

West Hertfordshire Hospitals NHS Trust

Quality report

Trust Headquarters
Vicarage Road
Watford
Hertfordshire
WD18 0HB

Tel: 01923 436228
www.westhertshospitals.nhs.uk

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This report describes our judgement of the quality of care at this trust. 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 trust	Requires improvement	●
Are services at this trust safe?	Requires improvement	●
Are services at this trust effective?	Requires improvement	●
Are services at this trust caring?	Good	●
Are services at this trust responsive?	Requires improvement	●
Are services at this trust well-led?	Requires improvement	●

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Letter from the Chief Inspector of Hospitals

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

This was the third comprehensive inspection of the trust the first taking place in April and May 2015. It was rated as inadequate overall and went into special measures in September 2015. The hospital was inspected again in September 2016 and was rated requires improvement overall. It remained in special measures

Part of the inspection was announced taking place between 30 August and 1 September 2017 during which time Watford Hospital, St Albans Hospital and Hemel Hempstead Hospital were all inspected. Unannounced inspections of all three hospitals were undertaken on the 12 September 2017.

The key questions for safe, effective, responsive and well led were rated as requires

improvement. Caring was rated as good.

Four services were rated as requiring improvement overall and eight rated as good. One was rated inadequate.

This was an improvement on the inspection we carried out in September 2016, where five services were rated as requiring improvement, five rated as good and two were rated inadequate, although one of these services is no longer run by this trust.

Overall, we rated West Hertfordshire Hospitals NHS Trust as requires improvement because:

- The medical 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 medical and surgical 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 trust was in breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation: Regulation 11: Need for consent, as there was no evidence, that decision specific mental capacity assessments were always fulfilled when staff completed DNACPR forms.
- The medical and surgical services 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 medical 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 24 hours of initial treatment.
- The medical 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 outpatient service at St Albans City Hospital was in breach of Regulation 13; Safeguarding. The service was not 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.
- The medical and surgical 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 were no robust systems in place to assess, improve and monitor performance and quality of services in the urgent care centre at Hemel Hempstead Hospital. There was no monitoring of waiting times to initial assessment of patients.
- The trust was in breach of Regulation 18 (1) Staffing. There was an insufficient number of nursing and medical staff on duty in the emergency department to ensure the safety of patients. Not all nursing staff who had direct contact with children in outpatient clinics had undergone level 3 safeguarding children training, which was not in line with national guidance. Compliance with fire safety training in the radiology department was worse than the trust target of 90%. Overall staff compliance was 76%. Nursing staff compliance was 40% for clinical staff and 80% for non-clinical staff.

- There had been three never events in the trust, all at the Watford site between June 2016 and June 2017. These were all unrelated and had happened in different departments.
- In the ED at Watford General Hospital, there were differences in opinions between the leaders. This caused 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 had lowered staff morale. In addition, there were concerns within the safety and responsive domain, with regards to staffing levels, lack of staff trained in ALS/PILS, response times and breaches of national targets. Although caring and effective were good, safe, responsive and leadership was rated inadequate. This led to an overall rating of inadequate for this service.
- We were not fully assured that the consultant body within the ED were working the hours required to safely staff or manage the emergency department.
- Only 66% of nursing staff in the ED 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 medical middle grade cover on the rota overnight and at weekends.
- The percentage of patients leaving the ED 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 (RCM) 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 attended Watford General Hospital experienced delays of more than 30 minutes to hand over a patient.
- Between July 2016 and June 2017 the trust reported 3211 "black breaches". This was an increase on prior 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 in ED 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 ED 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 surrounded that the negative culture had not been adequately addressed by the trust. This had 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.
- There was variable compliance with infection control and prevention practices, in some departments, with staff not consistently washing their hands at the appropriate points, or using hand sanitiser when exiting or entering clinical areas.
- Flood and fluid charts were not always completed, in some areas, as details of total input and output were missing.

- Flow through the hospital did not appear to always be managed effectively, with escalation areas used frequently.
- Clinical specialities did not always meet the national average referral to treatment times.
- The Vanguard theatre in St Albans City hospital did not allow for waste and dirty linen to be removed without travelling outside or through a clean area.
- Imaging, diagnostics and dietetics and speech and language therapy services were available Monday to Friday from 9am to 5pm in St Albans. If support was required outside of these hours, for example for an x-ray or scan, it was undertaken at the Watford Hospital site. Patients were transferred to the Watford site via non-emergency ambulance transport.
- Pharmacy support was available on site at St Albans Monday-Friday but there was no on site support at weekends. Medicines and support were supplied from the Watford site.
- Those who had surgery cancelled were not always treated within the following 28 days in line with guidance.
- Theatre five and the recovery area within surgery services at Watford General Hospital, did not meet national guidance with regards to Department of Health Building Note Guidance 26 (2004) and the Royal College of Anaesthetists (RCOA) guideline; the provision of paediatric anaesthesia (2017).
- The day surgery unit at Watford General Hospital did not provide appropriate facilities. 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 engaged in the implementation of the National Local Safety Standards for Invasive Procedures (LocSSIPs).
- Audits of the Five Steps to Safer Surgery audited the completion of the paper form only. There were no observational audits to assess how well the team participated in the steps.
- The surgery audits on the trust's audit register were nearly all behind schedule.
- Patients' records were not always available at pre-operative assessment.
- The route to administer the painkiller Paracetamol was not clearly documented on some patients' prescription charts.
- Patients did not always get the written information they needed about their treatment.
- Systems and processes related to the maintenance of equipment in the critical care department 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 in the critical care unit, 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 but 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 critical care unit three times a week. This did not meet the daily requirement as stated in GPICS (2015).
- The emergency caesarean section rate had been 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, although 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, specifically vitamin K given to babies at birth, 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 in the maternity department had evidence of annual safety testing.
- 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.
- At our previous inspection in September 2016, there was insufficient space, in the neonatal unit, which did not reflect current guidelines. This was still the case. During our inspection we saw 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.
- The trust had systems in place to identify risks, this was not always effective. We were not assured the trust was aware of the risks for the end of life care and mortuary services.
- We saw evidence that learning from incidents was shared across Watford General Hospital, Hemel Hempstead and St Albans 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.

- In outpatients, 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.
- Not all band 5 nursing staff who had direct contact with children in outpatients had received level three safeguarding children training.
- 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 outpatient department.
- Risks that were identified during both the previous and most recent inspections, such as missing records were not on the departmental risk register.
- Significant progress had been made with trust governance since our last inspection in 2016. The architecture had been strengthened through review of the committee structure. However, the quality assurance framework lacked maturity and with that so did the processes in place to identify, manage and mitigate risk.
- There was a lack of understanding with regards to both controls assurance and correlation between the risks identified between the board assurance framework and corporate risk. Overall this meant that the board could not be fully assured that all risks were identified, managed and mitigated.

However:

- Leadership within the trust 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.
- Staff knowledge of duty of candour was evident. Most services were able to demonstrate where the duty of candour had been applied following incidents. However, we found when reviewing complaints, trust wide, there was often lack of evidence that candour had been applied.
- Lessons from incidents were mostly being learnt trust wide.
- We observed good hand hygiene practice, in ED.
- Safeguarding of vulnerable adults and children training compliance had improved in ED since the last inspection.
- ED had significantly improved the management and treatment of patients with sepsis. The 'sepsis six' pathway was well embedded and audit results demonstrated good outcomes for patients diagnosed 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.
- Pain was assessed on arrival in ED 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 in both adult and children's ED had received training in understanding learning disabilities and patients with 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 within ED had improved since the last inspection.

- The medicine 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 in the medical wards 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, in the medical wards and information was contemporaneous and accurately reflected patient care.
- Staff mandatory training was overall 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 medical wards ensured adequate staffing levels. Locum doctors and agency nursing staff supplemented staffing numbers and were integrated into the trust using generic templates and checklists.
- Some staff on the medical wards 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 trust 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 lower than expected at a value of 93 (better) 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 (better) 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 on the medical wards.
- 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. This was an improvement since the last inspection.
- All staff treated patients in a respectful 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 on the medical wards were aware of their roles in line with the trust escalation plan.
- The service had reduced the number of inpatient moves to other wards, 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 that arose in the medical wards, 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. (Medicine.) Team and clinical leads

were accessible and respected by all staff.

- Local managers on the medical wards were enthusiastic about improving their ward, team and sharing knowledge.
- 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 services 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.
- Surgery services had taken action to improve access to unplanned and planned treatment.
- Referral to treatment times had improved since our last inspection and were similar to the England average. The emergency surgical assessment unit provided timely review from appropriately skilled medical staff and consultants.
- Surgery services leaders had a clear understanding of risks and how these were mitigated and monitored. They took action to resolve risks by making the business case for funding.
- Leaders were driving standardisation so that surgical patients received consistent treatment and care. There were a number of initiatives to improve care and treatment, such as cross-site meetings to review reasons for cancelled operations.
- There was a culture that supported the reporting and learning from incidents in the surgical departments. This was used to improve services and make them safer.
- Staff asked for feedback from patients and relatives to check they were satisfied with their care. Surgery services provided a timely and responsive investigation of complaints. Action was taken to improve services based on feedback and complaints.
- In surgery consent to treatment was taken in line with expected standards.
- Staff protected the rights of people with a mental health condition in the surgical departments. There was an effective and patient centred process to make sure people were kept safe without depriving them of their liberty.
- Patients we spoke with in the surgical wards, commented on the caring, attentive, and compassionate service they received.
- Staff spoke positively about working within surgery 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 surgical ward and theatre staff. Doctors in training were receiving appropriate training and support.
- In critical care, 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.
- The critical care service was provided in appropriate facilities to care for critically ill patients and relatives and visitors had access to appropriate areas of the unit.
- In critical care, as well as attending mandatory training, completing competencies and underwent annual appraisals of their development needs, staff also received support from the unit's professional development nurse.
- The critical care 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 critical care 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 critical care 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 in the critical care unit 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.
- In maternity and gynaecology 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.
- A dedicated team of midwives provided support, care and treatment to women who were thought to be in vulnerable circumstances. Staff understood their responsibilities for safeguarding vulnerable adults, children and young people and were confident to raise concerns. 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 within maternity and gynaecology. 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 in the maternity and gynaecology departments. 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 within maternity and gynaecology. Action was taken to improve performance.
- Women 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.
- In the children and young people's service 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.

- 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 (children's) 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 in the children's departments, 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.
- There were systems in place to protect patients who were receiving care at the end of life from harm and in addition, 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 (NCDHA) 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.
- 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 outpatient 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 in outpatients at Watford general Hospital. 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.
- Multidisciplinary meetings were held in various specialties within the outpatients department 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 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 had 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,' as promoted by the dementia society, were introduced for patients living with dementia attending the diagnostic imaging department to assist with restlessness.
- Some outpatient 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. People were encouraged to provide feedback and we saw their comments used to improve. 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.
- There were high levels of staff satisfaction, and individuals were proud to work for the trust.

St Albans City Hospital, was rated requires improvement overall, although surgery was rated good.

This was because:

- There was no initial clinical assessment of adult patients in the minor injuries unit. This had not improved since our last inspection and meant that patients' condition was at risk of deteriorating while they waited for treatment.
- Although children were assessed quickly during our inspection, the trust could not provide assurance that this took place consistently.
- Staff did not use an early warning scoring system in order to identify deteriorating patients.
- There remained a lack of monitoring of patient outcomes, performance measures and compliance with evidence-based protocols.
- X-ray services were not always available when patients needed them.
- There was no job description for the lead nurse role meaning that their responsibilities were unclear. The matron of the unit also managed a neighbouring emergency department and an urgent care centre that was several miles away. This left little time for direct clinical leadership of the MIU.
- There was a lack of understanding of the risks that could affect the delivery of good quality care. We raised this with the trust at our last inspection. There had been some improvements but not all risks had been added to the risk register.
- The vanguard theatre did not allow for waste and dirty linen to be removed without travelling outside or through a clean area.
- Imaging, diagnostics and dietetics and speech and language therapy services were available Monday to Friday from 9am to 5pm. If support was required outside of these hours it would be at the Watford hospital site. If a patient required diagnostic imaging, for example an x-ray or scan, outside of these hours they would have to be transferred to the Watford site via non-emergency ambulance transport.
- Pharmacy support was available on site Monday-Friday but there was no support at weekends, but this was available from the Watford site
- Those who had surgery cancelled were not always treated within the following 28 days in line with guidance.

However:

- Within surgery, there were clear processes in place for reporting incidents and providing feedback. Learning from incidents was shared across all areas.
- 'Test your care' nursing care indicators were consistently high and meeting trust targets.
- Written records were consistent across areas, clearly maintained with risk assessments and nursing/medical records easy to locate. Records were stored securely throughout our inspection.
- Improvements had been made in relation to standardisation of World Health Organisation safer surgery checklists and compliance with these met the trust target.
- Infection control practices had improved since the previous CQC inspection and audits demonstrated good levels of compliance.
- There was a dedicated orthopaedic ward and a dedicated general surgical ward to manage patient's specific needs.
- Policies were up to date in line with guidance from the National Institute for Health and Care Excellence (NICE) and other professional associations.
- Care bundles were embedded in patient care to improve patient outcomes.
- Significant work was being carried out in relation to enhanced recovery. Enhanced

recovery pathways were used to improve outcomes for patients in general surgery, breast, urology, orthopaedics and ear nose and throat (ENT). Outcomes for enhanced recovery were collected and monitored within the service.

- The average length of stay for patients was better (shorter) than the England average.
- The re-admission rate for elective patients were slightly better than the England average overall. However, the re-admission rate for elective orthopaedic patients was slightly worse than the England average.
- The service continuously reviewed and improved patient outcomes through participation in national audits including the elective surgery Patient Reported Outcome Measures (PROM) programme, the National Joint Registry and surgical site infection audits.
- Staff told us they had opportunities for personal development and to enhance their skills. Practice development support was available to all staff.
- All staff provided a caring, kind, and compassionate service, which involved patients and their relatives in their care. All the feedback from patients and their relatives was positive.
- Staff provided emotional support to patients and staff directed patients to clinical nurse specialists for support where required.
- Patients' and relative feedback was sought on the care they received to ensure they were satisfied with the care provided.
- Changes in senior leadership had led to positive operational and cultural changes within surgical service.
- Senior managers had a clear understanding of risks to the service and how these were being mitigated and monitored.
- All staff spoke positively about working within the service and felt local and senior managers were approachable.
- Staff understood the trust's vision and values and portrayed these in their day to day role.
- Cross site working occurred to improve risk and quality management within the service.
- The service demonstrated a drive to improve clinical services and supported innovations.

Hemel Hempstead Hospital was rated requires improvement overall, although outpatients and diagnostic imaging were rated good.

This was because:

- At Hemel Hempstead Hospital there had been several improvements in assessing and responding to patient risk within the urgent care centre. All patients were assessed by a triage nurse, usually within 20 minutes of arrival. This compared well to our last inspection when patients were waiting up to two hours for an initial clinical assessment.
- Staff used an early warning scoring system to identify patients at risk of deterioration.
- All practitioners had undertaken further training in the assessment and treatment of sick children and there was always access to a specialist children's nurse if necessary.
- There was good multi-disciplinary working and the unit met 18 of the 19 standards set out in the Royal College of Medicine (RCEM) report on "Unscheduled care facilities" 2009.
- We observed staff maintaining patients' privacy, dignity and confidentiality. They demonstrated empathy towards patients who were in pain or distressed and were skilled in providing reassurance and comfort.
- Almost all patients (99%) were treated, discharged or transferred within four hours, with an average time to treatment of 27 minutes.
- An escalation plan had been introduced that provided support to the unit if patients were waiting more than two hours for treatment.

- Staff engagement had improved and clinical staff were encouraged to attend monthly clinical governance meetings.
- Since our previous inspection in September 2016, an outpatient quality improvement plan (QIP) had been implemented for issues raised. Performance data had improved and the service was performing in line with their planned trajectory.
- There was a positive incident reporting culture across the services provided. All staff we spoke with knew how to report an incident and details of recent incidents and learning.
- Radiation protection in the diagnostic imaging department was robust.
- The main outpatient department had no nursing vacancies at the time of our inspection.
- Since our previous inspection in September 2016, the availability of patient notes had improved.
- Medical records were comprehensive, legible, accurate and up-to-date. They were stored safely in a locked office or in lockable trolleys when being used in clinics.
- Medicines and prescription pads were stored securely in all areas we visited.
- Waiting lists for outpatient appointments were reviewed weekly. Risk assessments and individual treatment plans were completed for patients who waited 30 weeks or more. At the time of our inspection, no clinical harm had occurred to patients because of waiting over 30 weeks.
- In outpatients care and treatment was delivered in line with evidence-based guidance, standards and best practice. Pathways were in place for the management and treatment of specific medical conditions that followed national guidance.
- There was a local audit programme in the outpatient department that included monitoring compliance with 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).
- Clinics were run by specialists in their field and staff were supported to develop based on their professional and clinical interests. Multidisciplinary meetings were held to assess, plan and deliver co-ordinated patient care.
- The outpatients department communicated regularly with patients' GPs and worked with the trust's GP liaison manager to share information.
- Staff understood their responsibilities for obtaining consent and making decisions in line with legislation, including the Mental Capacity Act (MCA) 2005.
- Patients were treated with kindness, dignity, respect and compassion. Staff were considerate of people's personal, cultural, and religious needs.
- Chaperones were available throughout the outpatient and diagnostic imaging services.
- Staff communicated with people so that they understood their care, treatment and condition. Patients we spoke with felt well-informed about their treatment and could explain what would happen next.
- Staff recognised when people needed additional support to help them understand and took action to meet their needs.
- Patients we spoke with described being offered emotional and social support.
- 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 worse than national standards for waiting times. During this inspection, we found that most waiting times had improved to meet national standards.
- 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.

- Services were planned and delivered to take into account different people's needs. This had improved since our previous inspection with the introduction of written information in languages other than English.
- The main outpatient department was working towards gaining a Purple Star accreditation for the care and treatment they provided to patients with a learning disability.
- The phlebotomy service engaged with people in vulnerable circumstances and took actions to overcome barriers when people found it difficult to access services.
- 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.
- The culture in across outpatient and diagnostic imaging services encouraged openness, candour and honesty. All staff we spoke with felt supported, respected and valued.
- Patients, relatives and visitors were actively engaged and involved when planning services. People were encouraged to provide feedback and we saw their comments used to improve.
- Leadership of the diagnostic imaging department was focused on driving improvement and delivering high quality care to patients.

However:

- During our previous inspection, we found that not all staff working in clinics that saw children had the appropriate level of safeguarding training. This was still the case at the inspection in August 2017.
- 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.
- Hand hygiene and environmental infection control audits were not carried out in the phlebotomy department.
- Compliance with fire safety training in the radiology department was worse than the trust target of 90%.
- Staff compliance with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) training was below the trust target.
- There were no seven-day outpatient services provided at the time of inspection. Some ad-hoc Saturday clinics had been provided, but this had not taken place since March 2017. There were no plans to introduce evening or weekend clinics.
- Friends and Family Test scores for outpatient services across the trust were worse than the England average from January to June 2017. This had improved in July 2017.
- Five out of 16 specialties were not meeting the England overall performance for patients being seen within 18 weeks of referral.
- During the previous inspection, it was raised that hearing loops were not in use to aid people with hearing impairment. This was still the case at the most recent inspection.
- Staff were not always informed in advance if a new patient had mobility issues, a learning disability or dementia. This meant adjustments could not be made prior to their attendance to facilitate their journey through the department.
- At the time of inspection, there was only one risk on the outpatient department risk register. This was related to clinics being overbooked. However, during our inspection we identified other risks that should have been recognised.
- In the urgent care centre risks that we had identified at previous inspections did not feature on the risk register.
- There was no medical oversight of the UCC. The matron was also responsible for a neighbouring emergency department and a minor injuries unit that was several miles away. This left little time for active clinical leadership in the UCC.

We saw several areas of outstanding practice throughout the trust including:

- At Watford General Hospital, 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.
- 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.
- The trust had implemented 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 their current nursing establishments and had allowed the progression of band 5 nurses using a quality improvement approach. This had provided independent career development opportunities for the nursing team and supported link roles within the service and the wider children’s network.
- 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.
- 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.
- At Hemel Hempstead Hospital the phlebotomy service engaged with people in vulnerable circumstances and took actions to overcome barriers when people found it difficult to access services. For example, phlebotomists carried out home visits for housebound patients who were on blood-thinning medicines. Patients who are on blood-thinning medicines must be assessed regularly to monitor their condition and assess dosage of the drug. Phlebotomists conducted finger-prick tests in housebound patients’ homes to facilitate their access to treatment. This also reduced the need for these patients to have blood tests, which is beneficial if the patients are elderly as taking blood can be difficult and distressing. In the urgent care centre at Hemel Hempstead Hospital, staff had taken photographs of the unit in order to compile a book to help communicate with people who had cognitive impairment. This consisted of photographs that illustrated common practices in the unit such as having an X-ray taken or a dressing applied. This helped people to understand the treatment that had been planned for them.
- The enhanced recovery care of patients at St Albans was working effectively to improve patient outcomes. Staff managing the enhanced recovery care pathways were proactive

and passionate about improving patient care.

- The enhanced recovery care of patients at St Albans was working effectively to improve patient outcomes. Staff managing the enhanced recovery care pathways were proactive and passionate about improving patient care.
- The phlebotomy service engaged with people in vulnerable circumstances and took actions to overcome barriers when people found it difficult to access services. For example, phlebotomists carried out home visits for housebound patients who were on blood-thinning medicines. Patients who are on blood-thinning medicines must be assessed regularly to monitor their condition and assess dosage of the drug. Phlebotomists conducted finger-prick tests in housebound patients' homes to facilitate their access to treatment. This also reduced the need for these patients to have blood tests, which is beneficial if the patients are elderly as taking blood can be difficult and distressing.

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

Importantly, the trust **MUST**:

- Ensure governance quality systems, including the reporting of incidents, identification of risk and management of risk registers provide assurances that ED 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 within ED.
- The trust must ensure that appropriate action is taken to improve the culture within the ED.
- 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 in outpatients 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 within outpatients.
- 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 staff within the radiology department are up-to-date on fire and evacuation training.
- Ensure that venous thromboembolism reassessments for admitted patients are repeated and recorded in line with national guidance on both the medical and surgical wards.
- Ensure that patient personal identifiable information on medical and surgical wards is not displayed or discussed openly within earshot of unauthorised persons.
- Ensure that all staff caring for patients under 18 years of age complete safeguarding children level 3 training.
- Ensure staff in outpatient services are aware of the trust policy and fulfil the mandatory reporting duty for cases of female genital mutilation.
- Monitor compliance with hand hygiene and environmental infection control in the phlebotomy department.
- Ensure that all risks relating to outpatient services are identified, recorded and managed on the departmental risk register.

The trust was placed into special measures in September 2015. Due to the improvements seen at this inspection, I have recommended to NHS Improvement that the special measures are lifted.

Professor Edward Baker
Chief Inspector of Hospitals

Background to West Hertfordshire Hospitals NHS Trust

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.

There are 600 inpatient beds throughout the trust and over 4300 staff are employed. In addition, there are 350 volunteers. The majority of acute services are delivered at Watford Hospital, which provides a full range of district general hospital services, with over 600 inpatient beds, of which 48 are maternity and 19 are critical care. Hemel Hempstead Hospital provides an urgent care centre and outpatients and diagnostic services. The one 22 bed medical ward was handed over to another trust in August 2017.

St Albans City Hospital is the trust's elective care centre. It provides inpatient low risk surgery, both on an inpatient and day case basis as well as outpatient and diagnostic services. It has 40 beds and a minor injuries unit.

In the latest financial year, April 2016 to March 2017, the trust had an income of £322,643,000 and costs of £352,074,000 meaning it had a deficit of –£29,431 for the year. The trust predicts that it will have a deficit of £15,040 in 2017/18.

Bed occupancy fluctuates between 90% and 92% over the three sites.

We carried out an announced comprehensive inspection of the trust from 30 August to 1 September 2017. We undertook unannounced inspections at St Albans City Hospital, Hemel Hempstead Hospital and Watford General Hospital on 12 September 2016.

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 was placed 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.

Prior to the inspection we held focus groups and drop-in sessions with a range of staff in the trust, including staff representatives; black, minority and ethnic staff; nurses, consultants, midwives, healthcare assistants, student nurses, administrative and clerical staff, managers and allied health professionals. We also spoke with staff individually as requested.

In addition we asked Healthwatch Hertfordshire to gather the views of patients in a variety of wards and departments, prior to our inspection at Watford General Hospital and St Albans City Hospital.

The inspection team inspected the following eight core services at Watford General Hospital:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care

- Maternity and gynaecology
- Services for children's and young people
- End of life care
- Outpatients and diagnostic imaging.

The following three core services at Hemel Hempstead Hospital:

- Urgent and emergency services
- End of life care, the mortuary only
- Outpatients and diagnostic imaging

The following three core services at St Albans City Hospital:

- Minor injuries unit
- Surgery
- Outpatients and diagnostic imaging

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, Head of Hospital Inspections, 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, an 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, GPs, NHS Improvement, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and Hertfordshire Healthwatch.

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 2016.

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

What people who use the trust's services say

In the CQC Inpatient Survey 2015, (the latest available) 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 three questions and worse than other trusts in seven questions.

The trust's Friends and Family Test performance (% recommended) was generally about the same as the England average between May 2016 and May 2017. In latest period, May 2017 trust performance was 96% which was the same as the England average.

In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for seven of the 34 questions, in the middle 60% for 20 questions and in the bottom 20% for seven questions.

The trust performed worse than the England average in the Patient-Led Assessments of the care environment (PLACE) 2016 for assessments in relation to food, privacy/dignity/wellbeing and facilities.

Facts and data about this trust

West Hertfordshire NHS Trust has three locations:

- Watford General Hospital
- Hemel Hempstead General Hospital
- St Albans City Hospital

Number of beds

The trust has a total of 670 beds spread across various core services:

- 407 Medical beds (407 Inpatient, 0 day case)
- 215 Surgical beds (173 Inpatient, 27 day case)
- 80 Children's beds (69 Inpatient, 11 day case)
- 72 Maternity beds and (Inpatient, 0 day case) 28 gynaecology beds
- 19 Critical Care beds (19 Inpatient, 0 day case)

Clinical Commissioning Group

The trust's main CCG (Clinical Commissioning Group) is Herts Valley CCG.

Population served

The trust primarily serves a population of 1 million individuals predominantly in North London, Bedfordshire, Buckinghamshire and East Hertfordshire.

Health and deprivation

The health of people in Hertfordshire is generally better than the England average. Hertfordshire is one of the 20% least deprived counties/unitary authorities in England, however about 13% (29,300) of children live in low income families. Life expectancy for both men and women is higher than the England average.

Summary of findings

Are services at this trust safe?

Requires improvement ●

In the safe domain six services were rated as requires improvement and six as good. One (ED) was rated inadequate. This is an improvement on our last inspection where eight services required improvement; four were good and two inadequate.

We rated safety in the trust overall as requires improvement because:

- The medical 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 medical and surgical services were 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-authorized persons.
- The surgical service at Watford General Hospital 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-authorized persons.
- The medical and surgical service were 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 medical and surgical services were 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 24 hours of initial treatment.
- The medical 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 medical 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.
- The emergency department was in breach of Regulation 18 (1) Staffing, due to an insufficient number of nursing and medical staff on duty in the emergency department to ensure the safety of patients. Not all nursing staff who had direct contact with children in outpatient clinics had received level 3 safeguarding children training, which was not in line with national guidance. We could not be assured that the outpatient service at St Albans City Hospital 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. Compliance with fire safety training in the radiology department was worse than the trust target of 90%. Overall staff compliance was 76%. Nursing staff compliance was 40% for clinical staff and 80% for non-clinical staff.

- We were not fully assured that the consultant body within the ED were working the hours required to safely staff or manage the emergency department.
- 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 (RCM) which recommend that patient's initial assessment is undertaken within 15 minutes of arrival.
- 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 vanguard theatre in St Albans City hospital did not allow for waste and dirty linen to be removed without travelling outside or through a clean area.
- Theatre five and the recovery area within surgery services did not meet national guidance with regards to Department of Health Building Note Guidance 26 (2004) and the Royal College of Anaesthetists (RCoA) guideline; the provision of paediatric anaesthesia (2017).
- The route to administer the painkiller Paracetamol was not clearly documented on patients' prescription charts.
- Systems and processes related to the maintenance of equipment in the critical care department 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 in the critical care unit, should be checked.
- Medicines, specifically vitamin K given to babies at birth, 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 in the maternity department had evidence of annual safety testing.
- 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.
- We saw evidence that learning from incidents was shared across Watford General Hospital, Hemel Hempstead and St Albans 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.
- There had been three never events in the trust between June 2016 and June 2017.
- In outpatients, 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.
- Not all band 5 nursing staff who had direct contact with children in outpatients had received level three safeguarding children training.
- The nursing recruitment strategy was incorporated into the; "Workforce and development strategy for our people and organisation 2016/19". However, there was not a specific recruitment strategy for nursing or allied health professionals (AHP) in place.
- Compliance with fire safety training in the radiology department was significantly below the trust target of 90%.

However:

- Staff knowledge of duty of candour was evident. Most services were able to demonstrate where the duty of candour had been applied following incidents.
- Lessons from incidents were being learned trust wide.

- We observed good hand hygiene practice, in ED.
- Safeguarding of vulnerable adults and children training compliance had improved in ED since the last inspection.
- ED had significantly improved the management and treatment of patients with sepsis. The 'sepsis six' pathway was well embedded and audit results demonstrated good outcomes for patients diagnosed with sepsis.
- 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 in the medical wards 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, in the medical wards 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 medical wards ensured adequate staffing levels. Locum doctors and agency nursing staff supplemented staffing numbers and were integrated into the trust using generic templates and checklists.
- Some staff on the medical wards had completed a training exercise in line with the major incident policy.
- 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 on the medical wards.
- Staff on the medical wards were aware of their roles in line with the trust escalation plan.
- Surgery services had taken action to improve access to unplanned and planned treatment. Referral to treatment times had improved since our last inspection and were similar to the England average. The emergency surgical assessment unit provided
- There was a culture that supported the reporting and learning from incidents in the surgical departments. This was used to improve services and make them safer.
- In critical care, as well as attending mandatory training, completing competencies and underwent annual appraisals of their development needs, staff also received support from the unit's professional development nurse.
- There were low infection rates in the critical care unit and good adherence to infection prevention and control policies, including use of handwashing and personal protective equipment.
- A dedicated team of midwives provided support, care and treatment to women who were thought to be in vulnerable circumstances. Staff understood their responsibilities for safeguarding vulnerable adults, children and young people and were confident to raise concerns. 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.
- Systems were in place for assessing and responding to risk in the maternity and gynaecology departments. Staff received multidisciplinary training to help them manage emergencies.
- In the children and young people's service 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 staff did not always follow the correct security procedures for entering and exiting the neonatal unit, Starfish and Safari (children's) 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.
- We observed the majority of staff in the children's departments, 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.
- 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.
- We saw good practice in prescribing anticipatory medicines for patients who were at the end of life.
- There was a positive incident reporting culture across the outpatient services. 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 in outpatients at Watford general Hospital. 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.

Duty of Candour

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires

providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

- The trust had a comprehensive duty of candour policy dated November 2015, for review November 2017 which detailed the background, responsibilities, reporting arrangements, key performance indicators and template for letters and a communication log.
- The chief nurse was the nominated executive lead for championing and implementing the principles of being open and duty of candour. The safety and quality team had overall responsibility for the being open and duty of candour process. Duty of Candour compliance was reported on in the quality and safety integrated performance report which was presented to the safety and quality committee at its meeting which took place every two months.
- We reviewed five incidents that had been rated moderate or serious and found that duty of candour had not been applied according to the trust's policy. For example, the final letter to one patient did not include the findings of the investigation. In addition, we reviewed nine complaints, none of which we could find evidence that duty of candour had been applied.
- There was a mandatory field in the electronic incident reporting system to log and record compliance. It was clear who had communicated with the patient, what had been said, both verbally and in writing. We were therefore assured that all incidents that met the threshold had been identified, but trust policy was not consistently followed. However, this was an improvement from our last inspection in September 2016, where candour had not been embedded.
- In September 2016, staff knowledge of the duty of candour was variable across the trust. However, staff we spoke with during this inspection were clear about the regulation and when it would be applied. Many were aware it went beyond just, 'being open and honest.'

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. We saw evidence of this from the board, through senior staff and staff in the hospital.
- Policies and procedures for safeguarding were in place and were updated to reflect changes in national guidance and legislation. The adult policy had been reviewed in 2017 and included the defined responsibilities of the lead nurse, named professionals and other board members. In addition it included a skin assessment form and flow chart for onward referrals.
- The children's safeguarding policy had also been reviewed in 2017 and included roles and responsibilities and reflected latest guidance. For example, 'think family' and 'voice of the child.'
- There was safeguarding information on both the trust's intranet and website.
- Staff told us they felt confident reporting safeguarding concerns and were given support with this. In addition, they were able to tell us how they would report concerns through the trust procedures and knew who they should contact.
- The executive lead for safeguarding was the chief nurse. There was a named nurse for safeguarding children and another for adults. In addition there was a named safeguarding doctor in post.
- Each department had a safeguarding champion. During our inspection there was a training day for all the safeguarding leads and champions' day planned. We saw the programme and it included external speakers on a range of topical safeguarding issues.
- We saw the safeguarding training strategy 2016-2018. Overall the trust had exceeded their 90% completion target for all staff safeguarding training modules at all three sites. Safeguarding children level 3 had the highest completion rate at 98%. However, there were areas within the trust that saw patients aged 16-18 years that did not have training to level

three, for example, outpatients. This was not compliant with best practice outlined by the Royal College of Paediatrics and Child Health (2014) Intercollegiate document, which states that level three is the required level of training for those staff potentially assessing, planning or intervening with children, young people and/or their parents or carers where there are safeguarding concerns.

- We were told by trust staff of the strong links with the adult and children safeguarding boards and this was reflected in the trust safeguarding annual report. In addition we saw the board minutes dated March 2017, where there was evidence of discussions and actions with regards to adult and children's safeguarding.
- The trust's safeguarding children handbook (May 2016) included information and support for staff to use in the assessment and decision making process when they had safeguarding concerns about a child. In addition, it included relating to the mandatory duty to report female genital mutilation (FGM), child sexual exploitation (CSE) and Prevent. However, staff at St Albans City Hospital were not aware of this policy or that they were required to report any patients who they suspected of being subjected to FGM.
- The trust produced a bi-annual safeguarding newsletter which was distributed to all staff. This provided information on the safeguarding team, contact numbers and key safeguarding issues. The fourth issue had been distributed during our inspection.

Incidents

- Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses, and to report them. This was an improvement since our last inspection in September 2016, where staff knowledge was variable.
- There was a comprehensive policy, dated June 2016, clearly detailing the roles and responsibilities of the board, senior staff and relevant committees with regard to incident management. However, this had not been updated to reflect changes to the governance committee architecture as it referenced the integrated risk and governance committee and safety and quality committee, neither of these committees were in place at the time of our inspection.
- The policy was, however, in the process of being updated, the intention being to remove the requirement to hold an initial meeting with the person/s involved within two week of the incident happening. This was due to go to the policy ratification group in November 2017 for ratification.
- We saw from the board minutes that the numbers and types of incidents were reported to them at every meeting.
- There had been three never events reported between June 2016 and 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 never events had taken place in different departments maternity, outpatients and in one of the medical wards. There were no themes between the three. Thorough root cause analysis had been undertaken for each and there was evidence of learning both locally and trust wide from these events. For example, the event in outpatients was described to us by a junior member of staff on the children's ward as there had been trust wide learning from it. We saw that in all three cases, actions taken to mitigate future risk.
- In order to maximise learning opportunities for all staff we saw a copy of the trust's patients safety newsletter, dated July 2017. This was a new initiative as this letter was issue number two. It described the number and type of incidents reported in June 2017 and detailed three incidents, including one never event and described actions taken and lessons to be learnt. In addition there was short report on how human factors affect staff performance and increased likelihood of making an error.
- In accordance with the Serious Incident Framework 2015, the trust reported 52 serious

incidents (SIs) which met the reporting criteria set by NHS England between June 2016 and June 2017. Of these, the most common type of incident reported was the development or admission with a grade 3 or above pressure ulcer. These accounted for 46% (24 ulcers) of serious incidents reported.

- An incident decision meeting took place three times a week, comprising an executive director, or their deputy, a representative from the serious incidents team and a divisional representative. This team ascertained whether any reported serious incidents should be considered a serious incident and therefore warrant a full root cause analysis.
- There were 8,271 incidents reported to NRLS between June 2016 and June 2017, 19 deaths, 42 incidents reported as causing severe harm, 137 moderate, 724 causing low harm and 7290 reported as causing no harm.
- The proportion of incidents that were listed as severe was similar to the England average. In the same period NRLS incidents were reported at a rate of 8.2 per 100 admissions, lower than the England average of 8.7 per 100 admissions.
- We reviewed the trust's electronic reporting system and found that there were:
 - 1155 open, one of which had been reported in September 2014
 - 529 were overdue, that is the investigation had not been completed in a timely manner
 - 226 were ready to be closed (complete) but had not been
 - 1077 required further investigation.
- Six incidents had been opened in 2014/15 and 118 from 2016. However, there was some information with regards to these reports that were held outside of the electronic system, which was not compliant with the trust's policy. The team were not aware that some of the incidents were so longstanding.
- We reviewed 5 incidents at random and found that:
 - One investigation had not been completed within the trust's 45 day performance indicator.
 - One investigation had not been completed thoroughly, failed to identify the root causes
 - Another had no evidence that the investigation had been thorough
 - Two incidents had no actions identified within the electronic record, despite actions being identified. One of which did have an action plan, but it lacked specifics.
 - One had good evidence that there had been shared learning.

Staffing

- The trust employed 4,300 staff and 350 volunteers.
- As at July 2017, the trust reported a vacancy rate (nursing staff) of 16.4% against a target of 9%.
 - Watford General Hospital had an average vacancy rate of 15.7%
 - Hemel Hempstead General Hospital had an average vacancy rate of 21.4%
 - St Albans City Hospital had an average vacancy rate of 23.7%.
- In medical staffing the vacancy rate was 8.6%, there had been a number of newly appointed doctors at all grades and the trust reported that by October 2016, they would have no consultant grade vacancies.
 - Watford General Hospital had an average vacancy rate of 8.5%
 - Hemel Hempstead General Hospital had an average vacancy rate of 100%
 - St Albans City Hospital had an average vacancy rate of 0%.
- During the last two years the trust had employed just over 2000 new staff, this included 995 nurses and midwives.
- The agency spend in 2015/16 was £37m, but had reduced in 2016/17 to 27m. The trust had planned that this be reduced further for the 2017/18 financial year to £17m.
- As at July 2017, the trust reported a turnover rate for nurses and midwives of 7.7% against a target of 12%.

- Watford General Hospital had an average turnover rate of 8.8%
- Hemel Hempstead General Hospital had an average turnover rate of 3.8%
- St Albans City Hospital had an average turnover rate of 0%.
- In medical staff the turnover rate was of 49.5%. Watford General Hospital had an average turnover rate of 49.5%. However, Hemel Hempstead General Hospital and St Albans City Hospital reported 0% turnover rate.
- As at July 2017, the trust reported an average sickness rate of 2.2% against a target of 3.5%.
 - Watford General Hospital had an average sickness rate of 2.6%
 - Hemel Hempstead General Hospital had an average sickness rate of 2.2%
 - St Albans City Hospital had an average sickness rate of 5.1%
- As at July 2017, the trust reported an average bank and agency staff usage at 24%;
 - Watford General Hospital had an average rate of 26.4%
 - Hemel Hempstead General Hospital had an average rate of 10.7%
 - St Albans City Hospital had an average rate of 8.6%.
- Medical and agency staffing was slightly lower in the same period at 17.3%.
 - Watford General Hospital had an average rate of 16.8%
 - Hemel Hempstead General Hospital had an average rate of 50%
 - St Albans City Hospital had an average rate of 10.2%
- The trust reported that at 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.
- The nursing recruitment strategy was incorporated into the; “Workforce and development strategy for our people and organisation 2016/19”. However, there was not a specific recruitment strategy for nursing or allied health professionals (AHP) in place. The strategy had four strategic priorities and 16 goals with measurements and processes incorporated. A delivery programme, action plans and progress reports against the strategy were in place and were robust. The strategy was clear and fit for purpose. Comprehensive workforce metrics were produced and reported weekly to the trust executive committee and more comprehensively to the Board “Patient and staff experience committee” monthly.
- Nursing and allied health professionals (AHP) recruitment was not identified separately in the HR strategy documents but included as part of the clinical workforce in both the human resource and trust clinical strategy. The trust continued to use the; “see, start, support, sustain” approach to recruitment and retention and outcomes metrics were improving. Band 5 nurse vacancies at 25%; continued to be the biggest nurse/AHP recruitment and retention challenge. The HR director told us that this was mainly because band 5 staff tended to be younger and more geographically mobile and were often attracted to London hospitals, twenty minutes travel time away, where they could sub specialise and command higher salaries.
- There were robust and comprehensive recruitment policies and procedures on the trust’s intranet and all were in date. The trust’s main policy and procedure was rewritten in July 2017.
- There was a robust, inclusive resourced governance structure that governed non-medical and medical education.
- There was a named senior leader for AHP who reported professionally to the Chief Nurse. All trust AHPs had a ‘dotted’ professional accountability line to the chief nurse. The trust’s professional advisory group was scoped for both nurses and AHPs.
- The trust was planning for an inclusive approach to preceptorship and continuous professional development by scheduling joint training for nurses, AHPs and some junior doctors. This new programme for preceptorship was due to commence in Q3 (October to December) 2016/17.
- A training needs analysis had been completed and funded against the trust strategic priorities. The funds allocated were approximately £300,000. National funding had been

significantly reduced this financial year and the trust identified the 300k from within its own income, to ensure training and development continues as it is seen as critical to further develop a positive culture and competent and motivated workforce.

- Mentorship was seen as a priority to ensure new staff were inducted and supported into their roles.
- The full nurse and AHP development programme had been requested, but was not received.
- There were described opportunities for bands 1-4 through apprenticeships, external funding and in house training. There was a focus on leadership programmes and talent management. The latter was due to commence in September 2017.
- Anecdotally staff were encouraged to stay and develop their career in the trust although there was no documentary evidence to support this, although we requested evidence. There were 16 Nursing Associates in training as part of the national pilot scheme.
- The nurse adaptation programme had been in place in the trust for two years and had successfully achieved 100% pass rate for 34 people during the current financial year. The programme was planned to create joint training and development for the nurses and junior doctors, especially, but not exclusively, in the skills laboratory. The written programme, which included details about supervision and support, had been requested but not received. The education leads were very proud of the intense training these staff underwent before being tested. The evidence of success was the pass rate.
- The director of human resources gave assurance that there was a system in place which identified when a practitioner's PIN, from either the Nursing and Midwifery Council (NMC) or the Health and Care Practitioners Council (HCPC) was a month from expiring. The practitioner was written to, a copy was sent to their manager and then this was followed up with the individual to confirm registration, or that there had been no restrictions placed on the practitioners registration.
- An in date nurse revalidation policy was in place. Nurses we spoke with all said they had been supported with their revalidation.
- In 2016 there had been seven nurses referred to the NMC. At the time of the inspection, two cases had been closed and the remaining five were still open.
- In the same period, two AHPs had been referred to the HCPC and both were closed.

Are services at this trust effective?

Requires improvement 

Within the effective domain seven of the trust's services were rated as good and three as requires improvement. In outpatients at all three sites, the effective domain was not rated as the CQC does not consider there is enough evidence to rate these services.

This is better than our last inspection where six services were good and five required improvement.

We rated effective in the trust overall as requires improvement because:

- The urgent care centre at Hemel Hempstead Hospital and the minor injuries unit at St Albans City Hospital was in breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 (1) (2) (a) (b) (c) (f) Good Governance. Hand hygiene and environmental infection control audits were not carried out in the phlebotomy department. Not all risks to outpatient services had been identified, recognised and managed on the departmental risk register. There were no robust systems in place to assess, improve and monitor performance and quality of services in the urgent care centre at Hemel Hempstead Hospital. There was no monitoring of waiting times to initial assessment of patients. This had been identified at the last inspection by us as a risk, but had not been acted on.

- The urgent care centre at Hemel Hempstead Hospital and the minor injuries unit at St Albans City Hospital was in breach of Regulation 18 (1) Staffing, as not all nursing staff who had direct contact with children in outpatient clinics had received level 3 safeguarding children training, which was not in line with national guidance. We could not be assured that the outpatient service at St Albans City Hospital 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. Compliance with fire safety training in the radiology department was worse than the trust target of 90%. Overall staff compliance was 76%. Nursing staff compliance was 40% for clinical staff and 80% for non-clinical staff.
- The middle grade ratio of the emergency 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 attended Watford General Hospital experienced delays of more than 30 minutes to hand over a patient.
- Between July 2016 and June 2017 the trust reported 3211 "black breaches". This was an increase on prior 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.
- Those who had surgery cancelled were not always treated within the following 28 days in line with guidance.
- Flow through the hospital did not appear to always be managed effectively, with escalation areas used frequently, limiting services available and 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.
- When patients' surgery was cancelled, they were not always treated within the following 28 days in line with expected standards.
- Theatre five and the recovery area within surgery services did not meet national guidance with regards to Department of Health Building Note Guidance 26 (2004) and the Royal College of Anaesthetists (RCOA) guideline; the provision of paediatric anaesthesia (2017).
- The day surgery unit at Watford General Hospital did not provide appropriate facilities. 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.
- 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.
- Surgery services were not engaged in the implementation of the National Local Safety Standards for Invasive Procedures (LocSSIPs).
- Audits of the Five Steps to Safer Surgery audited the completion of the paper form only. There were no observational audits to assess how well the team participated in the steps.
- 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.

- 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.
- The emergency caesarean section rate had been 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.
- 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.

However:

- Although there were two outlier alerts, the trust were taking effective action to reduce and mitigate these.
- 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.
- Pain was assessed on arrival in ED 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.
- 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 trust 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 lower than expected at a value of 93 (better) 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 (better) than expected at a value of 90 compared to 100 for England.
- Multidisciplinary team working was inclusive of all professions and patient centred.
- Surgery services 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.
- Surgery services had taken action to improve access to unplanned and planned treatment. Referral to treatment times had improved since our last inspection and were similar to the England average. The emergency surgical assessment unit provided timely review from appropriately skilled medical staff and consultants.
- In critical care, as well as attending mandatory training, completing competencies and underwent annual appraisals of their development needs, staff also received support from the unit's professional development nurse.
- The critical care 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.

- The critical care unit had an active research and development programme and patients' care and treatment was assessed and delivered according to national and best-practice guidelines.

Staff had the right qualifications, skills, knowledge and experience to do their job within maternity and gynaecology. 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 in the maternity and gynaecology departments. 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 within maternity and gynaecology. Action was taken to improve performance.
- Women had access to care and treatment in a timely manner. Gynaecology referral to treatment times were generally better than the England average.
- 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.
- 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.
- 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 (NCDAAH) 2014 to 2015. Local audits were in place to measure the effectiveness and outcomes of the service.
- The SPCT saw 91% of patients within 24 hours of referral.
- 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.
- Multidisciplinary meetings were held in various specialties within the outpatients department so that all necessary staff were involved in assessing, planning and delivering patient care.
- 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 had 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.
- Staff completed a weekly monitoring of waiting lists and clinics flexed to meet any changes in demand or noted increased numbers.

Evidence based care and treatment

- Care was mostly delivered in line with legislation, standards and evidence-based guidelines from the National Institute for Health and Care Excellence (NICE), Intensive Care Society and Faculty of Intensive Care Medicine Guidelines and specialist guidance from royal colleges. Local policies were written and referenced in line with these guidelines.
- There was a trust process to update, review and ratify policies, and policies were available on the intranet. All divisions 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.
- The trust took part in national audits, for example National Audit of Cardiac Rhythm Management (CRM) Device Audit, which is an official record of CRM device procedures in the United Kingdom, the National Joint Register to ensure outcomes for patients undergoing joint replacement surgery were monitored and *Saving Lives, Improving Mothers' Care* (2016) and *Perinatal Confidential Enquiry: Term, singleton, normally-formed, antepartum stillbirth* (2015). We saw action plans to improve compliance with national audits, which had arisen from reviews held at governance meetings.
- 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.
- Care pathways were in place for managing patients, for example, for patients that needed care following a stroke, following a fractured neck of femur 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 trust had two active mortality outlier alert (a service that lies outside the expected range of performance) at July 2017 for catheter acquired urinary tract infections and another dating back to 2016. The trust had developed action plans to address these outliers. We saw the February 2017 mortality review group-meeting minutes, which identified there had been 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 second outlier was for maternity; 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. 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 had taken steps to increase the awareness of the importance of early recognition and treatment of sepsis to prevent avoidable deaths. The trust had 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.
- The surgical assessment unit was auditing compliance with national guidelines on the recognition of sepsis at the time of our inspection. There were no audits on the wards so there was no assurance that patients were having rapid, effective treatment according to national guidelines.
- Surgery services did not manage their local audit programme effectively. Surgery audits on the trust's audit 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's audit 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.

Patient outcomes

- Patient outcomes were monitored regularly throughout the trust. All departments took part in national audits and made improvements and changes to practice as a result of audits.
- 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 lower 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 than expected at a value of 90 (compared to 100 for England) and 1,955 deaths compared to an expected 2,184 deaths.
- There were no outliers or mortality outliers linked to the emergency department. (ED)
- The ED 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.
- 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.
- The ED 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 had decreased from 1.7 per 100 patients in 2014/2015 to 0.8 per 100 patients in 2016/2017 although this was still above the national average.
- Between April 2016 and May 2017, the trust's unplanned re-attendance rate to the ED 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%.

- 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 ED's performance for patients seen by a specialist grade doctor graded at ST4 or above was worse than the national average.
- The children's ED undertook a head injury audit which identified learning around neurological observations. This learning was shared on a bulletin, with a plan to review the proforma to make it clearer where to record a patient's neurological vital signs.
- In medicine, 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. 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 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 infarction (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 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 a national standard of 43%). 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.
- 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.

- Watford General Hospital 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 hospital had produced an action plan to address areas for improvement.
- The service had processes in place to monitor patient outcomes and report findings through national and local audits, and to the trust board.
- In maternity 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%.
- The 2016 MBRRACE-UK audit showed the trust's perinatal mortality rate was more than 10% higher than the national average. The service had taken action to improve perinatal mortality rates, such as implementation of the *Saving Babies' Lives* care bundle.
- There was a maternity deaths policy in place and in date and does reference reporting and investigating but has no reference to learning. There was no evidence on the trust's intranet of any document which would relate to this, however evidence from senior staff, the medical and assistant medical directors is clear that the requirements mandated by NHs Improvement for all aspects of mortality management and reporting are in place. Proposals were due to be presented at the trust board in September board for ratification.
- In end of life care, there were 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).
- In surgery, outcomes for patients at the hospital were generally similar to or better than the English average.
- Patients having unplanned surgery had a lower (better) than expected risk of readmission from March 2016 to February 2017. The re-admission rate for planned admissions across the trust in that period was similar to the England average except for orthopaedic patients, which had a higher (worse) rate.
- 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 for patients receiving emergency surgery was better than the England average, and slightly worse for patients having elective surgery. The average length of stay for emergency surgical patients admitted to the hospital was 4.8 days from April 2016 to March 2017, 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 were similar to or slightly higher than the England average, while trauma and orthopaedics had an average stay of 4.3 days compared to an England average of 3.4 days. Low risk patients generally had their elective surgery undertaken at St Albans City Hospital while higher risk patients were admitted to Watford General Hospital.

- The trust submitted data to all relevant national audits. Case ascertainment rates, an indication of how well audit outcomes represent the trust's performance, was good for fractured neck of femur, emergency laparotomy, bowel cancer and carotid endarterectomy (removal of a clot from an artery), but worse than the England average for abdominal aortic aneurysms.
- National Hip Fracture Database (NHFD) audit results, 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%.
- The trust was meeting six of the seven cancer standards and are 'better than the national average' in all. 94.7% of patients with breast cancer symptoms are seen within two weeks.
- New cardiac centre – new MRI/CT scanner. Only DGH in England to offer both CT coronary angiography and cardiac MRI.
- Ongoing project work to improve RTTs, cancelled appointments and backlog of patients has decreased.

Multidisciplinary working

- There were some good examples of multidisciplinary working. This was most evident in maternity services and within the stoke unit. However there were also some examples of where multidisciplinary working was not as effective as it could be, for example in the emergency department.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- During our last inspection in September 2016 we found that patients did not have their mental capacity assessed in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and associated code of practice. There was no trust database relating to the total number of patients, the expiry of initial authorisation or the date of external assessment. This meant that patients were potentially being deprived of their liberty without appropriate authorisation made. During this inspection we found this had improved, but not all patients who had been subjected to a DNACPR had evidence of a mental capacity assessment being done.
- During our last inspection, Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form did not prompt staff to complete a capacity assessment as part of the decision making process. This had improved. We reviewed 32 DNACPR forms across all ward areas and saw that 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.
- In September 2017 we found that there had been improvements to ensure that the trust knew how many patients who had been subjected to a Deprivation of Liberty Safeguards (DoLS) were in the hospitals.

- There were leads in each division who could carry out mental capacity assessments and who acted as the professional to approach should any support or advice be needed.
- There was a system in place whereby each matron updated a register weekly of any patients who had been subject to a DoLS application, or if this was about to expire. In the case of an imminent expiry, the supervisory body would be informed.
- On the wards we found that there were magnets in place on whiteboards to indicate that a patient was subject to a DoLS, or that an application had been made.
- Most staff we spoke with had an understanding of those patients who were being cared for under a deprivation of liberty safeguard (DoLS). Several staff told us this was because training in safeguarding, DoLS and Mental Capacity Act had been reviewed and delivered as separate subjects. This training was undertaken by allied health professionals as well as doctors and nurses.
- Provision for patients who had a mental health problem had improved in the emergency department. The room where patients waited had been upgraded: CCTV had been installed, personal alarms had been supplied to staff, new furniture purchased and ligature points removed. A risk compliance assessment had been completed by the local mental health trust.
- In addition the hospital had a rapid assessment, interface and discharge team, (RAID) who were able to respond to a patient who required expert help from a professional who specialised in mental health.

Are services at this trust caring?

Good ●

Caring was rated good throughout each core service. This was better than our last inspection where two services had been rated requires improvement, although previously one, (children and young people's services) had been rated outstanding.

- Patients we spoke with in all wards and departments, commented on the caring, attentive, and compassionate service they received.
- Patients were treated with dignity, respect and kindness.
- We saw that staff closed curtains and doors to protect patients' privacy and knocked on doors before they entered.
- 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
- The trust's Friends and Family Test performance (% recommended) was generally about the same as the England average between May 2016 and May 2017. In latest period, May 2017 trust performance was 96% which was the same as the England average.
- The trust performed worse than the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to food, privacy/dignity/wellbeing and facilities.

Compassionate care

- The trust's Friends and Family Test performance (% recommended) was generally about the same as the England average between May 2016 and May 2017. In latest period, May 2017 trust performance was 96% which was the same as the England average.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for seven of the 34 questions, in the middle 60% for 20 questions and in the bottom 20% for seven questions.
- The trust performed worse than the England average in the Patient-Led Assessments of the care environment (PLACE) 2016 for assessments in relation to food,

privacy/dignity/wellbeing and facilities.

- 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.
- 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.

Understanding and involvement of patients and those close to them

In the CQC Inpatient Survey 2015, 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 three questions and worse than other trusts in seven questions.

- 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.
- 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.

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 provided support 24 hours per day to those of any faith or no faith. 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.
- 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 services at this trust responsive?

Requires improvement ●

There were nine services rated as good and three rated as requires improvement. One (ED) was rated inadequate. This is an improvement on the previous inspection as there were nine services that required improvement, two that were inadequate, one of which the trust does not run anymore, and four that were good.

Overall we rated responsive as requires improvement because:

- The medical 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 medical 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-authorized persons.
- Flow through the hospital did not appear to always be managed effectively, with escalation areas used frequently, limiting services available and patient journey.
- The percentage of patients leaving the ED 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 (RCM) 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 attended Watford General Hospital experienced delays of more than 30 minutes to hand over a patient.
- Between July 2016 and June 2017 the trust reported 3211 "black breaches". This was an increase on prior 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.
- Those who had surgery cancelled were not always treated within the following 28 days in line with guidance.
- Patients did not always get the written information they needed about their treatment.
- 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).
- Some outpatient departments had developed services, such as one-stop clinics, in order to better meet the needs of patients and improve service provision.
- 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. People were encouraged to provide feedback and we saw their comments used to improve. Clinical leads led an outpatient user group to gather information on patient experience.
- Complaints were investigated and responded to in line with trust policy. However learning and outcomes from complaints were not always effectively implemented in ED to improve

care.

However:

- All staff treated patients in a respectful and in a considerate manner. Discussions were open and inclusive. Patients and their relatives were included in decision making about treatment and care. Patients we spoke with felt well informed about their care and treatment.
- Access to treatment had improved significantly since the last inspection and both pathways, admitted and non-admitted were around the England average. There was a system in place to risk assess patients who had been waiting longer than 18 weeks.
- Patients with a suspected cancer received their initial consultation quicker than the England average.
- Surgery services had taken action to improve access to unplanned and planned treatment.
- Staff asked for feedback from patients and relatives to check they were satisfied with their care. Surgery services provided a timely and responsive investigation of complaints. Action was taken to improve services based on feedback and complaints.
- Relatives were satisfied 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.
- Chaperones were available throughout the outpatient and diagnostic imaging services. Information on the chaperone policy was displayed in clinical rooms and waiting areas.
- Our last inspection identified issues with patients being treated in the corridor in dermatology. During 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.
- 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.
- 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.
- There was good awareness of the needs of patients with a learning disability and dementia. 'Twiddle muffs,' as promoted by the dementia society, were introduced for patients living with dementia attending the diagnostic imaging department to assist with restlessness.
- Some outpatient departments had developed services, such as one-stop clinics, in order to better meet the needs of patients and improve service provision.
- Patients, relatives and visitors were actively engaged and involved when planning services. People were encouraged to provide feedback and we saw their comments used to improve.

Service planning and delivery to meet the needs of local people

- The trust worked closely with commissioners and other stakeholders to ensure services were planned, delivered and co-ordinated to meet the needs of local people. The premise was that this would enable the local population to access timely care and treatment closer to home.
- There were plans to reconfigure some services, for example, the respiratory ward was to move to the acute admissions building as a large portion of patients admitted through AAU had a respiratory illness. In addition there were plans to separate elective and emergency orthopaedics. Nursing staff told us of the plans and the changes required to enable the moves to go ahead.

Meeting people's individual needs

- Services were planned, delivered and coordinated to take account of people with complex needs, for example those living with dementia or those with a learning disability.
- The trust had a named lead nurse to support patients and offer advice to staff with regards to learning disabilities. The adult safeguarding lead had a trust wide remit for patients with a learning disability. There were also 2.6 whole time equivalent learning disability nurses.
- We saw the, "This is me" document in use across all areas for patients admitted to hospital with a learning disability. "This is me" is a standardised template, which is completed by carers or family members and details the patient's social and medical history, their likes and dislikes. The nursing documentation included a section on the "this is me" document, which gave guidance on completion of recording of key information.
- A range of leaflets were available to patients and their relatives most were only available in English although staff could access them in other languages, easy read format and Braille as required.
- 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.

Dementia

- There was a policy in place to support dementia care, which had recently been updated. The dementia lead was a consultant physician who was supported by a number of nurse specialist dementia leads. Each ward and department across all three sites had dementia champions in place, whose role it was to ensure that they were up to date with dementia care, be a resource for their colleagues so that patients received the most favourable care.
- 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 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%.
- 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.
- 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 trust scored fairly 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.

Access and flow

- Bed occupancy fluctuated at around 90% and was similar to the England average. When the level rises above 85% it was generally accepted this could start to affect the quality of care provided to patients and the orderly running of the trust.
- The main reasons for delayed transfer of care at the trust was ‘Awaiting care package in own home’ (35.5%), followed by ‘Waiting further NHS non-acute care’ (15.5%). This was recorded between May 2016 and April 2017. The trust was working both internally with clinical teams and externally with stakeholders to reduce these unnecessary waits.
- 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.
- The trust had a higher proportion of delayed transfers of care at 26.7%; this was nearly 10% higher than the proportion for all trusts in England. The trust stated this averaged 32 patients per day, however, this had reduced from over 100 patients per day at our previous inspection in September 2016.
- The trust had taken action to try and improve flow through the trust, for example most elective surgery took place at St Albans City Hospital in an attempt to separate elective and urgent/unscheduled care.
- Bed meetings took place at three times a day even at weekends, in an effort to ensure beds were utilised effectively. These were attended by senior staff who had the authority to effect changes and make clinical and managerial decisions.
- Patients, who were ready for discharge and awaiting transport home or for ongoing care, were taken to the discharge lounge to free up any available beds. However, we saw on one occasion during the inspection a patient who was waiting to receive two final doses of intravenous antibiotics in the discharge lounge, which meant they were still getting treatment. In addition, we saw that patients waited, sometimes for several hours for take home medicines to be dispensed from the pharmacy.
- Patients had timely access to initial assessment, diagnosis and treatment. Between July and December 2016, the trust’s referral to treatment (RTT) indicators were below the England average at around 87%. However, there had been an upward trajectory and the trust had reached and sustained an improvement, around 90.5% which was still slightly below the target, but showed an improving picture. The trust had a number of actions in place to address this such as waiting list initiatives, streamlining referral processes, the introduction of demand management and seeking capacity from other providers.
- The national cancer waiting standard requires at least 93% of patients urgently referred by their GP with a suspicion of cancer should wait no longer than two weeks to be seen. Since our last inspection this had improved from 65%, which was below the national average being seen within the two week timeframe. There had been an upward trajectory with over 90% being seen by July 2017. This was above (better than) the national average.
- 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. The latest 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 of 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: 50%
 - Oral: 99%
 - Urology: 79%
 - Vascular: 64%.
- Some surgical specialities had long waiting lists. At July 2017, ophthalmology had 250 patients and orthopaedics had 457 patients on their waiting lists (adults and children).
- 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 speciality available to another speciality.
- 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.
- Medical patients were transferred multiple times within the acute admissions unit and between wards, often out of hours.
- 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, however, 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 ED 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 breach data information provided from September 2016 and July 2017 there remained a concern with how responsive the emergency department was to moving patients through in a timely way. On average 50% of all breaches recorded are linked to lack of available beds and 50% to emergency department performance.
- Black breaches are when it has taken over one hour from the time of the ambulance arriving at the hospital to handing over to staff. The trust saw a rise in such breaches year on year, between November 2015 and August 2016 there were 2107 breaches. Between July 2016 and June 2017 the trust reported 3211 “black breaches”.
- 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 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 (RCM) 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 attended Watford General Hospital experienced delays of more than 30 minutes to hand over a patient.

Learning from complaints and concerns

- Complaints were handled confidentially. The complainant had regular updates. However, not all services were able to resolve complaints within the trust’s policy timeline.
- There was an in date policy in place, dated January 2016, which had an appropriate owner

and an executive lead. The policy was based on the NHS complaints procedure (2009). However, according to the policy, a quarterly complaints report was submitted to the safety and quality committee, this meant that the policy had not been updated to reflect the latest committee structure. The policy clearly identified the processes to be followed when managing complaints and the timescales to be adhered to. The policy set out a two point process: stage one was local resolution and stage two where the complaint was taken to the Parliamentary and Healthcare Services Ombudsman. (PHSO)

- Complaints had been identified as a risk on the trust's risk register. The issue had been described but there were some gaps in the controls which did not reflect future actions needed to minimise risk.
- The trust, at the time of the inspection had six open complaints with the Ombudsmen.
- Staff who would be involved in complaints had undergone specific training, which was an ongoing process.
- Once a complaint had been received, a senior member of staff would telephone the complainant to discuss their concerns, agree what outcome the complainant would prefer and agree timescales. The complainant was given the name, title and contact details of the person responsible for handling the complaint. This was a new initiative and had commenced in August 2017.
- There was no reference in the policy with regards to complaints that had been closed and then reopened as the complainant had been dissatisfied with the response. There were a number of complaints that had been closed and then reopened and no guidance how to manage this.
- Between May 2016 and July 2017, there were 890 complaints about the trust. The trust took an average of 52 days to investigate and close complaints. There were 146 open complaints at the time of the inspection, which the trust were working towards reducing.
- The main reasons for complains were due to all aspects of clinical treatment (234) attitude of staff (136) and communication (139). However, this did not include complaints made directly to the Patient Advice and Liaison Service (PALS), unless the complainant wanted their concerns escalated.
- Records of complaints were kept in both a paper and on the trust's electronic system.
- We reviewed nine complaint files. All had received an acknowledged in writing which outlined the whole process, including advocacy involvement of the PHSO at stage two. There was a robust process for quality assuring the letters. The response letters were generally good, sympathetic, detailed the perceived lapse in care or service and outlined the steps taken to resolve the issue. All offered a sincere apology. However, there was no formal consideration of duty of candour.
- All final complaint letters were read, scrutinised and signed by the chief executive.
- There was a new process being trialled for managing complaints concerning the attitude of staff, which involved the staff member being interviewed rather than them supplying an account of what had happened. This had significantly reduced the time frame for managing this type of complaint.
- We saw that there was evidence of challenge with regard to performance surrounding complaint responses from the board minutes dates May 1 2017, in addition we saw evidence of board level discussions about complaints at the November 2016 board minutes.
- We saw that there was shared learning from complaints through ward meetings, teaching sessions, post-handover 'huddles' and newsletters.
- There had been six whistle-blowers: (staff members who complain either openly or anonymously to the trust. All six were in relation to the Watford site. No clear themes and all related to different issues.

Are services at this trust well-led?

Requires improvement



Ten services were good, two required improvement and one was inadequate. At the last inspection seven services were good, three required improvement and five, including one service that the trust no longer runs, were inadequate.

We rated well-led as requires improvement overall because:

- There was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 (1) (2) (a) (b) (c) (f) Good Governance. The trust did not ensure that all risks were effectively identified and some departmental risk registers did not have all the risks associated with the department detailed. 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.
- There was a lack of understanding of the risks that could impact on the delivery of good quality care. Risks that we had identified at previous inspections (For example, lack of monitoring of waiting times) had not been placed on the risk register. There were no robust systems in place to assess, improve and monitor performance and quality of services in the urgent care centre at Hemel Hempstead Hospital. There was no monitoring of waiting times to initial assessment of patients.
- The culture within the ED 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 had 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 saw evidence that learning from incidents was shared across Watford General Hospital, Hemel Hempstead and St Albans 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.
- Significant progress had been made with governance since our last inspection in 2016. The architecture had been strengthened through review of the committee structure. However, the quality assurance framework lacked maturity and with that so did the processes in place to identify, manage and mitigate risk.
- There was a lack of understanding with regards to both controls assurance and correlation between the risks identified between the Board Assurance Framework and corporate risk. Overall this meant that the board could not be fully assured that all risks were identified, managed and mitigated.

However:

- Leadership was strong, supportive and visible. Team and clinical leads were accessible and respected by all staff. 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.
- There was a stable senior team and board.
- Staff were aware of the trust's vision and aims.

- Staff were committed to the trust and had pride in their role.
- A new committee structure was in place, reporting to the board, so that the board remained strategic rather than operational. This was due to be formally evaluated in November 2017.
- Equality and diversity was promoted within the organisation. The trust had clearly done a great deal of work to build upon their equality and diversity programme since the previous inspection, this was evidenced by the improvement in the Workforce Race Equality Standard (WRES) data and the improvement in the staff survey.
- The trust senior team were working collaboratively with other organisations to strengthen its position both clinically and managerially.
- The trust had freedom to Speak up Guardian. The senior staff knew about this role and could name the person; however, more junior staff were unaware of the person and the role they played within the trust.
- There were developmental programmes in place for staff from band five to divisional director level.
- Plans were in place to rebuild the Watford Hospital site, replacing the current ageing estate.

Leadership of the trust

- At the previous inspection in September 2016, many of the executive directors were both new to the trust and to an executive role. However, these personnel had matured into their roles and there was a stable executive team in place, with no changes since the last inspection.
- The chair had been in post since November 2015, there was a stable group of non-executive directors with the most recent appointment in June 2015.
- Staff and stakeholders spoke positively about the chief executive.
- The trust had updated its board, division and support structure in June 2016. There were five clinical divisions, each with a divisional director, a divisional manager and a head of nursing. There were associate divisional managers and assistant service managers for each speciality within the division as well as a deputy head of nursing and matrons who supported the speciality and divisional team.
- A management programme had been developed to support the divisional directors in these new roles. It was clear that over a year after its launch, the structure was well embedded. It was however, due for review in November 2017, the outcome of which was scheduled to be reported to the board in February 2017.
- The trust had also identified the need for a leadership programme for nursing staff at band six and seven, which had been ongoing for over a year. In addition, there was a clinical leadership programme for clinical directors, which was ongoing at the time of the inspection. Staff who had taken part in this spoke highly of its value.
- The trust had received the support from an improvement director from NHS Improvement during the 18 months prior to our inspection.

Vision and strategy

- The trust's vision was; 'to deliver the best care for every patient, every day. This was underpinned by four aims:
 - To deliver the best care for our patients
 - To be a great place to work
 - To improve our financial stability
 - To develop a strategy for the future.
- In addition, there were four values: commitment, care and quality.
- The vision and commitment to care was demonstrated in a picture of a tree. We saw this in every department around the hospitals and most of the staff we spoke with referred to it.

- Staff we spoke with in every department were aware of the vision and strategy.
- There was a new committee structure in place, consisting of eight committees, all reported through to the board:
 - Clinical outcomes
 - Patient and staff experience –which included the patient panel.
 - Safety and compliance
 - Remuneration
 - Finance and investment
 - Audit committee
 - Charitable funds
 - Trust executive committee, including strategy delivery board and executive performance reviews.
- Both the executive team and board members told us that the board was now more strategic as they had more assurance that operational issues would be addressed by the various committees. However, all were aware that this structure was in its infancy and had yet to reach its full potential. A review was planned in November 2017, which was due to be presented to the board in February 2018.
- The trust had a joint partnership with the Royal Free NHS Trust, London and shared care pathways and had a joint training programme for medical staff. This relationship was described as equal in that each trust learnt from each other.
- In addition there were trauma links to St Mary's Hospital, London, which was one of London's four major trauma centres.
- There had been some consideration with regards to providing tertiary care to gynaecology, vascular and patients requiring interventional radiology, or remain as a good 'spoke' with a hub elsewhere. However, this was still under consideration.
- The trust was within the footprint of the Hertfordshire and West Essex Sustainability and Transformation Plan.
- The trust 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

- Significant progress had been made with governance since our last inspection in 2016. The architecture had been strengthened through review of the committee structure where eight committees reported through to the board. However, the quality assurance framework lacked maturity and with that so did the processes in place to identify, manage and mitigate risk.
- The corporate risk register contained 23 risks all of which had the risk, its type, (for example clinical, financial) the division it belonged to, the risk lead, the date it had been opened. It outlined the primary and secondary risk, for example, with regards to recruitment, the primary risk was failure to recruit to full establishments, the secondary being the inability to provide safe, effective and high quality care. In addition, there were primary and secondary board assurances. For the risk with regards to recruitment, the board assurances were listed as the patient and staff committee and the safety and compliance committee.
- Controls and gaps in controls were in place for all risks. In addition assurances and gaps in assurances were also included. There were contingency plans listed for all risks on the register. All risks were rated numerically, according to the level of risk.
- We found that there appeared to be a misunderstanding with regards to what gaps in assurance were. In several areas, for example with regards to all the areas where failure of equipment was a risk, the gaps in listed as assurances were in fact, gaps in controls. In some cases there were gaps in assurances listed but no actions to address the gaps.

- One risk was with regards to the bleep system failing. The assurance was that the system was tested regularly, however, it gave no further detail, for example, how often tests were undertaken and who the results were reported to.
- This meant there was a lack of understanding with regards to both controls assurance and correlation between the risks identified between the Board Assurance Framework and corporate risk. Overall this meant that the board could not be fully assured that all risks were identified, managed and mitigated.
- The quality improvement plan (QIP) was submitted to CQC in October 2015 in response to the trust entering special measures. It was subject to a full post September 2016 inspection and was updated again following the published report in March 2017. We saw that the QIP was updated regularly and reported to an oversight meeting monthly.
- There were 19 live projects as of Q1 (April - June) 2017. Some items on the QIP had been closed as their action had been completed, for example, environment and estates, and safety equipment and security projects.
- IT transformation and ICT and information projects had remained red since the cyber-attacks in August 2017. We saw evidence that a recovery plan was to be presented to the board and the oversight meeting after our inspection.
- The QIP progress reports showed the number of open actions had consistently reduced at each reporting period.
- Main performance challenges included mandatory training compliance, vacancy rate, ED performance (the 15 minute triage), cancelled appointments in outpatients, and the number of serious incidents submitted to CCG within a given timescale.
- Referral to treatment time performance had improved, in addition there had been a reduction in the historic backlog.
- A number of individual projects had been undertaken, which included 'deep dives' to review progress of individual projects. These had been presented to the monthly oversight group by the individual departments and led by NHSI. For example, flow through ED and improvements in the neonatal unit.
- There was a trust surge plan, dated July 2017, which outlined the beds to be used if there was a surge in patients, for example during a 'flu epidemic or an incident. The plan was RAG rated and described the beds to be used, the actions required to implement, the authorisation level required and which team would provide medical cover.
- The trust had a financial deficit in the latest financial year, April 2016 to March 2017, the trust had an income of £322,643,000 and costs of £352,074,000 meaning it had a deficit of –£29,431 for the year. The trust had predicted that it would have a deficit of £15,040 in 2017/18. The finance director was aware of the need to reduce this deficit, however, not at the cost of patient safety. There were inbuilt inefficiencies within the trust, for example an ageing estate, which required investment, but was not seen. An example of this was replacement of the air handling unit at Watford and repairs to a chimney at Hemel Hempstead. In addition there were some small wards of 10-15 beds which were not cost effective. The main focus to ensure that the deficit was reduced surrounded recruitment and retention of key staff and reduction in agency usage.
- There was a cost improvement plan in place, which outlined each scheme its cost and the division it belonged to. Each was red, amber, green rated according to impact. We saw this was reviewed at the finance and investment committee which reported through to the board.

Culture within the trust

- The culture was centred on the needs and experience of people who use services. The trust executive team and board had a focus on quality improvement, led by the clinical leadership teams. Historically, clinical leaders did not have a voice on the board and were excluded from decisions. This had now changed and the board and executive team were

focused on patient safety and quality of care.

- Most staff felt respected and valued and were respectful of the leadership team. However there were areas where this was not the case, particularly amongst more junior members of staff. All staff we spoke with were proud to work for the trust, described their job satisfaction with regards to the pleased of the work they did to contribute to patients' receiving good care. In addition, they were energised by the improvements the trust had made.
- The role of the National Guardian and Freedom to Speak Up Guardians (FTSG) had been created as a result of recommendations from Sir Robert Francis' Freedom to Speak Up review, published in February 2015. FTSG 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.
- The trust were one of the early adopters of a FTSG, who was already a non-executive director and appointed to fulfil this additional role in October 2015. There was a job description in place and support for the role was given via the board and the HR department.
- We saw minutes from the patient and staff experience committee dated 31 August 2017, which gave a freedom to speak up update. Within this there were 13 principles, which were all red, amber, green (RAG) rated against progress from August 2015 when the FTSG appointment was first made, to July 2017. It was clear from the commentary and the RAG ratings that progress had been made to support the spirit of this initiative.
- We saw that newsletters had been distributed to the staff with their pay slips and we saw posters and postcards around the hospitals which gave staff details of how to raise concerns and contact information, all which emphasised that any concerns would be treated confidentially. The FTSG told us that there had been a slow start with regards to concerns being raised, however, as their role became more widely known, concerns were being raised more regularly.
- We asked staff about their FTSG. Senior staff were aware of who the person was and could name them, furthermore they had seen the person regularly around the hospital, particularly Watford General. More junior staff we spoke with were mostly not aware that there was such a role or who the person was. However, they all knew the term, 'whistleblowing,' knew how to raise concerns, either through a senior member of staff or HR if they had any anxieties about patient safety, staff morale or behaviour that did not fit with the trust's values.

Equalities and Diversity – including Workforce Race Equality Standard

- Equality and diversity was promoted within the organisation. The trust had clearly done a great deal of work to build upon their equality and diversity programme since the previous inspection, this was evidenced by the improvement in the Workforce Race Equality Standard (WRES) data and the improvement in the staff survey.
- The trust employed 31.9% of staff from BME groups; however 15% of the voting members of the board were BME. In addition:
 - 7% of non-clinical staff in Band 8a, 9 and very senior managers were from BME backgrounds, compared to 11% of white non-clinical staff.
 - 4% of clinical staff in Band 8a, 9 and very senior managers were from BME backgrounds compared to 6% of white staff.
 - The relative likelihood of white staff being appointed from shortlisting were 2.38 greater compared to BME staff.
 - The relative likelihood of white staff accessing non-mandatory training/continuing professional development (CPD) compared to BME staff was 0.96.
 - The relative likelihood of white staff accessing non-mandatory training/CPD has decreased from 1.14 to 0.96 from 2014/2015 to 2015/2016
 - Staff believing that the organisation provides equal opportunities for career

progression or promotion White 87% BME 68.4%

- In the last 12 months have you personally experienced discrimination at work from manager, team leader, or other colleague: white staff 6%, those from a BME background 14%
 - BME staff were 2.3 times more likely to be subject to formal disciplinary proceedings compared to white staff.
 - 68.4% of BME staff believed that the trust acted fairly with regard to promotion and career progressions compared to 87% of white staff. This was significantly below the national average for such trusts.
 - 14.3% of BME staff experienced discrimination from a manager, team leader or other colleagues during 2016, compared to 6.2% of white staff.
- The trust was compliant with the completion and submission of Equality Delivery System (EDS2) and WRES; the next EDS2 is due for submission in 2018.
 - The trust had in place a 0.5 whole time equivalent, equality and diversity lead who was shared between WHHT and another nearby trust and had been in post for three years. They reported to the HR director. Their role was to support managers and staff and their aim was for the trust to become; 'Effortlessly inclusive.' The manager saw equality and diversity as being part of 'business as usual' rather than something that is focused on separately. The manager had a clear understanding of the work needed to be undertaken in order to improve equality and diversity across the organisation and was dynamic and highly motivated.
 - There was Equality and Human Rights policy in place dated September 2016. The aims of the policy were clear, including its scope and contained definitions about types of discrimination, victimisation. Protected characteristics were clearly stated. Responsibilities for all staff types were explicit. The policy was monitored through the recruitment process and information submitted through Workforce Race Equality Standard (WRES.)
 - The WRES second report was published in April 2017, reporting on the findings in 2016. Almost one in five of the staff working in the NHS are from a black and minority ethnic (BME) background, yet the treatment and opportunities that they get in the workplace often do not correspond with the values that the NHS represents. Since its introduction, the WRES has required healthcare providers to self-assess on this agenda and to understand the specific challenges they face in ensuring all staff are treated equally and are supported to fulfil their full potential.
 - The WRES contains nine indicators; the report showed that improvements had been made in some indicators from the previous year. In addition there was a comprehensive action plane in place which identified what the report was conveying, the owners of each action, a deadline and regular updates. A copy of the WRES and an accompanying action plan was available on the trust website. The action plan which was relevant and appropriate focused on each element of the WRES, it was appropriate to the issues identified and demonstrated a good focus on equality and diversity. There is a recognition that the work has to be done in stages recruitment has been identified as a priority.
 - A workforce equality forum consisting of a mix of staff groups from across the organisation facilitates the completion of this work through focused work streams. The forum is made up from staff from across the organisation. This forum works alongside the disability focus forum, which is a group consisting disable staff and patients.
 - The Raising Concerns (Whistle blowing) policy is within date. Its purpose was to support employees who wish to raise concerns, it clearly identifies roles and responsibilities, definitions and the process for raising concerns; starting with reporting to a manager and escalating to the Non-Executive Director if necessary. The policy was clear that anonymity would be protected. External support and employee specific support was identified.
 - The Board members had all undergone a half day equality and diversity training in January 2017, which had challenged any unconscious bias. The Board have endorsed the equality

and diversity objectives and these are included in the Workforce and Development Strategy. From this strategy there is a Workforce development plan

- The rest of the staff underwent training as part of their induction and had ongoing mandatory training. In addition, there was a 'let me hear you see you panel, chaired by a member of staff with a physical disability and a multicultural staff network. Both of these committees had regular meetings.
- External engagement was undertaken through the Patient Engagement forum which meets quarterly. In addition there were other forums:
 - Patient participation forum.
 - Disability focus forum, chaired by a nurse.
 - Let me see you hear me panel, chaired by a member of staff with a physical disability.
 - There was a BME cultural network which allows these staff to share what was happening across the trust and allowed them to engage with work the trust was doing. This group was chaired by the Director of Midwifery.
- There was a bullying and harassment policy – Promoting Dignity and Respect at Work, dated September 2016. Again, the aims, objectives and scope of the policy were clear. There was a four step process for resolution process to be followed in the case of any bullying and harassment claims:
 - Informal resolution
 - Facilitated meetings
 - Mediation
 - Formal investigation.
- There had been 17 bullying and harassment claims from June 2016 – July 2017, all of which had been resolved informally.

Fit and Proper Persons

- We reviewed 25 files of senior staff, including the executive team, directors and senior medical staff that were leading divisions.
- We found that eight files did not contain all the required information; however this was because there had been a decision made in late July 2017 to include divisional directors' files to adhere to the fit and proper person requirement. The policy, at the time of our inspection had not been updated to reflect this, but all the files contained that the relevant information which was appropriate to reach compliance with the trust's current fit and proper person's policy. Two of the divisional directors had not had their disclosure and barring service record updated within the past five years in line with trust policy, however, there was evidence that this had been pursued.

Public engagement

- The trust had developed a patient experience and carer strategy for 2016-2019. It involved patients, carers, volunteers and staff. This was reviewed twice a year. We saw the minutes of the board meeting dated 1 July 2017. It was clear that the patient panel was actively involved in this strategy. There were four priorities:
 - Involve, Listen, Communicate
 - Getting the basics right
 - Improve the patient journey
 - Making best use of our volunteers.
- Patients were given the opportunity to provide feedback regarding their care and treatment through the friends and family test.
- There was a written plan with regards to development of a scorecard that was planned to provide evidence of achievement against the success measures within the patient experience and carer strategy 2016 - 2019.

- There was an active patient panel, who reported through to the board.
- There were volunteers throughout the hospital who undertook a range of tasks including meeting and greeting patients, helping people with directions and as well as working on specific wards.
- Wards displayed their 'I want great care' scores which were generally high, for example 4.5 out of five.
- The trust had links with a variety of groups in the community, for example, Hertfordshire Action on Disability. In addition previous patients were invited to speak about their experience at Board meetings, in Schwartz rounds and in individual departments. For example, the maternity department invited a woman back to the department after she had complained about her care, to talk to the staff about her complaint.

Staff engagement

- Generally staff felt actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. Many staff, on all three sites, had worked at their respective hospitals for a number of years, felt very loyal and were proud to work for the trust. Many staff told us that they had been promoted over the years into senior roles and were grateful for all the opportunities the trust had been able to offer them with regards to training, development and prospects for promotion.
- In the NHS Staff Survey 2016, the latest one available, the trust performed better than other trusts in five questions, worse than other trusts in five questions and about the same as other trusts in the remaining questions.
- The questions for which the trust performed better than other trusts were:
 - Percentage of staff reporting good communication between senior management and staff - 40% compared to the England average of 33%
 - Support from immediate managers – 3.83 compared to the England average of 3.73
 - Organisation and management interest and action on health and wellbeing -3.17 compared to the England average of 3.61
 - Percentage of staff/colleagues reporting most recent experience of harassment/bullying or abuse – 49% compared to the England average of 45%
 - Effective team working – 3.81 compared to the England average of 3.75
- The questions for which the trust performed worse than other trusts were:
 - The percentage of staff experiencing physical violence in the last 12 months – 4% compared to the England average of 2%
 - Percentage of staff experiencing discrimination at work in the last 12 months – 14% compared to the England average of 11%
 - Staff experiencing physical violence from patients, relatives or the public in the last 12 months – 17% compared to the England average of 15%
 - Percentage of staff who believe the organisation provides equal opportunities for career progression or promotion – 83% compared to the England average of 87%
 - Staff would recommend the organisation as a place to work or receive treatment – 3.66 compared to the England average of 3.76
- Of 315 providers the trust is 189th in terms of overall engagement score which puts it within the top 60% for all trusts. The trust's position when compared to acute trusts only, that is excluding for example, mental health and community trusts is that it is 32nd of 97 trusts. This puts it into the top third for acute trusts.
- Staff all expressed how disappointed they had been after the previous inspection in September 2016 and despite improvements being made, the trust had remained in special measures. However, many expressed that they had been looking forward to the current inspection as they were proud of the further improvements that had been made.
- Most staff felt respected and valued however, this varied by department and it was clear that this relied on who their manager was.
- Overall sickness absence remained lower than the national average and had been for

some time.

Innovation, improvement and sustainability

- Overall the trust had improved since the last inspection in September 2016 and significantly improved since September 2015 when the trust was first placed into special measures. Positive progress was seen in most services since the last inspection. Most services at Watford had been rated requiring improvement at our last inspection in 2016, except critical care, maternity and end of life, which had all been rated good. However, at this inspection all services had been rated good, with the exception of medicine and surgery which was rated as requiring improvement, the same as 2016, and ED which remained inadequate. Children's services received an outstanding rating for caring in 2016, but it had been rated good at the latest inspection in September 2017.
- St Albans City Hospital was rated as requires improvement at our last inspection, with an inadequate rating for the urgent care centre. Although the overall rating remained the same, there were more good ratings and no inadequate ratings.
- Hemel Hempstead Hospital was rated inadequate at our last inspection in September 2016. The main reason for this was because of the medical ward there. In August 2017, the management of the ward was transferred to another provider, so it was not inspected on this occasion. The urgent care centre had improved. The overall rating remained the same, requires improvement, however, the previous inadequate rating for well led, was requires improvement as opposed to inadequate, the rating given in 2016.
- Stroke services had been rated AA, which is within the top stroke services nationally. This was an improvement from 2016.
- The hospital has six laboratories, five of these have a national quality assurance warrant; ISO15189
- The Hospital Standardised Mortality Rates (HMSR) is a measure of overall mortality. This indicator had been lower than the national average for two and a half years.
- Cancer and diagnostics performance had improved and at the time of the inspection was better than the national average.
- The room in Watford's ED used for patients with mental health needs had been improved.
- Following the success of the Advanced nurse practitioners in ED at Watford, the UCC at Hemel Hempstead and the MIU in St Albans, there were plans to appoint a nurse consultant. In addition two new ED consultants had been appointed to strengthen this key clinical team further.
- The trust had won a 'highly commended' award in the 'collaboration' category of the Healthcare Supply Association Awards for consortium working across trusts in Hertfordshire and Bedfordshire. Collaboration has led to savings of nearly £1 million for the trust.
- In June 2017 maternity services were awarded stage one accreditation by the Unicef 'Baby Friendly' initiative.
- Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. The purpose of rounds is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care. The trust's Schwartz rounds are held monthly and are attended each month by over 100 staff. The Schwartz team's work was recognised at the Schwartz Community Conference, winning the award for 'the most powerful Schwartz Round'.
- In 2017, the vascular ultrasound and St Alban's day surgery teams join the abdominal aorta screening team in being awarded "purple stars" by Hertfordshire County Council. The award recognises services that go the 'extra mile' for people with learning disabilities.
- Following the installation of a new MRI/CT scanner at WGH the trust now offers both CT coronary angiography and Cardiac MRI to enable definitive assessment of cardiomyopathies and structural heart disease. The trust are the only DGH in England to

offer both modalities of cardiac imaging.

- Due to the fabric of the estate the trust had significant challenges in maintaining a harm free environment and providing care that maintained patients' privacy and dignity. However, we were shown an outline plan for re-development of the whole of the Watford site, which, at the time of the inspection, was being considered at a national approvals committee. It was hoped that this would commence in 2020.
- The surgical assessment team had continued to develop developed an outreach service that enabled elderly and frail patients to be pre-assessed in their own home. This took place over three weeks, with a residential carer with a view to them staying at home.
- Mandatory training with regards to fire had been reviewed and all staff were being trained to fire marshal level, rather than just undergoing basic training. This meant there were more people in each department who had an advanced awareness of how to lead within their department, should there be a fire.

Overview of ratings

Our ratings for Watford General Hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & emergency services	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 & family planning	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

Our ratings for St Albans City Hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Minor injuries Unit	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Outpatients & diagnostic imaging	Requires improvement	Inspected but not rated ¹	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Our ratings for Hemel Hempstead Hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent Care centre	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients & diagnostic imaging	Requires improvement	Inspected but not rated ¹	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

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

Notes:

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

Outstanding practice

- The trust had implemented 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 their current nursing establishments and had allowed the progression of band 5 nurses using a quality improvement approach. This had provided independent career development opportunities for the nursing team and supported link roles within the service and the wider children’s network.
- 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.
- 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.
- 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 enhanced recovery care of patients at St Albans was working effectively to improve patient outcomes. Staff managing the enhanced recovery care pathways were proactive and passionate about improving patient care.
- The phlebotomy service engaged with people in vulnerable circumstances and took actions to overcome barriers when people found it difficult to access services. For example, phlebotomists carried out home visits for housebound patients who were on blood-thinning medicines. Patients who are on blood-thinning medicines must be assessed regularly to monitor their condition and assess dosage of the drug. Phlebotomists conducted finger-prick tests in housebound patients’ homes to facilitate their access to treatment. This also reduced the need for these patients to have blood tests, which is beneficial if the patients are elderly as taking blood can be difficult and distressing.
- In the urgent care centre at Hemel Hempstead Hospital, staff had taken photographs of the unit in order to compile a book to help communicate with people who had cognitive impairment. This consisted of photographs that illustrated common practices in the unit such as having an X-ray taken or a dressing applied. This helped people to understand the treatment that had been planned for them.

Areas for improvement

Action the hospital SHOULD take to improve:

These are all included in the individual core service reports.

Action the trust MUST take to improve

- In ED, 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 always runs safely and effectively.
- The trust must ensure that the staffing levels in ED 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.
- In outpatients throughout the trust, 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 within outpatients.
- Ensure that infection prevention and control standards are maintained in outpatient rooms and medical wards where minor operations are performed.
- Monitor compliance with hand hygiene and environmental infection control in the phlebotomy department.
- Ensure that all risks within the outpatient department are included on the departmental risk register.
- Ensure clinical staff within the radiology department are up-to-date with fire and evacuation training.
- Ensure that there are processes in place in the medical and surgical wards to complete patients' venous thromboembolism risk assessments on admission and then repeat assessments 24 hours after admission.
- Ensure that patient risk assessments within the medical and surgical wards are detailed with information to allow an accurate assessment of the patients' clinical condition.
- Ensure that there are processes in place to manage and effectively report mixed sex accommodation 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 identifying medicines and contraindications with any anticoagulant treatment necessary.
- 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 clinical staff within the radiology department are up-to-date on fire and evacuation training.
- Ensure that all risks relating to outpatient services are identified, recorded mitigated and managed on the departmental risk register.
- In the MIU at SACH, ensure that there are effective triage/streaming systems in place in the unit and all staff have had appropriate training to carry out this process.
- Ensure that systems and processes are in place to monitor and review all key aspects of

performance in MIU and UCC so that areas for improvement are identified. For example patient waiting times.

- Develop a clinical audit process in the MIU to monitor compliance with clinical guidelines and protocols in line with other areas of the unscheduled care division.
- Ensure there are processes in place to monitor arrival time to initial clinical assessment for all patients in UCC.
- Develop an audit process in the UCC to monitor compliance to protocols/pathways in line with other areas of the unscheduled care division.

This section is primarily information for the provider

Enforcement actions

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 or injury Diagnostic and screening Surgical procedures	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014: Dignity and respect. Regulation 10(2)(a)</p> <p><u>Why the regulation was not being met:</u></p> <p>Patient identifiable information was displayed on ward whiteboards, and discussions took place within earshot of non-authorized persons.</p> <p>Patients of the opposite sex were being cared for in the same clinical area. There were no processes in place to manage and effectively report mixed sex accommodation.</p>
Treatment of disease, disorder or injury Diagnostic and screening Surgical procedures	<p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11: Need for consent. Regulation 11: Need for consent</p> <p><u>Why the regulation was not being met:</u></p> <p>There was no evidence, that decision specific mental capacity assessments were always fulfilled when staff completed DNACPR forms.</p>
Treatment of disease, disorder or injury Diagnostic and screening Surgical procedures	<p>Regulation 12:(2) (a))(b) (c) (d) Safe care and treatment</p> <p><u>Why the regulation was not being met:</u></p> <p>The trust did not ensure WHO safety checklists were completed on all patients undergoing</p>

minor operations.

Appropriate standards of cleanliness and hygiene were not always followed.

The trust did not ensure staff within the radiology department were up-to-date on fire and evacuation training.

Patient risk assessments were not always completed fully, predominantly using risk assessments as a “tick box” exercise.

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. The provider must ensure that medication reviews must be part of, and align with, peoples care and treatment assessments, plans or pathways and should be completed and reviewed regularly when their medication changes.

The provider must ensure that medication reviews must be part of, and align with, peoples care and treatment assessments, plans or pathways and should be completed and reviewed regularly when their medication changes.

The Deep Vein Thrombosis Clinic was not always managed by a member of staff who had knowledge of side effects and contraindicated medicines.

The provider must ensure that only relevant regulated professionals with the appropriate qualifications must plan and prescribe care and treatment, including medicines. Only relevant regulated professionals or suitably skilled and competent staff must deliver care and treatment.

There was no formal process to prioritise adult patients who needed to be seen and assessed quickly at St Albans City Hospital MIU.

Nationally recognised tools to identify deteriorating adults and children were not used routinely at St Albans City Hospital MIU.

Regulated activity	Regulation
<p>Treatment of disease, disorder or injury Diagnostic and screening Surgical procedures</p>	<p>Regulation 13; (1) (2) (3) Safeguarding</p> <p><u>Why the regulation was not being met:</u></p> <p>There was lack of assurance that the outpatient service at St Albans City Hospital 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.</p>
Regulated activity	Regulation
<p>Treatment of disease, disorder or injury Diagnostic and screening Surgical procedures</p>	<p>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 (1) (2) (a) (b) (c) (f) Good Governance.</p> <p><u>Why the regulation was not being met:</u></p> <p>The outpatients' departmental risk register did not have all the risks associated with the department detailed.</p> <p>Systems or processes for governance were not embedded or robust in all areas.</p> <p>The trust did not have oversight of incidents as all were not being reported therefore learning opportunities were missed.</p> <p>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.</p> <p>Hand hygiene and environmental infection control audits were not carried out in the phlebotomy department.</p> <p>Not all risks to outpatient services had been identified, recognised and managed on the departmental risk register.</p> <p>There were no robust systems in place to assess, improve and monitor performance and quality of services in outpatients. There was no monitoring of patients waiting times to their initial assessment.</p>

	<p>There was a lack of understanding of the risks that could impact on the delivery of good quality care. Risks that we had identified at previous inspections (For example, lack of monitoring of waiting times) had not been placed on the risk register.</p> <p>There were no robust systems in place to assess, improve and monitor performance and quality of services in the urgent care centre at Hemel Hempstead Hospital. There was no monitoring of waiting times to initial assessment of patients.</p> <p>There was a lack of understanding of the risks that could impact on the delivery of good quality care. Risks that we had identified at previous inspections (For example, and lack of monitoring of waiting times) had not been placed on the risk register.</p> <p>Hand hygiene and environmental infection control audits were not carried out in the phlebotomy department St Albans and Hemel Hempstead Hospitals.</p> <p>Not all risks to outpatient services across all three sites had been identified, recognised and managed on the departmental risk register.</p>
<p>Regulated activity</p>	<p>Regulation</p>
<p>Treatment of disease, disorder or injury Diagnostic and screening Surgical procedures</p>	<p>Regulation 18 (1) (a) Staffing:</p> <p><u>Why the regulation was not being met:</u></p> <p>There was an insufficient number of nursing and medical staff on duty in the emergency department to ensure the safety of patients.</p> <p>Not all nursing staff who had direct contact with children in outpatient clinics had received level 3 safeguarding children training, which was not in line with national guidance.</p> <p>We could not be assured that the outpatient service at St Albans City Hospital 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.</p>

	Compliance with fire safety training in the radiology department was worse than the trust target of 90%. Overall staff compliance was 76%. Compliance was 40% for clinical staff and 80% for non-clinical staff.
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