried out in 12 months. On inspection, we saw that the stickers had not been introduced; however, respiratory specialist nurses were clearly recording in notes when they reviewed patients.
- Between January and December 2016, patients at the hospital had a lower than expected risk of readmission for elective and non-elective admissions. There was one exception, with elective gastroenterology patients having a slightly higher risk of readmission to hospital than the national average.
- Between February 2016 and January 2017, the average length of stay for medical elective

patients across the trust was four days, which was the same as the England average. For medical non-elective patients, the average length of stay was six days, which was similar to the England average.

- The service participated in the National Audit of Dementia, which included a section for carers to free text comments, for the first time in 2016. The results showed that 35 out of 60 responses were positive about the care and communication from the service. Carers were less satisfied with the mealtimes and apparent lack of patients' mobility whilst in hospital. In response to the findings, the service produced an action plan to address areas for improvement. The Dementia Implementation Group were responsible for monitoring progress.
- The hospital participated in the patient-led assessments of the care environment (PLACE). PLACE assessments provide a snapshot of how an organisation is performing against a range of activities, which impact on the patients' experience of care. The 2016 results showed that the hospital scored worse than the England average in nearly all of the categories with the exception of cleanliness, which was just below the England average of 99% at 98%. The hospital scored low in their dementia care at 53% (England average 80%) and disability care at 60% (England average 85%). The executive team confirmed they were aware of the results of the PLACE audit and had an action plan in place. Staff confirmed the outcomes of the "test your care" audit monitored the PLACE audit.

Competent staff

- We saw that staff completed roles that they were trained and competent to do. However, we saw that there was an elevated risk within the Deep Vein Thrombosis (DVT) clinic where nursing staff completed an assessment and planned treatment for patients with a suspected DVT. The DVT nurse completed a review of the patients past medical and medicine history on referral to the service. Following investigation to confirm a DVT, a DVT pathway was followed to identify the appropriate treatment. The nurse would complete a prescription template for DVT medicines, which was then signed by a doctor. The form did not include details of the patients past medical history or current medicines. This meant that the doctor was signing for treatment on the basis that the nurse had reviewed the patient's medical history and identified any contraindicating medicines. When the DVT clinic nurse was not available, an assistant practitioner managed the service. Assistant practitioners are not trained in medicines management and may not know different medicines in detail, such as their correct dosage, reasons for use or contraindications. There was therefore a potential risk that the assistant practitioner did not know the risks or side effects of the patients' current medicines and the planned treatment. We saw that the assistant practitioners had completed local training in DVT management to ensure they followed the correct pathway; however, there was no evidence to suggest that they had training in the recognition of medicines that may interact with DVT treatment. There was no evidence to suggest that an error had occurred, however, during inspection our specialist advisor intervened in the decision making process by the practitioner, advising that the patient required a medical review. The risk was escalated to the service during inspection and we saw that the service was under review on our unannounced inspection.
- The trust reported that at the end of June 2017, 92% of nursing staff had undergone an appraisal. There was an ongoing human resource management plan, which highlights to managers those staff that are currently non-compliant as well as those that require an appraisal to be brought in line with incremental dates. Medical staff appraisal rates were 96%.
- The managers informed us they were planning appraisals in advance to increase compliance and confirmed there were weekly returns of planned dates for appraisals in progress. This includes those that are due to "drop off" so that they are able to set dates before they expire.
- There was an induction programme for all new staff. This included mandatory training and

competency based ward skills. All staff that we spoke with confirmed they had attended an induction.

- Nursing staff were supernumerary for a short period when commencing a new role. This was to ensure competence and offered new staff the opportunity to learn new skills and methods of working.
- All transitional (overseas) nurses had access to a clinical skills facilitator. Their role was to support the nurses on employment with the hospital, which included training such as end of life care, tissue viability, falls awareness and dementia. The facilitator also ensured and supported nurses with their International English Language Test (IELTS) where applicable.
- We saw that nursing staff within specialist clinical areas had additional competencies to ensure they were able to manage patients safely. Examples included; heart rhythm recognition, performance of electrocardiograms (ECG - tracing of the heart) and heart failure recognition and management and competencies in administering medicines.
- During our visit to the cardiology unit, senior staff confirmed that all staff had received their appraisal. We saw evidence of this in the documentation provided. There were processes in place for staff to receive one to one supervision, which staff confirmed.
- The managers informed and staff confirmed and showed us updated spreadsheets, which outlined how they monitored, and ensured staff appraisals were up to date.
- Staff within the cardiology wards informed us they had not undertaken a cardiology course and were awaiting dates for course attendance. Staff told us they felt they would benefit from additional training in heart failure.
- Senior staff confirmed doctors provided training and once proficient, they trained other staff members. This meant that we could not be sure that staff had received the appropriate training to maintain the care and welfare of patients requiring coronary services. However, staff within the coronary wards confirmed they attended daily teaching sessions including for example: blood transfusions, pressure ulcers and cardiac monitoring.
- Staff within the Catheterisation laboratory (Cath lab) confirmed the majority of their training was in-house but there were certain procedures where they trained externally which included; all percutaneous coronary intervention (PCI) and pressure wire insertion. PCI is a non-surgical procedure that uses a catheter (a thin flexible tube) to place a small structure called a stent to open up blood vessels in the heart. Pressure wire is a device that can be used during coronary angiography (a type of x-ray used to check the blood vessels to determine if a narrowing in one of the heart arteries requires further treatment).
- Senior staff within the Cath lab informed us that when they used agency staff, they had to perform three PCIs and three pacemaker procedures before they were judged to be competent to attend patients independently.
- Wards visited for example Sarratt and Oxhey ward had agency induction checklists in place. We saw the folder appropriately completed. Areas covered included for example; an induction to the ward and intravenous competencies.
- We attended an AAU junior doctor departmental meeting set up by the consultants. This occurred every Thursday between 1pm and 2pm. Areas covered included; clinical governance and incident reporting. The pharmacists provided a presentation regarding the setting up of palliative care medication, which included pain control and the use of the intravenous pump. The session also included a case study to ensure the dissemination of lessons learnt. This meant there were processes in place to ensure junior doctors were able to discuss and ask questions as part of their learning.
- Medical locum staff told us that they attended the weekly medical training sessions, clinical supervision and felt they received adequate support.
- Staff were supported to complete professional revalidation with their professional bodies such as the General Medical Council (GMC) and Nursing and Midwifery Council (NMC).
- We saw that the trust had provided staff with access to professional training to support their clinical roles and encourage development. Examples included external training courses, which included coronary care specialist training, leadership training and assistant

practitioner training.

- In addition to external training opportunities, senior staff told that the service had introduced a number of internal training programmes to develop staff. During our last inspection, staff informed us of the leadership programme for band seven (ward managers). During this inspection, staff told us that the course had developed further and now included a further two-year programme. The attendees designed the first year with content chosen by staff attending the course while the second year considered the attendees delivering the programme to develop additional skills in planning and delivering training.
- The service had introduced a band six (ward sister) training programme which was designed to expose ward sisters to management roles and responsibilities.
- Both band 6 and 7 staff told us that the internal training had been excellent. They had found comfort in knowing that their peers were experiencing similar issues and shared ideas about managing situations. One ward manager told us that previously she would not have been confident attending another ward, but following the programme "felt confident to visit any ward, be known by name and be spoken to in friendly manner".

Multidisciplinary working

- All necessary staff assessed; planned and implemented patient care. Medical records detailed an admission treatment plan; amended according to clinical findings and patient condition.
- Staff work together to assess and plan ongoing care and treatment in a timely way when people moved between teams or services, including referral, discharge and transition. The medical doctors used the e-referral system, found the system easy to use, and supported them during consultant ward rounds.
- Multidisciplinary team (MDT) working was evident throughout the medical wards. Clinical leads took responsibility for their service and included all staff in decision making about care and treatment. In all clinical areas, daily board rounds included the MDT. We saw good interaction between nursing and medical teams and allied health professionals, which included dietitians and occupational therapists.
- We saw that all patients had a multidisciplinary team assessment completed within 14 hours of admission to hospital with a clear treatment plan outlined during the first consultants ward round following admission. This was in line with the London Quality Standards.
- In addition to admission assessments, patients records showed that weekly multidisciplinary team meetings were completed a minimum of weekly, with all staff participating in treatment planning.
- We were told that social services attended MDT meetings for complex discharges however, this did not always happen. The ward discharge coordinator liaise with social services on a regular basis and communicated any changes to the MDT in their absence.
- There was a supportive and visible pharmacy service with good multi-disciplinary working (particularly on AAU). The trust pharmacy team undertakes leadership on medicines and medicine use within the organisation. A seven-day service was available which included access to medicines and pharmacist advice if needed during out or hours.
- The records showed that the MDT reviewed all patients, which identified and enabled baseline conditions and the formulation of treatment plans. This included a review from the ward pharmacists.
- Medical staff within the acute admissions unit (AAU) worked alongside the emergency department (ED) with the aim of managing and maintaining patient flow.
- The Rapid Assessment Interface and Discharge (RAID) team is a specialist mental health service, based in Watford General hospital. The RAID team offered assessment, diagnosis and treatment for emotional and psychiatric ill health patients. The RAID team also

provided additional support for staff, patients and relatives with diagnosed or suspected mental health conditions. The RAID team were available from Monday to Sunday 9am to midnight. For example, we saw that ward rounds on Bluebell ward were completed in conjunction with the mental health team, which effected good communication between services.

Seven-day services

- The medical team reviewed patients daily while nominated consultants saw patients a minimum of twice weekly. We saw patient records showed regular assessments and adjustment to plans depending on their condition or progress.
- In addition to ward rounds, daily board rounds supported discussion about patients, any identified actions required to prepare the patient for discharge. The ward discharge coordinator, nurse in charge and therapy staff attended these meetings. Daily board rounds discussed each patient together with shared information such as awaiting assessment for a care home, waiting for equipment or not fit for discharge. During a board round, we asked how information was shared between the nurse in charge and the nurse caring for the patient. In response, each ward had a handover at lunchtime when the team met to share information from the ward and board round.
- The specialist service provided a seven day, 24 hour a day service. For example:
    - The gastroenterology provided a gastrointestinal bleed service
    - The respiratory consultant provided non-invasive ventilation (NIV) advice seven days a week with a weekend respiratory review in the acute assessment unit (AAU). NIV supports a patient to breathe more deeply by blowing extra air into their lungs via a mask.
    - Stroke nurses with a stroke consultant review during the weekend mornings.
- The ambulatory care unit provided a service Monday to Friday 8am to 9pm and Sunday 9am to 7pm.
- The medical consultants provided weekday cover between 8am and 6pm, with on call facilities overnight and at weekends. All wards reported that at weekends, patients would continue the treatment plans identified by their consultant unless they became acutely unwell.
- Patients requiring continued assessments or reviews at weekends were seen by on call consultant. Medical notes confirmed that weekend assessments were completed.
- Local diagnostics services were available daily with out of hour's facilities for emergency procedures, such as x-ray and pathology. Staff reported no issues with accessing diagnostic testing out of hours.
- The critical care outreach team were available to offer advice and support on all aspects of acutely unwell patients 24 hours seven days a week. Their expertise included assessing and advising on for example: patients with a National Early Warning Score (NEWS) above four, care of a deteriorating patient, those with a fractured neck of femur, sepsis, acute kidney injury and cardiac arrests.
- The hospital at night team had changed since our last inspection and had introduced a twilight service to support the on call medical team. We saw that at 5pm, the critical care outreach nurse and an assistant practitioner attended a handover and discussed areas of risk across the hospital. The outreach nurse screened all calls to the on call team and allocated tasks according to individual's role. For example, the assistant practitioner completed roles such as catheter insertion, cannulation (needle inserted into a vein for intravenous treatment) and blood tests. We were told that the introduction of a twilight shift had meant that tasks were completed sooner, allowing patients to have an improved hospital experience. The twilight shift was provided Monday to Friday with the weekend service being managed by the on-call team.
- At 8pm, the hospital at night team received a handover from the outreach nurse and

assistant practitioner. They then became the person responsible for screening and allocating tasks until 8am when the local teams took over. The medical on call team attended both the 5pm and 8pm meetings and we were told that the surgical and orthopaedic on call teams never attended either meeting.

- Pharmacy operated a weekday 9am to 5pm service. A weekend dispensing service operated from Watford Hospital. Out of hours, an on-call pharmacist was available for dispensing urgent medicines as well as the provision of medication information or advice across all sites.
- Physiotherapy and occupational therapy services were delivered 7 days per week 8am to 4pm with an additional overnight on-call service.
- The discharge lounge was open seven days per week, which enabled patients to be discharged, await transport home and free up their bed.

Access to information

- Staff told us that they had access to all the information required to enable them to care for their patients. However, the IT system was old and required updating. The age of the system affected the speed that staff could access information and staff previously reported that the system failed. The trust had robust systems in place to manage patient care when the IT system did not work. During this inspection, no staff reported any issues with the IT system.
- The service provided patients' GPs with an electronic summary, which enabled the continuous care and relevant information of the patients once discharged from hospital. The trust target was for all GPs to receive the discharge summary within 24 hours of discharge. The Integrated Performance Report – Elective Medicine dated June 2017 showed an achievement rate of 76% which was below the trust target of 95%. We requested a copy of the action plan to address the audit findings, however, one was not provided by the service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- During our September 2016 inspection, we found that there was no oversight of patients managed under a deprivation of liberty safeguards (DoLS) application and issued a requirement notice. During this inspection, we found the service had addressed this requirement. Ward staff tracked every patient cared for under a DoLS, noting the date of referral and date of expiry. The ward sisters and matron responsible for the clinical area tracked and shared the DoLS applications. When information changed, or patients no longer required the referral they notified the local safeguarding team and updated the list. Matrons were able to provide the board with details of the DoLS patients cared for in hospital if necessary.
- Staff demonstrated a good understanding of their responsibilities regarding the Mental Capacity Act 2005 (MCA) and knew what to do when patients were unable to give informed consent. The data for September 2017 showed that 76% of medical staff and 95% of nursing staff had completed their MCA and Deprivation of Liberty Safeguards (DoLS) training.
- The mandatory e-learning package provided to staff, including safeguarding, information about the MCA and DoLS. Staff said they would seek advice from a senior member of nursing staff should a formal assessment of mental capacity require completing. We saw that a variety of staff had completed MCA and DoLS referrals.
- We saw that nursing staff and doctors completed the mental capacity assessments (MCAs) for specific decisions regarding patients care. For example, we saw some MCAs relating to inability to consent to care and treatment and other regarding the inability to consent to discharge planning. Each assessment we viewed provided the reason as to why the patient was not being able to consent.

- MCAs also included details of conversations held with patients loved ones relating to decision making, which showed clear involvement in treatment planning.
- We reviewed the notes of five patients who had a DoLS in place and found that the form had been completed and sent to the local authority. The trust reported delays in the local authority assessing patients cared for under a DoLS, and had agreed that unless the patient clinical condition changed the original referral would stand until such a time as the local authority could complete a full assessment.
- Both nursing and medical staff understood consent, the decision-making requirements and guidance. We saw consent forms in place. Staff understood when to use the forms and whether the consent provided was implied, verbal or written. Implied consent is "consent which is not expressly granted by a person, but rather by their actions and the facts and circumstances of a particular situation". Verbal consent means that patients "read a verbal version of a consent form such as an information sheet and give their verbal consent rather than a written consent."
- We observed consent clearly recorded for all physiotherapy treatments.
- We saw one patient complain that they did not want their intravenous medicine. We saw the nurse explain the rationale for the medicine and the reason for the medicine. We noted the patient providing their consent after the nurse's intervention and explanation.

Are medical care services caring?

Good

We rated caring as good because:

- All staff treated patients with respect and in a considerate manner. Discussions were open and inclusive. Patients and their relatives were included in decision making about treatment and care.
- Staff maintained patients' dignity by using appropriate screens.
- Patients and their relatives felt that they were involved with care and treatment plans.
- Patients and their relatives had access to multi-faith support when required.

Compassionate care

- Staff took the time to interact with patients and those close to them in a respectful and considerate manner.
- Patients' privacy and dignity was respected especially during physical or intimate care. For example, we spoke with patients who told us that staff always pulled the curtains when assisting them with personal care. Patients felt their privacy was respected and they were treated with courtesy.
- We observed staff used the "Hello, my name is" campaign. The aim of the campaign is to encourage all staff to introduce themselves to the patient and visitors to improve the hospital experience of all patients. Patients confirmed staff introduced themselves and spoke to them appropriately. We observed staff introducing themselves to patients during our visits to the ward.
- On Bluebell ward, we observed staff talking kindly and patiently to a patient with dementia who was distressed.
- Patients were positive about their experience within the inpatient services. Staff spoke in a kind and considerate manner with patients and their relatives. We saw staff closing curtains to protect patients' privacy.
- Most wards had examples of compliments received from patients. Examples included;
    - Thank you for all your help, support, kindness, care and compassion
    - Thank you for being so nice and making me welcome on the ward.

    - Good communication on all levels
    - Staff very professional and caring
    - Everything explained clearly
- The Friends and Family Test (FFT) is a national feedback tool that enables people who use the service the opportunity to provide feedback on their experience. The FFT from May 2016 to April 2017 Watford General Hospital had a 25% response rate for medical inpatients. This was considerably lower than the previous rate of 52% (May 2015 to April 2016). We saw FFT results displayed on wards along with any actions taken by staff in addressing any issues raised by patients or their relatives. For example, we saw that Tudor ward had an average score of 79% from June to August 2017. Comments included "staff were polite, ward was clean. I felt safe", "staff were very attentive and helpful" and "the care from doctor was amazing. Never met a more patient doctor. So kind and caring and explained in accessible way". Senior staff confirmed they discussed the outcome of the FFT at weekly team meetings as part of the action plan to increase patient's response rate.
- The Catheterisation laboratory survey results for June 2017 showed that 99% of patients (53 responses) were happy with the care given.
- The trust participated in the National Cancer Patient Experience Survey 2016, (published in July 2017). Patients were asked to rate their care on a scale of zero (very poor) to 10(very good). The trust's overall rating was 8.6. Between October 2016 and March 2017 464 eligible patients from the trust were sent the survey, and a response rate of 64% was achieved, which was just below the national rate of 67%. The trust scored below the national average of 73% and 29% respectively in two questions which included; patient's family or someone close definitely had the opportunity to talk to a doctor at 66% (149 patients) and taking part in cancer research discussed with patient at 14% (259 patients). However, 92% (169 patients) confirmed they received understandable answers to important questions all or most of the time. This was above the national average of 88%.

Understanding and involvement of patients and those close to them

- Patients told us they were involved in their care and understood their treatment and care plans. Patients described conversations with the doctors and consultants, they had been able to ask questions and had been told how their illness or injury might improve or progress. Doctors confirmed they aimed to involve patients, their family or relative in management decisions. We saw documented evidence in the records reviewed on Sarratt ward to confirm this.
- The service had introduced the "End PJ Paralysis" scheme, which aimed at getting patients out of bed, dressed and walking around. However, on visiting the wards we found most patients lying in their beds in their nightclothes. Staff said they found it difficult to encourage patients to try to get up and get dressed. In addition, many patients did not have additional clothing to support the scheme and they were aiming to get relatives and friends to bring in additional clothes to encourage patients to get dressed in day clothes.
- The patient experience and carer strategy 2016/19 was developed with the involvement of patients, volunteers, carers and trust staff with four priority focus areas, which is in line with the national patient experience framework. Areas identified included:
    - Communication, listen, involve which has re-launched the "Hello my name is" initiative
    - 'Get the basics right,' has resulted in the consent to treatment forms being revised
    - 'Improve the patient journey,' has been the driver to introduce the safer discharge project within elderly care
    - 'Making the best of our volunteers,' with revised volunteer recruitment and work experience policies.
- In the CQC Inpatient Survey 2016, published May 2017, the trust did not perform better than other trusts in any of the 12 questions examined by the CQC, about the same as other trusts for six questions and worse than other trusts in six questions. Examples

included poor understanding of doctors answering their questions in a way they could understand, being involved in decisions about their care and treatment and involvement in decisions about their discharge from hospital.

Emotional support

- Patients and their relatives told us that all staff were approachable and they could talk to them about their fears and anxieties.
- The hospital chaplaincy service was multi-faith and provided support 24 hours per day. It provided services to patients across the hospital. Staff were aware of how to contact spiritual advisors to meet the spiritual needs of patients and their families.
- Staff were aware of the emotional and mental health needs of patients and were able to refer patients for specialist support if required. Assessments tools for anxiety, depression and well-being were available for staff to use when required.
- During our visit to the acute admissions unit (AAU), we observed staff providing emotional support to a patient who was very distressed. They also supported all the surrounding patients to ensure they were not anxious or required specialised assistance.

Are medical care services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The flow of patients through the hospital, from admission to discharge was not managed effectively, with patients cared for in escalation areas with limited facilities.
- Mixed sex breaches appeared to not always be reported as incidents, with limited actions in place to mitigate risks.
- Clinical specialities did not always meet the national average referral to treatment times.
- The service did not always manage complaints effectively with frequent delays in response to complainants.

However:

- The medical division had plans to develop clinical specialities through the relocation of services to different clinical areas. This was part of a trust wide project.
- The trust had clear escalation processes in place, which detailed actions staff should take according to their role and hospital activity.
- The service had reduced the number of inpatient moves and out of hours patient moves since our last inspection.
- The discharge lounge could facilitate a small number of bed bound or stretcher patients.
- The service had access to facilities to meet the needs of individuals, this included interpreters, patient advocates, specialist equipment such as pressure relieving mattresses and patient passports/ “This is Me” to inform care.

Service planning and delivery to meet the needs of local people

- The hospital participated in both the national and local Commissioning for Quality and Innovation (CQUINs) payment framework, which encourages providers to improve the delivery of care to improve patient experience. The medical service participated in for example:
    - antimicrobial resistance which included the reduction in antibiotic consumption and

ensuring antibiotic review within 72 hours
    - managing long-term conditions – diabetes by implementing and promoting different forms of education and system wide joint up training for staff
    - stroke services by improving the patient stroke pathway
    - supporting proactive and safe discharge by enabling patients to get back to their usual place of residence in a timely and safe way
- Each clinical area was able to describe plans for their service. For example, there were plans to move the respiratory ward to the Acute Admissions building as a large portion of patients admitted through AAU had a respiratory illness. Nursing staff told us of the plans and the changes required to enable the move to go ahead.

Access and flow

- The bed management team managed the flow of patients across the hospital. This consisted of two managers who split the hospital into admission and non-admission areas. Patients admitted to the emergency department, admission ward or clinics requiring an inpatient stay were referred to the bed manager responsible for admissions. They referred information to the second bed manager who liaised directly with wards to identify when and where wards beds would be available.
- Bed occupancy was not tracked electronically and details of bed availability and patient discharge was collected by the discharge team, usually through communication with the ward nurse in charge or discharge coordinators. The trust completed regular bed meetings to discuss the predicted admissions (based on previous year's data) and the pending discharges. The bed meetings were the team's opportunity to agree escalation plans against the current position. Decisions to open additional inpatient areas, such as beds within the Ambulatory Care Unit, Emergency Surgical Assessment Unit and the Frailty Unit was completed in line with the trust escalation policy, with decisions made by the manager on call. The escalation policy detailed actions each staff group should complete according to the hospital activity.
- Each ward had a dedicated discharge coordinator who assisted with the management of patients discharges. Staff told us that they did not see flow of patients through the hospital as an issue, however we found that patients were cared for in either the wrong location, or for longer than would be expected. We observed poor discharge processes across the service. For example, the records showed patients' length of stay in AAU was greater than four days despite their mission statement that states that patients "do not stay in the AAU for more than 48 hours." The length of stay on the wards was variable. Each ward board detailed the number of days patients had been in hospital and we saw that the length of stay varied from two to 140 days. We did not find adequate processes in place to manage the flow within the wards to facilitate early discharge.
- The presence of a small portable medicine storage unit on the AAU ward enabled discharge medicines to be available and therefore ensured discharge of patients could happen quickly.
- The trust had a target of just below 4% for patients' delayed transfer of care (DToC). The data within the board papers for July 2017 showed the DToC ranged from 5% to 10% between May 2016 and May 2017. For example, the number of DToC patients for May 2017 represented 7% of occupied beds, which is equivalent to 1459 bed days (47 beds). The main reasons for delayed transfer of care from May 2016 to April 2017 was 'awaiting care package in own home' (35%), followed by 'waiting further NHS non-acute care' (15%). The medicine service's oversight of the survey resulted in daily patient monitoring and briefings with the discharge co-ordinators.
- The hospital had an ambulatory care unit (ACU) that saw patients who did not necessarily need an admission but who may have required further investigation or review. GPs were able to refer direct to the ACU avoiding unnecessary delays or overnight stays. However, this area and the frailty unit, was used as an escalation area to care for patients requiring

an inpatient stay when capacity across the hospital was full. When possible, care was provided by substantive members of staff, however during our inspection, we saw that this area was managed at night by agency staff. The agency staff on duty told us that they were overseen by the bed management team. During the inspection, the ACU had five long stay patients and one on the frailty unit.

- The NHS operating framework for 2012-2013 confirmed that all providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient. During our visit to the cardiology ward (purple), we observed a breach of the mixed sex accommodation guidelines. We saw that within one bay there was a mixture of two female patients and two male patients. This was brought to the attention of senior staff, who told us that due to the ward layout occasionally bays were occupied by mixed sex patients. We were told that these occasions were reported as an incident using the trust incident reporting tool. We reviewed the incident reports for the department from March 2017 to August 2017 and found that no mixed sex breaches had been reported as incidents in cardiology or across the medical services from March 2017 to August 2017.
- In the September 2016 inspection, we identified that patients were moved frequently between wards and within departments such as admissions areas due to the design of the wards. This was to accommodate single sex wards where possible. Trust data showed that, between June 2016 and May 2017, 29,144 patients were admitted to Watford General Hospital. The service completed an audit to capture the number of moves between wards, and found that 26,744 (92%) of patients were not moved, 1,921 (7%) patients had one move, 363 (1%) had two moves, and 86 (<1 %) and 30 (<1%) had three and four moves respectively. This was an improvement in patients' moves from the previous inspection. We did not see an action plan to address the findings.
- Medical service data showed that there had been 163 patient moves between 10pm and 7am from January to June 2017. This was equivalent to 27 moves per month. This had significantly improved since our previous inspection when we found that on average 300 patient moves were recorded between 10pm and 7am per month (December 2015 to May 2016).
- Due to capacity issues, medical patients were often moved to non-medical speciality wards. For example, we saw that 12 medical speciality patients were located on Letchmore surgical ward. We saw that these patients were transferred to the ward following a review of their clinical condition and a decision by the consultant that the patient was stable and able to be cared for on non-medical wards. Letchmore (surgical) and Elizabeth (gynaecology) wards had admission criteria set out to identify suitable patients for the nursing skill.
- We spoke with surgical staff who told us that following a meeting with the medical head of nursing, they had agreed the number of patients to be transferred to Letchmore ward. Staff reported that the patients were reviewed daily and if they became unwell, the medical team were responsive to moving the patient back to a medical speciality ward.
- The medicine service had an established delirium recovery programme. This programme enabled patients to return home with sufficient support to promote the patients normal activity and identify any ongoing care needs. This reduced the inpatient length of stay and promoted patients recovery within their own homes, resulting in a reduction of patients requiring admission to a care home.
- The high occupancy rate of around 97% for inpatient beds meant there was no capacity to absorb additional patients during periods of peak demand. During the busiest times, the corridors around the emergency department were designated as clinical areas.
- In England, under the NHS Constitution, patients 'have the right to access certain services within a maximum waiting times and for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'. The NHS Constitution sets out that those patients should wait no longer than 18 weeks from GP referral to treatment (RTT). From March 2016 to February 2017, the trust's RTT for admitted pathways for medicine showed that 92% of patients were treated within 18 weeks. This was higher than

the England average of 90%. The trust performance has been consistently in line with the England average.

- The June 2017 integrated performance report for elective medicine showed that the trust had 15 diagnostic tests including endoscopy. As of May 2017, the percentage of patients who were waiting for a diagnostic test and seen within six weeks was 97%. This was lower than the trust target of 99%.
- The following specialities were above the England average for admitted RTT. Gastroenterology scored 96% and rheumatology 100%, which was above the England average of 95%. Dermatology was on par with the England average at 86%. However, the following specialities were below the England average; cardiology 70% (England average 84%), geriatric medicine 89% (England average 98%) and thoracic medicine 91% against an England average of 95%.
- Clinical waiting times were highlighted as a concern within the cardiology department and identified on their risk register. During our inspection, we found that cardiology was compliant with the required targets. This had been achieved with the recruitment of three new doctors.
- The trust had a discharge lounge, which was open seven days per week. The aim of the service was to manage patients' discharges to enable new admissions. We saw that the unit had changed since our last inspection and could now facilitate two patients on beds or stretchers. Staff told us that patients were collected from the wards and accompanied to the department where they would assist them to prepare for discharge. This included the organising of tablets to take home, discharge letters and transport.
- Staff told us that they often received complaints from patients relating to the length of time spent within the department. This was usually because ward staff did not usually make it clear how long patients could wait for their medicines or transport to arrive. We reviewed the admission book and found that the majority of patients were discharged within two hours (55%) of admission to the unit. A further 30% patients were discharged within four hours and the remainder over four hours (15%).
- Patients who became unwell whilst waiting for transport home and those whose transport did not arrive were readmitted to hospital, usually via the emergency department or acute admissions unit.

Meeting people's individual needs

- All staff spoken with showed a good awareness and knowledge of equality and diversity and gave examples of how they previously had to alter their care to ensure patient's beliefs were respected.
- Patients who were admitted to the ambulatory care unit as an inpatient did not have access to bathrooms. There was one toilet with a sink. Staff told us they accompanied patients to use a bathroom in the Acute Admissions Unit if they wished to shower.
- The trust supported the "This is Me" passport for patients with a learning disability. This was owned by the patient and detailed personal preferences, likes/dislikes, anxiety triggers and interventions, which are helpful in supporting them during difficult times. All patients with a learning disability had a purple folder, which was easily identifiable enabling staff to support and provide the right care. The nurse specialist for patients with a learning disability identified, in conjunction with carers and ward staff, what reasonable adjustments were required to support the patient whilst in the trust. This could include pre-visits for procedures to support desensitisation and flexible visiting.
- A translation service was available for non-English speakers and staff showed awareness on how to access this. Although we observed a commitment to providing services to patients who did not have English as their first language, we did not always see information on display concerning interpreting services.
- Whilst we observed information boards showing a range of information for patients and

visitors, these boards did not provide any information in different language formats.

- The trust did not have a flagging system, which meant staff dependency on the triaging system and information on the patient's individual records to identify patients living with dementia or a learning disability.
- The division had appointed specialist nurses for vulnerable patient groups, such as those living with dementia and those patients with a learning disability.
- Staff ensured patients with dementia were appropriately screened, treated for any underlying cause that may be contributory to a delirium and were signposted for further assessment if needed. Where a patient diagnosis of dementia was confirmed, the division had a designated care pathway supported by specialist practitioners such as therapists and specialist nurses.
- Staff recognised meal times could cause concerns for many patients and their family members. The trust used both the red tray, which identified patients who required support and a blue tray scheme for patients with a diagnosis of dementia.

Learning from complaints and concerns

- As at July 2017, the hospital received 65 complaints about medical care. The trust took an average of 69 days to investigate and close complaints. This was not in line with the trust policy, which states that a response to the complainant should be within 25 working days or 35 days if the complaint is complex. Twelve complaints were currently still open at the time of the inspection. The main themes related to clinical treatment, admissions, discharges and transfer arrangements. Communication was an overall theme across all the complaints. The medical service had improved its response time from 60% in March 2017 to 100% in May 2017.
- Complaints were discussed at trust board every month as part of the integrated performance report. Complaints were also discussed at the patient experience group, patient and staff experience committee, quality, and safety group meetings.
- Patients and relatives could access the process for raising concerns and formal complaints on the trust website, through leaflets and posters on the wards and clinical and public areas. The Patient Advice and Liaison Service (PALS) worked with staff to resolve concerns within 48 hours.
- The medicine division held monthly quality and safety meetings, producing a report for the trust board, which detailed complaints and complements. Learning shared during this meeting was fed back to local teams during their team meetings. We saw the meeting minutes for example, cardiology and noted that the discussion of complaints was included in the agenda.
- The Cath lab had received 15 formal complaints from January to July 2017. We saw they had evaluated the complaints to look at themes. Key areas identified were; admission, discharge and transfer arrangements, delays and cancellation of appointments, clinical treatment and patients' privacy and dignity. The Cath lab completed a daily communication book and we saw that complaints were included on the agenda. This meant that up to date information was provided to staff to ensure patients were dealt with appropriately as part of the lessons learnt process.

Are medical care services well-led?

Good

We rated well-led as good because:

- There was clear leadership across the speciality. Clinical leads took responsibility for their service and development.
- Local managers used peer support and were enthusiastic about improving their ward,

team and sharing knowledge.

- Team and clinical leads were accessible and respected by all staff.
- Staff were aware of the trusts vision and aims.
- Staff were committed to the trust and had pride in their role.
- Locum staff were included in all activities and felt valued and supported.

Leadership of service

- The service structure included a divisional director, head of nursing and a service manager. Each speciality had an associate divisional manager and assistant service manager, plus a deputy head of nursing and matrons. All staff knew who their leads were and reported that they were always supportive and willing to listen.
- We saw strong clinical leadership across specialities, and clinical leads we spoke with were enthusiastic about the service they provided. For example, the clinical lead for stroke medicine was looking at ways to develop the service further and maintain the quality of care and patient outcomes. Nursing staff reported that clinical leadership was more focused since our last inspection, and that they were fully engaged and supportive of the wards and teams.
- Local leaders were visible and approachable and ward managers understood some of the challenges at a local level within the medical service.
- The trust had developed a variety of leadership programmes, which included a medical leadership programme and ward manager, deputy ward manager and staff nurse programmes. We spoke with three senior nurses who confirmed they were aware of the programme and a nurse who was on the programme. They said it enable them to learn from each other's experience and share ideas on how they should be managing clinical areas.
- Staff found their managers friendly and supportive and had good training opportunities.
- Nursing staff across the medical wards felt well supported by the matrons. During our inspection, we observed matrons in various clinical areas communicating with both staff and patients.
- We observed that ward staff worked well together and supported each other. Staff across medical wards reported feeling pressurised by the bed management team. During our visit to the wards, we overhead several phone calls requesting updates of patient discharges.
- All staff were committed to delivering good, safe and compassionate care. They told us that they were proud to work for the trust.
- Staff said that they were aware of the executive team and had visited and participated in the day to day running of the wards.

Vision and strategy for this service

- The trust had a vision to provide "the very best care for every patient, every day." Staff we spoke with were aware of the trust vision, and we saw posters displayed across all clinical areas referring to the trust vision and aims.
- The trust had set themselves four aims:
    - Aim one – to deliver the best quality care for our patients
    - Aim two – to be a great place to work and learn
    - Aim three – to improve our financial sustainability
    - Aim four – to develop a strategy for the future
- The medical services did not have a specific vision for the service, however did have a strategy for the continued development of services. For example, the service was in the process of reviewing the hospital at night team by auditing all calls to identify needs. The plan was to analyse the data to complete a business case for additional senior nursing support at weekends. Additional strategies included the introduction of an "in reach service"

to the emergency department, where specialist staff attend the ED to identify patients that could be quickly moved to ward areas, for example, the respiratory specialist nurse would identify patients to be moved to the respiratory ward. The service was also planning the introduction of “admiral nurses” who would attend care homes to prevent admission to hospital, to reduce admissions to ED.

- We were told that the service was planning to review services, which were currently outsourced to other providers. This was to identify specialities or procedures, which were provided at other hospitals that could be provided by medical services at Watford General Hospital.
- Staff were able to tell us about service developments and their role in the planning and implementation of any planned changes.
- The trust values were; commitment care and quality. Both medical and nursing staff could describe the trust’s vision and values and directed us to posters visible across the service. Staff said they could contribute and submit ideas on how to improve the service based on the trust values.
- The service had clear aims and objectives for their continued development which included the maintenance of the stroke service rating, currently AA rating (top 18% nationally) and the results from the National Audit of Dementia (care in hospitals).

Governance, risk management and quality measurement

- The service had a clear governance structure, which included escalation processes, which were identified in the departmental clinical governance meeting minutes. Information was captured within departments, and then shared across the division, the trust quality and safety group and trust executive boards. We observed the information was shared across the multidisciplinary team and most highlighted the actions, which showed when and who should complete the actions.
- Speciality meeting minutes seen included a review of complaints and compliments, details of incidents, details of activity and pressure on capacity, staffing and recruitment, training, finance overviews and risks. The minutes seen were well structured and inclusive.
- The medical service risk register contained 20 risks identified across all specialities. For example, we saw risks relating to follow up appointments for endoscopy patients, the use of agency staff within the cardiac catheter lab, resources for diabetic services, staffing and inpatient chemotherapy. Staff we spoke with told us that the risk register reflected their main concerns.
- Risks identified on the register had clear mitigation recorded, and were reviewed and updated regularly. For example, we saw that the risk register had been updated to reflect the completion of a business case for a specialist nurse in May 2017, June 2017 and interview dates for an in July 2017.
- We saw the cardiology minutes identified the review of their risk register. Areas identified on their register included; clinic waiting times, typing backlog and the recruitment of staff including physiologists and secretaries. The risk registered was reviewed and updated regularly and reflected risks identified across each clinical area.
- The cardiology meeting minutes also highlighted areas of the quality improvement plan applicable to the speciality. This included for example the implementation of a ward checklist for staff so that they could easily identify and document key information and results needed as part of the referral to tertiary centres.
- The medicine service contributed to the safety and quality committee, which was identified in the February 2017 meeting minutes. The committee oversaw the quality performance regarding good practice and areas that required improvement. Areas covered included incidents, complaints, clinical reviews and the safety risk report.
- The service had a robust audit calendar, which detailed what audits were required each month. We saw that audit results were clearly displayed at ward reception areas detailing

results and action in response to the previous months audit data. In addition to the local display of information, audit compliance was recorded on scorecards, which were used to monitor and track changes or trends by the ward managers and matrons. The matrons reported on scorecard data monthly to the clinical leads and trust board.

- Ward managers used audit data results to highlight areas, where staff required additional training or support. For example, we saw that the ward manager on Croxley ward had completed additional training and introduced a patient body map in response to an increase in pressure ulcers reported.
- Ward managers meetings were held monthly. The meetings were used to discuss any planned changes to the service, review of ward scorecards and audit results, a review of complaints and associated actions, and a review of any serious incident investigations, training needs, finance and shared learning. We were told that since the ward manager development programme, these meetings had promoted a support network. We were told that "we [ward managers] realised we are all in the same situation" and "someone has probably dealt with the same issue before".
- The Cath lab had a service development portfolio on display within their area which showed their achievement for example the maintenance of their referral to treatment time of 18 weeks and their future plans which included the introduction of a new monitoring system so patients could have an echo cardiogram and see the consultant at the same time.
- We were told that partners and third party providers were involved with all service planning. For example, the commissioners and social services were involved with the planning of care pathways for stroke patients. We were told that regular meetings included all parties.

Culture within the service

- Consultants spoke of the positive relationship with other consultants across the three hospitals. They confirmed an open policy regarding the sharing of views in relation to medical services.
- There was an open and transparent culture where staff were encouraged and felt comfortable about reporting incidents.
- Staff said they were proud to work for the trust; they were enthusiastic about the care and services they provided for patients. They described the trust as a good place to work and some staff we spoke with had worked at the hospital for a number of years.
- Teams worked collaboratively, with support and advice provided as necessary. On the wards, we observed senior staff supporting junior staff in their tasks.
- Ward staff appeared to work together well and supported each other when short staffed.
- All staff spoke positively about the service, and clinical area they worked in. This included clinical and non-clinical staff.
- Nursing staff were very positive about the contributions they made to patients' health and wellbeing. This was particularly evident in the care of the elderly wards, where staff were very enthusiastic about the patient group.
- Patients acknowledged a positive and caring ethos and were mostly happy with their care.
- Locum staff felt included, respected and supported by all staff. We were told that they were frequently included in training, offered supervision and enjoyed working for the trust.

Public engagement

- Staff within medical services recognised the importance of gathering the views of patients and actively sought patients' views and feedback on the services provided.
- We saw evidence of patient feedback discussed in ward meeting minutes and on display on the ward notice boards and in staff newsletters.
- We saw thank you cards, expressing the gratitude of patients and relatives for the kindness and support they had received. All ward areas displayed responses from patients for staff

to see.

Staff engagement

- We were told that the medical service had recruited several new clinical leads to specialities and that they had been empowered to take ownership of their service. This was echoed by ward managers who described clinical leads as being enthusiastic about the service and wanting to improve care and treatment.
- The trust recently created a new staff engagement survey based on 11 engagement measures on a scale of one (not at all or strongly disagree) to five (completely or strongly agree). The data showed staff proud to work for the trust and their local place of work, but felt frustrated with day to day issues. Staff would also recommend the trust as a place of treatment more strongly than a place to work. The medicine service scored an engagement score of 3.66.
- Staff we spoke with reported that there had been a change in staff engagement since our last inspection. Nursing staff reported that they felt empowered to make decisions about their wards and as a result were proactive in making suggestions for improving their clinical areas.
- Croxley ward had introduced a “staff member of the month” programme managed by the deputy ward manager. Staff anonymously voted for a member of the team, and the person with the most votes was highlighted as the team member of the month. The programme was being reviewed to include why the person was voted and the number of votes received. The details were included in the team ward meeting minutes.
- Nursing staff told us that the wards “felt like a team”, that there had been “improved opportunities for learning across the trust” and that they “constantly feel like we are developing and learning”.
- Two ward managers were in the process of developing Care of the Elderly competencies for qualified nurses and healthcare assistants across the service, with the aim to ensure that all staff had the same level of training and opportunities.
- Croxley ward nursing staff were in the process of planning a training day which would be taught by their ward staff with specialist knowledge and experience and offered to staff from across the medical services to share their learning and understanding of care of the elderly patients.

Innovation, improvement and sustainability

- Staff demonstrated that they were focused on improving services across the medical division with an increased ownership of making changes locally for the benefit of patient care.
- Local development projects were shared across teams and learning used to identify better ways of working. Not all changes were embedded due to the speed of development. Staff recognised that they would need to stop and assess changes to ensure that practice was moving in the right direction. However these checks had not always been planned at the time of inspection.
- All staff recognised that improvements had been made and demonstrated awareness that the journey of improvement had just begun.
- The clinical leadership had improved since our last inspection, which meant that whole teams were engaged in improving services. This could impact on the sustainability, as change was being driven from the front.

Surgery

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

Information about the service

West Hertfordshire Hospitals NHS Trust surgery services are provided at two hospital sites, Watford General Hospital and St Albans City Hospital. Findings about services at St Albans City Hospital are in a separate report.

Surgery services are managed within the trust's surgery, anaesthetics and cancer division. The division is led by a clinical director, divisional manager and head of nursing. There are clinical leads and managers for each surgical speciality and for theatres.

Watford General Hospital (the hospital) provides a range of elective (planned) and emergency (unplanned) surgery services for the community it serves. This includes trauma and orthopaedics, urology, general surgery, vascular and ophthalmology. There were 14,257 treatment episodes from February 2016 to January 2017. Of these, approximately 35% were day case procedures, 20% elective and 45% emergencies.

The hospital has five operating theatres, five inpatient wards (Cleves, Flaunden, Langley, Letchmore and Ridge) a pre-assessment unit, an emergency surgical admissions unit and an admissions area combined with a day surgery unit.

During our announced inspection between 30, 31 August and 1 September 2017, and an unannounced visit on 12 September 2017, we visited all areas providing surgery services at the hospital, spoke with 12 patients or their relatives, observed patient care and treatment and looked at 22 patient care records. We spoke with 50 members of staff including nurses, doctors, surgeons, therapists, healthcare assistants, administrators, theatre staff, ward managers, matrons and senior managers. We also considered the environment, held a discussion with a group of junior doctors and physician assistants, acknowledged the views expressed at focus groups attended by trust staff, and reviewed the trust's surgery performance data.

Surgery was previously inspected in September 2016 and was rated good for effective, caring and well-led, and required improvement for safe and responsive. The overall rating was requires improvement.
Our inspection in September 2017 found there had been improvements, but overall surgery was rated requires improvement.

Summary of findings

We rated this service as requires improvement because:

- Ward staff were not protecting patients' confidentiality because identifiable personal information was visible in public areas on the wards and patient sensitive information was discussed within earshot of other patients and members of the public
- Doctors did not routinely record reassessments of patients' risk of developing a blood clot.
- Nearly half ophthalmology patients were waiting more than 18 weeks for surgery. There was a risk that their sight would deteriorate before treatment.
- When patients' surgery was cancelled, they were not always treated within the following 28 days in line with expected standards.
- The surgery audits on the trust's audit register were nearly all behind schedule.
- The theatres, recovery area and the day surgery unit needed refurbishment in order to comply with national standards.
- Patients were sometimes cared for on the Emergency Surgical Assessment Unit (ESAU) and in recovery overnight because there were not enough beds on the wards.
- Surgery services were not fully engaged in the implementation of national standards or checking they were doing everything they could do prevent avoidable harm to people having a surgical procedure.
- We found examples of consultants and doctors undermining teamwork because of their attitude to nursing staff.
- Patients' records were not always available at pre-operative assessment.
- The route to administer a commonly used painkiller was not clearly documented on patients' prescription charts.
- Patients did not always get the written information they needed about their treatment.

However

- Surgery services had taken action to improve access to unplanned and planned treatment. The emergency surgical assessment unit provided timely review of patients from appropriately skilled medical staff and consultants. Most patients had waited less time for planned surgery than when we last inspected.
- Surgery services leaders had an understanding of risks and the actions needed to manage these so that patients were kept safe from avoidable harm. They made the case for additional resources so that risks, such as a shortage of consultant staff, were eliminated.
- There was a drive to standardise treatment and care. Examples included ward staff taking action to prevent patients getting pressure ulcers, and consultants managing patient treatment. There were a number of initiatives to improve care and treatment, such as cross-site meetings to review reasons for cancelled operations.
- Staff followed national guidance in order to provide effective treatment and care. Surgical specialities participated in national audits and used the results to make improvements to treatment. Outcomes for surgical patients were similar to or better than the national average.
- There was a culture that supported the reporting and learning from incidents. There was a shared understanding among all professions of the importance of being open when things did not go well. Patients were kept informed when there was an investigation of a serious incident.
- Ward staff completed risk assessments to make sure patients were given the care and treatment they needed. When a patient's condition deteriorated, there was action to make sure they received a prompt review. An outreach team was available at all hours

to support ward staff with a sick patient.

- Surgery services assessed staffing levels to make sure there were enough staff to keep patients safe from avoidable harm. Locum doctors and bank or agency nurses covered vacancies, sickness or other absences. Physician assistants and the hospital at night team helped junior doctors manage their workload. There was recent recruitment of additional anaesthetists and surgeons.
- There was work to improve the information provided to patients so that they had a better understanding of what to expect before they came to hospital. Patients and their relatives told us staff explained their treatment clearly when they were in hospital.
- Staff protected the rights of people with a mental health condition. There was an effective and patient centred process to make sure people were kept safe from harming themselves without depriving them of their liberty.
- Therapy staff encouraged patients to become mobile by leaving their beds as soon as possible after surgery. An enhanced recovery nurse supported some patients to prepare for and to recover from surgery.
- Staff spoke positively about working within the service and felt local and senior managers were approachable. Nursing and theatre staff told us they had opportunities for professional development. Practice development support was available to all ward and theatre staff. Doctors in training were receiving appropriate training and support.

Are surgery services safe?

Requires improvement

At our previous inspection in September 2016, we rated safe as requires improvement for surgery services. On this inspection, we have not changed the rating.

We rated safe as requires improvement because:

- Doctors did not record reassessments of patient's risk of venous thromboembolism (VTE) 24 hours after admission.
- Ward staff did not protect patient confidentiality. Whiteboards displaying patient details were visible to all ward visitors. Nursing handovers were sometimes completed in areas where patient identifiable information could be overheard by other patients and visitors.
- The premises in theatre five and the ventilation in theatre preparation areas did not comply with national guidance. The recovery area and the combined admissions and day surgery unit did not have appropriate facilities. These risks, and the action to resolve them were documented on the surgery, anaesthetics and cancer division risk register. There was action to mitigate the risks and the trust was submitting a full business case for refurbishment to NHS Improvement.
- Morbidity and mortality meeting minutes lacked recorded actions and learning.
- The route in which the painkiller Paracetamol was to be administered was not clearly documented in patients' prescription charts.
- Audits of the World Health Organisation (WHO) Surgical Safety Checklist and five steps to safer surgery were non-observational and audited the completion of the paper form only.
- Hand hygiene audits indicated compliance of medical staff on Langley Ward had been consistently poor.

However:

- Staff understood their responsibilities to report and learn from incidents and gave us examples of when services had improved as a result of this.
- There was a procedure for reporting all new pressure ulcers and falls, and there was action

to promote harm free care.

- The environment was visibly clean and staff followed the trust policy on infection control.
- Audits of hand hygiene in theatres indicated significant improvements in medical staff compliance to standards.
- There was access to appropriate equipment to provide safe care and treatment.
- Medicines were appropriately managed and safely stored, in line with trust policy.
- Nursing and medical handovers were well structured.
- Risks to patients were assessed, monitored and managed on a daily basis.
- Physician assistants and the hospital at night team helped junior doctors manage their workload. Locum doctors and bank or agency nurses were used to cover vacancies, sickness or other absences.
- Safeguarding of children and adults training for all staff was above the trust target of 90%.

Incidents

- Surgery services at Watford General Hospital (the hospital) had processes in place to prevent harm to patients and staff understood their responsibilities to raise concerns, to record safety incidents and to report them internally and externally.
- The hospital used an electronic online system for reporting incidents. Ward and theatre staff in surgery services described the process for reporting incidents and gave examples of when they had done this. They told us their managers encouraged them to report incidents and supported them with this process. Consultant surgeons generally did not complete an incident report themselves, and there was an example of delayed reporting of a serious incident because the consultant did not assign responsibility for completing a report.
- Surgery services for Watford General Hospital and St Albans City Hospital reported 1321 clinical incidents from June 2016 to June 2017. The trust graded the majority of incidents (97%) as either no injury or low harm. This demonstrated a positive culture of reporting incidents because staff reported near misses, when there was no harm to patients.
- When there were incidents that harmed, or had the potential to harm patients, the service learned from these and took action to reduce the chance of this happening again.
- There were no never events reported for surgery services at the hospital from June 2016 to June 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- The hospital reported 12 serious incidents in surgery from June 2016 to June 2017 that met the reporting criteria set by NHS England in the Serious Incident Framework 2015. Of these, the most common type of incident reported were pressure ulcers meeting serious incident criteria (42%).
- When there were serious incidents, there was a timely review to decide on the type of investigation and who should lead this. We looked at four investigation reports of serious incidents and saw that these included a detailed review of records and interviews with staff. The reports identified root causes of the incidents and allocated action to prevent a reoccurrence to named members of staff. However, we saw an investigation that found only one root cause, relating to the actions of a locum doctor. The report did not identify the barriers needed to prevent the actions of one doctor having an impact on patient safety.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to the person.
- Staff understood their responsibilities with regard to the duty of candour regulation and

were aware of the trigger for the application of duty of candour, which was for moderate harm and above. Staff described a working environment in which any errors in a patient's care or treatment were investigated and discussed with the patient and their relatives. We saw evidence from investigations that the service had applied duty of candour following serious incidents. A senior member of staff was appointed as duty of candour lead to liaise with the patient or their family and to meet them to share the investigation report. The trust offered a verbal and written apology to patients or their relatives and told them of any actions to help prevent a similar incident happening.

- There was strong evidence of learning from incidents in all areas we visited and staff provided us with many examples of this. For example, the theatre manager told us staff had incorrectly documented, transferred and stored blood products in theatre. This was a reoccurring problem and resulted in blood products being disposed of. Therefore, all theatre support workers received new training on correct blood product management. Since this training, the number of wasted blood products and incidents relating to them significantly reduced. From June to December 2016, surgery services across both sites reported 19 incidents relating to the incorrect storage, documentation and transfer of blood products. From January to June 2017, this reduced to four reported incidents.
- Lessons learned from incidents were cascaded to the team during ward and theatre handovers. The staff we spoke with confirmed the service shared learning through individual feedback, handovers and the trust newsletter enclosed with their payslip. We saw boards in staff areas that displayed details of incident investigations and learning from all surgical areas across the trust.
- A senior nurse on Ridge Ward had created a communication folder for the ward staff. This folder contained the investigations from relevant incidents that occurred on both surgical and medical wards. This helped to improve cross-departmental learning. The staff we spoke with on Ridge Ward were aware of the folder and told us they checked it regularly. The folder also contained information on ward updates and a copy of the patient safety newsletter.
- Each surgical speciality held monthly mortality and morbidity meetings to discuss patient deaths and other adverse events and review the care provided. We viewed mortality and morbidity meeting minutes for the anaesthetic and orthopaedic specialities. The minutes included a brief overview of the cases discussed and some recommendations to prevent reoccurrence. However, they lacked recorded actions and learning.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring, and analysing patient harms and harm free care. Data is collected on a single day each month to indicate performance in key safety areas, such as falls, new pressure ulcers and catheter associated urinary tract infections. The surgical wards displayed NHS Safety Thermometer information in the ward corridors to provide staff, patients and visitors with information on the service's performance. To help reduce the number of hospital acquired pressure ulcer incidents the service used a 'Best Shot Pressure Ulcer Prevention Pack', which a sister from Langley Ward initially created in 2014. The prevention pack was used trust wide. The pack ensured all pressure ulcer documentation was recorded in one place and provided nurses with information on caring for patients with pressure ulcers and caring for patients to prevent pressure ulcers. For example, the pack contained a checklist of patients' common high-risk areas for developing a pressure ulcer. On our inspection, it was clear these initiatives were effective because of the infrequent occurrence of a pressure ulcer on the surgical wards.
- In addition, the service implemented 'SSKIN' champions in each clinical area. The champions, usually junior nurses, were given 7.5 hours a month to provide training and educate the staff on their wards. The nurses ensured collaborative working between the

tissue viability team, dieticians and continence teams to address or prevent pressure ulcers.

- For surgery services overall there were four pressure ulcers at grade two or above from July 2016 to July 2017. The service reported no new pressure ulcers at grade two or above for 10 of the 13 months. At the time of our inspection, it was over a year since Letchmore and Langley wards had reported a pressure ulcer.
- The trust reported one fall with harm and three new urinary tract infections in patients with a catheter from July 2016 to July 2017 on surgical wards.
- Ward managers investigated all falls and pressure ulcers to identify learning to prevent reoccurrences.
- In the period July 2016 to July 2017, surgery services reported three venous thromboembolisms (VTE) over both hospital sites. This gave a VTE rate of 0.31, which was below the national average of 0.59. A VTE is a blood clot that can form in the veins of the leg or lungs.

Cleanliness, infection control and hygiene

- At the time of our inspection, there were reliable systems in place to prevent and protect people from a healthcare associated infection.
- We saw cleaning checklists on both the wards and theatres, which provided evidence of daily cleaning. The appropriate green 'I am clean' stickers were on equipment to demonstrate it was clean and ready for use.
- Staff received training about infection prevention and control (IPC) during their initial induction and annual mandatory training. We saw that 97% of surgery services nursing staff and 90% of medical staff across both sites had completed their IPC training. This was in line with the trust target of 90%. Staff also received hand hygiene training as part of their annual update. The trust's training record for August 2017 showed that 83% of surgery services staff had completed hand hygiene training. This was below the trust target of 90%.
- The trust conducted hand hygiene audits each month. Reported nursing staff compliance exceeded the trust target of 95% in five out of the six months from December 2016 to May 2017. In February 2017, the compliance rate for nursing staff was 93%. Langley Ward had a 60% compliance rate that month, which brought down the average for the service. Results for medical staff reported consistently poor compliance on Langley Ward, ranging from 23% (March 2017) to 84% (May 2017). Doctors' compliance on other surgical wards was reported to be 100%. We raised concerns about poor medical staff hand hygiene compliance on Langley Ward at our last inspection in September 2016. At this inspection, we were told there was not an action plan to address this, but staff discussed hand hygiene compliance at the monthly divisional governance meetings. Minutes from the May 2017 meeting confirmed this and stated that senior managers would speak to the individual non-compliant doctors. However, it was unclear whether this had been done.
- Medical staff had variable rates of reported compliance with hand hygiene in theatres. From December 2016 to February 2017, the compliance rate was 50%, but this was reported to have improved to 100% from March to May 2017. We were told the improvement was due to the implementation of 'Test Your Care' in theatres, a national audit to check adherence to care standards.
- In all areas we visited, we observed a high level of staff compliance with IPC practices such as hand washing, use of alcohol hand gel, use of personal protective equipment (PPE) and 'arms bare below the elbow' in clinical areas. We observed staff washing their hands appropriately before and after patient contact. This was in line with the National Institute for Health and Care Excellence (NICE) quality standard (QS) 61, statement three. This standard states people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.
- Hand hygiene gels were available for use at the entrance and exit of the wards, bays,

theatres and the pre-operative assessment clinic. There was also a verbal prompting system and hand hygiene advice at the entrance to the wards, which reminded staff, visitors and patients to decontaminate their hands prior to entry. We observed all staff using alcohol hand gel when entering and exiting the wards and theatres.

- Specimens were stored in line with trust policy, and staff called the trust's porters to collect patient specimens and transport them to the laboratory. If the specimen required urgent testing and there was a delay with the porters, the staff took them directly to the laboratory themselves.
- The trust's IPC team conducted monthly code of practice audits on the surgical wards. The areas audited included: correct storage and cleaning of equipment, safe management of sharps and staff awareness of IPC procedures. We saw copies of the audits for April 2017. During this period, the audit results ranged from 89% (Flaunden Ward) to 100% (Langley and Letchmore wards). All of the surgical wards displayed the audit results.
- When compliance did not meet trust targets, or areas of consistent non-compliance were identified, the ward managers implemented action plans. During our inspection, we saw evidence of the effectiveness of the action plans on Ridge Ward, when compliance increased from 75% in December 2016 to 94% in April 2017.
- The IPC team also carried out a regular audit of theatres. The audit focused on the theatre environment and equipment, waste disposal, sharps handling, decontamination and clinical practices. We saw a copy of the June 2017 audit where there was an 87% compliance rate.
- The trust used a contracted cleaning company to deep clean the theatres every three months on a rolling contract.
- The service participated in the NHS Improvement 90 day IPC improvement programme together with 21 other trusts across England. The area of improvement chosen was equipment and environmental cleanliness in theatres at the hospital. The programme encouraged theatre staff to implement changes relating to IPC processes and practices, and monitor the effectiveness of the changes over a 90-day period. If the changes were successful, the trust rolled out the new initiatives across other areas of the trust.
- The hospital outsourced the decontamination and sterilisation of equipment from theatres to an accredited supplier. The supplier had three designated times for collection, and delivered throughout the day. The standard turnaround time for equipment was 24 hours, but if theatre staff required this equipment sooner, the supplier offered an accelerated and priority service. The trust completed an annual site inspection of the outsourced supplier to monitor the quality and reliability of the service. The most recent inspection completed in July 2017 highlighted no major concerns with the supplier.
- The trust's target for MRSA bacteraemia was zero avoidable cases. Surgery services reported no cases of MRSA from September 2016 to August 2017.
- Trust policy was to screen patients having elective surgery for MRSA at their pre-operative assessment. If the result was positive, staff informed the patient and provided them a course of treatment. During this inspection, we observed staff adhering to the trust guidelines.
- Surgery services reported one case of *Clostridium difficile* (*C. difficile*) from September 2016 to August 2017. *C. difficile* is a potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patients who have had antibiotic therapy. This case occurred on Letchmore Ward in February 2017. Senior staff informed us that the infected patient was a medical outlier (a medical patient on a surgical ward). Staff took appropriate actions to treat the patient and to reduce the spread of infection by isolating the patient.
- All surgical wards had single rooms where patients with infections were isolated to reduce the risk of the spread of infection. During our unannounced inspection, we observed a side room used to isolate a patient with a suspected infection. The management of the isolated patient was appropriate, for example, the door was kept closed at all times and staff used personal protective equipment (PPE) stored outside the patient's room before entering the

room. We observed that staff disposed of the PPE in the room to prevent the spread of infection.

- Just over 7% of patients at the hospital developed a surgical site infection (SSI) following their hip replacement surgery from January 2017 to March 2017. This was an increase of 4% from the prior four reporting periods. There were no reported SSIs for patients following knee replacement surgery for the same period. Similarly, the hospital reported a 0% infection rate for patients following hip surgery.
- The trust took part in the Public Health England (PHE) SSI surveillance service for hip and knee replacements. This allowed the trust to benchmark its infection rates against other trusts. PHE informed the trust that their SSI rate was above the 90th centile and the service took action to address this. The service completed a root cause analysis for all identified SSI and the trust's SSI prevention panel discussed cases at the division governance meetings. In addition, the trauma and orthopaedic team asked for external advice about reducing the number of SSIs and immediately put the recommendation into action. At the time of our inspection, there was building work on the surgical wards creating an elective orthopaedic ward so that these patients would be cared for separately from trauma patients.

Environment and equipment

- Senior managers recognised that the environment of theatres, the recovery unit and the day surgery unit were not compliant with national guidance and there were actions to mitigate some of the risks, documented on the divisional risk register. The trust's executive and finance board had recently approved a theatre refurbishment business case to address the compliance and space issues. Senior management informed us that NHS Improvement (NHSI) had just approved the initial proposal and the division was now drafting a full business case.
- The theatres and recovery area was cramped and one staff member told us; "we do the best we can, with the resources and environment we have". We observed some equipment and theatre supplies were stored in theatre corridors due to the lack of space and two medication fridges were stored on top of each other outside the recovery area.
- Theatre five was previously a plaster room and we found it did not comply with national standards. This was documented on the divisional risk register. The scrub facilities were inside the theatre and not recessed. This did not comply with the Department of Health Building Note Guidance 26 (2004). This states that if there is no separate scrub room, there should be a recessed scrub and gowning area with space for a minimum of three people. The theatre did not have sufficient dirty utility rooms or an anaesthetic room. Due to the inadequate facilities in theatre five, it was not suitable for major emergencies and therefore, surgeons completed these procedures in the other four theatres. Theatre five was suitable for minor emergency procedures. We raised the issues with theatre five at the time of the inspection and senior managers informed us all problems with this theatre had been addressed in the theatre refurbishment plan.
- The recovery area did not have space for the separation of children and adults, as recommended in the Royal College of Anaesthetists (RCOA) guideline, the provision of paediatric anaesthesia (2017). The service took action to mitigate risks by putting children first on the theatre list, where possible, and screening off an area of the existing recovery, as recommended by RCOA (2017).
- The combined admissions and day surgery unit area was small and did not provide appropriate facilities. The three day surgery cubicles used by both men and women and patients coming to the admissions unit before surgery, and their relatives, walked past the cubicles while patients were recovering from surgery. The toilet facilities were in the corridor outside the area.
- The emergency surgical assessment unit (ESAU) had been refurbished to improve

facilities and provide additional beds. However, four of the six cubicles had limited space. The unit policy excluded patients with limited mobility or who were acutely ill because of this. The ESAU team reviewed these patients in the emergency department. ESAU was hot during our inspection and staff working in the ESAU confirmed that most patient complaints were due to the temperature in the unit on warm days during the summer. Staff showed us the fans they used when it was hot.

- During our last inspection in September 2016, we reported that ESAU used the dirty utility area in the adjacent surgical ward to dispose of clinical waste. There had been no assessment to review this potential infection control risk. Senior staff told us that following our inspection, they organised a risk assessment, which indicated no action was needed. The ESAU continued to use the neighbouring ward's dirty utility area. ESAU did not have resuscitation equipment on the unit, but had access to the resuscitation trolley on the ward directly next to the unit.
- The maintenance of facilities and the checks on most electrical equipment protected people from avoidable harm.
- We observed staff kept fire exits clear and free from obstruction in all surgical areas, and evacuation slides were accessible, where necessary.
- In order to maintain the security of patients, visitors were required to use the intercom system outside the wards to identify their arrival before they were able to access the area.
- In all clinical areas we visited, we saw the correct segregation of clinical and non-clinical waste into different coloured bags. This was in line with the Health Technical Memorandum 07-01, Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations. We saw that staff had labelled sharp bins and the bins were not overfilled.
- There was sufficient equipment on the wards and in theatres to maintain safe and effective care, including hoists for assisting patients, blood pressure and temperature monitors, air mattresses (used to minimise the risk of patients acquiring pressure ulcers), commodes and bedpans. Nursing staff we spoke with also said there was an adequate supply of equipment to meet the needs of the patients.
- Staff told us they could access bariatric equipment when requested, for example bariatric beds, hoists and wheelchairs. During our inspection, we observed a porter bringing a bariatric wheelchair to one of the surgical wards.
- There were adult resuscitation trolleys on all surgical wards, theatres and in the pre-operative assessment clinic. We saw from checklists that registered healthcare professionals checked the resuscitation equipment daily and documented the equipment was ready for use. There was a paediatric resuscitation trolley for use in the recovery department, which staff also checked regularly.
- Most electrical appliances and equipment we checked during our inspection were electrical safety tested to ensure they were safe to use. However, we found some items in theatres where the electrical safety tests were overdue, including the orthosonic system for cemented arthroplasty revision (OSCAR), which is used in hip replacement surgery (due June 2016) and CMAC anaesthetic equipment (due March 2017).
- All anaesthetic rooms in theatres displayed 'rules of use', which outlined the required daily checks, appropriate storage of medication and replenishment of stock.
- We checked the anaesthetic machines in the theatres and saw log books showing evidence of daily checking with no gaps. This was in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines.
- There was a difficult airway trolley available in theatres. Staff told us they checked this equipment daily and we saw evidence of these checks on our inspection.
- The airflow systems in the theatres were revalidated regularly by an external organisation. Trust board minutes from September 2017 confirmed that validation of theatre ventilation was recently completed across both sites. All theatres were operational and met the standards set out in the national guidance, Health Technical Memorandum (HTM) 03-01: Specialised Ventilation for Healthcare Premises. However, the ventilation in theatre

preparation rooms was not compliant with these standards. Therefore, staff prepared the sterile equipment in the theatres as a precaution. The issue with the ventilation in theatre preparation rooms was documented on the estates risk register and was addressed in the theatre refurbishment plan.

Medicines

- Arrangements were in place for the safe management of medicines. This included obtaining, prescribing, recording, storage and security, dispensing, safe administration and disposal.
- Medicines within the wards and theatres were stored safely behind locked doors or cupboards, and were only accessible to appropriate staff.
- Controlled drugs (CDs) (a medicine that is controlled under the Misuse of Drugs legislation 2001), were stored appropriately in a locked cupboard and the keys held separately from the main keys. Two nurses checked the CDs daily in each clinical area and we saw that all CD records checked were accurate and up to date.
- Medicines that required refrigeration were kept at the correct temperature and we saw staff checked and recorded the fridge temperatures daily in both theatres and the surgical wards. This ensured that medicines that were temperature sensitive were stored correctly. The recording sheets indicated the acceptable temperature range for the fridges and treatment rooms. We saw evidence that when a fridge temperature was above the recommended maximum temperature, the nurse reported it as an incident, informed the ward sister and transferred the medication to another medicines fridge within the department.
- During our last inspection in September 2016, we raised concerns that ambient room temperature levels in treatment rooms on Ridge and Flaunden wards were higher than the recommended levels. High temperatures can affect the shelf life of medicines. We raised this with the senior management team at the time of our inspection and managers alerted ward staff to the importance of informing pharmacy when temperatures rose above 25^0C. During this inspection, we found the treatment room temperatures on Ridge, Letchmore and Flaunden wards were within the recommended maximum limit because the estates department had recently installed air-conditioning units for use when the temperature rose. Nursing staff informed us the temperature had not exceeded 25^0C since the installation of the air-conditioning.
- At our last inspection, we identified inconsistencies with the storage of patients' own medications. During this inspection, ward staff told us patients' own medications were stored in locked bedside cupboards and nurses looked after the cupboard keys. Staff checked and recorded these medications daily. An audit of controlled drugs confirmed staff were storing them safely.
- During the week, a clinical pharmacist visited the ward daily, monitored and reviewed patients' prescribed medicines, and was readily available for advice about medicines. The pharmacist had completed a comprehensive medicines reconciliation for each patient record we reviewed. This included the pharmacist taking a patient's medical history and checking for any medicine contra-indications. Medication reconciliation is a check to ensure that people receive the correct medicines on admission to hospital.
- Pharmacist support was available during pre-operative assessments to ensure patients received the correct medicines on admission to hospital. The pharmacy team also reviewed any medicines that patients needed to stop prior to surgery, for example Warfarin (a blood thinning medication).
- The majority of prescription charts we reviewed accurately reflected the patients' care plans. They clearly documented patient allergies, the dose and route of the medication prescribed, and why medication had been omitted. However, we found poor practice in the prescribing of the painkiller Paracetamol. Paracetamol can be prescribed to be given rectally, intravenously (IV) or orally, but we noted that doctors prescribed both IV and orally

on the same prescription with no clear distinction between the two. There is a difference in the prescribed dose for IV and oral based on a patient's weight and these are not interchangeable. In addition, it was not always clear from the medicine records whether staff gave the patient the Paracetamol orally or intravenously. However, on all prescription charts reviewed, we noted that the pharmacist updated the chart when these medication errors occurred. We raised this with pharmacy staff during our inspection. They agreed it was not good practice and told us incident forms were not completed when these errors occurred.

- The service participated in an antimicrobial (an agent that kills microorganisms or stops their growth) programme which is a key component in the reduction of healthcare associated infections. The trust conducted an annual survey of antimicrobial procedures in November 2016. This survey recommended that the 72-hour review of antibiotics needed to include a defined stop/review date if the antibiotic course was to continue. In the prescription records we reviewed, reviews of prescribed antibiotics were completed and all had stop/review dates.
- Antibiotic prescribing also complied with NICE QS61, and junior doctors informed us they downloaded the trust's programme 'micro guide' onto their mobile phone. They used this when they prescribed antibiotics to make sure they used the most suitable antibiotic, for example, to treat a urinary tract infection.

Records

- We found that patients' individual care records were managed, written, legible, and stored correctly according to best practice. All entries were dated and signed, and included the clinician's bleep number, when appropriate.
- Each patient had two sets of records: a nursing risk assessment and care plan folder, and a medical notes folder. We looked at 21 sets of records, which included pre-operative assessments, consent forms, theatre records, risk assessments and care plans identifying the patients' needs. Most records reviewed were legible, accurate and up-to date.
- The initial risk assessment on admission was largely 'tick box' with small sections for additional written information. When nursing staff identified a risk, they completed a more detailed risk assessment, for example a falls risk assessment. A nursing assessment provided more detail about individual needs.
- During our last inspection in September 2016, we found the service was not compliant with the NICE clinical guideline (CG) 92, venous thromboembolism: reducing the risk for patients in hospital (2015). This guideline states that a patient's risk of bleeding and VTE must be assessed on admission and reassessed within 24 hours of admission and whenever the patient's clinical situation changes.
- At this inspection, we found medical staff documented the majority of initial VTE assessments on admission and all patients had VTE prophylaxis (preventative treatment) prescribed. We reviewed 18 sets of medical notes that should have had a completed VTE reassessment within 24 hours of a patient's admission, but none of these recorded a VTE reassessment. We were therefore not assured that medical staff adequately assessed patients' risk of bleeding or thrombosis (blood clot). We raised this with senior managers at the time of our inspection.
- The September 2017 trust board meeting included the findings from the VTE risk assessment audit undertaken in April 2017. The audit showed that of the VTE risk assessment forms categorised as non-compliant, the majority of patients received appropriate preventative treatments.
- Both ward staff and medical staff informed us VTE assessments and prophylaxis were reviewed at the daily ward rounds, but this was not recorded unless there was a change in prescription. We asked a nurse to show us evidence of a change in VTE prophylaxis prescription during our evening visit to a ward. A patient's medical notes for that morning included a note about the risk of a bleed and the subsequent discussion with the

haematologist about the change of prescription. There was a new thrombophrophylaxis medicine chart in the patient's records, although the doctor had not yet completed the new prescription.

- Nurses told us they constantly needed to remind junior doctors to record decisions in the patients' notes. New patient record continuation sheets had been used to improve the recording of routine medical checks by prompting doctors to check and review VTE assessments and other clinical assessments, such as blood test results and X-rays. However, we saw that medical staff did not use the continuation sheets appropriately, and the tick boxes remained blank.
- Patients' medical and nursing notes were stored away from public view in lockable trolleys in the ward corridors or bays. The trust used trolleys with the same access code to enable all clinicians to access notes in an emergency.
- The surgical wards used 'Patient Safety at a Glance' (PSAG) white boards to display patient names, their location on the wards and some treatment information. Hospital wards use PSAG boards to display important information such as the patient's infection risk, mobility, discharge readiness and lead consultant.
- The PSAG boards were visible to staff, patients and visitors to the ward. We raised this with senior staff who told us the boards should not contain patients' full names. However, on our inspection some wards displayed the patient's first and last name, which was a breach of data protection. On our unannounced inspection on 12 September 2017, we noted that the boards only contained last names. However, this was still a breach of patients' data protection as it could allow them to be easily identified.
- The PSAG board on Letchmore Ward had a cover that staff folded over the patient names to improve confidentiality. However, when we revisited this area on the unannounced visit, we observed staff were not using this cover. The service planned to change all other PSAG boards to the same style as the board on Letchmore Ward.

Safeguarding

- There were clear systems, process and practices in place to ensure that patients were kept safe from avoidable abuse. The hospital had safeguarding policies and procedures available to staff on the intranet, including contact details for relevant hospital staff, for example contact numbers of the trust leads and the safeguarding team. These contact details were clearly displayed by nursing stations and in staff communal areas.
- The staff we spoke with demonstrated a good understanding of their responsibilities in relation to safeguarding adults and children in vulnerable circumstances and could describe the correct processes for reporting safeguarding concerns. For example, both a newly qualified operating department practitioner (ODP) and the theatre manager confidently demonstrated how they would address safeguarding concerns, such as a suspected non-accidental injury.
- On our unannounced visit, we were informed about patient on a surgical ward who was particularly distressed and staff were concerned the patient was at risk of harming themselves or other patients. Therefore, they submitted an incident report and completed a referral to the safeguarding team. The staff also contacted the enhanced recover team for an assessment and escalation of the care plan. The patient was receiving one to one care as a result.
- Safeguarding adults and children was part of the mandatory training programme and staff received training in the safeguarding of vulnerable adults and children through electronic learning and face-to-face sessions. The trust provided different levels of training according to their job role.
- All staff within surgical areas were required to complete up to and including level two safeguarding adult and children training. Trust data from August 2017 showed 93% surgery services staff at Watford General hospital had completed this safeguarding

training. This was above the trust target of 90%. The trust did not provide this data for each staff group.

- At our last inspection in September 2016, not all staff caring for young people under the age of 18 had the appropriate safeguarding training. During this inspection, we observed that some 16 and 17 year old patients were seen for pre-operative assessments at Watford. Nine nursing staff were trained in level three safeguarding children training within pre-operative assessment clinic.

Mandatory training

- Mandatory training was provided for staff and covered key topics, such as basic life support, fire, patient moving and handling and conflict resolution. Staff received some of their mandatory training through face-to-face sessions and the rest through online courses. Staff told us they completed their mandatory training during quiet periods in their clinical area. Theatre staff told us they completed training during their clinical governance days.
- The trust's training record for August 2017 showed that 86% of surgery services staff at Watford General hospital had completed their mandatory training, against a trust target of 90%. The trust target was not met for six of the 11 modules. Fire training for non-clinical staff had the lowest completion rate of 76%, while non-patient moving and handling had the highest completion rate of 98%. The trust did not provide this data for each staff group.
- The practice development facilitator told us they kept records of staff mandatory training and sent email reminders to staff who had of any outstanding training.
- All staff we spoke with told us that they were up to date with their mandatory training. Staff were unable to complete additional non-mandatory training or other courses until their mandatory training was up to date.
- There was a structured induction and mandatory training programme for new staff and this included any required local training. The trust had taken steps to increase the awareness of the importance of early recognition and treatment of sepsis to prevent avoidable deaths. The trust held a number of events in 2016, and had taken part in the NHS sepsis awareness day in May 2016. There had been teaching on the wards on the sixth of every month. Ward staff had not attended formal training sessions on sepsis. They told us there were regular reminders at shift handover about the importance of early recognition.

Assessing and responding to patient risk

- Staff told us they were aware of risks to patients and how to monitor these. When they had concerns, there was always someone available to assess a patient.
- Nursing staff on the surgical wards had three daily 'safety huddles'. We observed a safety huddle on Ridge Ward. Staff highlighted workload issues, patients due for discharge and high-risk patients who required extra monitoring. This included patients with pressure ulcers, patients with safeguarding issues and patients at high risks of falls. This ensured staff were continually updated on the plan of care for every patient on the ward and the nurse in charge maintained an effective oversight of the patients in their care. However, we saw the nurses completed the safety huddle at the workstation by the entrance to the ward, which meant patient confidentiality was not always maintained.
- The trust recently implemented the 'Safer' checklist, which all wards completed once a day. The checklist helped to highlight the number of deteriorating patients or patients that required monitoring on each ward. For example, the checklist assessed the number of falls the ward had in the previous 24 hours, the number of patients with nasogastric tubes and the number of patients with enhanced care needs. The senior nurse for each ward presented their checklist at the 12.30pm bed management meeting. This new initiative ensured all senior staff had oversight of what was happening on each ward. Senior staff told us the trust wanted to make the checklist data available to all staff and was developing an electronic version of the checklist.

- There were senior medical staff on duty at all times, with 24-hour access to consultants on call.
- The trust had a critical care outreach team to provide extra clinical support with deteriorating patients at all times. Staff could contact the critical care outreach team directly from 8am to 8pm. The hospital at night team triaged the critical care outreach calls from 8pm to 8am, and contacted the outreach clinician on-call, if required.
- All patients having elective surgery attended a pre-operative assessment clinic where staff carried out essential pre-operative tests. This complied with NICE guideline (NG) 45, routine pre-operative tests for elective surgery (2016). The tests included MRSA screening, electrocardiogram monitoring and blood tests.
- The pre-operative clinic was nurse led. Nurses referred patients for an anaesthetic assessment if required. An anaesthetist attended the clinic two days a week and saw all patients who were having upper gastrointestinal surgery and colorectal surgery.
- When the nurse had concerns about a patient's clinical condition or co-morbidities (existing medical conditions), they referred them for further investigations and an anaesthetic or consultant review. For example, a pre-operative nurse detected a patient had a heart murmur and referred this patient for further investigations.
- The pre-operative nurses were aware of how long an assessment was valid for before a patient required a reassessment. This was three months for a general or orthopaedic patient, and four weeks for a cancer patient.
- On admission and throughout a patient's stay in hospital, nursing staff completed risk assessments covering areas such as falls, malnutrition and pressure ulcers. Staff completed supplementary care plans when they identified risks. We reviewed a sample of risk assessments and these were all completed, with the exception of the VTE risk re-assessments.
- Ward staff used the national early warning score (NEWS) to record routine physiological observations, such as blood pressure, temperature and heart rate against pre-determined parameters in accordance with the trust's deteriorating patient policy. There were clear directions for actions to take when the NEWS increased and indicated a patient was deteriorating. We saw evidence that appropriate actions were taken and recorded in patient notes.
- In the anaesthetic and recovery areas a range of observation charts and pathways, including NEWS, were used to identify patients who had deteriorated.
- A sepsis screening tool was incorporated into the risk assessment documentation within the patient notes. This gave clear, best practice guidance on the assessment and treatment for sepsis (the presence of harmful bacteria and their toxins in the body). Nursing and medical staff working in ESAU were aware of the importance of early identification and treatment of sepsis. Nursing staff on surgical wards confidently described the signs of sepsis and what action they would take, for example, completing the Sepsis six pathway in the patient's notes and immediate escalation to medical staff. The Sepsis six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. It consists of three diagnostic and three therapeutic steps to be delivered within one hour of the initial diagnosis.
- The service used the American Society of Anaesthesiologists (ASA) grading system to pre-assess patients' level of risk for general anaesthesia. There were five grades within the ASA system. Grade one patients were normal healthy patients and grade five patients were patients not expected to survive more than 24 hours with or without surgery. The hospital had level two and three critical care facilities for critically ill patients to recover in following surgery. This allowed them to treat patients of all ASA grades safely.
- The theatre department had a simulation suite where staff could practise emergency scenarios, such as patient deterioration and cardiac arrest. This meant skills needed to assess and respond to a clinical emergency were maintained and improved where needed.
- During the last inspection in September 2016, we identified concerns about the lack of

consistency in the use of the WHO Surgical Safety Checklist and five steps to safer surgery, a national set of safety checks for use in any operating theatre environment. The five steps are team briefing, the three steps of the WHO checklist (sign in, time out and sign out) and team debrief.

- Following the last inspection, the trust standardised the paperwork to ensure it followed the five steps as some areas were previously carrying out only the three WHO surgical safety checklist steps.
- Surgery services audited the paper records used to record adherence to the five steps and found high levels of compliance of 97 to 98% from April 2017 to June 2017. During this period, the service audited the records of between 150 and 155 operations each month. However, these audits were non-observational and audited the completion of the paper form only. Therefore, the service could not be assured that the checks were completed at the appropriate time with the whole team present, or that the team worked well together to keep patients safe from avoidable harm.
- We observed theatre staff carrying out step one to four of five steps for two operations. We were unable to observe step five due to the length of the theatre list. However, theatre staff completed steps one to four correctly and the checklist forms we reviewed in the patient notes were all signed, dated and fully completed.
- We witnessed a handover of patient care following surgery. The anaesthetist and scrub nurse waited until the recovery nurse was satisfied with the patient's condition before they left. This meant they were present in case the patient suddenly deteriorated.

Nursing and theatre staffing

- The service planned and reviewed staffing levels and skill mix so that levels were in line with relevant tools and guidance. Senior staff used the national safer nursing tool to assess, identify and plan staffing levels. The safer nursing care tool is an evidence-based tool developed to help hospitals measure patient acuity and dependency and determine workforce levels. Staffing levels were appropriate to meet patients' needs during our inspection.
- Vacancy rates in surgery services at the hospital in May 2017 were just under 17%. There was 279 whole time equivalent (WTW) nursing staff in post against a requirement of 325 established posts. General theatres had the highest level of vacancies with 21% (24) fewer staff than required.
- At our last inspection in September 2016, recruitment of theatre staff was also a challenge for the trust and was on the local and directorate risk register. During this inspection, the theatre manager told us about initiatives to improve theatre nurse recruitment and retention. This included offering rotational placements to junior nurses, which allowed them to work in several rotational placements before deciding on a preferred speciality. In addition, the trust was in the process of developing a trust wide rotational programme, for newly qualified nursing staff, where they would rotate between A&E, theatres and critical care. This programme was due to start in February 2018.
- Pre-operative assessment nursing staff worked across the St Albans and Watford sites. There were two vacant nursing sister posts at the time of our inspection. We were told the vacancies were filled, with the new staff due to start in October 2017.
- The trust performed biannual staffing reviews for all adult inpatient wards, including the surgical wards. The biannual review, presented in the trust board minutes from September 2017, highlighted that Ridge Ward comprised of 45% registered staff vs. 55% unregistered staff. However, the surgical wards were in reconfiguration at the time of our inspection and a senior nurse from Ridge Ward informed us this reconfiguration would address the staffing issues across all surgical wards.
- During this inspection, a number of members of staff told us there were not enough suitably skilled staff on Flaunden Ward. This was because the ward had seven transitional nurses (overseas nurses, who were not registered nurses in the UK until they had

completed an induction and competency based programme) and they were sometimes in charge of a bay of patients. There were three health care assistants to cover the four bays on Flaunden Ward, but on other wards there was one health care assistant for each bay. However, the transitional nurses we spoke with told us they referred to the nurse in charge or a qualified nurse when they needed support or advice. We observed a fully qualified nurse on wards at all times.

- Ward sisters were aware that the high turnover rate was an additional burden because of the need to continually retrain staff. From June 2016 to May 2017, there was a turnover rate of 21% within surgery services at the hospital, higher than the trust turnover rate of 12%. Flaunden Ward had the highest turnover rate at just under 69%. Staff informed us one reason for this was because once transitional nurses received their registration, they often transferred to a different area within the trust or left the trust completely.
- Staff worked extra shifts and bank and agency staff were used to cover nursing vacancies sickness, or other absences. Staff on both Letchmore and Ridge wards told us it was usual for there to be only one permanent member of staff on a night shift with two agency nurses.
- On a surgical ward, a nurse told us that the use of agency staff; “is really affecting staff morale”. This was because agency staff could not always perform the same tasks as the permanent staff, for example the administration of intravenous medicines. They felt this put extra pressure onto the permanent nurses to ensure patients continued to receive appropriate and safe care.
- From July 2016 to June 2017, the service reported a bank and agency usage rate of 18%, which was below the trust average of 25%. ESAU had the highest bank and agency usage at 52% and general theatres had second highest usage at 34%. However, ESAU only had an establishment of two registered nurses. Therefore, the bank and agency usage appeared higher than other clinical areas.
- New bank and agency staff received a local induction to each area on their first shift. This ensured staff were familiar with ward layouts and emergency procedures. In theatres, staff showed us an induction booklet used for new agency staff and we saw copies of signed induction sheets.
- To ensure safe staffing levels, nursing staff were often moved between surgical wards to cover vacant shifts. Staff understood the reasons for ward moves and spoke positively about it.
- The sickness rate from June 2016 to May 2017 for the service was 3% against a target of 3.5%.
- Nursing handovers happened at the change of each shift. We observed that the handovers were well structured, concise and used a standardised handover sheet. The nurse in charge summarised the plan of care for each patient to all of the incoming team. This included information about patients going to theatre, discharges, and home circumstances. However, the nursing staff completed these board handovers in areas where patient identifiable information could be overheard.
- After the main ward handover, the individual nurses handed over their patients to the newly allocated nurse. However, there were inconsistencies as to where the individual handovers happened. For example, we observed that some handovers occurred in the bays at the end of each patient’s bed. This meant other patients and relatives easily overheard the conversations, especially when handovers took place during visiting hours. We also observed a handover completed outside the bay, which ensured patient confidentiality was maintained.
- A yellow ‘nurse in charge’ badge identified the nurse in charge of each area. This meant they were easily identifiable to staff, visitors and patients. We found that the nurses in charge had a good knowledge of their area and the status of patients and staff.

Surgical staffing

- In May 2017, the overall vacancy rate for medical staff in surgery services was 23%. With

the exception of general surgery, which had a vacancy rate of 5%, and orthopaedics, which were overstaffed by 2%, all other specialities had a vacancy rate of between 14% to 25%.

- Anaesthetic staffing levels were documented on the divisional risk register. Actions included the use of locums and the reliance on the flexibility and goodwill of existing staff. During the inspection, senior staff told us the executive board approved a business case for 12 new anaesthetists a week before the inspection, and these roles were advertised.
- Surgery services employed a lower proportion (5% lower) of consultant staff than the England average. The proportion of junior staff in foundation years one and two working at the trust was about the same as the England average.
- Locum staff ensured service continuity at times of staff shortages. From June 2016 to May 2017, the hospital reported a bank and locum usage of 34% for the surgery services.
- There were six physician assistants working in surgery services. They took on many tasks such as reviewing patients and completing discharge summaries. Nurses, junior doctors and consultants told us they played an important role in managing patients.
- After 8pm, a middle grade doctor covered the surgical wards. An on-call registrar and consultant for surgery were available to provide support and advice, if required. A medical registrar was also available for support.
- The hospital at night team, staffed by a senior nurse and an assistant practitioner was available from 8pm to 8am to support junior doctors. The trust recognised junior doctors struggled with their workloads after senior staff finished their shifts and had recently introduced additional support between 5pm and 8pm with an assistant practitioner and a senior nurse from the outreach team. When we visited the surgical wards in the evening, we observed an assistant practitioner completing requests from a junior doctor, such as inserting cannulas and taking blood.
- Doctors ward rounds occurred twice daily, one in the morning and one again in the afternoon. The morning ward round was led by a consultant surgeon and the afternoon ward round led by the registrar of the week. At both handovers and ward rounds, the medical staff reviewed surgical patients who were on a non-surgical ward (outliers).
- Surgery services were working towards ensuring consultant led treatment and decision-making. A consultant was on call for emergencies 24 hours a day, seven days a week. Junior doctors told us that the consultants were supportive and accessible, even out of hours.
- We observed a morning trauma and orthopaedics meeting. Doctors completing their night shift discussed patients of concern on the wards and new admissions. The process was effective and well attended by all medical grades, including consultants. The consultants discussed workloads and allocated actions to their junior staff.
- There was no surgical team attendance at the handover meeting to the hospital at night team we attended. This did not follow good practice and meant that the hospital at night team did not have a full picture of risks when they came on duty.
- We observed a handover of patient care following surgery by the anaesthetist and theatre nurse to the recovery nurse. They passed on relevant information in a timely manner and checked the recovery nurse was happy with the patient's condition before they left.

Major incident awareness and training

- There were appropriate policies in place with regard to business continuity and major incident planning.
- Senior staff in surgery services were aware of the procedures for managing major incidents and most junior staff we spoke to were aware of the trust's major incident policy on the internal website.
- The theatres had an area specific business continuity plan, which outlined clear actions staff needed to take in the event of an electric failure or other major incident.
- The hospital had back-up generators to ensure an uninterrupted power supply if the mains supply failed.

- There was a major incident pack in theatres, which contained action cards on what to do for specific incidents and contact numbers for important services. The theatre manager told us that all theatre staff knew where this was stored.
- We saw the surgical wards had evacuation slides available for non-ambulatory patients in the event of a major incident, such as fire.
- The emergency resilience manager provided regular training to senior staff and the service planned to deliver this to all staff.
- Staff told us the emergency resilience manager carried out unannounced major incident scenarios throughout the trust. This ensured staff were familiar with procedures and the role they would take if a major incident occurred. Staff reported they found these practice scenarios helpful. During these sessions, the manager also updated the staff on the major incident trust policy.

Are surgery services effective?

Good

Overall we rated surgery services as good for effective because:

- Policies were up-to-date and in line with guidance from the National Institute for Health and Care Excellence (NICE) and professional associations.
- Surgery specialities participated in all relevant national audits. These demonstrated that outcomes for patients were generally similar to, or better than the England average.
- The average length of stay and readmission rates for emergency surgical patients was better than the England average. The average length of stay and readmission rates for elective patients were similar to the England average. However, the re-admission rate for elective orthopaedic patients was slightly worse than the England average at the hospital.
- The emergency surgical assessment unit (ESAU) team made sure patients referred to them received prompt assessment 24 hours a day.
- There were surgery theatres available and consultants on call 24 hours a day so that patients received timely surgery in an emergency.
- Surgery services followed the trust consent policy. The trust provided mandatory training in the Mental Capacity Act.
- Staff protected the rights of people with a mental health condition. There was an effective and responsive process to make sure people were kept safe from harming themselves without depriving them of their liberty.
- There were enhanced recovery pathways for some cancer patients requiring surgery.
- There were examples of patient centred multidisciplinary team working that included all relevant professions.
- Ward staff assessed and monitored patients' care to make sure these met good practice standards.
- Patients on surgical wards received the nutrition and hydration they needed.
- Staff made sure patients received pain relief after their operation. The hospital's acute pain team supported ward staff in prescribing appropriate pain relief.
- There was an improved appraisal of work performance process for ward and theatre staff. There were opportunities for staff development.
- Doctors in training received appropriate training and teaching.

However:

- Patient's records were not always available at pre-operative assessment. There was a risk that clinic staff were assessing patients without their full medical history.

- IT infrastructure and systems were poor, but staff had back-up processes to keep patients safe.
- The surgery audits on the trust register were nearly all behind schedule.
- Anaesthetists did not routinely provide instructions to nursing staff on the wards and admissions unit to help prevent patients become dehydrated before surgery.
- There were examples of an offhand approach from some surgical teams towards nursing staff that undermined patient centred care.

Evidence-based care and treatment

- Surgery services used current evidence-based guidance and good practice standards to inform the delivery of care and treatment. There was a trust process to update, review and ratify policies, and policies were available on the intranet.
- The surgery, anaesthetics and cancer division worked with the trust governance team to ensure policies were up-to-date by allocating authors to review policies. The authors took account of publications from the National Institute of Health and Care Excellence (NICE), guidance from professional bodies and good practice from other NHS trusts. They presented the policies to the trust's policy review group for ratification.
- An example of this process was the updating of the Theatre Operational Policy. Theatre practice educators responsible for writing the policy referred to guidance from the Association for Perioperative Practice (AfPP), Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the Royal College of Surgeons. They consulted staff working in theatres during the drafting of the policies and looked at other NHS trusts' operational policies.
- We saw staff were able to access policies on the trust's intranet and that these were up-to-date. These included hand hygiene (renewal 2018), consent to treatment (renewal 2019) and antimicrobial prescribing (renewal 2019). The policy on the recognition of and response to acutely ill patients reflected recent national guidance.
- The trauma and orthopaedic team continually reviewed their practice in the care of patients with fractured neck of femur to improve the effectiveness of the treatment pathway. Weekly multi-disciplinary team meetings, attended by consultants, doctors, nursing staff and therapists, discussed patients and reviewed whether their pathway adhered to best practice. There was a dedicated ward for these patients. The nurse practitioner on the ward monitored the patients' pathway, trained ward staff to provide optimum care and worked with members of the multi-disciplinary team, to make sure all patients had the treatment, therapy and care they needed.
- The assessment and treatment of unplanned general surgery patients was in line with national best practice and patients received a timely assessment and urgent surgery when needed. There was appropriate staffing on the ESAU to review patients referred by GPs or the emergency department.
- There was effective management of colorectal and upper gastro-intestinal patients who required surgery. The enhanced recovery nurse planned and monitored the support provided to patients based on best practice and advice from a specialist centre at another trust. The nurse tracked patients' treatment and care and monitor outcomes such as length of stay. The enhanced recovery nurse, a pharmacist, a dietician and an anaesthetist were available to review patients attending the pre-operative assessment clinic to discuss treatment and recovery. The nurse saw patients on the ward daily during the week and trained all ward staff in the care of patients post-operatively. She worked with the stoma nurses and other members of the multi-disciplinary team to optimise recovery. The nurse stayed in touch with patients when they left the hospital to support them during their recovery.
- There were no enhanced recovery nurses for orthopaedic patients at the hospital at the time of our inspection. These patients did not receive specialist advice to optimise their

recovery. There were plans to train the sister on the new elective orthopaedic ward in enhanced recovery, but at the time of our inspection there was no information on the scope of her role, for example in supporting patients before admission or after they left hospital.

- The hospital had introduced a post of trauma rehabilitation co-ordinator as a pilot. The role included the review of patients referred back to the hospital after treatment in a tertiary centre. The aim was to maximise recovery by providing the most appropriate rehabilitation by referring patients to services specialising in the care of patients with traumatic injuries such as head and spinal injuries.
- There were audits and checks in place on the wards to monitor the processes that helped to keep patients safe. These included audits of tissue viability care, medicines administration and early warning scores. The hospital used, 'Test Your Care', a national audit tool to check adherence to care standards on wards. Matrons and senior nurses reviewed the care received by 10 patients in a ward in a different division. They collected data from patient experience questions and nursing care indictors, such as missed doses of medication and nutritional assessments. A recent audit found a 99% compliance rate to standards on surgical wards.
- ESAU was auditing compliance with national guidelines on the recognition of sepsis at the time of our inspection. .
- Identification and treatment for sepsis in acute inpatient settings to assure themselves that patients were having rapid, effective treatment according to national guidelines. The trust audited about 50 sets of patient notes a month. Recent data provided by the trust indicate that in the quarter July to September 2017 91% of patients who met the criteria for sepsis screening were screened, an increase from 61% in the previous quarter. The percentage of patients with sepsis treated with intravenous antibiotics within the appropriate timeframe was 80% for the latest quarter, a slight decrease from 83% from the previous quarter. The figures for a review within three days of the prescribing of antibiotics were 100% and 98%.
- Care bundles were used to improve the effectiveness of care. A care bundle is a selected set of elements of care that improve patient outcomes when implemented as a group. For example, surgery services used the peripheral intravenous cannula care bundle and urinary catheter care bundle to improve outcomes for patients.
- Surgery services did not manage their local audit programme effectively. Surgery audits on the trust register included audits to monitor improvements introduced following incidents, and standard audits such as consent. However, in the year April 2016 to March 2017 only one of the 21 audits on the trust register relating to surgery had started and finished on schedule.
- Junior and middle grade doctors completed further local audits under the supervision of consultants or registrars and shared the findings at monthly clinical governance meetings. There was a process in place to follow up on the results of these audits to make sure there was action in response to findings.
- The trust recorded medical device implants on the National Joint Register to ensure outcomes for patients undergoing joint replacement surgery were monitored.

Nutrition and hydration

- Ward staff assessed patients' nutrition and hydration needs and made sure these were met.
- Nurses on the surgical wards assessed hydration and nutrition as part of the patient risk assessment on admission. They assessed hydration within six hours of admission and reviewed this once a day, or when a patient's condition changed. Nurses used the Malnutrition Universal Screening Tool (MUST) to assess patients. When they identified medium risk, they introduced food and drink intake charts and allocated a red tray to the patient to indicate the need for support with eating. In addition, they referred high-risk patients to a dietitian. We saw staff had implemented these actions in the records we

reviewed.

- Staff managed mealtimes on the wards to support patients to eat well. The whiteboard had information marked next to the patient so that staff had a quick overview of the patients needing support with nutrition. We saw patients with a red tray who had nutritional needs, and saw that patients living with dementia had a blue tray indicating they needed support to eat their meal. We saw staff managing mealtimes efficiently on two wards, and observed them providing support and encouragement to patients.
- Patients on the wards were able to have drinks and snacks when they wanted them. Patients had a jug of water in easy reach and we saw staff refilling these. There was a trolley on the ward and we saw housekeeping, domestic and ward staff regularly offering drinks and snacks to patients.
- Nursing staff took steps to prevent patients become dehydrated before surgery to reduce discomfort and enhance recovery. However, there was no standard process for anaesthetists to advise ward and admissions unit staff when patients should have something to drink.
- The letter inviting patients for surgery informed them about the fasting time before surgery for food (six hours) and drink (two hours). However, the pre-operative assessment clinic staff did not routinely give patients advice on fasting or tell them of the importance of drinking up to two hours before surgery.
- The enhanced recovery nurse and the dietician provided additional advice to for colorectal and upper gastrointestinal surgery patients at the pre-operative assessment clinic and provided nutritional drinks so that patients had extra calories before surgery.
- Admissions unit staff asked patients about when they had last had something to eat and drink when they arrived on the morning of their procedure. Ward staff made sure the patients admitted before surgery followed fasting rules. Ward and admissions unit nurses tried to make sure patients were not kept without fluids unnecessarily. We saw an anaesthetist's advice written on a printed copy of the afternoon list with details on the type and amount of fluids the admissions nurse could give to patients who were later on the list. However, this practice was not standardised, and admissions unit staff told us some anaesthetists did not provide them with this information.
- Admissions and ward staff liaised with the theatre person in charge to find out up to date information about the order of lists. When theatre staff told them that patients were later on the list they gave them a small pot of water to sip. Patients who were frail or ill and most at risk from dehydration received fluids intravenously. Ward staff gave patients waiting for surgery a sponge to dip into water to prevent their mouth becoming dry.
- Consultants and medical staff advised nurses when patients should drink and eat after their operation, depending on the type of surgery. Most post-operative patients on the wards received intravenous (IV) fluids. When patients were in recovery for long periods because a bed was unavailable, staff provided drinks and snacks.
- Patients' post-operative nausea was managed through prescribing of an antiemetic (anti sickness medicine).

Pain relief

- Staff assessed and managed patients' pain effectively. The patient records we reviewed showed that ward staff assessed patients' pain regularly as part of their routine observations using the National Early Warning Score. Nursing staff said they contacted medical staff or members of the pain team to review a patient and change their prescription if necessary. We saw members of the pain team, who were non-medical prescribers, regularly on the wards to offer staff advice or to review patients during weekdays. In the evening and at weekends, ward staff contacted one of the anaesthetists on call to review any patients who were in pain. Consultants asked patients about pain during ward rounds. Nurses discussed pain management for individual patients at handover at the patient's bed

to make sure there were no missed doses of pain relief.
- Patients told us ward staff regularly asked them about their pain, both before and after the administration of pain relief. They said pain relief was prompt and effective.

Patient Outcomes

- Outcomes for surgical patients at the trust were similar to or better than the English average. Lengths of stay and readmission rates were higher for elective patients at Watford General Hospital, which operated on higher risk patients, than for St Albans City Hospital, which only saw low risk patients.
- Patients having emergency surgery had a lower than expected risk of readmission from March 2016 to February 2017. The re-admission rate for elective patients across the trust in that period was similar to the England average except for orthopaedic patients, which had a higher rate.
- The average length of stay was better than the England average for patients receiving emergency surgery and slightly worse for patients having elective surgery at Watford General Hospital. The average length of stay for emergency surgical patients admitted to the hospital was 4.8 days from April 2016 to March 2017, slightly lower than the England average of 5.1 days. The average length of stay for elective surgical elective patients was 3.5 days, slightly higher than the England average of 3.2 days. The length of stay for general surgery and urology patients was similar to or slightly higher than the England average, while orthopaedic patients had an average stay of 4.3 days higher than the England average of 3.4 days.
- The audit results from the National Hip Fracture Database (NHFD), which is part of the national falls and fragility fracture audit programme, showed improvements in patient outcomes in the last few years. The 2016 audit reported a risk-adjusted 30-day mortality rate of 3.9%, which was better than expected and continued the year on year improvement since 2013, when it was 12%. Average length of stay for patients with fractured neck of femur was 15 days, which is in the best 25% of trusts. The proportion of patients not developing pressure ulcers was 97.8%, which was in the middle 50% of trusts in England. An orthogeriatrician assessed nearly all (99.2%) of patients within 72 hours of admission, which continued the improvement from previous years towards meeting the national standard of 100%. However, the proportion of patients having surgery on the day of or day after admission was 82%, slightly lower than the national standard of 85%.
- In the 2016 National Vascular Registry (NVR) audit, the trust performed within the expected range for outcome measures following surgery for abdominal aortic aneurysms (a swelling in the main blood vessel that runs from the heart down through the abdomen) and carotid endarterectomy (a surgical procedure to reduce the risk of stroke by correcting the narrowing of the carotid artery in the neck).
- The 2015 National Bowel Cancer Audit data, which is the latest available, for patients undergoing a major bowel resection (removal of all or part of the bowel), showed the risk-adjusted 90-day post-operative mortality rate was within the expected range. However, the rate was worse than the previous year's rate and worse than the national average. The two-year post-operative mortality rate for bowel surgery was within the expected range. The percentage of patients with a post-operative length of stay greater than five days was worse than the national average.
- The 2017 National Emergency Laparotomy Audit (NELA,) published in October 2017, reported that mortality for patients undergoing emergency, open abdominal surgery at the hospital was within expected levels. There had been a total of 225 emergency laparotomies audited. The audit rates performance on a red, amber, green scale where green is best and red is the worst. The hospital had improved its performance over the last two years and the audit showed green for six out of the 10 indicators. The proportion of highest-risk cases admitted to critical care post-operatively had improved from red to amber. The audit showed green for access to theatres within clinically appropriate time

frames, and the proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. The hospital was rated red for preoperative assessment by a consultant anaesthetist when the risk of death was more than 5%, and for assessment by an elderly care consultant when the patient was over 70 years old. The hospital had an amber rating for the proportion of cases with which documented the risk of death and a discussion with patients about this, an improvement on the previous red rating. Surgery services had audited records in 2016 to assess the quality of the recorded risk and discussions with patients.

- Patient Reporting Outcome Measures (PROM) audits measure health gain in NHS patients in England. Patients having hip or knee replacements, varicose vein surgery or groin hernia surgery were invited to complete PROMs questionnaires regarding their health and quality of life before and after they had surgery. There were no results for PROMS for knee surgery because not enough patients completed the questionnaire asking them to report outcomes. The percentage of patients reporting improvements following hip replacement (100%) and groin hernia (56%) was slightly higher than the England average. The PROM measure for varicose veins indicated that a higher percentage of patients reported a worsening than the England average, 62% compared to the England average of 39%. The trust list of required action plans following the publication of national audits did not include the PROM audit for varicose veins.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- Newly qualified nurses followed a preceptorship programme to support them when they started working at the trust. They received a week's training and their progress was monitored. Each nurse completed a competency booklet, which prompted reflection on their practice. Nurses were able to carry out tasks, such as insertion of intravenous lines, when they had received training and demonstrated competency. A practice development nurse supported qualified nurses across the two hospital sites.
- A second practice development nurse supported non-qualified staff. We met several healthcare assistants who had been encouraged to attend college to gain qualifications. One of these had become an associate nurse and was attending college to become a fully qualified nurse.
- The trust addressed the shortage of nursing staff by recruiting overseas. These 'transitional nurses' worked on the wards as non-qualified staff until they passed nursing competencies and language tests to register in the UK. They received an induction and the practice development nurse attended wards to support them. All the overseas nurses we spoke with said the trust provided good training and support and helped them to pass their exams. There was an educational folder on Flaunden Ward, which included an explanation of common terms used on the ward.
- Theatre staff were responsible for completing their own personal professional development folders. Theatre clinical governance days were used for training and education, for example training in the use of equipment by medical representatives. All theatre staff had paediatric intermediate life support training.
- The practice development nurse told us funds were not readily available for external training. However, we were told that there was funding for two theatre nurses to complete the anaesthetic course and for six nurses to complete the high dependency care of the child.
- Since our last inspection in September 2016, the system for appraisal had improved, with human resources keeping managers informed of when appraisals were due. All the ward and theatre staff we asked had undergone an appraisal or had one due. At July 2017, 88% of registered nursing staff in surgery services had undergone an appraisal. Staff told us they were encouraged to set objectives and take advantage of training opportunities. There

was the expectation of a one to one meeting with the line manager every month. Ward managers confirmed they met the matron every month and this was recorded.

- Ward sisters and junior sisters attended the local leadership programme for personal development and career progression. Posts such as advanced practitioner roles offered progression for experienced nurses.
- Consultants had taken action to address criticisms by previous doctors in training. All the doctors in training we spoke with said they were well supported and had opportunities for learning. A nominated consultant with responsibility for supporting junior doctors attended a regular forum where doctors could ask questions and voice concerns. The divisional service manager met the doctors in training monthly to address any operational issues.

Multidisciplinary working

- There were examples of close multi-disciplinary (MDT) working, with staff from all disciplines working together to provide person centred, effective care.
- Patients and staff commented on the effective way that all members of the MDT on Langley Ward, including consultants, dieticians, stoma nurses, physiotherapists and pharmacists, worked together with the enhanced recovery nurse to improve the care and treatment of patients who had colorectal and upper gastrointestinal conditions. A trust nurse commented, “This is multidisciplinary working at its best”.
- We observed effective MDT working for patients who had a fractured neck of femur. The orthogeriatrician, who specialised in the care of older orthopaedic patients, worked with the surgical team and staff on Cleves Ward to make sure patients received optimum care and treatment. Physiotherapists had good working relations with the staff on wards and involved them in supporting patients to become active as soon as possible.
- Good teamwork within theatre and ward teams promoted effective, safe care. Staff on all the wards we visited told us they worked closely together to make sure patients received the care they needed, supporting colleagues who had a heavy workload. A consultant commented on the hard working theatre team performing effectively in spite of the challenges they faced working in an out-of-date theatre with some limited facilities.
- A simulation lab had opened in July 2017 to give theatre teams the opportunity to simulate emergency scenarios and reflect on their response as a team. Members of the team discussed these at clinical governance meetings.
- There were daily ward rounds on all surgical wards. Nursing staff, the pharmacist and therapists joined the ward round when appropriate. However, staff told us it was sometimes difficult for ward sisters or their senior staff to accompany every consultant’s ward round. For example, Flaunden Ward often had 10 or more consultant teams with patients on the wards.
- There were daily meetings between the surgical emergency department and the ESAU and trauma and orthopaedic teams to discuss patients.
- Consultants and registrars generally communicated well with ward, admissions and theatre staff. Nurses and theatre staff praised some surgical specialities for their patient-centred approach to care. However, nursing staff gave us examples of an unhelpful approach that undermined teamwork. These included a consultant ignoring a nurse who asked a question about a patient, a registrar leaving a ward following a review of a patient without communicating with nurses, and a member of a consultant team making a sarcastic remark to a nurse in front of patients and other staff. We observed that some nurses did not appear comfortable to approach medical staff directly when they wanted to a task to be completed, but asked the matron to intervene on their behalf.
- When a surgical patient needed a review by a medical consultant, the junior doctor made a referral on the electronic handover system to the relevant medical speciality with information about the patient. We saw an example of a doctor’s referral on the system and the prompt response about the tests the patient required. The consultant indicated they would visit the patient the next day when the test results were ready.
- Discharge planning started at pre-operative assessment when a patient’s expected

discharge date was discussed so that a plan could be put into place for requirements at home. The wards had a red to green system to highlight when post-operative tasks were outstanding or had been completed. We observed outstanding actions, such as a therapy assessment, were usually completed promptly. However, we noted a category red task that was outstanding for three days. Ward staff told us this was because there was a plan for a patient to transfer to a specialist service for treatment, but the surgical team had not followed this up promptly with the receiving trust. We observed that nursing staff were reluctant to pursue this directly with the surgical team.

- There was a hospital integrated discharge team with a discharge coordinator for elective surgical patients and one for emergency surgical patients. We observed they were often present on the ward to assist with promoting a smooth discharge.
- The times taken for medicines to be available for patients were causing some discharge delays. The pharmacy team took part in discussions with the discharge planning working group and there were plans to recruit more independent pharmacist prescribers, who can prescribe medicines, over the next three years to help with prescriptions being available for discharge.
- Wards used a checklist for patients who were discharged to a care home. They had introduced this following an incident when a care home was not expecting a patient and there was no discharge summary sent to them.
- The trust was taking action to discharge a higher percentage of patients in the morning so that beds became free for other patients earlier in the day. The average percentage of patients discharged between 8am and 12 noon from surgical wards was 19% for the three months to June 2017. Patients were not discharged home late at night unless the patient and their relatives wanted them to go home.
- Doctors or physician assistants completed electronic discharge summaries to send to the patients' GP to share relevant information promptly. The trust target was for all GPs to receive the discharge summary within 24 hours of discharge, but there had been slow progress in meeting this target. We noted action to address this by improving the speed of electronic system and by giving ward clerks more responsibility to check the progress with discharge summaries. The percentage of electronic discharge summaries sent to GPs was still below the target, but was increasing and reached 70% in June 2017.

Seven-day services

- Surgery services organised medical cover out of hours and at weekends to provide a prompt response to wards and to the emergency department.
- There was a registrar on duty seven days a week and 24-hour registrar and consultant on call cover. At the weekend, a rota of senior trust doctors carried out a full ward round of elective patients.
- Diagnostic services were available seven days a week, with imaging, pathology and endoscopy available out of hours in an emergency. Staff on ESAU confirmed they were able to access diagnostic tests out of hours.
- The ESAU team was available 24 hours a day seven days a week. When the unit was closed because the beds were used for inpatients, the team reviewed patients in the emergency department instead of in ESAU.
- Emergency theatres were available seven days a week. Consultant surgeons, anaesthetists and theatre teams were available, with additional staff on call in case of unexpected demand in an emergency.
- The hospital at night team operated from 5pm to 8am every day of the week, staffed by a senior nurse and an assistant practitioner (AP) to undertake tasks usually done by junior doctors.
- Ward staff could contact the critical care outreach team directly from 8am to 8pm for advice or for review of a deteriorating patient. After 8pm, staff contacted the hospital at night team who called the member of the outreach team on call when needed.

- Pharmacy operated a weekday 9am to 5pm weekday service, with an evening and weekend pharmacist available for dispensing urgent medicines. There was a weekend dispensing service at the hospital.
- Physiotherapists were available at weekends and visited surgical wards to enable treatment to continue every day.
- The discharge lounge was open seven days per week.

Access to information

- Staff generally had all the necessary information to deliver patient care. Risk assessments, clinical notes and other relevant information were contained in paper patient records. Other information, such as test results were accessible on electronic systems. All staff, including agency and locum staff, had access to patient-related information and records.
- Staff told us there were poor IT systems and infrastructure. This affected the speed that staff could access patient information, such as discharge summaries and test results, and systems sometimes failed. This was on the trust risk register and there had been some recent action to prevent IT systems from failing and to improve speed of access. There were back up paper systems in case of IT failures. The trust was working with commissioners to plan an overhaul of the infrastructure and software.
- There were no failures in the IT systems during our visit. There were computers available to junior doctors and nurses in the ward areas to see patient diagnostic test results. The trauma team was able to view X-ray images of fractures at their morning meeting.
- The wards kept paper patient records, which were well ordered and accessible. Junior doctors focused on updating the electronic system called 'e handover' and shared this at handover and at ward rounds. However, the information held on this system was not always replicated in the paper records stored on the ward.
- Patients' notes were not always available at pre-operative assessment clinic. Staff told us that at least two sets of patient records were unavailable in each clinic. From January 2017 to August 2017, notes were not available on average 8% of the time. In these cases, staff used patients' details from the trust's online system and the patients' clinic letters to undertake the assessment. However, there was a risk clinic staff were assessing patients without a full medical history. The clinic nurses told us that when notes were missing, they informed the admissions department, but they did not always report missing notes as incidents.
- When patients moved to another part of the hospital, staff passed information to the receiving team. Nursing staff completed a form for every patient transfer that happened within a 24-hour period within the hospital. This included key items of information and indicated whether the patient records were transferred with the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood consent, decision-making requirements and guidance.
- The trust had four nationally recognised consent forms in use. For example, there was a consent form for patients who were able to consent, another for patients who were not able to give consent for their operation or procedure, and another for procedures not under a general anaesthetic. Consultant surgeons or members of their teams informed patients about the risks and benefits of surgery in the outpatient clinic. Patients either signed the consent from at that time or were asked to consider their decision and sign the consent form before surgery. Middle grade doctors and registrars told us they only completed consent forms with a patient when they were taking part in the operation, in line with the trust consent policy. There were checks that the consent form was signed before the patient went to theatre and after they arrived in theatre. We viewed three consent forms, which were completed appropriately and showed evidence of informed consent.

- Nursing, therapy and medical staff understood the principles of different forms of consent. They took verbal consent, when a patient verbally agrees to treatment after they have received information, and implied consent, when they assume permission to do something from the patient's actions. They always checked with patients before they undertook tasks such as administering medicines or taking bloods, regardless of the type of consent obtained.
- Staff demonstrated a good understanding of their responsibilities regarding the Mental Capacity Act 2005 (MCA) and knew what to do when patients were unable to give informed consent. There was a trust focus on training all staff, including doctors, in the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). This was now part of mandatory training. Surgery services had a compliance rate of 82%, up from 64% at our last inspection.
- We saw an example of a mental capacity assessment completed by a doctor, which addressed whether the patient had capacity to consent to surgery and the best interest decision on their behalf. However, there was no information about a discussion with family on the form.
- During our last inspection in September 2016, we found junior ward staff who were not able to explain when a DoLS application was appropriate. During this inspection we found overseas nurses, health care assistants and nursing staff on the wards were clear about not depriving people of their liberty without the correct procedures.
- Ward staff monitored patients who lacked capacity to make decisions about their care and treatment and took prompt action to make sure they were safe without depriving them of their rights. The 'safer' checklist on wards, which staff referred to several times a day, included a check on whether there was anyone on the ward who might lack mental capacity and whether they might need to have their liberty restrained, for example to prevent them from leaving the ward. Nursing staff immediately completed an incident form when they were concerned that a patient without capacity might harm themselves or others. They contacted the social work team for a DoLS assessment and made a referral to the enhanced care team. The enhanced care team was made up of a senior nurse and matrons, and one of them was available at all times to assess a patient at risk and to arrange appropriate support, such as one to one care for the patient. The team provided a timely, responsive assessment. We observed a health care assistant providing one-to-one care to a patient with post-surgical delirium, and saw there was a prompt re-assessment when the patient recovered. There were plans for the development of an enhanced care team, trained to provide appropriate care and support for the patients. Nurses confirmed that patients were less likely to become agitated when they had this level of care. In addition, ward staff had more time for other patients because they were not spending so much time monitoring patients at risk.

Are surgery services caring?

Good

We rated surgery services as good for caring because:

- Staff were caring and compassionate and met the needs of patients.
- Staff were respectful of patient's privacy and dignity.
- Patients we spoke with felt informed about their care and treatment.
- Patients were encouraged to be as independent and mobile as possible following their surgery.
- The NHS Friends and Family test response rates were higher than the England average. Overall, a slightly lower percentage of patients recommended the hospital as a place to receive care and treatment.

However:

- The day surgery unit did not provide appropriate facilities and men and women were cared for in the same area.
- Patients did not always get the written information they needed about their treatment.
- The national inpatient survey results indicated that patients wanted to receive better information about what to expect when they had their procedure and when they were discharged.

Compassionate care

- Staff in all the areas we visited interacted with patients in a respectful and considerate manner.
- Nursing staff introduced themselves to patients and their relatives, in line with the trust, "Hello, my name is" campaign. We also observed consultants introduce themselves on the wards, and anaesthetists introduce themselves when patients arrived in theatre. Patients confirmed that all hospital staff introduced themselves and treated them with consideration.
- We observed that even when the ward was busy, staff took time to check on patients and to provide them with the care and support they needed. A patient told us, "Staff take the time to get to know you and your needs". We observed staff responding to call bells promptly; some patients reported they did not need to use the bell because staff were always aware of their needs.
- The 10 patients and two relatives we spoke with during the inspection praised the staff. A patient told us, "The care and attention I received from all staff was second to none, nothing was too much trouble".
- There were comments on the friendliness and good spirits of the staff. These included, "Very well looked after by all staff on Langley Ward. We laughed and smiled all the time".
- Staff respected patients' privacy and dignity. On the wards and in the pre-assessment unit, staff pulled curtains around the bed space to ensure privacy when they were providing personal care or examining the patient. Staff on the combined admissions unit and day surgery unit made sure that in spite of the limited space patients did not change into the theatre gown until their procedure was due and they had a private space to change. We observed a patient who was waiting for surgery had a shawl over their gown to preserve her dignity.
- Staff encouraged patients to complete the NHS Friends and Family Test (FTT) to say whether they would recommend the hospital as a place to receive care and treatment. The response rate for surgery from June 2016 to May 2017 at the hospital was 46%, which was better than the England average of 26%.
- The average percentage of friends and family that recommended the hospital as a place to receive treatment was 93% during this period compared to an England average of 95%. Cleves Ward and Flaunden Ward had the lowest recommendation rates of 88% and 89% respectively. The highest rate of 98% was from patients using the day surgery unit. ESAU and Langley Ward both had a recommendation rate of 97%.

Understanding and involvement of patients and those close to them

- Patients and relatives told us they received the information they needed to understand their treatment. However, patient surveys indicated that more could be done to give patients and their families information to prepare them for surgery and to explain what happened once they were discharged.
- In the CQC Inpatient Survey July 2016, published in May 2017 the trust performed about the same as other trusts for six questions and worse than many other trusts in six questions about explanations and information, they received.
    - The results were similar to other trusts for patients indicating they were given an explanation that they could understand about the risks and benefits of an operation.

    - The results were worse for being given an explanation of what would happen and how they could expect to feel after the operation or procedure.
    - The results were also worse about their involvement in decisions about their discharge from hospital.
- Surgery services took action in response to the survey results by creating a working group with the objective of improving the explanations given to patients.
- The trust had stopped using the online system that staff had used to get information leaflets for patients, but had not replaced this system. Pre-operative assessment clinic staff went onto the NHS choices website to download and print information, but staff said the website was not as easy to use as the previous system and that it did not hold information on all the procedures performed at the hospital. There was no access to written information in different languages
- We observed four pre-operative assessment appointments, with the patients' permission, and observed the nurse communicating well, and answering questions clearly and precisely. However, there were limited discussions regarding post-operative arrangements, for example discharge and care at home.
- Some patients saw the enhanced recovery nurse or a clinical nurse specialist at the pre-operative assessment clinic. The nurses provided information to patients before surgery to help them understand their treatment and what they could expect following surgery.
- Patients told us ward staff kept them informed about what they were doing and gave them time to ask questions. We observed the anaesthetist and operating department practitioner explaining what they were doing and checking the patient understood when they were preparing patients for surgery.
- Consultants visited patients on the wards daily during the week and answered their questions. They kept patients informed of what to expect and how their treatment was progressing. A patient told us how the surgical team explained the options to them and involved them fully in discussions about the next steps they were planning to take and the risks involved.
- Ward managers and nursing staff kept relatives informed when appropriate. Relatives of a patient admitted to Cleves Ward told us the fractured neck of femur nurse practitioner had given them a cup of tea while explaining the plan of treatment and care.
- We saw that a ward sister had arranged to meet relative of a patient living with dementia who would need care after discharge to explain the options and the implications of these.

Emotional support

- Ward staff were sensitive to the impact of hospital admission on patients and their relatives.
- Patients commented on the compassion of staff. One patient told us how nurses took time to comfort them when they were upset. They commented, "You mean something to them". Nurses reassured the patient that they would not discharge them until they were ready to go home.
- We observed staff in the admissions unit reassuring a patient who was anxious about surgery.
- Clinical nurse specialists provided emotional and practical support to patients receiving surgical treatment for cancer.
- Ridge Ward displayed thank you cards and regularly updated these. One of the cards was from a family whose mother had died on the ward, which commented: "the whole family is grateful for the warmth, care and kindness with which you looked after my mum in her last few weeks".

Are surgery services responsive?

Requires improvement

We rated surgery services as requires improvement for responsive because:

- Nearly half of ophthalmology patients were waiting more than 18 weeks for surgery. One-third of vascular surgery patients were also waiting more than 18 weeks.
- Some patients whose surgery had been cancelled did not have their procedure rebooked within 28 days, which is a breach of the standard set for England.
- The trauma team did not always respond promptly to requests from the emergency department to take responsibility for patients.
- Patients were sometimes cared for on the Emergency Surgical Assessment Unit (ESAU) and in recovery overnight because there were not enough beds on the wards.

However:

- Surgery services had taken steps to improve patient flow and to reduce the impact of emergency surgery on elective lists.
- Patients in some surgical specialities waited less time for their treatment than when we last inspected in September 2016.
- There were processes in place to support patients living with dementia and a learning disability.
- The response to complaints had improved so that patients and their families received a timely response and an explanation that answered their questions.

Service planning and delivery to meet the needs of local people

- The trust worked with commissioners, the local authority and health services in West Hertfordshire to plan services for local people. Surgery services worked within strategic clinical networks in the region to ensure patients received the most effective care. These included the trauma network and cancer networks.
- The trust was a tertiary (secondary referral) centre for colorectal and upper gastrointestinal cancers and received referrals from other hospitals in the region.
- The division monitored demand for its services and planned services to meet this. For example, there were plans to employ more hand surgeons because of an expected increase in demand.
- There were additional outpatient clinics, pre-operative assessment clinics and theatre lists to reduce the time taken to treat patients.
- There was a steady increase in the number of patients receiving laparoscopic (or keyhole) surgery, which reduced the recovery time. There were plans to expand the facilities for day surgery at St Albans City Hospital.
- Although the hospital building was old, which posed inherent challenges, the trust was making a full business case to refurbish theatres, the recovery area and the day surgery area following their successful submission of the outline business case to NHS England.

Meeting people's individual needs

- Surgery services took account of the needs of different people.
- Pre-operative assessment documentation had been modified since our previous inspection in September 2016 and included prompts to identify patients that lived with dementia or a learning disability.
- Staff who worked in pre-operative assessment advised patients on healthy weight loss when appropriate and gave patients information on how to get advice and support.

- The nursing assessments completed on wards contained information about mental health, emotional, communication and other needs of the patient so that ward staff were better able to meet individual needs. For example, whether the patient had a hearing impairment and what should be put in place to address the need.
- There was equipment, such as beds and wheelchairs for heavy patients.
- Staff participated in the dementia 'This is me' scheme by documenting patients' needs and preferences in their individual care passport, to enable staff to support them. The staff noticeboard on Langley Ward had tips for staff about communicating with patients living with dementia, such as speaking clearly using short sentences and allowing plenty of time for a conversation.
- Ward staff knew how to contact the learning disability lead and the dementia lead at the hospital when they needed advice or support to provide appropriate care for a patient. There was a team based at the hospital that provided assessment and treatment for patients with mental health needs. The Rapid Assessment Interface and Discharge (RAID) team) were contactable every day of the week from 9am to midnight.
- Patients were encouraged to be as independent and mobile as possible following their surgery. Patients got dressed and moved to a chair rather than staying in bed. We observed physiotherapists spending time with patients who were frail and anxious so that they started walking as soon as possible. A patient recovering from a fractured neck of femur described her physiotherapist as "a wonder" in the way they were as supported to make their way to the toilet unaided except for a walking frame.
- Language needs were identified at booking or within pre-operative assessments. An interpreting service was available for non-English speakers and people who used British sign language. Surgical consultants always used this service when it was needed to inform patients about the risks and benefits of treatment and to take consent. We saw examples of appointments rescheduled when an interpreter did not attend a clinic appointment.

Access and flow

- During our last inspection, we found patients did not always have timely access to treatment. Referral to treatment times (RTT) were worse than the national average for surgical specialities and the cancellation rate for surgery was higher than the national average. The demand for emergency surgery affected the operation lists for planned surgery. During this inspection, we reviewed the action taken to improve access to treatment and to reduce the number of cancellations.
- Surgery services had introduced improvements to manage the demand for emergency surgery. The facilities for the emergency surgical assessment unit (ESAU) had improved since our last inspection and it was operating 24 hours seven days a week to prevent unnecessary admissions and to reduce the demand on the emergency department. The ESAU consultant team reviewed patients referred by their GP, the emergency department and the acute assessment unit.
- During our visit, we found the ESAU was operating effectively with a timely review of patients. One patient who had undergone diagnostic investigations was sent home until the next day when they came back for day surgery. Another patient had arrived with severe abdominal pain and an operation was planned for that evening. Two patients were staying overnight for further assessment and review. Emergency department staff confirmed that the ESAU team improved the flow of patients coming to the hospital for unplanned care. When the unit closed because beds were used for admitted patients, the team attended the emergency department to review patients.
- There was 24-hour availability of an emergency theatre. A theatre team and recovery nurse was on site at all times, with consultant surgeons and anaesthetists on call out of hours. There was a process to open and staff a second emergency theatre. The theatre escalation policy listed the steps to take when the numbers of trauma and emergency

general surgery patients was high, including stopping elective surgery lists. However, three theatres were sometimes needed in an emergency, and the escalation policy did not include action to address this situation. The theatre working party was reviewing the 2015 theatre escalation policy and the new draft policy was due in September 2017.

- The trust had prioritised action to improve access to initial assessment, diagnosis and treatment. There had been a gradual improvement in the percentage of surgical patients receiving treatment within 18 weeks of referral to treatment for most surgical specialties. There was action documented to reduce the waiting lists and waiting times, such as outsourcing patients to other NHS and private hospitals for surgery, and making vacant lists in one specialty available to another specialty. For example, oral surgery had an additional list in the evening. Nearly all patients having oral surgery were treated within 18 weeks.
- Despite improvements, in July 2017, nearly half of ophthalmology patients were waiting more than 18 weeks for surgery. Ophthalmology had 250 patients on their waiting lists (adults and children). One of the ophthalmology consultants was on long term leave, but no locum had been appointed to cover. The divisional performance report for August 2017 indicated that the two other surgeons had agreed to take on two of the lists. In addition, nearly one-third of vascular surgery patients were waiting more than 18 weeks. There were 457 patients orthopaedic patients on the waiting list, (adults and children).
- National data of 26 September 2017 showed referral to treatment (RTT) on completed admitted pathways in surgery at the trust was 72% compared to an England average or 70%. The surgery services performance report for July 2017, reported the following percentage of RTTs within 18 weeks for the trust.
  - General Surgery: 75%
  - Orthopaedics: 76%
  - Ophthalmology: 51%
  - Oral: 99%
  - Urology: 79%
  - Vascular: 64%.
- There were weekly meetings to review RTTs. There were individual patient level review of patients from 30 weeks and above to ensure all patients had plans for next steps in the pathway. No incidents of severe harm had been identified.
- No patients had waited more than 52 weeks for their surgery.
- The trauma and orthopaedic team did not always attend patients in the emergency department promptly. The team inspecting urgent and emergency care during our visit found that three patients, including one with a fractured neck of femur, waited for between one and two hours to be seen by the team. It is best practice that there is a bed always available on a specialist ward to admit patients with a fractured neck of femur from the emergency department. However, because of the demand for beds, Cleves Ward was unable to keep a bed free at all times to accept such patients.
- There was action documented to reduce the waiting lists and waiting times, such as outsourcing patients to other NHS and private hospitals for surgery, and making vacant lists in one specialty available to another specialty.
- There were weekly meetings to review RTTs. Harm reviews were being carried out on all patients who had exceeded the 18-week wait. Those who were categorised as higher risk were bought back to clinics and then prioritised accordingly. No patients had exceeded the 52-week wait for their surgery.
- The plan to reduce the waiting times for pre-operative assessment following outpatient clinic appointments had not been fully implemented because there were not enough clinic staff to open routinely at weekends. More pre-operative assessment staff had been recruited and were due to start work.
- Surgery services monitored the rates of patients who did not attend (DNA) their booked pre-operative assessment appointments. Data provided by the trust showed that from April

2017 to August 2017, DNA rates were on average 4% within pre-operative assessment clinics.

- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. We asked the trust to send us recent data by hospital site. There were 192 last minute cancellations for non-clinical reasons at Watford General Hospital from September 2016 to August 2017. The most usual reasons for cancellation were lists overrunning, prioritising an emergency patient and no bed available. Emergency lists were separate from elective lists. National data for the trust for the period April to June 2017 indicated a cancellation rate of 1.1%, slightly higher than the England average of 1%. The percentage of trust patients not treated within 28 was 10.9%, a fall since our last inspection. However, this was higher than the England average of 7.2%.
- There were patients who had their procedure rebooked more than once. A patient in the pre-operative assessment clinic told us they had their procedure cancelled twice because of emergencies and this had caused them particular difficulty because they needed to go on a special diet two weeks before surgery. There had been no urgent cancellations of operations for a second time during the three months to June 2017, but the trust did not report the number of non-urgent cancellations for a second time.
- Theatre utilisation averaged 75% in the year to April 2017.
- The trust commissioned an external review of theatre lists in 2016 to improve theatre utilisation, carry out more procedures and limit the number of cancellations. As a result, changes were introduced in November 2016, with two lists each weekday, one running from 9am to 1pm an one running from 2pm to 7pm, with dental and ophthalmology services running late lists on some days.
- An activity group of theatre managers, administrators, managers for each surgical speciality and ward staff met weekly to plan the theatre lists. The group reviewed a five-week schedule of lists on both trust sites looking at activity, utilisation, staffing and cancellations. All planned lists were reviewed the day before they were scheduled to check for any last minute changes. Surgical on-call rota meetings discussed any gaps in the rota in advance to reduce last minute vacancies.
- Administrators sent a report on cancelled operations to the service manager with the date by which the operation should be rebooked to reduce the number of patients not rebooked within 28 days. Cancellations for non-clinical reasons were discussed at the weekly RTT access meetings.
- The shortage of beds in the hospital was one reason for cancellations of operations. On each day of our inspection, at least 10 of the 25 patients on Letchmore Ward were medical ‘outliers.’ These patients were admitted for medical rather than surgical care, as there was no beds on the medical wards for them. This affected the capacity to admit surgical patients from ESAU.
- There were surgical outliers on the gynaecology ward during our visit. On one day, there were nine surgical patients on the ward. Patients with complex needs were not placed on this ward and the relevant surgical teams included these patients in their ward rounds.
- ESAU unit staff told us patients were regularly admitted overnight to the unit when there were no beds available on wards. They stayed in the four-bed area that was curtained off from the rest of the unit, and ESAU staff continued to review patients referred to them. When more than four patients stayed overnight, the unit was closed because the other two beds were not in the separate curtained off area. On one day of our visit, ESAU was closed until 12 noon because five patients (all men) stayed on the unit overnight. The unit was reopened when a patient was moved to a ward. The patients staying in the unit overnight were cared for as an extension of the neighbouring ward and had access to the ward’s facilities.

- The availability of beds was not on the divisional risk register. There were plans, however, to reduce the size of the gynaecology ward to increase the number of medical beds.
- During our last inspection we found that some patients stayed overnight in recovery. Because the recovery area was small and there was limited space, this sometimes affected morning lists. There was no data available about the numbers of patients who stayed overnight, or the impact on surgical lists at that inspection. We asked for data about patients staying overnight in recovery, as part of our data request for this inspection and were informed no patients stayed overnight in recovery. However, we saw during our visit an entry of an overnight stay in the recovery unit register of patient information for 8 August 2017. Staff confirmed that patients occasionally stayed overnight, but this was less usual than in previous years.

Learning from complaints and concerns

- The divisional service manager oversaw the response to complaints, working with the complaints coordinator. They followed the trust's complaints policy on record keeping and confidentiality.
- There had been action to improve the speed and quality of response to complaints since our last inspection. The complaints coordinator or a senior nurse contacted the complainant directly to clarify their concerns so that the investigation and complaint response met the patient's expectations. This had reduced the number of people asking for a reinvestigation of their complaint following an initial response. Complainants were kept informed about progress with the investigation.
- From August 2016 to July 2017 there had been 120 complaints about surgical care. The trust took an average of 26 days to investigate and close complaints, a reduction in response times, but not all were within the trust target of 25 days.
- Complaints were categorised according to their type. All aspects of clinical treatment accounted for 32%, admissions, discharge and transfer arrangements 19%, staff attitude 13% and appointments, delay/cancellation (out-patient) 11% of all complaints received
- Managers received all the complaints relevant to their area and gave feedback to staff. Complaints were considered at clinical governance meetings to share lessons learnt.
- We saw evidence of actions put into place because of concerns raised by patients. There was now allocated responsibility for informing patients about changes to appointments, as a common complaint was poor communication.
- There were leaflets and posters displayed on the wards advising patients and their relatives how they could raise a concern or complaint, either formally or informally. Staff directed patients to the patient advisory and liaison service (PALS) when they were unable to resolve the concerns.

Are surgery services well-led?

Good

We rated well-led as good because:

- Clinical governance processes in the surgery, anaesthetics and cancer division (the division) provided clarity about performance and risks and the accountability for these. The division took action to control identified risks and to eliminate these when possible.
- All staff spoke positively about working within surgery services and told us local and senior managers were approachable.
- Leaders were driving standardisation so that patients were receiving consistent treatment and care.
- There was cross-site working, for example with theatre teams, to address challenges in the delivery of services.

- There was a drive to improve clinical services and support innovations.
- Staff were engaged in providing a patient-centred service and adhered to the trust vision.

However:

- There had been action to improve referral to treatment times and patients in most surgical specialities did not wait longer than the England average. However, some patients still had long waits.
- Surgery services were not fully engaged in the implementation of the National Local Safety Standards for Invasive Procedures (LocSSIPs).
- There was further work needed to improve the flow of patients and reduce cancelled operations.
- Ward staff meetings were rarely held.

Leadership of service

- The divisional leaders of divisional director, service manager and head of nursing provided cohesive leadership. They understood the division's performance, the challenges they faced and of the actions needed to address those challenges.
- The clinical director was a member on the trust board and he told us this had increased the focus on the treatment and care of patients at board discussions. Consultant staff felt they had a voice at the board. Senior staff on the wards and in theatres commented that the head of nursing and the service manager were approachable and responded to concerns they raised.
- Ward and theatre staff said they felt well supported. We observed the constant presence of the matron for surgical wards. The ward managers confirmed the matron had a detailed knowledge of the pressure on the wards and took prompt action to address any problems.
- Theatre staff said they were able to raise worries they had with their new manager and were confident that she would pass on any concerns.
- Surgery services used a number of methods to communicate with junior staff. Managers sent information to ward and theatre staff by email, produced newsletters with key items of information, and had folders of information for staff. Staff on one of the wards had started an encrypted electronic communication group, accessible on their mobile phones, to share information, and other wards had taken up this idea. We saw that information on noticeboards in theatres and on wards were up to date at the time of our visit.
- There was a focus on standardisation so that patients received consistent treatment and care.
- We found strong management on the wards, with the matron and ward managers reinforcing standards. There were examples of initiatives on the wards to improve patient care, such as a pressure care recording tool, which was effective in reducing the number of pressure ulcers. Ward staff were aware of their roles and took responsibility for adhering to expected standards. We saw that when care did not meet expected standards, senior staff took action. For example, following an incident, all staff on a ward completed an e-learning module on the deteriorating patient and were given a certificate when they completed this successfully.
- There was action to standardise the practice of surgical teams and to make sure consultants took responsibility for decisions about patient treatment. Following the investigation of a serious incident in July 2016, when a consultant did not review a patient for 10 days, there was an action point to standardise consultant presence on ward rounds. There had been examples of poor discharge documentation by junior doctors, and there was an agreement that consultants or a senior member of their team

should review discharge summaries. However, it was unclear how these actions were monitored and how consultants were held to account.

- We found examples of inconsistencies between surgical specialities. Vascular surgery continued to have one theatre list following the implementation of the standard schedule of two lists (morning and afternoon) for other specialties. It was standard practice for day surgery patients to be on the theatre list early in the day to allow for post-operative recovery before they went home. However, on one of the days of our visit we saw an example of a patient waiting until late in the day for their procedure. The admissions staff had informed the bed manager so that a ward bed was available for the patient overnight.

Vision and strategy for this service

- Staff in all the areas we visited emphasised their commitment to providing safe care and improving patients' experience of care. They demonstrated they understood the trust's vision to provide the very best patient care for every patient, every day, and the values of commitment, care and quality.
- Surgery services were working to meet the priorities set out in the trust's clinical strategy and operational plan. They had had made further progress towards reducing the referral to treatment times by redesigning pathways, providing additional clinics and reorganising theatre lists. theatre lists. However, further work was needed to reduce waiting times in some specialties.
- There were plans to increase the proportion of patients receiving day surgery at the St Albans City Hospital by expanding and developing the facilities at the site, which would reduce demand for surgery at Watford General Hospital. These plans were at an early stage.
- Since our last inspection, the division had continued to improve emergency surgery care pathway by expanding the ESAU and providing surgical and medical cover out of hours.
- Surgery services demonstrated their commitment to the priorities outlined in Patient Experience Strategy: improving communication, getting the basics right and improving the patient journey.

Governance, risk management and quality measurement

- The division had developed a robust clinical governance framework and there was clear accountability for managing risk and making service improvements.
- Departments and specialities within the division, such as trauma and orthopaedics, general surgery and urology, held monthly clinical governance meetings, which combined mortality and morbidity discussions, presentation of audits and a review of activity data, risks, complaints and incidents. Consultants and senior nursing and theatre staff attended quarterly divisional clinical governance meetings. Consultants were expected to attend clinical governance meetings and to account for non-attendance.
- Consultant staff we spoke with commented on the open discussion at the departmental and divisional meeting, with attendees contributing their views and expertise. They felt there had been marked improvements in the clinical governance and accountability processes in the last two years.
- Senior managers, finance, human resources and clinical governance teams met weekly. These meetings focused on key areas including staffing, departmental issues and incidents.
- The leaders of the division had access to safety, quality, activity and financial information. The integrated performance report for the division provided summary data on a variety of key indicators, including whether targets were met. When targets were

not met, there was action to improve performance. In some cases, such as children sharing the recovery area with adults, when the division was unable to fully resolve the issue, the item was entered on the divisional risk register.

- Risks were owned by senior staff and the risks were manged effectively. There was discussion about risks at divisional governance meetings and agreement from the meeting before a risk was put on the register. The divisional risk register recorded the key risks, the controls in place and any gaps in controls. The register listed the assurances to address these gaps and any further action planned. The division had successfully made a business case to address some of the gaps in assurance, such as the recent appointment of additional consultant staff.
- There was a quality improvement plan (QIP) in place that covered key risks and issues that required improvement across surgery services at St Albans and Watford. The QIP contained clear milestones, which member of staff owned each area, and an intended end date. Included within the QIP were items relating to patient discharges, embedding WHO surgical safety checklists and reducing cancellations.
- We did not find evidence that surgery services were fully engaged in implementing the national safety standards for invasive procedures (NatSSIPs), which were published in September 2015 to support hospitals to provide safer surgical care. All NHS organisations were expected to develop their own Local Safety Standards for Invasive Procedures (LocSSIPs) and to have allocated responsibility for doing this for each area. The trust medical director reported to the trust board on progress and had identified variation in LocSSIP availability and use across specialities. This was on the trust risk register, but surgery services had not identified this variation as a risk. Compliance with LocSSIPs includes consideration of human factors and how teamwork, tasks, equipment, workspace, culture and organisation affect human behaviour. Surgical services had recently begun to use simulation facilities to observe how teamwork affects performance in a theatre emergency. However, we did not find a coherent approach to improving understanding of human factors, for example in how teams work together in the effective implementation of the WHO Surgical Safety Checklist and five steps to safer surgery.
- The trust Sepsis reference group oversaw compliance with standards for reducing avoidable harm from sepsis. The group was chaired by the medical lead for sepsis and. its membership included divisional, microbiology and pharmacy representatives. Information about the sepsis programme was reported to the Quality and safety group.

Culture within the service

- Staff of all roles and levels of seniority talked with pride about the focus on providing safe and patient centred treatment and care.
- There was a notable shared understanding across specialties and staff groups of the importance of reporting and learning from incidents. Staff, including consultants said they thought there was an open culture in which staff could raise and discuss concerns.
- Staff gave us examples of the support they had received from their managers when they had health or family problems. Staff in theatres and some of the wards told us managers promoted adherence to standards in a reassuring and encouraging way. However, we also heard examples of staff being rebuked rather than encouraged to improve performance.

Public engagement

- All wards distributed patient feedback forms regularly to ensure they captured patient comments and any concerns.
- Each ward had a ‘welcome board’, which displayed results of monthly feedback from patients. This was visible to staff, patients and visitors. For example, Langley Ward

scored 4.9/5 in July. Staff also wrote positive and negative feedback from patients.
- Pre-operative assessment clinic staff gave questionnaire to patients about their experience and displayed examples of these in the staff room.
- Surgery services used information from patient surveys and complaints to improve the service.

Staff engagement

- The trust had improved engagement with front line staff since the appointment of the chief executive in July 2016. Staff we spoke with knew about the chief executive and executive team and some had attended their regular engagement meetings.
- There were regular meetings of theatre staff, who felt they could contribute to discussions about how to address issues in their sphere of work. There were no ward staff meetings and we did not see evidence that front-line staff were asked to contribute their ideas for improvements in the running of wards.
- The NHS staff survey for 2016 showed the engagement score was in the bottom fifth of trusts in England. The trust performed better than average on good communication between senior managers and staff (40% compared to an England average of 33%). The trust performed worse than average in the percentage of staff who said they experienced discrimination at work (14% compared to the England average of 11%).
- The trust had introduced their own staff engagement survey. The results showed that staff were proud to work for the trust, but felt frustrated with day-to-day issues. Staff recommended the trust as a place to undergo treatment more strongly than a place to work.

Innovation, improvement and sustainability

- There were examples of initiatives to improve the service. These included the ward initiatives to understand the risks to patients and to take action to address these. The theatre activity group took action to reduce the number of cancellations. There were notable improvements to the way that doctors in training were supported.
- Leaders took decisive action to make improvements to the running of surgery services. However, the actions did not always include an assessment of the potential impact of these changes or a process for monitoring unwanted consequences.
- The divisional leaders had implemented the new schedule for theatre lists following a consultation exercise with theatre staff, surgeons and anaesthetists. However, some theatre staff felt the leaders had made the decision regardless of the views of staff. There were concerns that the new sessions (a four-hour and a seven-hour session daily) did not allow enough time for breaks and for staff to have the food and drink they needed for the demanding schedule. This was not being monitored to check whether it was a risk.
- Ward staff were concerned that the formation of a new larger ward to allow for a ward for elective orthopaedic patients would be difficult to manage. Flaunden ward already had the highest staff turnover and the lowest patient satisfaction. There was no space for a staff room with the rebuild.
- At this inspection, we found the following improvements since our inspection in September 2016:
    - Staff received feedback on incident reports and knew about lessons learned from serious incidents.
    - The temperature of treatment rooms on all surgical wards was appropriate for storing medicines and dressings.
    - Staff who cared for children and young people received appropriate safeguarding training.

- Patients' own controlled drugs were stored safely.
- There was consistency in the recorded use of the five steps to safer surgery in the operating theatres.
- There was an effective process for ensuring staff received an appraisal of work performance.
- Staff at all levels understood the importance of protecting the rights of patients who might not have capacity to make decisions.
- There had been action to improve referral to treatment times and patients in most surgical specialities did not wait longer than the England average.

- There were areas where there was action to address the risks we found at our last inspection, but further improvement was needed:
  - Facilities in theatres, recovery and the day surgery unit were poor.
  - The number of patients not offered another appointment within 28 days of a cancelled operation remained higher than the national average.
- There were areas where there had not been any changes since our inspection in September 2016. These included:
  - Venous thromboembolism (VTE) assessments were initially recorded but repeat assessments were not consistently recorded in line with best practice.
  - Patients sometimes stayed in the recovery area overnight. These were not recorded, neither was the impact on surgical lists.

Critical care

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

Information about the service

Critical care services for West Hertfordshire NHS Trust are located at Watford Hospital. Critical care includes areas where patients receive more intensive monitoring and treatment for life threatening conditions. It provides expertise and the facilities for the support of vital functions and uses the skills of medical, nursing and other personnel experienced in the management of these patients.

The Critical Care Unit (CCU) provides care to critically ill patients (level two and level three), who require organ support or closer monitoring in the immediate post-operative period. There are 19 critical care beds for the care and treatment of people aged 16 years and above. The unit has five side rooms, for the management of patients who require isolation, mainly for infection prevention and control purposes.

Critical care also provides a critical care outreach service, which supports patients at risk of clinical deterioration on the wards of the hospital. This was available 24 hours a day, seven days a week.

There were 922 admissions to the unit from April 2016 to March 2017, with 785 emergency admissions and 137 elective admissions (Intensive Care National Audit and Research Centre data).

During our inspection, we spoke with 38 staff, including nursing staff, junior and senior doctors, administrative staff, and allied healthcare professionals working within CCU, as well as other doctors and nurses supporting patients on CCU. We spoke with 13 patients and relatives. We checked the clinical environment, observed ward rounds, multidisciplinary team meeting, nursing and medical staff handovers and assessed patients' healthcare records.

The Care Quality Commission carried out a previous inspection at West Hertfordshire Hospitals NHS Trust in September 2016, during which, the critical care service was rated good overall.

Summary of findings

We rated this service overall as good because:

- Leaders fostered a culture where patient safety was the highest priority. This was supported by an active incident reporting culture, maintenance of healthcare records, medicines management and the appropriate level of monitoring for patients.

- Staff attended mandatory training, completed competencies, received annual appraisals of their development needs and received support from the unit's professional development nurse.
- The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) that monitored patient outcomes and mortality indicators. The annual report for 2016/17 showed the unit was performing as expected (compared to other similar services) in all the indicators, except for two related to delayed discharges.
- Despite the delays encountered with discharges from the unit, patients were not being transferred out to wards in the hospital overnight nor transferred to other units as a result.
- The critical care unit nursing and medical staffing was in line with guidance for the provision of intensive care services (GPICS 2015).
- The unit had an active research and development programme and patients' care and treatment was assessed and delivered according to national and best-practice guidelines.
- There were low infection rates and good adherence to infection prevention and control policies, including use of handwashing and personal protective equipment.
- Patients were treated with dignity, respect and kindness. The critical care team were committed to involving patients and their relatives in care and treatment decisions.
- The service was provided in appropriate facilities to care for critically ill patients and relatives and visitors had access to appropriate areas of the unit.

However:

- Systems and processes related to the maintenance of equipment were not always effective. We found five items of equipment that had not been serviced appropriately. We raised this issue and it was addressed during our inspection.
- Staff were not clear how often the contents of the difficult airway trolley should be checked.
- The unit did not meet the guidance for the provision of intensive care services (GPICS 2015) standard of 50% of nursing staff having a qualification in critical care. This was 42% at the time of the inspection.
- Despite actions being taken in conjunction with the trust regarding delayed discharges, this remained an issue for many patients in the critical care service. This also reflected in the increasing number of mixed sex accommodation (MSA) breaches, from June 2016 to May 2017, there were on average 10 each month.
- Delayed discharges from critical care appeared to impact the services ability to always admit critically ill patients in a timely manner.
- Divisional level mortality and morbidity meetings included critical care services. However, local review minutes were brief and actions to be taken were not always clear.
- There were risks to the provision of the critical care service we found that were not included in the risk register. For example, the delays with servicing equipment.
- The microbiologist was available on call and attended the unit three times a week. This did not meet the daily requirement as stated in GPICS (2015).

Are critical care services safe?

Good

We rated safe as good because:

- There was an active incident reporting culture and evidence of sharing learning from incidents.
- There were low infection rates and good adherence to infection prevention and control

policies, use of handwashing and personal protective equipment.

- Staff appropriately observed and monitored patients in order to assess and respond to risk.
- The nursing and medical staffing was in line with guidance for the provision of intensive care services (GPICS 2015).
- Medicines were stored, prescribed and administered in line with trust policies and guidance.
- Records were maintained appropriately in order to guide care and treatment.
- There was an overall compliance with mandatory training by the service of 96%.

However:

- Systems and processes related to the maintenance of equipment were not always effective. We found five items of equipment that had not been serviced appropriately. We raised this issue and it was addressed during our inspection.
- Staff were not clear how often the contents of the difficult airway trolley should be checked.
- The critical care mortality and morbidity reviews minutes were often brief and actions to be taken and by whom, were not always clear.

Incidents

- The trust had guidance for staff regarding reporting incidents in the incident and serious incidents policy. There was an electronic process in place for incident reporting. Staff were able to discuss incident reporting and types of incidents that should be reported. They felt that they were actively encouraged to report these and were kept informed about learning from incidents that occurred throughout the trust.
- Staff attended weekly spotlight meetings. These meetings included discussion of local learning from incidents. Nursing staff we spoke with had attended these meetings and we saw minutes of the meetings confirming this.
- Critical care services had an active incident reporting culture. We checked records provided that showed that CCU had reported 582 incidents in the 12 months ending June 2017. The majority of these (528) resulted in no harm and 51 resulted in low harm. Three incidents were classed as resulting in moderate harm. Details of these incidents were provided, two of which related to pressure ulcers. Following further review, they had been regraded. For example, one of the patients had developed a pressure ulcer prior to admission to the hospital and was not attributable to the care provided by the unit.
- The largest category of incidents reported (369) were classed as the result of administrative processes. A further 56 incidents were categorised (second highest) as the result of pressure ulcers. From June 2016 to May 2017, there were no incidents classified as never events for critical care. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- There were no serious incidents reported by critical care from June 2016 to May 2017.
- In the 12 month period to May 2017, there had been three incidents reported externally due to patients developing pressure ulcers. However, in the same time period no catheter related urinary tract infections and no falls resulting in harm had been reported by CCU.
- Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. There was a trust policy relating to duty of candour, which outlined actions to be taken when something went

wrong. Staff were aware of the thresholds for when duty of candour was triggered. However, there had been no incidents reported that met the threshold to comply with the regulation.

- The trust held regular mortality review meetings to discuss mortality and morbidity across the divisions. Critical care services were under the management of the surgical, anaesthetic and oncology division. Meeting minutes showed a consultant anaesthetist attended the meetings. The division's standard mortality ratio was 83.62, which was statistically 'as expected' (April 2017). There were also local reviews of cases including readmissions and deaths. However, the minutes were often brief and actions to be taken and by whom, were not always clear.

Safety thermometer

- The safety thermometer is used to record the prevalence of patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Data collection takes place one day each month. Information related to the safety thermometer was on display at the entrance to the unit.
- Data from the patient safety thermometer showed that critical care reported three new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from May 2016 to May 2017. Included in this data was the number of patient falls and pressure ulcers.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were mostly being maintained. At the time of our inspection, the environment and equipment in the unit were visibly clean and tidy.
- We observed that staff followed the trust's policy regarding infection prevention and control. This included staff being 'arms bare below the elbow', hand washing and the correct wearing of disposable aprons and gloves.
- Hand hygiene gels were available throughout CCU. We observed all staff using alcohol hand gel when entering and exiting CCU.
- There was access to hand-wash sinks throughout the unit, including in the side rooms.
- Critical care carried out monthly audits, including commode cleanliness, joint domestic service and ward staff cleaning scores, code of practice audits and standards for insertion and care of peripheral and central venous devices. Results from February and March 2017, show mainly 100% compliance. However, the scores had gradually deteriorated in some areas by May 2017. For example, standards related to insertion of venous devices had 75% compliance. The service had action plans in place following the audits. Further data was provided that showed 100% compliance related to ongoing care of peripheral and central devices had been achieved in audits in June and July 2017.
- An infection control audit carried out on the unit in June 2017; found that staff were not always wearing aprons during procedures that involved contact with bodily fluids, contaminated items, or significant patient contact. Action taken following the audit included reminding the staff regarding infection prevention principles. However, during our inspection we found that personal protective equipment, such as gloves and aprons were used appropriately and were available in sufficient quantities.
- An audit carried out in December 2016 against the infection control and prevention code of practice (Department of Health 2015), found overall compliance was 89% which was worse that the target of greater than 95%. Staff repeated this in April 2017 and the results had improved to 94%.
- Staff attended mandatory training regarding hand hygiene and principles of infection prevention and control. Compliance with this training was 91% for hand hygiene and 99% for infection control for August 2017.
- Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste, sharps bins, which we observed were not overfilled.

- We saw good use of 'I am clean' stickers on equipment and other items to indicate that were cleaned, ready to be used.
- The trust reported one incidence of MRSA blood stream infection for critical care in May 2017. However, subsequently there was a detailed investigation, which found there had been no lapses in care, and the incidence was assigned to a third party.
- The CCU submitted data to the Intensive Care National Audit and Research Centre (ICNARC) an organisation reporting on performance and outcomes for intensive care units nationally. The ICNARC report for the 12 month period ending March 2017 showed the rate of unit-acquired infections in blood per 1000 patient days for CCU was 2.4. This value was within the expected range.
- There were five side rooms in total on the unit. Two of which had anterooms. It had recently been discovered that these rooms were not pressurised in order to reduce spread of infection. Therefore, staff sought the microbiologist's advice before their use. However, this issue was not documented on the unit's risk register.

Environment and equipment

- The environment was spacious and well lit and corridors were free from obstruction to allow prompt access. The unit was split into two distinct areas, although patients requiring either level two or three care could be placed in either section.
- The unit complied with the Department of Health guideline Health Building Notes 04-02, in terms of space and equipment required for intensive care facilities.
- Access doors to the CCU were controlled via by an intercom and visitors were required to identify themselves upon arrival. However, we found that on one occasion the doors were not locking properly, which meant that the unit was not secured appropriately. We informed the ward clerk who immediately made the nurse in charge of the unit aware and reported the fault to the estates department for urgent attention.
- Staff had access to adequate supplies of equipment. CCU was equipped to provide care for 19 ventilated patients.
- Resuscitation equipment, for use in an emergency was checked daily and documented as complete and ready for use. The trolleys were secured with tamper evident tags, which were removed weekly to check the contents were all in date. There were also oxygen cylinders available for use in evacuation. We saw that they were stored in appropriate secure holders.
- There was a difficult airway trolley on the unit, which contained equipment to be used in the event of an airway emergency. We saw that the outside of the trolley and the tamper evident tag was checked daily by the registrar. However, it was not clear from the checklist or from speaking with medical staff how often the full contents of the trolley should have been checked. We saw that this was checked November 2016 and again in July 2017. This meant there was a risk that contents may have passed their date range and would not have been available in the event of emergency.
- During the inspection, we checked 24 items of equipment. We found that five items equipment had not been serviced appropriately. This included a dialysis machine that had been in clinical use. We raised this immediately with the matron. They reported the incident, ensured all of the equipment in the unit was checked, escalated the equipment to be serviced urgently and labelled them not to be used. The trust also contacted the manufacturer. The manufacturer explained safety features such as internal automatic tests had reduced the risk to patients. Subsequently, the issue was investigated thoroughly in conjunction with the medical devices manager. Changes were immediately made to the processes in place for monitoring, reporting and escalation of high risk category equipment items.
- We saw that staff received training to use equipment specific to the unit, such as ventilators and haemodialysis machines.

Medicines

- Medicines were stored, recorded, reconciled and administered accurately. There was a dedicated clinical pharmacist for CCU that worked on the unit Monday to Friday. An on call pharmacist would visit the unit during the weekend. The CCU pharmacist checked medicines daily, reconciled patients' medicines daily as well as monitoring the prescribing of medicines. The pharmacist was available for advice about medicines management and usually attended the weekly multi-disciplinary team (MDT) meeting.
- Medicines were stored in a secure temperature controlled room that had suitable storage and preparation facilities for all types of medicines such as controlled drugs and antibiotics.
- Medicines that required refrigeration were kept at the correct temperature. We checked the refrigerator temperature checklists in the unit, which were signed to say the temperature had been checked each day as required. The checklists indicated what the acceptable temperature range should be to remind staff when to report if the refrigerator temperature was out of that range. All the temperatures recorded were within the required range.
- Controlled drugs were stored in a locked unit and the keys held separately from the main keys. We reviewed the controlled drug cupboards, which were tidy and did not hold any other items.
- Entries in the controlled drug register were appropriate and included administration records, new stocks checked and signed for, destruction of out of date medicines had been recorded.
- There was a medicines management policy, which included information on safe administration of controlled drugs and administration of medicines, which staff could access via the hospital intranet.
- Medicines including intravenous fluids were stored securely behind locked doors and were accessible by appropriate staff. Medicine refrigerators were also locked, except for one, containing emergency medicines.
- 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 trust's policy.
- We reviewed the prescription charts of seven patients and found records of medicine administration were completed correctly. These records were clear and fully completed. Patient's allergies to any medicines were recorded and antibiotics prescribed in line with the trust's policy.
- We observed the weekly multidisciplinary team (MDT) meeting that was held to discuss long-term patients. We saw that the patients' medicines were reviewed and adjusted at the MDT meeting. The pharmacist usually attended this meeting.

Records

- Records were stored safely, were fully completed and legible with entries timed, dated and signed for. We looked at eleven sets of nursing and medical records.
- Risk assessments had been carried out, which included falls risks, patient manual handling assessment, wound care and communication charts. Records demonstrated personalised care and multidisciplinary input into the care and treatment provided.
- There was documented evidence of the decision and time to admit to CCU, in line with the National Institute of Health and Care Excellence (NICE) CG50 guidance.
- The nursing and medical notes were stored by the patient's bedside, to allow staff to access them quickly. These were stored in a folder to maintain patient confidentiality. The patient's main healthcare records (not from the current admission) were stored in a locked trolley.
- Daily observation charts were used to record vital signs along with cardiac and respiratory indicators. Fluid intake and output records were complete, and reviewed during the daily handover between shifts from nurse to nurse. There were also critical care specific risk assessments that were completed on the back of the daily chart. For example, an eye

assessment tool guided staff to check for signs of infection, dryness, and that eyelids fully closed.

Safeguarding

- There were safeguarding systems and processes in place to protect patients from abuse. The hospital had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details. The staff were able to explain safeguarding arrangements, and when they were required to report issues to protect the safety of vulnerable patients.
- Staff had access to the trust's safeguarding team and we saw that they contacted the team to discuss concerns during the inspection. Information and relevant contact numbers for safeguarding were also seen on staff noticeboards and in public areas.
- The unit admitted young people between the ages of 16 to 18 years. The Royal College of Paediatrics and Child Health (RCPCH) guidelines or those contained in the Intercollegiate Document (March 2104) which states that clinicians who are potentially responsible for assessing, planning, intervening and evaluating children's care, should be trained to level three safeguarding. Two of the doctors and six of the senior nursing staff had completed this in order to support the staff with any children's' safeguarding issues.
- Staff compliance with safeguarding training for August 2017 was 96% for safeguarding adults (level two) and 98% safeguarding children (level two).

Mandatory training

- Staff were required to attend mandatory training according to their role.
- Mandatory training included; adult basic life support, conflict resolution, equality and diversity, health and safety, infection prevention and control and moving and handling. Some training was delivered via face-to-face sessions and others were available electronically.
- Information provided by the trust showed there was an overall compliance with mandatory training by the service of 96%. All mandatory training topics had met the trust's target of 90% or above.

Assessing and responding to patient risk

- On CCU, patients were closely monitored so staff could respond rapidly to any deterioration. Patients were cared for by levels of nursing staff recommended in the core standards for critical care Guidance for the Provision of intensive Care Services 2015 (GPICS 2015). Patients who were classified as needing intensive care (level three) were cared for by one nurse, for each patient. Patients who needed high dependency type care (level two) were cared for by one nurse for two patients.
- Admission to CCU should be within four hours of the decision to admit, although the trust was not always meeting this indicator. Figures provided by the trust show that on average 62% of patient were admitted within four hours (12 months ending August 2017). This meant patients who required critical care could not always do so in a timely manner. This risk to patients' safety was documented on the risk register. We observed a patient being admitted to CCU from another area of the hospital, safely, and effectively. There was good interaction and handover from ward staff to CCU staff.
- We observed that when the nursing staff arrived on duty in the morning they attended a team brief prior to being allocated their patients to care for. This highlighted safety issues not just at a unit level. For example, there had been an alert regarding a person impersonating a pharmacy technician in another trust, so staff were reminded about the security of the unit and checking identification.
- A critical care outreach team provided 24 hours a day seven days a week service

throughout the hospital. This team consisted of a senior nurse allocated on the duty rota to provide a 24 hour seven day a week service for the whole hospital. The outreach nurses were also supported by an on call anaesthetist.

- Risk assessments were undertaken in areas such as venous thromboembolism (VTE), falls, malnutrition and pressure ulcers. These were assessed and documented in the patients' records and used to guide care and treatment.
- The national early warning score (NEWS) was used to monitor acutely ill patients in accordance with NICE clinical guidance CG50. NEWS charts were used to identify if a patient was deteriorating. In accordance with the trust's deteriorating patient policy, staff used the NEWS charts to record routine physiological observations, such as blood pressure, temperature and heart rate, and continually monitored a patient's clinical condition. There were clear directions for actions to take when patient's scores increased, and members of staff were aware of these.
- There was a trust policy for management of sepsis (blood infection) and a sepsis bundle care pathway could be implemented if sepsis was suspected. CCU had access to appropriate antibiotics when required to facilitate immediate antibiotic treatment for those patients with suspected sepsis. We also saw that sepsis had been a topic recently at one of the unit's spotlight meetings, to raise awareness of best practice.
- During inspection, we observed staff requesting advice from senior staff in the unit when required, to ensure that patients received safe care and treatment.
- We saw from meeting minutes, that staff attended training to ensure they could safely transfer critically ill patients, both locally and to other hospitals. This was in line with the East of England critical care network 'magnificent seven' standards. All consultants and senior medical staff had attended the training. Thirteen trainee medical staff had also been trained in August 2017. The majority of clinical nursing staff (80%) had completed the training and the remaining staff were booked to attend this in November 2017.
- Critical care safety huddles took place throughout the day on the unit. We observed one of the meetings and this included patients treatment plans, resuscitation status and treatment escalation plans, safeguarding issues, unit workload and key messages.
- The use of ''Fresh Eyes'' stickers had been implemented in the unit. This was a system that prompted a peer review of patient observation records. Staff swapped patients to undertake a set of routine observations and evaluate care twice each day. This process allowed clarification to be sought regarding the care and treatment that was being provided and allowed a second check to reduce the risk of errors. Following the review, the stickers were placed on the chart to document that this check had occurred.

Nursing staffing

- Nursing staff levels in CCU met the Guidance for the Provision of Intensive Care Services 2015 (GPICS). Staffing related to levels of patient care was in line with core standards at all times during the inspection; that is, level three patients (intensive care) cared for on a one to one basis, whereas level two patients (high dependency) had one nurse for two patients.
- Planned and actual staff levels for the shift were displayed on the entrance to CCU.
- We were told and observed the nurse in charge of CCU was supernumerary (does not have a patient allocated to care for) leaving them free to co-ordinate the shift. There was also a role of supervisory nurse, who was supernumerary to support the shift. This was in line with the GPICS 2015 guidelines for units with greater than 10 patients.
- The nursing staffing consisted of 80.5 whole time equivalents (WTE) at May 2017. However, there was a vacancy rate of 16.9%, which was higher than the trust target of 9%. The unit also had a turnover rate of 20.5% from June 2016 and May 2017, which was higher than the trust target of 12%. Issues regarding recruitment and retention of staff on the unit were described on the units risk register. The leaders of the service explained

plans regarding recruitment of staff. For example, they were planning rotational posts with some of the London hospitals to reduce turnover rates.

- We were told that 13 new staff had been recruited, which would reduce the vacancy rates.
- The CCU used agency staff and the hospital's own bank staff to ensure staffing levels remained safe. An enhanced rate of pay for CCU staff had been agreed to encourage staff to work extra hours through the trust bank system.
- We reviewed nursing staff rotas and saw that actual numbers of staff met planned levels. This included bank and agency staff, who were booked in advance to ensure correct numbers of staff were on duty.
- From May 2016 to June 2017, CCU had a bank and agency usage rate of 18.1% compared to the trust average of 20%.
- The unit had processes in place to ensure that temporary staff received an orientation to the unit, which was documented and kept in a folder on the unit. Many temporary staff were substantive staff working extra shifts (bank) or worked on the unit frequently. During our inspection, we saw an agency nurse on duty, who told us they had received an orientation to the unit on commencing the shift. We also saw that documentation had been completed to support this orientation.
- The nursing sickness rate from June 2016 to May 2017 for the unit was 2.7%. This was below (better than) the trust target of 3.5%.
- We observed the nurses' handover. Each nurse had a handover at the bedside for the patient they were looking after, and the senior nurse in charge, had a one to one meeting with the senior nurse from the previous shift. This handover was recorded on a standardised handover sheet.
- We were told that on occasion staff from the unit had been required to work on ward areas. This had caused concern as they were unaccustomed working in these areas. In response, the director of nursing was involved to find a resolution. The trust safe staffing policy had been updated to include that CCU staff were to be reallocated to areas such as emergency department resuscitation area and would be released back to CCU when needed.
- The band seven nurses and the matron provided an on-call service, to support the unit each night.

Medical staffing

- Medical staffing was provided mainly in line with GPICS 2015 guidelines.
- During the week (Monday to Friday), there were two consultants and two residents covering CCU during the hours of 8am and 6pm. The resident doctors were staff grades or clinical intensive care fellows. There were also trainees in a supernumerary capacity.
- Overnight from 6pm to 8am, there was one consultant on-call for critical care. From 8pm to 8am, two residents were on-call for critical care. However, from 6pm to 8pm, there was one resident on-call. During this two hour period, the service was not complaint with GPICS standard of two resident medical staff. This was documented on the risk register and actions included further recruitment of medical staff, which was planned to be complete by the end of 2017.
- At weekends, there were two residents on call and one consultant on-call from 8am to 8pm. The resident doctors were staff grades or clinical intensive care fellows.
- We were informed that there was a further resident, who although not based in critical care, could assist if required throughout the 24-hour period.
- Consultant to patient ratio met the GPICS recommended ratio. There were two consultants on duty during each day for a maximum of 19 beds. The GPICS recommended ratio of one consultant for a maximum of 15 beds. During the inspection, the consultant to patient ratio met the GPICS 2015 standards and did not exceed a range between 1:8 to 1:15.
- Care in CCU was consultant led and delivered. There were consultants who worked in rotation and were responsible for providing senior cover within critical care. Consultants

provided a good level of continuity. A consultant would usually cover the unit for a week at a time (Monday to Friday).

- A consultant in intensive care medicine was immediately available 24 hours a day, seven days a week for ICU. There was always a consultant anaesthetist, who specialised in intensive care, covering the unit and there was a designated clinical lead consultant.
- 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.
- There was a resident senior trainee doctor immediately available 24 hours a day, seven days a week (with advanced airway skills) for ICU. This resident was responsible for critical care cover with no other areas of responsibility.
- Staff told us and we saw evidence in patients' health records, that ward rounds took place twice daily each day, including at the weekend.
- The hospitals' anaesthetist vacancy rate was 0.6% at the time of the inspection. Regular locum doctors were used to cover unfilled shifts, we reviewed doctors' rotas and saw these were booked up to six weeks in advance and the same locums used to ensure consistency. We were told that locum staff had an induction and support from other medical staff to orientate them to the unit. The trust provided locum temporary medical staffing figures for anaesthetics (which included CCU), which showed that for ten months ending June 2017, there were from 9% and 31% usage each month.
- We observed the medical staff handover was relevant and comprehensive. Ward rounds were twice daily, which was in line with national guidance (GPICS 2015). The rounds were at the patient bedside, led by the consultant with input from other relevant staff. This included junior doctors, nurses, and allied healthcare professionals.

Major incident awareness and training

- There was a trust emergency preparedness policy regarding major incidents in place. This was detailed and relating to all services including CCU. For example, the matron and consultant for CCU would lead one of the operational coordination hubs in the event of a declared major incident.
- The CCU was listed as having a key role in the event of a major incident situation. Staff were aware of the policy and how to access this.
- Clinical staff attended mandatory training regarding fire and evacuation. The compliance with this training was 97% at August 2017. The unit also had four named fire marshals to advise staff.

Are critical care services effective?

Good

We rated effective as good because:

- Patients' care and treatment was assessed and delivered along national and best-practice guidelines; for example, the critical care operational network evidence-based quality principles.
- The unit had an active research and development programme and carried out local audits in order to provide effective care and treatment.
- The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) that monitored patient outcomes and mortality indicators. The annual report for 2016/17 showed the unit was performing as expected (compared to other similar services) in all the key indicators.
- Pain relief was well managed and patients' hydration and nutritional requirements were

assessed and supported.
- Staff had received annual appraisals of their development needs and received support from the unit's professional development nurse.

However:

- The unit did not meet the guidance for the provision of intensive care services (GPICS 2015) standard of 50% of nursing staff having a qualification in critical care. This was 42% at the time of the inspection.
- The microbiologist was available on call and attended the unit three times a week. This did not meet the daily requirement stated in GPICS (2015).

Evidence-based care and treatment

- Patients' care and treatment was assessed during their stay and delivered according to national and best-practice guidelines. For example, the National Early Warning Score (NEWS) with a graded response strategy to patients' deterioration complied with the recommendations within National Institute for Health and Care Excellence (NICE) Guidance 50 Acutely ill patients in hospital.
- Patients were ventilated using recognised specialist equipment and techniques. This included mechanical invasive ventilation to assist or replace the patient's spontaneous breathing using endotracheal tubes (through the mouth or nose into the trachea) or tracheostomies (through the windpipe/trachea). The unit also used non-invasive ventilation to help patients with their breathing using masks or similar devices. The ventilated patients were continually monitored and checks documented each hour.
- The CCU met best practice guidance by promoting and participating in a programme of organ donation, led nationally by NHS Blood and Transplant. In the NHS, the number of patients suitable for organ donation is limited for a number of reasons. The vast majority of suitable donors will be cared for in a critical care unit. There was a specialist nurse for organ donation (SNOD) working within CCU. They directly supported the organ donation programme and worked alongside the clinical lead. The link nurse also supported a regional and community programme for promoting organ donation.
- Staff carried out an audit of every patient's death that occurred on the unit out in order to check that the team were not missing any referrals for organ donation. The SNOD told us that the unit performed well. For example, from April to August 2017 the unit had not missed any suitable referrals. In this time, 12 families had been approached during their loved one's end of life phase and seven donations had taken place.
- Patients on the unit received an initial short clinical rehabilitation assessment within 24 hours of admission and individualised rehabilitation prescriptions. This was in line with NICE guidance CG83, rehabilitation after critical illness.
- Venous thromboembolism (VTE) assessments were recorded, ensuring best practice in assessment and prevention and offered treatment in accordance with NICE Clinical guideline (CG92 VTE: reducing the risk for patients in hospital). VTE prophylaxis was re-assessed each day during the ward round. This was also prompted by the daily ward round check incorporated onto the CCU observation charts.
- The trust had specific guidance on delirium in accordance with National Institute for Health and Care Excellence guidance. We saw evidence that patients were screened on admission and this was documented on the daily observation charts.
- The CCU submitted data to the Intensive Care National Audit and Research Centre (ICNARC) an organisation reporting on performance and outcomes for intensive care patients nationally. There was a small dedicated team to collate this information.
- The unit had developed care plans for their patients called 'gold standards'. These were best practice principles for the staff to bench mark and evaluate the patient's care and treatment against. These included areas such as nutrition, sedation and hydration.

- The unit followed the 'magnificent seven' which were evidence-based quality principles agreed by the critical care units in the East of England network. We saw that local audits were carried out to check compliance and changes made as required. The seven principles included:
    - Diagnostic tests should only be ordered in response to specific clinical questions rather than at regular intervals.
    - Red blood cells should only be transfused at a haemoglobin concentration less than 70 g/L in haemodynamically stable, non-bleeding ICU patients.
    - Parenteral nutrition should not be given to adequately nourished, critically ill patients in the first seven days of a critical care stay.
    - Minimise sedation for mechanically ventilated patients.
    - Continuation of life support for patients at high risk for death or severely impaired functional recovery should be reviewed with patients and their families, offering the alternative of care focused entirely on comfort.
    - Antibiotic use in critical care should be only initiated in patients with clinical evidence of bacterial infection after cultures are obtained.
    - Transfers within and between hospitals should be undertaken by the appropriately trained personnel.
- The service undertook local audits to assess performance and drive improvements. One area that had been looked at was an unmet need audit, to estimate the requirement for critical care. The overall conclusion was that the team was meeting the needs of all known critically ill patients. Changes that were made following the audit were to ensure they were made aware about patients who may need critical care. These included re-emphasis on NEWS, sepsis and providing one bleep number for referrals for critical care, which was held by a senior doctor or consultant.
- The unit was involved in research and development. There was a research nurse employed by the unit and one of the consultants was the lead. From April 2016 to March 2017, the unit was involved in five projects and had recruited 77 patients. The project areas included; arrests and resuscitation, delirium, abdominal sepsis, over 80 year olds in CCU and critical care after surgery.

Pain relief

- Pain relief was well managed. Patients' records showed that pain had been assessed using the scale provided on the CCU observation chart and medicine was given as prescribed. We noted that the pain assessment tool did not include non-verbal signs of pain.
- Pain management for individual patients was discussed at handovers.
- We saw that some patients had been provided with patient controlled analgesia infusions, to give patient some control over their pain relief. Staff also had access to the trust's acute pain team who were based in the anaesthetic offices located next to the CCU.
- Patients we spoke with during the inspection told us staff had asked about presence of pain and they had been provided with pain relief as required. The CCU patient survey from January to June 2017, asked patients whether they were always pain free and comfortable while on CCU. Four patients (out of 41) disagreed with this statement and three gave neutral responses. This meant that 33 out of 41 (80%) CCU patients considered they were always pain free.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of malnutrition. This was in line with the unit's gold standard care plans. However, dieticians stated that MUST was not a reliable tool for CCU and would assess each patients' individual nutritional requirements.

- During the inspection, we saw that the dietitian reviewed patients each day, providing nutrition treatment plans and advising staff of patient's dietary needs. The dietitian also participated in the weekly multidisciplinary meeting. This was in line with the GPICS 2015.
- Staff said they monitored patient's nutritional state and, where required, would make a referral to the dietitian. For example, we observed a nurse request advice from the dietitian regarding a patient who was vomiting.
- We reviewed eleven patient records, and found that fluid balance charts were used to monitor patients' hydration status and were completed appropriately.
- The critical care units in the East of England agreed with the 'magnificent seven' evidence-based quality principles. One on these principles was that parenteral nutrition (intravenous feeding) should not be given to adequately nourished, critically ill patients in the first seven days of an intensive care stay. The staff told us they had carried out audits and were meeting this standard.
- Any feeding through tubes or intravenous lines was prescribed, recorded and evaluated. There were protocols for nursing staff to commence enteral feeding for critical care patients out of hours and at weekends before discussion with dietitians.

Patient outcomes

- Around 95% of adult, general critical care units in England, Wales and Northern Ireland participate in Intensive Care National Audit and Research Centre (ICNARC) the national clinical audit for adult critical care; the Case Mix Programme (CMP). Following rigorous data validation, all participating units received regular, quarterly comparative reports for local performance management and quality improvement. The CCU fully participated and completed a full set of data for this audit.
- The ICNARC annual report for 2016/17 showed that the unit was performing as expected (compared to other similar services) in all key indicators. These included:
    - Unit-acquired infections in blood
    - Unplanned readmissions within 48 hours
    - Risk-adjusted acute hospital mortality
    - Risk-adjusted acute hospital mortality - predicted risk less than 20%.
- There was ongoing engagement between critical care services and the bed capacity team or a daily basis, to reduce delayed discharges. The issue was documented on the divisional risk register and performance was being monitored.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- There was a comprehensive induction for new staff. This included both a trust induction and local induction. We spoke with staff that had been in post for around a year. They had received supernumerary time for around four to six weeks when they started on the unit, which was in line with GPICS 2015.
- There was a dedicated practice development nurse working in CCU that was responsible for coordinating the education, training of CCU staff as well as supporting the induction of new staff. This was in line with GPICS 2015.
- The practice development nurse inducted new staff to the unit and familiarised them with the equipment and layout of the unit. Each new member of staff had a network competency booklet to work through to ensure they gained the correct skills knowledge and competencies to work in critical care. The attendance of study days and completion of the competencies was termed the band five development programme. The trust also provided development programmes for all nursing staff at bands six and seven.
- Staff were required to receive a yearly appraisal to discuss progress and devise personal

development plans. Data for July 2017 showed that 99% of staff within the unit had received an appraisal, which was better than the trust's target of 90%. Staff we spoke with had clear objectives set for the following year and discussed their progress.

- A post registration qualification in critical care, was held by 34 out of 82 (42%) nursing staff on the unit at the time of the inspection. This was not in line with GPICS standard of at least 50% of nursing staff to be in post with this qualification. We discussed the situation with the practice development nurse during the inspection. They explained that currently they had a junior nursing team and the criteria for the course included, two years critical care experience and completion of the mentorship course. Currently four staff were due to attend the critical care course in September 2017 and five applications were in progress for the mentorship course. This meant that while the service was not currently meeting the GPICS standard, the unit was supporting junior staff on a day-to-day basis and to develop, achieve their competencies and eventually achieve the qualification. The nurses completed intensive care competencies (level one) when they joined the team, which could take up to two years. However, the issue was not documented on the unit's risk register.
- The practice development nurse described good relationships with the Hertfordshire University.
- Junior doctors we spoke with were satisfied with their supervision. They each had personal development plans, which they felt enhanced their training opportunities. Junior doctors working on CCU told us that they felt that the unit was well staffed and they had been supported by the team including medical and nursing staff. They also enjoyed regular critical care teaching timetable, with both consultants and trainees presenting.
- Medical and nursing staff told us that they had sufficient support relating to revalidation. Revalidation is a process by which doctors and nurses can demonstrate they practice safely before they can be reregistered with their professional body.

Multidisciplinary working

- We observed good interaction and communication between the various teams in order to deliver care and treatment for patients on the critical care unit.
- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place. Key staff were involved as required; for example, we saw midwifery staff involved in ward rounds for obstetric patients, while another patient was receiving joint care provision with mental health teams. Specialists were involved in patients care as required. We also saw vascular clinical nurse specialists and the palliative care team involvement.
- There was a collaborative approach with medical staff. We observed a medical physician in attendance at the ward round. We were informed that a respiratory physician attends ward rounds on CCU each weekday.
- A dedicated critical care pharmacist provided advice and support to clinical staff in the unit and physiotherapy staff that worked on the unit and supported patient needs daily. A dedicated dietitian worked on CCU and advised staff of patient dietary needs. The pharmacist, dietitian and physiotherapist participated in the weekly MDT meeting. This was in line with the GPICS 2015.
- The GPICS 2015 standards included daily microbiology input into the ward rounds. However, a microbiologist did not always attend the ward rounds. We were told that they attended the unit three times per week and telephone advice was available 24 hours a day seven days a week. This was unchanged from our finding from our previous inspection in September 2017. There was no evidence of a negative impact on the CCU service and we noted that staff sought advice from the microbiology team when required.
- We observed an MDT meeting, which was attended by members of medical staff, a band seven nurse from CCU and a physiotherapist. The consultant intensivist led the meeting. Each patient was reviewed, their dependency any test results and ongoing treatment plans were discussed. In addition, new patient admissions and discharges from the unit were

discussed. There was good communication between the team and staff participated and shared information. Actions and priorities were agreed and allocated to staff.

- Patient's relatives were also invited to attend the MDT meeting for the discussion regarding their relative. This had been a recent project, which had been positively received by relatives. We requested more details regarding the project from the trust. It was in line with a recommendation published in January 2017 called guidelines for family-centred care in the neonatal, paediatric, and adult intensive care units. It stated that family members of critically ill patients should be offered the option of participating in interdisciplinary team rounds to improve satisfaction with communication and increase family engagement. Those patients with capacity would be asked to consent to the relative attending the meeting.
- Staff described the multidisciplinary team as being very supportive of each other. Healthcare professionals told us they felt supported and that their contribution to overall patient care was valued.
- The critical care outreach team provided a 24-hour seven-day a week service. The team worked closely with the hospital at night service. Overnight, the hospital at night team triaged calls, including those for the critical care outreach team. From 5pm to 9pm, the critical care outreach team were holding the hospital at night team bleep as a trial.
- Following discharge from the unit to a ward area, a member of the critical care outreach team would visit patients to advice on further care and treatment.

Seven-day services

- There was a consultant on call to the service out of hours. This was in line with the GPICS 2015.
- Staff told us that at the weekend, the consultant attended the unit, carried out ward rounds and was available. We saw evidence in patient healthcare records of consultant led ward rounds being documented, including at the weekend. Overnight a critical care consultant (on-call) was available for advice and assistance. Medical staff were allocated to work in CCU 24 hours a day, so staff always had access to doctors.
- We saw evidence that a consultant assessed patients admitted into the unit within 14 hours of admission, which met the national standards.
- Facilities were available out of hours at night and weekends, to support critical care services. These included operating theatres, physiotherapists, pharmacists, imaging facilities with on call radiographers and radiologists.

Access to information

- Staff had access to relevant information to assist them to provide effective care to patients during their stay within the critical care unit.
- The CCU employed reception staff, who coordinated the provision and requests for medical records. Staff told us they had good access to patient related information and records when required.
- We observed the doctors' handover between shifts where patients' progress was reviewed. There was good use of electronically held information such as results of x-rays and blood results during the handover.
- The nurses had a separate handover at the patient's bedside, and 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 medicine errors, delayed discharges, how they had been responded to and a detailed evaluation of each patient's clinical status.
- There were computers throughout the unit to allow access to patient information including test results, diagnostics and records systems. Staff were able to demonstrate how they accessed information on the trust's electronic system.
- When patients were admitted to the unit, staff had access to the relevant information

including healthcare records.

- Patients that were discharged from CCU to the wards had a comprehensive discharge summary completed, which included a rehabilitation prescription that was designed to ensure continuation of care.

Consent and Mental Capacity Act

- There was a trust policy to guide staff regarding their responsibilities related to consent and the Mental Capacity Act (2005). Staff understood consent, decision-making requirements and guidance.
- Patients gave their consent when they were mentally and physically able. Staff acted in accordance with Mental Capacity Act 2005 when treating an unconscious patient, or in an emergency. Staff understood principles of best interest decisions and this was reflected in healthcare records.
- During the inspection, staff demonstrated their knowledge and ability to safely, effectively manage patients who were delirious and required restraint in order to prevent harm to them and others. The patients' relatives were involved throughout and plans were put in place in line with the trust's restraint policies.

Are critical care services caring?

Good

We rated caring as good because:

- Patients were treated with dignity, respect and kindness during interactions with staff of all disciplines.
- Staff responded compassionately when patients needed support and helped them to meet their personal needs. There was evidence of the critical care team's ability to overcome barriers to deliver care that was based on the needs of the patient.
- During the inspection, patient's privacy and confidentiality was respected at all times.
- The critical care team were committed to involving patients and their relatives in care and treatment decisions.

Compassionate care

- All of the critical care team we observed were caring and compassionate towards patients. We observed numerous interactions between staff and patients. Hands on care was not seen to be provided just by the nursing staff. For example, a relative spoke to a doctor about a patient who required assistance to reposition in the bed. The doctor assisted without hesitation.
- The critical care unit completed a patient survey from January to June 2017. A total of 41 survey responses were returned out of a potential 461 patients. Overall, the feedback was very positive. Reponses received included that the staff "were very helpful" and they felt "very humble… (and) grateful for care…every member of staff was kind, caring and a credit to their profession". Many responses included the thanks to staff for their "excellent care". Actions taken by the CCU following survey included, planning for an improved response rate the next time a survey was done.

Understanding and involvement of patients and those close to them

- Staff reported that they communicated with patients and their relatives so that they understood their care, treatment and condition. However, staff told that in response to a disappointing previous friend and family survey result, the critical care service was actively looking for ways to involve the patient's relatives. One example was involving patients if possible and

their relatives in the ward rounds that took place on the unit. Traditionally relatives had been excluded from these discussions, we observed relatives being actively engaged in the ward round process. Staff we spoke with had found that the effects had been positive, with the relatives having a greater understanding of the care treatment plans and reasons for these.

- Patients who had longer stays or complex needs were discussed at the weekly multidisciplinary team (MDT) meeting. In another attempt at ensuring relatives were involved in patients plans; relatives were being invited to join the meeting for the specific patient. This was a new project yet, it appeared to be beneficial. We observed the MDT meeting and afterwards asked a relative about it. They told us that they felt grateful to be invited and found it a positive experience. We saw that the meeting gave the relatives opportunity to ask questions about the patients care and treatment.
- The unit used patient diaries on the unit. They are described as a simple but valuable tool in helping patients come to terms with their critical illness experience. We spoke with a family who had a diary completed. They felt that it was very useful were able to share with their loved one when they were ready.

Emotional support

- Staff on the unit were aware of the emotional support required by patients and their relatives during a period of critical illness.
- On discharge, each patient received a leaflet and a letter saying they would be phoned four to six weeks post discharge. A senior nurse called all discharged patients and offered them the opportunity to attend a follow up clinic appointment with a consultant. The clinic was held each month. About twenty patients a year took up the opportunity to attend the follow up clinic.
- A relative explained how supportive the staff had been when their loved one reached the stage when they were receiving end of life care. The whole unit stayed quiet as staff facilitated a telephone call on speakerphone, to allow an absent relative to say their goodbyes.
- Monthly coffee, cake and chat mornings took place in the unit as an open invite to ex-patients and carers. A relative we spoke with had really appreciated the coffee, cake and chat morning that they had attended. It was informal and as topics discussed were not necessarily about the unit, they had found it, “really lovely”. It had encouraged them, “to look beyond the horizon”.
- We observed that due to a patient’s distressed state, a relative had been allowed to lie on the bed with them for comfort. This was a demonstration of the critical care team’s ability to overcome barriers to deliver care that was based on the needs of the patient.
- The CCU team had recently started to provide a bereavement service to support relatives of those patients’ who had died on the unit.

Are critical care services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Patients experienced delays when they were ready for step-down to a ward.
- Delayed discharges from critical care appeared to impact on the services ability to always admit critically ill patients in a timely manner. On average, 62% of patients were admitted within four hours in the 12 months ending August 2017.
- From June 2016 to May 2017, there were on average 10 mixed sex accommodation (MSA) breaches each month, which was an increase from the previous year.

However:

- There was a range of information for patients and relatives including in large font and different languages.
- There were appropriate facilities provided in to care for critically ill patients. Relatives and visitors had access to appropriate areas of the unit.
- Despite the delays encountered with discharges from the unit, patients were not being transferred out overnight nor transferred to other units as a result.
- Complaints were investigated and learning shared with staff at team meetings.

Service planning and delivery to meet the needs of local people

- The critical care service was delivered in facilities in line with the Department of Health guidance for critical care facilities, Health Building Note 04-02 (2013).
- There was provision of facilities for visitors to the CCU. Visitors had access to a waiting room, and an area in which hot, and cold drinks were available. This was located just outside the unit for visitors to wait or to enable visitors to step away from the unit if they wanted a break. There were toilet facilities and a private room, which could be used for discussions and overnight accommodation.
- Visiting times were between 2pm and 8pm each day. However, they could be flexible to meet the needs of the patients and their loved ones.
- National Institute for Health and Care Excellence (NICE) guidance recommends there should be a follow-up clinic for critical care patients, to determine if they needed further input, two to three months after being discharged home. A regular follow-up clinic was in place and was led by one of the CCU consultants. All discharged patients were offered this service.

Meeting people's individual needs

- There was a range of information for families and friends displayed in the visitor's room on topics such as admission and discharge and follow up clinics.
- There was a leaflet explaining CCU was a mixed sex environment and that all efforts would be made to maintain patient's privacy and dignity. We observed the screens drawn around patients or doors being closed when any patient received personal care.
- To ensure patients had sufficient rest and were not disturbed or deprived of sleep, the unit promoted an initiative called 'Silent Night'. This included reminders to staff to ensure dimming of lights by a certain hour, muting of phones to reduce noise level and for staff to wear soft-soled shoes.
- The trust had a named dementia lead and learning disability lead. Staff confirmed they were able to readily access these staff to discuss any concerns and to receive advice.
- There was a telephone translation services available. This could be booked through the Patients Advisory Liaison Service (PALS) if an interpreter was required. During the inspection, a patient was in the unit whose first language was not English. Relatives were translating when they visited, which is not considered to be best practice. We raised this with the matron who explained that for treatment and sensitive discussions, a translation service would be used.
- There were information leaflets available for both patients and relative, for example about sedation and ventilation, discharge from critical care and a general guide to intensive care. Some of these leaflets were printed in large font and different languages. Relatives we spoke with had been provided with relevant leaflets.
- The CCU was accessible for wheelchair users and a disabled toilet was available.

Access and flow

- The CCU had an operational policy that detailed patient flows into and out of the service.

CCU admitted both elective surgical patients who required close monitoring post operatively and emergency patients. The policy included admission criteria. Certain categories of patients who needed specialist services were transferred to appropriate units in London.

- Patients requiring emergency admission were required to be referred between consultants. A patient requiring critical care should be admitted within four hours of the decision in order to comply with core standards for critical care (GPICS 2015). Figures provided by the trust show that on average 62% of patient were admitted within four hours (12 months ending August 2017). We reviewed an investigation report following the death of a patient in 2017. Due to the CCU having 19 patients at the time, eight of which were waiting for a bed on the ward, there was a delay in the patient's admission. There was almost five and a half hours from the decision to admit to when the patient reached the CCU. Although the report concluded that the delay did not affect the outcome, it demonstrated the issues related to patient flow on the unit.
- A consultant reviewed all new admissions to the unit within 12 hours of admission.
- The trust provided information regarding the number of admissions to critical care. This showed an increasing number of admissions. For example, from April 2016 to March 2017 there were 965. This was an increase of 151 admissions compared to the previous year.
- From June 2016 to May 2017, the CCU adult bed occupancy fluctuated around the England average of 83%. However, the bed occupancy rate had been below the England average for seven of the 12 months. This is different to the previous year (June 2015 to May 2016) when the adult critical care bed occupancy was higher than the England average for all but one month. Occupancy reached 100% on seven occasions.
- We found during our inspection, that patients who were no longer requiring critical care had delayed discharges to the wards. Each day when we visited the unit, seven patients were waiting for beds. These were not the same seven patients each day, as some had been discharged. However, one patient had been waiting three days for a bed. The Intensive Care National Audit Research Centre (ICNARC) annual report for 2016 showed that percentage of bed days occupied by patients with a discharge delay for more than eight hours, was 12%. This was not in the worst 5% of units nationally. This was a decrease (an improvement) from 14.8% in the 2015 annual report. This issue had been raised during our previous inspection of the service in September 2016.
- Despite the delayed discharges out from the unit, no patients had been transferred out to other units for non-clinical reasons (ICNARC annual report 2016). Patients were also not discharged at inappropriate times to ward areas on a regular basis. 1.1% of discharges took place between 10pm and 7am. Compared with other units, this unit was within the expected range.
- The nature of most CCUs meant there was often limited opportunity to provide single-sex wards or areas and this is not required until patients are considered ready for discharge to a ward. Staff said they would endeavour to place patients as sensitively as possible in relation to privacy and dignity. From June 2016 to May 2017 there were on average 10 mixed sex accommodation (MSA) breaches. This was an increase from our previous inspection's findings (September 2016), when there were on average eight single sex breaches reported each month (April 2016 to July 2016). The trust stated that all the breaches for the surgical division occurred in CCU and were due to pressures on the emergency care pathway.
- The monitoring and management of patients requiring step down from critical care was reviewed daily. We observed staff from critical care attend the bed capacity meetings to inform the teams about the number of patients that were waiting for ward beds during the inspection.
- In previous inspections, we found that patients were being cared for in theatre recovery area while awaiting a critical care bed. During this inspection, we checked theatre records and spoke with staff. They reported an overall improvement in the relationship between the

departments and less patients requiring long stays in recovery. Theatre held records correlated with CCU and showed that in the last six months ending June 2017, two patients per month on average had longer stays (greater than two hours) in recovery before being transferred to CCU. No patients required this during May and June 2017.
- Patients were not being ventilated (placed on a machine to assist breathing) outside of the critical care unit due to bed pressures (June 2016 to July 2017).
- There had been no elective surgery cancelled due to unavailable critical care beds in the twelve months ending July 2017.

Learning from complaints and concerns

- From July 2016 to July 2017 there were nine complaints regarding critical care. Five complaints had been classed as related to 'all aspects of clinical treatment'. We saw from minutes from the unit team meeting that formal complaints were discussed amongst the staff. Key messages to the staff were shared. For example, there was a reminder to staff to document all discussions with relatives and visitors on the purple communication sheets.
- Information was available in the main hospital areas on how patients could make a complaint. There was also information about access to the patient advice liaison service (PALS) in the CCU waiting room, should relatives have a concern about the service. PALS provided support to patients and relatives who wished to make a complaint. Staff told us that they directed patients and relatives to the PALS if the CCU unable to deal with their concerns directly.

Are critical care services well-led?

Good

We rated well-led as good because:

- Critical care managers and local leaders were experienced, capable and available to staff.
- Leaders fostered a culture that was supportive, valued teamwork, was open and where patient safety was the highest priority.
- There was a governance structure in place to escalate risks and monitor performance.
- Leaders valued staff and public engagement, sought ways of receiving feedback and used this to make improvements to the service.

However:

- There were risks to the provision of the critical care service that we found were not included in the risk register. For example, delays with servicing equipment.
- Despite actions being taken in-conjunction with the trust regarding delayed discharges, this remained an issue for many patients in the critical care service.

Leadership of service

- Critical care services were under the management of the trust's surgical, anaesthetic and oncology division. The critical care unit was led by a matron and a clinical lead consultant for critical care services. This met national guidelines for the provision of intensive care services (GPICS 2015). These leaders were visible, accessible and experienced.
- During the inspection, the nurse in charge of CCU was always supernumerary (did not have a patient allocated to care for), leaving them free to co-ordinate the shift, this met the national core standards for critical care units.
- We saw strong leadership, commitment and support from the senior team within the local service. The senior staff were responsive, accessible and available to support staff during challenging situations.

- Band six and seven staff had access to leadership development courses. We saw that five staff were planned to attend in September 2017.
- The junior nursing staff on CCU all told us their immediate nursing support was good, and there was clear leadership from the sisters and matron. This was demonstrated when we observed the junior nurses were supported to care for the most ill and dependant patients on the unit.
- Junior surgical doctors reported consultants to be supportive and encouraging. Junior doctors told us they felt well supervised by consultants and they had opportunities for development.

Governance, risk management and quality measurement

- The trust had a governance structure in place. CCU was part of the surgical division, which held divisional governance meetings that fed into the trust quality safety group, and trust board. We saw that performance within the surgical division was monitored and detailed dashboards were used. For example, the number of mixed sex accommodation breaches (all on CCU) was monitored and reported each month.
- There was a risk register complied via an electronic system at a divisional level. It contained four risks for critical care:
    - Non-compliant with GPICS regarding medical staffing
    - Patient safety in two of the side rooms
    - Delayed discharges from CCU
    - High vacancy rate of nursing staff in CCU.
- We noted that despite actions being taken related to the risks on the register they were largely unchanged from the previous inspection in September 2016. Capacity issues within the trust were identified as the greatest contributor to delayed discharges and therefore it was difficult to reduce the numbers. In addition, there were areas of risk that had not been acknowledged by documenting them on the risk register. For example, the lack of nursing staff with a qualification in critical care.
- CCU held regular team meetings to disseminate information to staff.
- There was an operational policy in place for the unit with guidelines for the services, which included admission and discharge criteria.
- The CCU contributed data to the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme for England, Wales and Northern Ireland as recommended by the faculty of intensive care core standards. This enabled the trust to show patient outcomes and other quality data benchmarked against other similar units.
- There was a divisional risk lead whose role included supporting teams in the surgical divisions, with incident investigation and the serious incident process. They confirmed that delayed discharges were the largest reporting category and the critical care team investigated incidents promptly.
- The CCU team were part of the East of England critical care network. We saw that the staff from CCU were actively involved with the East of England critical care network and attended meetings.

Vision and strategy for this service

- The critical care service had clinical strategy for 2016 to 2020. Their vision was to provide ‘the very best care for every patient every day’ and their mission was to provide care for the critically ill patient. The services priorities were broken down into four critical care pathways:
    - Early recognition and treatment of the acutely ill.
    - Timely admission to critical care.
    - Care delivered to nationally agreed standards.

- Rehabilitation and follow up care.
- The staff we spoke with on the unit did not describe the strategy as outlined above. However, we found during the inspection that the team were passionate about the delivery of the four key areas listed above.

Culture within the service

- Staff we spoke with worked well together as a team. This culture of supportive teamwork and was evident within the unit. They told us this made it an enjoyable place to work.
- Patient safety was clearly the priority for staff of all disciplines in the CCU. Staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered.
- Senior managers said they were supported and there was effective communication with the executive team. There was a culture of openness and transparency.

Public engagement

- Patients and relatives were encouraged to provide feedback and information leaflets available in the relatives' room. We saw some positive comments from patients displayed on the feedback notice board, along with letters of thanks relatives had sent.
- CCU had commenced the monthly coffee, cake and chat sessions with relatives past and present, and relatives told us they found this useful and informative.
- A bereavement service had also recently started, with the CCU team making contact with relatives whose loved ones died on the unit.

Staff engagement

- Following a positive letter of feedback about the unit's staff, they were nominated as being the team of the month for the trust (May 2017).
- The matron for critical care felt that giving the staff opportunities to discuss any issues was important. The matron was available every Thursday in the coffee room for staff to talk with them. We saw that this happened during the inspection, although no staff had come forward.
- Nursing staff told us that alongside the annual appraisal process they also had informal catch ups with their team lead every three months. This was on a one-to-one basis where staff could discuss any arising issues.

Innovation, improvement and sustainability

- During the inspection, we found there were areas that the service had made improvements from findings at previous inspections. These included:
  - Senior doctors and nurses had completed safeguarding level three training to support and advise the staff to protect children from abuse.
  - Medicines were managed safely.
  - Critical care had a strategy in place for their service.
  - There were less patients being cared for in theatres while waiting for admission to the unit. Although, 62% of patient admissions were within four hours of the decision to admit (12 months ending August 2017).
- There were areas where there had not been any changes since our inspection in 2016. These included:
  - Although the annual ICNARC report to March 2017, showed some improvement in delayed discharges; during the inspection, we found that this was still a concern.
  - The number of mixed sex occupancy breaches had increased.
  - A microbiologist did not attend daily ward rounds.
- An area that had deteriorated from our findings at the September 2016 inspection was:
  - The service no longer met the GPICS standard of at least 50% of nursing staff to be in post with a post registration critical care qualification. This was held by 34 out of 82 (42%) nursing staff on the unit.

- The trust informed us of improvement projects on the unit, including training in areas such as tracheostomy, simulation and transfer training for nursing and medical staff. Spotlight meetings used to discuss specific situations and incidents were also highlighted.

Maternity and gynaecology

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

Information about the service

West Hertfordshire Hospitals NHS Trust provides maternity and gynaecology services to women living in West Hertfordshire and the surrounding areas. Inpatient maternity services are provided solely at the Watford General Hospital (WGH) site. Inpatient gynaecology services are provided at Watford General Hospital and St Albans City Hospital. Outpatient maternity and gynaecology services are provided at all three sites, Watford General Hospital, St Albans City Hospital and Hemel Hempstead General Hospital.

The maternity and outpatient gynaecology service is under the trust's women and children's division. The current leadership structure includes divisional director, divisional manager, separate clinical directors for obstetrics and gynaecology, and associate director of midwifery and gynaecology. Gynaecology inpatient services are under the surgical division. The current leadership structure includes divisional clinical director, divisional manager and head of nursing.

The maternity service at Watford General Hospital is one of the largest in the region and provides consultant-led and midwife-led care for high risk and low risk women. The consultant-led delivery suite has seven delivery rooms, two dedicated obstetric theatres, three-bedded recovery bay for post-operative women, one bereavement suite, one assessment admission room and a two-bedded midwifery triage bay. The delivery suite also has a two-bedded high dependency observation bay, for women who need higher levels of care and observation than those provided on the general maternity wards.

Women who have a straightforward pregnancy can choose to have their baby at home or in the Alexandra Birth Centre (ABC) at WGH. The ABC provides midwife-led care for women with uncomplicated pregnancies and who are anticipating a normal birth. The centre has seven delivery rooms, all of which have en-suite toilet and shower facilities. It also has one sensory room and two birthing pools. The ABC facilitated 868 births between April 2016 and March 2017, 156 of which were water births. This is a 14% decline in the number of births in the ABC, compared with April 2015 to March 2016 data.

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

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

WGH provides outpatient gynaecology clinics and services, which includes hysteroscopy, colposcopy, endometriosis service, specialist recurrent miscarriage services, fertility, and gynaecology oncology.

The hospital employs community midwives, who care for women and their babies both during the antenatal and postnatal period and provides a home birth service. From April 2016 to March 2017, the trust reported 92 (1.9%) babies were born at home. This was below the national average of 2.3%. The community midwives are aligned to local GP practices and children's centres.

The trust reported 4,736 births between January and December 2016. Of these, 54% were normal (non-assisted deliveries), which is lower than the England average (60%). Additionally, 11% were elective caesarean deliveries, which is slightly lower than the England average (12%), and 20% were emergency caesarean deliveries, which is higher than the England average of 15%.This is a 9% decline in the total number of births at the trust, compared with January to December 2015 data.

WGH provides a termination of pregnancy service for fetal abnormality only. From April 2016 to June 2017, the hospital carried out 22 medical terminations of pregnancy.

The service was last inspected in September 2016 and was rated good for effective, caring, responsive and well-led, and requires improvement for safe. The service was judged to be good overall.

We carried out an announced comprehensive inspection of Watford General Hospital from 30 August to 1 September 2017. We also carried out an unannounced inspection on 12 September 2017. During our inspection, we visited clinical areas in the service including delivery suite, antenatal and postnatal wards, the ABC, theatres, gynaecology day assessment unit, and maternity day assessment unit.

We spoke with 17 women and their relatives and 75 members of staff, including midwives, nurses, matrons, consultants, junior doctors, senior managers, and support staff. We observed care and treatment and reviewed 32 medical care records and/or prescription charts. We also reviewed the trust's performance data.

Summary of findings

We rated this service as good because:

- Staff understood their responsibilities to raise concerns and report patient safety incidents. There was a robust governance and risk management framework in place to ensure incidents were investigated and reviewed in a timely way. Learning from incidents was shared with staff and changes were made to the delivery of care because of lessons learned.
- Staff understood their responsibilities for safeguarding vulnerable adults, children and young people and were confident to raise concerns. A dedicated team of midwives

provided support, care and treatment to women who were believed to be in vulnerable circumstances. There was effective engagement with other professionals and teams to ensure women in vulnerable circumstances were protected. A female genital mutilation (FGM) clinic had been established, which provided tailored care, treatment and support to women with FGM.

- Staff had the right qualifications, skills, knowledge and experience to do their job. There were systems in place to develop staff, monitor competence and support new staff. Mandatory training compliance figures had improved and generally met the trust target.
- Systems were in place for assessing and responding to risk. Staff received multidisciplinary training to help them manage emergencies.
- Women's care and treatment was planned and delivered in line with current evidence-based practice. National and local audits were carried out and actions were taken to improve care and treatment when needed.
- Performance outcomes and measures were regularly monitored and reviewed. Action was taken to improve performance.
- Woman had access to care and treatment in a timely manner. Gynaecology referral to treatment times were generally better than the England average.
- Women were positive about their care and treatment. They were treated with kindness, dignity and respect. Women felt involved in their care and were given an informed choice of where to give birth. Actions were taken to improve service provision in response to complaints and concerns received.
- Leadership was strong, supportive and visible. The leadership team understood the challenges to service provision and actions needed to address them. Continued improvement had been made to ensure staff and teams worked collaboratively. There was a positive culture, which was focused on improving patient outcomes and experience. Staff were proud to work at the trust.

However:

- The emergency caesarean section rate was significantly higher than the national average. However, the trust had introduced a number of initiatives to address this and the latest delivery figures showed caesarean section rates were declining.
- The trust's perinatal mortality rate was worse than trusts of a similar size and complexity and the number of full term babies admitted unexpectedly to the neonatal unit had increased since our previous inspection. A quality improvement plan had been developed to address this. The service was compliant with the majority of recommendations made in the MBRRACE-UK perinatal audit report.
- Due to bed pressures, patients from other medical specialities were cared for on the gynaecology ward. This meant there were times when gynaecology patients were cancelled on the day of their planned surgery. The high number of medical outliers had had a detrimental effect on staff morale.
- Although staffing levels and skill mix was planned and reviewed so that patients received safe care, staffing levels were generally below planned levels in both maternity and gynaecology. Bank and agency staff were used to meet staffing needs whenever possible.
- The service received the highest number of complaints within the trust and took, on average, 66 days to investigate and close complaints. This was not in line with trust policy.
- Medicines were not always documented in line with national guidance. The trust took immediate action to address this concern. However, there had been improvement in the storage and management of medicines.
- Not all equipment had evidence of annual safety testing.

Are maternity and gynaecology services safe?

Good

We rated safe as good because:

- Safety was a priority. Incidents were reported and investigated and there was good evidence of shared learning. Changes were made to the delivery of care because of lessons learned from incidents.
- Women were told when something went wrong, received an apology and were told about any actions taken to improve practice and prevent recurrence.
- Standards of cleanliness and hygiene were maintained.
- Staff were aware of the procedures for safeguarding vulnerable adults and children. There was active and appropriate engagement with other relevant professionals and teams to ensure women in vulnerable circumstances were protected.
- The majority of staff had completed mandatory training.
- Systems were in place for assessing and responding to patient risk. Staff received multidisciplinary training in the management of obstetric emergencies and regular impromptu emergency scenarios were held to maintain and improve the skills needed.
- Wards and the delivery suite had locked doors, which could only be accessed by staff swipe cards or an intercom buzzer system. This meant staff could identify all visitors to ensure women and their babies were kept safe.
- The gynaecology ward's combined harm free care score was better than the England average.

However:

- Vitamin K, a medicine offered to all newborn babies, was not documented in line with national guidance. The trust took immediate action to address this.
- Not all equipment had evidence of annual safety testing.
- Venous thromboembolism (VTE) assessments were not always completed in line with trust guidance.
- Although staffing levels and skill mix was planned and reviewed so that patients received safe care, staffing levels were generally below planned levels in both maternity and gynaecology.
- Resuscitaires (equipment used to support newborn babies who may need resuscitation after delivery) were not always checked on a daily basis. However, we found adult resuscitation equipment was checked daily, in line with trust policy.

Incidents

- The trust reported one never event between June 2016 and May 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. The never event occurred in November 2016 and was classified as 'surgical/invasive procedure incident meeting serious incident (SI) criteria', where gauze swabs were retained during suturing of the perineum following an assisted vacuum delivery. This never event was similar to the never event of December 2015, when a tampon was retained during suturing of the perineum following vaginal delivery.
- There were no never events reported for the gynaecology service during this period.
- There were eight serious incidents reported through the Strategic Executive Information System (STEIS) in the maternity service between June 2016 and May 2017, including the one never event. Serious incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or

the potential for learning is so great that a heightened level of response is justified (NHS England *Serious Incident Framework*, March 2015).

- Five of the serious incidents were classified as 'maternity/obstetric meeting SI criteria: baby only'. Two were classified as 'maternity/obstetric incident meeting SI criteria: mother only'. There were no common themes to these incidents.
- We reviewed the investigation reports for the never event and four serious incidents and found comprehensive investigation, lessons learned and actions taken to mitigate future risk. For example, in response to the never event, the trust changed the content of delivery and perineal repair packs from small swabs to large swabs with tails attached, to enable easy identification and removal of swabs used. This was in line with national patient safety recommendations (NPSA, *Reducing the risk of retained swabs after vaginal birth and perineal suturing*, 2010). Whiteboards were fitted in all delivery rooms to enable quick and easy recording of the swab count, and relevant guidelines had been updated to include management of a retained foreign object and use of whiteboards. All actions had been completed or were ongoing, such as staff education and audits. We saw the average audit compliance score was 97%, for perineal repair following episiotomy, from April to August 2017.
- One serious incident was reported for the gynaecology service, which was classified as 'surgical/invasive procedure incident meeting SI criteria'. The serious incident concerned a patient who sustained a perforated bowel during surgery; this is a recognised risk for abdominal surgery. We saw evidence that lessons were learned and actions were taken to reduce the risk of recurrence.
- From June 2016 to June 2017, there were 1,724 incidents reported for maternity and gynaecology through the National Reporting and Learning System (NRLS). Incidents were graded from no to low harm, or moderate to severe harm or death. The majority of incidents were graded as having caused no or low harm (94.3% and 4.2% respectively). The remaining 1.5% were graded as having caused moderate harm (0.9%), severe harm (0.5%) and death (0.1 %).
- Trust policies for reporting incidents, near misses and adverse events were effective in the service. All staff we spoke with said they were encouraged to report incidents, and felt confident to do so.
- Staff told us they received direct feedback when they had been involved in incidents. Staff also told us they received feedback about incidents that had occurred within the service. They were kept informed about incidents through team huddles, which were held at the start of each shift, noticeboards, safety alert messages, message of the week, email and governance meetings. We observed this during our inspection. Learning folders were also available within each department of the maternity service, as a method of providing feedback and communication to all staff. We reviewed the learning folder on delivery suite, the ABC and antenatal ward during our inspection and saw they contained messages of the week, lessons learned, risk board, maternity safety alerts, complaints, serious incidents, and divisional investigations.
- All incidents were reviewed daily at the patient safety meeting. We attended one of these meetings during our inspection, which 20 members of the multidisciplinary team attended. We observed that all incidents were discussed and where necessary investigations, including root cause analyses, and audits were initiated to identify any themes and actions to minimise reoccurrence.
- Senior staff held regular meetings to identify where trends had occurred and put in place systems to prevent similar occurrences. They also monitored whether the required actions had been completed.
- We saw a continued improvement in the time it took to report and review incidents from our two previous inspections in April 2015 and September 2016. From June 2016 to June 2017, trust data showed that the time taken to report incidents to NRLS within the maternity service was better than the trust average; 63% of maternity incidents were

reported between zero and 30 days, 21% were reported between 31 and 60 days and 16% were reported between 61 and 90 days. The trust average was 51%, 24% and 25% respectively.

- As of 1 September 2017, the maternity service had 36 incidents awaiting closure. The oldest of which was dated from 7 May 2017. This was an improvement from our previous inspection in September 2016, when we found 80 incidents were outstanding in August 2016. Therefore, we were assured that incidents were reviewed in a timely manner in order that lessons could be learned when things went wrong and improvements made to the safety of services for patients.
- Monthly perinatal and maternal mortality and morbidity meetings were well attended by members of the neonatal, obstetric and midwifery team. Minutes of meetings held in April, May and June 2017 showed serious incidents, themes, stillbirths and neonatal deaths were discussed, lessons were learned and actions were taken to improve patient outcomes where indicated.
- The maternity service reported all premature births between 22+0 and 23+6 weeks gestational age who did not survive the neonatal period, in line with national recommendations (MBRRACE-UK, 2015).
- The trust had a duty of candour policy, which staff could access via the trust intranet. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Staff we spoke with were aware of the importance of being open and honest with patients and those close to them when something went wrong, and of the need to offer an appropriate remedy or support to put matters right and explain the effects of what had happened. Staff were able to describe examples where the duty of candour had been applied. This was an improvement from our previous inspection in September 2016, where we found not all staff were familiar with the duty of candour.
- We saw evidence that duty of candour regulations were followed in the incident reports we reviewed. Women and families were involved in the investigation process and informed of the outcomes. A copy of the investigation report was sent to the woman, her family and/or representative(s) on completion.
- Since our previous inspection, the maternity service had introduced a 'being open/duty of candour' sticker. The sticker was used to evidence when staff had applied the principles of being open and honest with patients when something went wrong or when care had caused harm or distress. Whilst the principles were the same, 'being open' was used for no and low harm incidents and the duty of candour applied to incidents that caused moderate harm or above. This was in line with the duty of candour regulation. We saw one example when 'being open' was used in the medical records we reviewed. In this instance we saw that an apology and explanation had been given to a woman who underwent an emergency caesarean section.

Safety thermometer

- The maternity service used the national maternity safety thermometer, which was designed to support improvements in patient care and experience. It records harm associated with maternity, such as perineal trauma, infection and women's psychological perception of safety, and the proportion of mothers who have experienced 'harm free' care. The trust's combined harm free score was 79%, better than the England average of 74%, in a snapshot of the maternity safety thermometer for June 2017.
- The snapshot showed that the trust scored better than the England average in six of the nine indicators, including maternal infection, post-partum haemorrhage (excessive blood

loss of more than 1,000mls following delivery), and concerns about safety during labour and birth not taken seriously. The trust scored worse than the England average for women who were left alone at a time that worried them, women's psychological perception of harm free care, and the number of babies born with an Apgar score of six or less at five minutes. The Apgar score is an evaluation of the condition of a newborn infant based on a rating of 0, 1 or 2 for each of the five characteristics of colour, heart rate, response to stimulation, muscle tone and respiration, with 10 being the optimum score. We saw evidence that the trust had taken action in response to these results.

- We saw the maternity safety thermometer results displayed publically on delivery suite and the antenatal ward.
- The gynaecology service used the NHS safety thermometer, an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. The safety thermometer measures the proportion of patients that were kept harm free from pressure ulcers, falls (with harm), urine infections (in patients with a catheter) and venous thromboembolism (the formation of blood clots in the vein).
- Overall, harm free care was provided in the gynaecology service. From July 2016 to June 2017, the gynaecology ward's combined harm free score averaged 98%. This was better than the England average of 94%.
- The NHS safety thermometer results were displayed publically on the gynaecology ward.

Cleanliness, infection control and hygiene

- All areas of the maternity and gynaecology service we visited were visibly clean and tidy during our inspection. Women we spoke with said they found the patient areas were clean.
- Midwifery, nursing and support staff were responsible for cleaning the equipment and we saw that stickers were placed on items of equipment stating when they had last been cleaned. In all areas we visited, we observed equipment had been cleaned that day or the previous day.
- Monthly cleaning audits were carried out within the service. From November 2016 to May 2017, the average compliance rate for the gynaecology ward, gynaecology and obstetrics theatres, postnatal and antenatal wards, delivery suite and the ABC was 98%.
- Staff complied with infection prevention and control policies. Observations during the inspection confirmed that all clinical staff adhered to the trust's 'arms bare below the elbow' policy to enable effective hand washing and reduce the risk of spreading infections. There was access to hand washing facilities and a supply of personal protective equipment (PPE), which included gloves and aprons, in all areas of the service.
- Hand sanitising gel dispensers were readily available at all entrances, exits and clinical areas for staff, patients and relatives to use. We observed staff apply hand-sanitising gel when they entered and left wards.
- The service participated in monthly hand hygiene audits, in line with the trust's infection prevention programme. From December 2016 to May 2017, clinical staff scored 100% compliance for the antenatal ward, postnatal ward and delivery suite, with the exception of January when the postnatal ward scored 99% compliance, and May when delivery suite scored 80% compliance. We observed staff clean their hands before and after patient contact.
- As of August 2017, training records showed that 94% of staff had completed infection control training and 88% had completed hand hygiene training. This was an improvement from our previous inspection, when compliance was at 84% and 82% respectively.
- Side rooms were available on each ward, which could be used to admit patients with a known or suspected infection. Staff we spoke with could describe what they would do if a patient required isolation due to infection.
- From May 2016 to April 2017, no cases of hospital acquired methicillin-resistant Staphylococcus aureus (MRSA) or methicillin-susceptible Staphylococcus aureus (MSSA)

infection were reported within the division. For the same period, one case of clostridium difficile (C-diff) infection had been reported.

- Women who were booked for elective caesarean section and elective gynaecology surgery were screened for MRSA during their pre-operative assessment appointment. Women who were admitted as an emergency were screened for MRSA at the point of admission, such as the gynaecology day assessment unit (GDAU), emergency department (ED) or delivery suite. The medical records we reviewed confirmed that MRSA screening was completed when indicated. MRSA screening compliance was audited monthly; the trust target was 95% compliance. From February to April 2017, the division exceeded the trust target for elective MRSA screening, with an average score of 99% compliance. Emergency MRSA screening was below the trust target, with an average score of 93% compliance.
- The service had processes in place for cleaning the birthing pools. Each birthing pool was cleaned and flushed daily and following every patient use. The estates department also carried out a weekly thermal disinfection. We reviewed the daily decontamination and flushing records from 1 June to 12 September 2017 and all were complete. Water quality was tested monthly, which included screening for legionella bacteria. Trust board papers indicted that no legionella had been identified in the birthing pools.
- Women were offered screening for infectious diseases, such as rubella and hepatitis B. Women were also offered flu and whooping cough vaccination in pregnancy, in line with national recommendations (NICE *Antenatal care for uncomplicated pregnancies: CG62,* updated January 2017). The antenatal handheld records we reviewed confirmed this.
- The maternity and gynaecology risk register detailed one risk (out of 16) related to cleanliness, infection control and hygiene, which concerned the poor condition of the dirty utility room on the postnatal ward. Since our previous inspection in September 2016, we found actions had been taken to address this risk and the macerator and sink had been replaced.

Environment and equipment

- The design, maintenance and use of facilities and premises were suitable for purpose.
- Since our previous inspection in September 2016, the service had introduced stricter security controls within the unit. Access to the delivery suite and all wards was by means of swipe card or an intercom buzzer system to gain both entry to and exit from the wards. This meant staff could identify visitors and ensure women and their babies were kept safe.
- The delivery suite, obstetric theatres and neonatal unit were all situated on the third floor, which enabled timely transfer when required. The Alexandra Birthing Centre (ABC) was situated on the second floor; a dedicated patient lift was available to transfer women and/or babies when required.
- Flooring was non-slip and was in good condition in all areas we visited. Window restrictors were in place to reduce the risk of falls from windows and blind cords seen were not a ligature or strangulation risk.
- We found a defunct external fire door on the antenatal ward that was partially held closed by plastic tags tied around the bars of the door. The room was used to store medicines and equipment. This meant unauthorised persons could potentially gain entry to the storeroom and ward. We raised this with staff, who took immediate action to address this risk and when we revisited the ward the following day, we found the door had been sealed shut. The door was also found shut on our unannounced inspection.
- The service had adequate equipment to ensure safe care and treatment was provided. Staff confirmed they had sufficient equipment to meet the needs of women and babies.
- Adult resuscitation equipment was available on delivery suite, ABC, wards, theatres and outpatient areas. Resuscitation trolleys were checked daily to ensure they were stocked, equipment was in working order, and medicines were in-date. Tamper evident seals were in place. We reviewed the checklists for delivery suite, postnatal ward, gynaecology ward

and maternity day assessment unit from 25 July to 30 August 2017 and all were complete. The resuscitation trolley on the ABC had been checked daily from 14 August to 12 September 2017, with the exception of two occasions.

- Resuscitaires (used to support new born babies who may need resuscitation after delivery) were available on all maternity inpatient areas and obstetric theatres. Daily checks to ensure they were in working order and fully stocked were carried out. We reviewed the checklists for three resuscitaires on delivery suite from 1 to 31 August 2017 and two resuscitaires on the ABC from 1 July to 12 September 2017 and found 11 occasions when they had not been checked. This equated to 4.5% of checklists not completed, which was worse than our previous inspection, when we found 2% of checklists had not been completed.
- We checked a range of consumable items from the resuscitation trolleys and resuscitaires and all were in-date (54 items).
- Cardiotocography (CTG) machines were available for women who required continuous electronic fetal heart monitoring. A CTG machine is used to record both the fetal heart and uterine contractions during pregnancy and labour. Its purpose is to monitor fetal wellbeing and allow early detection of fetal distress. Fetal blood gas analysers were available on delivery suite and the neonatal unit, in line with national recommendations (RCOG *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour,* 2007).
- A laboratory facility for blood and blood products was available at the hospital. A dedicated secure fridge for blood and blood products was situated on the third floor, in close proximity to delivery suite and theatres.
- Matrons were responsible for ensuring equipment was serviced and maintained. We checked 53 items of electrical equipment for evidence of annual safety testing on inspection, including resuscitaires, CTG machines, ultrasound scanners, fetal Doppler's and vital signs monitors. We found 44 items (83%) had evidence of annual safety testing. However, we found a delivery bed that was last safety tested in April 2013; the other remaining eight items had been due safety testing in April, June or July 2017. This meant there was a risk that patients were placed at risk of avoidable harm from equipment that had not been serviced, maintained, tested or calibrated. We informed the associate director of midwifery and gynaecology of our findings and were assured that out-of-date equipment would be safety tested. The trust advised that they had a maintenance target of 90% compliance for high risk devices and 85% target for low to medium risk devices, to be achieved by January 2018.
- Waste was handled and managed appropriately with separate colour coded arrangements for general waste, clinical waste and sharps. All sharps boxes were clean, dated and were not overfilled. However, five of 13 sharps boxes (38.5%) we observed on delivery suite and the postnatal ward, during both the announced (two without closures) and unannounced (three without closures) inspection, did not have temporary closures in place. Temporary closures are recommended to prevent accidental spillage of sharps if the bin was knocked over and to minimise the risk of needle stick injuries. We also found this on our previous inspection. On our unannounced inspection we observed the midwife-in-charge of the postnatal ward remind staff to ensure all sharps boxes had temporary closures in place, following a recent needle-stick injury involving a member of staff.
- Cleaning equipment was stored appropriately in locked cupboards. We found all cupboards were locked on inspection. This meant unauthorised persons could not access hazardous cleaning materials. This was an improvement from our previous inspection when we found a storage cupboard on the postnatal ward left open.
- The delivery suite did not meet the Department of Health's recommendation that all birthing rooms should include en-suite facilities (DH *Children, young people and maternity services. Health Building Note 09-02: Maternity care facilities,* 2013). The building where maternity services were located pre-dated this guidance. The birthing rooms on the ABC all had en-suite facilities. The service planned to reconfigure delivery suite, which would include en-

suite delivery rooms. Plans for the proposed reconfiguration were still in their infancy, at the time of our inspection.

Medicines

- Medicines were securely stored in all clinical areas we visited. This was an improvement from our previous inspection when we found the door and medicine cupboards in the anaesthetic room were open and we were able to enter unchallenged. Adult and neonatal emergency medicines were stored in tamper proof boxes. All medicines we checked were within the use by date.
- Medicines that needed to be kept below a certain temperature were stored in locked fridges. The midwife/nurse in charge of each ward held the keys for medicine cupboards and fridges. This prevented unauthorised personnel from accessing medicines.
- Trust policy stated that the ambient and fridge temperatures should be checked daily to ensure medicines stored kept patients safe from avoidable harm. We reviewed the ambient and fridge temperature checklists for delivery suite, antenatal clinic, antenatal ward, ABC and the gynaecology ward between 1 and 31 August 2017 and found three omissions; this meant 99% of temperature checklists were completed.
- Within this period, the antenatal clinic reported three occasions when the maximum fridge temperature exceeded the recommended range. Staff told us that this sometimes occurred when the fridge was open for an extended period for cleaning. All current temperatures were within the appropriate range. The fridge temperature records for delivery suite, antenatal ward, ABC and the gynaecology ward were all within the recommended range.
- Between 1 and 31 August 2017, we found current and maximum ambient room temperatures regularly exceeded 25°C. We saw evidence that incident reports were submitted when temperatures exceeded the maximum range. However, we found this was not consistently documented on temperature checklists. We reported consistently exceeded storage temperatures as a concern on our previous inspection in September 2016. The trust had recognised this as a risk and had carried out a risk assessment of medicines stored at temperatures greater than 25°C within wards and departments. According to the trust, the average time a medicine was stored on a ward was a maximum of three weeks. Medicines with a shelf life of one year could be safely stored at 30°C for a maximum of 16 weeks. Therefore, we were assured that actions had been taken to ensure the safety, quality and efficacy of medicines within the service. Furthermore, the service was in the process of having air conditioning units installed in the treatment rooms, which would ensure ambient room temperatures were maintained within the recommended range. On our unannounced inspection, we saw this work had commenced, for example the postnatal and antenatal wards had air conditioning units installed, and the ABC had been given a date in mid-September for installation.
- Controlled medicines were stored correctly within wall mounted locked cupboards and staff checked the physical stock held against the stock level recorded in the register at least once daily. We reviewed the controlled drug (CD) register on delivery suite from 7 July to 31 August 2017 and found it was reconciled twice daily, at each shift change. We also reviewed the CD register on the antenatal ward and ABC from 1 August to 12 September 2017 and found it was reconciled at least once daily, with the exception of two occasions on the ABC.
- Controlled medicine destruction kits were available on all wards. This was an improvement from our previous inspection when we found unused or partially used controlled medicines were not denatured (rendered irretrievable) at ward level.
- Controlled medicines brought in by patients were secure and there were adequate controls in place to prevent misuse. We saw that patients own controlled medicines were recorded in the CD register on admission to the ward and were reconciled daily and every time they were administered. This was an improvement from our previous inspection when we found patients own controlled medicines were only checked on admission, discharge or when they were no longer needed.

- FP10 prescriptions were stored securely and monitoring systems were in place to ensure all prescriptions were accounted for. FP10 prescriptions are the common form on which a prescription is written. They are used for outpatients and can be taken to any pharmacy for the medicines to be dispensed.
- The prescription charts we reviewed were all signed, legible, patient allergies were clearly documented, and medicines were given as prescribed. However, patients' weight was not always recorded. This is important because the correct dose of some medicines is determined by the patient's weight.
- We were not assured that the administration of Vitamin K, a medicine given to newborn babies shortly after delivery to aid blood clotting, was always documented in line with national standards (NMC *Standards for medicines management,* 2007). On our announced inspection, we reviewed three maternity records and found Vitamin K had been given, but this had not been documented on a prescription chart. We raised this with the associate director of midwifery and gynaecology who took immediate action to address our concerns, including reminding staff at team huddles and via message of the week, of the need to record the administration of Vitamin K on a prescription chart. We also saw posters displayed on the delivery suite and ABC advising staff of their responsibility to correctly document the administration of Vitamin K. In response to our concerns, the service also carried out an audit of Vitamin K prescribing and documentation and found that no Vitamin K medication errors were reported between March 2016 and August 2017. A neonatal prescription chart had also been designed, which would be implemented from 1 October 2017. On our unannounced inspection, we reviewed eight prescription charts and found Vitamin K had been documented in line with national standards.
- Prescription records were designed so that the medical team reviewed courses of antibiotics at appropriate intervals, usually 72 hours.
- Medicine incidents were reported via the electronic incident reporting system. Between June 2016 and May 2017, the maternity service reported 39 and the gynaecology service reported 25 medication incidents. This equates to approximately 4% of total incidents reported. Two of the 64 incidents were graded as having caused 'moderate harm', three as 'low harm' and the remaining 59 incidents were graded as having caused 'no harm'. Common themes included the administration of contra-indicated medicines, wrong frequency and missed and/or delayed administration. We saw evidence that actions were taken and learning from incidents was cascaded to staff.
- A clinical pharmacist supported ward staff during weekdays. The pharmacist monitored the prescribing of medicines and was available to provide advice to patients and/or staff, as needed.
- We saw that prepacks of frequently used medicines were available on the gynaecology ward to facilitate the timely discharge of patients.

Records

- Medical records were generally stored securely in trolleys. The trolleys were secured by means of a lock and staff had to enter a key code in order to access the records. However, during our inspection we found two occasions when the trolleys were left unlocked on the antenatal ward and ABC. We returned to these areas and found the trolleys were locked.
- The maternity service used the standardised maternity notes developed by the perinatal institute for antenatal, labour and postnatal care.
- The misfiling of patient identifiable information within the wrong patient handheld records was added to the maternity service's risk register in July 2017, following the submission of multiple incident reports. We saw from the incidents submitted from June 2016 to June 2017 that 15 were related to the misfiling of patient information. This equates to 0.9% of incidents reported during that period. Mitigating actions were in place to reduce this risk.
- In July 2017, an audit to establish whether patient records met trust standards showed

variable compliance. For example, compliance was 100% for visibility of contact telephone numbers on the front page of handheld notes and 95% for every entry dated, timed, legible and signed. However, compliance for patient identifiers documented on every page was 51%, and records filed in chronological order was 30%. The audit report concluded that poor compliance with storage and filing of patient records presented a safety risk and potential for information governance breaches. We saw actions to address these risks, such as the development of a folder to store documentation in a chronological order. The service planned to re-audit this in December 2017.

- Women carried their own pregnancy records, which they were advised to bring to each antenatal appointment and any occasion when they attended the hospital. The handheld records were supported by hospital-held information to ensure staff had access to essential patient information and could make informed decisions on patients care, management and treatment.
- We reviewed 14 maternity records and found these were generally completed to a satisfactory standard. All were contemporaneous, legible, dated and signed. The named midwife and/or consultant was documented.
- Regular clinical assessment was evident in the handheld antenatal records. Clinical assessments such as blood pressure and urine analysis were documented. Relevant previous and current clinical information was completed and risk assessments were evident, with details of actions taken where appropriate.
- Antenatal screening results and ultrasound scan findings were also included in the handheld records. This was in line with national recommendations (NICE *Antenatal care for uncomplicated pregnancies: CG62,* last updated January 2017; NICE *Antenatal care: QS22 (3),* last updated April 2016).
- Medical records included individualised care plans and referrals to specialist services when indicated, such as coagulation nurse specialists.
- Since our previous inspection, the midwife-in-charge of delivery suite was required to review the labour notes for completion prior to transfer to the postnatal ward. The check included whether the birth notification was complete and correct, swabs and instruments were checked and double-signed, and the venous thromboembolism assessment was completed. We saw evidence of this in the maternity records we reviewed.
- The personal child health record (also known as the 'red book') was given to mothers on discharge. The red book is a national standard health and development record and is used to monitor growth and development of the child, up to the first four years of life.
- We reviewed eight medical records of gynaecology patients and found they were comprehensive and completed to a good standard. The records were legible, dated and signed, and included risk assessments and care plans.
- The patient information boards on the postnatal and gynaecology ward were positioned on the wall, in the main corridor. We saw that screens had been fitted so that patient names could be covered from public view to protect patient confidentiality.
- As of August 2017, data showed 84% of staff had completed information governance training. This was below the trust target of 95% compliance.

Safeguarding

- There were processes and practices in place to safeguard adults and children from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements. Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- Midwives, medical staff, and maternity care assistants were required to undertake safeguarding children level three training; this was in line with national recommendations (*Working together to safeguard children*, 2015; *Safeguarding children and young people: roles and competences for health care staff. Intercollegiate Document*, March 2014).

Updates were provided annually on the third (out of three) mandatory maternity education day. We saw evidence that training was multidisciplinary and inter-agency, and included scenario-based discussion and learning from serious case reviews. The study day covered all aspects of safeguarding adults and children, including professional responsibilities, categories of abuse, safeguarding processes, child protection, domestic violence, child sexual exploitation (CSE), parental drug and alcohol misuse, perinatal mental health, female genital mutilation (FGM) and the Prevent strategy, aimed at reducing the risk of radicalisation and terrorism.

- Training data showed that as of August 2017, 97% of medical and midwifery staff within the women and children's directorate were compliant with safeguarding children level three training and 96% were compliant with safeguarding adults level two training. This exceeded the trust target of 95% compliance.
- The trust had a named lead midwife for safeguarding. The service also had a designated team of midwives (known as the Lavender team) who provided care, support and treatment for women in vulnerable circumstances, such as those who had a history of substance misuse, those with perinatal mental health concerns, teenagers, travellers and asylum seekers. The team liaised with other professionals and agencies, such as social workers, the police, independent domestic violence advisors and the community perinatal mental health team.
- A member of the Lavender team was on call from Monday to Friday, 8am to 6pm to provide advice and support to women in vulnerable circumstances, as needed. We saw the on call rota for August 2017, which confirmed this. A secure email and voicemail service was available out of these hours, which was checked daily. Staff could contact the Lavender team if they needed any advice and support with any safeguarding concerns. A member of the team also visited the wards daily to review any women referred to the Lavender team and to assist with any safeguarding concerns.
- The team had a secure database of all women with safeguarding concerns under their care. Information held on the database was reviewed regularly and updated as required. Each woman was graded as low, medium or high risk. The database provided midwifery and medical staff with up-to-date details of the care plan for each woman, so that if they were admitted and/or discharged from the hospital, appropriate actions were taken by staff to protect these women and/or their babies.
- The database also included a record of all known women with FGM. The associate director for midwifery and gynaecology was the FGM champion for the trust. Since our previous inspection, the service had established an FGM clinic, which was held fortnightly. The FGM clinic was available to all women within the East of England area. Since the FGM clinic was established in April 2017, nine women had been seen and a further two new referrals had been received; none of whom were under the age of 18 years. The trust had an up-to-date policy on FGM, which was in line with national guidance. Staff we spoke with were aware of their mandatory duty to report all cases of FGM in children and young people under the age of 18 and children/young people at risk of FGM being performed, and could describe the reporting process. Community midwives, following the initial 'booking' appointment, made the majority of referrals to the Lavender team but they would accept referrals at any point of care provision. Social workers also made direct referrals to the team and women could refer themselves.
- We saw evidence that learning from serious case reviews was shared at multidisciplinary clinical governance meetings and the mandatory maternity education day.
- All staff we spoke with were aware of their safeguarding responsibilities and were confident to make safeguarding referrals.
- The trust had an up-to-date abduction policy, and measures and controls were in place to minimise the risk of a baby being abducted from the unit. The trust had carried out a simulation of an abduction of a baby to test the effectiveness of the controls.
- A baby identity tagging system was in use within the maternity unit. Every baby had an

identity tag applied to each ankle shortly after birth, which included the baby's name, date of birth and the mother's name. The identity tags were checked on admission to the postnatal ward following transfer from delivery suite and on a daily basis, as part of the routine postnatal check. Staff told us if they found a baby with only one tag they would apply a second. If both tags were missing staff would report it via the electronic incident reporting system and all babies in the unit would be checked to confirm their identity. No such incidents had been reported from June 2016 to June 2017.

- A security guard was present by the main reception desk (situated by the entrance of the Women and Children's unit), from 8pm to 8am, seven days a week. Ward staff would inform the security guard of any visitors who were not allowed access to the unit.
- We were not provided with safeguarding training compliance figures specifically for the gynaecology ward. Gynaecology nursing staff were under the surgical division and data provided by the trust for this division showed that 97% of nursing staff were compliant with safeguarding adults at level two training and 98% were compliant with safeguarding children at level two training. This exceeded the trust target of 95% compliance.

Mandatory training

- The service had effective processes in place to ensure staff received mandatory training in safety systems, processes and practices. We saw an improvement in mandatory training compliance from our previous inspection in September 2016, particularly concerning the management of blood transfusion.
- A dedicated practice development team had full oversight of training needs within the service and of training compliance rates. The practice development lead produced a monthly training compliance report, which was reviewed at the quality and safety group meeting. Training compliance was also discussed at other forums, including the divisional management meeting.
- Mandatory training covered a range of topics and included health and safety, manual handling, infection control, hand hygiene, conflict resolution, equality and diversity, information governance and adult basic life support. Staff within the maternity and gynaecology service understood their responsibility to complete mandatory training.
- Training was provided via e-learning modules or face-to-face sessions. Staff could access e-learning modules at work or home. As of August 2017, the maternity service exceeded the trust target of 95% compliance for conflict resolution (97%), health and safety (96%), and equality and diversity (96%) training. The service did not meet the trust target for adult basic life support (89%), fire and evacuation (84%), and patient moving and handling (92%). However, all training compliance figures showed an improvement from our previous inspection.
- Following our previous inspection, we reported that (as of August 2016) only 7% of midwifery staff were compliant with blood transfusion training. On this inspection, we saw that actions had been taken to address this. As of August 2017, 82% of midwifery staff were compliant with blood transfusion training. The service planned to achieve 100% compliance by December 2017.
- Maternity staff were required to complete annual cardiotocography (CTG) training. An e-learning training programme was used to facilitate this. Staff were also required to attend a minimum of two CTG meetings per year, which were held once a week and included individual case reviews. We saw the minutes of the maternity and gynaecology governance meeting which demonstrated this. As of August 2017, 100% of doctors and 96% of midwives were compliant with CTG training. This was an improvement from our previous inspection, where although 100% of doctors were compliant, only 83% of midwives were. 'CTG Masterclass' study day's had also been held at the hospital and were delivered by a leading expert in CTG interpretation. The study day was offered to all midwives, student midwives and obstetricians.

- Since our previous inspection, the practice development team had redesigned the maternity specific education days from four to three. Education day one included revalidation, antenatal screening and diabetes, smoking cessation and carbon monoxide testing, infant feeding, epidural analgesia, medicine management, promotion of normality and public health, anti-D, and customised growth charts (GROW). As of August 2017, 90% of midwives had attended this training.
- Education day two was multidisciplinary and covered 'skills and drills' training, in line with national guidance (RCOG *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour,* 2007). A PROMPT style approach was used for staff to maintain their skills in obstetric emergencies, including management of the severely ill woman, shoulder dystocia, breech, cord prolapse, major obstetric haemorrhage, eclampsia and neonatal resuscitation. PROMPT (practical obstetric multi-professional teaching) is an evidence-based multi-professional training for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working in an emergency. As of August 2017, 96% of staff had attended this training. This was an improvement from our previous inspection where there was 82% compliance.
- Education day three included safeguarding adults and children, bereavement, risk management, and mentorship. As of August 2017, 91% of midwives had attended this training.
- Action had been taken to address non-compliance with mandatory training.

Assessing and responding to patient risk

- The maternity service used a modified early obstetric warning score (MEOWS), which was designed to allow early recognition and deterioration in pregnant and postnatal women by monitoring physical parameters such as blood pressure, heart rate and temperature. MEOWS completion was audited in June 2017 and the results showed that observations of vital signs were not always repeated when indicated, nor was potential deterioration always acknowledged and escalated appropriately by the midwife. An action plan had been devised to address this non-compliance with MEOWS, which included re-iterating to all staff the importance of completion and escalation via 'message of the week'. The service planned to re-audit the completion of MEOWS in October 2017. We reviewed six MEOWS charts and saw they were generally completed and scored in line with trust guidance. However, we found one instance when observations were not repeated in line with the MEOWS trigger and escalation process. We raised this with staff at the time of our inspection.
- Since our previous inspection in September 2016, the service had introduced the use of a new born early warning score, which was designed to identify babies at risk of clinical deterioration following birth and initiate prompt investigation and intervention. We found action was taken when observations were outside normal parameters. For example, a baby's temperature was recorded as 36.4°C and skin-to-skin contact was encouraged to promote thermoregulation. The temperature was rechecked approximately one hour later and had normalised to 37°C.
- The maternity service did not use customised fetal growth charts to help identify babies who were not growing as expected. During our last inspection, we were told they planned to introduce customised growth charts by September 2016, but they had still not been introduced one year later. We were told that staff had undertaken the relevant training and the service was working with the sonography team to ensure individualised growth charts were implemented. This was included on the service risk register and mitigating actions were in place. For example, the monthly 'test your care' audit included SFH measurement. From June to August 2017, audit compliance was between 91% and 94%. We saw evidence that symphysis-fundal height measurement was routinely performed from 24 weeks gestation. This was in line with national guidance (NHS England *Saving Babies'*

Lives: A care bundle for reducing stillbirth, 2016). Women who measured three centimetres more or less than expected were referred to the maternity day assessment unit for review and further investigations, such as growth scan. However, we found the SFH measurement was only plotted once in one out of four sets of antenatal records we reviewed. In this instance, we found the photocopy of the growth chart was poor and it was difficult to see where the SFH had been recorded.

- We reviewed 15 sets of maternity records and saw evidence that risk assessments were carried out at booking, which included social, medical and mental health assessments. Women who were identified as unsuitable for midwifery led care were referred to the obstetric team for review and management.
- Risk assessments were carried out for smoking, pre-eclampsia and gestational diabetes, in line with national guidance (NICE *Antenatal care: QS 22,* last updated April 2016). For example, women who were at high-risk of gestational diabetes were referred to the MDAU for glucose tolerance testing.
- We saw evidence that women were routinely asked about their baby's movements at each antenatal contact. Written information was also given to women by 16 weeks gestation. This was in line with national guidance (NHS England *Saving Babies' Lives: A care bundle for reducing stillbirth,* 2016). Women were advised to contact the MDAU or triage if they had any concerns about their baby's movements.
- The unit used the 'fresh eyes' approach to CTG interpretation and classification, whereby a second midwife checked the CTG recording of fetal heart and uterine contractions during labour, to ensure the CTG trace had been correctly interpreted and appropriate actions were taken when indicated. This was in line with national guidance (NHS England *Saving Babies' Lives: A care bundle for reducing stillbirth,* 2016). We saw evidence that 'fresh eye' reviews were generally carried out hourly and non-reassuring and pathological CTG traces were appropriately escalated.
- The maternity service audited the completion of venous thromboembolism (VTE) risk assessments (used to determine a patient's risk of developing a blood clot) against national recommendations (RCOG *Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium. Green-top Guideline No. 37a,* April 2015). In July 2017, the results showed that VTE risk assessments were completed at booking (97% compliance) and the immediate postnatal period (100% compliance). However, only 48% of women were risk assessed upon admission to the maternity unit. An action plan had been developed to improve compliance, which was due to be completed by September 2017. We reviewed 15 sets of maternity records and found VTE assessments were generally completed in line with national recommendations. However, we did find one postnatal VTE assessment that had not been fully completed.
- There were arrangements in place to ensure clinical checks were made prior to, during and after surgical procedures, in accordance with national recommendations (NPSA *Patient Safety Alert: WHO Surgical Safety Checklist,* January 2009). We saw World Health Organization (WHO) surgical safety checklists were completed for patients who underwent caesarean section or gynaecology surgery. Completion of the WHO checklist paperwork was audited monthly. From April to June 2017, compliance averaged 97%. We observed that staff adhered to the WHO checklist in theatre.
- There was a designated three-bedded triage unit, situated alongside delivery suite, which provided 24-hour assessment, review and ongoing care planning for pregnant women over 20 weeks gestation and postnatal women up to 10 days post-delivery. Women could telephone for advice or present to the triage unit if they had any concerns or health issues such as pain, reduced fetal movements or vaginal bleeding. The unit used a traffic light system to determine the time in which a woman required midwifery and/or obstetric review, based on the symptoms they had. For example, no fetal movements, severe abdominal pain or imminent delivery was red rated and required urgent admission to delivery suite. Early labour, suspected broken waters or nausea/vomiting was green rated and required

baseline assessment of maternal and fetal wellbeing within 45 minutes of arrival. If a woman was admitted to triage in advanced labour and could not be transferred immediately to the delivery suite, one private room with delivery bed and birthing equipment was available to facilitate safe delivery of the baby.

- Since our previous inspection, the service had introduced a patient tracker form. The form was completed each time a woman was seen outside of their antenatal pathway. This enabled staff to see at a glance any recurrent issues and/or concerns, such as reduced fetal movements, headache, suspected ruptured membranes, and prompt appropriate investigation and referral to the obstetric team.
- The delivery suite had a two-bedded observation bay for women who needed higher levels of care and observation than provided on a general maternity ward. We observed that midwives who had completed training in obstetric high dependency care staffed the bay. The critical outreach team were also available to support midwives with the care and management of high dependency women. Critically ill women were transferred to the hospital critical care unit. We saw evidence of this during our inspection.
- There were up-to-date policies in place for transfer arrangements to ensure women and/or their babies received care and treatment in the most appropriate location. These included transfer from homebirth to hospital, transfer from the emergency department to delivery suite and transfer to another hospital.
- A local agreement with the ambulance service was in place for attendance at emergencies, such as babies born unexpectedly at home.
- Women who were booked for elective caesarean section or gynaecology surgery attended a pre-operative assessment clinic. We saw evidence that appropriate risk assessments were carried out, including MRSA screening, blood tests and anaesthetic review.
- We reviewed eight gynaecology patient records and found that staff carried out comprehensive risk assessments. These included the malnutrition universal screening tool (MUST), Waterlow score (which is used to determine a patient's risk of developing a pressure ulcer), falls risk and continence assessment. These were completed and actions were taken to minimise risks to patients when indicated. However, whilst VTE assessments were completed on admission, there was no evidence that patients' risk was reassessed within 24 hours of admission. This was not in line with national recommendations (NICE *Venous thromboembolism: reducing the risk for patients in hospital: CG92,* last updated June 2015).

Midwifery and nursing staffing

- Although staffing levels and skill mix was planned and reviewed so that patients received safe care, staffing levels were generally below planned levels in both maternity and gynaecology.
- The maternity service commissioned a formal workforce review in December 2016, to determine the midwifery establishment required to deliver high quality safe care. Birthrate Plus was used for this purpose, which is a national tool used to calculate the level of midwifery staff needed based on the trust's activity, case mix and demographics.
- According to Birthrate Plus, the midwife to birth ratio required to provide safe care was one midwife to 26 births. However, according to data provided from February 2016 to January 2017, the trust had a ratio of one midwife to every 29.6 births.
- The whole time equivalent (WTE) planned establishment for midwifery staff was 193. As of July 2017, the trust employed 172 WTE midwives. The vacancy rate was 10.8%. With full establishment, the trust would meet the ratio of one midwife to 26 births.
- The failure to recruit to full establishment, retain and engage staff was listed on the risk register for maternity. A recruitment strategy was in place and the service was actively recruiting for band five and band six midwives to mitigate this risk.
- Bank and agency staff were offered unfilled shifts to ensure establishment was met. We

spoke with agency and back staff during our inspection and were told they had received a comprehensive induction and orientation before they commenced duties. We saw evidence that checklists for agency staff were completed.

- The service consistently achieved one-to-one care in labour from January to August 2017. The average compliance score for this period was 100%.
- During periods of high activity and/or lack of available staff, midwives were deployed from other areas to support delivery suite.
- Staffing levels and skill mix were reviewed daily to ensure women received safe care and treatment. A traffic light system was used to rate and flag any staffing issues. A green rating showed staffing levels were safe, given the workload and patient acuity. An amber rating indicated staffing levels were as planned but additional staff were needed because workload and acuity were high and adjustments were needed to meet demand. A red rating indicated staffing levels were inadequate to cope with workload and patient acuity.
- The maternity staffing report for July 2017 showed that the percentage of day and night shifts green rated per ward were 68% delivery suite, 85% ABC, 90% antenatal ward and 31% postnatal ward. There were no red rated shifts. We saw evidence that action was taken to mitigate staffing risks when indicated, such as the redeployment of staff.
- The service had sufficient staff, of an appropriate skill mix, to enable the effective delivery of care and treatment on the days of our inspection.
- Staff we spoke with told us that staffing levels were improving, but it was still common to be short of midwives on shift.
- In order to support staffing throughout August and September 2017, when activity is traditionally high and maximum levels of staff are on annual leave, the service had added an additional night shift and weekend day shift to the staffing template. This meant an additional midwife was available at night and weekends to work in the unit where needed.
- Midwifery handover took place at the change of each shift. Handover included any safeguarding concerns, an overview of all high-risk women and/or their babies and the allocation of workloads. A detailed bedside handover of each patient took place between midwives. Handover also included a 'safety huddle' where information regarding incidents, for example, was shared with staff.
- The service employed two WTE consultant midwives, which exceeded national recommendations (RCOG *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour,* 2007). One of the consultant midwives was soon to retire; the service planned to recruit to this post.
- A senior midwife coordinated the activity for each shift on delivery suite. The coordinator was mostly supernumerary, which enabled them to have oversight of ward activity and support staff as needed.
- Student midwives were supernumerary and not included in the midwife-staffing establishment. Every student was assigned a midwife to work with on shift.
- Ward managers and some specialist midwives were supernumerary, which meant they were able to support ward staff clinically when needed.
- Staffing levels were displayed publically in all clinical areas for midwifery/nursing staff and health care assistants.
- An escalation plan was in place to address any staffing issues. A midwifery manager was on call 24 hours a day, seven days a week; they were the point of escalation for staffing concerns.
- The surgical division had responsibility for gynaecology nurse staffing.
- The gynaecology service used the safer nursing care tool (SNCT), a recognised patient acuity tool, to determine levels of nursing staff required on the ward.
- Planned establishment for the gynaecology ward was 21.06 WTE registered nurses and 13.36 WTE healthcare assistants. As of May 2017, there were 16.31 WTE nurses in post and 12.37 WTE health care assistants. This meant there was a vacancy of 4.75 (23%) WTE nurses and 0.99 (7%) WTE healthcare assistants. This was worse than our previous

inspection in September 2016, when we found there were no nursing vacancies on the gynaecology ward.

- At the time of our inspection, senior staff told us there were five WTE vacancies and a further four staff planned to resign from post. We were told that retaining staff had become difficult due to the high numbers of medical outliers admitted to the ward.
- Staffing red flags were monitored in line with national recommendations (NICE *Safe staffing for nursing in adult inpatient wards in acute hospitals,* July 2014). In July 2017, the gynaecology ward did not report any shifts when less than two nurses were on duty (planned staffing was four nurses per shift). However, for the same period, 23 shifts had more than eight hours less staffing than planned. The overall fill rate for July 2017 was 87%.
- We reviewed the staff rota from 21 to 27 August 2017, out of a total of 98 nurse and healthcare assistant shifts planned for the week 48 (49%) were filled by bank or agency staff and 13 (13%) were not filled. At the time of our inspection, the staff rota for the following week (week commencing 28 August 2017) had 18 nurse shifts to fill.
- The gynaecology ward staffing report for August 2017 showed that the percentage of day and night shifts green rated was 47%. There were no red rated shifts.
- During our inspection, we observed that despite high acuity, the gynaecology ward was calm and organised and there was sufficient staff to safely manage patient care and treatment.

Medical staffing

- The service provided 98 hours of consultant obstetric cover on delivery suite per week. This was in line with *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour* (RCOG, 2007), which recommends that units with between 4,000 and 5,000 births a year should provide at least 98 hours a week of consultant presence.
- The proportion of consultants and middle grade/specialist registrar doctors was higher than the England average at 43%. The average was 41%. At registrar level, the trust had 55%, whereas the England average was 53%.
- The proportion of junior doctors was lower than the England average with the trust at 3% where the England average was 6%.
- At the time of our inspection, we were told that the service had four vacancies for middle grade doctors; two posts had been recruited to and interviews had been scheduled for the remaining two vacancies.
- Locums were used to fill gaps in the consultant and medical rotas. Data provided by the trust showed the average locum use from April 2016 to May 2017 was 5% for consultant grades, 19% for middle grade/specialist registrars and 8% for junior doctors.
- A consultant was on a rota from 8am to 1pm Monday to Friday, to cover the elective caesarean list.
- On-call arrangements were in place and worked well. Staff we spoke with did not have any concerns about contacting the on-call team when needed.
- An obstetric consultant provided on-site cover (consultant presence) from 8am to 10pm, seven days a week. After 10pm and until 8am a first and second consultant was on-call from home.
- The gynaecology consultant provided on-site cover from 8am to 5pm Monday to Friday. At other times, the on-call obstetric consultants provided cover.
- Dedicated obstetric anaesthetic cover was available 24 hours a day, seven days a week. Middle grade anaesthetists provided this. In addition, two consultant anaesthetists were present Monday to Friday from 8am to 5pm, and one consultant anaesthetist was present from 5pm to 8pm. From 8pm to 8am and at weekends, one non-resident consultant anaesthetist was on-call.

- There were three multidisciplinary ward rounds per day on delivery suite and a consultant-led ward round of all other wards once a day, seven days a week. We observed a morning handover on delivery suite, which included structured discussion on all maternity and gynaecology inpatients and overnight deliveries. Care was assessed and planned at this handover and work allocated to appropriate medical staff.
- A medicine consultant attended the gynaecology ward a minimum of three times a week to review medical outliers. The term 'outlier' refers to a patient who has been admitted to a non-speciality ward due to a lack of speciality beds. A junior medicine doctor was present on the ward from 9am to 5pm, Monday to Friday. On-call assistance was available out of these hours.

Major incident awareness and training

- The trust had contingency plans in place for maternity services, which included staffing, closure of the unit, abandoned baby and abducted baby. We saw clear escalation processes in place and senior staff were able to describe them. From October 2015 to June 2017, the maternity service had not suspended any services.
- Maternity mandatory training included security awareness, and fire and evacuation.
- We saw evidence that regular impromptu emergency scenarios were held to maintain and improve the skills needed in the event of an obstetric emergency. These included post-partum haemorrhage, shoulder dystocia, abduction of a baby and evacuation of the birthing pool. We reviewed evaluation records of three simulated emergencies carried out in March and June 2017. Areas of good practice, areas for improvement and learning was detailed and shared within the service.
- In April 2017, the practice development team hired a flat in Watford for community midwives to practise the management of obstetric emergencies in a home setting. Members of the local ambulance service also participated in this event.
- The trust had a major incident policy, which included regional area risks, organisational risks and actions to be taken in the event of a mass casualty incident.

Are maternity and gynaecology services effective?

Good

We rated effective as good because:

- Women's care and treatment was planned and delivered in line with current evidence-based practice. This was monitored regularly to ensure consistency of practice.
- Staff participated in national and local audits and actions were taken to improve care and treatment when indicated.
- Women had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing.
- A range of pain relief methods was available to labouring women, including birthing pools. Epidural analgesia was available to women in labour in a timely manner.
- Staff had appropriate skills to manage care and treatment with systems in place to develop staff, monitor competence and support new staff.
- Staff worked collaboratively to meet the needs of women and there was evidence of effective multidisciplinary team meetings.

However:

- The trust had a higher than expected number of emergency caesarean deliveries when compared with other trusts. The trust had taken action to address this and the latest delivery figures showed caesarean section rates were declining.

- The trust's perinatal mortality rate was up to 10% higher when compared with trusts of a similar size and complexity.
- There had been an increase in the number of full term babies admitted unexpectedly to the neonatal unit since our previous inspection. A quality improvement plan had been developed to address this.

Evidence-based care and treatment

- From our observations, review of medical records and guidelines, and discussion with staff we found that care was planned and delivered in line with current evidence-based guidance, such as the National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG).
- There was an effective system in place to ensure policies and guidelines reflected national guidance. A monthly forum was held for the review of maternity guidelines, which was led by a consultant obstetrician and gynaecologist and consultant midwife. Updated guidelines were ratified at the monthly women's services quality and safety group (QSG) meeting; this was confirmed from minutes we reviewed for April, May and June 2017. This was in line with national recommendations (RCOG *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour,* 2007). All doctors, midwives and students within the service were invited to attend the guideline forum and comment on updated guidelines before the contents were finally agreed and ratified.
- Maternity mandatory education day one included a presentation on updated guidelines.
- We reviewed 16 guidelines and policies and found all had been reviewed within the last three years. This was in line with national recommendations.
- Following the never event in November 2016, the *Operative Vaginal Delivery, Care of Women in Labour* and *Perineal Repair* guidelines had been updated to reflect changes to clinical practice and included guidance on retained swab. The service had also collaborated with the surgical division to ensure this information was included in the *Operating Department Swab, Instrument and Needle Count Policy.*
- Trust policies were assessed to ensure guidance did not discriminate because of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation and/or age.
- The service was actively involved in local and national audit programmes, and collated evidence to monitor and improve care and treatment. There was an audit schedule for 2016/17 and 2017/18, which included six gynaecology related audits and 26 obstetrics/maternity related audits. These included; urinary incontinence, use of antenatal steroids for fetal lung maturation, practice compliance with venous thromboembolism prophylaxis, reduced fetal movement in pregnancy, and continuity of carer in antenatal and postnatal community midwifery.
- We saw evidence that additional audits were also undertaken in response to incidents and clinical performance data.
- An audit update report was presented monthly at the women's services quality and safety group meeting. We reviewed minutes for the meeting held in June 2017 and saw 12 audits were discussed.
- Antenatal records showed that women received care in accordance with national guidance and standards (NICE *Antenatal care: QS22,* last updated April 2016). For example, all hand-held maternity records we reviewed contained a complete record of antenatal test results (NICE *QS22: statement 3*).
- Women at risk of gestational diabetes were referred for glucose tolerance testing (NICE *QS22: statement 6*). Management plans for women who had gestational diabetes were developed and in place. Combined consultant led endocrine and obstetric clinics were available for women with diabetes. This was in line with national guidance (NICE *Diabetes in pregnancy: management from preconception to the postnatal period,* 2015).

- Maternity records, guidelines and discussion with staff showed that women who planned or needed a caesarean section were managed in accordance with national guidance (NICE *Caesarean section: QS32,* June 2013). For example, a birth options clinic was offered to all women who have had a previous caesarean section and/or traumatic birth. This provided women with the opportunity to discuss birth options in their current pregnancy (NICE *QS32: statement 1)*. Planned caesarean sections were carried out at or after 39 weeks, unless clinically indicated (NICE *QS32: statement 5*). We saw that a consultant obstetrician was involved in the decision for both elective and emergency caesarean sections (NICE *QS32: statement 4 and 6*).
- The service had implemented the S*aving Babies' Lives* care bundle (NHS England, 2016), which was designed to reduce stillbirths. We saw that smoking status was recorded at booking and staff could refer women to the smoking cessation team, if agreed. Symphysis-fundal height was routinely monitored from 24 weeks gestation. The unit used a 'fresh eyes' approach for the interpretation and classification of cardiotocography (CTG) traces. Women were asked about their baby's movements at each antenatal contact and were advised to contact the unit if they had any concerns.
- We saw the trust reviewed reports published by MBRRACE-UK, a collaboration that runs the national maternal, newborn and infant clinical outcome review programme. The trust benchmarked themselves against key areas of *Saving Lives, Improving Mothers' Care* (2016) and *Perinatal Confidential Enquiry: Term, singleton, normally-formed, antepartum stillbirth* (2015). The trust was compliant with the majority of recommendations from these reports and had actions to improve non/partial compliance.
- The gynaecology service participated in the national refine ovarian cancer test accuracy score (ROCkeTs) study, which was funded by the National Institute of Health Research (NIHR). The research aimed to identify better tests for ovarian cancer. The trust had the highest rates of patient participation in the United Kingdom.

Pain relief

- Pain was assessed and managed on an individual basis and was regularly monitored by midwifery and nursing staff.
- Midwifery staff provided pregnant women with evidence-based information about the availability and provision of different types of analgesia, in line with national recommendations (OAA/AAGBI *Guidelines for Obstetric Anaesthetic Services,* 2013).
- The trust's website included a direct link to the Obstetric Anaesthetists' Association (OAA) public information website, which was designed to help women make an informed decision about the choices of pain relief in labour. This information was available in over 20 of the most common non-English languages, including Polish, Punjabi, Chinese and Gujurati.
- Pharmacological methods of pain relief were readily available and included 'gas and air' (Entonox), opioids (such as pethidine and oral morphine) and epidural anaesthesia, which was offered 24-hours a day.
- We found the time for women requesting an epidural for pain relief in established labour had improved from our previous inspection in September 2016. An audit carried out from June to July 2017 showed the average time from which a woman requested an epidural to the time an anaesthetist attended was 11 minutes in the daytime, Monday to Friday, and out-of-hours it was four minutes. The average time from start to siting the epidural was 28 minutes in the daytime, Monday to Friday, and 32 minutes out-of-hours. This was in line with national guidance, which recommend that the time from which a woman requested an epidural to the time they are ready to receive one should not normally exceed 30 minutes (OAA/AAGBI *Guidelines for Obstetric Anaesthetic Services,* 2013).
- From September 2016 to August 2017, 99% of women received regional anaesthesia for elective caesarean section and 90% for emergency caesarean section. This was better than the national targets (OAA/AAGBI *Guidelines for Obstetric Anaesthetic Services,*

2013).

- Non-pharmacological methods of pain relief were also available. The Alexandra Birth Centre (ABC) had two birthing pools, which were available for women to use in labour and/or birth. From April 2016 to March 2017, the trust facilitated 156 water births; this equated to 18% of all deliveries on the ABC. During this period, a further 130 women used a birthing pool during their labour.
- We saw that regular analgesia was prescribed for post-operative women, including opioids and non-steroidal anti-inflammatory drugs (NSAIDs).
- Women were routinely given local anaesthetic analgesia prior to perineal suturing and were offered NSAID medication per rectum following perineal suturing, unless contraindicated. This was in line with national recommendations (NICE *Intrapartum care for healthy women and babies: CG 190,* last updated February 2017).
- Women, who had undergone surgery including caesarean section, were given pain relief for use at home when they were discharged.
- Patients we spoke with told us they had received good pain relief. One patient on the postnatal ward told us they were asked regularly if they needed analgesia. Another patient told us they had requested an epidural in labour, which was given without delay.
- The gynaecology ward had access to pain nurse specialists as needed.

Nutrition and hydration

- Women received support and advice for breastfeeding their babies, including positioning and attachment, and hand expression. Breastfeeding initiation rates were monitored monthly. From January to August 2017, average breastfeeding initiation rates were 77%. This was in line with the national average of 75%. For the same period, an average 61% of women were solely breastfeeding at discharge and 19% were partially breastfeeding. The service had developed an action plan to increase breastfeeding at discharge rates.
- Since our previous inspection in September 2016, the maternity service had been awarded with the United Nations Children's Fund (UNICEF) baby friendly initiative stage one, awarded to services that promoted breastfeeding. The service hoped to achieve stage two by 2018.
- The maternity service had three infant feeding specialist midwives who provided education and support to women and maternity staff. The team had also trained 18 volunteers, who offered breastfeeding peer support to mothers on the postnatal ward.
- The hospital did not routinely provide infant formula to mothers who had made the decision not to breastfeed their baby. Mothers were informed they would need to bring their own supply of formula feed and equipment, such as bottles and teats, with them. Infant formula was provided for babies when it was clinically indicated, such as concerns about weight and hypoglycaemia (low blood sugar), following paediatric review.
- One mother who had made the decision not to breastfeed her baby told us that staff supported her decision and were non-judgmental.
- Women with hyperemesis gravidarum (a complication of pregnancy characterised by severe nausea and vomiting such that weight loss and dehydration occur) were treated with intravenous fluid therapy to correct dehydration and ketosis (a chemical imbalance in the body).
- A dietitian saw women with pre-existing or gestational diabetes. Advice on diet to help control blood sugar levels and weight gain was given. A dietitian was present at the joint diabetes and antenatal clinics, which were held twice a week. This was in line with national guidance (NICE *Diabetes in pregnancy: management from preconception to the postnatal period,* last updated August 2015).
- We saw that the malnutrition universal scoring tool (MUST) was used to assess the nutritional needs of gynaecology patients.
- Dietetic support was available for patients on the gynaecology ward. A member of the

dietetic team visited the ward daily and additional support could be obtained via the bleep system, as needed.

Patient outcomes

- The service had processes in place to monitor patient outcomes and report findings through national and local audits, and to the trust board.
- From January to December 2016, the proportion of deliveries by recorded delivery method were:
    - Normal (non-assisted) delivery was 54%; which was lower than the England average of 60%
    - Elective caesarean delivery was 11%; which was slightly lower than the England average of 12%
    - Emergency caesarean delivery was 20%; which was higher than the England average of 15%
    - Low forceps cephalic delivery was 1%; which was lower than the England average of 3%
    - Other forceps delivery was 7%; which was higher than the England average of 4%
    - Ventouse (vacuum delivery) was 7%; which was higher than the England average of 5%
    - Breech vaginal delivery was 0.2%; which was in line with the England average of 0.4%
- As of June 2017, the trust had one maternity outlier for emergency caesarean delivery rates. This meant the trust had a significantly higher than expected number of emergency caesarean deliveries when compared with other trusts. In response, the service developed an action plan to reduce caesarean rates and improve the quality of care and experience for women. This included a weekly multidisciplinary team review of all potential elective caesarean sections to see if any women were suitable for a normal birth. At the time of our inspection, the majority of actions had been completed or were 'on track' to be completed by December 2017. We saw the caesarean section rate was declining. From January to May 2017, the combined caesarean section rate was on average 30%. For August 2017, the combined caesarean section was 24%, which was below the national average of 27%.
- The trust took part in the 2015 MBRRACE-UK perinatal mortality audit, the results of which were published in June 2017 (MBRRACE-UK, *Perinatal Mortality Surveillance Report 2015,* June 2017). The audit results showed the trust's stabilised and risk-adjusted stillbirth, neonatal and extended perinatal mortality rate was up to 10% higher when compared with trusts of a similar size and complexity. The service had compiled an action plan in response to the MBRRACE-UK audit report, which included implementation of the *Saving Babies' Lives* care bundle. We saw evidence that the majority of actions had been completed or were on track to be completed within the allotted timescale. From January to August 2017, the trust reported eight antenatal stillbirths, which was lower than the trust's threshold. For the same period, the trust reported zero intrapartum stillbirths, which was in line with the trust's threshold.
- There were 755 unexpected admissions to the neonatal unit from April 2016 to March 2017; 410 of these were full term babies (babies born from 37 weeks gestation). This equated to 16% of all deliveries, 9% of which were full term babies. This was higher than our previous inspection. The data provided did not show the number of babies who required intervention for clinical signs of deterioration or poor outcome at delivery, such as birth asphyxia or hypoglycaemia, versus the number of babies admitted for preventative treatment, such as antibiotic therapy because the mother showed signs of infection in labour. A quality improvement plan based on national recommendations (NHS Improvement, *Patient Safety Alert: Resources to support safer care for full-term babies,* February 2017) had been developed in collaboration with children's services to reduce term admissions to NICU. This included work streams for hypoglycaemia, respiratory

distress syndrome, jaundice, asphyxia, hypothermia and suspected sepsis.

- The maternity and gynaecology service each maintained a quality and performance dashboard, which reported on activity and clinical outcomes.
- In maternity, performance was monitored for a range of outcomes including normal vaginal deliveries, instrumental deliveries, caesarean section deliveries, unexpected maternal and neonatal admissions to intensive care, and the number of third- and fourth-degree perineal tears.
- The trust's maternity dashboard parameters had been set in agreement with the clinical commissioning group (CCG). The dashboard tracked monthly and year-to-date performance against locally agreed standards, in line with RCOG recommendations (RCOG, *Maternity Dashboard: Clinical Performance and Governance Score Card (Good Practice No. 7)*, January 2008). A total of 49 performance measures were detailed on the trust's maternity dashboard, covering birth activity, workforce, and obstetric and neonatal clinical indicators. A traffic light system was used to flag performance against agreed thresholds. A 'red flag' indicated areas that required action, in order to maintain safety and restore quality.
- According to the maternity dashboard from January to August 2017, the service met the threshold for elective caesarean section deliveries, shoulder dystocia's resulting in neonatal injury, early neonatal deaths, and late neonatal deaths. There were no reported cases of maternal death, post-partum hysterectomy, massive obstetric haemorrhage (blood loss more than 5,000mls), intrapartum stillbirth, and eclampsia.
- For the same period, the service generally met the threshold for normal delivery rates.
- There is no national threshold for clinical maternity indicators; these are set locally, in agreement with the CCG. We saw evidence that the service had actions in place to monitor, investigate and address any issues related to the clinical indicators, such as daily multidisciplinary case review and audits of practice.
- The service participated in national audits to benchmark service provision against national standards and key performance indicators. We saw all actions identified in the trust's *National Screening Committee Antenatal and Newborn Screening Programme Annual Report* had been completed.
- The trust participated in the National Neonatal Audit Programme (NNAP), which was designed to improve the provision of neonatal care. The audit measures service provision against five standards/benchmarks. The trust performed better than the national average against all three standards/benchmarks related to maternity and neonatal care provision (the remaining two standards were related to neonatal care provision only). The trust's results against these standards/benchmarks were:
    - Do all babies of less than 32 weeks gestation have their temperature taken within an hour of birth? The NNAP standard was 98-100%; the trust achieved 96%, which was better than the national average of 93%.
    - Are all mothers who deliver babies between 24 and 34 weeks gestation inclusive given any dose of antenatal steroids? The NNAP standard was 85%; the trust exceeded this standard with a score of 88% compliance.
    - What proportion of babies less than 33 weeks gestation at birth were receiving any of their own mother's milk at discharge to home from a neonatal unit? The trust achieved 74%, which was significantly higher than the national average of 58%.

Competent staff

- Staff had the appropriate clinical skills, knowledge and experience for their roles and responsibilities within the clinical area worked. The service had processes in place to identify training needs and compliance, and address any issues identified.
- As of August 2017, 93% of maternity staff and 97% of gynaecology staff had received an annual appraisal. This was an improvement from our previous inspection in September 2016.

- All staff underwent a trust induction programme, which included mandatory and role specific training. Staff told us they had received a good induction.
- Newly qualified midwives completed a comprehensive preceptorship programme. Preceptorship packages were individualised and provided a framework to develop midwives from band five to band six. The programme included competency assessments in perineal suturing, cannulation, venepuncture, CTG interpretation and medicines management.
- Preceptorship midwives were rotated to work in all areas of the maternity service during their 12-month programme. The associate director of midwifery and gynaecology held a drop-in session once a month for preceptor midwives. They were invited to discuss any issues and development needs they had. Staff told us they felt well supported during their preceptorship.
- We spoke with bank and agency staff who told us they had received a good induction before they commenced clinical duties.
- Midwifery staff were given the opportunity to undertake additional training courses, such as mentorship, obstetric high dependency care, and non-medical prescribing.
- If poor or variable performance was identified, for example following an incident, complaint or feedback, staff were required to write a reflective account detailing what they had learned from the event and how they had changed or improved their practice as a result. The practice development team provided support, training and education to staff as needed.
- The role of supervisor of midwives (SoM) was discontinued on 1 April 2017 following changes to legislation. The trust planned to implement the new A-EQUIP (advocating for education and quality improvement) model of midwifery supervision, with professional midwifery advocates (PMAs). The existing fulltime SoM had agreed to continue in a supervisory role until the A-EQUIP model of supervision was in place. A-EQUIP is a continuous improvement process that aims to build personal and professional resilience, enhance quality of care for women and babies and support preparedness for professional revalidation (NHS England, 2017).
- Since our previous inspection, the service had introduced mandatory annual CTG competency assessments. This was in line with national recommendations (NHS England *Saving Babies' Lives: A care bundle for reducing stillbirths,* 2016). As of August 2017, 100% of doctors and 96% of midwives had passed the CTG competency assessment.
- Nursing staff told us they had received additional training, which included percutaneous endoscopic gastronomy (PEG) feeding and use of incontinence pads, to help them provide appropriate care and treatment to medical patients admitted to the ward.
- The results of the General Medical Council (GMC) *National Training Scheme Survey 2017* for doctors working at the trust as part of their training showed the trust was 'within expectations' for supportive environment, clinical supervision out of hours, local teaching and adequate experience. The trust scored 'below expectations' for clinical supervision and induction.
- Junior doctors attended protected weekly teaching sessions and participated in clinical audits. They told us they had received a good induction, which included a comprehensive induction pack sent to them in advance of their placement. They felt there was good support from senior medical staff and they could approach them for advice at any time.
- We saw that consultants, senior midwives and gynaecology nurse sisters had undertaken root cause analysis training. This was in line with national guidance (RCOG *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour,* 2007).

Multidisciplinary working

- Observation of practice, review of records and discussion with staff confirmed that all necessary clinicians were involved in assessing, planning and delivering women's care

and treatment.

- When a pregnant woman was admitted to a medical ward for treatment, obstetric and midwifery staff were involved in their management and care.
- A multidisciplinary handover took place three times a day on delivery suite and included an overview of maternity and gynaecology patients. The obstetrics and gynaecology medical team, anaesthetists and delivery suite co-ordinator attended the handover.
- Since our previous inspection in September 2016, a multidisciplinary elective caesarean section meeting had been introduced. Each referral for caesarean section was reviewed for validity. If the multidisciplinary team felt the woman was suitable for vaginal birth they were offered an appointment for the birth options clinic.
- Obstetrics and midwifery staff worked jointly with a number of specialities, including endocrinology, haematology, paediatrics and psychiatry.
- Potentially high-risk patients, such as those with a history of spinal surgery, were referred to the consultant-led anaesthetic clinic for review. A record of all potentially high-risk patients was shared with the anaesthetic team.
- Women with multiple pregnancies were cared for by a multidisciplinary team, which included fetal medicine specialist obstetricians. Women who needed higher levels of care were referred to neighbouring trusts with tertiary fetal medicine centres.
- Women who experienced a third of fourth-degree perineal tear were referred to a physiotherapist for follow-up care and advice.
- We observed good multidisciplinary attendance at the daily patient safety meeting and weekly clinical incident review panel. We saw representatives from maternity, obstetrics, neonatology and anaesthetics. Meeting minutes confirmed that regular multidisciplinary meetings were held and were well attended. These included perinatal and maternal mortality and morbidity meetings, quality and safety group and CTG meetings.
- A member of the Lavender team visited the wards daily to review any women referred to them and assist with any safeguarding concerns. The team liaised closely with other professionals and agencies, such as health visitors, social workers and the community perinatal mental health team.
- Staff reported good multidisciplinary working. We observed this during our inspection.
- We were told communication between community maternity teams and the hospital was good. Staff confirmed they were informed when a woman had suffered a pregnancy loss.
- A social worker attended the gynaecology ward daily to assist with arranging the discharge of patients waiting for social care packages.

Seven-day services

- ‘Out-of-hours’ services were available to women 24 hours a day, seven days a week. Women could self-refer to the hospital via A&E or directly to the maternity unit.
- Seven-day medical cover was provided with the minimum of a resident middle grade doctor. Dedicated consultant presence was from 8am to 10pm, with on-call arrangements out of hours.
- Anaesthetic cover was available for emergencies on delivery suite and/or within the maternity service 24 hours a day, seven days a week. This was in line with national recommendations (OAA/AAGBI *Guidelines for Obstetric Anaesthetic Services,* 2013).
- A dedicated obstetric theatre team was on-site 24 hours a day, seven days a week.
- The maternity triage unit was available to women 24 hours a day, seven days a week. Women (or their partners/relatives) could telephone for advice or present to the unit if they had any concerns or health issues.
- The maternity day assessment unit was open from 8am to 5.30pm, Monday to Friday. Out of these hours, women could self-refer to the maternity triage unit or delivery suite.
- Community midwives offered seven-day services for home births.
- Hospital inpatients had seven-day access to diagnostic services such as x-ray,

computerised tomography (CT) and pathology.

- Staff on the gynaecology ward told us they had access to therapy services, such as occupational therapy and physiotherapy, seven days a week. Inpatients were routinely seen Monday to Friday, and those who required additional assistance and/or review were seen at weekends. We observed members of the therapy services team on the ward during our inspection.
- The gynaecology day assessment unit was open from 9am to 5pm, Monday to Friday. The unit accepted referrals from GPs, A&E or other consultants/wards.
- Gynaecology ambulatory care services were available from 7.30am to 8pm, Monday to Friday.

Access to information

- Staff had access to the trust intranet and e-mail, which enabled them to keep pace with changes and developments within the service and elsewhere in the trust. Staff could also access guidelines, policies and pathways via the intranet to assist them in their specific role.
- Discharge summaries were sent to community midwives, health visitors and GPs. The summary included information about the woman's pregnancy, labour and postnatal care, any medications they had been prescribed, and any ongoing risks and/or follow-up care needed. A copy of the discharge summary was also given to the woman.
- Women used handheld notes for the duration of their pregnancy, which included risk assessments, screening results, clinical observations, birth plans and discussions from all antenatal appointments attended. Women were advised to bring their handheld notes to every appointment. Women were also discharged home with handheld postnatal notes, which detailed all observations and care provided for the woman and baby during the postnatal period. The use of handheld notes ensured continuity of care was facilitated.
- Failure to secure medical records for outpatient clinic appointments was listed on the maternity service's risk register. We saw evidence that mitigating actions had been taken to reduce this risk. According to the risk register, medical records were available for over 95% of patients. Staff told us it was uncommon for medical records to be unavailable.
- Information and communication technology (ICT) was recognised as a trust wide challenge. An ICT transformation programme was in place but we were told that progress towards achieving the programme had been slow.
- Blood test results and diagnostic imaging results were available via the trust's electronic reporting system. However, staff told us the electronic reporting system was slow.
- Community midwives had limited access to electronic information. Senior community midwives (band seven) had smartphones, which enabled them to access their trust e-mail account. However, other community midwives were not provided with smartphones. They accessed electronic information from computers in the community base office or GP surgeries.
- Community midwives working from local children's centres did not have access to computers. If they required information such as test results, they would have to telephone the relevant GP surgery or hospital.
- The gynaecology ward sent care summaries to the patient's GP on discharge. These included a clinical summary, diagnoses, treatments and procedures, medications prescribed, and follow-up plan and action. A copy was also given to the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had up-to-date policies regarding consent, the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff could access these via the trust intranet.
- Staff understood their responsibilities regarding consent. Women confirmed they were

given enough information to enable them to make informed decisions about their care and treatment.

- The service carried out an audit of consent for elective and emergency caesarean sections in June 2017, and found the process was inadequate and inconsistent. Frequent risks, such as pain/discomfort following surgery, hospital readmission and repeat caesarean section, and serious risks, such as hysterectomy and future scar rupture, were not consistently documented. This meant there was no evidence that these risks were discussed with women. The service proposed to introduce a pre-filled consent form, in line with national guidance (RCOG *Caesarean Section (Consent Advice No. 7,* 2009), to address the issues identified from the audit.
- Some specific consent forms were used in the gynaecology service. These contained additional information regarding potential risks associated with specific procedures, such as endometrial ablation, hysteroscopy and vaginal hysterectomy.
- The MCA and DoLS were included in mandatory safeguarding training. Staff we spoke with confirmed they had received MCA and DoLS training and understood their responsibilities to ensure patients were protected.
- Staff had access to specialist midwives and nurses who had particular expertise in dealing with women in vulnerable circumstances, such as those with learning disabilities and mental health concerns.

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

- All women we spoke with were positive about the care and treatment they had received. They felt well supported and cared for by staff.
- Staff were observed to interact with women in a friendly, respectful and considerate manner. There were arrangements in place to ensure privacy and dignity was respected.
- Women were involved in their choice of birth at booking and throughout the antenatal period. Women said they felt involved in their care; they understood the choices available to them and were given options of where to have their baby.
- Women received emotional support where needed. Specialist bereavement and midwifery support was available and tailored to meet the individual needs of women.

Compassionate care

- All women with spoke with were positive about the care they had received on both the maternity and gynaecology wards. One woman and their partner told us their experience had “been amazing, really impressed”. Another woman told us her experience had improved significantly with her current pregnancy compared to a couple of years ago, and felt she had been “genuinely really cared for”.
- Staff confirmed that when they assessed patient’s needs they took into account personal, cultural, social and religious needs. Patients we spoke to and patient records we reviewed corroborated this.
- Patients’ privacy and dignity was respected. We saw that staff closed curtains and doors to protect patients’ privacy and knocked on doors before they entered. All women we spoke with felt their privacy and dignity was maintained.
- We observed staff interacting with women and their relatives in a polite, friendly and respectful manner. Staff introduced themselves to women and their birthing partners and made them aware of their roles and responsibilities.

- Women told us they had a named midwife. We saw evidence of this in the patient records we reviewed.
- We observed one emergency caesarean section. Staff were empathetic and provided reassurance and support to the woman and her partner throughout the procedure.
- We saw many complimentary comments from women and relatives displayed on noticeboards throughout the unit. For example, “All staff were fantastic, they made me feel welcome and comfortable. The staff are an asset to the NHS” and “Everyone caring, attentive and encouraging. Lots of checks, very reassuring”.
- The trust’s NHS maternity friends and family test (FFT) results between May 2016 and April 2017 were:
    - Antenatal care performance (percentage recommended): the trust scored lower than the England average for eight of the 12 months. The trust’s average score over the 12-month period was 93%, which was lower than then England average of 96%. The trust’s latest score for June 2017 was 91% versus the England average of 96%.
    - Birth performance (percentage recommended): the trust’s average score over the 12-month period was in line with the England average of 96%. The trust’s latest score for June 2017 was 95%, which was slightly lower than the England average of 97%.
    - Postnatal ward performance (percentage recommended): the trust scored lower than the England average for seven months, no data was submitted for July 2016. The trust’s latest score for June 2017 was 93%, which was slightly lower than the England average of 95%.
    - Postnatal community performance (percentage recommended): the trust scored higher or in line with the England average for seven months, no data was submitted for June 2016. The trust’s latest score for June 2017 was 100%, which was slightly higher than the England average of 98%.
- The trust’s inpatient friends and family test (FFT) results between May 2016 and April 2017 for Elizabeth Ward (gynaecology ward) were lower than the England average for nine of the 12 months. For the other three months, the trust scored in line with the England average. The trust’s average score over the 12-month period was 91%, which was lower than the England average of 95%.The trust’s latest score for June 2017 was 89%, which was lower than the England average of 96%.
- The gynaecology ambulatory care unit introduced the inpatient FFT in December 2016, no data was submitted for January 2016. The results between December 2016 and June 2017 were lower than the England average for all six months. The trust’s average score over the six-month period was 83% versus the England average of 96%. The average score was significantly lower than the England average because only 70% of patients said they would recommend the service to family and friends in March 2017, versus the England average of 96%. For all other months, the gynaecology ambulatory care unit scored between one and six percent lower than the England average.
- From February to July 2017, data from the maternity safety thermometer showed that 6.3% (April), 7.7% (May) and 10.5% (June) of women reported they ‘were left alone at a time that worried them’. In response, the service carried out a local review of women’s experience in June 2017. Women’s concerns were shared with staff at relevant forums and the impact of leaving women alone was reiterated to staff via “message of the week”. The service also introduced the ‘golden hour’ initiative, whereby the midwife stayed in the delivery room with the woman and her baby for a minimum of one hour following delivery. For the remaining three months of data, which included July 2017 following the local review, 0% of women reported they were left alone at a time that worried them.

Understanding and involvement of patients and those close to them

- Staff communicated with women so that they understood their care and treatment. We observed a ward round completed that was inclusive of the women and their birthing

partners.

- Women were involved in their choice of birth at booking and throughout the antenatal period. Women said they had felt involved in their care; they understood the choices available to them and were given options of where to deliver their baby.
- Senior midwifery staff and the consultant team were involved in supporting plans of care for women who made birth choices outside of trust and national guidance, such as women who requested a water birth or homebirth with either a current or a previous high-risk pregnancy.
- Birthing partners were included and involved in the care of their partner and newborn baby, including being offered the option to cut their baby's cord at delivery. Birthing partners could attend caesarean section deliveries carried out under regional anaesthesia (epidural and/or spinal) and were able to sit beside their partner and support them throughout the procedure.
- Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment. For example, we observed translation services used to assist women for whom English was not their first language. The service also had a learning disability specialist midwife, who provided additional support to women with a learning disability throughout their pregnancy and the postnatal period.
- Members of the local Healthwatch team carried out an 'enter and view' visit on 7 August 2017 and spoke with one mother who explained how impressed she had been with the midwife who had explained everything and what was happening to her body during the delivery of her baby. Another mother said she was kept well informed during her labour. Healthwatch is the independent champion for people who use health and social care services in England.

Emotional support

- There was ongoing assessment of women's mental health during the antenatal and postnatal period. The maternity service had an established team of specialist midwives and consultants, including a psychiatrist, who provided care, support and treatment for women in vulnerable circumstances, such as those with mental health concerns.
- Bereavement policies and pathways were in place to support parents in the event of a pregnancy loss, such as stillbirth, neonatal death or miscarriage. Two specialist bereavement midwives supported families from their initial loss, throughout their time in hospital and their return home.
- We spoke with a woman on the gynaecology ward who was receiving care and treatment for a late miscarriage. She described the care and support she had received as "outstanding". She also told us that staff had ensured her wishes regarding burial were carried out sensitively and in accordance with her religious beliefs.
- The trust had a chaplaincy service, which provided spiritual care and religious support for patients, carers and relatives as needed. Multi-faith options were available. The chaplain told us that the lead bereavement midwife went "over and above" to support women and their families experiencing pregnancy loss. An example of which included arranging a priest from a minority denomination to be present for the birth of a baby that was not expected to live, in accordance with the families wishes.
- Since our previous inspection in September 2016 and in response to feedback received, the maternity service had introduced "iSeeU". This initiative used face-time technology to enable mothers who were separated from their babies at birth the opportunity to see their baby receiving care and treatment on the neonatal intensive care unit (NICU). We observed this during our inspection. The mother was clearly able to watch her baby whilst she was in recovery. The trust's magazine featured an article on "iSeeU" and a mother who had used it said, "This has been a very emotional experience for me. My baby had to be moved to the neonatal unit, but with the live screen, I was able to see him and be involved

in his care as I could speak with the nurse and get updates" (West Hertfordshire NHS Trust *Hearts & Minds*, summer special 2017).

- We saw a letter from a local GP thanking a gynaecology consultant and their team for the care they provided to one of their patients. The GP wrote that "[they] gave an exceptional service to one of my more emotionally and physically vulnerable female patients, who came for an operation which apparently was almost cancelled due to pressures, but [the consultant] ensured she had the surgery. She say's [the consultant] "made her feel special"; the hospital stay was a very positive experience, which has made a difference to her emotional wellbeing too. Thank you".
- The maternity service offered a 'birth reflections' clinic, which provided women and their partners with the opportunity to discuss any unresolved concerns or issues they had regarding their pregnancy or birth experience. A dedicated counsellor for women's services was also available.
- There was access to national and local advisory groups to offer both practical advice and emotional support to women and their families. Examples included SANDS (stillbirth and neonatal death charity) and the community perinatal team, for women experiencing or at risk of significant perinatal mental health disorders.
- The trust held an annual service of remembrance for all babies and children who had died before, during or after birth. The service was held at a local church. Anyone affected by such circumstances was invited to attend, including people who had lost a baby many years ago as such losses often went unacknowledged in the past.

Are maternity and gynaecology services responsive?

Good

We rated responsive as good because:

- The service was flexible and provided choice and continuity of care.
- Services were planned, delivered and co-ordinated to take account of women with complex needs. There was access to specialist support and expertise from medical, midwifery and nursing staff.
- There were processes in place for women to make a complaint. There was learning and improvements were made to the quality of care because of complaints and concerns received. However, the service generally took longer than the trust target to investigate and respond to complaints.
- Women had access to timely care and treatment. Gynaecology referral to treatment times were generally better than the England average.

However:

- Due to capacity issues, patients from other specialities were cared for on the gynaecology ward. This meant there were occasions when gynaecology patients were cancelled on the day of their elective surgery. This was identified on our previous inspection and remained an issue. The service planned to address this by splitting the gynaecology ward into two wards, which would create separate gynaecology and medical wards.
- The maternity and gynaecology service received the highest number of complaints within the trust and, on average, took more than twice as long as the trust target to investigate and close complaints. However, learning from complaints and patient feedback was shared with staff and action was taken to improve patient experience and care provision.

Service planning and delivery to meet the needs of local people

- The service worked closely with commissioners and other stakeholders to ensure services were planned, delivered and co-ordinated to meet the needs of local people.
- Representatives from the service attended the local Mothers Voices Partnership (MVP) (formerly known as the Maternity Services Liaison Committee) meetings, which were held quarterly. The MVP provided a forum for people who used services, health professionals and the clinical commissioning group (CCG) to work in partnership to plan, monitor and improve maternity service provision in the local area. For example, we saw evidence from MVP meeting minutes that service users had voiced their frustration regarding the lack of support with diagnoses of tongue-tie and clear clinical pathways for correction. As a result, the service had worked collaboratively with the local CCG and developed clinical pathways and a frenulotomy clinic for the division of tongue-tie.
- Women were given an informed choice about where they gave birth, in conjunction with consideration of their potential risk. Low risk women were encouraged to deliver at home or at the Alexandra Birth Centre (ABC), which provided midwifery-led care. Women who had an existing medical condition, complication of pregnancy or had experienced previous complications in pregnancy and/or labour, were advised to have their baby on the delivery suite, which was obstetric-led.
- In response to recommendations outlined in the *National Maternity Review: Better Births* (NHS England, 2016), the service had piloted the Phoenix Team; a team case loading service for women with uncomplicated pregnancies who wanted to give birth at home or at the birth centre. At their initial appointment, women who were suitable for this model of care were given the name and direct telephone number of their primary named midwife and associate midwife, who they saw for most of their antenatal and postnatal care. After they reached 37 weeks of pregnancy, women contacted their midwife directly when they thought they were in labour. The midwife assessed them at home and, depending on their findings and agreed birth plan, continued to care for them. They attended the woman in labour at home until the delivery of her baby, or accompanied them to the ABC, where they stayed with the woman until the delivery of their baby. If their midwife was not on duty when they telephoned, women were automatically diverted to the Phoenix midwife on-call. Monthly drop-in 'meet the midwives' sessions were held, so women could meet all members of the Phoenix Team in case their midwife was not on duty when they went into labour.
- A birth options clinic was available for women who did not meet the criteria for low risk birth but who wished to consider alternative options for delivery, this included women who planned to have a vaginal birth after previous caesarean section.
- The service had established a female genital mutilation (FGM) clinic, which provided tailored care, treatment and support to women with FGM. The clinic accepted referrals from a wide geographical area, covering the East of England. The associate director of midwifery and gynaecology, who was trained to perform de-infibulation under local anaesthetic, led the clinic.
- Since December 2016, the service had established Bacillus Calmette-Guerin (BCG) vaccination clinics for babies who were at risk of developing tuberculosis (TB).
- Women could access maternity services via their GP, local children's centre or by contacting community midwives directly. A self-referral form was available on the trust's website, which women could complete to access care.
- Postnatal follow up care was arranged as part of the discharge process with community midwives and, where necessary, doctors.
- Partners were able to stay overnight in the hospital if they wished. However, there were limited facilities for them to rest comfortably. The service was aware of this issue and were in the process of obtaining quotes for the purchase of reclining chairs, in order to improve partners' experience of their stay on the postnatal ward.
- The trust's website contained information on choosing a place of birth. This information

was available in large print, braille and audio for women with sight or hearing difficulties. Women could also request this information in other languages. Other information available on the website included the schedule for antenatal care, health during pregnancy, parent education courses and breastfeeding support groups within West Hertfordshire. The trust's website directed women to other websites for antenatal and postnatal screening information and pain relief options during labour. This information was available in other languages.

- At the time of our inspection, the service was working with commissioners and stakeholders to introduce a flu vaccination clinic for pregnant women. This was planned to commence in October 2017. The Lavender Team had also secured funding to undertake training in family planning, in response to an increase in the number of women with learning disabilities falling pregnant a short time after a previous birth. This would enable the team to counsel women in vulnerable circumstances on family planning and contraception.
- The gynaecology service offered an enhanced recovery integrated care pathway following major abdominal gynaecology surgery, which aimed to reduce the physical trauma of surgery and achieve a complication-free recovery. This reduced the length of time women were admitted to hospital. Enhanced recovery nurse specialists led this service.
- The gynaecology service offered some rapid access clinics, such as hysteroscopy (a procedure used to diagnose abnormal bleeding). Patients attending these clinics received consultant review and outpatient diagnostics in a single visit to promote timely diagnosis and treatment.
- The service was working with local commissioners and stakeholders to provide community based consultant-led gynaecology services. The premise was that this would enable women to access timely care and treatment closer to home.

Access and flow

- From October 2015 to June 2017, the maternity service had not suspended the service. Contingency plans were in place if the unit was required to close due to lack of capacity.
- From January to August 2017, an average of 92% of women had booked for antenatal care by 12 weeks and six days. This was better than the trust target of 90%.
- The National Institute for Health and Care Excellence (NICE) recommends that women should ideally be able to access antenatal care by 10 weeks, so that antenatal screening tests can be provided in a timely manner (NICE *Antenatal care: QS1,* last updated April 2016). In April and May 2017, an average 66% of women had accessed antenatal care by 10 weeks. We saw evidence of an improvement plan. This included posters displayed in community settings such as children's centres, GP surgeries and supermarkets, advising women to book with a midwife before 10 weeks of pregnancy.
- Routine antenatal care appointments for nulliparous and parous women were scheduled in line with NICE guidance (NICE *Antenatal care,* last updated April 2016).
- There was a policy in place to ensure women who did not attend appointments were followed up.
- The antenatal clinic (ANC) was staffed from 8am to 6pm, Monday to Friday. Staff advised women if the clinic was running late when they arrived. We observed this during our inspection. There was also a white board, which midwifery staff updated with clinic waiting times. During our inspection, the clinic was running approximately one hour late. In August 2017, an audit of clinic waiting times showed 34% of women waited 0 to 15 minutes, 23% waited 16 to 30 minutes, 11% waited 31 to 45 minutes, 10% waited 46 to 60 minutes and 22% waited over 60 minutes. The audit found that longer waiting times were associated with combined clinics. An action plan had been developed to improve waiting times, which included a review of combined clinic scheduling at the hospital. In addition waiting times at St Albans City Hospital and Hemel Hempstead Hospital were audited. A report was due to

be published in December 2017.

- Since our previous inspection in September 2016, the maternity day assessment unit (MDAU) had introduced an appointment system, which meant women who needed to be monitored and reviewed regularly during their pregnancy could arrange an appointment for a time that suited them. Women could also self-refer to the MDAU if they had any concerns, such as reduced fetal movements. No appointment was required for women needing urgent, immediate referral. We reviewed the attendance record from 21 to 31 August 2017; the majority of women were seen and discharged within two hours.
- Elective caesarean section lists ran five times a week, Monday to Friday, 9am to 1pm, with a maximum of three operations scheduled on a list. The dedicated theatre team was not available from 1.30pm. In May 2017, an audit of elective caesarean section delays found 50% started after 9.30am and 40% had three operations per list, none of which were finished by 1pm. No cancellations were reported. The audit concluded there was not enough dedicated theatre time to accommodate three elective caesarean sections, in particular when there were late starts. Lessons learned from the audit were shared with staff and an action plan had been developed to improve service provision.
- Women could telephone the maternity triage unit for advice at any time during the day or night. They attended the unit for review, if indicated by the symptoms and/or concerns they described. A traffic light system, using red, amber and green (RAG) ratings, was used to ensure women were assessed and reviewed in a timely way. In July 2017, an audit of triage waiting times showed compliance rates had improved from our previous inspection in September 2016, when we found that women waited three times longer on average to be seen by a doctor at night. Triage waiting time compliance rates for women to be seen by a doctor at night were 100% for each RAG rating.
- Women who presented to the triage unit with imminent delivery were red rated and were admitted directly to delivery suite. If direct admission to delivery suite could not be facilitated, one private room with a delivery bed and birthing equipment was available on the triage unit.
- From September 2016 to August 2017, 0.25% of babies were delivered in areas not designated as delivery suite, such as triage and antenatal ward. From January to August 2017, 18 babies were born before arrival (BBA) and/or in transit to the hospital. This equates to 0.6% of total births. In June 2017, the service reported six BBA deliveries. An audit was conducted in response, which showed two women had not booked for antenatal care and the remaining four were found to have had precipitate labour. We saw actions and learning were identified.
- The trust's access to treatment performance data for gynaecology had improved since our previous inspection in September 2016.
- Between May 2016 and April 2017, 18-week referral to treatment times for non-admitted gynaecology patients was 95.1%, which was better than the England average of 94.2%
- For the same period, gynaecology 18-week referral to treatment times for incomplete pathways (non-admitted) was 95.8%, which was also better than the England average of 91.3%
- Between April to July 2017, trust data for the gynaecology wards at Watford General Hospital (WGH) and St Albans City Hospital (SACH) combined showed:
    - 100% oncology patients were treated within 18 weeks of referral; this was better than the trust target 95%
    - 94% patients with suspected gynaecological cancer were seen within two weeks; this was slightly better than the trust target 93%
    - 96% patients with suspected gynaecological cancer commenced treatment within 31 days; this was in line with the trust target
    - 92% patients with suspected gynaecological cancer commenced treatment within 62 days; this was better than the trust target 85%
    - 91% patients for admitted pathways were treated within 18 weeks of referral; this

was slightly worse than the trust target 92%
    - 91% patients had a scan within 24 hours of referral to the early pregnancy unit; this was in line with the trust target
    - 100% patients had a diagnostic appointment within six weeks of referral; this was better than the trust target 99%
    - Nine patients breached the four-hour A&E target (bed and review).
- On our previous inspections in April 2015 and September 2016, we found there were high numbers of medical outliers admitted to the gynaecology ward. On this inspection, we found this was still a common occurrence; 32 patients were admitted, 21 of which were non-gynaecology patients. From March to August 2017, 338 medical outliers were admitted to the gynaecology ward. The average length of stay was 6.5 days. The trust had clear guidelines regarding the types of medical patients that were suitable for admission to the ward. There were plans to create a dedicated gynaecology ward by splitting the current ward into two wards. A proposal had been submitted to the bed reconfiguration group, which we were told had been agreed in principal. At the time of our inspection, work was yet be commenced on the reconfiguration of the ward.
- Senior staff told us that the high number of outliers on the ward did not generally affect gynaecology patient access and flow. From March to August 2017, 40 patients had elective surgery cancelled on the day. The majority were cancelled because operating lists overran (40%). Five were cancelled because no bed was available (12.5%). Out of the total 40 patients, two were not rebooked within 28 days because they were unfit for surgery and one was not rebooked due to patient choice. The gynaecology dashboard for WGH and SACH combined from April to July 2017, showed month-on-month decline in the number of patients cancelled on the day.
- The gynaecology ambulatory care unit had been temporarily relocated to provide an additional four-bedded bay on the gynaecology ward. This was used as a ‘surge’ area when the trust faced bed pressures. From March to August 2017, this additional bay was used for 116 days (63%).
- The gynaecology ambulatory care unit was staffed from 7.30am to 7.45pm, Monday to Friday. One room was designated for women with hyperemesis gravidarum who needed intravenous fluid hydration, and could accommodate four patients. A further four individual rooms were available for women having day case surgery or awaiting admission to the gynaecology ward. Since it was established on 5 September 2016, 830 patients had been seen on the unit, which had reduced the demand for beds on the gynaecology ward.
- The gynaecology ward ring-fenced one side room for women experiencing miscarriage or termination of pregnancy for fetal abnormality.

Meeting people’s individual needs

- The maternity service had arrangements in place to support women who had complex needs. These were managed by specialist midwives and/or consultants and included a joint endocrinology and obstetrics clinic for women with diabetes, perinatal mental health clinic, fetal medicine clinic and female genital mutilation (FGM) clinic.
- The Lavender Team provided care, support and treatment for women in vulnerable circumstances, such as those with learning disabilities, substance misuse, perinatal mental health concerns, teenagers and asylum seekers.
- Combined obstetric and psychiatric clinics were available for women with complex mental health needs. The Lavender team saw women with mental health needs up to 28 days after the birth of their baby, from when care was transferred to the community perinatal mental health team.
- The service had a simulation baby, which they used to help teach parenting skills to prospective parents with learning disabilities.
- There was a six-bedded transitional care unit, where care was provided jointly by the

maternity and neonatal service. This meant that babies who required more specialised neonatal care, such as phototherapy treatment for jaundice, were not separated from their mothers.

- The service provided a birth options clinic. The clinic provided an opportunity for women who have had a caesarean section or traumatic birth to explore birth choices for their current pregnancy.
- Women who requested a caesarean section because of anxiety about childbirth were referred to a specialist counselling service. This was in line with national recommendations (NICE *Caesarean section: QS32, statement 3,* June 2013).
- All women were offered fetal anomaly screening, in line with national recommendations (NICE *Antenatal care: QS22, statement 10*, last updated April 2016). Women identified as high risk for a fetal abnormality, such as Down's syndrome, were seen in the fetal medicine clinic for on-going treatment and support. Referral to specialist tertiary centres was made when indicated.
- The service employed a bereavement midwife, whose role was to develop bereavement care, provide support for parents and training and education for staff.
- The delivery suite had a dedicated bereavement room to ensure bereaved parents had time with their baby. There was a cold cot available, which meant that babies could stay longer with their parents. Memory boxes, which included photographs and hand and footprints, were made up for parents who had suffered a pregnancy loss.
- Parents were supported with making funeral arrangements and counselling services were arranged where necessary. The hospital had a chaplaincy service, which offered support to parents who faced the loss of their baby. Chaplains of various denominations and faiths were available on request.
- Parents who had experienced a stillbirth, neonatal death or termination of pregnancy for fetal abnormality were offered a post-mortem examination in order to enhance future pregnancy counselling.
- There were processes to ensure disposal of pregnancy remains were handled sensitively. Women were provided with a choice of how they wished to dispose of pregnancy remains, following pregnancy loss or termination of pregnancy for fetal abnormality.
- Interpreter services were available for women for whom English was not their first language. These were provided face-to-face or via a dedicated telephone translation service. There was a range of information leaflets available to women. These were available in different languages if required.
- We saw posters displayed on the back of toilet doors advising women who were experiencing domestic violence how to access support. This information was in English and five other languages.
- The service offered a range of parent education courses, including preparation for labour and birth for first time parents, a course for couples expecting twins, refresher courses for women that have had a baby before, and breastfeeding workshops. A pregnancy club was also available. This was held monthly and was designed to support women throughout their pregnancy.
- The layout of the maternity unit was designed so that women attending for antenatal appointments did not pass through the postnatal ward.
- Partners were able to stay overnight if they wished. Friends and relatives could visit at fixed times. This enabled new parents to spend protected time with their babies.
- The maternity and gynaecology service was accessible to wheelchair users.
- Women had a choice of meals, which took account of their individual preferences, respecting cultural and personal choice.

Learning from complaints and concerns

- Between July 2016 and July 2017, the hospital received 70 complaints about the maternity

and gynaecology service. This was the highest number of complaints received by any core service. The trust took an average of 66 days to investigate and close complaints. This was not in line with trust policy, which stated that a response to the complaint should be within 25 working days or 35 days if the complaint was complex. As of July 2017, 14 complaints were open.

- We were told the most common themes of complaints received regarded attitude of staff, communication/information to patients and clinical treatment. We saw evidence that action was taken because of complaints received in order to improve patient experience and care provision. For example, the face-time initiative was introduced in response to a complaint received from a mother who was separated from her baby when they were admitted to the neonatal care intensive unit for care and treatment.
- Staff told us that where possible, informal complaints were resolved immediately.
- The service had a dedicated patient experience team, which managed complaints, compliments, the debriefing service and patient experience activities.
- Women were offered a local resolution meeting to discuss the outcome of their complaint once it had been investigated. The patient experience team and/or associate director of midwifery and gynaecology visited women and their partners at home if they preferred.
- Learning from complaints was integrated in the governance framework. We saw that complaints and patient feedback was discussed at weekly and monthly meetings, which included patient experience group, clinical incident review panel, quality and safety group, and clinical governance education meetings.
- Learning from complaints and feedback was shared with staff via emails, 'message of the week' bulletins and daily staff huddles. We saw that learning folders also contained details of complaints received, including copies of the complaint received and the trust's response.
- We were told that staff who were directly named in a complaint were required to reflect on their involvement and how they intended to change their practice as a result of the complaint. Their response was included in the investigation report.
- We saw information leaflets regarding the hospital's patient advisory liaison service (PALS). PALS provided advice and support to women (and those close to them) who wished to raise a concern or complaint. Information on how to complain was also published on the trust website.

Are maternity and gynaecology services well-led?

Good

We rated well-led as good because:

- Leadership, governance and culture were used to drive and improve the delivery of high quality care.
- We found a strong, cohesive senior leadership team who understood the challenges of providing good quality care and of managing the service, and had identified strategies and actions to address these.
- The service was focused on providing quality care and had a defined strategy, which was aligned to its vision and values, organisational aims and national recommendations for maternity care provision.
- Governance and risk management systems were robust and well established. Risks were identified, monitored and managed, with mitigating actions in place to minimise risk. Regular robust detailed reporting was evident at departmental, directorate and divisional level. Meeting minutes were well documented.
- There were high levels of staff satisfaction across all groups in maternity. Staff were proud to work at the trust and spoke positively of the culture. Staff at all levels were encouraged to raise concerns and drive service improvement.
- Staff and public engagement was valued. Feedback was encouraged from women,

relatives and staff, and was used to inform service improvements.
- Staff felt that leadership was strong, with visible, supportive and approachable managers.

However :
- Staff satisfaction in the gynaecology department was general lower.

Leadership of service

- The maternity and outpatient gynaecology service was under the women and children's division and had a clear management structure with defining lines of responsibility and accountability. A divisional director had overall responsibility for the division. They had joined the service since the last Care Quality Commission (CQC) inspection in September 2016. There were separate clinical directors for obstetrics and gynaecology, an associate director of midwifery and gynaecology and a divisional manager. An assistant divisional manager, assistant service manager, a quality and governance facilitator, human resources business partner, divisional head of finance, and matrons supported this team.
- Gynaecology inpatient services were under the surgical division. The leadership structure included a divisional clinical director, divisional manager and head of nursing. The surgical division was responsible for nursing staff, whilst medical staff were under the leadership of the women and children's division.
- The divisional director for the women and children's division did not have a background in obstetrics and gynaecology, but had led improvement initiatives within the respiratory medicine department prior to this appointment. The leadership team were focused on continuously improving service provision, with a strong focus on safety.
- Directorate leads spoke with pride about the work and care their staff delivered on a daily basis.
- Medical and midwifery leads worked collaboratively to improve service provision. For example, the clinical director for obstetrics was the lead consultant for the Phoenix team initiative, designed to promote normal birth, improve women's experiences and reduce the caesarean section rate.
- The associate director of midwifery and gynaecology had access to the trust board and attended trust quality and safety group meetings. Issues affecting women's services were presented at this forum. A non-executive and executive director at board level represented maternity services. We saw that the trust board had oversight of the service in minutes of board meetings held in July and September 2017.
- Staff told us they felt well supported by the associate director of midwifery and gynaecology, matrons, managers and deputies.
- All staff we spoke with were overwhelmingly positive about the associate director of midwifery and gynaecology. Staff told us she had instilled an ethos of continuous improvement within the unit.
- Community staff described the associate director of midwifery and gynaecology as motivational and very visible.
- During our inspection, we observed matrons attending wards to support staff, discuss activity and any issues that had arisen.
- The delivery suite was co-ordinated by an experienced senior midwife who, wherever possible, was supernumerary to the staffing numbers required for the provision of one-to-one care in labour.
- There were consultant leads for specific services, such as perinatal mental health, diabetes, audit and clinical risk.
- The associate director of midwifery and gynaecology had developed a future management structure for the maternity service, to ensure succession planning was in place. The planned structure included a deputy head of midwifery and associate head of midwifery.
- Nursing staff on the gynaecology ward were less positive and told us they did not feel

supported by the ward manager. They were not under the remit of the women and children's division but formed part of the surgical division.

Vision and strategy for this service

- The service had a clear vision and set of values, which focused on quality and safe care. The vision for the maternity service was; "exemplary care; where little things matter". The aim of the service was "to create a centre of excellence, which delivers best practice in high quality care". The values were "empathetic, listening, responsive, respectful and positivity". We saw the vision and values publically displayed in the entrance to the women and children's unit.
- The vision and values were developed through a process of engagement with staff and patients. Staff we spoke with understood what the vision and values were and had been involved in there development.
- The vision and aims of the service had been translated into a local strategy plan for 2017/18. It consisted of 39 objectives, which were designed to deliver safe, high quality women's services and encompassed national recommendations for maternity care provision (National Maternity Review, *Better Births: Improving outcomes of maternity services in England,* 2016; NHS England *Saving Babies' Lives: A care bundle for reducing stillbirth,* 2016). The objectives were aligned to one of five key domains, which were safe, effective, caring, responsive and well-led. These domains mirrored the five key questions asked by CQC.
- We saw evidence that an action plan had been developed to monitor progress against achieving the services' objectives. As of July 2017, 25 objectives had been completed and the remaining 14 objectives were 'on track' to be completed within the timescale that had been set. Staff we spoke with understood the strategy and their role in achieving it.

Governance, risk management and quality measurement

- The service had an effective governance structure and risk management framework to support delivery of the strategy and good quality care.
- All incidents reported via the incident reporting system were reviewed daily, Monday to Friday, at the patient safety meeting. The premise of this meeting was to ensure the service was safe and whether any immediate actions were required to address safety concerns. We attended a patient safety meeting during our inspection. The meeting was well attended by members of the multidisciplinary team. We observed immediate actions were identified to reduce the risk of reoccurrence, which included prompt dissemination to staff via safety huddles and 'message of the week'. Any potential serious incidents were reviewed in more depth at the clinical incident review group (CIRG) and were escalated to the trust serious incident panel.
- The serious incident panel met three times a week to review all potential serious incidents. If an incident was declared as a serious incident the panel would appoint an appropriate senior member of staff to lead the investigation and conduct root cause analysis (RCA).
- We reviewed the root cause analyses of five serious incident investigations. We saw detailed root cause analyses had been completed, which included recognition of care management and service delivery problems, contributory factors, lessons learned and actions to be completed to reduce the risk of further incidents.
- Since our previous inspection in September 2016, the service had commissioned a neighbouring NHS trust to externally peer review serious incident investigations. This was to ensure serious incidents were robustly investigated and actions to reduce reoccurrence were identified. At the time of our inspection, an external consultant was conducting a thematic review of poor neonatal outcomes including stillbirths and hypoxic ischaemic encephalopathy (HIE) in term babies. HIE is a type of brain damage that occurs when the baby does not receive enough oxygen and/or blood during the birthing process and can

cause cerebral palsy. The review was expected to be completed by the end of September 2017.

- We attended the weekly clinical incident review panel during our inspection and observed incidents, risks, lessons learned and patient feedback was discussed.
- Monthly governance, quality and safety group meetings were held, which reported to the divisional quality and safety group, who in turn reported to the trust quality and safety group. We reviewed six sets of meeting minutes, which confirmed that performance, incidents, patient safety alerts, risks, complaints and patient experience, training compliance, clinical audit, and guidelines were discussed. Minutes were detailed and contained copies of relevant reports, action plans and lessons learned.
- The division had produced a booklet for staff entitled *Risk Management: Everyone's Responsibility* (August 2017), which explained the importance of risk management and how it helps all staff to learn and improve practice and the care they provide to patients.
- Audits were discussed at governance education meetings, which were held monthly. We reviewed three sets of meeting minutes, which were detailed and contained audit presentations, incidents, action plans and lessons learned. The meeting held in June 2017 showed key learning from maternity and gynaecology incidents. Lessons learned included mandatory use of infant feeding charts and launch of the 'golden hour' initiative.
- The service risk register identified each risk in detail, alongside a description of mitigation and assurances in place. An assessment of the likelihood of the risk materialising and its possible impact was included. We saw that risks were reviewed regularly and updated when changes to mitigation had been taken.
- Staff we spoke with were aware of the main risks within the service, which included midwifery vacancies and the information and communications technology infrastructure.
- The service had a clearly defined audit plan for 2016/17 and 2017/18. Audits were used to ensure the service was continuously improving their patient care. This was informed by national guidance, patterns of incidents and clinical data outcomes. Findings from audits were shared with staff through a variety of means, which included clinical governance meetings, daily team huddles, staff noticeboards and learning folders.
- The maternity and gynaecology service both used clinical dashboards to monitor activity and clinical outcomes. The dashboards were used to help identify patient safety and quality issues. We saw evidence that timely and appropriate actions were taken to address areas where locally agreed performance standards were not met. If noticeable improvement was also seen, this would prompt audit in order to establish areas of best practise that could be replicated. Clinical dashboards were discussed at departmental, divisional and trust wide quality and safety group meetings. Minutes we reviewed confirmed this.
- Termination of pregnancy was undertaken in line with legislation. An audit of HSA1 and HSA4 forms completed from May to September 2017 showed 100% compliance.

Culture within the service

- The service was committed to promoting a positive culture, which was focused on staff engagement and improving the quality of care and patient experience.
- The maternity service held a team-building day in July 2017, which was facilitated by an external psychologist. Minutes of the meeting showed 43 members of staff attended, which included the trust's medical director and chief nurse. For part of the day, attendees were split into three teams (management, midwifery and doctors) and were asked to come up with three 'promises' for standards of behaviour they would adhere to. For example, the management team promised less exclusivity, the midwifery team promised more ownership, collaboration and innovation, and the doctors promised better communication and better outcomes for patients. Staff were congratulated by members of the leadership team for the work they had achieved.
- All staff we met were welcoming, friendly and helpful. It was evident that staff cared about

the services they provided and told us they were proud to work at the trust.

- Maternity staff described the unit as “unrecognisable” from when we first inspected the service in April 2015. A woman who asked to speak with us during our inspection echoed this sentiment. She described the delivery of her first baby two years ago as “a terrible experience”. However, the delivery of her second baby had been “a completely different experience” and she felt she had “genuinely been cared for”.
- Staff told us the associate director for midwifery and gynaecology had an ‘open-door’ policy and encouraged staff to voice concerns and share any ideas they had for service improvement. Staff felt she listened to them and she was described as a “team player”.
- All staff we spoke with were committed to providing the best possible care for women and their babies.
- Maternity staff felt there was a positive working culture and reported good team working.
- Staff agreed there was a culture of openness and honesty throughout the service. Multidisciplinary teams worked collaboratively and were focused on improving patient care and service provision. During our inspection, we attended multidisciplinary team meetings and observed positive and respectful interactions, which were focused on meeting women’s needs and providing safe care and treatment.
- Community staff felt part of the overall maternity service. They told us that teamwork and communication was good.
- There were processes in place to protect lone workers. Community midwives told us they attended homebirths in pairs. When community midwives were asked to attend women at home, they would inform staff on the Alexandra Birthing Centre (ABC) when they arrived and when they left. Community staff also carried panic alarms, which sent an alert to an external provider.
- Staff were proud to tell us of improvements they had made since our previous inspection. They told us that everyone felt ownership for the service and were excited to be part of it.
- Staff did not express concerns about bullying or harassment to the CQC team during our inspection.
- GP trainee doctors we spoke with described the support they received with their training as “outstanding”. One GP trainee told us they would support and encourage any member of their family to deliver their baby at the unit.
- Nursing staff on the gynaecology ward were less positive. The high numbers of medical outliers admitted to the ward had affected staff morale, as staff had chosen to specialise in gynaecology but were increasingly looking after medical patients. Staff we spoke with told us they were unhappy and felt overwhelmed by workloads. This had resulted in a high turnover of nursing staff.

Public engagement

- Staff within the service recognised the importance of gathering the views and experiences of patients. Feedback received was acted on to shape and improve service provision.
- Between July 2016 and June 2017, the patient response rate from the maternity friends and family test birth performance only was variable (no national response rate data was available for antenatal care, postnatal ward and postnatal community performance). For seven of the 12 months the trust’s response rate was lower than the England average. This was significantly so in July, August and December 2016, when the response rate was 1% (versus England average of 23%), 5% (versus 23%) and 10% (versus 22%) respectively. We saw evidence that the service had taken action to address response rates and the average response rate over the 12-month period was 24%, which was slightly better than the England average of 23%. From June to August 2017, the average response rate was 47%, which was significantly higher than the England average.
- The gynaecology service used information from the inpatient FFT and complaints to monitor and improve services provided. Between July 2016 and June 2017, the patient

response rate from the FFT was higher than the England average for 10 of the 12 months. The average trust's response rate over the 12-month period was 41%, which was significantly higher than the England average of 24%.

- We saw evidence in meeting minutes that FFT results were reviewed regularly and patient feedback was shared with staff in a variety of methods including team huddles, staff meetings and learning folders.
- Since our previous inspection in September 2016, the service had added complaints and customer awareness to maternity mandatory training. The training session included women who had complained about their care. They were invited to share their experience with staff. We saw a letter from a member of staff sent to the associate director of midwifery and gynaecology, expressing their thanks to the woman and to her, for inviting women to speak to them. She said: "This is a really powerful exercise for us to be reminded about the difference that we can all make with just a smile, a touch, or a kind word...I think this is the thing [training session] we will remember most of all".
- We saw the noticeboard on delivery suite displayed both positive and negative feedback received. It also included examples of actions the service had taken in response to feedback, which was entitled "you said; we did". Examples included changing the number of appointments in each clinic to reduce waiting times, introducing caseload midwifery via the Phoenix team to enable continuity of care, and the "iSeeU" initiative.
- The service took account of the views of women through the Maternity Voices Partnership (MVP). Minutes from the meeting held in March 2017 showed patient experience of clinic appointment waiting times, maternity triage, and antenatal education were discussed, including suggestions for improvements to service provision. Clinical pathways and a frenulotomy clinic for the division of tongue-tie had been established following feedback from the MVP.
- Women who had complained about their care were being invited to speak to staff on mandatory maternity training days.
- The local strategy included plans to increase public engagement. At the time of our inspection, the maternity service was conducting a local survey entitled "50 voices".

Staff engagement

- Staff were involved and engaged in the development of the vision, values and strategy for the maternity service.
- Staff told us they had regular team meetings. We saw evidence of this in minutes we reviewed. Information was shared with staff in a variety of ways, such as face-to-face, email, posters, and learning folders.
- At one of the meetings we attended during our inspection, staff told us they felt empowered to share ideas for service improvement. One midwife told us they had submitted a proposal to the associate director of midwifery and gynaecology for staff on the ABC to be trained in hypnobirthing. The ultimate aim was for the service to run hypnobirthing classes for women and their partners.
- The maternity service had introduced a monthly staff recognition award for exemplary care provision. Two awards were given a month, one for clinical staff and one for non-clinical staff. We saw the certificates of winners displayed on delivery suite.
- We also saw "stars of the month" displayed, where staff were invited to write comments about other members of staff. For example, one member of staff had written: "First shift on delivery suite in years; [midwife] was so supportive and understanding and knowledgeable, calm and helpful".
- Community midwives were part of the overall maternity team and felt they had good contact and communication with the hospital service.
- We saw the staff room in antenatal clinic had dedicated space for staff to write comments for managers and their responses.

- The local strategy included plans to increase staff engagement. At the time of our inspection, the maternity service was conducting a local staff survey.
- We saw effective team working across all clinical areas.
- The minutes of meetings we reviewed showed good staff engagement at all levels.
- Staff told us they felt confident to raise concerns with managers and knew of the trust's whistleblowing policy.
- The gynaecology nursing staff were less engaged, due to their dissatisfaction about the high number of medical patients admitted to the ward.

Innovation, improvement and sustainability

- We found the service had continued to make improvements to service provision. This was reflected in the ratings we gave, from 'inadequate' in April 2015, to 'good' in September 2016 and September 2017.
- Following the last inspection, the service had made improvements in the following:
    - The time it took to report and review incidents had improved and was better than the trust average.
    - Cleaning equipment was stored appropriately and meant unauthorised persons could not access hazardous cleaning materials.
    - Medicines were securely stored in all clinical areas we visited.
    - Air conditioning units were being installed in treatment rooms to ensure temperatures did not exceed recommended safe limits for medicines.
    - Controlled medicine destruction kits were available and processes were in place for the safe storage and recording of patients own controlled medicines.
    - A female genital mutilation (FGM) and BCG vaccination clinic had been established.
    - Mandatory training compliance had improved, particularly with regards to the management of blood transfusion.
    - A new born early warning score had been introduced to help identify babies at risk of clinical deterioration.
    - A patient tracker form had been introduced to help staff see at a glance any recurrent concerns and prompt appropriate investigation and referral to the obstetric team.
    - Recruitment and retention of staff within the maternity service had improved . The midwifery vacancy rate had fallen from 25% in April 2015 to 11% in July 2017.
    - There was a reduction in the time women waited for epidural pain relief in established labour.
    - Baby friendly initiative stage one had been awarded to the maternity service.
    - Appraisal compliance rates had improved.
    - A multidisciplinary elective caesarean section meeting had been introduced to help reduce the section rate and promote normal birth.
    - Initiatives to enhance the patient experience and care provision had been developed, such as "iSeeU", the 'golden hour' and the Phoenix team.
    - The trust's access to treatment performance data for gynaecology patients had improved.
    - A neighbouring trust had been commissioned to externally peer review serious incident investigations.
    - Complaints and customer awareness had been added to maternity mandatory training.

Services for children and young people

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

Information about the service

The children's inpatient service operates two wards, both based at Watford General Hospital within the women and children's block. The service cares for children up to the age of 16. Young people aged 17 and 18 are cared for in the adult service. The trust has 50 inpatient and 10 day case beds. The children's inpatient service operates two wards, both based at Watford General Hospital. All day case beds are associated to the Safari Day Unit.

The service is led by an overall divisional director for women and children's services. In addition there is a clinical director and matron for the children's service and a head of nursing for children's services. The neonatal service has a clinical lead and an acting matron.

Starfish is a 20 bedded general paediatric ward caring for children up to the ages of 16 years. The ward cares for children with both medical and surgical conditions and includes two high dependency beds. The Safari Day Unit has10 beds and provides day care for children up to 16 years of age. The unit provides care for children requiring day surgery and treatments such as chemotherapy and administration of intravenous antibiotics and for investigations.

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

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

The trust had 5,389 admissions from April 2016 to March 2017. Emergency episodes accounted for 70% of trust activity, 20% were day case episodes and the remaining 10% were elective.

During the inspection we visited the paediatric wards and the neonatal unit, theatres and outpatient services. We talked to 12 parents and five children and 55 staff including consultant paediatricians and neonatologists, junior doctors, nurses, therapists, play specialists, a dietician and radiotherapists, ward clerks and domestic staff and managers. We observed interactions

between staff, patients and parents. We reviewed 15 patient records, 16 medicine charts and13 guidelines, policies and procedures as well as other documentation as necessary. We received comments from people who contacted us to tell us about their experiences. Before our inspection we reviewed performance information from, and about the trust.

Summary of findings

Overall, we rated services for children and young people as good for safe, effective, caring, responsive and well-led because:

- Staff were confident to report incidents and staff were encouraged to raise concerns. There was a robust governance and risk management framework in place to ensure incidents were investigated and reviewed in a timely way. Learning from incidents was cascaded to staff and actions were taken to minimise risk and prevent incidents from reoccurring. This was an improvement from our previous inspection in September 2016 where feedback from staff had been mixed as to whether incident reporting was encouraged.
- At our previous inspection in September 2016 there had been a significant division of staff concerning opinion and practice in the neonatal unit. Some staff felt this might have had an impact on patient care. Following a thematic review and implementation of the recommendations there was evidence of good local leadership from clinicians and managers. Consultants in the neonatal unit were working well together.
- There was clear and visible leadership from the divisional clinical lead, clinicians, the lead nurse, matrons and managers who were approachable and fully engaged with providing high quality child centred care.
- All staff were aware of the Duty of Candour Regulation and knew how to apply it which was an improvement from our last inspection in September 2016.
- At our previous inspection in September 2016 staff did not always follow the correct security procedures for entering and exiting the neonatal unit, Starfish and Safari wards. During our inspection we observed it was not possible to enter or leave the ward and unit without being challenged by staff who always followed the correct security procedures.
- At our previous inspection in September 2016 there was no safety thermometer on Starfish ward which was contrary to guidelines issued by the NHS. A safety thermometer was implemented in April 2017 which reported 100% harm free care on Starfish ward for the period April to July 2017.
- At our previous inspection in September 2016, children who showed signs of deterioration were not always escalated to a senior nurse or doctor. During our latest inspection we saw in patient records that patients were appropriately escalated to either the nurse in charge or the doctor, whichever was indicated.
- At our previous inspection in September 2016, there were gaps in management and support arrangements for staff, such as mandatory training and appraisal. During our latest inspection all staff in children's services were achieving 93% for mandatory training and appraisal.
- At our previous inspection in September 2016, there were a high number of cancellations of outpatient appointments for children. Children's services had reduced cancellation rates for appointments less than six weeks. There was an improving picture for cancellations over six weeks.
- We observed the majority of staff followed best practice guidance for infection control to reduce the risk of infection through staff washing their hands, using personal protective equipment and following sterile techniques.
- Suitable arrangements were in place for the management of medicines which included the safe ordering, prescribing and dispensing, recording handling and storage of

medicines. There was a paediatric pharmacist in post.

- Staff treated children with kindness, dignity and respect. All parents and children we spoke with told us how “wonderful” the service was and staff always went the ‘extra mile’ when caring for children and families. There was a strong child centred culture across the service and staff told us how “proud” they were to work in the children and young people’s service.
- Staffing levels were safe for the number and acuity of children. There were effective measures in place to ensure that when there was increased activity, staff numbers increased. There were sufficient medical staff in post to provide 24 hour, seven day a week care for babies, children and young people.
- There were practice nurses in post to identify and deliver individual and service wide training needs. Staff had the relevant experience, knowledge and qualifications to care for and treat patients.
- There was effective multidisciplinary team working. This included, safeguarding services, mental health services, dieticians, physiotherapists and occupational therapist, play specialists and pharmacists. There were effective working relationships with other trusts, tertiary services and external organisations.

However:

- At our previous inspection in September 2016, there was insufficient space, which did not reflect current guidelines, in the neonatal unit. During our inspection we saw there was still insufficient space. A thematic review had been undertaken which had identified the unit to be safe in the interim and mitigating arrangements were in place to manage patient flow and safe staffing levels on a daily basis.
- Children who were moved from inpatient wards to the operating theatre travelled along a corridor that was not fit for that purpose. However, a risk assessment was in place and a health and safety review had been undertaken to mitigate the risks to children and young people.
- Operating theatre and recovery arrangements did not consider adequately the specific needs of children.
- Standards of cleanliness and hygiene were not consistently maintained on Starfish ward. We raised this at the time of the inspection and senior staff immediately addressed the issues.
- The information technology system for the paediatric diabetes service was not fit for purpose and required the clinical team to spend extensive periods of time on non - clinical activities.
- Results from the Picker 2016 national inpatient survey for children’s services were worse than the trusts previous survey in 2014. Results were worse than average compared to similar trusts in 2016.
- The children’s service took an average of 47 days to investigate and close complaints compared to the trust standard of 25 days.
- Children’s services were incorporated into the trust clinical strategy 2015 - 2020 and the children’s services strategy 2017. However, not all staff in the service were clear about the longer term development of children’s services at the trust.
- Although efforts were being made by the service to engage children and carers in feedback about the service, response rates around the Friends and Family Test were consistently low.

Are services for children and young people safe?

Good

We rated safe as good because:

- There was a well-embedded culture of incident reporting and staff said they received feedback and learning from incidents.
- There were no never events reported in the period June 2016 to May 2017.
- During our inspection staff always followed the correct security procedures for entering and exiting Starfish Ward, Safari Ward and the neonatal unit.
- All staff were aware of the Duty of Candour.
- Safety thermometer data from the last four months reported 100% harm free care in the child health division.
- The majority of staff followed individual best practice guidance for infection control to reduce the risk of infection through staff washing their hands, using personal protective equipment and following sterile techniques.
- Suitable arrangements were in place for the management of medicines which included the safe ordering, prescribing, dispensing, recording, handling and storage of medicines.
- There were robust arrangements in place to safeguard children and young people from abuse, which reflected relevant legislation and local requirements. Staff had undertaken the required level of safeguarding training.
- Mandatory training and appraisal levels were above trust targets.
- Appropriate systems were in place to assess risk and to recognise and respond to the deteriorating patient.
- Nurse and medical staffing levels were appropriate to the activity and dependency of the patients during the inspection.

However:

- Standards of cleanliness and hygiene were not consistently maintained on Starfish ward as the ward was cluttered and clinical waste was not disposed of appropriately.
- There was insufficient space, which did not reflect current guidelines in the neonatal unit.
- Children were moved from the inpatients' wards to the operating theatre along a corridor that was not fit for that purpose.
- Operating theatres and recovery did not consider adequately the specific needs of children.
- Access to emergency equipment was impeded. However, this had been rectified by the time of our unannounced inspection.
- There was unsecured storage of dietary supplements.
- None of the staff we spoke with had been involved in a major incident exercise or had undergone major incident training.

Incidents

- At our previous inspection in September 2016, the incident reporting culture was variable. The service did not ensure staff complied with the policy and procedures for reporting incidents. During this inspection we observed staff understood their responsibilities to report incidents and children and parents were informed when things went wrong. Incidents were reported and investigated and were subject to a high quality review by matrons in the children and young person's service. Evidence of decisions and discussions at team meetings were consistent and learning outcomes were recorded in the minutes of team meetings and on staff handover sheets.

- There had been a total of 645 incidents in children's services in the period June 2016 to May 2017. There were 590 incidents reported as no harm, 49 low harm and 12 as moderate harm and one as causing severe harm. No incidents were classified as safeguarding incidents.
- In accordance with the Serious Incident Framework 2015, the trust had reported a serious incident (SI) between June 2016 and May 2017, in children's services which met the reporting criteria set by NHS England. The type of incident reported was maternity/obstetric incident meeting SI criteria: baby only (including foetus, neonatal and infant). The incident had been investigated appropriately and learning shared with staff
- There were no never events in the period June 2016 to May 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The trust used an electronic incident reporting tool to record incidents. The staff we spoke with were confident in the use of this system and told us they always reported incidents.
- Staff we spoke with told us they were given feedback about incidents at daily handovers and in team meetings. Printed handover sheets contained information prompts following children's incidents. For example, where staff were required to ensure the completion of children's documentation.
- Where incidents had occurred actions were identified to limit the risk of a further occurrence. Actions were monitored through divisional governance meetings and we saw evidence of this in minutes of the April 2017 meeting.
- At our previous inspection in September 2016, some junior doctors in the neonatal unit reported they felt anxious about reporting incidents or near misses. They also told us they were not supported through the reporting and investigation process and felt they were blamed and punished when an incident involving them had been investigated. During this inspection junior doctors said they were supported to report incidents and were copied into the minutes of governance and safety meetings.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. At our previous inspection in September 2016, not all nursing staff knew what this meant. During this inspection all staff we spoke with understood what duty of candour meant and told us they would share information with children and their parents or carers following an incident. Staff were aware of the trust policy called: "Being Open". This policy provided guidance to staff to ensure all processes and procedures were recorded and reported correctly and children, young people and their parents were communicated with openly and in a timely fashion about their care and treatment. Where SI or incidents relating to moderate harm had occurred the Duty of Candour policy had been appropriately implemented by staff
- Nursing and medical staff attended monthly mortality and morbidity meetings as well as those presenting a case investigation. Discussions were held around each case presented. Learning was discussed at monthly governance meetings and we saw evidence of this in the minutes of the April 2017 meetings. At our previous inspection in September 2017, some doctors told us they had not received the minutes from the divisional mortality and morbidity meetings after they had been held. This meant that if a person was absent from the meetings, lessons learned were not shared fully. During this inspection, doctors told us they were now receiving the divisional mortality and morbidity minutes and felt fully informed.

Safety Thermometer

- The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline enables staff to focus on patient harms and how they can be eliminated.
- The trust monitored safety thermometer indicators including falls, pressure ulcers, nutrition, medication, safeguarding and MRSA and Clostridium difficile rates. Data was collected monthly and a quality dashboard was used to analyse key performance indicators.
- At the time of our previous inspection in September 2016 there was no safety thermometer in use on Starfish ward. During this inspection we observed the safety thermometer had been in use on Starfish ward since April 2017. Data from the safety thermometer showed that there were no new pressure ulcers, no falls with harm and no new catheter urinary tract infections between May 2016 and May 2017 for children's services. This meant 100% care delivered was harm free. The safety thermometer was not in place on Safari ward.
- The trust had a rigorous process for safety thermometer data collection, validation and submission and clinical leads in the service monitored progress and reviewed any lapses in care.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were not consistently maintained in the paediatric areas we visited. At the time of the inspection Safari ward, the neonatal unit and the children's outpatient department were seen to be visibly clean and mainly clutter free. However, Starfish ward was cluttered and clinical waste had not been disposed of appropriately. We raised this with the nurse in charge who acted immediately on our concerns.
- In the CQC latest children's survey in 2014, the trust scored 8.66 out of 10 for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts.
- There were no reported cases of MRSA or *Clostridium difficile* in the preceding 12 months. When a child had been transferred from another hospital or a child was at risk of carrying MRSA, they were isolated until they were proven to be free from MRSA infection.
- On Starfish ward, where children might be isolated for the prevention of cross infection, there was a preparation room between the ward and the patient's room. However, on the neonatal unit the isolation rooms did not have a preparation room but we observed staff following the correct isolation procedures. Waste was appropriately segregated in clinical areas with separate colour coded arrangements for general waste, clinical waste and sharps, (needles). Bins were clearly marked and were pedal operated and within safe fill rates.
- All machinery and equipment we saw was labelled with a date and signature when it had been cleaned, confirming it was safe to use.
- There were paper towels, liquid soap and pedal bins at each hand-washing basin. Antibacterial hand gel dispensers were at the entrance to all wards and departments. We observed staff were 'arms bare below the elbow' and wore personal protective equipment as required which was available throughout the areas we visited. We observed staff regularly cleaning their hands with gel or washing their hands as required, according to trust policy.
- Children's services participated in monthly hand hygiene and environmental cleanliness audits as part of the trust's infection prevention programme. Data was used to highlight areas for improvement. Hand hygiene audits from December 2016 to May 2017 showed 100% compliance against the trust target of 95% on the neonatal unit, Safari and Starfish wards for five of the six months audited. A score of 92% was recorded for the neonatal unit in March 2017.

- Four of the six environmental audits, cleanliness and decontamination of patient equipment on Starfish and Safari wards had scored consistently below the trust target of 95%. Scores ranged from 76% to 86%. Action plans were in place which included monthly reviews and reporting of staff training compliance. The service was compliant (above the 95% standard) from May to August 2017.
- An audit of infection control practices in the neonatal unit in June 2017 identified areas of non-compliance. For example, the infection control board was out of date and the water outlet and toilet brush holder required cleaning. We reviewed the action plan and saw actions had been taken to address areas of non-compliance.
- We saw toys on Starfish and Safari wards and in children's outpatients were cleaned in line with trust policy and were clearly documented.
- Cleaning schedules were clearly displayed in paediatric areas which identified the frequency of cleaning and documented when areas had been cleaned.
- All staff completed infection control training. Over 97% of staff had undertaken infection control training in the last 12 months which was above the trust training target of 90%.
- The hospital had a lead nurse for infection prevention and control. The infection control committee met monthly and monitored the trust's performance. Infection control policies were available on the trust's intranet site and staff told us they knew how to access them. There were divisional and department link nurses with responsibility for infection control and prevention. All staff we spoke with knew who their infection control link nurse was and how to contact them.

Environment and equipment

- Access to the paediatric wards and the neonatal unit were through a set of double doors controlled by an entry buzzer and swipe access and monitored by using a CCTV security system. There were clear signs instructing staff and visitors not to "tailgate" through the doorways.
- At our previous inspection in September 2016, it had been possible to open a door and leave Starfish, Safari and the neonatal unit without being challenged by staff. At this inspection all areas where children and young people were treated as inpatients were secured with entry systems and video surveillance. It was not possible to enter or leave the children's area without being challenged by staff. This meant the risk to children being abducted from the ward without permission from staff or parents, had been mitigated by the provision of a robust security system which was embedded in practice.
- High locks were in place on the doors to clinical rooms as well as the main kitchen and the parents' kitchen to prevent children from gaining entry.
- On Starfish ward there was a well-supplied playroom and a separate adolescent room. Parents and carers were able to use the parents' room to relax, store food and make hot drinks.
- There was adequate and appropriate equipment for the delivery of treatment to children. This included machines to monitor blood pressure, equipment to deliver intravenous medicines and equipment for the care of complex needs of babies in the neonatal unit. All equipment used for the treating children that we saw was clean and regularly checked and was within required service dates.
- Staff we spoke with told us equipment repairs were undertaken promptly and equipment failures immediately addressed. This meant that risks to children from unsuitable equipment were reduced. However, senior leaders we spoke with expressed concerns about delays in the capital equipment programme for the replacement of cardiac and blood pressure monitoring equipment for the division. This was recorded on the divisional risk register and senior leaders had identified where (in the division) equipment could be accessed in the event of an equipment failure.
- Resuscitation trolleys were tamper- evident and were checked daily, which was clearly

documented in each clinical area.

- At our previous inspection in September 2016 we reported that the neonatal unit did not meet the criteria of the British Association of Perinatal Medicine's (BAPM) 2004 service specification on designing a neonatal unit, nor the more recent document Health Building Note 09-03 2013 from the Department of Health-Neonatal Units. This document recommends the layout and minimum specification for each baby's incubator or cot. In particular the access to the incubator or cot in an emergency. This meant that due to limited space, if there was a clinical emergency, doctors or nurses may have had difficulty easily accessing the patient. There was also insufficient space to accommodate a parent on a chair by the cot side or in a hospital bed if required.
- During or inspection we saw in the minutes of the safety and compliance committee (April 2017), a thematic review of the neonatal (NICU) service had been undertaken which included a staffing review. Actions had been taken to mitigate the risks around the layout of the unit and an escalation plan was in place regarding intensive and high dependency care costs. For example, ensuring the layout of the area used the available space in the most effective way. The committee agreed that NICU was thought to be safe and fit for purpose in the interim and mitigating arrangements were in place to manage patient flow, for example the appointment of a dedicated admission nurse provided the unit with the flexibility to respond to neonatal emergencies and provided specialist support.
- On Starfish ward, there were four small rooms for babies in cots. There was a fold out bed for parents to use when staying in the room overnight. These rooms did not provide enough space for the required staff to be able to treat a patient in an emergency. However, there was a large, well equipped resuscitation room in Starfish ward, to which a patient could be quickly taken if necessary. At the time of our inspection there were six pieces of portable equipment awaiting repair which could have impeded access to emergency equipment if needed. We raised this concern with senior staff who took immediate action to rectify the issue.
- On Starfish ward babies' feeds and nutritional supplements were stored in an unsecured milk kitchen. There was a risk that products could be tampered with due to the unsecure method of storage which could pose a potential risk to the safe care of children and young people. We raised this at the time of the inspection with senior staff who took immediate action to rectify the issue.
- There were dedicated children's outpatient facilities at Watford and Hemel Hempstead hospitals. Departments were child friendly and members of the multidisciplinary team such as dieticians and physiotherapists reviewed and treated children. Children's waiting areas were well equipped and were supplied with age appropriate toys, books and game consoles. All children were able to access the trust wide Wi-Fi networks so that they could use social media.
- At our previous inspection in September 2016 we tracked a patient who used the surgical pathway to access operating theatre and recovery areas. Patients were moved from the inpatient wards to the operating theatre along a corridor that was not fit for that purpose. During our inspection we followed a patient to theatre and reviewed the risk assessment as the journey presented a safety risk to children because of the distance from the ward to the operating theatre. Staff carried portable resuscitation equipment and had undertaken appropriate training in paediatric life support. We saw the risk assessment had been reviewed in August 2017 and a health and safety inspection had recently been undertaken.
- In the operating department there was no specialist paediatric theatre or recovery area. Children were treated within the same clinical areas as adults. There was limited segregation and screening throughout the child's stay in the operating department. An area had been screened in recovery area. No complaints or incidents reported about the children's surgical pathway.

Medicines

- There were suitable arrangements in place for the management of medicines which included the safe ordering, prescribing, dispensing, recording, handling and storage of medicines.
- A named pharmacist for the children's service worked Monday to Friday with the ward staff. Out of hours provision was by the on call pharmacist.
- Medicines were stored securely on paediatric wards, the neonatal unit and in children's outpatients. Controlled drugs were stored securely and were in accordance with required legislation.
- A controlled drug (CD) register was used to record the details of CDs received, administered as well as CDs that had been disposed of. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. Stricter legal controls apply to controlled medicines to prevent them being misused, being obtained illegally and causing harm.
- On discharge, nurses would organise any medication children were required to take home. Parents told us it could take several hours for their child to receive their medication. We were told there were often delays receiving medicines from pharmacy. During our inspection the parent of a child on the neonatal unit had been unable to wait for their child's medication. Therefore, the pharmacist had contacted the child's GP to ensure the child received their medication.
- A system had been introduced by the division in June 2016 called a "druggle". This was a weekly safety meeting concerning any medicine issues. For example, reminders about safe prescribing based on age or weight and depending on the medication involved, completion of allergy information and signing of medication records. A nursing "druggle" had recently been implemented which reviewed medication issues each day and was reported at the twice daily handovers.
- Room and fridge temperatures were checked and were within the required temperature range and checks had had been performed consistently in paediatric areas. Staff were aware of what actions to take if the temperature fell out of range.
- Medication records had been completed appropriately in the patient files we reviewed. Each patient had their weight checked and prescriptions were written accordingly. If patients were allergic to any medicines, this was recorded on their prescription chart. We reviewed 12 prescription records and saw that the methods of prescribing and administering medicines to children were safe and were recorded on the medicine administration chart. Patient information was clearly documented, including any allergies and the patient's weight. Medication records showed that antibiotics had been prescribed and administered in accordance with the trust policy on the use of antimicrobials.
- Monthly medication audits were undertaken and reported on as part of the service dashboard. Data was collected on the number of medication incidents and errors and learning applied across the service.

Records

- Records were clear, accurate and legible. We looked at the medical and nursing records of 16 children across inpatient areas including Starfish and Safari wards and the neonatal unit. At our previous inspection in October 2016, some notes by medical staff had gaps between entries. This meant that additional entries could have been made later. When reviewing neonatal records, we saw that doctors had sometimes used the term, "written retrospectively" up to 12 hours after an event. During our inspection we saw medical notes were comprehensive, fully completed and up to date and there were no gaps between entries and were dated and signed.
- Records were stored securely on wards in locked cabinets with security coded locks.

- Nursing assessments were made on admission to hospital and care given was recorded in a timely manner. The assessments were designed based on evidence and guidelines from the Royal College of Nursing Standards for assessing, measuring and monitoring vital signs in infants, children and young people 2013.
- Records detailed GP visits and interactions with health visitors, occupational therapists, children's community nursing, speech and language therapists and physiotherapists.

Safeguarding

- There was a clear structure in place for safeguarding children responsibilities within the trust. The trust safeguarding policies reflected relevant legislation and local requirements for safeguarding children and young people.
- There was a team of safeguarding nurses within the hospital and local safeguarding link nurses for all areas were responsible for identifying children subject to a safeguarding plan. These children would then be alerted to ward staff. The children had an identifying symbol on the ward board and on their records. All of the staff that we spoke with knew who the safeguarding link nurse was and how to contact them.
- The Intercollegiate Document (March 2014) states that: "Any clinician who is responsible for planning or assessing the needs of children who may be vulnerable or at risk of harm, require level three safeguarding training". This included clinicians whether a doctor, nurse or allied health professional. Therefore, level three safeguarding training is the expected level for people caring for and assessing the needs of children and young people.
- The trust had a target of 90% compliance for the completion of safeguarding training levels one to three. The division had a completion rate of 92% for level one safeguarding training, 95% for level two safeguarding training and 96% for level three safeguarding training for all staff groups in the women's and children's division. This meant the division was meeting the trust's compliance target for people caring for and assessing the needs of children and young people.
- There were weekly safeguarding supervision sessions on the paediatric wards and in the neonatal unit for all paediatric nurses and doctors. Staff were required to attend three to four sessions each year which were recorded on their training passports. Ongoing teaching sessions were in place to support level three safeguarding updates. For example, there had been a recent case of fabricated induced illness, where staff had been supported through debriefing and reflection on practice sessions.
- The safeguarding team were able to access the computerised community records of children in their care. Nurses responsible for safeguarding were able to see if any children were subject to a child protection plan. The system gave safeguarding staff 24 hour access to safeguarding information and the children and young people in their care. Children and young people who may have been aggressive or had mental health issues were provided with one to one supervision by a mental health trained nurse from a local mental health care trust or from an agency.

Mandatory training

- Structured induction programmes were in place for new staff and were supported by local induction in the division.
- Staff received mandatory training in safety systems, processes and practices in line with the trust's training programme.
- Mandatory training included safeguarding children and young people and vulnerable adults at level one, equality and diversity, fire training, infection prevention, information governance and record keeping, manual handling and health and safety, sepsis recognition, diagnosis and early management and resuscitation training. In August 2017 the division was meeting the trust target of 85% for all mandatory training modules with an

attendance rate (for all staff groups) of 93%.

- Staff we spoke with told us they had completed their mandatory training, either through e-learning modules or 'face to face' mandatory sessions.
- Staff we spoke with told us their managers monitored staff attendance and ensured staff were meeting their mandatory training requirements.

Assessing and responding to patient risk

- Appropriate systems were in place to assess risk and to recognise and respond to deteriorating children and young people. Comprehensive assessments were completed by nursing and medical staff when assessing a child or young person's suitability for treatment. Patients were assessed in terms of their health, care and individual needs on admission to Starfish ward and in a pre-assessment appointment on Safari ward. Each child or young person had a paediatric risk assessment on admission. This included risk assessments in relation to manual handling, nutrition, pain, pressure ulcer risk and mental health concerns. These were completed in all of the 15 records we reviewed during the inspection.
- If an individual risk was identified, a plan of care was put in place, risks were mitigated and actions taken to provide the additional support that was required. For example, if a child or young person's mental health posed a risk to themselves or anyone else, a registered nurse (mental health) would be arranged to support the child and the staff caring for them.
- The service admitted children with acute mental health and behavioural problems into the acute inpatient area of the children's emergency department in accordance with national guidance from the National Institute of Health and Care Excellence (NICE). A small number of children with more complex needs were admitted to Starfish ward for ongoing assessment. Approximately 12 children a year were required to stay on the ward due to the unavailability of specialist inpatient mental health beds.
- Paediatric wards and the neonatal unit used age appropriate specific observation charts. This included a paediatric early warning (PEWs) score that helped staff to recognise when a patient's condition was deteriorating and when to seek further help and support from medical staff. The staff we spoke with were familiar with the PEW scores and how to use them. At our previous inspection in September 2016, children and young people who showed signs of deterioration were not always escalated to a senior nurse or doctor as recommended by the trust guidelines. During our inspection we found that observations had been completed accurately and legibly with evidence that the care of children and young people were appropriately escalated to either the nurse in charge or the doctor, whoever was indicated.
- The "test your care" team audited compliance with the use of PEW scores completed. We found that in most cases observations were completed accurately and legibly with evidence that the care of children and young people was appropriately escalated to either the nurse in charge or a doctor, whichever was indicated.
- On the wards we saw the service used a pre-operative checklist for all children undergoing surgery incorporating recommendations from the World Health Organisation (WHO) and NICE. In the records we saw the checklist was used in preparation for surgery at ward level.
- WHO surgical safety checklists were used in day theatre. Staff were aware of the checks to be undertaken to ensure consent had been obtained for each child and the correct procedure had been undertaken. When children were moved to the recovery area staff followed discharge criteria to ensure children were safe to return to the ward. Parents were allowed to be with their child once they were awake. A paediatric trained nurse escorted the child to the ward with the parent(s) and a porter. The forms we reviewed had been completed correctly.
- A seriously ill child who required transfer to another hospital would be cared for by suitably

qualified staff until transport could be arranged. This was provided by the special transfer service that operated throughout a network of local hospitals. This included critically ill children, young people and neonates. While awaiting transport, there was a service level agreement which ensured arrangements to care for children were in place.
- A "live" skills simulation exercise was held each month in the neonatal unit using information from incidents and incorporating members of the multidisciplinary team.

Nursing staffing

- At the time of the inspection nurse staffing levels across the service were appropriate to deliver safe care to children and young people. In May 2017, the trust reported a vacancy rate of 22% in children's services compared to the trust target of 9%. In the period June 2016 to May 2017 the service reported a turnover rate of 18% compared to the trust turnover target rate of 12%.
- The trust was aware of the demand, capacity and workload pressures staff faced and where this had the greater impact. Recruitment concerns were recorded on the divisional risk register for children's services and were regularly reviewed.
- Nursing recruitment had continued to be a challenge for the trust particularly for band 6 (senior nurses) on Starfish ward and in the neonatal unit. A focused recruitment programme for band 5 (junior) nurses was in place to provide a "grow your own" concept at Watford hospital. The approach had enabled the trust to enhance current establishments and had allowed progression for band 5 nurses using a quality improvement approach. This had provided independent career development opportunities for the nursing team and had supported link roles within the service and the wider children's network. Five whole time equivalent (WTE) nurses had been recruited from overseas for children's services and had recently taken up post on Starfish ward.
- Service provision and safe staffing standards on the neonatal unit were guided by the British Association of Perinatal Medicine (BAPM) 2010 guidance. However, the recommendations in the tool kit were not always achieved due to the national shortage of neonatal staff. The service mitigated this through the use of bank and agency staff, development of new roles and enhanced training of junior staff. The tool kit was used in conjunction with the neonatal admission and escalation policy that allowed the service to plan safe staffing levels 48 hours ahead of shifts.
- The child or young person to nurse ratio was: one nurse to one intensive care child (ITU), one nurse to two high dependency children (HDU) and one nurse to four special care babies. In response to the unpredictable surges in activity, the service had recently introduced the role of an admission nurse. The nurse managed admissions to the unit and was supernumerary which allowed flexibility to respond to neonatal emergencies in addition to providing specialist support within the existing workload. In May 2017 there was a 78% reported fill rate for the neonatal unit of planned versus actual staff. There was always a band 7 senior sister on duty in all areas and some band 6 junior sisters were being trained to be able to take responsibility for a shift.
- The paediatric nursing establishment was benchmarked against the Royal College of Nursing (RCN) Children's Nursing recommendations. With nurse to patient ratios as; one nurse to two HDU children, one nurse for three children under two years and one nurse for four children over two years old. In May 2017 there was a 90% reported fill rate for Starfish ward of planned versus actual staff. There was always a band 7 senior sister on duty and some band 6 junior sisters were being trained to be able to take responsibility for a shift. All registered nurses on Starfish and Safari wards were children's trained. The ratio of qualified to unqualified staff was above the trust planned ratio of 70% to 30% and was reported as being 80%.
- Senior nurses monitored staffing levels daily in line with trust policy. Staff were used flexibly to achieve this. For example, if the ward was full with HDU beds occupied, the ward would work with other areas such as paediatric outpatients to move staff to the areas

where they were most needed.

- All nurses on the paediatric wards were registered nurses (child branch). All shifts had a member of staff trained to the required level in life support. This was in accordance with the RCN 'Defining Staffing Levels for Children and Young People's Services (2013)' on staffing levels which states "At least one nurse per shift in each clinical area will be trained in Advanced Paediatric Life Support (APLS) / European Paediatric Life Support (EPLS), depending on the service need. We reviewed a sample of 10 whole shifts and identified that all shifts had (at least) one member of staff trained in EPLS and /or APLS.
- The children's service used an in house bank staff provider whenever possible. Agency staff were used when required using agencies known to the trust. A policy was in place for the induction of bank and agency staff.
- Nursing staff handed over the children they were caring for twice a day and printed handover sheets were used to ensure all information was handed over to the next shift. Nurses were allocated children and young people with whom they would care for throughout their shift. We observed a nursing handover on the neonatal unit from the night to day shift and found it to be thorough and organised.

Medical staffing

- Medical staffing was appropriate and there was an effective level of cover to meet children's needs at the time of the inspection. Medical staffing levels and skill mix were planned in advance and were in accordance with relevant guidance to ensure children and young people received safe care and treatment.
- In March 2017, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior staff (foundation year 1-2) was higher than the England average. This meant there were a higher number of the most junior doctors requiring supervision in children's services. Up to June 2017, the consultant establishment in children's services was 25.2 WTE. The vacancy rate was 5.6% and turnover was 58%.
- The Royal College of Paediatrics and Child Health 14-hour consultant review standard was being met. There was a 24 hour, seven day a week consultant led paediatric service in place for children and young people at the trust.
- A recent reconfiguration of the neonatal consultant workforce had resulted in a change in the cover from a one in five rota to a one in four rota. Consultant cover was provided from Monday 08.30am to 6pm Friday with one weekday on call every week and one in five weekends from Friday 5pm to Monday 9am. On call gaps were covered internally as locum and weekday cover was prospective with no backfill. Gaps in the registrar rota required consultants to be resident when on call to provide safe business continuity.
- The paediatric consultants had an on call rota. A consultant was on call for four days of the week, Tuesday to Friday. Saturday to Monday were shared amongst the paediatric consultants who covered Starfish and Safari wards.
- Consultant and junior doctor's' rotas were compliant with the European working time directives. On the wards and the neonatal unit there was consultant cover from 8.30 am to 6pm. At night there was a consultant on call during the week. At weekends consultants provided shared cover with the Children's Emergency Department from 9am on Saturday until 9am on Monday.
- The children's doctors were mostly general paediatricians with special interests in particular conditions. For example, epilepsy, neurology and diabetes. Paediatricians who were not on call and who had a particular special interest would not necessarily have been available for immediate telephone advice for acute problems in their speciality. However, dedicated neonatal and paediatric consultant rotas ensured immediate availability to return to the hospital. This meant that two consultant paediatricians were available quickly. In addition, there were frequent informal contacts between consultants who made themselves

available even when they were not on call. Senior nurses told us they had excellent working relationships with consultant paediatricians who were always able to be contacted even if they were not on call.
- We were advised that several paediatricians were working above their job plans and this was being reviewed by the clinical director for children's services.
- The paediatric oncology service was reported as being understaffed at both consultant and clinical nurse specialist (CNS) level and had been entered onto the divisional risk register. A locum consultant was appointed in August 2017 supported by an additional 0.6 WTE CNS planned to be in post in September 2017.
- Handovers took place twice a day and were led by a paediatrician or neonatologist. We observed a handover and found it to be appropriate, relevant and pertinent information was discussed with appropriate guidance for junior medical staff. Parents on the neonatal unit were encouraged to be present on ward rounds and told us they felt included in the ongoing care of their child.

Major incident awareness and training

- The trust had a major incident plan which was located on the trust intranet and was displayed in areas we visited. Nursing staff demonstrated they were aware of the plan and senior nurses were aware of their specific roles in the event of a major incident. None of the staff we spoke with had been involved in a major incident exercise or had undergone major incident training.
- Service managers and senior staff considered seasonal demands when planning paediatric beds within the trust. For example, additional paediatric consultant cover was planned for the winter months to help reduce waiting times for children and young people attending the paediatric wards and neonatal unit.
- At our previous inspection in September 2016, we were told a plan was being progressed to increase the number of high dependency beds on Starfish ward from two to four. This was partly in response to winter pressures which included an increase in bronchiolitis. (An acute lung condition in babies and young children). During this inspection staff we spoke with told us the plan was continuing to be developed.

Are services for children and young people effective?

Good

We rated effective as good because:

- Patient care and treatment was planned and delivered in line with evidenced-based guidance.
- Children and young people's pain was assessed and managed on an individual basis and was regularly monitored by nursing staff. Children and young people's hydration and nutrition needs were being met.
- The service performed well in a number of national audits including the National Neonatal Audit (2015) and the Epilepsy 12 Audit 2014/15.
- The directorate participated in national and local audit activity. Staff reviewed the outcomes of audits and there was evidence of action plans and changes to practice.
- Staff had the appropriate knowledge, clinical skills and experience to deliver effective care and treatment to children and young people.
- We saw effective multidisciplinary team working that delivered coordinated care to children and young people.
- Staff understood the guidance and legislation relevant to consent and informed decision making with regards to children and young people.

However:

- The information technology system for the paediatric diabetes service was not fit for purpose and required the clinical team to spend extensive periods of time on non - clinical activities.

Evidence-based care and treatment

- Children and young people's care was consistently planned and delivered in line with evidenced-based guidance. The service participated in Baby Friendly (Unicef) and BLISS baby charter initiatives and national audits were used to monitor the effectiveness of the standard of care provided. For example, Epilepsy12 (2014) the National Neonatal Audit (2015) and the national Children's Diabetes Audit (2015/16).
- We saw evidence that staff followed the National Institute of Health and Care Excellence (NICE) guidance. For example, NICE guidance on managing head injury and sepsis in children and young people.
- Policies and procedures were developed in line with national guidance and were on the trust intranet. For example, the British Association of Perinatal Medicine (BAPM) as well as the Royal College of Paediatric and Child Health (RCPCH).
- The division was involved in national and local audit programmes for example, national paediatric epilepsy, diabetes and asthma audits.
- Local audits included the consent to surgery audit, neonatal jaundice, guideline of the heart murmur in neonates and first hour care in neonates. We saw audit findings and recommendations were shared within the division and in the Women's and Children's Services and changes to local practice were made when indicated. For example, in the consent to surgery audit the overall findings showed that compliance was good and there was evidence of good documentation of assessments and information given to children and relatives. Areas for improvement were around staff documenting their job titles (90% compliance) and details around next of kin (90% compliance).
- The neonatal unit was part of the Central Newborn Network. The group agreed guidelines for shared working and developing audit tools to assist consistency of approach and to provide continual improvement of services.

Pain relief

- Pain was assessed and managed on an individual basis and was regularly monitored by nursing staff. We observed nursing staff monitoring the pain levels of children and young people using age appropriate pain tools and observation sheets, recording the information and taking appropriate action to control patients' pain.
- Pain levels were routinely assessed during the completion of patient observations and were recorded on patients Paediatric National Early Warning Score (PEWS) charts. We observed nursing staff asking children and young people if they were in pain and helping them to identify where the pain was and the intensity of the pain by using pictures and diagrams to aid understanding.
- Children's pain was continually assessed using the age appropriate pain tools to review the effectiveness of pain relief and was recorded on the observation record. We reviewed the records of 15 children which supported that pain was routinely monitored and managed in line with best practice.
- We reviewed 16 paediatric medication charts which showed the appropriate prescribing of pain relief. Medical staff prescribed anticipatory pain relief for children and young people following procedures. Staff told us medical staff would prescribe pain relief for parents to take home if required.
- In the latest Care Quality Commission children's survey in 2014 in children aged 0-15

years, the trust scored 8.54 (out of 10) for the question "How well was your child's pain managed during their hospital stay?" This was rated as being about the same as other similar size trusts in England. In the national Picker Children and Young People's Inpatient and Day Case Survey 2016, the trust was rated as performing about the same as other similar size trusts in England for the management of pain.

- There was a trust pain team which provided support and advice to the children and young people's service. There was no dedicated children's pain team.

Nutrition and hydration

- The service recognised the importance of good nutrition and hydration as an essential part of the care of children and young people.
- Staff assessed and documented children and young people's nutritional requirements using a paediatric nutrition and hydration tool.
- Children's nutrition and hydration needs were being met. Menus identified a variety of nutritious meals that took into account the choices made by young people. Parents and children told us they were happy with the choice, variety and quality of the food. However, in the national Picker Children and Young People's Inpatient and Day Case Survey 2016, and reported in June 2017, some children had reported they did not completely like hospital food. Parents had commented they would have liked to have prepared their own food in hospital but were unable to do so. Senior staff told us they had set up a working group which involved parents, children and staff to review the findings from the survey including the issues concerning hospital food.
- Fifteen sets of records we reviewed showed fluid and dietary intake was monitored, recorded and where necessary reviewed. Neonatal feeding plans and feed charts were reviewed, were up to date and clearly documented. These ensured babies, children and young people were receiving age appropriate nutrition and hydration.
- Staff were aware of how to access the dietician service and how to order specialist menu choices such as vegetarian and gluten free meals.
- The neonatal unit was working towards the Unicef Baby Friendly Awards status which championed evidence based practice to promote and support breast-feeding. This meant that staff were able to support mothers to recognise the importance of breast feeding. For example, giving advice on milk supply, initiating lactation, pumping, transition to responsive feeding and other breast feeding issues.
- In the National Neonatal Audit 2015, 74% of babies born under 33 weeks at the trust were receiving mother's milk, either exclusively or as part of their feed at time of discharge from the unit compared to the national average of 58%.

Patient outcomes

- Outcomes of care for children and young people were monitored in line with national requirements. Intended outcomes varied and most were better than the national average.
- The National Diabetes Audit 2015/16 showed the trust performed at or around the national average in the majority of performance indicators. The trust performed better in five of the seven key care processes recommended by NICE. These included patients having their blood pressure, eyes and feet examined. The trust had developed an action plan in response to the audit; from April 2017 every child was allocated an annual review appointment to look at co morbidity and a blood form was sent prior to their appointment to check their thyroid function and other blood parameters.
- Acute attacks of asthma are amongst the most common medical reasons for hospital admissions in children in England. Between March 2016 and February 2017 the trust performed better than the England average for the percentage of patients aged one to 17 years old who had multiple readmissions due to asthma. The National Paediatric Asthma

Audit 2016 showed the trust had performed at or around the national average in the majority of performance indicators. The trust had developed an action plan in response to the audit; a 'wheeze' action plan was implemented to compliment the quality improvement strategy for the treatment of children attending the children's emergency department for the treatment of asthma and pre-school wheeze. An accompanying leaflet giving easy to understand guidance ensured children and carers were able to identify and receive appropriate first line rescue care.

- Epilepsy affects around one in 200 children and young people in England aged 18 and under. Between March 2016 and February 2017 the trust performed better than the England average for the percentage of patients aged one to 17 years old who had multiple readmissions for epilepsy. Following the Epilepsy 12 Childhood Epilepsy Audit in 2014/15 the trust had made changes to the service. An additional clinic had been implemented to allow more children to be seen and the trust was no longer an outlier for multiple readmissions. A business case had been developed to employ an epilepsy nurse. Doctors had been made aware through training that unnecessary electroencephalograms (EEGs) should be avoided and always discussed with a consultant first.
- The trust took part in the National Neonatal Audit 2015. The trust performed above the national average in the following areas:
    - Screening of babies at risk of eye disease affecting prematurely born babies. Data showed 100% of babies underwent screening (ROP) against the England average of 98%.
    - Documented consultations with parents in the neonatal unit within 24 hours of admission. Data showed 90% of consultations had taken place compared to the national average of 88%.
    - Rates of normal survival at two years of age compared to babies in similar neonatal units. Data showed 79% of babies had attended their two-year health assessments at the trust compared to the national average of other units of 62%.

Competent staff

- Staff had the appropriate clinical skills, knowledge and experience for their roles and responsibilities within the clinical area in which they worked. The service had processes in place to identify training needs and compliance, which ensured staff were confident and competent to undertake their roles.
- The trust was a teaching hospital and therefore the trainee doctors within the service were supported locally and at the university by the tutors. Training was overseen by the regional deanery.
- Practice development nurses supported staff in the children's division through the provision of individual and group teaching sessions and competency based clinical assessments. A rolling programme of block study days helped facilitate staff release in the neonatal unit. For example, level three safeguarding updates, airway management, intravenous drug calculations and syringe pump updates, paediatric diabetes, oncology and asthma updates.
- All nurses in the neonatal unit had either completed or were attending a post graduate neonatal training course which ensured the trust was meeting the British Association of Perinatal Medicine (BAPM) standard. Nursery nurses on the unit undertook the first module of the course to support their professional development.
- Student nurses undertook clinical placements in children's services and mentorship arrangements were clearly displayed in ward offices.
- Staff attended trust staff induction and a local induction programme on joining the trust. Trust induction covered such topics as trust values, information governance, and clinical skills training such as basic life support and fire safety.
- Staff we spoke with had all received an appraisal. Staff appraisal rates in the children's division for the period February to April 2017 were 76%. This was below the trust appraisal

target of 95%. Following actions taken by the senior team to address outstanding appraisals we saw improvements had been made. In August 2017, 93% of appraisal had been completed and plans were in place to complete outstanding appraisals.

- Nurses were supported with the revalidation process. Revalidation was introduced by the Nursing and Midwifery Council (NMC) IN 2016 and is the process all nurses and midwives must follow every three years to maintain their registration.
- There was a process in place to ensure all medical and nursing professionals had their registration status checked. We saw that the trust monitored that this was happening.
- Children's services published a monthly newsletter on Paediatric Essential Learning which summarised news, events and information from across children's services to help promote good practice and learning from events. For example, feedback from the "druggle", the drug-focused safety huddle, the trialling of a new paediatric drug chart and the new forum for the parents of children with complex needs and feedback from parents and children who had used the service.

Multidisciplinary working

- All appropriate members of the multidisciplinary team in children's services were involved with assessing, planning, and implementing patient care. Multidisciplinary teams involved paediatricians, nurses, physiotherapists, neonatologists, speech and language therapists (SALT), dieticians and play specialists. There was a cohesive and thorough approach to assessing the needs of children and young people which involved setting individual goals and providing child-centred care.
- Nurses worked alongside therapists and specialist children's nursing services for example diabetes and oncology to provide a multidisciplinary approach. We saw evidence of this in the patients' records we reviewed. All staff we spoke with described good collaborative working practices.
- Liaison psychiatry was practiced as defined by the Royal College of Psychiatrists. This was a monthly joint clinical and psychiatric clinic. It was held so that children with conditions such as chronic fatigue were reviewed and managed using a multidisciplinary approach. This was a unique service offered by the children's and young people's service in Watford. When children or young people needed more than one specialist service or consultant, their care was coordinated on an individual basis with consultants and other multidisciplinary team members liaising as required.
- Other children with a diagnosis requiring input from mental health were seen and initially assessed by the community children's assessment team and were then managed by the local child and adolescent mental health service (CAMHS) within Hertfordshire.
- A termly multidisciplinary meeting also took place with colleagues from education, health, physiotherapy and psychiatry to discuss children requiring a multidisciplinary approach to their health needs in relation to school nonattendance.
- There was no policy for transition of children and young people to adult services. However, senior leaders of the service told us that when a patient moved between the children's and adult services the process was discussed up to two years before the transition was made. There was liaison with the relevant specialities as required which was usually through children's outpatient services. For example, diabetes, neurology, cystic fibrosis and respiratory services. The gastroenterology nurse specialist held joint clinics for young people over 16 years of age. Improvement of transitional support for young people moving into adult services was documented in the trusts clinical strategy 2016-2020 under their "Lifetime of Care" pathway.
- Collaborative working arrangements between the neonatal unit and the maternity service supported the safer care of full-term babies. For example, neonatal jaundice, hypothermia, hypoglycaemia and suspected sepsis. Multidisciplinary team meetings were held in relation to the palliation of babies at the trust.

- When a child was discharged from the hospital, a letter was sent to the patient's GP providing details of any completed or ongoing treatment required and of future appointments.

Seven-day services

- There was seven day access to diagnostic services such as x-ray, ultrasound, computerised tomography, magnetic resonance imaging, echocardiography, endoscopy and pathology.
- Children and young people had access to an on call physiotherapist at weekends.
- Mental health services were available at weekends.
- The out of hours on call service for pharmacy was provided by the pharmacy service, not necessarily a specialist pharmacist.
- Play specialists provided a five day service and supported children and young people across the division. This was entered on the divisional risk register as the service recognised the risk to children and young people of being unable to provide a seven day service, particularly in emergency situations.

Access to information

- Staff had access to the information needed to deliver effective care and treatment in a timely manner most of the time. This included care and risk assessments, care plans, case notes and test results. The record system included a flag to alert staff to children and young people with a confirmed diagnosis of a learning disability, autism and a visual impairment.
- However, the trust continued to experience slow progress on the information technology transformation programme and the impact of managing cyber-security issues. This was an issue for the paediatric diabetes service whose information technology (IT) system was not fit for purpose. For example, members of the clinical team were required to spend extensive periods of time on non - clinical activities as the data fields did not match the mandatory fields for inputting data for the National Diabetes Audit and completion of the Best Practice Tariff. There was a significant risk that some clinical data would be missed that could be used to calculate medication doses or in assessing the general stability of children and young people with diabetes.
- Children's services had recorded the risk on the divisional risk register and had taken steps to mitigate the risks to patient's and the service. For example, sourcing an alternative IT provider and working with the IT team around providing ongoing support to the clinical team.
- The community information system was able to provide up to date and multidisciplinary records between the hospital and community services. This allowed the safeguarding team to make full assessments of children who may have been at risk, as well as liaise with health and social care professionals as required.

Consent

- Staff we spoke with had a good understanding of gaining consent from children and young people and the guidance around this with regard to capacity to consent, including Gillick competency. Gillick competency is used to help decide whether a child or young person was mature enough to make their own decisions and helps to balance their rights and wishes with the hospital's responsibility to keep children and young people safe from harm. Gillick competency is concerned with determining a child or young person's capacity to consent.
- The trust's consent to treatment policy described how young people under the age of 16 years might be considered to be Gillick competent to consent to treatment. This meant that

children who have sufficient understanding to enable them to understand fully what was involved in a proposed intervention would have the capacity to consent to the intervention.

- The service did not provide beds for young people between the ages of 16 and 18 years. However, the trust treated 16-18 year olds in adult wards and departments.
- We saw all grades of staff seeking appropriate consent from patients and relatives (where required) before undertaking any intervention.
- Nursing staff gained verbal consent before undertaking interventions such as taking clinical observations or giving medication. Where children and young people were unsure about a procedure, the play specialist supported them to make an informed decision.
- Staff understood the Mental Capacity Act 2005 and explained how they would assess children and young people's mental capacity and a decision would be made in their best interest and recorded in their notes.

Are services for children and young people caring?

Good

We rated caring as good because:

- There was a strong child centred culture that recognised children as individuals and respected their needs and choices. Staff worked in partnership with children and their families and involved them in their child's care.
- Staff were very friendly, professional, compassionate and helpful to children and young people in all the interactions we observed.
- All relatives and carers we spoke with said their child or young person was cared for by staff that were kind, compassionate and ensured their privacy and dignity needs were being met. Feedback from families and children was continually positive about the way staff treated them.
- We observed children were truly respected and valued as individuals and encouraged to self-care and were supported to achieve their potential within the limitations of their clinical condition.
- Parents said staff went the 'extra mile' and the care and support they received exceeded their expectations.

However:

- Results of the Picker national inpatient survey for children's services were significantly worse for six questions than other trusts in England.

Compassionate care

- Staff were very friendly, professional, compassionate and helpful to patients in all the interactions we observed.
- Parents/ carers we spoke with told us they were very happy with the care and support they received throughout the children's service. A parent said "staff were always very kind to their child and spent as much time as was needed to explain what was going to happen to them". Another parent said; "My child has recently been diagnosed with a long term clinical condition and has lots of questions for the doctors and nurses. No matter how many questions my child asks staff always find the time to answer and asked my child to write down any further questions they had". We observed the patient had been given a wipe off sheet so she could keep adding her questions to the list and wipe them off when the question had been answered.
- During our inspection we saw excellent interactions between staff, children and young

people and their parents/carers. Staff we spoke with told us how important it was to recruit the right staff to children's services and actively sought the opinion of children and young people on the paediatric wards. Two children had been part of the recent recruitment of nurses to Starfish ward. They were asked about their views on the candidates and had been confident about expressing their opinions which were taken into account by staff on the interview panel.

- In the neonatal unit parents told us how caring and compassionate and insightful staff were. Parents had often been on the unit for several weeks and had built close and trusting relationships with members of the care team. Parents told us how their children had been transferred from other hospitals and although they had been very anxious at the time staff had been overwhelmingly kind and supportive at a very challenging and difficult time. The parents had been able to use a family room on the unit which had helped them to bond with their child and given them an opportunity to share the experience with their family.
- Inpatient services for children regularly scored above the England average in the NHS Friends and Family Test. This is a method used to gauge people's perceptions of the care they received and how likely patients would be to recommend the services to family and friends. In the period February 2016 to April 2017, 98% of respondents said they would recommend Starfish ward and the neonatal unit, compared to the national average of 95%. However, response rates varied between 6% and 12% and inpatient children's services were performing below the national response rate of 25% which indicates the sample was not representative.
- Staff acknowledged the response rate was low and were actively encouraging children and young people and families to leave feedback. Staff also utilised other methods of collecting feedback about the services. Suggestion boxes were displayed in areas we visited and a weekly patient forum had been established on Starfish ward. Parents were encouraged to attend the ward rounds on Starfish ward and the neonatal the unit.
- The Picker survey is a national children's inpatient and day case survey which measures people's experience with care. In the June 2016 survey, the trust had performed about the same as other trusts in England for 31 questions, had worsened significantly on four questions (from the 2014) and was performing below the average of other trusts on six questions. For example:,
    - parents not kept fully informed when their child was in hospital,
    - children did not completely like the hospital food
    - staff not fully explaining how the operation or procedure had gone.
- Senior staff told us they were working with Picker to better understand their results and had established a working group which involved parents, children, young people and staff to ensure any changes undertaken were implemented successfully.

Understanding and involvement of patients and those close to them

- Children, young people and parents we spoke with told us communication had been very good with all members of the care team. Parents told us they were listened to and their views and opinions were always considered when their child's care was being reviewed.
- We saw how staff explained things to parents, children and young people. For example, we saw a play specialist explaining a procedure to a child and their parent. We saw how this reassured the child and the parent. We observed a clinical intervention on a child. We saw how the parent and child were prepared for the procedure by a nurse who used age appropriate communication and praised the child following the procedure.
- Staff used a wide range of information that was available on the paediatric wards, in the neonatal unit and in the children's outpatient department. These added to the verbal explanations children and their parents had been were given.
- Parents we spoke with on Starfish and Safari told us they were kept well informed about the care of their child and could tell us what was going to happen to them. Older children

were involved in the planning of their care and were able to choose to speak to clinicians on their own if they did not want their parents to be present.
- All parents we spoke with told us they felt involved in the care of their child and staff went out of their way to ensure they were involved in any changes to their child's care and treatment.

Emotional support

- Staff were able to build relationships very quickly with children, young people, parents and their families. We saw evidence of this in all the areas we visited. For example, in pre assessment clinics and day surgery where staff were able to support the child and parent and ensure they understood what was going to happen to them and procedures were explained in a way that the child or young person could understand.
- Starfish ward received a high level of support from a carer support team who provided practical and emotional support to parents and carers. The service was highly rated by parents/carers who told us the service was "invaluable" particularly for children with complex and long term conditions who attended the hospital regularly. The team had recently expanded and was now able to provide support to families in the Children's Emergency Department.
- Starfish and Safari wards were working with youth connection Hertfordshire on a pilot project where young people were providing peer support and sign posting to improve emotional support for children and young people attending children's emergency departments.
- Play specialists were familiar with children who had complex needs who attended the ward regularly. Each child had a pictorial 'This is me" developed in partnership with the child and their parents to support their care in hospital. For example, their likes and dislikes were recorded and how the child communicated when they were happy or in pain.
- Children and young people who were experiencing mental or emotional distress had access to a child psychologist. There was information for parents which had been developed in partnership with the Children and Adolescent Mental Health Services (CAMHS) at the hospital.
- Staff we spoke with told us they had received specialist training on how to care for children and young people with mental health conditions which had been developed with support from CAMHS.
- Parents with babies on the neonatal unit were provided with information about Bliss, an organisation to support parents of children born prematurely from staff on the unit.
- Starfish ward had a 'bereavement box' for families who had suffered a loss. This contained trinket boxes that play specialists had decorated for families to keep children's keepsakes in and a kit for taking hand and footprints. There was guidance for staff on caring for bereaved families which included information on bereavement support organisations from a variety of religions and beliefs.

Are services for children and young people responsive?

Good

We rated responsive as good because:

- Services were planned and delivered to meet the needs of individual children and young people their parents and families and the local community.
- The majority of outpatient services were provided to children and young people in designated outpatient departments.
- At our previous inspection there had been a high number of cancellations of outpatient appointments for children and young people. The service had reduced the cancellation

rates for appointments less than six weeks and there was an improving picture for cancellations over six weeks.
- The service had developed strong partnership working with tertiary services where specialist or intensive care services were required.
- There were facilities to engage and support children and young people admitted to the paediatric wards.
- Parents and children were complimentary about the play specialists who provided support to children and families.
- There were facilities in place to support children and young people with learning and physical disabilities.
- Translation services were provided to people who were unable to speak English.
- Patients and their parents were supported to make complaints.

However:

- Complaint themes were mainly around staff attitude and the service was taking action to address this.
- The children's services took an average of 47 days to investigate and close complaints compared to the trust standard of 25 days.

Service planning and delivery to meet the needs of local people

- Services were planned to meet the needs of individual children and young people in acute and community settings. Effective relationships had been established with commissioners, GPs education, mental health services, local authorities, charities other NHS trusts and people who used services to reflect the needs of the local community.
- In the trusts Clinical Strategy for 2016-2020, there were plans to deliver children and young people's services more locally in community hubs and strengthen the child and young people's mental health liaison service in partnership with community services and commissioners.
- Strong links were in place with the local community trust that was responsible for children's community services. Where children and young people required on going care in the community this was easily arranged.
- The service had developed strong partnership working with tertiary services where specialist or intensive care was required. For example, cardiology, neurology and urology services.
- Robust arrangements were in place with paediatric wards and high dependency units across neighbouring counties as part of the regional transfer network. Critically ill children in the high dependency unit and those requiring intensive care and specialist intensive care required transfer to a regional intensive care unit. All children aged 16 years and under were cared for on paediatric wards. Wards had been adapted to meet the needs of children and young people and there were dedicated facilities for teenagers. There were facilities for parents to stay overnight and parents were able to access eating and drinking facilities.
- The neonatal unit provided care for new-born babies who required specialist high dependency care or intensive care nursing. The unit was part of the Central Newborn Network and was designated a level two unit. This meant it was able to provide intensive care for babies of 27 weeks' gestation or above. Babies over 34 weeks were only admitted to the unit if they required specialist care. Appropriate policies and procedures were in place to aid transfer and retrieval to ensure services were meeting the needs of children and babies.
- Children's outpatient appointments were held mainly in dedicated paediatric facilities at Watford and Hemel Hempstead Hospitals. Departments were child friendly and age appropriate play areas were in place for children and young people and were well supplied

with toys and games. There was access to a play specialist if required.

Access and flow

- In the period from April 2016 to March 2017 there were 5,509 admissions to children's services at the trust. Emergency activity accounted for 70%, day case activity accounted for 20% and the remaining 10% were elective admissions. This was a decrease of 7% on the previous reporting period (February 2015 to January 2016). This placed the trust in the third largest quintile (activity levels) for similar trusts in England.
- The most common diagnosis groups for emergency admissions for children under one year were: acute bronchitis, other perinatal conditions, haemolytic jaundice and perinatal jaundice, viral infection and intestinal infection.
- For children and young people aged 1-17 years, the most common diagnosis groups for emergency admissions were: viral infection, acute bronchitis, abdominal pain, asthma and intestinal infection.
- In the period June 2016 to May 2017, the trust had seen neonatal bed occupancy peak above 75% once in the 12 month period, and had spent 11 of the 12 months below the England average.
- The number of admissions to the neonatal unit in the period April 2016 to March 2017 was 755. The neonatal unit had not closed in the period April 2016 to March 2017.
- The number of full-term babies admitted to the unit had increased from 376 in the period April 2015 to March 2016, to 410 in the period April 2016 to March 2017. The neonatal unit and midwifery services had developed a strategy to support the safer care of full-term babies which was currently in the data collection and analysis stage of the project.
- The neonatal service was part of the regional network. There were daily monitoring systems within the network to continually assess where cots were available.
- Children's services provided consultant led care to children locally. These included diabetes, respiratory, cardiology and epilepsy. There was a level two oncology service for children and young people. If children required more specialist treatment support agreements were in place with more specialist tertiary units.
- In England, under the NHS Constitution, patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'. Referral to treatment time (RTT) for admitted pathways are the waiting times for patients whose treatment started during the month as an inpatient or day case. The waiting time starts from the point the hospital or service receives a referral. The date shows how long a patient has waited before their treatment began.
- Children and young people's RTT waiting times for incomplete pathways in the reporting period (February to April 2017) performed consistently above the trust target of 92%. This meant that the majority of children and young people had waited no more than the 18 week waiting time target from referral to treatment. Parents told us they often waited between eight and 10 weeks, particularly for allergy clinics.
- At our previous inspection in September 2016, an average of 16% of outpatient appointments were cancelled for the service each month. The division were continuing to address the cancellation of outpatient appointments of less than six weeks and performance was improving. Performance in April 2017 was 3.8% compared to the trust target of 3% and was being monitored through the introduction of new service indicators.
- The service was focussing on the cancellation rate for appointments above six weeks. The trust target was 8% and the year to date position was 10.1%. This was being monitored by the division and new service indicators were in place as there had been an increase in the number of patient initiated cancellations to 14.6%. The service was planning to undertake a detailed review of the cancellation rates now the paediatric cancellation rate (under six weeks) was reducing month on month.

- We were told the outpatient data base recorded a changed appointment as a cancellation. This gave a false impression of the number of cancelled appointments. The majority of changes were due to appointment times being changed to accommodate the needs of patients and families and to manage the changes in doctor's rotas due to staff shortages to ensure clinics were covered and not cancelled. Clinical directors in children's services were responsible for agreeing each doctor's study and annual leave and the importance of ensuring children's clinics were not cancelled.
- Children and young people requiring a planned admission were referred by their GP or by the children's emergency department (CED) or by the most suitable consultant who would see the patient in the outpatients department. There was a link consultant for local GP practices and GPs had access to the hospital's electronic patient record system.
- Patients attended Safari ward for a pre-assessment appointment prior to their elective admission. Routine observations were undertaken and the procedure/operation was explained to the child or young person (where appropriate) with the support of the play specialist and using age appropriate information. Children and young people requiring an unplanned admission were seen in the CED by a paediatric doctor and would be transferred to Starfish ward or the neonatal unit if less than one month old.
- An electronic referral pathway had improved the care for infants with prolonged neonatal jaundice. The pathway had been developed in partnership with GPs, health visitors, community midwives and local commissioners. This had resulted in a reduction in the referral to appointment time (under 48 hours) and the overall time for parents to receive their child's results was two weeks from referral.
- Discharge planning processes included both out of hours and nurse led discharge. Parents told us they were kept informed throughout the discharge process. A multidisciplinary approach to discharge was in place and children and young people would only be discharged when all services (as required) were in place.
- Children and young people with a mental health illness who required treatment for a clinical condition were able to access a mental health professional 24 hours a day, seven days a week. Children requiring care from a specialist mental health nurse (whilst on the ward) was arranged through the local mental health trust or an agency. There was joint working between the services for children and young people and the child and adolescence's mental health services that were based on the hospital site.

Meeting people's individual needs

- Staff on the paediatric wards and in the neonatal welcomed the involvement of parents and carers and visiting times were not restricted. Other visitors were able to visit at times agreed with the paediatric wards and the neonatal unit. Siblings were encouraged to visit but needed to be supervised. Parents told us they were happy with the visiting arrangements and knew they could talk to staff to arrange a time for families to visit.
- Parents on the neonatal unit were actively involved with the care of their child and an integrated model of care was in place. For example, close involvement of families, bonding with babies (skin to skin kangaroo care) breast feeding support and parenting classes.
- The neonatal service had reorganised and redeveloped their neonatal outreach service to support parents when their child was discharged from the unit. The service was working towards streamlining the neonatal chronic lung disease and home oxygen discharge planning arrangements and follow up care pathways to improve the service to patients.
- Age appropriate facilities and toys were in place on the paediatric wards and there was a high visibility from the play specialists who supported children and young people both in the children's division and within the trust. For example, accompanying children to theatre and supporting play in the children's outpatient department. There was a school and activity room and designated room for young people on Starfish ward. All areas had toys and books and sensory equipment for children and young people of all ages.

- Children's services were planned to take into account the individual needs of children and young people. Patients with complex needs were supported by staff to access hospital facilities. For example, access to consulting rooms for children in a wheelchair in the children's outpatient department.
- Parents of children and young people with complex needs such as learning disabilities attended a user group which had been developed in response to patient feedback. Following the first meeting, the ward was developing plans to improve the access to a bathroom on the ward for children with a disability. Individual rooms were available for children who required a quieter environment due to individual special needs and they were supported through the provision of sensory and diversional therapies.
- Parents of children or young people requiring palliative care or end of life care were supported by staff to identify how they wanted the care of their child or young person to be managed. The service worked closely with a local hospice and community nurses were available to support the care of children at home. There was no dedicated end of life care nurse for children's services.
- Children and young people who were looked after in local authority care, were flagged in their notes and by a symbol on the ward status board.
- When referrals were required for any specialist services outside of the acute setting, a referral was made to the specific team and discharge planning meetings would invite a service representative to attend to ensure all aspects of care were discussed and appropriate plans were agreed.
- Children, young people parents and carers were provided with information in written and verbal form at the time of discharge with relevant instructions for the use of medication and future appointments. A range of patient information leaflets was made available to them. Languages covered were English, Urdu and Polish and additional languages could be provided as required. Information leaflets were displayed throughout children's services and were regularly reviewed and updated.
- The trust had access to translation services for children and young people and their families who did not have English as their first language. Staff we spoke with told us they knew how to access the service. The service was available through the patient advice and liaison service (PALS) during normal office hours and could be contacted directly, by staff, out of hours.

Learning from complaints and concerns

- There were processes in place for responding to complaints and information was available to make children, young people and relatives aware of how to complain. Leaflets informing patients how to make a complaint or how to contact the patient advice and liaison service (PALS) were available in the paediatric wards, the neonatal unit and in children's outpatient services.
- Parents told us they knew how to make a complaint and if they had any concerns about their child's care would discuss it with the nurse in charge. There had been no complaints received from the children themselves.
- We were told that most complaints were resolved and responded to immediately and were mostly due to communication issues from medical and nursing staff.
- In the period between May 2016 and June 2017 there were15 complaints about children's services. None of the complaints had been escalated to the health service ombudsman. The trust took an average of 47 days to investigate and close complaints. This was not in line with the trusts complaints policy which states that complaints should be responded to and closed within 25 days.
- Of the 15 complaints we reviewed all had been promptly investigated in a timely way. Children and young people and their carers were involved in the process if they said they wanted to be, and apologies were given in a timely way. The main themes were staff

attitude, changes to outpatient's appointments communication across the care team and delays in discharge medication.
- The lead nurse and matron monitored the complaints which were also recorded on the monthly divisional performance report and discussed at governance and safety meetings, team meetings and nursing handovers. Lessons learnt were shared with staff on an individual and team basis as appropriate and displayed in ward offices for staff to read and sign that they had read them.

Are services for children and young people well-led?

Good

We rated well-led as good because:

- At our previous inspection in September 2016, there had been a significant division of staff concerning opinion and practice in the neonatal unit. Following a thematic review and implementation of the recommendations there was evidence of good local leadership from clinicians and managers and consultants in the neonatal unit were working well together.
- There was clear and visible leadership from the divisional clinical lead, the clinical lead, the lead nurse and matrons and managers who were approachable and fully engaged in providing child centred high quality care.
- The trust had a clear statement of vision and values which was recognised by staff and were starting to be integrated into the services we visited.
- There was a clear governance structure throughout the service that supported the organisation in the delivery of the vision and values and the delivery of high quality care. Governance and risk management arrangements were in place supported by risk registers which had actions in place to manage risks.
- There was an internal audit programme aimed at improving patient care and treatment and outcomes. Audit and data were used to inform practice and change within the service.
- Services were well-led and there was evidence of effective communication within ward and department teams.
- Staff felt well supported and were able to speak up if they had concerns. Staff were positive about the changes in the leadership of the service and felt they were valued and listened to by managers at all levels of the service.
- Staff in the women and children's service scored above the trust average in the local trust surveys used to measure the level of staff engagement at the trust and within their service.
- Staff were proud to work at the trust and were passionate about delivering a child centred service to children and young people.
- The service captured views of people who used the service to inform change and improvements.
- The directorate was continually developing children and young people's services to allow innovation, improvement and sustainability of services.

However:

- Children's services were incorporated into the trust clinical strategy 2015-2020 and the children's services strategy. However, not all staff in the service were clear about the longer term development of children's services at the trust.
- Although efforts were being made by the service to engage patients and carers in feedback and forums about the service response rates around the Friends and Family

Test were consistently low.
- We were not assured that all relevant people attended or received minutes from mortality and morbidity meetings.

Leadership of service

- At our previous inspection in September 2016, service leaders had expressed concerns about the relationships between the consultants on the neonatal ward. This had been confirmed by some junior doctors who told us the conflicting opinions, different styles of management and changes in children and young people's care plans could have had a detrimental impact on patient outcomes.
- During our inspection we found the service had made a series of changes to address the concerns. For example, changes to the leadership structure had been implemented and were evaluated by staff as being 'positive,' in a temperature check questionnaire undertaken in June 2017. A team building programme had commenced (June 2017) which involved all staff groups and was planned to be completed by September 2017. An open culture had been promoted and conversations with staff around expected behaviours and standards had taken place.
- Staff on the neonatal unit told us they had experienced a period of significant organisational change which was still ongoing. However, the neonatal unit was now a better place to work and the high quality care of babies was everyone's priority. Staff told us they felt supported by their managers and felt able to approach them with any concerns or comments they might have. There was strong local and service leadership and staff spoke positively about their ward leaders and managers. Staff could explain the leadership structure within their ward and the neonatal unit and were aware of who the board members and senior team were.
- The lead nurse and matron in the service provided strong and consistent leadership through the sharing of best practice, service developments and learning from incidents and complaints and patient feedback and about children and young people's services. There was a designated children's lead reporting to the board.
- Staff meetings were held monthly to share the learning from incidents, complaints and compliments and where specific actions were required these were fed back at twice daily handovers and recorded on printed handover sheets. For example, documenting on children and young people's care records.

Vision and strategy for this service

- The trust had a clear vision, values and aims which focused on providing "the very best care for every patient, every day'. The trust aims were to deliver the best quality care for patients, to be a great place to work and learn, to improve financial sustainability and to develop a strategy for the future. The trust values were commitment, care and quality.
- The shared vision for children and young people's services mirrored the aims and objectives of the trust and focused on effective team working, robust governance processes performance and service improvements. For example, open communication and valuing staff, a clear governance structure and being open and transparent, being in the top percentile in neonatal services and clinic utilisation and developing the nurse specialist service and improving the environment for children in theatre.
- However, not all staff we spoke with were clear about the longer term development of children's services and were concerned about the constraints the clinical environment placed on service delivery, particularly in relation to the lack of space in the neonatal unit.

Governance, risk management and quality measurement

- The service had an effective governance structure and risk management framework to support the delivery of good quality care. Monthly children's services governance meetings fed into the women's and children's divisional meetings which reported to the trust governance group. We reviewed three sets of children's services divisional governance minutes which showed incidents, risks, audits, safety and quality improvements, clinical effectiveness and patient experience were discussed. Action points were clearly shown.
- The governance framework in children's services ensured the responsibilities were clear and quality, performance and risks were understood and managed. Staff were clear about their roles in relation to governance and their accountability.
- At our previous inspection in September 2016, some of the governance meetings such as the mortality and morbidity meetings had been cancelled and some junior doctors had not always received minutes of meetings they had been unable to attend. During this inspection staff we spoke with told us they were not aware of any meeting being cancelled and received minutes of meetings they had been unable to attend.
- The division had an effective risk register, which identified each risk with a description of the mitigation and assurances in place and a nominated risk owner. There were 19 risks identified on the risk register. These included areas such as consultants working over their job plans, staffing levels in the neonatal unit and the communication and working relationships within the consultant team in the neonatal unit.
- At our previous inspection in September 2016 not all risks in children's services had been entered onto the risk register. During this inspection we identified there was a process in place for identifying, recording and managing risks, issues and mitigating actions which were regularly reviewed. All risks in the service had been entered onto the risk register.
- Children's services were monitored through a monthly integrated performance report for women's and children's services. In the April 2017 performance report, paediatric services were rated as green for safety performance indicators. For example, falls, pressure ulcers and hand hygiene audits. This meant expected standards had been met. However, paediatric services were rated as red for process. For example, the Friends and Family Test response rates were between 9% and 15% against the national standard of 25%. The number of nursing shifts over eight hours long varied between seven on Safari and Starfish wards and 42 on the neonatal unit. Overall agency/bank fill rates on the neonatal unit were 78% and 90% on Starfish against the trust standard of 95%. This meant the expected standards were not being met. We saw in the minutes of the May 2017 governance and safety meetings where areas of non-compliance had been discussed and actions to address shortfalls put in place.

Culture within the service

- During our previous inspection in September 2016, the culture, particularly in the neonatal unit had some significant challenges. We were told there was a significant division of staff within the neonatal unit which some staff felt may have had an impact on patient care. An external thematic review of the neonatal unit had been undertaken and recommendations to improve the culture and behaviours in the unit were being implemented. For example, the promotion of an open culture to ensure staff felt safe in raising concerns and reporting of incidents, team meetings with each staff group to provide reassurance around the proposed team building activities and conversations with staff around the expected behaviours and standards required within children's services.
- Throughout the inspection we observed a strong child centred culture was in place across children's services and staff we spoke with told us they were encouraged to speak up when they had concerns. We observed good working relationships across the service. It was evident morale was good on Starfish and Safari wards and was improving on the neonatal unit. All staff we spoke with felt respected and valued and told us they were proud to work in the service how they would always go the 'extra mile' when supporting children

and families.

- During our previous inspection in September 2016, staff told us that they did not feel supported when things went wrong and were reluctant to report incidents as they felt they would be blamed and this had affected staff morale. During our inspection staff told us there were good working relationships amongst their peers and other disciplines. Staff at all levels told us there was good team working throughout the service. All staff we spoke with told us they were encouraged to report incidents and felt confident in doing so. Staff were aware of the importance of sharing information with patients and families when an incident had occurred which involved them.

Public engagement

- The trust recognised the importance of gaining the views of children, young people, parents and the public and used a variety of approaches to gather information and feedback to enable services to improve. For example, surveys, questionnaires and suggestion boxes. Children on Starfish ward were encouraged to use post it notes on a "did we sink or swim?" board to provide feedback on their care. Comments from children and young people were all positive For example, "the morning staff were very caring" and "the play specialist was fun and very helpful".
- Starfish ward were working with the cancer charity Be Child Cancer Aware to bring the Beads of Courage initiative to the ward The charity worked with organisations to raise awareness of childhood cancer and supports families of children and younger people with cancer. The Beads of Courage is a unique scheme which gives every child the courage they need to undergo their treatment. Each bead represents a personal achievement by the child and their family and helps to give them coping strategies and make sense of their experience.
- The neonatal ward worked closely with the Baby life support systems (Bliss) the leading UK charity for babies born either prematurely or sick and aims to provide the best care through the provision of information and support to families, influencing policy and practice and enabling life-changing research. The unit were working towards the Bliss baby charter which is an accredited framework to assess neonatal unit's ability to deliver family friendly care.

Staff engagement

- Staff we spoke with at all levels felt informed about their own areas and the trust. Staff had attended open forums with the chief executive and managers and spoke positively about engagement with patients and staff. Staff told us they were consulted about the development of new services and the expansion of the hospital site.
- Senior managers said they were well supported and there was effective communication with the executive team.
- The trust had developed a number of engagement measures made up of 11 engagement questions for staff to be used on a quarterly basis. The aim being to support the staff survey and provide additional data which enables the trust to identify an engagement score for each question which can be provided for each division and can be used to track progress.
- Staff in the woman and children's service (WCS) participating in the local staff surveys scored 4.11 (out of 5) for "I feel proud to work in my local place of work". This was the highest score in the trust. The service also scored highly for the questions "I generally feel well informed about what's going on in my local place of work" and "How likely are you to recommend this trust to friends and family as a place to work" and "I am able to do my job to the standard I am personal proud of". This meant that staff rated their experience of working in the WCS highly, and were able to perform their roles to a standard they were personally pleased with. Their total engagement score was 3.66 compared to the trust

engagement score of 3.62.

- The trust published a monthly newsletter called Herts and Minds, which helped to keep staff informed of trust wide changes and celebrated staff achievements.

Innovation, improvement and sustainability

- The trust was continually developing children and young people's services to allow innovation, improvement and sustainability of services.
- Nursing recruitment had developed a "grow your own" concept to enhance the current nursing establishment and allow band 5 (junior nurses) to progress through career development opportunities in the trust.
- Children services were actively involved in the publication and presentation of research at national and international conferences. For example, Neonatal Jaundice- local audit of UK national guideline at the International Clinical Commissioning Network conference in Turin in 2016 and Massive Retinal Haemorrhages in preterm infants, Neonatal Ethics Conference in the UK in 2016.
- The service participated in clinical research activities and has been approved as a recruiting site for the multi-centre baby OSCAR trial in 2017. The aim of the study was to find out whether or not early treatment should be offered to preterm babies with patent ductus arteriosus (a heart condition in preterm babies).
- The Neonatal Emergencies Team Training Simulation provided training days for the **neonatal** department to help improve team working, situational awareness and crisis resource management during emergency situations.
- Children's services were working with the trust to increase the establishment for more trainee Assistant Neonatal Nurse Practitioners to help address the expected gaps in the junior doctor rotas and were drafting a business case to improve the nursing establishment on the paediatric wards and in the neonatal unit
- Following the last inspection the trust had made improvements in the following:
    - An increase in the reporting of incidents to ensure lessons learnt including the cascade of information to all staff.
    - Evidence of a 'no blame' culture in the reporting of incidents and concerns.
    - Improved governance quality systems including duty of candour, meetings not being cancelled and minutes being circulated to relevant staff.
    - The observation and escalation of children and young people who could be acutely unwell.
    - The safety thermometer for paediatrics had been implemented on Starfish ward.
    - Nursing and medical staff compliance with mandatory training had significantly improved.
    - Management and support arrangements for staff were in place and staff were up to date with appraisals.
    - Staff appraisal and support arrangements had significantly improved.
    - Staff reported that consultants in the neonatal unit were working well together and there was strong local leadership from clinicians and managers.
    - There had been a reduction in the number of cancelled appointments in the children and young people's outpatient clinics.

End of life care

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

Information about the service

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

The hospital reported that between April 2017 and June 2017, 357 referrals were made to the Specialist Palliative Care Team (SPCT), of these referrals, 44% (134) were cancer related and 56% (170) were non-cancer related.

The hospital reported 1424 in-hospital deaths between February 2016, to January 2017. There are no dedicated wards for the provision of end of life care at Watford hospital or Hemel Hempstead hospital. This is delivered on most wards in the trust.

There are 5.3 whole time equivalent (WTE) clinical nurse specialists (CNS) in palliative care, based at Watford hospital. The service has three consultants who provide 0.8 WTE hours. However, at the time of inspection, one consultant was away on a long-term basis, the remaining consultants were providing four sessions; consultant sessions were available on Mondays, Wednesdays, Thursdays and Fridays. The SPCT nursing team provided a Monday to Sunday 9am to 5pm face-to-face palliative care service at Watford Hospital. One CNS was on duty at Watford General Hospital on Saturday and Sunday to see inpatients with complex needs and any urgent new referrals.

The trust employs two chaplains who provide chaplaincy support to the trust 44.25 hours a week (1.2 WTE) who, with the support of approximately 20 volunteers, cover all Christian denominations. The chaplaincy team has access to contacts in the community for support for other religions. In addition to the chaplaincy team, the patient affairs office provides support to relatives after their loved one's death. The hospital has a multi-faith prayer room.

There are five full-time mortuary staff, comprised of one mortuary manager, one deputy manager and three trainee Anatomical Pathology Technologists (APTs). All staff work across both sites. (Hemel Hempstead hospital and Watford hospital). The mortuaries are staffed by the APTs from 8am to 4pm. Out of these hours the mortuary could be accessed via the senior operational team. The viewing area and access for relatives was open seven days a week.

During our inspection, we spoke with five relatives. We also spoke with 38 members of staff, including the palliative care team, mortuary staff, chaplaincy, nursing, medical staff, a resuscitation officer, a porter, an operations manager and patient affairs staff. We observed care and treatment, and looked at care records and 32 do not attempt cardio-pulmonary resuscitation

(DNACPR) forms. We visited wards across the hospital, the multi-faith room at Watford hospital and the mortuaries at Watford hospital and at Hemel Hempstead hospital. We received comments from people who use the service and we reviewed the trust's performance data.

Summary of findings

We rated the service as good for the safe, caring, responsive and the well-led key questions. End of life services requires improvement across the effective key question:

- There were systems in place to protect patients from harm and a good incident reporting culture.
- Medicines were provided in line with national guidance. We saw good practice in prescribing anticipatory medicines for patients who were at the end of life.
- The trust had a replacement for the Liverpool Care Pathway (LCP) called the 'individualised care plan for the dying patient' (ICPDP). The document was embedded in practice on the wards we visited.
- The service had produced a detailed action plan to address the shortfalls and issues raised by the national care of the dying audit of hospitals (NCDAH) 2014 to 2015. Local audits were in place to measure the effectiveness and outcomes of the service.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) records we reviewed were signed and dated by appropriate senior medical staff.
- Relatives were happy with the care their relatives had received and felt involved in their care planning at the end of their life. Staff demonstrated compassionate patient centred care throughout the inspection.
- Care and treatment was coordinated with other services and other providers. The specialist palliative care team had good working relationships with discharge services and their community colleagues. This ensured that when patients were discharged their care was coordinated.
- All adult wards had compassionate care champions who were trained in providing end of life care and were a direct link to the SPCT.
- The SPCT saw 91% of patients within 24 hours of referral.
- The trust had an executive and a non-executive director on the trust board with a responsibility for end of life care.
- There was a clear vision and strategy for end of life care.

However:

- We could not find evidence that decision specific mental capacity assessments were always fulfilled when staff completed DNACPR forms. In 11 forms we reviewed, the doctor implied the patient did not have capacity. However, in four (36%) of these cases, we could not see any evidence a formal decision specific mental capacity assessment had been undertaken of the patient's ability to understand this decision and to participate in any discussions. This meant that staff did not act in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and associated code of practice.

Are end of life care services safe?

Good

We rated end of life care services as good for safety because:

- Staff reported incidents appropriately. Incidents were investigated, shared, and lessons learnt.

- Staff understood their responsibilities and were aware of safeguarding policies and procedures. The safeguarding team aligned the level of training to positions following the Intercollegiate Document (2014). All of the specialist palliative care team (SPCT) were compliant with their safeguarding children levels one and two and safeguarding adults level one and two training.
- Medicines were provided in line with national guidance and we saw good practice in prescribing anticipatory medicines at end of life. The document met national guidance such as Palliative Adult Network Guidelines (PANG) (2011) and the Palliative Care Formulary (2011).
- Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) documentation and records were signed and dated by appropriate medical staff.
- All wards had compassionate care link nurses trained in providing end of life care; they also acted as a link to the SPCT.
- Mandatory training was provided for SPCT and patient affairs staff, compliance was 100%.
- Equipment was visibly clean, well maintained and fit for purpose.
- The temperature of the mortuary fridges was checked and recorded twice daily and we saw these were within acceptable limits.
- There were alarm systems in place to alert staff in the event of mechanical failure of the fridges in the mortuaries.

However:

- There was insufficient consultant staffing levels in palliative care provision at the trust. The service had three consultants who provided 30 hours (0.8 WTE). However, at the time of inspection, one consultant was away on a long-term basis, the remaining consultants were providing four programmed activities (PAs) of four hours (16 hours in total); consultant sessions were available on Mondays, Wednesdays, Thursdays and Fridays. There was no consultant presence on Tuesdays.

Incidents

- The trust used an electronic incident reporting tool to report incidents. Staff we spoke with understood their responsibilities to raise and record safety incidents, concerns and near misses.
- There had been no never events or serious incidents relating to end of life care from 1 June 2016 and 30 June 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- End of life care and mortuary services staff had reported twelve incidents between 1 June 2016 and 30 June 2017. Two incidents, reported as accidents/falls were reported to have resulted in low harm.
- All other (ten) incidents had resulted in no harm.
    - Five of these incidents were reported to be as the result of administrative processes (excluding documentation).
    - One was reported as a result of a documentation process due to failure of medical devices, equipment, supplies.
    - Two incidents were reported as the result of accidents or falls.
    - One no harm incident was recorded as the result of service disruptions. (environment, infrastructure, human resources).
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other

relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. The specialist palliative care team (SPCT), chaplaincy team and mortuary team had not recorded any incidents of moderate or severe harm that meet the requirements of the duty of candour regulation. However staff were aware of their responsibilities and principles with regard to duty of candour regulation, including the thresholds for application of the duty of candour. They were aware they would be required to inform the patient or their relatives of the incident, make an apology and explained how the trust should respond to any actions identified.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were maintained in the multi-faith prayer room, mortuaries and viewing areas. These areas were visibly clean and well ventilated. In the mortuary, a designated member of staff cleaned all clinical areas. Cleaning schedules for each area were seen. This showed that cleaning had been completed routinely and in a timely manner, which provided assurance that the areas were cleaned regularly and within a specified time scale.
- SPCT staff wore clean uniforms. We saw staff complied with the trust's infection prevention and control policies. This included being 'arms bare below the elbow', hand washing before and after every episode of direct contact, and correct use of protective personal equipment (PPE) such as disposable gloves and aprons.
- There were sufficient facilities for hand washing, bins for general and clinical waste, and appropriate signage in both of the mortuaries (Hemel Hempstead and Watford Hospitals).
- The service ensured that after death, the health and safety of everyone that came into contact with the deceased person's body was protected. The trust had safety precautions and systems in place to prevent and protect patients and staff from a healthcare-associated infection.
- Trust infection control guidelines were up to date, reflected national guidance and were available in both of the mortuaries and on the intranet. There was a standard of practice document for the receipt of bodies (suspected infection), on the intranet and in both of the mortuaries. Staff were able to direct us to policies necessary for their practice. Mortuary staff and porters told us about the procedures they followed and equipment they used, which assured us they were able to recognise, assess and manage risks.
- Ward staff we spoke with were aware of the procedures to be taken when performing 'last offices' in order to minimise infection risks. The term last offices relates to the care given to a body after death. It is a process that demonstrates respect for the deceased and is focused on respecting their religious and cultural beliefs, as well as health and safety and legal requirements.
- Porters we spoke with said that they were aware of the PPE protocol for both of the mortuaries and said they were able to access the necessary equipment.

Environment and equipment

- There was not a designated ward for patients receiving end of life care. Staff told us they tried to allocate side rooms to patients who were receiving end of life care, in order to offer quiet and private surroundings for the patient and their families. However, they said often patients at the end of life had to be cared for on open wards, as the use of single rooms were prioritised for patients who required isolation.
- Appropriate equipment was available to meet patient needs, such as syringe pumps and pressure relieving equipment. Equipment was stored in a central storage library. Staff told us and we saw, syringe pumps, used to give a continuous dose of painkiller and other medicines, were available to help with symptom control in a timely manner. Syringe pumps were maintained and used in accordance with professional recommendations. The trust provided a comprehensive education programme for all nursing staff on the use of the syringe pump. All new nursing staff received training on this equipment as part of their

induction. On-going training was provided to maintain competence and confidence in using the equipment. Nurses who used the equipment regularly told us they felt confident and competent in using this equipment. Nursing staff, who did not routinely use this equipment, knew where to gain advice and support to enable them to use the equipment confidently. We saw an entry on the current risk register about a decreasing number of syringe pumps being available due to a failure to track the syringe pump when they left the medical equipment library. However, we saw additional pumps had been purchased and a system was in place to track the syringe pumps. We were assured that were a sufficient number of pumps available.

- The Watford site provided cold safe storage for adults, children and babies who had died at Watford General Hospital and had the facility for the family and next of kin to view their deceased relative. The mortuary at Watford was equipped to store 59 deceased patients, 54 in fridges and five in long-term storage. Staff told us these facilities were usually sufficient to meet the needs of the hospital and local population. Additional temporary storage facility was available. The trust used this during time of high demand, for example, during bank holidays. There were five spaces for very heavy patients; there were specific storage trolleys and large fridges to accommodate them. The Hemel Hempstead site was equipped to store 55 deceased patients, 50 in fridges and five in long-term storage. The mortuary department had an arrangement with local funeral directors if the need arose for a patient who was extremely heavy.
- The temperature of the mortuary fridges was checked and recorded twice daily and we saw these were within acceptable limits. The mortuary department had a 24-hour seven-day, service level agreement (SLA) should urgent repair be required. Audible alarms would sound if fridges were not maintaining their temperature. The alarm was linked to the main reception out of hours, to alert staff that immediate maintenance was required.
- Equipment in both the mortuaries was maintained. We saw test stickers on equipment, which ensured us the equipment maintenance schedule, was timely.
- During the last inspection in September 2016, some staff we spoke with thought that the trolley used for transporting bodies to the mortuary was in a poor condition and was due for replacement. We found the trolley at that time, to be in a poor state of repair. We saw on the current inspection, a new trolley was in use. No further concerns had been raised about the method of transporting bodies to either of the mortuaries.

Medicines

- The specialist palliative care nurses worked closely with ward based medical and nursing staff and pharmacy staff to support the prescription of anticipatory medicines. The pharmacy department had a link pharmacist who provided support to the SPCT and reviewed patients with palliative and end of life care needs.
- Medicines were readily available to patients requiring treatment for palliative care and they were stored securely but on some wards, the temperatures of treatment rooms where these medicines were stored were consistently above the recommended storage temperature of 25°C. The trust had recognised this as a risk and had carried out a risk assessment of medicines stored at temperatures greater than 25°C within wards and departments. According to the trust, the average time a medicine was stored on a ward was a maximum of three weeks. Medicines with a shelf life of one year could be safely stored at 30°C for a maximum of 16 weeks. Therefore, we were assured that actions had been taken to ensure the safety, quality and efficacy of medicines within the service. Furthermore, the service was in the process of having air conditioning units installed in the treatment rooms, which would ensure ambient room temperatures were always maintained within the recommended range.
- The trust was not following their own policy of reducing the expiry dates of medicines in line with the increased temperatures. This was also raised at the last inspection, in September 2016.
- On the announced inspection in 2017, we saw the trust was aware of the issue and were in

the process of taking action to mitigate the risk. The trust had installed air conditioning units; however, these were not in working order during the announced inspection. When we returned to the trust for the unannounced part of the 2017 inspection, the air conditioning units were working and that room temperatures had decreased. Temperatures were recorded between 18 and 25 degrees across all wards.

- When medicines were prescribed to patients who required them to be administered via a syringe pump (by continuous injection through the skin), staff followed trust policy. The prescription included an infusion solution (diluent) either on the prescription or on the administration records. It was identified during the last inspection, in September 2016; the prescription for medication to be administered via a syringe pump did not always include an infusion solution (diluent), either on the prescription or on the administration records. We saw on the current inspection, guidance for staff about this was in place. There was evidence of sharing of this guidance across the hospital via the medicines safety news and information about the guidance was shared by the coordinator of the day.
- There were clear guidelines for medical staff to follow when writing up anticipatory medicines for patients. The trust had guidance on anticipatory prescribing /just in case medication at end of life. These were reviewed, up to date; it had been ratified in January 2016 and was due to review in January 2019. The document met national guidance such as Palliative Adult Network Guidelines (PANG) (2011) and the Palliative Care Formulary (2011).
- The storage of and recording of the use of controlled drugs was appropriate.

Records

- Medical records were stored in lockable cabinets. The cabinets were locked when we visited the wards, which reduced the risk of people who did not have appropriate authority accessing the notes.
- The care records and individual care plans we looked at were written in line with trust policy. In the medical notes of patients approaching the end of their lives, we saw clear descriptions of their conditions and of the rationale behind the decisions to stop active treatment, whilst still supporting the patient and their families.
- Individualised care plans for the dying patient (ICPDP) we reviewed were written in a way that kept patients 'safe from avoidable harm.'
- We saw staff completed mortuary records following trust protocol that provided an audit trail.
- The do not attempt cardiopulmonary resuscitation forms (DNACPR) forms were stored at the front of the patients' notes. This meant the forms were easy to find. The trust were about to introduce a new DNACPR form which was based on the resuscitation council form. The resuscitation team had a comprehensive training package to ensure all staff would be aware of the new form.
- We saw an improvement in completion of the DNACPR forms. During the current inspection, we reviewed 32 forms all of which had been countersigned. All (100%) forms were dated, signed and had patient details completed. During the September 2016 inspection, we reviewed 36 DNACPR forms across all ward areas. Thirty four (94%) were countersigned by a senior clinician. This meant there had been an improvement.
- On the current inspection, all but one form had the summary of communication with either patient or with patient's relatives or friends section completed. In one case, we could not see any evidence the decision had been discussed with either the patient or the relative. This was raised with the nurse in charge at the time of inspection.

Safeguarding

- There had been no reported safeguarding concerns relating to patients receiving end of life care from February 2016 to January 2017.

- There were appropriate arrangements in place to safeguard adults and children from abuse. Staff we spoke with told us they understood their responsibilities and adhered to safeguarding policies and procedures. The trust's policies for safeguarding adults and children reflected local and national guidance. Staff were able to tell the inspection team what signs of abuse were, and how to use the trust policy. In addition, staff were able to identify their responsibilities with regard to reporting safeguarding concerns. Support was also available from the trust's safeguarding leads when required.
- The safeguarding team aligned the level of training to positions following the Intercollegiate Document (2014). The SPCT were required to complete safeguarding children level one and two. We saw all of the SPCT team were compliant with their safeguarding children levels one and two and safeguarding adults level one and two training. This met the trust target of 90%. In addition five of the six (83%) SPCT staff had completed safeguarding children level three. The Intercollegiate Document guidance advises staff such as the chaplains, porters, bereavements officers and the mortuary team are required to complete safeguarding adults level one and safeguarding children level one. All the mortuary and chaplaincy staff were up to date with safeguarding adult level one training and safeguarding children level one training.

Mandatory training

- Most staff had received effective mandatory training in the safety systems, processes and practices. All of the SPCT were compliant with their mandatory training. 100% of the patient affairs team and 98% of the mortuary team were up to date with their mandatory training, which was above the trust target of 90%. The chaplaincy team at 86% compliance were slightly below the trust target of 90%. Mandatory training included equality and diversity, health and safety, fire safety, moving and handling.
- The SPCT provided an awareness training session on end of life care for all staff as part of their induction training.
- The National Care of the Dying Audit of Hospitals (NCDAH) 2014- 2015, published in March 2016 confirmed that the trust provided formal in-house training for medical staff, registered nursing staff and non-registered nursing staff. This included communication skills training for care in the last hours or days of life. However, the trust were not able to demonstrate they provided similar training for allied health professionals. Since the audit, the trust had started to provide education for all nursing staff, medical staff and allied professional staff on the care of dying patients as part of mandatory training.

Assessing and responding to patient risk

- Appropriate systems were in place to recognise and manage patients whose condition was deteriorating. The service carried out comprehensive risk assessments for patients and these were reviewed frequently by the SPCT. There was a triage system for SPCT referrals. The SPCT clinical nurse specialists held daily review meetings to discuss and allocate new referrals, review their workload, and discuss patients seen. Staff identified and responded appropriately to the changing risks to patients, including deteriorating health and wellbeing. The team also held weekly multidisciplinary meetings where caseloads would be reviewed and patients allocated appropriately. During these meetings, the team discussed diagnostic challenges, management options and any other pertinent issues relating to their current patients.
- The trust report that 91% of patients referred to the palliative care team were seen within 24 hours between June 2017 and July 2017 and 100% patients were seen within 48 hours. This was an improvement since the last inspection, when the trust reported that 81% of patients referred to the palliative care team were seen within 24 hours in January 2016.
- We saw that risk assessments, such as moving and handling, risk of falls and tissue viability were effectively completed and filed in patients' notes. We saw actions were

documented to take place where risks were identified, for example, a specific mattress requested for a patient with tissue viability issues.

- The trust used the National Early Warning Score (NEWS) assessment tool for ensuring that deteriorating patients were identified and treated appropriately. The assessment tool scored each patient according to their blood pressure, pulse, respirations and conscious status. It prompted staff to follow clear procedures, should a patient's vital signs fall out of expected parameters. We saw evidence staff used this system to monitor patients' risk of clinical deterioration, including those patients receiving end of life care.
- The ICPDP was in place on the wards to monitor patients' needs. The care plan provided a structured approach to prompt staff to conduct regular checks on patients at end of life to assess and manage their fundamental care needs. Care needs such as changes required to medication or the need to commence mouth care was monitored by staff during these checks.

Nursing staffing

- There were sufficient specialist palliative care team (SPCT) clinical nurse specialists (CNS) at Watford hospital. Nurse staffing levels met patients' needs at the time of the inspection. Actual staffing levels met planned staffing levels. We saw evidence of this on inspection.
- There were 5.4 whole time equivalent (WTE) CNSs in post, which included a team leader. The staffing levels were above National Institute of Health and Care Excellence (NICE) guidelines, commissioning guidance for palliative care, published collaboratively with the association for palliative medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK. The guidance recommends 1.0 WTE hospital specialist palliative care nurse per 250 hospital beds. Watford Hospital has 521 beds, which would require just over two specialist palliative care nurses.
- In July 2017, the trust reported to be overstaffed by a rate of 1.7 WTE in end of life care. The trust reported a turnover rate of 0% in end of life care.
- No bank and agency staff had been utilised for this service during the inspection period.
- As at July 2017, the trust reported a sickness rate of 0% in end of life care.
- The SPCT nursing team provided a Monday to Sunday 9am to 5pm face to face palliative care service at Watford Hospital. One CNS was on duty at Watford General Hospital on Saturday and Sunday to see inpatients with complex needs and any urgent new referrals. This met the recommendation from the NICE guidelines for 'End of life care for adults', which states "Palliative care services should ensure provision to: Visit and assess people approaching the end of life face-to-face in any setting from 9am to 5pm, seven days a week".
- Nursing handovers we observed were well structured and informative. The handover included a review of all current palliative and end of life care patients. Care and treatment was assessed and planned and workloads allocated.
- There were nominated compassionate care champions for end of life care on most wards across the trust. The champions received additional training on developing confident and competent staff to provide care with a focus on maximum comfort and awareness of patient wellbeing in end of life care.

Medical staffing

- The service had three consultants who provided 30 hours (0.8 WTE). However, at the time of inspection, one consultant was away on a long term basis, the remaining two consultants were providing four programmed activities (PAs) of four hours (16 hours in total). Consultant sessions were available on Mondays, Wednesdays, Thursdays and Fridays. There was no consultant presence on Tuesdays. The staffing levels were below,

by over 50%, of the National Institute of Health and Care Excellence (NICE) guidelines, commissioning guidance for palliative care, published collaboratively with the association for palliative medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK.

- The service had recognised the insufficient provision and were in the process of taking action to address the issue. Telephone support was available for the SPCT on Tuesdays from the consultants providing programmed activities on the other days. A business case for funding five locum consultant sessions had been submitted to the board and agreed, recruitment was underway. It had been recognised though that locums for this speciality were in very short supply nationally. The trust was working with the human resources department to recruit to this locum post.
- No locum staff had been utilised for this service at the time of the inspection.

Other staffing

- The trust employed a resuscitation team that comprised one whole time equivalent (WTE) senior resuscitation officer and three part time resus officers. The team provided the basic life support and immediate life support training on site. They attended emergency calls within the hospital where resuscitation was likely to be required.
- There were five WTE staff working in the mortuary team. A mortuary manager, a deputy manager and three trainee anatomical pathology technologists.
- The trust employed two chaplains who provide chaplaincy support to the trust 44.25 hours a week (1.2 WTE) and had the support of approximately 20 volunteers. The service was in the process of recruiting a chaplaincy team leader. The chaplains, with the support of two additional back-up chaplains, provided an on-call service, which could be accessed 24 hours a day seven days a week.
- The SPCT had a full time administrator who supported the team.

Major incident awareness and training

- Mortuary staff told us there were alarm systems in place to alert staff in the event of mechanical failure of the fridges. These alarms were routed to main reception staff who would alert the mortuary manager. On the occasion of an out of hours' fridge failure, the on-call mortuary staff would be contacted via the main reception. Main reception staff or the mortuary manager would contact the on-call repair service.
- Porters in the trust received training in the use of the fridges and the alarm systems and they followed a procedure to alert mortuary staff if there were storage or other issues relating to either of the mortuaries.
- The trust had a major incident plan in place. There were clear instructions for staff to follow in the event of a fire or other major incident. SPCT and mortuary staff we spoke with were aware of this.
- The mortuary had storage contingency plans, additional storage was provided in a stand-alone refrigeration unit, which could be used in time of high demand. There was also an additional foldable racking system available on site that could be used to increase storage facilities. The manager told us that the hospital had arrangements with local funeral directors in the case of a major incident if more capacity was required.

Are end of life care services effective?

Requires improvement

We rated end of life care services as requires improvement because:

- We could not find evidence that decision specific mental capacity assessments were always fulfilled when staff completed DNACPR forms. In eleven forms, we reviewed, the doctor implied on the forms, the patient did not have capacity. However, in four (36%) of these cases, we could not see any evidence a formal decision specific, mental capacity assessment had been undertaken of the patient's ability to understand this decision and to participate in any discussions. This meant that staff did not always act in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and associated code of practice.

However:

- Patients had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice.
- Appropriate systems were in place to assess and manage patients' pain relief needs. There was trust guidance for prescribing palliative medication and guidance for the use of anticipatory medication at end of life, which provided guidance for providing pain relief.
- Care was delivered in a co-ordinated way when different teams or services were involved. The SPCT team had established close links with other providers in the local area of end of life care, including the local hospice, primary care providers and community nurses. The aim of this was to improve patients' experiences as they moved between care settings.

Evidence-based care and treatment

- Patients had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice.
- A care planning tool called the individualised care plan for the dying person (ICPDP) to replace the Liverpool Care Pathway had been implemented and was embedded across all wards in the hospital. The ICPDP was in line with the recommendations published in June 2014 by the Leadership Alliance for the Care of Dying People (LACDP 2014), National Institute for Health and Care Excellence (NICE) guidance QS13 'End of Life Care for Adults' and NICE CG140 'Opioids in Palliative Care'. It provided individual care plans for patients believed to be dying and provided staff with guidance for individuals' care and treatment.
- We reported following the last inspection the trust had taken part in the National Care of the Dying Audit of Hospitals (NCDAH) 2014- 2015. The results were published in March 2016. The trust achieved five of the eight organisational key performance indicators (KPIs).
    - The trust did seek bereaved relatives' or friends' views during the last two financial years (from 1 April 2013 to 31 March 2015).
    - The trust provided formal in-house training, which included communication skills training for care in the last hours or days of life for medical staff.
    - The trust provided formal in-house training, which included communication skills training for care in the last hours or days of life nursing staff registered.
    - The trust provided formal in-house training, which included communication skills training for care in the last hours or days of life for non-registered nursing staff
    - The trust provided access to specialist palliative care for at least 9am - 5pm Monday to Sunday.
- The trust could not demonstrate there was documented evidence that:
    - The trust had a lay member on the trust board with a responsibility for end of life care between 1 April 2014 and 31 March 2015.
    - Formal in-house training included or covered specifically, communication skills and training for care in the last hours or days of life for allied health professionals.

    - The trust had one or more end of life care facilitators as of 1 May 2015.
- The trust scored better than the England average in two of five of the clinical audit KPIs. The trust could demonstrate:
    - There was documented evidence, within the last episode of care that it was recognised the patient would probably die in the coming hours or days.
    - There was documented evidence within the last episode of care, there was health professional recognition the patient would probably die in the coming hours or days and imminent death had been discussed, with a nominated person important to the patient.
- The trust could not demonstrate their was documented evidence that:
    - The needs of the person important to the patient were asked about.
    - A holistic assessment of the patient's needs regarding an individual plan of care had been carried out in the last 24 hours of life.
    - The patient was given an opportunity to have concerns listened to.
- We saw at the last inspection, the service had produced an action plan to address the shortfalls and issues raised by the NCDAH 2014-2015. The SPCT monitored and reviewed the action plan on a monthly basis at the team meeting and every two months by the compassionate end of life care panel. Since the audit, the trust had appointed a non-executive director on the trust board with a responsibility for end of life care and agreed funding and appointed an end of life educator (or facilitator). These actions addressed two of the organisational KPIs the trust had previously not met.
- Since the last inspection, further improvements had been made. The trust provided formal in-house training that included, or covered specifically, communication skills and training for care in the last hours or days of life for allied health professionals through the hospital induction. Staff using the ICPDP were carrying out a holistic assessment of the patient's needs regarding an individual plan of care in the last 24 hours of life.
- The service had a local audit programme. This ensured relevant and current evidence-based guidance, standards, best practice and legislation was identified and used to develop how services, care and treatment was delivered. For example, the service carried out a number of audits such as an audit of laxative and anti-emetic (medicines to prevent or minimise nausea and vomiting) prescribing for patients started on strong opioids. The service also carried out an audit of do not attempt cardiopulmonary resuscitation (DNACPR) form completion. Further audits of the documentation of spiritual care, advanced care planning and individualised care plans for the dying person had been completed. An audit of patients who died in hospital in April to June 2017 evidenced whether they were on an end of life register and had an advanced care plan. We saw evidence of shared learning from these audits through governance meetings, team meetings and safety news bulletins.
- The mortuary policies were up to date, evidence based and relevant for the service they provided. Ward staff, mortuary staff, and porters were aware of these policies and told us about the procedures they followed and equipment used. Standards of practice for the mortuary were based on national guidelines.
- The mortuary on both sites had been licenced by the Human Tissue Authority (HTA) to allow post-mortem examinations and storage of bodies. The trust informed us that the HTA renewed the licence annually, following a self-assessment audit. The HTA were due to visit the trust in November 2017 to carry out a licence audit.

Pain relief

- Appropriate systems were in place to assess and manage patients' pain relief needs. There was trust guidance for prescribing palliative medication and guidance for the use of anticipatory medication at end of life, which provided guidance for providing pain relief. The guidance was in line with NICE CG140 'Opioids in Palliative Care' and the Core Standards for Pain Management Services in the UK (Faculty of Pain Medicine, 2015).

- There were clear guidelines for medical staff to follow when writing up anticipatory medicines for patients. We saw that anticipatory end of life care medication was appropriately prescribed. Anticipatory medications refer to medication prescribed in anticipation of managing symptoms, such as pain and nausea, which are common near the end of a patient's life. These are prepared in anticipation so medicines can be given, if required, without unnecessary delay.
- The service used comprehensive prescription and medication administration record charts for patients. These charts facilitated the safe administration of medicines including pain relieving medications. Specialised prescription charts supported prescribers to follow the agreed protocols for patients who had medicines administered via syringe pumps. We saw medicines delivered via syringe pumps were prescribed appropriately.
- Patients' pain and its control was reviewed regularly, prompted by the individualised care plan for the dying patient (ICPDP). For example, the document prompted staff to assess regularly and observe for verbal and non-verbal signs of pain, anticipate when pain might occur (such as, on movement), record pain, intervention and outcomes. This ensured that 'as required' medication was prescribed to manage any breakthrough pain.
- We saw 'as required' pain relief was given in between regular, scheduled pain relief. Breakthrough pain is a sudden flare of pain that "breaks through" the long-acting medication prescribed to treat moderate to severe persistent pain. Relatives told us patient's pain was well managed by staff.
- The NCDAH 2016 identified patients reviewed in the last 24 hours of life, had their pain controlled in 75% of cases. This was 12% lower than the national average of 87%.
- The service carried out an audit of pain assessment in new referrals to SPCT from 2 December 2016 to 16 December 2016. We saw from the 27 sets of notes reviewed that while there was evidence patients' pain was considered, there was not a consistent method of management. As a result, the service had introduced a pain assessment based on gold standard framework (GSF) pain assessment tool. (GSF is a systematic, evidence based approach to optimising care for all patients approaching the end of life, delivered by generalist frontline care providers.) This was an improvement since the last inspection in September 2016 where we did not see evidence of use of a consistent pain assessment tool, or evidence of the SPCT carrying out a pain relief audit. An audit of pain relief was not included on the SPCT audit plan or the quality improvement plan.

Nutrition and hydration

- Patients' dietary and hydration needs were being met. The individualised care plan for the dying patient (ICPDP) prompted staff to review patients' nutrition and hydration needs. Nutritional assessments were completed in the notes we reviewed. Nutrition and fluid charts were thorough and summarised accurately.
- Medical staff we spoke with were aware of the General Medical Council (GMC) guidelines for nutrition and hydration in end of life care.
- Referrals were made to the dietitian, and the dietitian visited the ward to assess and support the patient with their nutrition needs.
- Patients' risk of malnutrition was assessed using the Malnutrition Universal Screening Tool (MUST). However, we saw nutrition and fluid charts were not always completed in full on the adult wards. This was brought to staff attention by the inspection team and as a result was addressed at the time of the inspection.

Patient outcomes

- The service had processes in place to monitor patient outcomes and report findings through national and local audits to the trust board. The trust used this information to benchmark practices against similar organisations.
- Between April 2017 and June 2017, 357 referrals were made to the Specialist Palliative

Care Team (SPCT), of these referrals, 44% (134) were cancer related and 56% (170) were non-cancer related. The service had processes in place to monitor patient outcomes and report findings through national and local audits to the trust board. The trust used this information to benchmark practices against similar organisations.

- The trust took part in the National Care of the Dying Audit of Hospitals (NCDAH) 2014 to 2015. The results were published in March 2016, which is the latest data available. The trust achieved five of the eight organisational key performance indicators (KPI's).
    - The trust did seek bereaved relatives' or friends' views during the last two financial years (from 1 April 2013 to 31 March 2015).
    - The trust provided formal in-house training, which included communication skills training for care in the last hours or days of life for medical staff.
    - The trust provided formal in-house training, which included communication skills training for care in the last hours or days of life nursing staff registered.
    - The trust provided formal in-house training, which included communication skills training for care in the last hours or days of life for non-registered nursing staff.
    - The trust provided access to specialist palliative care for at least 9am - 5pm Monday to Sunday.
- The trust could not demonstrate there was documented evidence that:
    - The trust had a lay member on the trust board with a responsibility for end of life care, between 1 April 2014 and 31 March 2015.
    - Formal in-house training included or covered specifically, communication skills and training for care in the last hours or days of life for allied health professionals.
    - The trust had one or more end of life care facilitators as of 1 May 2015.
- The trust scored better than the England average in two of five of the clinical audit KPIs. The trust could demonstrate:
    - There was documented evidence, within the last episode of care that it was recognised the patient would probably die in the coming hours or days.
    - There was documented evidence within the last episode of care, there was health professional recognition the patient would probably die in the coming hours or days and imminent death had been discussed, with a nominated person important to the patient.
- The trust could not demonstrate their was documented evidence that:
    - The needs of the person important to the patient were asked about.
    - A holistic assessment of the patient's needs regarding an individual plan of care had been carried out in the last 24 hours of life.
    - The patient was given an opportunity to have concerns listened to.
- The service had produced an action plan to address the shortfalls and issues raised by the NCDAH (2014 to 2015). The SPCT monitored and reviewed the action plan on a monthly basis at the team meeting and reported to the trust's board.
- The resuscitation team carried out routine compliance audits on the cardio pulmonary resuscitation of adult patients in the trust. They used the information to identify areas to focus training.
- The trust was not part of the Gold Standards Framework accreditation scheme at the time of inspection.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their job and were supported by effective supervision and appraisal systems.
- The SPCT, mortuary and chaplaincy teams had arrangements in place for supporting and managing staff. All staff had undergone appraisal in the last 12 months. The SPCT received monthly clinical supervision.
- The SPCT had monthly team meetings where staff were updated on changes within the trust and caseload reviews were carried out. All staff had undertaken additional training

relevant to their role in palliative or end of life care.

- At the time of the last inspection, a quality improvement plan (QIP) had identified the trust needed to develop an e-learning package for end of life care, mental capacity act (MCA) and deprivation of liberty (DoLS) and introduce this via a new mandatory training web-link to relevant staff. The time scale for this was identified as January 2017. We saw on the current inspection, this had been established within time scale.
- The SPCT team had delivered a number of education sessions in the last year, including:
    - Continuous teaching on the individualised care plan for the dying person (ICPDP),
    - Communications skills training,
    - Teaching to acute medicine, medicine, and care of the elderly teams on do not attempt cardio pulmonary resuscitation (DNACPR) discussions and how to document these as well as completion of the forms.
    - Teaching to foundation doctor Y1s and foundation doctor Y2s on symptom control, breaking bad news, DNACPR discussions. (A foundation doctor FY1 or FY2 also known as a house officer is a grade of medical practitioner in the United Kingdom undertaking the Foundation Programme – a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training.)
    - Teaching to joint medical governance meeting on DNACPR and Treatment Escalation Plans (TEPs).
    - Teaching on the rose project to all staff. (The trust used a "rose symbol" to promote dignity, respect and compassion at the end of life. A rose symbol was displayed on wards when a person was expected to die in the next few hours or when a person has just died. The symbol was to alert staff and to encourage an atmosphere of quiet and respect at this significant time.)
    - Teaching the compassionate care champions about providing care. The training focused on developing confident competent staff awareness to provide care with a focus on maximum comfort and awareness of patient wellbeing.
    - Teaching to nursing staff and pharmacists on the use of syringe pumps. At the time of the inspection, 100% of all staff nurses had been trained to use syringe pumps.
- The SPCT deliver end of life care training as part of the core essential teaching sessions that must be attended by new starters to the trust.
- The resuscitation team provided the basic life support and immediate life support training on site. The team were responsible for the trust's resuscitation policy.
- The mortuary manager provided training for porters and the bed managers in the trust's procedures for transporting bodies to the mortuary and the use of equipment. For example, the trolley used to transport the deceased from wards to the mortuary. The porters told us they felt they had the necessary training; they supported each other with training needs. An experienced porter accompanied new staff to ensure they were confident and were able to follow the required protocols. At the time of the inspection, the mortuary manager was in the process of organising refresher training for the bed managers to ensure they had up to date knowledge of the procedures for accessing the mortuary out of hours.
- The patient affairs office provided education and support for staff that:
    - Provided support to the medical staff, included assisting and advising on completion of legal documentation necessary for the release of the deceased patients for cremation or burial.
    - Liaised with the coroner's office for complex cases and/or those requiring a post mortem examination, reporting of deaths for patients with DoLs in place.
    - Assisted in the training for nurses and health care assistants (HCAs) with regards to what happens after death.
- The annual report for end of life care for 2015-2016, (presented to the board in January 2017) and identified as part of the CQC inspection, highlighted that staff working in the patient affairs office and in the mortuary had not received communication skills training or

training in how to recognise those who would benefit from support during the first stages of bereavement. Staff confirmed appropriate support was now in place. Staff had received training in having difficult conversations, and recognising distress. All staff were provided with the opportunity to attend group support and supervision sessions once a month provided by the chaplaincy team.

- There were 'rose symbol' resource box files on each ward. These box files were easily identifiable with the rose symbol on the front side, contained information such as information on completing the ICPDP, flow charts for the end of life care process and anticipatory prescribing guidance. Staff told us that they found this information and resource useful.

Multidisciplinary working

- Care was delivered in a co-ordinated way when different teams or services were involved. The SPCT team had established close links with other providers in the local area of end of life care, including the local hospice, primary care providers and community nurses. The aim of this was to improve patients' experiences as they moved between care settings. We saw documented evidence of a multidisciplinary approach to care.
- The trust had devised a process of ensuring the patient's GP was made aware of their patient's death. It was planned a deceased patient summary would be sent to the GP. The trust had commenced training with the junior doctors on completing the summary; however at the time of inspection, no date had been set to commence the process.
- The SPCT attended weekly multidisciplinary team (MDT) meetings at the local hospice, with the community teams, to ensure continuity of care of the patients moving from Watford hospital to the community or the hospice.
- Medical staff told us they sought guidance and acted upon advice from the specialist palliative care team. The SPCT also regularly attended the specialist teams' MDT meetings to provide support and guidance.
- There was a county wide electronic palliative care co-ordination system (EPaCCS) to identify end of life care patients on admission. The SPCT had access to view the records of the patient if they had been identified as in their last year of life and had recorded their details with another provider. As SPCT identify a patient who was thought appropriate for referral to this system, with the patient's agreement and consent they could be added to EPaCCS to ensure continuity of care and ensure their wishes and ceiling of care was known to other health care professionals. The system had been rolled out to the East of England Ambulance Service and to key areas in the trust. If a patient was recognised that they were at the end of their life in the community or local hospice and required admission to the acute trust, the doctor or nurse reviewing the patient in the community contacted the SPCT to notify them of the forthcoming admission. Once admitted via the emergency department (ED) or acute assessment unit (AAU) if a referral to the SPCT team was required then the ED/AAU staff would refer to the team. The number of patients known to the palliative care team currently in the acute trust on 12 July 2017 who have EPaCCS in place on admission was 2 out of 20.
- The SPCT received referrals from all wards in the trust. They had supported patients in accident and emergency, resus, intensive care unit, care of the elderly, surgery, gynaecology, the medical wards and the acute admissions unit.

Seven-day services

- The SPCT provided seven-day, face-to-face access to specialist palliative care. The team was available from 9am to 5pm, Monday to Sunday. Outside these hours, specialist palliative care advice was available via a 24-hour advice line, which was manged by a local hospice. The staff in the hospital accessed the on-call doctors if a patient required a review during an evening or weekend, when members of the palliative care team were not available.

- The mortuaries on both sites were staffed by the anatomical pathology technologist's (ATPs) between 8am and 4pm. Out of these hours the mortuary could be accessed via the senior operational team. The viewing area and access for relatives was open seven days a week.
- The patient affairs office was open from 9am until 4pm Monday to Friday and 10am until 4pm on Sundays. The service told us in exceptional circumstances, arrangements could be made to issue death certificates out of hours on the grounds of religious or cultural needs. The senior operational team coordinated this.
- The chaplaincy team provided cover 24 hours a day, seven days a week. They provided an on-call service outside their normal working hours.

Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.
- DNACPR forms had red edging, and were stored at the front of the patients' notes, which made them easily identifiable and allowed easy access in an emergency. We saw on occasion forms stayed with the patients, following them into the community and back into hospital. Six patients we reviewed had come into hospital with a community DNACPR, which had resulted in the doctor completing a hospital DNACPR form.
- Trust policies, procedures and guidelines were available to nurses, doctors and support staff on the intranet. They were able to access them when necessary.
- Referral documentation for the SPCT, information about five priorities of care and information about end of life care for patients and their relatives were available on the intranet. All staff had access to this information 24 hours a day, seven days a week. Staff on the wards were able to direct us to this information. Staff told us they used it to support their practice.
- The chaplaincy team had access to contacts in the community for support for all religions. We saw evidence of clear liaison processes in place for when patients transferred to the community. The chaplains maintained phone contact with patients' own community spiritual leaders.
- At the September 2016 inspection, we saw there was no end of life register in the trust, or countywide information technology system between the trust, mental health services, GPs and primary care teams. The SPCT had their own database of patients referred to the service care teams. However, at the 2017 inspection, we saw there was a county wide electronic palliative care co-ordination system (EPaCCS) to identify end of life care patients on admission.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We could not find evidence that decision specific mental capacity assessments were always fulfilled when staff completed DNACPR forms.
- At the last inspection, we did not see clear evidence of mental capacity assessments being carried out and recorded regarding the decisions about CPR, and did not see mental capacity assessments for the patient's ability to understand a decision regarding DNACPR. The trust's DNACPR form did not prompt staff to carry out a formal assessment to establish if the patient had mental capacity to make and communicate decisions about CPR, as recommended by Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2015). We had reviewed 36 DNACPR forms across all ward areas. In seven cases we saw that decisions had been made about patient's capacity where there was no evidence of formal assessments used in the decision making progress or information documented in progress notes. This meant that staff who obtained consent of people who use the service did not always follow the principles and codes of conduct associated with the Mental Capacity Act 2005.

- On the current inspection, we saw an improvement. We reviewed 32 DNACPR forms across all ward areas. Since our last inspection the trust had used a stamp to introduce a prompt for staff to consider the patients' capacity and the need to complete a decision specific mental capacity assessment. In eleven forms, we reviewed, the doctor implied on the forms, the patient did not have capacity. However, in four (36%) of these cases, we could not see any evidence a formal decision specific mental capacity assessment had been undertaken of the patient's ability to understand this decision and to participate in any discussions. This meant that staff did not always act in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and associated code of practice.
- We did however see evidence in the notes of seven (64%) patients that the doctor carrying out the decision used the two-stage test to identify the patients who did not have capacity. The two-stage test is where the clinician identifies whether there is an impairment of or disturbance in the functioning of the person's mind or brain. If an impairment or disturbance of the mind or brain is identified, then staff move onto the second stage of the test. The second stage of the test assesses whether that the person is able to understand the information about the decision to be made, retain that information in their mind, use or weigh-up the information as part of the decision process and communicate their decision. If a person is unable to meet these four criteria, they are found to lack mental capacity (Mental Capacity Act 2005: Code of Practice).
- We saw three forms where the doctor completing the form had not identified the patient did not have capacity however; the doctor had not informed the patient directly where a clinical decision for a DNACPR had been made. Decisions relating to cardiopulmonary resuscitation guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (previously known as the 'Joint Statement') 3rd edition (1st revision) 2016 recommends that effective communication is essential to ensure that decisions about CPR are made well and understood clearly by all those involved. There should be clear, accurate, honest and timely communication with the patient and (unless the patient has requested confidentiality) those close to the patient, including provision of information and checking their understanding of what has been explained to them. Agreeing broader goals of care with patients and those close to patients is an essential prerequisite to enabling each of them to understand decisions about CPR in context.
- In one case where a DNACPR had been put in place, we could not see evidence the doctor had discussed the DNACPR with the patient or their relative. This is in breach of the Mental Capacity Act Section 1(2) Mental Capacity Act which states:
    - A person must be assumed to have capacity unless it is established that he lacks capacity.

Section 1(2) Mental Capacity Act states:

- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

Section 1(6) Mental Capacity Act states:

- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

- It is illegal for a capacious patient not to have been included in the discussions about inserting a DNACPR (Tracey) v Cambridge University Hospitals NHS Foundation Trust [2014] EWCA Civ 822 – the trust placed a DNACPR on the patient's record (who had capacity) without telling her. This was found to be in breach of Article 8 Human Rights Act 2000. In his remarks Lord Dyson, the Master of the Rolls, said: A "DNACPR decision is one which will potentially deprive the patient of life-saving treatment, there should be a presumption in favour of patient involvement. There needs to be convincing reasons not to involve the patient." (Para. 53). He went on to warn, "doctors should be wary of being too ready to exclude patients from the process on the grounds that their involvement is likely to

distress them." (Para. 54)

- We did see in 26 (81%) of the patients' medical records or treatment escalation plan included a summary of communication about DNACPR with either the patient or their relatives.
- Decisions relating to cardiopulmonary resuscitation (CPR) are set out in guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (previously known as the 'Joint Statement') 3rd edition (1st revision) 2016. The guidance recommends clear and full documentation of decisions about CPR, the reasons for them, and the discussions that informed those decisions, is an essential part of high-quality care. This often requires documentation in the health record of detail beyond the content of a specific CPR decision form. Where such discussions are not practicable or not appropriate, the reasons for this must be documented fully. Six (19%) sets of medical notes or treatment escalation plans did not evidence that the decision about DNACPR had been communicated with the patient, a relative or next of kin or why this had not been done. Clinicians may be asked to justify their decision. Without a summary of the discussion, there was a risk that staff completing the document would not have evidence of the discussion they had.
- Most staff we spoke with demonstrated a good understanding of their responsibilities regarding the MCA and knew what to do when patients were unable to give informed consent. We saw mental capacity assessments for decisions around provision of treatment and consent for intervention. We saw seven decision specific mental capacity assessments for the patient's ability to understand a decision regarding DNACPR.
- We saw the trust carried out routine DNACPR audits. The trust provided us with the data from a DNACPR audit carried out between August 2016 and August 2017. The audit showed there was limited evidence of a formal mental capacity assessment being carried out.

Are end of life care services caring?

Good

We rated end of life care services as good for caring because:

- Patients were supported to make decisions and plan their care and were treated with dignity, respect and kindness.
- Feedback from relatives was consistently positive. Relatives said how caring staff were to their needs. Relatives told us they were involved in planning their relatives care and had positive relationships with the specialist palliative care team (SPCT).
- The specialist palliative care team (SPCT), nurses and doctors helped patients and relatives to cope emotionally with their care and treatment.
- Patients were responded to compassionately, and supported by staff to meet their personal care needs.
- The chaplaincy team offered spiritual support to patients of all or no faiths. The bereavement survey October 2016 to September 2017 found 31% families said they had been given spiritual or pastoral and emotional support.
- Patient affairs staff and mortuary services supported families of the bereaved with kindness, sensitivity and respect. We saw cards addressed to both teams, thanking staff for their care and support.

Compassionate care

- Staff understood and respected patient's personal, cultural, social and religious needs. All staff had access to multidisciplinary care records, which provided a care plan, and specified the patients' wishes. Individualised care plans for the dying patient (ICPDP) were

in place for patients who were in their last days or hours of life. The ICPDP specified patients' wishes regarding end of life care. Records we saw on the wards indicated the patients' preferred place of care and place of death. Staff had documented the wishes and preferences of patients and their families. We saw and relatives told us staff provided care in line with patient wishes.

- We observed staff taking the time to interact with patients and those close to them in a respectful and considerate manner.
- Staff responded in a compassionate, timely and appropriate way when people experienced physical pain, discomfort or emotional distress.
- The trust used a "Rose symbol" to promote dignity, respect and compassion at the end of life. The symbol was developed by the bereavement and compassionate end of life care panel. A rose symbol was displayed on wards when a person was expected to die in the next few hours or when a person had just died. The symbol was to alert staff and to encourage an atmosphere of quiet and respect at this significant time. Use of the symbol was in use on the wards during the inspection, we saw evidence that staff did follow the principles.
- The mortuary staff and porters we spoke with said they did not have any concerns about the way ward staff cared for patients shortly after death. There was a last offices policy. The term last offices relates to the care given to a body after death. A process demonstrates respect for the deceased and is focused on respecting their religious and cultural beliefs, as well as health and safety and legal requirements. Nursing staff were provided with training and told us they felt confident in performing procedures respectfully.
- We observed the mortuary staff handling bodies in a professional and respectful way.
- The chaplaincy team held an annual remembrance service for those whose babies and children had miscarried or died. We saw a wide range of people had attended this.
- The chaplaincy team had held a non-religious remembrance service for families and friends of adults who had died in the trust's hospitals in the previous year, in November 2016. This was now an annual event with a service planned for November 2017.
- The trust did not have facilities in either mortuary for honouring spiritual and cultural wishes of the deceased person and their family and carers whilst preparing the body for transfer however, this could be arranged at the funeral director's premises.
- The trust had processes in place to honour people's wishes for organ and tissue donation.
- We saw from the National Care of the Dying Audit of Hospitals (NCDAH) 2014/15 and published in March 2016 that the trust performed worse than the England average on the clinical indicator that patients were given an opportunity to have concerns listened to. Since the last inspection, the service had increased the opportunities for patients and those close to them to be listened to. There was a paragraph in the patient information leaflet, which explains the ways any concerns can be dealt with, and has contact details for patient advisory and liaison service (PALS). The ICPDP also prompts staff to offer opportunities for patients to have concerns listened to.

Understanding and involvement of patients and those close to them

- We looked at 13 patients' notes which demonstrated that patients were kept actively involved in their own care and documented conversations with relatives. Patients and their relatives we spoke with told us staff communicated with them so they could understand their care, treatment and condition.
- The trust scored better than the England average in the clinical audit key performance indicators (KPIs) in the results of the National Care of the Dying Audit of Hospitals (NCDAH) 2014/15 and published in 2016. There was documented evidence within the last episode of care, there was health professional recognition the patient would probably die in the coming hours or days and imminent death had been discussed, with a nominated person important to the patient.

- The trust provided a patient affairs service and, with the support of the chaplaincy team, staff arranged visits, both in and out of hours, for relatives who wished to view the deceased. They ensured that people could take the time they needed to say goodbye to their relative and ask the staff any questions they may have.
- The trust offered the opportunity for relatives to feedback to the service about their experience of the service. We were provided with information from their last review of bereavement questionnaires returned between October 2016 and September 2017. 161 surveys had been returned approximately 10% response rate. Feedback from the survey was used to make changes to the information provided to relatives, for example the patient information leaflets.

Emotional support

- Staff understood the impact that a patient's care, treatment or condition had on their wellbeing and on those close to them emotionally. Relatives we spoke with told us the SPCT had provided them with emotional support. The SPCT told us, emotional, psychological and bereavement support and advice for families was an important part of the service.
- We saw numbers of thank you cards in the SPCT office thanking them for supporting the patient and their families "at such a difficult time".
- We saw patients were offered appropriate and timely support and information to cope emotionally with their care, treatment or condition.
- The chaplaincy team offered spiritual support to patients of all or no faiths. We saw patients who did not have family, friends or carers to support them, had received end of life care and had been supported emotionally. The chaplaincy team provided company and support to patients who had limited social support.
- The SPCT, the patient affairs service and chaplaincy team signposted patients and those close to them to have contact and support from external bereavement services and the patients' usual social networks within their communities.
- The patient affairs office provided support for relatives that:
    - Supported bereaved relatives and carers involved in the death of a patient, adult or child.
    - Provided information, support and guidance for relatives or carers on funeral arrangements.
    - Provided information in the event that there was no next of kin and the team assisted in making funeral arrangements in such cases.
    - Assisted with viewings of the deceased patient in hours.
    - Provided information on organ/tissue donation and, if required, facilitated the donation of tissues for transplantation.
    - Fast tracked processes to ensure burial could take place quickly for people who required swift funerals.
    - Oversaw the process when patients had requested to leave their body to a school of anatomy.
    - Assisted people who have lost a baby during pregnancy, including making funeral arrangements for those who wished, and gave advice on registering a death.
    - The chaplaincy team, the Specialist Palliative Care Team and the local hospices signposted bereaved relatives to ensure that they received appropriate support.

Are end of life care services responsive?

Good

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

- The specialist palliative care team (SPCT) saw 91% referrals within 24 hours.
- A rapid response discharge service enabled patients in the last eight weeks of life to be supported to die in their preferred location. Between April 2017 and July 2017 81% of patients were supported to die in their preferred place of death.
- There were no visiting time restrictions for family or friends visiting a patient in the last days or hours of life.
- Compassionate care champions had received training in the care of patients with dementia or learning disabilities.
- The chaplaincy service had a trained team of 20 volunteers who supported patients (including those at the end of life).
- Relatives and staff gave consistently positive feedback on the mortuary and patient affairs teams.
- The trust routinely collected separate data on patients who did or did not have cancer. The SPCT received 357 referrals, between April 2017 and June 2017. 44% were cancer related and 56% were non-cancer related.
- The trust collected data on the percentage of patients discharged within 24 hours to their preferred location. 26% of patients were discharged to their preferred place of care within 24 hours between April 2017 and July 2017.
- There was a complaints system in place. Staff were able to tell us how they would support patients and relatives to raise a concern. Relatives we spoke with told us they knew how to make a complaint or raise concerns if it was necessary.

However:

- The trust had a poor response rate to their bereavement survey. October 2016 to September 2017. There were 161 respondents. The total number of deaths for this period was 1625 against the 161 questionnaires returned/recorded giving a response rate of 10%.

Service planning and delivery to meet the needs of local people

- The service collected information about the needs of the local population, and used this to inform how services were planned and delivered.
- Between April 2017 and June 2017, 357 referrals were made to the Specialist Palliative Care Team, of these referrals 44% (134) were cancer related and 56% (170) were non-cancer related.
- The SPCT team had close links with other providers in the local area, including the local hospice, primary care providers and community nurses. The aim of this was to improve patients' experiences as they moved between care settings. The SPCT attended a community based multidisciplinary team meeting to discuss end of life care patients across the services. We saw documented evidence of a multidisciplinary approach to care.
- The SPCT were part of the Bedfordshire and Hertfordshire specialist palliative care group and attended regular quarterly meeting with the clinical commissioning group. They used these groups to bench mark their services and review how they reflected the needs of their local population.
- The trust had a rapid discharge process. Information collated by the SPCT demonstrated from April 2017 and July 2017, 26% of patients were discharged to their preferred place of care within 24 hours, 20% within 48 hours and 5% within 72 hours. Delays in discharging a

patient to their preferred place of care, such as the patient's home could occur because of the lack of available community care packages, particularly when patients needed two carers more than twice a day. Concerns about delayed discharges had been raised through the compassionate care group and fed back to the trust board. The board were in liaison with the local care commissioning group (CCG) who were reviewing provision for patients requiring end of life care.

- The hospital did not have any designated beds for end of life care, staff delivered end of life care in most wards and were supported by the SPCT. Staff told us they tried to allocate side rooms to patients who were receiving end of life care, in order to offer quiet and private surroundings for the patient and their families. However, patients at the end of life often had to be cared for on open wards, as the use of single rooms were prioritised for patients who required isolation.
- The hospital did not have designated overnight accommodation facilities on site; however wards provided recliner chairs for those who wished to remain at their relative's bedside. Some wards made their day room available for relatives to use on such occasions.
- Reduced parking fees for relatives of patients receiving end of life care could be arranged, to enable relatives to spend the maximum amount of time with their relative.

Meeting people's individual needs

- Services were generally planned and delivered in a way that took account of the needs of different people on the grounds of age, disability, gender, race, religion or belief and sexual orientation.
- In the 2016 to 2017 bereavement survey, there were 161 respondents. The total number of deaths for this period was 1625 against the 161 questionnaires returned/recorded giving a figure of 10%. The results identified:
    - 98% of responds said they had been given a bereavement booklet.
    - 81% patients were as comfortable as possible in their last days
    - 89% patients were given help to alleviate pain.
    - 81% were given enough physical and hygiene care
    - 89% were treated with dignity and respect.
    - 77% felt well informed of the patient's condition.
    - However, only 17% were given the opportunity of discussing organ, tissue or body donation by the clinical staff.
- Results of the bereavement survey were discussed at the compassionate care panel and the SPCT had monthly team meetings. We saw action had been discussed to ensure learning was taken from the results.
- Nursing staff told us there were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life. This allowed family and friends unlimited time with the patient. While designated overnight accommodation facilities was not available staff supported relatives through the provision of recliner chairs where they were available and there was free access to tea and coffee making facilities in all the wards we visited.
- The trust provided information to relatives, while the patient was dying and when the patient had died. For example, a leaflet outlining the changes that may occur in the patient in the hours before death and a leaflet explaining local procedures undertaken after the death of the patient. While we did not see information in any other language other than English however, staff told us the booklet could be provided in other languages.
- Compassionate care champions had received training in the care of patients with a learning disability or with a diagnosis of dementia. We saw evidence the training had been cascaded to staff on wards and in clinical departments. The training focused on developing confident competent staff awareness to provide care with a focus on maximum comfort and awareness of patient wellbeing.
- There was a multi-faith prayer room on site. The room was open 24 hours a day, seven days a week and was used by patients, relatives, carers and staff. The chaplaincy team

provided Christian, spiritual and pastoral care and religious support for patients, relatives and staff across the trust. Staff alerted the chaplaincy team if a patient asked to see them or patients could refer themselves. For patients who wished to take communion, but could not attend the chapel, the chaplain or an authorised member of the team brought communion to their bedside. There was a book for people to write their prayer requests in.

- The multi-faith prayer room was a quiet space where people of all faiths and none could pray or reflect. Staff, patients and relatives used the room regularly. Attempts had been made to make the area welcoming to people of all faiths, for example, an A4 size computer generated sign with the word Qibla had been secured to the ceiling with tape to identify the direction of Mecca. In Islam, the word Qibla is used by Muslims to indicate the direction to face to perform ritual prayers and points towards the city of Mecca. There were religious books available such as Guru Granth Sahib, the Bible and the Koran. There were staff toilets next to the room that could be used for a wudu (an Islamic washing ritual). However, the general public could not access these. We discussed the location and environment of the prayer room, the team had plans to develop the space into a warm and inviting multicultural space.
- Spiritual needs resource boxes were also available on all wards. These boxes contained information about relevant considerations following death for various religions such as Jehovah's Witness, Islam, Judaism and Sikhism and items of spiritual comfort such as a book of Jewish prayers, Bhagavad Gita a 700-verse Hindu scripture, a rosary, crucifix, compass for showing direction of Qibla.
- The trust scored better than the England average in two of five of the National Care of the Dying Audit of Hospitals (NCDAH) 2014/15 (published in March 2016) clinical audit KPIs. The trust could demonstrate:
    - There was documented evidence within the last episode of care, it was recognised, the patient would probably die in the coming hours or days.
    - There was documented evidence within the last episode of care, there was health professional recognition the patient would probably die in the coming hours or days and imminent death had been discussed, with a nominated person important to the patient.

  However the trust could not demonstrate there was documented evidence that:
    - The needs of the person important to the patient were asked about.
    - In the last 24 hours of life, a holistic assessment of the patient's needs regarding an individual plan of care had been carried out.
    - That the patient was given an opportunity to have concerns listened to.
- The trust did not have facilities in the mortuary for honouring spiritual and cultural wishes of the deceased person and their family and carers whilst preparing the body for transfer however, this could be arranged at the funeral director's premises.
- At the time of the last inspection, the trust had introduced a bereavement focus group the first group was held in June 2016. A second event was planned for September 2016.
- The chaplaincy service provided a multi-faith or no faith services to patients, relatives and staff at the trust. This was provided in the multi-faith prayer room or on the wards. The chaplaincy service was supported by 20 volunteers, who provided a programme of daily and weekly visits to wards and clinical departments.
- The trust provided a 24 hour interpreting service to patients whose first language was not English. Staff were aware of the service and told us it worked well.
- The hospital had a Macmillan cancer support information centre to ensure that people affected by cancer had access to comprehensive and appropriate information and support. The centre was open from 9am to 5pm, Monday to Friday. The service offered a drop-in service for information and support, as well as health, financial and life management advice.
- We saw on a number of older peoples' wards, staff had made some changes to the side room on their ward to make them more suitable for use of patients receiving end of life

care. They had introduced lights that could be dimmed and a notice board family could leave either messages, pictures or cards on.

Access and flow

- Patients had timely access to initial assessment, diagnosis or urgent treatment.
- There was an improvement in the time to assessment from referral since the last inspection. 92% of patients were seen on the same day of referral between April 2016 to March 2017. At the time of the last inspection, 81% of patients were seen within 24 hours of referral from April 2015 to March 2016.
- Between April 2017 and July 2017 81% of patients were supported to die in their preferred place of death. 74% of patients had preferred place of death identified on their individualised care plan for the dying person (ICPDP). At the time of the last inspection in September 2016, 82% of patients had died in their preferred place of death from January 2016 to March 2016. It was reported in the trust's annual review for end of life care for 2015 to 2016 presented to the trust board in January 2017, the service had achieved compliance with the clinical commissioning group (CCG) target for ensuring appropriate patients had an advance care plan (ACP) in progress and achieved their preferred place of death (PPD).
- Patients who were identified as requiring palliative care such as symptom control in end of life care were referred to the SPCT by individual consultants or ward staff. 100% of patients were seen within 48 hours.
- There was a formal process to identify end of life care patients admitted to the hospital. The team accessed the electronic palliative care coordination system (EPaCCS) in primary care where information for patients at the end of life was available. Patients at the end of their lives were documented at the daily handover sheets completed by each ward and shared at daily safety huddles. This ensured the hospital had an overview of all patients at the end of life.
- The SPCT collected information on preferred place of death for patients known to SPCT. At the last inspection, we saw the team had reviewed care records of patients known to the SPCT who had died at the hospital from January 2016 to March 2016, 82% had died in their preferred place of death.
- The SPCT monitored the reasons for patients not being able to be discharged to their preferred place of care. They used this information to evaluate the quality of the information collated in the care plan, assess effectiveness of the service and tailor training needs. Between April 2017 and July 2017 179 patients' records were audited. 29 (16%) patients were unable to be discharged to their preferred place of care. 14 patients had identified home as their preferred place of care, but five were unable to return home as their physical condition did not permit transfer, seven patients had experienced an unexpected deterioration in their condition, one person died prior to discharge and one person was waiting for a care package. Twelve patients who had identified a local hospice as their preferred place of care were unable to be discharged. Two were delayed due to discharge process, two due to there being no beds available, one person died unexpectedly and six people were unable to be discharged, as their physical condition did not permit transfer. Three people had identified a nursing home as their preferred place of care however two were unable to be discharged, as their physical condition did not permit transfer. One person was delayed due to delays in the discharge process.
- The SPCT clinical nurse specialists picked up referrals and phone messages for the SPCT each time they went back to the office. The SPCT held a bleep and urgent referrals could be made by bleeping the SPCT. Staff told us and we saw patients who required end of life care were identified at daily board rounds. Once identified, the ward team would refer the patient for specialist palliative care.
- Porters told us that they were able to respond promptly to requests to transfer deceased

patients to the mortuary. We spoke with ward staff who told us they did not have concerns about response times.

Learning from complaints and concerns

- There was a complaint system in place. Staff were able to tell us how they would support patients and relatives to raise a concern. Relatives we spoke with told us they knew how to make a complaint or raise concerns if it was necessary.
- From July 2016 to July 2017, there were four complaints about end of life care. The trust took an average of 162 days to investigate and close complaints. Two complaints related to staff attitude, one related to clinical treatment and the fourth complaint related to communication. We saw evidence investigations had been completed and learning had been shared with staff.
- The SPCT lead told us they were provided with information about complaints from other services. The SPCT had access to the investigations and identified learning. The SPCT reviewed these complaints and discussed within their team, to see if improvements to services could be made and to identify needs for future end of life care training they provided to hospital staff to ensure lessons were learnt.
- The patient affairs service sent out a bereavement survey, results were discussed at the compassionate care panel and the SPCT had monthly team meetings.

Are end of life care services well-led?

Good

We rated end of life care services as good for well-led because:

- The trust had executive and non-executive board representatives for end of life care, which provided representation and accountability for end of life care at board level.
- The specialist palliative care team (SPCT) told us there was clear and consistent leadership for end of life care at the trust and were actively supported to improve end of life care.
- The trust had an end of life strategy and work plan for end of life care from 2016 to 2019.
- There were robust governance arrangements in place to ensure the delivery of the strategy and good quality end of life care.
- The service had local audits in place to measure the effectiveness and outcomes of the service.
- There were effective plans in place to address the outcomes of audits such as the National Care of the Dying Audit of Hospitals (NCDAH) 2014/15 and published in March 2016.

However:

- The service had three consultants who provided 30 hours (0.8 WTE). However, at the time of inspection, one consultant was away on a long term basis, The staffing levels were below the National Institute of Health and Care Excellence (NICE) guidelines, commissioning guidance for palliative care, published collaboratively with the association for palliative medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK.

Leadership of service

- The chief nurse was the trust executive lead with responsibility for end of life care within the trust and was the chair of the compassionate end of life care panel (CEOLCP). Since the last inspection, the trust board had appointed a non-executive director for end of life

care. The SPCT felt end of life care was represented and supported at board level.

- Staff told us there was good leadership in the SPCT. The SPCT felt their line manager, had the capacity and capability to lead the service effectively. They felt well supported by matrons, lead nurses, lead clinicians and directors in the trust.
- All staff we spoke with were aware of who their immediate managers were and were aware of the roles of the senior management team.
- The mortuary, patient affairs staff and the chaplain told us that they felt supported and listened to by their line management.
- All the ward staff we spoke to knew who the leads were for end of life care.
- The mortuary and patient affairs staff and the chaplain told us that they felt supported and listened to by their line management.
- All the ward staff we spoke to knew who the leads were for end of life care.

Vision and strategy for this service

- The service had a clear robust, realistic end of life care vision and strategy.
- Staff were able to tell us about the vision; “to deliver the very best care for every patient every day.” For patients at the end of their lives the aim was; “to deliver the care I want, where I want and when I want during my life and after death for myself and my family/carer(s) delivered by competent, confident and compassionate professionals.”
- The strategy had been approved by the trust board July 2016. It outlined the vision, ambitions and measures of success, which were in line with the National Framework: Ambitions for palliative and end of life care: A national framework for local action 2016 – 2019. The strategy provided a summary of the implementation plan for the trust and milestones for achievement. We saw a robust monitoring process through the compassionate care panel and the panel reported end of life activity to the quality and safety group.
- Staff we spoke with had a good understanding of the vision and strategy and their role in achieving them.
- We saw evidence in the minutes of board meetings where EOLC was discussed
- The individualised care plan for the dying patient (ICPDP) and the associated training ensured end of life care was assessed, monitored and managed on a day-to-day basis and reviewed regularly.

Governance, risk management and quality measurement

- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken.
- The service had local audits in place to measure the effectiveness and outcomes of the service, for example an audit of laxative and anti-emetic prescribing for patients started on strong opioids, audit of pain assessment in new referrals and an audit of DNACPR form completion. The service had produced action plans to address the shortfalls and issues raised by the audits and evidence of learning from audits had been shared with staff.
- The service had taken part in the National Care of the Dying Audit of Hospitals (NCDAH) 2014 to 2015. The service planned to take part in future NCDAH audits.
- SPCT meeting minutes and compassionate end of life care panel minutes seen, included a review of complaints and compliments, details of incidents, details of activity and pressure on capacity, staffing and recruitment, training, finance overviews and risks. The minutes seen were well structured and inclusive.
- The trust had systems in place to identify risks. There was evidence of the risks on the end of life care and mortuary register being discussed at board level. The annual report for end of life care for 2015-2016 was presented to the board in January 2017. The report contained risks associated with end of life care. The end of life care and mortuary service held its own risk register and clinical leads, and team members we spoke with were able to

identify risks. Each risk has an assigned owner and a review date.

- We reviewed the end of life care and mortuary risk register, which contained four risks.
    - Failure of body store refrigeration and freezer units and associated remote monitoring system at Hemel Hempstead hospital mortuary.
    - Lack of Syringe pumps in the trust. (While there were sufficient pumps at the time of inspection, the team were concerned that supplies can rapidly diminish if not properly managed.)
    - Failure to meet national palliative care guidance for consultant establishment.
    - Individualised Care Plans: Lack of trust wide documentation for our patients who are recognised to be dying (lack of replacement for the Liverpool care pathway LCP).
- We saw the risk register had been updated with specific plans although the risks remained the same. However, not all descriptions were an accurate representation of the risks. One risk identified lack of trust wide documentation for patients who were recognised to be dying (lack of replacement for the LCP) but we saw the ICPDP was fully embedded across the trust. We asked why this risk was on the risk register we were informed a new ICPDP policy was awaiting ratification. This was raised with the SPCT at the time of the inspection.
- We saw the SPCT team meeting minutes identified the review of their risk register. The risk register was also discussed at the compassionate end of life care panel (CEOLCP) meetings and actioned. Staff we spoke with told us issues and concerns were escalated to the trust risk register meeting if felt to be appropriate.
- The SPCT were part of the Bedfordshire and Hertfordshire specialist palliative care group and attended regular quarterly meeting with the clinical commissioning group, they used these groups to benchmark their services and review how their services reflected the needs of their local population.

Culture within the service

- Nurses, doctors and support staff told us they felt respected and valued. They were committed to provide safe and caring services and spoke passionately their involvement in the delivery of end of life care.
- Nurses and doctors told us they were confident in their knowledge and abilities to care for patients at the end of life. They felt the training and support they had received from the SPCT was appropriate. All staff we spoke with were very complimentary about the service and support the SPCT provided.
- The SPCT were respectful and maintained patient's dignity; there was a person-centred culture. We saw staff responding to patients wishes.
- Staff told us they were proud to work in the trust. Staff said they were supported in their roles.
- SPCT, mortuary and chaplaincy staff told us there was a clear management structure, staff felt able to raise any concerns with managers and that they would be listened to. They were aware of the hospital's whistleblowing policy.
- Staff felt end of life care service provision was well represented at board level and sufficient priority was given to the end of life care service as a whole.

Public engagement

- The SPCT organised an event within the hospital during the National Dying Matters Awareness Week in May 2017. An information stand was set up in the hospital café, the SPCT provided information and support from the stand.
- Bereaved relatives' views and experiences were gathered through the trust's bereavement questionnaire. The service aimed to use these views to shape and improve the end of life care service. However, the response rate was low. The trust provided us with information

from their last review of bereavement questionnaires surveys returned from October 2016 to September 2017. 161 surveys had been returned which was approximately a 10% response rate.

- The service was aware of the poor response rate to the survey so had set up a bereavement focus group relatives who did respond to the survey were asked if they would like to join the focus group. Groups were held quarterly. We saw at the last focus group in May 2017, relatives had been asked for feedback about the hospital information leaflet for bereaved relatives. Alterations had been made to the leaflet following feedback.

Staff engagement

- The trust carried out surveys on staff satisfaction, although these did not specifically identify end of life care results.
- The SPCT held regular formal team meetings where information and learning from safety and quality audits could be shared.
- Staff within the SPCT had been involved in the CQC self-rating process of the end of life care.

Innovation, improvement and sustainability

- SPCT supported the Intensive care unit to develop a bespoke end of life individualised care plan.
- The trust had held bereavement focus groups over the last year.
- The trust held a first adult memorial service in November 2016, which was attended by over 40 relatives, friends and carers.
- Staff demonstrated they were focused on continually improving the quality of care. The trust was part of the NHS Improvement (NHSI) programme for end of life care focussing on two care of the elderly wards with the aim of “developing a competent and confident workforce by focusing on education and development to improve the end of life care experience for patients and their significant others”. Learning from this work would be shared across other wards within the trust. At the time of inspection, significant progress had been made. Base line data and audits had been completed, and through weekly meetings, the results had been used to influence several work streams. These work streams were influenced by the National Ambitions for Palliative and End of Life Care Document. (2015) This was a collaborative project, with the ward teams working alongside the Macmillan End of Life Care nurse educator and Specialist Palliative Care Team to drive forward education and changes in practice. The results of the project were to be presented to NHSI in October 2017. NHSI is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. They offer the support providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, NHSI help the NHS to meet its short-term challenges and secure its future.

Outpatients & Diagnostic Imaging

Safe	Requires improvement	●
Effective	Inspected but not rated	●
Caring	Good	●
Responsive	Good	●
Well-led	Good	●
Overall	Good	●

Information about the service

West Hertfordshire Hospitals NHS Trust has outpatients and diagnostic imaging departments at three hospital sites: Watford General Hospital, Hemel Hempstead General Hospital and St Albans City Hospital. They provide outpatient services across a wide range of specialities, including cardiology, gynaecology, urology, dermatology, and rheumatology. The trust had 520,693 first and follow-up outpatient appointments from February 2016 to January 2017, with 282,031 of those appointments at Watford General Hospital.

Outpatients includes all areas where patients 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.

The main outpatient department at Watford General Hospital has 24 consultation rooms. Consultants and specialist nurses in the West Hertfordshire Cardiac Centre run cardiac clinics and diagnostics on the Watford General Hospital site. This includes rapid access clinics for patients thought to have had trans-ischaemic attacks (TIAs), chest pain and heart failure. Rapid access clinics are also provided in gynaecology and care of the elderly and there is an urgent treatment centre within ophthalmology.

There was a separate outpatient department for children and young people up to 18 years. Children and young people were also seen in the adult ophthalmology clinics, dermatology clinics, urology and ear, nose and throat (ENT) clinics.

The general outpatients department is managed within the trust's medical division. The surgical division manages some clinics, such as ophthalmology.

We inspected a number of the outpatient clinics and diagnostic services within the main site including:

- Cardiology clinic
- Care of the Elderly clinic
- CT scanning
- Diabetic and Endocrine clinic
- Ear Nose and Throat (ENT)
- Haematology clinic
- Head and Neck clinic
- Audiology clinic.
- Ophthalmology clinic

- Magnetic resonance imaging (MRI) department
- Nuclear Medicine department
- Ophthalmology clinic
- Rheumatology clinic
- Urology clinic
- X-ray department
- Fluoroscopy
- Phlebotomy

We spoke with 45 members of staff including nurses, doctors, therapists, administrators, and housekeepers. We spoke with 28 patients and their relatives. We considered the environment and looked at 15 care records. We also reviewed the trust's outpatients and diagnostic imaging performance data.

The service was previously inspected in September 2016 and was rated requires improvement for safe, caring, responsive and well-led and was rated requires improvement overall. We inspect but do not rate the effectiveness of the service, as we are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging.

Summary of findings

Overall, we rated the outpatients and diagnostic imaging service as good because:

- Since our previous inspection in September 2016, an outpatient quality improvement plan (QIP) had been implemented. This included all issues raised during the previous inspection and we found that 14 out of 15 had been completed in August 2017. Performance data had improved since the plan was implemented and the service was performing in line with their planned trajectory.
- There was a positive incident reporting culture across the services provided. We saw robust departmental learning from a recent never event.
- Our last inspection in September 2016 highlighted issues with non-compliance with hand hygiene and lack of hand hygiene audits. We found this had improved during our inspection in August 2017. Good standards of hand hygiene were maintained and the department was compliant with hand hygiene audits.
- Patient records were stored securely in locked rooms and trolleys. This was an improvement since our last inspection.
- Radiation protection in the diagnostic imaging department was robust and supervisors were appointed in each clinical area. Medical physics experts and radiation protection supervisors actively worked with staff to provide advice and ensure compliance with safety standards.
- Nurse staffing levels were appropriate with minimal vacancies and staffing levels met patient needs.
- Staff in all departments were aware of the actions they should take in case of a major incident.
- Risk to patients on the waiting list for outpatient appointments was discussed at weekly meetings. Clinical assessments were conducted if patients waited 30 weeks or more for outpatient services.
- Care and treatment was delivered in line with evidence-based guidance, standards and best practice.
- The diagnostic imaging department was working towards the Imaging Services Accreditation Scheme (ISAS).

- There was a comprehensive clinical audit programme in the radiology department to monitor compliance with trust policy and Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Results showed consistent compliance and actions taken to improve.
- Appraisal rates met the trust target, which was an improvement since the previous inspection.
- Multidisciplinary meetings were held in various specialties so that all necessary staff were involved in assessing, planning and delivering patient care.
- Patients were treated with compassion, kindness, dignity and respect.
- Chaperones were available throughout the outpatient and diagnostic imaging services. Information on the chaperone policy was displayed in clinical rooms and waiting areas.
- Patients we spoke with felt well informed about their care and treatment.
- Our last inspection identified issues with patients being treated in the corridor in dermatology. During this inspection, there was a dedicated room for wound care. This was an improvement.
- Improvements had been made in the ophthalmology department to maintain patient confidentiality. During our previous inspection, two orthoptists shared a clinic room and saw patients at the same time, which did not maintain confidentiality. At this inspection we found that clinic rooms were no longer shared.
- During our last inspection, we were not assured that patients had timely access to treatment as the trust performed worse than the England average for the percentage of patients receiving an outpatient appointment within 18 weeks of referral. However, this had improved and met the England average from April 2017 onwards.
- The trust had improved its performance for cancer waiting times and was meeting the national standard in four out of five measures.
- Patients had timely access to diagnostic imaging services and the percentage of patients waiting more than six weeks was lower than the England average.
- Diagnostic imaging services were available seven days a week and patients were able to change appointments to suit their needs.
- Outpatient specialties held additional evening and weekend clinics to reduce the length of time patients were waiting.
- Our last inspection identified issues with lack of written information for patients prior to their appointment, for example, what to expect on the day. During this inspection, we saw letters contained detailed information for patients. This was an improvement.
- Poor communication between medical and nursing staff was highlighted at our previous inspection for example, clinics were held that nursing staff were unaware of. During this inspection, staff said this had improved.
- Staff completed a weekly monitoring of waiting lists and clinics flexed to meet any changes in demand or noted increased numbers.
- A new cardiac suite had been opened and magnetic resonance imaging (MRI) was available seven days a week to meet the needs of patients.
- There was good awareness of the needs of patients with a learning disability and dementia. Twiddle muffs were introduced for patients living with dementia attending the diagnostic imaging department to assist with restlessness as promoted by the dementia society.
- Some departments had developed services, such as one-stop clinics, in order to better meet the needs of patients and improve service provision.
- Staff felt that managers were visible, supportive and approachable.
- All staff we spoke with felt respected and valued. The culture across outpatient and diagnostic imaging services encouraged openness, candour and honesty.
- Patients, relatives and visitors were actively engaged and involved when planning services. Clinical leads led an outpatient user group to gather information on patient experience.

- Leadership of the diagnostic imaging department was focused on driving improvement and delivering high quality care to patients. Radiology governance and risk management processes were robust and effective.
- The service had leadership, governance and a culture, which were used to drive and improve the delivery of quality person-centred care.
- There were high levels of staff satisfaction, and individuals were proud to work for the trust.

However:

- We saw evidence that learning from incidents was shared across Watford General Hospital, Hemel Hempstead Hospital and St Albans City Hospital; however, this learning was predominantly within divisions and did not include services provided by different divisions. For example, staff in the main outpatient department which was run by the medical division were unaware of any learning from the never event that occurred in ophthalmology, which was run by the surgical division.
- The World Health Organisation (WHO) five steps to safer surgery checklists had not been completed consistently for patients who had undergone minor surgery with local anaesthetic. For example, we looked at five patient records in the dermatology clinic and saw safety checklists had not been completed in three out of five records.
- Not all band 5 nursing staff who had direct contact with children in outpatients had received level three safeguarding children training.
- Compliance with fire safety training in the radiology department was below the trust target of 90%. Non-clinical staff compliance was 78% and clinical staff compliance was 73%.
- Patients attending the clinic for the first time and identified as having a learning disability or living with dementia were not always flagged in the patients' records or referral letter. This meant adjustment could not be made prior to their attendance to facilitate their journey through the department.
- Risks that were identified during both the previous and most recent inspections, such as missing records were not on the departmental risk register.

Are outpatients & diagnostic imaging services safe?

Requires improvement

Overall, we rated the outpatient and diagnostic imaging service as requires improvement because:

- The World Health Organisation (WHO) five steps to safer surgery checklists had not been completed on three out of five patient records we reviewed following minor surgery with local anaesthetic. This had been highlighted at our previous inspection in September 2016.
- Although naso-endoscopes were cleaned manually to keep patients safe, the trust did not follow the best practice guidelines for cleaning the scopes. This had been raised as an issue during our last inspection in September 2016.
- Not all band 5 nursing staff who had direct contact with children in outpatients had received level three safeguarding children training. This had been highlighted at our previous inspection in September 2016.
- Rooms were not always cleaned thoroughly between patients in the minor operations room in the dermatology clinic.
- Two hand-wash basins in the consultation and treatment rooms in the main outpatient department and audiology clinic had plugs and did not comply with Department of Health Guidance. Overflows and plugs are difficult to clean and may become contaminated, therefore posing an infection control risk.
- Compliance with fire safety training in the radiology department was below the trust target of 90%. Non-clinical staff compliance was 78% and clinical staff compliance was 73%. This

meant in the event of a fire, not all staff would have up-to-date competencies to safely evacuate patients and their relatives.

However:

- There was a positive incident reporting culture across the services provided. All staff we spoke with knew how to report an incident.
- Our last inspection identified issues with non-compliance with hand hygiene best practice. During this inspection, we saw hand hygiene audits were done and staff adhered to hand hygiene best practices, in line with national guidance.
- Medical records were comprehensive, legible, accurate and up-to-date. They were stored safely in a locked room or in lockable trolleys when being used in clinics.
- Radiation protection in the diagnostic imaging department was robust and supervisors were appointed in each clinical area. Medical physics experts and radiation protection supervisors actively worked with staff to provide advice and ensure compliance with safety standards.
- Risk to patients on the waiting list for outpatient appointments was discussed at weekly meetings. Clinical assessments were conducted if patients waited for outpatient services for 30 weeks or more.

Incidents

- From June 2016 to May 2017, the trust reported one incident which was classified as a never event for the outpatients department. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The never event occurred in the ophthalmology department at Watford General Hospital. It involved a patient being inappropriately administered eye injections that were prescribed for someone else. After the incident, the patient was reviewed immediately, over the next few days via telephone and in a face-to-face appointment two weeks later. Clinicians confirmed that no harm had occurred as a result of the never event. In response to this incident, patient identification wristbands had been introduced within outpatients across the trust to reduce the risk of a similar incident occurring. Using identification wrist bands for procedures such as eye injections is in line with best practice. The World Health Organisation (WHO) Surgical Safety Checklist had also been introduced for minor operations. We saw evidence of this in patient notes. We saw effective, departmental learning from this never event. For example, staff we spoke with demonstrated learning from this incident and could tell us how learning was shared within the ophthalmology department. The trust completed an investigation into this incident to highlight any actions that could be completed to prevent reoccurrence.
- We saw evidence that learning within the clinical divisions was shared across Watford General Hospital, Hemel Hempstead and St Albans Hospital. However, this was not always communicated to the outpatient services in other divisions. For example, staff in the main outpatient department which was run by the medical division were unaware of any learning from the never event that occurred in ophthalmology, which was run by the surgical division. We could not be assured that learning from incidents and complaints was shared across all outpatient departments.
- From June 2016 to July 2017, the trust reported 1,325 incidents in the outpatient and diagnostic imaging services. Of the reported incidents, two were graded as severe harm, eight as moderate harm, 102 as low harm and 1,212 were graded as no harm. The incident graded as catastrophic harm/death occurred in the diagnostic imaging department at Watford General Hospital and involved a missed opportunity for diagnosis for a patient who attended for an MRI scan in 2015. There was a robust investigation into this incident and

learning was shared across the trust.

- In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in outpatients that met the reporting criteria set by NHS England from June 2016 to May 2017. This was the incident that was also categorised as a never event in ophthalmology.
- Staff described when the duty of candour applied and demonstrated an understanding of when it should be implemented. They informed patients when things went wrong and there was evidence of apology in incident investigations we reviewed. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was able to demonstrate where the duty of candour was applied following incidents. For example, we saw evidence that staff complied with the duty of candour regulation following an incident where eye injections were inappropriately administered to a patient.
- All staff we spoke with about incidents, were able to explain what duty of candour was and when it would be needed.
- The radiology department reported four incidents to Care Quality Commission (CQC) under Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) requirements. IR(ME)R states that NHS trusts must notify CQC when a patient receives radiation exposure that is much greater than intended. Of the four incidents reported from May 2016 to June 2017, one occurred at Watford General Hospital. This incident involved a patient being given a second computer tomography (CT) scan eleven months earlier than scheduled. The request form had the correct date, but was incorrectly processed when the request was authorised. The patient was then recalled eleven months later for the CT scan on the correct date. Immediate actions included explaining the error to the patient and reminding staff to check request forms at each stage of processing. During our inspection, we found that radiology staff were aware of the incident and learning points.
- The service used the trust wide electronic incident reporting system to report incidents. Staff we spoke to were all aware of the system and how to use it and found it easy to manage.
- Nurses and healthcare assistants attended daily huddles where incidents and safety issues were discussed. This included the expected activity level of the clinic, any staffing issues and learning from previous incidents. There were also monthly team meetings where staff discussed safety and performance.
- Staff in radiology were able to describe how they completed an incident form using the electronic reporting system. They told us how the form was processed and who was responsible for investigating the incident. We were told feedback was always provided at team meetings so that everyone could learn from the incident. We saw the radiation protection committee meeting minutes from June 2017 where an incident from the radiology department had been discussed and actions were put in place to reduce the likelihood of similar incidents occurring in future.

Radiation Protection

- The medical physics department supported diagnostic imaging staff by providing radiation protection services. This team included radiation protection advisor (as required under Ionising Radiation Regulations 1999 [IRR99]), medical physics experts (as required under Ionising Radiation (Medical Exposures) Regulations 2000 [IR(ME)R]) and radioactive waste advisors. The medical physics teams provided scientific support to radiology departments in a number of areas, such as monitoring specialist radiology equipment, monitoring staff radiation doses and providing guidance on the various specialists' regulations surrounding the use of imaging equipment.
- A radiation protection supervisor (RPS) was available for each diagnostic imaging modality

as required by IRR99. The purpose of these roles was to ensure that staff followed local rules and adhered to radiation protection procedures in the department. The local rules summarised the key working instructions intended to restrict exposure in radiation areas. Staff we spoke with knew who their RPS was and could contact them for advice.

- Risk assessments had been carried out on all imaging equipment and staff wore radiation badges to monitor any occupational doses. The radiation protection policy was regularly reviewed and the radiation protection team carried out regular audits. Results from audits demonstrated compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). Radiation warning signs were clearly displayed outside all appropriate rooms in the diagnostic imaging department.

Cleanliness, infection control and hygiene

- During our inspection, most areas of the outpatient and radiology departments were visibly clean and tidy. All patients and relatives we spoke with told us that they found the departments to be clean and tidy each time they visited. However, we saw a visibly dirty disposable under-pad sheet in the procedure room where minor operations took place within the dermatology department. We raised this with senior staff who said this was poor infection prevention and control practice and was an area for improvement. Staff removed this at the time of our inspection.
- Two hand-wash basins in the consultation and treatment rooms in the main outpatient department and audiology clinic did not comply with Department of Health Guidance (Health Building Note 00-09: Infection control in the built environment). The sinks had overflows and recesses that were capable of taking a plug. They had plugs on chains that were tucked into the overflow. Overflows are difficult to clean and may become contaminated, therefore posing an infection control risk. A plug allows the basin to be used to soak and reprocess equipment that should not be reprocessed in such an uncontrolled way. When we raised this with the outpatient department manager, they said arrangements would be made for the plugs to be removed from the sink overflow.
- There were monthly audits to monitor the cleanliness of the environment in the outpatient service. Watford General Hospital outpatient department scored below the trust target of 95% in January and March 2017, when compliance was at an average of 86%. This improved in May 2017 to 95% and therefore met the trust target.
- Non-compliance with hand hygiene and lack of hand hygiene audits were highlighted as issues in our previous inspection in September 2016. We found that this had improved by the time of our inspection. The service now conducted audits to monitor staff compliance with hand hygiene and results had been above the trust target of 95% since December 2016. The outpatients department at Watford General Hospital had achieved 100% compliance across all groups of staff since January 2017.
- The trust tested water outlets in clinical areas for legionella (a bacterial infection) and pseudomonas aeruginosa (a bacterial infection) as water supply can be a source of infection. The bi-annual infection and control report from October 2016 to March 2017 stated that all outlets in clinical areas were returning negative results for pseudomonas aeruginosa and there were no cases of legionella identified. We saw in the dermatology department that taps were flushed three times per week.
- From December 2016 to May 2017, the outpatients department reported no incidents of MRSA or hospital acquired *C. difficile*.
- Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps, clearly marked with foot pedal operated lids. Bins were not overfilled.
- Hand sanitising gel dispensers were available in corridors, waiting areas and clinical rooms. Staff were observed using hand sanitisers and personal protective equipment as appropriate.
- All staff were observed to be ‘arms bare below the elbows’ and wearing appropriate

personal protective equipment in the relevant locations and departments, such as patient contact.

- Clinic rooms used for clinical procedures were adequately equipped to maintain safety and infection control standards.
- At our previous inspection in September 2016, we found that re-usable naso-endoscopes were not decontaminated in a washer-disinfector at the end of clinics. At our re-inspection in August 2017, this was still the case but the cleaning method used was appropriate to keep patients safe. Scopes were decontaminated between patients using a three-step cleaning technique, which met Department of Health Technical Memorandum (HTM) 01-06 essential requirements and was appropriate as they did not have lumens. However, it could have been improved to meet best practice by putting scopes through a washer-disinfector at the end of clinics. Senior staff had recognised this and had a review conducted by the cleaning detergent manufacturer to ensure their process was safe.
- Naso-endoscopes were appropriately tracked and traced, in line with best practice. Once a scope was used on a patient, the unique identifying number was recorded in a log book and in the patient's notes. This allowed identification of patients who may be affected if cross-infection occurred.
- There were disposable privacy curtains in the department that should be changed every six months, as a minimum. Curtains were dated with when they were last changed and were all in date.
- There were no designated rooms for seeing patients with communicable diseases, such as influenza or tuberculosis. Staff told us that if it was necessary to isolate a patient an appropriate consultation or treatment room would be designated for their use. The patient would not be seated in the waiting area, in order to reduce the spread of any known communicable diseases to other patients and visitors. The room would then be thoroughly cleaned prior to any other patient use. This was in line with infection control procedures.
- The diagnostic imaging department areas were well lit and free of clutter.

Environment and equipment

- The design, maintenance, and use of facilities, premises and equipment kept people safe.
- We examined the resuscitation trolleys in the main outpatient department, dermatology and ophthalmology clinics and found evidence that regular checks had been completed and documented to ensure the equipment was fit for use.
- All equipment we observed had evidence of electrical safety testing where appropriate.
- Clear and bright coloured signage was in place in the ophthalmology department to guide patients visiting the department.
- Clinical waste was appropriately separated and colour-coded for general waste, clinical waste and sharps. Sharps bins were dated, not overfilled and had temporary closures in place.
- There were systems to maintain and service equipment as required. Equipment had stickers with dates to show they had been serviced or safety tested and when the next service was due. Safety testing is an examination of electrical appliances and equipment to ensure they are safe to use.
- We observed phlebotomists taking blood from patients during our inspection. Staff labelled specimens appropriately with the patient's NHS identification number and managed according to trust guidance.
- There was specialist personal protective equipment (PPE) in the diagnostic imaging department. This included lead aprons for staff to wear during examinations. We saw specialist PPE were in good order and lead aprons were checked for damage on an annual basis.
- Radiation warning signs and lights were located outside all clinical diagnostic imaging areas, such as x-ray.

Medicines

- There were effective systems in place regarding the handling of medicines.
- Outpatient staff had some medicines available within the clinic areas and could access specific medicines from pharmacy, if necessary.
- Medication within the outpatient department was stored in a locked room and only registered nurses had key codes to the external door. All individual cupboards in the treatment room were key coded to limit access.
- Patient group directions (PGDs) were used in the ophthalmology service to cover the supply and/or administration of eye drops and eye ointments. A PGD is a document signed by a doctor and agreed by a pharmacist, to give direction to a nurse to supply and/or administer specific medicines to a pre-defined group of patients using their own assessment of patient needs, without necessarily referring back to a doctor for an individual prescription. The ophthalmology service had 11 PGDs in place. We saw that these had been authorised and signed appropriately.
- All medicines cabinets and refrigerators had thermometers, which recorded minimum and maximum temperatures. We saw records of daily temperature checks and guidance to staff for dealing with abnormal temperature readings. In the four weeks' records we reviewed, there had been no incidences of abnormal temperature readings.
- FP10 prescription pads were stored securely. FP10 prescription forms are used by medical and non-medical prescribers for outpatients and can be taken to any pharmacy. We saw that monitoring systems were in place to ensure that all prescriptions were accounted for. For example, recording the patient details, which drugs had been issued and being signed by a doctor and a nurse.
- Medical gases, such as oxygen, were stored securely in appropriate brackets with empty cylinders stored separately. There were signs on doors advising where compressed gases were stored. The dermatology service used liquid nitrogen for some procedures. Small canisters were filled from the central store which was external to the building, in line with national guidance. Only appropriately trained staff could fill the small canisters for storage and use in the main outpatient department. We observed that canisters were stored upright in a separate container in a locked utility room.
- Radiology patients requiring contrast (chemicals that improve pictures of the inside of the body) were screened using safety questionnaires. Staff discussed risks and potential side effects with patients prior to administration.
- We saw evidence that all contrast media was stored appropriately and warmers were used for the intravenous contrast in computer tomography.

Records

- Patient records were maintained and stored in accordance with trust policy.
- Patients' individual care records were mostly written and managed in a way that kept them safe. We reviewed 15 records and found that 12 were accurate, complete, legible and up to date. However, the World Health Organisation (WHO) checklist had not been completed in three patient records. This was raised with senior staff at the time of our inspection.
- The outpatient department used a combination of paper medical records and an electronic system. Staff maintained paper records for each clinic attendance and then scanned them into the patients' electronic record.
- The diagnostic imaging, pathology, and microbiology results were recorded electronically. Staff recorded referrals for diagnostic imaging electronically. This meant that patients were always able to be seen when attending the radiology department as electronic records were always available.
- The trust's outpatient strategy was to be 'paper-lite' by 2020 and paperless in 2022. By 2020, their aim was to have introduced electronic recording and document management

systems so that all patient records, requests and clinic forms were accessed electronically. At the time of our inspection, plans had been delayed due to a recent cyber-attack. To minimise risk, the trust had temporarily suspended the introduction of new IT systems and had shut down certain systems until the threat was reduced.

- The service conducted audits to monitor the availability of patient records for outpatient clinics. From August 2016 to June 2017, on average 97% of patients' notes were available for their outpatient appointment at Watford General Hospital. This was an improvement since our last inspection when 94% of patient notes were available. Where notes were missing, staff used electronic referral forms for their clinics and did not always record missing notes as an incident.
- If notes were not available in time for clinics, the trust mitigated this by preparing the patient's referral letter, patient labels and clinical note paper for new appointments, where appropriate. If the clinician considered that this was not appropriate, the appointment would be rescheduled. Follow-up appointments could still take place as many specialties held a record of previous test results and clinic letters on their record systems.
- The quality improvement plan included implementing a system to track patient notes to improve the availability for clinics. During our inspection, administrative staff demonstrated how they tracked patient notes that had not arrived for clinics that week and reported that this had improved record availability for clinics.
- Radiology records were held securely on the radiology information system (RIS) and patient archiving communication system (PACS). Staff had access to PACS across the trust and the systems were password protected. Staff received training on these systems as part of the departmental induction.
- Imaging requests were made electronically by doctors and other trained staff across the trust and the local GP community. Paper request forms were still in use for external referrers outside of the trust.

Safeguarding

- The trust set a target of 90% for completion of safeguarding training for both adults and children. For the training module safeguarding adults in August 2017, medical and nursing staff had a training completion rate of 100% for this module, which was above the trust target of 90%.
- Not all staff who worked in clinics that saw children had the appropriate level of safeguarding children training. The Royal College of Paediatrics and Child Health 2014 intercollegiate document for safeguarding children and young people states that all healthcare professionals directly involved in assessing and treating children should be trained to level three in safeguarding children. At the time of inspection, only consultants, the senior sister, and matron were trained to this level. All other nurses were trained to level two. We raised the issue with senior staff who told us the trust's safeguarding team had advised that level three was not required for all staff working in clinics that see children. This was not in line with national guidance (Safeguarding children – roles and competencies for healthcare staff) which states that health professionals with a mixed caseload (adults and children) should be able to demonstrate a minimum of level two and be working towards attainment of level three core knowledge, skills and competencies.
- Non-compliance with safeguarding level three training for children was highlighted during the last inspection in September 2016. The trust had included this as an action point on their outpatient quality improvement plan and reported that nursing staff were compliant. However, the training levels were not in line with national recommendations.
- Compliance rates for staff who were required to have safeguarding children levels one and two were 96% respectively, at the time of inspection. This met the trust target of 90%.

- Radiology staff across the trust achieved 100% compliance with safeguarding adults and children for levels one and two.
- Information on safeguarding from abuse was displayed in waiting areas so patients and visitors could see. The information included telephone numbers to contact for advice. There was also information displayed in staff rooms, such as flowcharts for referring vulnerable adults and children.
- Staff in diagnostic imaging followed safeguarding procedures such as 'Paused and Checked'. The 'Paused and Checked' process was developed by the Society and College of Radiographers and involves checking the justification of the exam, the pregnancy status of the patient, their examination history in case of duplication, the anatomical area to be examined and that radiation safety measures for staff and/or carers had been undertaken. Information was displayed in all imaging areas we visited and staff could describe the process.
- Staff we spoke to were able to provide definitions of different forms of abuse and were aware of safeguarding procedures, how to escalate concerns and relevant contact information.
- Some senior staff for main outpatient departments across all three sites were unaware of the female genital mutilation (FGM) policy. The trust had a policy for identifying and assessing the risk of FGM, but no staff members we spoke with knew what it included. We raised this with senior staff at the time of inspection and were advised that they had also been unaware of this policy.

Mandatory training

- The trust's mandatory training included adult basic life support (BLS), conflict resolution, equality and diversity, fire and evacuation, hand hygiene, health and safety, infection control, information governance, moving and handling and safeguarding.
- Compliance with mandatory training was 98% for medical and nursing staff in the outpatient departments at Watford General Hospital. This was above the trust target of 90%.
- The trust radiology department also achieved the trust target for overall compliance with mandatory training. Compliance was 100% in nine out of eleven modules; however, compliance with fire safety and evacuation training was below the trust target of 90%. Non-clinical staff compliance was 78% and clinical staff compliance was 73%. At the time of our inspection, staff said clinical staff had been booked onto fire and evacuation training. However, we could not be assured that in the event of a fire, clinical staff would have up-to-date competencies to evacuate patients and relatives.
- There was an induction programme for all new staff, and staff who had attended this programme felt it met their needs.
- We saw completed training workbooks for induction that had been reviewed, dated and signed by senior staff. This meant that staff working across the outpatient and diagnostic services were supported with their local induction. New staff were also supernumerary for a period of time at the commencement of post, the duration of which varied according to the area of work.
- Training was completed as e-learning modules with some face-to-face sessions, such as manual handling and basic life support. Staff completed basic life support training annually.
- Senior nurses monitored staff compliance with mandatory training on a monthly basis. Email reminders were sent to staff whose training was due the following month.

Assessing and responding to patient risk

- Risks to patients on the waiting list for outpatient appointments were discussed at weekly meetings. The trust policy was to conduct a clinical assessment via telephone if a patient

waited 30 weeks or more. Individual plans were then developed for each patient to ensure they were prioritised. The plans included identifying risk of further delays, for example if a patient had previously failed to engage with the service or capacity issues within the department. Operational managers worked with clinicians and schedulers from each specialty to monitor waiting times on an ongoing basis.

- In the dermatology clinic at Watford General Hospital, minor procedures like skin excisions were performed using local anaesthetic. We found World Health Organisation (WHO) five steps to safer surgery checklists were not completed in three out of five patient records reviewed. Staff had signed the forms but had not completed the checklists before induction of anaesthesia, before start of surgical intervention and had not ticked the allergy status of the patients. We could therefore not be assured that staff were aware of the allergy status of these patients. This meant that in the event where a patient was allergic to local anaesthetic, they may experience anaphylaxis if they were administered this medication without knowing their allergy status. We raised this with senior staff at the time of our inspection who acknowledged it as poor practice.
- If a patient became clinically unwell in an outpatient area, staff would monitor them and check their vital signs then call the direct number for emergency assistance if needed. Administrative staff told us that if a patient collapsed in the waiting area they would press the emergency button to alert other staff. This meant that in the event of a medical emergency appropriate action would be taken to assess and respond to the patients' needs without putting them at risk of deterioration.
- The radiology department had guidelines to ensure that female patients and staff of childbearing age were asked if they were, or might be pregnant. This was in line with IR(ME)R regulations.
- The service audited the percentage of patients who had their pregnancy status recorded to monitor compliance with IR(ME)R guidance. In 2017, 98% of patients had their pregnancy status recorded in their notes. There were signs in waiting areas and x-ray rooms reminding patients to inform staff if they may be pregnant. Staff we spoke with were aware of the importance of checking the pregnancy status of female patients.
- The diagnostic imaging department monitored requests for examinations, in line with IR(ME)R recommendations. Request forms from all three sites were included. Results showed that 92% of forms were appropriately filled in, signed and had patient identity checked against the electronic system. This was an improvement since our last inspection in 2016 when compliance was 88%. Audits were also conducted to ensure only approved healthcare professionals made referrals. The trust was 100% compliant with this measure.

Nursing staffing

- Nursing establishments for the outpatient department were planned and reviewed to ensure safe care for patients based on clinic volumes and capacity. There is no national baseline acuity tool for nurse staffing in outpatients. Staffing levels and skill mix across all of the trust's three sites were discussed during monthly senior nurse meetings.
- Nursing and healthcare assistant staffing levels were displayed in waiting areas. We observed that nursing staff figures were displayed throughout all areas, and met planned levels during our inspection. The areas that we visited displayed the required and actual staffing numbers. We reviewed historic nursing staff rotas and found staffing levels met the necessary planned levels.
- At our previous inspection in September 2016, there was a 25% nursing vacancy in the outpatient department at Watford General Hospital. This had not improved on during this inspection. The latest data for July 2017 showed that there remained a 25% nursing vacancy. Senior staff said the vacancies had all been recruited to and five new nursing staff were expected to start by September 2017.
- The outpatients department was meeting the trust target for nursing sickness rate. Across

the trust, there was an average of 3% nursing sickness, compared to the trust target of 3.5%.

- The culture of supporting new or bank staff was evident throughout the department. Health care assistants would assist with the management of the clinic lists and offer support to new staff who worked across the department to ensure that there were no areas of risk. New staff had mentors and coaches who regularly worked alongside them to ensure competence.
- New and bank staff were inducted locally using a checklist with an additional competency pack for substantive staff. Examples of these were observed during inspection.
- There was an outpatient physiotherapy department staffed by allied health professionals. This service was fully staffed at the time of inspection and had been since February 2017.

Radiology staffing

- Each area within the imaging department had superintendents. This was a senior practitioner who worked with the team to ensure completion of care, training, and competence management of staff.
- Radiologist workload was allocated according to a staffing tool. This was based on individual radiologist job plans, reporting parameters and the department's radiologists' rota. Additional staff had been recruited to maintain a 24-hour radiography shift system, seven days per week.
- Three new radiographic department assistants had been recruited to help transport patients from A&E to the X-ray department, assist with clerical duties and assist radiographers with positioning patients for x-raying.
- The radiology department was staffed by consultant radiologists from 8am to 6.30pm, Monday to Friday and from 8.30am to 3.30pm on Saturdays, Sundays and bank holidays. Out of those hours an external company provided a CT reporting service.
- The radiology department at Watford General Hospital had a medical vacancy rate of 23% in July 2017. The turnover rate was 6%.
- In July 2017, there was a medical vacancy rate of 23% across the trust's diagnostic imaging services. Locum staff were used to fill shifts. In May 2017, there was a 9% locum usage.
- Each clinical area within the radiology department had an appointed radiation protection supervisor.
- Final year medical students and undergraduate radiography students undertook clinical placements at the trust. Students worked with and were supervised by superintendent radiographers. There were plans to also have postgraduate radiology trainees and registrars to join the department. The timescale for this was 2017 to 2018.

Medical staffing

- We found that staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment.
- In the outpatient department medical staffing for clinics was arranged by the individual specialities, such as the medical or surgical divisions.
- The individual specialities arranged medical cover for their clinics. This was managed within the clinical directorates, who agreed the structure of clinics and patient numbers.
- Junior colleagues supported consultants in clinics where this was appropriate.
- In May 2017, the overall vacancy rate for medical staff across the outpatient specialties was 2%, which was better than the trust target of 9%. The overall medical staff sickness rate for this period was 1%, which was better than the trust target of 3.5%.
- From June 2016 to May 2017, the overall turnover rate for medical staff at Watford General Hospital medical services' was 49%, which reflected the changes in rotational training staff.

However, the turnover rate for permanent staff was 8% which was in line with trust targets.

- Locum staff were used to ensure staffing levels met demand and received local induction. From August 2016 to May 2017, the average locum usage was 12% across the trust's outpatient specialties.

Major incident awareness and training

- The trust had a major incident plan that had been updated in 2017.
- Fire safety assessments were completed for the outpatient areas at Watford General Hospital every two years. The appointed fire safety officers completed assessments in line with the trust policy. Fire safety officers made recommendations and departmental fire marshals managed action plans.
- Staff we spoke with were aware of the hospital's major incident plan and knew what they needed to do in the event of a major incident.
- Within the radiology service, there were effective arrangements in place in the event of a major incident occurring within the department.

Are outpatients & diagnostic imaging services effective?

Inspected but not rated

We inspected, but did not rate the service for effectiveness. We found:

- Staff had the information they needed to deliver effective care and treatment to patients.
- Care and treatment was delivered in line with national guidelines.
- Staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients.
- The diagnostic imaging department was working towards the Imaging Services Accreditation Scheme (ISAS). This was an improvement from our last inspection.
- Radiation dose administered to patients was recorded in their notes. This was in line with Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) recommendations. Audits were conducted to monitor compliance.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to high quality care. Staff were proactively supported to acquire new skills and share best practice.
- All teams reported effective multidisciplinary working and we saw evidence of joint working to improve service provision.

However:

- Staff compliance with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) training was 78% and this was below the trust target of 90%.

Evidence-based care and treatment

- Pathways were in place for the management and treatment of specific medical conditions that followed national guidance. For example, the dermatology specialty followed a care pathway for skin lesions based on the National Institute for Health and Care Excellence (NICE) guidance, *Improving outcomes for people with skin tumours including melanoma*. We saw evidence of this in patient notes.
- Up-to-date policies were in place to ensure patients were not discriminated against. Staff we spoke with were aware of these policies and gave us examples of how they followed this guidance when delivering care and treatment for patients.
- Treatment provided in ophthalmology was in line with NICE clinical guidance CG85, *Glaucoma: diagnosis and management*'. Patients in glaucoma clinics received slit lamp

testing for eye abnormalities and visual fields testing to monitor deterioration.

- The imaging department used diagnostic reference levels (DRLs) as an aid to optimisation in medical exposure. DRLs were monitored by an onsite physicist and were cross-referenced to national audit levels. High levels were reported to the radiation protection adviser. The diagnostic imaging service monitored its compliance by auditing best practice relating to patients receiving chest radiography. Guidance from the Royal College of Radiologists (RCR) states that it is best practice to undertake chest radiographs on patients in the poster anterior (PA) upright position, apart from when this is not appropriate due to immobility or ill health. The RCR set targets of 95% of outpatient and 75% of inpatient chest radiographs to be undertaken in PA position as it improves image quality. Following this audit, staff embraced the importance of change in practice especially in difficult casualty situations. In an audit in June 2017, the service achieved the outpatient target, but not the inpatient target. Actions had been developed to improve compliance and we observed that this was in place during our inspection. Staff we spoke with were aware of the recent audit and told us that all patients who were assessed as being suitable for PA positioning, were x-rayed in that manner.
- There was a comprehensive clinical audit programme in the radiology department to monitor compliance with trust policy and best practice, including adult general radiography written examination protocols, radiology reporting protocols and local rules. Local Rules are sets of working instructions staff should follow to minimise radiation exposure. Results for 2017 showed 96% of examinations reviewed were compliant with Adult General Radiography Written Examination protocols and 98% of attendances reviewed were reported in line with Radiology Reporting protocols. This was an improvement since the previous year. The percentage of staff members who had read and signed the local rules had also improved since 2016; however, compliance was 63%. Actions to improve this result included sending email reminders and displaying posters with the importance of reading local rules. We observed these posters throughout the department during our inspection.
- The radiation dose administered to a patient was recorded in their notes, in line with IR(ME)R recommendations. Audits were conducted to monitor compliance. Results for 2017 showed 94% of patients had their doses recorded in line with guidance. Audits and actions to improve were discussed at monthly meetings.

Nutrition and hydration

- Patients who attended clinic or diagnostic appointments were not generally in the department for long periods, therefore beverages and food were not provided. However, where patients had to wait long periods due to delays in patient transport, staff offered these patients hot drinks, sandwiches and biscuits while they waited.
- Glucose preparations were available in the outpatient department for patients with diabetes when required. Glucose preparations are recommended when a patient becomes hypoglycaemic (a sudden drop in blood sugar) and needs to increase their blood glucose levels rapidly. Staff also described giving diabetic patients glucose-drinks and biscuits if their blood sugars were found to be low.

Pain relief

- There was a chronic pain service run by four consultants who specialised in pain management, in line with the Royal College of Anaesthetists recommendations. The consultant we spoke with had undergone advanced pain training as part of their professional development.
- Analgesic (pain relief) cream was available in the phlebotomy clinic for patients who might experience pain while blood was taken. This was normally used for children but was available for adults if required. Phlebotomy staff also used cold sprays to reduce pain when

taking blood.

- Staff had access to simple analgesia in areas where patients were undergoing minor procedures. For example, ophthalmology stored analgesia for patients who attended clinics for eye injections. The ophthalmology clinic also had access to local anaesthesia preparations, which were prescribed by a doctor. Pain assessment was recorded in national early warning scores charts.
- Patients we spoke with had not required pain relief during their attendance at the outpatient departments.

Patient outcomes

- During our previous inspection in 2016, the trust stated that they planned to begin submitting data to national audits, such as the national diabetic foot audit 2016/17. At the time of our re-inspection in August 2017, the diabetes service had made a submission but results were not yet published. The trust had also reported that they planned to begin submitting data to other national audits to monitor outpatient outcomes; however, we found that this had not yet been introduced.
- The pain service submitted patient outcome data to the National Pain Audit to benchmark against other similar services. This involved collecting patient reported outcome measures (PROMS). The PROMS were questionnaires for patients to fill in at their first visit to the clinic, six months afterwards and 12 months after their initial appointment. This was used to calculate each patient's pain severity. Results for the trust show they performed in line with the national average. Staff also collected patients' pain outcomes locally by monitoring their pain scores at each visit and after treatments, such as injections.
- From February 2016 to January 2017, the follow-up to new rate for Watford General Hospital was lower than the England average. Follow-up to new ratios calculate the proportion of outpatient appointments that are patients' first attendance and the proportion that are follow-up appointments. There are no national standards for this measure; it is used to determine how much time is taken up with follow-up appointments, as this may reduce capacity to see new patients.
- The diagnostic imaging department was working towards the Imaging Services Accreditation Scheme (ISAS). This was an improvement since our last inspection when ISAS was not being considered. ISAS is a patient-focussed assessment and accreditation programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments. The lead superintendent radiographer had recently become a qualified ISAS assessor which meant they were aware of best practice and how to achieve this. The timescale for this work to be completed was April 2018. The service had trained another member of staff as an ISAS assessor ready to start their accreditation process in 2018.
- The outpatients department did not participate in the Improving Quality in Physiological Services (IQIPS) accreditation scheme. IQIPS is a professionally-led assessment and accreditation programme that is designed to help healthcare organisations ensure that patients receive consistently high quality services, tests, examinations and procedures delivered by competent staff working in safe environments.
- Results from the National Cancer Patient Experience Survey 2017 showed that the outpatients department scored in line with the England average for patients receiving all information they needed before starting radiotherapy and chemotherapy treatment.
- The diagnostic imaging department also scored in line with the England average for patients receiving all information they needed before their diagnostic test in the National Cancer Patient Experience Survey 2017.

Competent staff

- Data for July 2017 showed 94% of staff within outpatients had received an appraisal,

compared to a trust target of 90%. Our last inspection in September 2016 showed 90% of staff had had appraisal in the last 12 months. Achieving 94% during this inspection was an improvement.

- The radiology department met the trust target for appraisal rates. In August 2017, 91% of staff had received their annual appraisal. This was the highest it had been in the six months prior to our inspection when rates were from 71% to 90%.
- Staff in diagnostic imaging were given opportunities to develop. For example, radiographers had expressed an interest in becoming trained in barium swallow examinations (an x-ray imaging test used to visualise the structures of the oesophagus). This had been supported and a member of staff had commenced this training. The radiology department had introduced a radiographer-led barium swallow service and were actively seeking to expand the radiographer led fluoroscopy service.
- The radiology department had introduced a radiographer-led drainage service and were actively seeking to expand this service with the view to train more radiographers in this area.
- There was a clinical supervision policy in the radiology department. The policy stated all professional practitioners that had direct contact with patients should receive one-to-one supervision every six to eight weeks. Appointed supervisors were given training to ensure they were competent in this role. Staff we spoke with had received regular clinical supervision in line with the trust policy.
- Patients who attended outpatient clinics and the diagnostic imaging department told us that they thought the staff had the right skills to treat, care and support them. Staff told us that they had annual appraisals and were encouraged to manage their own personal development. Staff were able to access training and development provided by the trust and the trust would fund justifiable external training courses.
- The Nursing and Midwifery Council (NMC) introduced revalidation in April 2016 and this ensured that all nurses and midwives maintained their registration every three years. Electronic staff record (ESR) information was provided every month to all managers and matrons. The data included the name of all NMC registrants together with the expiry and revalidation date. Line managers and matrons reviewed the information to identify and check on the registrants' progress with submission.
- The service had monitoring processes in place to ensure that doctors were working within the General Medical Council (GMC) revalidation guidelines and would be able to revalidate in line with the scheduled date. Medical revalidation was introduced in 2012 to ensure that all doctors were up to date and 'fit to practice'. All of the consultants had either been revalidated or were working towards revalidation in line with the timescale notified to them by the GMC.
- There were education leads at the trust to support registered clinicians through revalidation. Continuous professional development sessions were held and staff were provided with certificates to support their revalidation.
- There were also champions for particular areas of interest, such as dementia, health and safety, infection prevention and control and health promotion. Champions were nurses or healthcare assistants who received up to date communication in their respective area of interest.

Multidisciplinary working

- Outpatient and diagnostic teams worked with speciality teams across the trust and external providers to plan and deliver care and treatment.
- One-stop clinics were provided in urology, respiratory, ear, nose, and throat (ENT) and breast care. A one-stop clinic involves a multidisciplinary team providing consultation, diagnostic testing, results and treatment options in one visit. For example, in ENT audiologists conducted hearing tests on patients prior to their ENT appointment so that

care could be co-ordinated.
- Outpatient and diagnostic teams worked with speciality teams across the trust and external providers to plan and deliver care and treatment.
- Booking coordinators worked together with divisional managers and the individual specialties to continuously manage waiting lists for outpatient services. Staff in the booking and scheduling offices described improved communication with the clinical specialties since our last inspection.

Seven-day services

- The magnetic resonance imaging (MRI) service was available seven days per week.
- A consultant radiologist was available Monday until Friday from 8am till 6.30pm and from 8.30am till 3.30pm on Saturdays, Sundays and bank holidays. Out of those hours computer tomography-reporting service had been outsourced to another company.
- Outpatient clinics were available from 8.30am to 6.30pm, Monday to Friday. When the demand for appointments was greater than clinic availability, we were told that further clinics would be created. For example, Saturday clinics were arranged to accommodate a backlog of ophthalmology patients. The matron told us that a seven-day working business case was being explored to manage patient demand.
- Outpatient clinics were available from 8.30am to 6pm, Monday to Friday. Staff had been working additional hours to provide outpatient clinics on a Saturday and occasionally on a Sunday, in order to meet patient demand.

Access to information

- The information needed to deliver effective care and treatment was available to relevant staff. However, this was sometimes delayed by the functionality of the IT systems. Medical records were paper-based; however, referrals and test results were also stored electronically. Staff told us that sometimes IT systems were slow which had an impact on administration staff ability to fulfil their roles in a timely way. Medical, nursing and administration staff we spoke with reported issues with the IT system and stated that they regularly caused delays in accessing information. The issue had been recognised by the trust and plans were in place to monitor progress. Computers in the outpatient department had been replaced; however, the systems they used were still causing delays. The trust was planning to replace all systems.
- Patients' records were in paper format and were stored in locked trolleys and rooms.
- Where temporary patient records were used, appropriate information was made available for clinicians to review patients attending outpatient appointments. This included a copy of the latest referral letter, the last consultation letter (if applicable) and results of any investigations undertaken. Staff would also contact the relevant medical secretary and patient's GP for additional information as required.
- Communication with GPs was via an electronic system and the trust's GP liaison manager. The GP liaison manager role was to promote communication between the three trust sites and local GPs. In May 2017, the GP liaison manager had attended the outpatient senior nurses meeting with staff from all three-outpatient sites. As a result, the June 2017 newsletter that was sent to GPs included a feature on the outpatient departments. This focused on the use of purple folders to improve continuity of care for patients with a learning disability or dementia. Patients living with learning disability and dementia carried purple folders were carried to share information between health and social care providers. The GP liaison manager also discussed the availability of results and inappropriate consultant requests.
- Electronic summaries of patients' care and treatment were sent to their GPs to enable continuous care. Administration staff sent the letters within 24 hours of discharge from the outpatient service.
- Imaging requests were received online and appeared on the radiographer's electronic

system. Any previous tests including images and blood test results could be reviewed online.

- In the National Cancer Patient Experience Survey 2017, the trust scored in line with the England average for doctors having the right notes and other documentation available.
- The diagnostic imaging department shared information with GPs via an electronic system for storing examination results. GPs could access their patients' reports for plain film x-rays, ultrasound examinations, nuclear medicine investigations and some computerised tomography (CT) scans.
- Diagnostic imaging departments used the picture archive communication system to store and share images, radiation dose information and patient reports. Staff were trained to use this system and were able to access patient information quickly and easily. The system was used to check outstanding reports and enabled staff to prioritise reporting and meet internal and regulator standards. Urgent results were also faxed to the relevant consultant if requested.
- Clinic rooms had computer terminals, which enabled staff to access patient information such as x-rays and blood results via the electronic reporting system.
- Staff had access to the trust intranet to obtain information relating to trust policies, procedures, NICE guidance, and e learning.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated a good understanding of their responsibilities regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and knew what to do when patients were unable to give informed consent.
- The mandatory e-learning package provided to staff, included information about MCA and DoLS. Staff said they would seek advice from a senior member of nursing staff should a formal assessment of mental capacity require completing.
- Staff received training in MCA and DOLS. Compliance was worse than the trust target for staff in the outpatient departments. Data for July 2017 showed 78% compliance, compared to a trust target of 90%. However, all staff we spoke with during our inspection could describe the appropriate actions to take if it was suspected that a patient may lack capacity.
- Both nursing and medical staff understood consent, the decision-making requirements and guidance. We saw consent forms in place. Staff understood when to use consent forms and whether the consent provided was implied, verbal or written. Implied consent is "consent which is not expressly granted by a person, but rather by their actions and the facts and circumstances of a particular situation."
- The service used different consent forms, depending on the patients' capacity to make the decision. This was in line with Department of Health guidance. They used four nationally recognised consent forms: one for adults with the capacity to consent to treatment, one for obtaining parental consent for treatment of a child or young person, one for treatment where consciousness was impaired and another for adults who had been assessed as lacking the capacity to consent to treatment.
- Consent was obtained prior to minor operations and was recorded in all five patients' notes we looked at in the dermatology department.

Are outpatients & diagnostic imaging services caring?

Good

We rated caring as good because:

- Staff were kind, compassionate and caring in all patient interactions that we observed.

- Chaperones were available throughout the outpatient and diagnostic imaging services. Information on the chaperone policy was displayed in clinical rooms and waiting areas. All patients we spoke with said they had been offered a chaperone or to have a friend or relative accompany them.
- Patients we spoke with felt well informed about their care and treatment.
- We observed reception staff greet patients in a courteous and friendly manner and direct them to the appropriate waiting area.
- The feedback received from the patients and relatives we spoke with was positive.
- Our last inspection identified issues with patients being treated in the corridor in dermatology. During this inspection, there was a dedicated room for wound care. This was an improvement.
- Improvements had been made in the ophthalmology department to maintain patient confidentiality. During our previous inspection, two orthoptists shared a clinic room and saw patients at the same time, which did not maintain confidentiality. At this inspection we found that clinic rooms were no longer shared.
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However:

- Friends and Family Test (FFT) figures from January 2017 to June 2017 were 92%, which was below the England national average of 94%.
- Patients being cared for in beds were sometimes sent to the department for treatment. They received treatment in the main waiting area as consultation rooms were not suitable for beds. This meant privacy and dignity was not always maintained.

Compassionate care

- All staff were kind, compassionate and caring in all patient interactions that we observed. We observed good examples of caring and considerate staff during our visits in all areas of the outpatient department in waiting and treatment areas and in other communal areas such as corridors.
- We spoke with 19 patients and nine relatives regarding care. All feedback we received on inspection was positive about the treatment staff provided at Watford General Hospital.
- Friends and Family Test (FFT) scores for the percentage of patients that would recommend the service from January 2017 to June 2017 was 92%, which was below the England average of 94%. However, FFT data for July 2017 showed outpatient services across trust performance was 94%. This was in line with the England average of 94%. FFT scores were nationally reported and were not broken down by hospital site. Scores were generated using the FFT feedback tool that supports people who use NHS services to provide feedback on their experience. It asked people if they would recommend the services they have used. Their average response rate for the trust was 4%, compared to an England average of 7%.
- Patients said staff were caring and friendly and their dignity and privacy was respected. We observed staff delivering kind and compassionate care.
- Patients were provided with the option of being accompanied by friends or relatives during consultations.
- Patients said they were greeted politely by receptionists and consultants made them feel at ease during consultations.
- Thank you cards from patients were displayed throughout the service. Comments included, ‘the treatment I have received here has always been very good’ and ‘I never feel rushed, whenever we have been here, it has always been clean and tidy’.
- Chaperones were available throughout the outpatient and diagnostic imaging services. Information on the chaperone policy was displayed in clinical rooms and waiting areas. All patients we spoke with said they had been offered a chaperone or to have a friend or relative accompany them.

- During our last inspection, leg ulcer treatment was given in a corridor in the dermatology department where other patients and staff were waiting. During this inspection, we saw there was a dedicated wound care room. Staff said where they had two patients requiring leg ulcer treatment; they would use a bay in the corridor and pull the curtains to provide privacy and dignity to the patient. This was an improvement from our previous inspection in September 2016.
- The last inspection identified ophthalmology areas for tests and consultations did not maintain confidentiality. For example, orthoptists shared a room and had appointments at the same time, which meant patient confidentiality was not maintained. During this inspection, we saw no clinic rooms were shared within the ophthalmology department. We observed confidentiality, privacy and dignity was maintained during clinics.
- Reception staff in ophthalmology department greeted patients in a courteous and friendly manner and directed them to the appropriate waiting area.
- We saw there was no dedicated area to care for inpatients who required care whilst in a bed. For example, staff said an inpatient who required care had to be suctioned in the outpatient waiting area because the bed would not fit into any clinic rooms. Privacy and dignity could only be maintained by using a screen. Whilst it was unclear why an inpatient required treatment in an outpatient area, we could not be assured that privacy and dignity was maintained.

Understanding and involvement of patients and those close to them

- All patients we spoke with felt that they were being kept informed and updated by staff on what was happening, and what they should expect regarding their or their relatives care.
- In the National Cancer Patient Experience Survey 2017, the outpatients department scored in line with the England average for 'Patient was able to discuss worries or fears with staff during visit', 'Patient given understandable information about whether radiotherapy was working' and 'Patient given understandable information about whether chemotherapy was working'.
- The diagnostic imaging department scored in line with the England average for patients 'given complete explanation of test results in an understandable way' in the National Cancer Patient Experience Survey 2017.
- Patients we spoke with felt comfortable asking questions about their care and described staff as 'friendly' and 'helpful'.
- We saw patients given copies of letters that the hospital consultant was sending to their GP. This included details of whether a follow-up appointment or diagnostic test was required.

Emotional support

- Patients and their relatives told us that all staff were approachable and they could talk to them about their fears and anxieties.
- Patients were supported if they received bad news and needed to discuss their concerns.
- Patients and staff had access to the chaplaincy service who offered support to patients and staff seven days per week. In addition, there were multi-faith options available and non-religious ministers who also supported the department.
- Phlebotomists understood the needs of children attending the clinic and used distraction techniques to minimise distress. They also used pictures of animals to distract children when having their blood taken.
- Staff understood and showed how they would support the emotional and mental health needs of patients and said they were able to access specialist support if necessary.
- Relatives of distressed or confused patients were able to attend the wards at any time to assist with the care and support of the patient.

Are outpatients & diagnostic imaging services responsive?

Good

We rated responsive as good because:

- During our last inspection, we were not assured that patients had timely access to treatment as the trust performed worse than the England average for the percentage of patients receiving an outpatient appointment within 18 weeks of referral. However, this had improved and met the England average from April 2017 onwards.
- The trust had improved its performance for cancer waiting times and was meeting the national standard in four out of five measures.
- Patients had timely access to diagnostic imaging services and the percentage of patients waiting more than six weeks was lower than the England average.
- Diagnostic imaging services were available seven days a week and patients were able to change appointments to suit their needs.
- During our inspection in September 2016, 24,270 patients were waiting for their first outpatient appointment. During this inspection, this had reduced to 15,222 patients waiting for first outpatient appointment. This was an improvement.
- Outpatient specialties held additional evening and weekend clinics to reduce the length of time patients were waiting.
- Our last inspection identified issues with lack of written information for patients prior to their appointment, for example, what to expect on the day. During this inspection, we saw letters contained detailed information for patients. This was an improvement.
- Poor communication between medical and nursing staff was highlighted at our previous inspection. For example, clinics were held that nursing staff were unaware of. During this inspection, staff said this had improved.
- Staff completed a weekly monitoring of waiting lists and clinics flexed to meet any changes in demand or noted increased numbers.
- A new cardiac suite had been opened and magnetic resonance imaging (MRI) was available seven days a week to meet the needs of patients.
- There was good awareness of the needs of patients with a learning disability and dementia.

However:

- Patients attending the clinic for the first time and identified as living with a learning disability or dementia were not always flagged in the patients' records or referral letter. This meant adjustment could not be made prior to their attendance to facilitate their journey through the department.
- The doors leading to the consultation rooms in the main outpatient department were all single and narrow. It was difficult to manoeuvre stretchers and wheelchairs into the rooms.

Service planning and delivery to meet the needs of local people

- Outpatient and diagnostic imaging services were planned and delivered to meet patient's needs. This was facilitated by the department's quality improvement plan. For example, during the last inspection of outpatient services across the trust, it was identified that clinic letters did not provide patients with enough information about what to expect. The outpatient quality improvement plan included actions to address this issue and we saw evidence at Watford General Hospital. All patients we spoke with had received letters before their appointments and knew what to expect. Letters now contained contact details, date and time of appointment, consultant name, information on any tests, samples or

fasting required and car parking.

- The outpatient and diagnostic teams offered bespoke appointments for patients. All departments described flexibility in services to meet the patients' needs. This was particularly evident in the ear, nose and throat (ENT) clinic, where all investigations were planned for one appointment, including audiology and discussions with clinicians. This meant that patients would only need to attend the hospital once to gain a diagnosis and discuss a treatment plan.
- All diagnostic imaging services had an established seven-day working pattern. This enabled patients to be seen at appointments to suit their needs.
- Clinic numbers and waiting times were reviewed weekly and additional clinics were held for specialities with a noted rise in waiting times. This included weekend and evening appointments in addition to normal service.
- The division had introduced a patient "self-check in terminal" electronic system. This electronic system allowed patients to check in upon arrival to the outpatient department. Most patients we spoke with found this system easy to operate. However, we spoke with two elderly patients who said they struggled to use the electronic system to check in. Receptionists were always available to provide support when needed.
- Our last inspection identified issues with car parking. We found that this had not improved during this inspection. All patients and relatives we spoke with who had travelled by car described how difficult it had been to park. Patients and their relatives said the car park was on a slope and they needed to leave home earlier than required to ensure they got a space to park and walk to the department. Senior staff said the hospital was planning to construct a multi-storey car park to meet the needs of patients.
- The outpatient and imaging departments were sign posted from the entrance of the hospital. Signage around the outpatient and diagnostic imaging department was in English only. We saw staff stopping to ask patients and visitors if they required assistance or directions, where needed.
- The radiology department had adapted how they deliver services to increase scanning and reporting capacity. This included introducing a new radiologist rota that meant the cardiac computerised tomography (CT) scanner was available for use in some non-cardiac outpatient clinics. New rotas for radiologists and radiographers had also improved the department's ability to provide emergency cover.
- The radiology department was well equipped with modern imaging equipment including two digital fluoroscopy units to meet patient needs.
- Most outpatient specialties provided clinics across all of the trust's three sites and patients we spoke with had been offered a choice for their appointment.
- The diabetic centre provided virtual telephone clinics to support patients living with diabetes who experienced problems with their insulin pumps.
- The trust worked with partners on the re-design of gynaecology, diabetes, community musculoskeletal, dermatology, discharge to access, ear, nose and throat (ENT) and ophthalmology care pathways.
- The main outpatient department was in close proximity to the hospital café where patients and visitors could buy food and drinks. We saw jugs of water and disposable cups available for patients in the main outpatient waiting areas.
- Specialist nurses at the cardiac centre ran clinics for chest pain, arrhythmia, and heart failure on the Watford General Hospital site.
- Senior staff said clinic utilisation had been improved by the introduction of room planners for all three-trust sites. Nursing and administration staff at Watford General Hospital demonstrated how they accessed this information and used it to plan ad-hoc clinics or re-schedule clinics that had been cancelled.
- Clinical leads said there was a business case to support improvement. For example, neurology was the biggest area of referral to treatment (RTT) backlog and there was a business case to employ extra neurologists to reduce the backlog.

Access and flow

- During our last inspection, we were not assured that patients had timely access to outpatient treatment. The service was found to be in breach of Regulation 12 of the Health and Social Care Act Regulations 2014: Safe care and treatment, due to being below national standards for waiting times. This included waiting times for accessing first appointments and consultations for cancer. At our re-inspection, we found that the trust had worked ahead of its trajectory for improving referral to treatment times (RTT) and was meeting four out of five national standards for cancer waiting times.
- From April 2017, the trust's RTT for non-admitted pathways met the England overall performance for the percentage of patients receiving an outpatient appointment within 18 weeks of referral. This was an improvement since our previous inspection when they were performing consistently worse that the England average (from May 2016 to March 2017). The latest figures for July 2017 showed 90% of patients were treated within 18 weeks, which was in line with the England average.
- In July 2017, ten out of 16 outpatient specialties were in line with or above the England average for non-admitted RTT. They were:
    - Ophthalmology
    - Oral surgery
    - General medicine
    - Gastroenterology
    - Dermatology
    - Thoracic medicine
    - Rheumatology
    - Geriatric medicine
    - Gynaecology
    - Other
- In July 2017, the following specialties were below the England average for non-admitted RTT:
    - General surgery
    - Urology
    - Trauma and orthopaedics
    - ENT
    - Cardiology
    - Neurology
- In July 2017, 17 patients waited over 40 weeks for an outpatient appointment. The longest wait reported at the time of inspection was one patient in ENT who waited 51 weeks for their appointment. The reason for some of the longest waits was the patient's own choice to wait for an appointment with a specific consultant, rather than the next available date. Patients who waited over 30 weeks were reviewed and prioritised for appointments. Waiting times were not included on the departmental risk register.
- The trust met the England overall performance for RTT for incomplete pathways since February 2017. This was an improvement since our previous inspection when they were performing consistently worse that the England average (from May 2016 to March 2017). The latest figures for July 2017 showed 90% of patients were treated within 18 weeks, which was in line with the England average.
- In July 2017, the 12 out of 16 specialties were in line with or above the England average for RTT incomplete pathways:
    - General surgery
    - Oral surgery
    - General medicine
    - Gastroenterology

    - Cardiology
    - Dermatology
    - Thoracic medicine
    - Neurology
    - Rheumatology
    - Geriatric medicine
    - Gynaecology
    - Other
- In July 2017, the following specialties were below the England average for RTT incomplete pathways:
    - Urology
    - Trauma and orthopaedics
    - ENT
    - Ophthalmology
- At the end of August 2017, there was a total of 15,222 patients waiting for first outpatient appointments. This was less than at our last inspection in September 2016, when there were 24,270 patients on the waiting list.
- The specialties with the most patients on their waiting lists at the time of our inspection were dermatology, ophthalmology and oral surgery.
- Booking co-ordinators were based at St Albans. If a patient breached 18 weeks waiting time, booking co-ordinators flagged this to divisional and service level managers who aimed to prioritise these patients.
- From April 2017, the trust performed in line with the 93% operational standard for patients being seen within two weeks of an urgent GP referral for cancer. This was an improvement since our previous inspection when they were not meeting the operational standard. In July 2017, 95% of patients were seen within two weeks of urgent GP referral.
- The trust improved their performance by analysing the reasons for breaches and had an action plan based on the results. The analysis showed the main reason for breaching the two-week wait was patient cancellation. The trust aimed to improve performance by increasing their capacity to offer appointments within seven days of referral, so that patient cancellations may be rescheduled within the two-week period. Prior to this, dates of first appointments were typically offered within ten to 14 days of referral. Operational plans included reviewing clinic capacity and staffing resources; creating additional appointments where possible and recruiting consultant posts to dermatology. Administrative staff who managed two-week waiting lists told us they were now managing to book most patients within five days of referral.
- Since our previous inspection, the trust consistently achieved the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis of cancer (decision to treat). In June 2017, the service achieved 100% and the latest data for July 2017 showed 98% of patients received treatment within 31 days of diagnosis.
- Since our previous inspection, the trust consistently achieved the 98% operational standard for patients receiving outpatient anti-cancer drug treatments within 31 days of diagnosis. From April to July 2017, performance was 100%.
- Since our previous inspection, the trust was performing better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The latest data for July 2017 was 90%.
- The trust was not meeting the 93% operational standard for patients with breast symptoms being seen within two weeks of urgent GP referral. This had not improved since our previous inspection. The latest data for July 2017 showed 88% of these patients were seen within two weeks.
- The trust had agreed a joint action plan with the clinical commissioning group to improve waiting times for patients with breast symptoms by increasing outpatient capacity. This

included reviewing the breast care service and engaging with GPs earlier if a patient did not attend their first offered appointment. A breast practitioner had put in a business case to support extra lists to meet increasing demand. At the time of inspection, the business case was being reviewed and the breast care unit offered nine clinics per week.

- From March 2016 to March 2017, the 'did not attend' (DNA) rate for outpatients at Watford General Hospital was 8% and was slightly higher than the England average of 7%. Patients who did not attend an appointment were contacted and offered another appointment. If they did not attend the second appointment, medical staff reviewed their notes and referred patients back to their GP, if clinically appropriate. If not, the medical staff could request another appointment be arranged by booking co-ordinators. If a child or young person did not attend an appointment, staff would attempt to contact their family and reschedule an appointment. If this happened a second time, a further appointment would be made and their GP would be informed as there may be safeguarding concerns.
- The service had systems in place to reduce the number of DNAs. There was a text message reminder service where patients who gave their mobile phone number were sent a message a week ahead of their appointment to remind them. Patients we spoke with had received reminder text messages. The service also displayed the cost to the NHS every time a patient did not turn up for their appointment, to remind people of the importance of attending.
- From May 2016 to April 2017, the percentage of patients waiting more than six weeks to see a clinician for a diagnostic test was 0.8%; this was lower than the England average of 1.8%.
- In the National Cancer Patient Experience Survey 2017, the diagnostic imaging department scored in line with the England average for 'The length of time waiting for test to be done was about right'.
- The overall cancellation rate for outpatient clinics from February to May 2017 was 13%. This had remained approximately the same since 2016. The average percentage of clinics that were cancelled at short notice (within six weeks) was 4%, which was slightly higher than the trust target of 3%. The main reasons for short notice cancellations were medical staff sickness, test results not being available, consultants' decision that appointments were no longer required and changes to clinic templates.
- The service aimed to minimise unnecessary short notice cancellations. Cancellation requests within six weeks of the scheduled clinic date were flagged by the clinic scheduling team to divisional management who could reject inappropriate requests. Clinic schedulers gave examples of where this had happened, including a consultant had requested annual leave within six weeks of a busy clinic. The request was rejected and the clinic went ahead.
- Waiting times in the department were displayed on boards in each clinic, which were updated every 30 minutes. We also observed staff verbally informing patients of expected delays. At the time of our inspection, the longest wait was 45 minutes. An electronic dashboard system had been introduced across the trust's outpatient services, which captured data on the timeliness of clinics.
- The diagnostic imaging service monitored how long patients waited for examinations once they arrived in the departments across the trust. From December 2016 to April 2017, patients waited an average of 36 minutes before being seen. This met the trust target of 40 minutes.
- There had been a review of reasons for patients waiting over 40 minutes for radiology appointments. Findings showed that one of the main reasons was patients arriving early for their appointment and being marked as attended on the IT system.
- The trust had introduced urology virtual clinics to reduce waiting times and also reduce hospital visits and outpatient burden for patients. This resulted in a significant reduction in new to follow up ratios.
- Patients could choose which of the trust's three hospital sites they attended for their outpatient appointment, where possible. This could be done via their GP referral or the

NHS ‘e-Referral’ system. The e-Referral is an electronic service that allows patients to request preferred place, date and time for their first outpatient appointment. Most patients we spoke with during our inspection had been offered a choice of location.

- Part of the outpatient quality improvement plan was to introduce clinic management tools to maximise utilisation of the environment across all three outpatient sites. During our inspection, senior staff demonstrated how this tool was used to facilitate ad-hoc clinics as they could easily see where rooms were available. Clinic scheduling staff also used this tool when managing requests and cancellations.
- The outpatient department audited the timeliness of doctors arriving in clinics. From August 2016 to June 2017, doctors arrived to clinics on average four minutes after the scheduled start time at Watford General Hospital. Clinics finished three minutes after the scheduled end time over this period. The trust recorded a clinic as starting or finishing late if the time between scheduled and actual time was over 15 minutes. Audit results showed that the time delays were consistently below six minutes.
- There were rapid access chest pain clinics at Watford General Hospital. Patients attending this clinic received consultant review and any required outpatient diagnostics in a single visit to promote timely diagnosis and treatment. The clinic had capacity to see 27 patients per week.
- The trust had recently changed their provider of transport services for patients with mobility issues and this had been causing significant delays for patients. Staff used the electronic system to record delays. There were examples of patients waiting in the department for up to three hours for return transport. The trust and departmental managers had recognised this issue and were taking action to mitigate impact on clinics. For example, patients who arrived late due to patient transport issues were prioritised to minimise further wait.
- In response to the increased demand in the radiology department, new CT and MRI scanners had been purchased to increase the capacity within the department and help to ensure patients receive scans in a timely manner.

Meeting people’s individual needs

- All diagnostic services had a seven-day service in place and patients were able to change appointment scheduling to suit their needs. The department had a ‘Purple Star’ for excellence with regards to caring for those living with learning disability. In addition, time was set aside when a patient living with a learning disability had an appointment.
- The main outpatient department had narrow doors which was not suitable to provide care for wheelchair users and patients in stretchers or beds. For example, we saw staff struggling to manoeuvre a wheelchair whilst assisting a patient out of a clinic room. This was identified as a risk by staff we spoke with but was not recorded on the risk register.
- Staff were aware of how to support patients living with dementia and had accessed the trust training programme in order to understand the condition and how to be able to help patients experiencing dementia. Some staff within the radiology department had attended additional training to become ‘dementia friends’. This meant they had additional knowledge to support the needs of patients living with dementia.
- Staff were not always informed in advance if a new patient had mobility issues, a learning disability or dementia. The electronic patient tracking system had the capability to flag this information; however, this was not being used at the time of inspection. Staff would only be made aware in advance if the referrer included it as an additional comment, but this regularly did not happen. This meant that staff could not make arrangements beforehand to facilitate the patient’s journey through the department, for example by putting them first on the list. Information on additional needs was recorded at their first appointment so that adjustments could be made in advance if follow-up appointments were needed.
- The diagnostic imaging department had introduced twiddle muffs for patients living with dementia to assist with restlessness as promoted by the dementia society.

- Starlight toy boxes had been donated by a local charity and were used in each x-ray room for children and patients with special needs.
- Translation services were also available and the electronic booking-in stand had over fifteen languages to choose from. The need for an interpreter was flagged at referral so that booking co-ordinators could arrange this in advance.
- The diagnostic imaging department had three new cubicles, which opened directly into the x-ray rooms. This meant there was an increased privacy and dignity for patients.
- A league of friends' refreshment area was available to patients at the entrance to the main outpatients department.
- A radiographic paediatric group was created to evaluate services for children. The group had developed paediatric information leaflets and had implemented distraction boxes for children in each radiology department.

Learning from complaints and concerns

- The trust reported 112 complaints related to outpatient and diagnostic imaging services from July 2016 to July 2017. Themes included delayed or cancelled appointments (52), communication with patients (25) and attitude of staff (20).
- The trust aimed to complete investigations into complaints between 25 and 35 working days after they were received, depending on the nature of the complaint. In the outpatient and diagnostic imaging department, 80% of complaints were managed within this timescale.
- Information on how to raise a complaint was displayed on notice boards in outpatient and diagnostic imaging areas.
- Complaints were discussed in outpatient and diagnostic team meetings. Staff we spoke with could describe common complaints within their service.
- A complaints management team dealt with formal complaints. Complaints that could not be resolved at local resolution meetings were passed to the relevant divisional lead to arrange an investigation. We saw examples of divisional and nursing leads contacting patients to offer apologies and inform complainants of the investigation progress.

Are outpatients & diagnostic imaging services well-led?

Good 

We rated well-led as good because:

- The service had leadership, governance and a culture, which were used to drive and improve the delivery of quality person-centred care.
- Since our previous inspection in September 2016, an outpatient quality improvement plan (QIP) had been implemented. This included all issues raised during the previous inspection and 14 out of 15 had been completed in August 2017. Performance data had improved since the plan was implemented and the service was performing in line with the planned trajectory.
- Leaders and staff across outpatient and diagnostic imaging services were continuously striving for improvement. In addition to the QIP, local leaders had further plans to improve services.
- There were high levels of staff satisfaction, and individuals were proud to work for the trust.
- Most issues raised during our last inspection had been addressed. For example, notes were now stored in locked trolleys.

However:

- We found the outpatient department was fragmented and learning was not always

shared between departments.
- Risks that were identified during both the previous and most recent inspections, such as missing records were not on the departmental risk register.

Leadership of service

- Clinical leads, divisional and directorate managers led outpatient specialties. At Watford General Hospital, the main outpatient department was managed by the medical division, ophthalmology was managed by the surgical division and phlebotomy was managed by clinical support services. The diagnostic imaging department was also part of the trust's clinical support services.
- Different matrons led nursing teams in outpatient areas. Matrons and senior nurses met on a monthly basis and there were separate monthly meetings within each department.
- Each clinical area had a nominated lead that worked and managed the clinical speciality. For example, in the imaging department each section had a superintendent who was a senior clinician and able to offer support and advice to the team. This ensured that staff had access to clinical experts at all times.
- Local leaders were visible and approachable and managers understood the challenges at a local level. For example, the matron for main outpatient services had been in the department from being a Band 6 nurse so understood the challenges of providing high quality outpatient care and took appropriate actions to address them.
- Senior staff reported having good support from clinical leads and having regular one to ones. They had been supported to undertake leadership courses provided by the trust. All staff reported that leadership within the department was very strong, with visible, supportive and approachable managers. Matrons and managers had developed supportive, appreciative relationships with staff across the service and that was evident on our inspection.
- Staff were clear who their managers were and felt they could approach managers with concerns. There was an assistant divisional manager who led the administration and operational staff for the outpatient departments.
- Matrons reported to their divisional heads of nursing. They described open, honest relationships and gave examples of when they had contacted them for advice.
- Staff we spoke with all reported that they felt motivated to perform well and were committed to the service provided to patients.
- Staff told us they were kept informed and involved in strategic working and plans for the future.

Vision and strategy for this service

- The trust values were commitment, care and quality. Both medical and nursing staff could describe the trust's values and directed us to posters across the service. Staff said they could contribute ideas on how to improve the service and felt involved in plans for the future.
- There was an outpatient strategy for 2017 to 2027 that was in line with the trust's vision and values. The strategic aims for 2018 were:
    - To consistently achieve the two-week cancer waits and referral to treatment times
    - To engage clinicians in technological advances and embed changes
    - To reduce the number of complaints regarding outpatients
    - To implement changes from the patient panel
    - To deliver a service that continually has the capacity to meet demand
    - To explore opportunities of integrated care
- By 2027, the service aimed to be a 'model outpatients department' using innovative patient pathways that integrated primary and secondary healthcare.
- The department aimed to be 'paperlite' by 2020 and paperless by 2022. The strategy

included introducing electronic patient record systems and contacting patients by email where they prefer.

- The outpatients department was working to meet the priorities set out in the trust's clinical strategy and operational plan .They had made further progress towards meeting the national 'referral to treatment' standards and providing additional clinics.

Governance, risk management and quality measurement

- Managers and representatives from the outpatient and diagnostic imaging departments attended monthly meetings and committees as part of the trust's clinical governance framework. For example, a supervisor in phlebotomy was a member of the trust's health and safety committee. The outpatient department had a clear governance framework and divisional governance meetings fed into the trust's quality safety group for escalation to the trust board.
- The trust had implemented a quality improvement plan (QIP) for the outpatients and diagnostic service since the last inspection. There were actions in place for key issues highlighted in the previous inspection and progress against these targets was monitored. At the time of inspection, 14 out of 15 actions were completed or on track to be completed by the recommended date. The outstanding action was to use the electronic booking-in stands to monitor how long patients waited in the department; however, had been delayed due to IT systems being temporarily shut down in response to a cyber-attack. The QIP included action plans to improve referral to treatment time (RTT) performance and cancer wait times. Data showed that performance had improved since the quality improvement plan was implemented.
- As part of the quality improvement plan to improve referral to treatment time (RTT), leaders planned to create a comprehensive capacity and demand model and present it to services in order for them to adequately meet demand. Template reviews were ongoing but incomplete. Leaders aimed to balance clinic utilisation before proceeding to the next stage.
- Local leaders led on individual projects that formed the overall outpatient QIP. There was also an outpatient user group led by divisional and nursing leads to improve monitor progress against the QIP and how this was impacting patient experience and service delivery.
- As part of the QIP to improve RTTs, leaders planned to create a comprehensive capacity and demand model to review how efficiently services were delivered. At the time of inspection, templates were still being developed. Leaders were focusing on maximising clinic utilisation before progressing.
- There was a task group to monitor the use of local safety standards for invasive procedures (LocSSIPs). A programme was in place that focused on ensuring current LocSSIPs were in line with national safety standards for invasive procedures (NatSSIPs). At the time of inspection, LocSSIPs were in place for steroid injections and the task group were focusing on implementing LocSSIPs across the specialties. The next phase of the programme was to develop a team of LocSSIP champions to conduct audits of compliance. The LocSSIP task group reported to the trust's medical director.
- Speciality meeting minutes seen included a review of complaints and compliments, details of incidents, details of activity and pressure on capacity, staffing and recruitment, training, finance overviews and risks. The minutes seen were well structured and inclusive.
- At the time of inspection, there was only one risk on the department risk register. This was related to clinics being overbooked and the impact this had on staff ability to manage and patient satisfaction. However, during our inspection we identified other risks which should have been recognised. For example, the environment in the main outpatient department was not suitable for wheelchair users, stretchers and beds. Senior staff we spoke with recognised the issues as risks but they had not been formally added to the risk register.
- In the diagnostic imaging department, risks to staff, patients and service delivery were identified, managed and reviewed. For example, staff wore whole body dose meters to

monitor the occupational radiation exposure. This was reviewed on a quarterly basis. No unusual results had been noted at Watford General Hospital.

- Leaders were auditing missing notes and missing notes audit showed 97%. Senior staff said missing notes were reported as incidents. However, staff we spoke with said they did not report missing notes as incidents. Medical staff said clinic and referral letters were available electronically and they were often able to pull up patient information in order to avoid cancelling appointments. No appointments had been cancelled as a result of missing notes in the six months prior to inspection.
- The trust held annual radiation incident summits where teams challenged each other on why each radiation incident had occurred and the lessons learned. These meetings were introduced in 2014 and three had been held at the time of our inspection.
- In the diagnostic imaging department, a computerised tomography (CT) optimisation team had been established with the aim of reducing risk to patients by standardising terminology in written protocols and guidance. In radiology, terminology can differ depending on the type of equipment and operating system used. This was an area of risk as radiographers use a range of scanners in their roles, which could lead to confusion. On inspection we found written protocols and staff were adequately trained. We looked at the computer programme used and saw how this assisted in dose reduction and showed doses for each scanner and body part.
- During our previous inspection, it was highlighted that the outpatient service did not use a dashboard to capture and monitor performance data. During our inspection in August 2017, this had improved and a dashboard was in use. Senior nurses could demonstrate how to access the dashboard during our inspection.

Culture within the service

- All staff felt that there was a positive working culture and a good sense of teamwork and good staff morale was evident. For example, domestic staff who worked for an external company were invited to social events in the ophthalmology department and reported feeling part of the team.
- The service promoted a culture where staff could challenge inappropriate behaviour, regardless of seniority. For example, managers supported nurses to challenge medical staff over starting and finishing clinics late.
- All staff we spoke with felt respected and valued. There was positive feedback from the recognition staff received from their divisional managers, service managers, matrons and senior nurses.
- The culture across outpatient and diagnostic imaging services at Watford General Hospital encouraged openness, candour and honesty. There were several posters displaying details of the trust's 'freedom to speak up guardian' and policy. Freedom to speak up guardians work with trust leadership teams to create a culture where staff are able to speak up in order to protect patient safety and empower workers. All staff we spoke with were aware of this role and where they could access information.
- Duty of Candour was followed throughout the services and we saw evidence of this discussed in team meetings.

Public engagement

- The service had a monthly patient experience group across all three sites (Watford General Hospital, Hemel Hempstead General Hospital and St. Albans City Hospital). The patient panel was used to collect feedback on patients' journey from referral to discharge.
- Managers and senior nurses in the outpatients department worked with members of the trust's 'patient panel'. The patient panel was a group of people from the local community who used or had previously used the hospital services. Members of the panel were involved in various projects in the outpatient department and provided feedback across the trust's three sites.

- The department had also included members of the patient panel in a trial of introducing a 'front of house' member of staff. An idea was put forward that patient experience could be improved by having a member of staff as a 'host' at the front door of outpatient departments across the trust. This staff member would act as a first point of contact to assist with queries and improve flow through the department. To determine the value of this role, managers invited volunteers from the patient panel to act as hosts. Patient feedback was then gathered. The result of this trial was patient experience was improved and a business case was being developed to add this as a permanent role.
- Patients who used outpatient services were actively engaged and involved when planning services. Patients and relatives were encouraged to provide feedback and we saw their feedback used to improve. It was clear that the department recognised the value of public engagement. Feedback forms were accessible in the patient waiting area and we saw staff encouraging patients to fill them in.

Staff engagement

- Staff told us they attended events held by the trust and they found they promoted team building. Staff felt they were listened to by senior management.
- The trust newsletter was distributed throughout the hospital to update staff on current issues and future plans.
- Quality champions had been appointed in outpatient and diagnostic imaging department. Their role was to pass on suggestions on service improvement from local staff to the executive leadership team. Champions attended forums where they could relay ideas to be escalated to the board.

Innovation, improvement and sustainability

- Leaders and staff across outpatient and diagnostic imaging services were continuously striving for improvement. This was evident throughout our inspection and from information we reviewed.
- The majority of concerns that were raised during our previous inspection in September 2016 had been addressed. The services had also made additional improvements outside of those that were raised. Improvement programmes were ongoing and further plans were in development. For example, during our last inspection in September 2016, we saw notes were stored in unlocked trolleys and patients were not informed about waiting times. Clinical leads said lockable trolleys were now used across the outpatient service and there were boards outside clinic rooms to inform patients about waiting times. We saw notes were stored in locked trolleys across outpatient areas and patients were informed about delays in clinics. This was an improvement.
- The last inspection identified audits were not completed. During this inspection, we saw the service carried out clinical audits, hand hygiene and environmental audits, friends and family test audits and daily waiting times audits which were collated monthly.
- Car parking had been identified as a big concern to patients. There were plans to build a multi-storey car park in the near future.
- A business plan was submitted to increase the number of trained nurses for all outpatients' services across all three hospitals. Five trained nurses and two healthcare assistants had been recruited.
- The superintendent in radiology department had looked at ways other radiology departments worked to access good working patterns and had introduced a new working initiative pattern within the department. Staff worked 12-hour shifts over three days per week, then had a week off and worked a normal 9am until 5pm shift on a three-week rotation. Each team had a lead radiographer from all specialities and staff were very positive about the new ways of working.

Outstanding practice

- There were a number of outstanding innovations in the children's emergency department to support the needs of parents, children and younger people. This included support from voluntary groups charities and volunteers to tackle important issues such as mental health and suicide awareness.
- The set up and design of the children's emergency department as an environment to children was outstanding as it enabled the service to undertake interventions on children quickly. The design and space for a district general hospital was unique and was modelled on the set up of the tertiary children's units.
- We observed outstanding care interactions provided by staff to children in the emergency department and in the children's observation bay.
- The pathways of care in the children's emergency department, their effective use within the department on patients was outstanding.
- Staff kept patients at risk of harming themselves safe without depriving them of their liberty. There was an effective process for prompt senior nurse assessment and the provision of enhanced care for patients at risk. An enhanced care team was receiving training to make sure they provided patient centred care.
- The "iSeeU" initiative provided women who were separated from their babies at birth the opportunity to use face-time technology to see their baby receiving care and treatment on the neonatal care unit.
- The pilot Phoenix team provided a case loading service for women with uncomplicated pregnancies who wanted to give birth at home or at the birth centre. The team sent a congratulations card to every mother who was part of their team once they had delivered their baby.
- An electronic referral pathway had improved the care for infants with prolonged neonatal jaundice. The pathway had been developed in partnership with GPs, health visitors, community midwives and local commissioners. This had resulted in a reduction in the referral to appointment time (under 48 hours) and the overall time for parents to receive their child's results was two weeks from referral.
- The diagnostic imaging service monitored its compliance by auditing best practice relating to patients receiving chest radiography. Guidance from the Royal College of Radiologists (RCR) states that it is best practice to undertake chest radiographs on patients in the poster anterior (AP) upright position, apart from when this is not appropriate due to immobility or ill health. Following an audit performed within the diagnostic imaging department, staff embraced the importance of change in practice especially in difficult casualty situations.

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure governance quality systems, including the reporting of incidents, identification of risk and management of risk registers provide assurances that the service runs safely and effectively.
- The trust must ensure that the staffing levels on duty are based on acuity, and ensuring the numbers on duty for nursing, medical and support staff are sufficient to ensure safe care.
- The trust must ensure that appropriate action is taken to improve the culture within the emergency department.

- Ensure that there are processes in place to complete patients' venous thromboembolism risk assessments on admission and repeated assessments 24 hours after admission.
- Ensure that there are processes in place to manage and report mixed sex accommodation and where possible prevent patients of the opposite sex being cared for in the same clinical area.
- Ensure that patient risk assessments are detailed with information to allow an accurate assessment of the patients' clinical condition.
- Ensure that patient personal identifiable information is not displayed or discussed openly within earshot of unauthorised persons.
- Ensure that staff working within the DVT clinic are competent at the identification of medicines and contraindication with treatment necessary.
- Ensure that venous thromboembolism reassessments for admitted patients are repeated and recorded in line with national guidance.
- 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. A formal decision specific mental capacity assessment must be undertaken of the patient's ability to understand this decision and to participate in any discussions.
- Ensure that all staff caring for patients less than 18 years of age complete safeguarding children level three training.
- Ensure staff in outpatient services are aware of the trust policy and fulfil the mandatory reporting duty for cases of female genital mutilation.
- Ensure that World Health Organisation (WHO) five steps to safer surgery checklists are completed in their entirety.
- Ensure that infection prevention and control standards are maintained in rooms where minor operations are performed.
- Ensure that all risks within the outpatient department are included in the departmental risk register.
- Ensure clinical staff within the radiology department are up-to-date on fire and evacuation training.

Action the hospital SHOULD take to improve

- The trust should review the arrangements for the collection of blood samples from the emergency department.
- The trust should review ambulance offload and handover times in the emergency department.
- The trust should consider how learning from complaints is fully implemented to improve patient experience.
- The trust should develop an integrated governance system for the children's emergency department, ensuring there are effective reporting system, and management of risk processes.
- Ensure that all staff maintain all infection control and prevention practices.
- Ensure that staff use the appropriate equipment when handling patients' food.
- Ensure that referral to treatment times are in line with recommendations.
- Ensure that patients' nutrition and fluids are accurately recorded and totalled daily.
- Ensure theatres are compliant with national standards, including the ventilation in the theatre preparation rooms.
- Take steps to ensure the facilities for day surgery patients are appropriate.
- Ensure patients are not nursed in recovery or ESAU overnight
- Ensure patients whose surgery is cancelled are treated within 28 days of the cancellation.

- Ensure all surgical patients have access to timely treatment after referral.
- Ensure all relevant staff, including junior doctors, are trained to recognise and respond to signs of sepsis.
- Ensure patient records are available at pre-operative assessment clinics.
- Ensure the route in which the painkiller Paracetamol is to be administered is clearly documented in patients' prescription charts.
- Ensure audits of the WHO Surgical Safety Checklist and five steps to safer surgery are improved to assess how well teams are participating in the checks.
- Ensure surgery services fully participate fully in implementing the National Local Safety Standards for Invasive Procedures.
- Ensure the audit programme is managed effectively and that actions identified are completed and re-audited. This should include an audit of the recognition of sepsis and the treatment provided to patients with signs of sepsis.
- Ensure all staff comply with the trust's hand hygiene policy.
- The trust should ensure the standards of cleanliness and hygiene continue to be monitored on Starfish ward.
- Ensure patients are discharged from the critical care unit within four hours of the decision to discharge, to improve the access and flow of patients within the critical care unit (CCU).
- Ensure patients requiring admission to CCU are received in four hours of the decision to admit.
- Ensure a microbiologist has daily input to the ward rounds on CCU to review patients care in line with the Guidance for the Provision of Intensive Care Services 2015 (GPICS).
- Take actions to reduce the incidence of mixed sex breaches in the critical care unit.
- Local mortality and morbidity review meeting minutes should include clear delegated actions and monitoring of these.
- Ensure the risk register contains all current risks identified to the provision of the critical care service.
- Ensure the service reviews its processes to provide at least 50% of nursing staff with a post registration critical care qualification in line with GPICS standard (2015) and mitigate for any gaps.
- Ensure medicines are stored within the recommended temperature range.
- Ensure all medicines given are documented in line with national guidance.
- Ensure all equipment is safety tested annually.
- Ensure resuscitaires are checked daily.
- Ensure symphysis-fundal height measurements are clearly plotted on growth charts.
- Ensure venous thromboembolism risk assessments are completed in line with trust and national guidance.
- Ensure actions are taken to reduce the caesarean section rate.
- Ensure actions are taken to improve the perinatal mortality rate and reduce the number of full term babies admitted to the neonatal care unit.
- Ensure complaints are investigated and closed in a timely manner.
- Reduce the number of medical outliers to the gynaecology ward.
- Take action to reduce staffing vacancies and turnover of staff.
- The trust should consider reconfiguring the neonatal unit as there was insufficient space, which did not reflect current guidelines in the neonatal unit.
- The trust should continue to monitor the movement of children from the inpatients' wards to the operating theatre along a corridor that was not fit for that purpose.
- The trust should consider ways of improving the environment for children in the operating and recovery areas of the trust.
- The trust should ensure that access to emergency equipment is not impeded.
- The trust should ensure the secure storage of dietary supplements.
- The trust should ensure that staff receive training in a major incident exercise or undergo

major incident training.

- The trust should ensure the information system for the diabetes service meets the needs of the service.
- The trust should ensure children's services are meeting the 25 day standard for the investigation and closure of complaints.
- The trust should consider ways to improve the response to the Friends and Family Test in children's services.
- The trust should continue to monitor the level of cancelled outpatient appointments over six weeks in children's services.
- The trust should consider how to improve the results of the next Picker survey in children's services.
- Review the risk register process to ensure the trust was aware of the risks for the end of life care and mortuary services.
- Ensure the main outpatient department had a dedicated area suitable to care for patients on a stretcher, bed or wheelchair.
- Decontaminate reusable naso-endoscopes in a washer-disinfector at the end of each clinic to meet best practice, as outlined in the Department of Health Technical Memorandum (HTM) 01-06 Decontamination of flexible endoscopes.
- Ensure staff are up-to-date on the mental capacity act and deprivation of liberty safeguards training.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of Disease, Disorder and injury	Regulation 10 (2)(a)HSCA 2008 (Regulated Activities) Regulations 2014 Dignity and respect Why the regulation was not being met: Patients were cared for in mixed sex areas. We saw no evidence that mixed sex accommodation was reported in the medical wards, although it was in the critical care unit. The provider must ensure that people using the service should not share sleeping accommodation with the opposite sex, and should have access to segregated bathroom and toilet facilities without passing through opposite sex areas to reach their own facilities.

Regulated activity	Regulation
Treatment of Disease, Disorder and injury	Patient identifiable information was displayed on ward whiteboards, and discussions took place within earshot of non-authorised persons. Regulation10(2)(a)
Treatment of disease disorder or injury Diagnostic and screening Surgical procedures	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation: Regulation 11: Need for consent. Regulation 11: Need for consent Why the regulation was not being met: There was no evidence, that decision specific mental capacity assessments were always fulfilled when staff completed DNACPR forms.
Treatment of Disease, Disorder and injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment 12 (2) (a) (b) (c) (d)

	How the regulation was not being met: Patient's venous thromboembolism assessments were not routinely repeated after 24 hours of admission to hospital. Patients antibiotic regimes were not always reviewed after 48 hours of administration. Patient risk assessments were not always completed fully, predominantly using risk assessments as a "tick box" exercise. The Deep Vein Thrombosis Clinic was not always managed by someone who had knowledge of medicine interactions. The trust did not ensure WHO safety checklists were completed on all patients undergoing minor operations. Appropriate standards of cleanliness and hygiene were not always followed. The trust did not ensure clinical staff within the radiology department were up-to-date on fire and evacuation training.
Treatment of disease, disorder or injury Diagnostic and screening Surgical procedures	Regulation 13; (1) (2) (3) Safeguarding Why the regulation was not being met: Not all nursing staff who had direct contact with children in outpatient clinics had received level three safeguarding children training, which was not in line with national guidance. We could not be assured that the service was fulfilling its mandatory duty to report cases of female genital mutilation (FGM) as all staff we spoke with were unaware of the trust policy on identifying and assessing the risk of FGM.

Regulated activity	Regulation
Treatment of disease, disorder and injury Diagnostic and screening Surgical procedures	Regulation 17 HSCA (Regulated Activities) Regulations 2014 (1) (2) (a) (b) (c) Good Governance. Why the regulation was not being met: Systems or processes for governance were not

	embedded or robust in all areas. The trust did not have oversight of incidents as all were not being reported therefore learning opportunities were missed. The trust did not ensure that all risks were effectively identified so that they could be managed through an appropriate risk process. The culture in the emergency department did not allow an open style where this could be done. Patient's venous thromboembolism reassessments were not routinely recorded 24 hours after admission to hospital. The departmental risk register failed to identify all risks within the outpatient department.

Regulated activity	Regulation
Treatment of disease, disorder and injury Diagnostic and screening Surgical procedures	Regulation 18 (1) Staffing: Why the regulation was not being met: There was an insufficient number of nursing and medical staff on duty in the emergency department to ensure the safety of patients.