Review of compliance

West Hertfordshire Hospitals NHS Trust Watford General Hospital	
Region:	East
Location address:	Vicarage Road Watford Hertfordshire WD18 0HB
Type of service:	Acute services with overnight beds
Date of Publication:	December 2011
Overview of the service:	Watford General Hospital, part of West Hertfordshire Hospitals NHS Trust, is an acute hospital just outside Watford town centre, serving the local population with an A&E department, and providing general and specialist, medical, surgical and maternity care.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Watford General Hospital was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 09 - Management of medicines
Outcome 14 - Supporting staff
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 27 October 2011 and checked the provider's records.

What people told us

We did not receive any information from people who use the service during this review, and did not actively seek their views in this instance as this was not seen as an appropriate method of seeking evidence in the specific issues that had been raised about the service.

What we found about the standards we reviewed and how well Watford General Hospital was meeting them

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

The trust is compliant with this outcome at this location. Appropriate action has been taken to address the concerns raised at the deanery visit. Only appropriately trained staff prescribe to approved guidelines. Staff are provided with appropriate training and supervision to ensure people are prescribed medicines safely.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

The trust is not compliant with this outcome at this location. Staff do not always feel supported in ensuring people receive safe and effective care. Junior doctors have not all

received relevant safeguarding training. Whilst there are intermediate measures in place to address the issues of medical staffing cover and support to junior doctors within A&E, the impact of these is not yet completely known.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The trust is compliant with this outcome at this location. There are systems and processes in place to report, monitor and address issues identified from never events and serious untoward incidents within the trust. The trust has an open culture of sharing learning from incidents to help improve patient care.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

The provider is compliant with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We did not receive any information from people using the service about this outcome.

Other evidence
Information received from the East of England Deanery raised concerns over the practice of junior doctor prescribing. This specifically related to the cytotoxic drug, methotrexate, as it was felt that doctors should not be prescribing drugs outside their competence as this raises patient safety issues and is contrary to guidance published by the Deanery. During a visit to the trust on 27 October 2011, senior management informed CQC that this practice had been stopped immediately following the deanery visit, and provided email evidence to confirm that this had been communicated to all medical staff.

During our visit, the trust outlined the systems that were in place to support junior doctors in prescribing medicines. The trust had a specific training programme in place for junior doctors that included a competency based test that ensured they had the skills and knowledge to prescribe a range of medications. To support this practice, the trust previously had a formal methotrexate policy in place. This included a pathway for doctors to follow, with teaching to prepare individuals to safely prescribe this medication, and an audit trail to identify any issues that may impact on the quality of care provided.

The trust stated that while they are aware that methotrexate is a dangerous drug, they

considered the training programme that all junior doctors completed, prepared individuals to prescribe this drug safely. The trust had clear guidelines of when the junior doctor could prescribe this drug, for example, only for people who are already taking this drug, and not to oncology patients. The rationale for training junior doctors to prescribe this drug was to ensure the medication could be prescribed without delay or to ensure people did not have a gap in their treatment that may impact on their health. The trust had implemented alternative arrangements to ensure that the changes to prescribing this drug post the deanery visit did not have a negative impact on the people using the service. Feedback from staff in A&E during our second visit to the trust on 02 November 2011, showed they were aware of this change in practice.

The trust also provided a presentation on safe prescribing to junior doctors during their induction to the trust, to ensure people using the service are prescribed medicines safely. This includes reference to safe prescribing and risks associated with methotrexate, as well as reporting incidents and medication never events and providing a variety of information and contact details to support junior doctors in safe prescribing.

Our judgement
The trust is compliant with this outcome at this location. Appropriate action has been taken to address the concerns raised at the deanery visit. Only appropriately trained staff prescribe to approved guidelines. Staff are provided with appropriate training and supervision to ensure people are prescribed medicines safely.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are minor concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We did not receive any information from people using the service about this outcome.

Other evidence
Following a visit from the East of England Deanery, CQC received information raising concerns over the lack of senior medical cover in Watford Hospital's A&E department between midnight and 08:00hrs. During our visit to the trust on 27 October 2011, senior management confirmed that there has been a lack of middle grade doctor cover in A&E during the hours of midnight and 08:00hrs. The trust confirmed that they have been working to address this issue since June 2011 and had implemented several initiatives to ensure that junior doctors were supported.

During our visit, we saw evidence that the trust had undertaken a number of steps to address the staffing issues identified at the deanery visit. These included raising awareness of access to other hospital middle grade doctors who are on-site during this time period, who will provide support, and ensuring staff had access to on-call consultants should they need them. The trust are increasing the numbers of A&E consultants who will provide cover between 08.00 and 19:00hrs, seven days a week. It was confirmed that access to senior medical and nursing staff had been highlighted during the junior doctors' induction, with the director of nursing meeting the junior doctors during their induction to re-iterate and encourage junior doctors to make use of the support available to them. The trust stated that matrons have also re-enforced the message about how junior doctors can access support, and a senior experienced nurse is always identified to run the department at night, to provide leadership and support to doctors as part of their role. The feedback we received from staff about these initiatives

was variable; most staff felt that while some improvements had been made to increase support, there was still considerable pressure to move people through the department, with the concern that the focus was more on speed than quality. This was particularly felt during night shifts and weekends when the department is usually much busier.

We were told that previously, the period between midnight and 08:00hrs had been covered by locum doctors. This arrangement provided additional cover and support for junior doctors; this was reported to be patchy and at times staff reported issues with the quality of the locum doctors. We were told that these issues led to increased risk to patients, as the quality of middle grade doctors was variable. To address this issue, the trust had previously employed career doctors, for example middle grade doctors who were not on a specific training programme and often from overseas. However, they are no longer able to appoint doctors from overseas due to home office restriction. The trust had now employed senior locums during the night shift, seven days a week. Initial feedback from staff was that these appointments have been beneficial in assisting with the training and support provided to juniors. However, feedback is limited, as this level of medical cover had only recently been implemented. It is therefore too early to assess how effective this has been in improving the support junior doctors receive overnight in providing patient care. The trust acknowledges that locum cover is not sustainable in the long term but that it is providing initial support until other initiatives are implemented, to reduce the risk to patients.

Other support mechanisms in place to support junior doctors include a consultant trauma rota and 'Major Nurse Practitioners' within the department. The consultant trauma rota identifies the consultant who will come in to support juniors in the event of a trauma case coming into the department. The two 'Major nurse practitioners', who have completed a master's programme in A&E and have advanced skills and knowledge in this area, are also available for support and advice.

The trust is aware that the measures they have put in place are not long term solutions, and they are actively seeking solutions to ensure appropriate staffing levels can be maintained. The issue of A&E medical staffing is a national issue and the trust stated that they were not aware of any units outside of London that have 24 hour,7 days a week cover by consultants. Most A&E departments have consultants who are on call 24 hrs but not present in the department. It is also recognised that there is a national problem in recruiting middle grade doctors which is impacting on the trust's ability to recruit this grade of doctor. External expert advice has been sought, including contacting the Royal College of Emergency Medicine to explore the possibility of additional trainees at the trust, exploring overseas rotation opportunities and looking at increasing the number of A&E consultants in post.

A review of complaints noted that in the last 12 months there have been nine complaints about A&E, with three relating to medical staff between midnight and 08.00hrs, with only one relating to a junior doctor. This shows that the measures that have been taken by the trust, are providing safe and appropriate medical support to the A&E department, whilst working towards finding longer term solutions to the staffing issue.

Discussions with staff during our second visit on 02 November 2011, raised concerns that junior doctors had not received all the relevant training to support them in their placement within the trust. Whilst evidence received showed that junior doctors

working in A&E had all received safeguarding children training during their induction, training records confirmed that a significant number of these staff had not received safeguarding vulnerable adults, mental capacity act or deprivation of liberties training. This means that staff may not be able to identify concerns or ensure people's liberties are safeguarded.

The trust had set up an emergency care task force committee with the aim of improving the emergency care pathway and addressing access and capacity issues, some of which relate to the experiences of junior doctors. Minutes from these meetings showed that the trust is taking seriously issues raised in relation to, or by junior doctors, in relation to their working environment. Examples include plans to implement a new IT system to locate and handover patients, an issue raised during conversations with staff during our second visit, and sessions/letters being communicated to consultants to enable issues with behaviours, culture and other concerns to be addressed. The trust had put feedback mechanisms in place to gain junior doctors' views on whether they feel supported during their placements at the trust.

The trust is required to submit an action plan to the Deanery by 10 December 2011, which includes demonstrating that they have addressed the issues discussed within this report.

Our judgement
The trust is not compliant with this outcome at this location. Staff do not always feel supported in ensuring people receive safe and effective care. Junior doctors have not all received relevant safeguarding training. Whilst there are intermediate measures in place to address the issues of medical staffing cover and support to junior doctors within A&E, the impact of these is not yet completely known.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not receive any information from people using the service about this outcome.

Other evidence
Information received from the Strategic Health Authority in October 2011, raised concerns over the nature and number of serious incidents, known as 'never events', that had occurred in the trust during the last 12 months. The trust had benchmarked never events with another acute trust providing services of the same nature, and found that this trust had a similar number of never events in similar areas of care.

During our visit of 27 October 2011, the trust presented evidence to demonstrate that there are systems and processes in place to capture incidents and never events, to monitor the quality of service delivered and make and share changes across the trust to ensure lessons are learned by all staff, and patient care is improved.

The trust used the NPSA guidance to categorise never events, and in the last 12 months there have been eight reported never events. All events have been investigated, learning shared and action taken to reduce the risk of similar incidents occurring. For example, following three similar events in a short period of time in the same theatre, work has been implemented to address the underlying causes and the service has been re-configured to enable practices to be improved. Evidence seen showed that staff have access to a range of training on never events and serious incidents, in different forms, including the use of short videos which are available in their workplace. Never events and serious untoward incident reporting is also included as

part of the junior doctors induction programme to ensure staff are aware of the importance of raising these events within the trust.

In addition, the commissioners had undertaken a quality assurance visit to the trust following the never events in relation to wrong site surgery. They found that all staff were able to demonstrate an understanding of the issues and the changes that had been made. In all cases, a review had taken place, and evidence demonstrated how systems and processes had been reviewed and changes made where necessary. The visit also found that not only were the trust demonstrating in practice the learning from serious incidents, but other aspects of patient care and the safe care programme.

Evidence provided demonstrated that the needs of the patient were assessed and care planned to meet these needs. The commissioner's report stated that a review of notes identified that clear assessments of specific aspects of care were recorded, for example pressure ulcers and nutrition. The notes were clear and in order. They found it was easy to follow the needs of the patient, how they had been assessed and what plan was in place to meet their needs. Staff were seen interacting positively with patients, sitting with them and discussing their needs. Call bells were answered immediately when they rang within the unit. This shows that people were receiving appropriate assessment and care to meet their needs.

The trust's incident reporting system included a prompt to remind staff to consider if the incident is a never event, and also included an escalation pathway. Senior managers at the trust told us that there is a high level of incident reporting in the trust. It was stated that one contributing factor for this was that staff are provided with training in this area, and there was a culture that encouraged staff to report incidents. In addition, staff are provided with support to manage serious incidents. This includes training, policies and access to the Serious Incident (SI) Co-coordinator, who provides guidance to staff in relation to the process of investigation, and clarifies the timescale required of reports.

Recommendations from an external review to reduce the incidents of similar incidents re-occurring have been implemented. For example, the trust carried out an internal review of how the maternity theatres were managed. The findings from this review has resulted in the trust re-configuring the way these theatres are run, to improve the quality of care provided.

There are systems in place to monitor the reporting of incidents and implementation of action plans. These include regular reports, which are produced to provide an overview of incidents, outcomes and action taken. The SI Co-ordinator also monitors progress, and where required, chases investigators to ensure the trust meets it obligations in relation to external reporting and in meeting its own assurance requirements in relation to the management and learning from serious incidents. Investigations into incidents are monitored through the bi-monthly meetings of the Divisional Integrated Standards Executive. All incidents are subject to overall review by the Serious Incident Review Group to ensure investigations have addressed all the issues and that recommendations are being taken forward to prevent recurrence. These arrangements facilitate sharing of learning, provide the trust board with an overview, and ensure implementation of actions are monitored.

Information regarding serious incidents is shared at a range of meetings to ensure

learning is shared, a culture of openness is promoted and actions are monitored. For example, serious incidents are an agenda item for the public and internal board meetings. Information seen by the public meeting includes number of incidents and their nature. The internal board meetings have sight of additional information in relation to the severity of the incident and the actions that have, or need to be taken to ensure there is no repetition. Feedback is also shared through the various governance committees within the trust, but the trust is aware that more needs to be done to ensure all relevant staff, including junior doctors, receive feedback from these events.

Our judgement
The trust is compliant with this outcome at this location. There are systems and processes in place to report, monitor and address issues identified from never events and serious untoward incidents within the trust. The trust has an open culture of sharing learning from incidents to help improve patient care.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: The trust is not compliant with this outcome at this location. Staff do not always feel supported in ensuring people receive safe and effective care. Junior doctors have not all received relevant safeguarding training. Whilst there are intermediate measures in place to address the issues of medical staffing cover and support to junior doctors within A&E, the impact of these is not yet completely known.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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