This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

### Facts and data about this trust

#### Acute hospital sites at the trust

A list of the acute hospitals at the trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watford General Hospital</td>
<td>Vicarage Rd Watford, Hertfordshire</td>
<td>Acute emergency services - the core location for inpatient emergency care, and for all patients who need the specialist emergency facilities (such as intensive care) of a major district general hospital. It also provides elective care for higher risk patients together with a full range of outpatient and diagnostic services. Also, the focus of the Trust's Women's and Children's services, including neonatal care.</td>
<td>Hertfordshire</td>
</tr>
<tr>
<td>Hemel Hempstead Hospital</td>
<td>Hillfield Road, Hemel Hempstead</td>
<td>Healthcare facilities such as diagnostic services, including MRI and cold pathology, as well as an outpatient service as well as a urgent care centre.</td>
<td>Hertfordshire</td>
</tr>
</tbody>
</table>
St Albans City Hospital  | Waverley Road, St Albans, Hertfordshire  | Trust's elective care centre. It provides a wide range of elective care (both inpatient low risk surgery and day-case) and a wide range of outpatient and diagnostic services and a Minor Injuries Unit (MIU), open every day of the week from 9am to 8pm.  | Hertfordshire

(Source: [http://www.westhertshospitals.nhs.uk/default.asp](http://www.westhertshospitals.nhs.uk/default.asp))

West Hertfordshire Hospitals NHS Trust has approximately 676 beds, of which 72 are maternity, 19 are critical care and high dependency beds located across Watford General, Hemel Hempstead and St Albans City Hospital. The trust serves a population of approximately 388,500 people in West Hertfordshire, and neighboring populations in North London, Bedfordshire, Buckinghamshire and East Hertfordshire.

The number of staff employed by the trust as of June 2018 was 4,313.

The trust’s services are commissioned mainly by Herts Valley Clinical Commissioning Group.

(Sources: Routine Provider Information Request (RPIR) – Beds and Total staffing tabs; trust website)

### Background to the 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.

West Hertfordshire Hospitals NHS Trust provides services from three sites, Watford General, Hemel Hempstead and St Albans City Hospital. The majority of acute services are delivered at Watford General Hospital, which provides a full range of district general hospital services. Hemel Hempstead Hospital provides an urgent care centre and outpatients and diagnostic services. 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 also has a minor injuries unit.

This was the fourth comprehensive inspection of the trust and the first inspection of the trust using a new methodology, whereby we inspected core services, and included an inspection of the well-led element of the trust overall and took place between 15 October and 30 November 2018.

The first inspection took place in April and May 2015. The trust was rated as inadequate overall and was placed 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

The third inspection took place between 30 August and 1 September 2017, which was announced, 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 2017, 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.

Due to the improvements seen at this inspection, special measures were lifted in January 2018.

**Facts and data about the trust**

There are 676 beds, of which 72 are maternity, 19 are critical care and high dependency beds. The trust has nine operating theatres, providing elective (planned) and emergency surgical facilities for general surgery, trauma and orthopaedics, vascular, breast, urology, oral maxillofacial and plastic surgery. The trust holds around 544,786 outpatient attendances annually across most specialties, such as trauma and orthopaedics, cardiology, dermatology, diabetes, and obstetrics.

There are six surgical inpatient wards and approximately 25 general medical and care of the elderly wards including specialist stroke, cardiology, respiratory and frailty wards. The surgical teams have an emergency surgical admissions unit (ESAU) and an admissions area combined with a day surgery unit (Surgical Admission Unit/Surgical day case area).

For women and children, the hospital has a level 2 neonatal intensive care unit, alongside a delivery suite, two dedicated obstetric theatres, one dedicated elective gynaecology theatre and two maternity wards.

As of June 2018, the trust employed 4,313 (headcount) staff, including 588 WTE medical and dental and 1,096 WTE nursing and midwifery staff.

**Patient numbers**

Trust activity (June 2017 to May 2018):

- 137,787 A&E attendances (increase of 3% compared to the same time 2016/17)
- 89,790 inpatient admissions (increase of 3% compared to the same time 2016/17)
- 544,786 outpatient attendances (increase of 3% compared to the same time 2016/17)
- 4,653 deliveries (decrease of 2% compared to the same time 2016/17)
- 1,541 deaths (increase of 6% compared to the same time 2016/17)

*(Source: Hospital Episode Statistics – HES – Facts and Figures)*
Is this organisation well-led?

Leadership

The trust had managers at all levels with the right skills and abilities to run the service. There was a mix of experience within the executive directors with some new to the executive role and others with considerable experience.

In order to assess if the organisation was well-led, we interviewed the members of the board, both the executive and non-executive directors, and held focus groups with a range of senior staff across the hospital. We met and talked with a wide range of staff to ask their views on the leadership and governance of the trust. Over the previous 12 months, we have observed board meetings, patient panel meetings, and serious incident panel meetings. We looked at a range of performance and quality reports, audits and action plans, board meeting minutes and papers, annual reports, investigations, and received feedback from patients, staff, and stakeholders.

Board members

Since our last comprehensive inspection, which was published in January 2018 there had been some changes to the trust board. The members of the trust board generally had the appropriate range of skills, knowledge, and experience. Its members had an appropriate level of operational and financial experience and expertise across both non-executive directors (NEDs) and executives. Two people were acting into their roles; the chief executive officer (CEO) and chief information officer (CIO) and were both interim at the time of the inspection. This reflected a level of turnover, which provided a degree of stability but also the opportunity for new ideas for be brought into the organisation. However, during our inspection, an offer of employment had been made to a CEO, and accepted. This was a substantive post.

The trust was managed overall by a trust board consisting of non-executive (NED) and executive directors.

- The chair, appointed 2014.
- Chief executive officer (CEO), acting into this role since January 2018 but working in the trust as a director since 2014, most recently as deputy chief executive.
- Chief nursing officer, appointed in 2014.
- Chief operating officer (COO), appointed on April 2016, but has worked in the trust at director level since 2015.
- Chief finance officer, appointed 2014.
- Medical director/director of patient safety, appointed in 2013 but has worked in the trust since 2005.
- Director of human resources and organisational development, workforce and information development appointed May 2015.
- Chief information officer (Interim) appointed September 2018.
- Director of environment appointed in December 2017.
- Director of strategy (Interim) appointed in June 2018.
- Director of communications appointed April 2016.
- Director of integrated care appointed January 2017.
• Director of performance appointed March 2015.

• Five non-executive directors who have been in post for between three and seven years.

Of the executive board members at the trust, 50% were female and one from BME community.

Of the non-executive board members none were from the BME community and 20% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>16%</td>
<td>50%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0%</td>
<td>20%</td>
</tr>
<tr>
<td>All board members</td>
<td>8%</td>
<td>39%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

In addition, there were a number of non-voting clinical directors that sat on the board.

Whilst most leaders were visible and all were described as approachable, there was no formal programme of visits to wards, departments on all the trust’s sites, by individual board members.

The executive team worked collaboratively to manage the trust and provide safe, quality care for all patients. All leaders spoke highly of their peers and of all staff in the trust. Most staff described the leadership team as approachable, knowledgeable and inclusive. Leaders had a shared vision which was to give the very best care for every patient, every day. They strove to deliver and motivated staff to succeed. Strategies were in place to ensure delivery and to develop the trust’s culture.

The previous CEO had left the trust in June 2018, the interim CEO was previously the deputy CEO, so knew the trust well. From discussions with leaders, we found that whilst the leaving of the previous CEO was disappointing, it had not destabilised the board. Staff of all levels across the trust told us they knew who the interim CEO was, due to their previous role at the trust. Visibility amongst most of the rest of the board was reported as very positive. The acting CEO was widely regarded by external stakeholders as being a strong leader who took swift, appropriate actions to manage service pressures without compromising the safety and quality of patient care and treatment, as well as actively driving forward the trust’s improvement agenda.

The non-executive directors (NEDs) spoke positively about their relationship with executive directors and vice versa. As a group, the NEDs met with the CEO and chair monthly. On a more formal basis, they explained how they could challenge issues of concern, for example, poor friends and family responses in maternity, cancer targets, finances and their challenge to senior staff and the responsible director.

The trust operated a clinically-led model of leadership, which aimed to create more local decision-making and ensure greater collaboration between medical, clinical, and managerial staff. Clinically-led models of leadership have been shown to produce better results and improve the quality and safety of care provision. The level of constructive challenge between clinicians on the executive team was evident. The level of challenge from non-clinicians and non-executive directors was captured on the trust papers presented to board.

Clinical leadership at the trust was provided through individual divisions according to speciality:

• Surgery, anaesthetics and cancer.
• Medicine.
• Clinical support.
• Women and children.
• Unscheduled care.

Each division had a divisional director, supported by a head of nursing, divisional manager, specialty clinical leads and business partners from the finance and human resources teams. The divisional directors were line managed by the Chief Operating Officer with professional accountability to the medical director. The clinical directors we met with spoke positively about their relationship with the executives and felt the smaller groups worked well as they had visibility with the staff. Although this structure had been in place for more than a year and had been reviewed in February this year, most of the board members we spoke with described it as being in its infancy.

Board walk rounds were undertaken. Each board member had a particular area allocated to them to ‘adopt’ and visit. The trust provided evidence of areas visited by board members which showed patient and staff areas were visited regularly by most board members. For example, the trust chair visited a ward or area monthly and the director of nursing conducted visits on a weekly basis. However, it was evident from the record of executive and non-executive director visits provided by the trust, that some members of the board had not visited any areas in the last 12 months.

It was clear from committee and board discussions that the leaders generally understood the challenges to quality and sustainability actions had not always been implemented to address all the issues.

For example, use of capital funding, the upward trajectory of referral to treatment times and clinical assessment and leadership in St Albans City Hospital Minor Injuries Unit.

Although there were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, changes to the leadership and succession planning were not yet fully in place.

The trust was in the process of implementing considerable changes to its leadership development and succession/talent management approach and processes at the time of our inspection. Previously there had been no formal trust-wide talent/succession approach in place other than the use of appraisals. Leadership and management programmes were offered in the form of a senior leadership academy in partnership with a local university. A new clinical leadership programme was being put into place, which had commenced in July 2018 and involved the formal establishment of a talent management process. The formal process was planned to be appraisal-led, but separate to the performance review cycle. The process was planned to involve full talent panels taking place twice a year at both divisional and executive levels, to identify and map talent (and therefore likely succession) by manager and/or peer review. Ultimately, it was planned that this would lead to ‘talent scores’ and the appropriate talent tracks for individuals and additionally contribute to the trust’s new continuous professional development grant allocation processes. This process was envisaged to be in place by the end of December 2018. Simultaneously, and in support of the talent management and succession process, leadership and management development was being re-developed through a leadership and management passport that mapped out the skills and behaviours required for every job role that had leadership or management aspects to it, across a framework of six leadership and management standards. Individuals in these job roles were expected to meet these standards at
the levels assigned to them, in both theory and practice, with all existing and new leadership and management programmes being mapped to these standards, thus creating the eligibility criteria for those programmes. It was envisaged that by making the processes of talent, succession and leadership development transparent and clear, would ensure that equality and diversity was sustained throughout these processes. However, this had not commenced at the time of the inspection.

We reviewed the board development programme which showed a series of six development sessions and business workshops that board members had attended in 2018. This included presentations from external stakeholders and informative sessions on financial recovery planning and cyber security. Board members told us the development sessions were invaluable, particularly those clinicians who had limited financial and budget expertise. In addition, they had been invited to suggest suitable subjects for future learning.

Fit and Proper Persons Requirement

**The trust had a system in place which ensured that all the board were fit and proper for their role.**

Trusts are required to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 19 of the Health and Social Care act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are of good character and have the right qualifications and experience to carry out this important role. This regulation includes those in interim positions. The trust had developed a fit and proper person’s checklist for the executive and non-executive directors. The checklist covered the requirements of the regulation, including the completion of annual appraisals. An annual declaration was made by non-executive directors and executive directors to confirm that there was nothing that would affect their fitness as a director of the trust. We saw completed declarations in all the files that we checked. An annual paper went to the board to confirm the process had been undertaken and that declarations of compliance had been received. *(Source - Board papers - January 2018).*

We reviewed 12 personnel files and found that all files were complete. For example, all files had evidence of relevant occupational health checks completed, evidence of an appraisal within the last 12 months and relevant statutory employment checks such as evidence of disclosure and barring service (DBS) checks.

**Vision and strategy**

Although there was no overarching strategy, the trust had a clear vision for what it wanted to achieve and a workable plan to turn it into action developed with involvement from staff, patients, and key groups representing the community. The current trust vision was built on the previous one, so staff were familiar with the principles.

There was a clear vision and set of values. The trust vision was to deliver the best care for every patient every day. The trust values were quality, commitment and care:

**Quality**

- Working together to provide the best possible service we can for our patients and their families.
- Striving to deliver best practice and best possible outcomes for all.
- Seeking to improve what we do as an organisation and completing all activities to agreed standards.
• Expecting ourselves and each other to produce high quality work based on evidence of what works.
• Acting in a professional manner at all times.
• Being part of a team that takes pride in their work and their environment.

Commitment
• Doing things that are going to make a positive difference.
• Being dedicated, motivated and optimistic and looking to the future.
• Not being afraid to do things differently or to challenge.
• Doing the right thing at the right time in the right place.
• Being flexible when needed, going the extra mile and delivering on our promises.
• Taking responsibility for personal development and performance.

Care
• Making sure that we consider the impact of our decisions on the care of all patients.
• Treating everyone with kindness, compassion, courtesy and respect.
• Listening, and communicating in a way that is clear, straightforward, effective and inclusive.
• Recognising vulnerability and showing empathy.
• Supporting and working with others to provide joined-up, compassionate care.
• Caring for each other, looking after our own wellbeing and that of our colleagues.

The trusts vision was described using four main strategic aims:
• Aim One: To deliver the best quality care for our patients.
• Aim Two: To be a great place to work and learn.
• Aim Three: To improve our financial sustainability.
• Aim Four: To develop a strategy for the future.

The trust’s vision was aligned to local proposals in the wider health and social care economy to plan services to meet the needs of the local population. Each of the four strategies were developed following engagement with staff, patients, members of the public from the local area and stakeholders. Staff engagement events included divisional and departmental sessions specifically designed to engage staff in the strategy. Leaders had the view that strategic objectives would only be delivered if staff were well-engaged. Senior clinicians we spoke with during core service inspections were generally able to describe the strategic priorities and documents that underpinned the aims. Junior nursing staff were less aware of the strategy but could describe strategic priorities that related to their individual areas of work.

During the development of the ‘Your care, your future,’ strategy for West Hertfordshire’s health economy, different options for models of care were consulted on. The outcomes were used to help shape the internal strategies and ensured services were planned to meet the needs of the
Progress against the delivery of the vision and local plans were monitored, reviewed and recorded monthly at the trust’s strategy delivery board. Executive oversight of progress was informed by divisional representatives and programme leads. Each of the four strategic aims had a set of associated measurable objectives. We saw evidence that the trust used the objectives to monitor progress. An overview of this featured in the trust’s annual report.

There were plans in place to expand the emergency department, as part of the trust’s winter planning programme. This was being funded from £1.2m awarded to the trust from the government’s winter funding programme. The board had been informed that the Clinical Commissioning Group (CCG) had agreed to fund the equivalent of 40 beds. Clinical leads at the trust were working closely with colleagues from the local community trust to develop this, particularly with regards to patient flow.

The trust had been working to formulate plans to support patient flow throughout the winter period. This enabled the formation of a joint surge, escalation and capacity plan. In addition to this and following the movement to a single Hertfordshire and West Essex sustainability and transformation partnership (STP) A and E local delivery board, the STP had coordinated the completion of a system winter assurance template that had been required by NHS England.

There had been a national review into the management of a surge in demand over the winter period. It was reported that, to date, the trust had not received a request for the board to sign off a winter plan and the chief operating officer advised that NHS Improvement (NHSI) would be undertaking a winter assurance visit on 30 October 2018. *(Source: Board papers October 2018.)*

One of the trust’s primary approaches to ensure high quality care throughout the organisation and maintain improvements was its clinical strategy, which had been developed in 2016 in conjunction with the clinicians. Underpinning this were several supporting strategies, including quality, workforce, finance, estate and education.

The plans in place to develop a clinical partnership with a north London NHS trust, which we saw at our last inspection in September 2017, were underway. This was to enable the review of pathways to reduce clinical variation and the development of quality improvement methodologies. This was progressing; however, this partnership was not within the trust’s STP.

**Culture**

**Staff satisfaction was mixed.** Managers across the trust generally promoted a positive culture that supported and valued staff, created a sense of common purpose based on shared values. Although most staff felt supported, respected, and valued there were areas where staff felt dissatisfied and not all staff felt comfortable to raise concerns.

The trust was not meeting the target of 90% for staff receiving appraisals, with one area at 54.6%.

**Action was taken to address behaviour and performance that was inconsistent with the trust’s vision and values.**

Staff we spoke with felt positive and proud to work for the organisation. We saw improvements in the culture, particularly in ED and amongst medical staff we spoke with. However, there were some staff groups that raised cultural issues and dissatisfaction, for example, in the estates department, although there had been some changes made in the department to drive efficiencies, some of these had caused some staff to feel disgruntled. Several concerns had also
been raised directly with the CQC inspectors about the culture in services for children and young peoples’ services, (CYP). We raised both areas as a concern with the trust leadership team who were in the process of taking action. For example, the trust’s freedom to speak up guardian had met with the estates staff to provide them with the opportunity to feedback on their concerns. In addition, this approach was taken as a good opportunity for staff to understand who their freedom to speak up guardian was and how they could contact them.

In relation to the issues raised in CYP, the chief executive and the chairman had met with the consultant body to discuss some of their concerns. However, it was unclear how and when some of the issues would be resolved.

The culture encouraged openness and honesty at all levels within the organisation, including with people who use services, in response to incidents. The trust had embraced the duty of candour regulation and had effective processes in place. There was a duty of candour policy in place dated November 2017. The policy was clear, appropriate and reflected the requirements of the regulation; it included a section on surgical consent and candour with hyperlinks to the consent to treatment policy. Incidents submitted as part of the provider information request and those that we checked at random, during the inspection, provided evidence of duty of candour had been appropriately applied. Staff knew the triggers (moderate harm and above) and awareness of the regulation was well-embedded in areas that we visited. All patients who had suffered harm (moderate or severe harm) received an apology within 10 days of the incident being reported. For minimal harm, duty of candour according to the regulation does not apply but there was an expectation at a local level of being open and honest: staff were expected to give an apology. Duty of candour was followed in all cases of a never event even when no harm had occurred.

The senior clinician involved at the time of the incident was responsible for duty of candour: all contacts to patient or relatives were undertaken by the consultant or matron level.

Most leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and action taken as a result of concerns raised. However, some staff told us they would not have felt comfortable raising concerns.

Whistle-blowing about the trust from staff members directly to the CQC included allegations that staff had been 'silenced'. This demonstrated that they felt unable to raise concerns with the leadership team or the freedom to speak up guardian.

Freedom to Speak Up Guardian

The Freedom to Speak Up review by Sir Robert Francis into whistleblowing in the NHS in 2015, concluded that there was a serious issue in the NHS that required urgent attention if staff were to play their full part in maintaining safe and effective services for patients. Several recommendations were made to deliver a more consistent approach to whistleblowing across the NHS, including the requirement for all NHS trusts to appoint a Freedom to Speak Up Guardian (FTSG), and the development of a single national integrated whistleblowing policy to help normalise the raising of concerns.

The trust had followed these recommendations and were one of the early adopters of a FTSG. The role was fulfilled by a non-executive director and had been appointed in October 2015. There was a job description in place and support was given through the board and the HR department.

In October 2018, an annual update was provided to the trust board. The paper included a self-assessment, undertaken in July 2018, of the trusts position against the 13 principles outlined in previous FTSS papers dated August 2015v and July 2017 as well as next steps. The trust had rated themselves as green against all but two of the principles: culture of safety and culture of valuing staff. Actions were planned to address to meet the recommendations.
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 of 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 the FTSG. Most staff knew what a FTSG was and how to find contact details if they wished to contact them. There were posters around the hospitals to let staff know how they could contact the FTSG, as well as information on the intranet. The CEO promoted the FTSG role through e-updates and a team brief messages sent on behalf of the executive team.

However, during staff focus groups, some staff told us they would not feel confident raising concerns as the FTSG was a non-executive director and had close working relationships with the senior leadership team. Some staff felt this was positive, however some felt this was the sole reason they wouldn’t speak with the FTSG. Those we spoke with who told us they had spoken with the FTSG described the guardian as approachable and skilled.

There had been 16 whistleblowing concerns raised from August 2017 to July 2018. Following one concern, minimum staffing levels were established for a particular ward area to ensure they were not understaffed, when other areas of the hospital needed additional resources.

The local guardian met regularly with the head of employee relations and shared information obtained from the National Guardian Office so that internal processes were amended accordingly, if required.

Bullying and harassment had been rebranded as ‘Respect Me’. This had included redesigning the harassment advisors to ‘Respect Me champions to remove any stigma that was often attached to the words ‘bullying’ and ‘harassment’. As part of the ‘Respect Me’ campaign, the trust had recruited new ‘Respect Me’ champions, devised a clearer role profile that all (including existing) champions were required to adhere to. The impact of recruiting more Respect Me Champions meant there were more resources and support available for employees.

The trust had four key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Finding 12. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.25</td>
<td>3.11</td>
</tr>
<tr>
<td>Key Finding 19. Organisation and management interest in and action on health and wellbeing</td>
<td>3.76</td>
<td>3.62</td>
</tr>
<tr>
<td>Key Finding 10. Support from immediate managers</td>
<td>3.84</td>
<td>3.72</td>
</tr>
</tbody>
</table>

The trust had two key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Finding 1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.63</td>
<td>3.75</td>
</tr>
<tr>
<td>Key Finding 2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.92</td>
<td>3.91</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)
Additionally, we saw some preliminary findings from the NHS staff survey 2018 and saw that whilst there were areas of improvement, there were many findings which compared positively to the 2017 results.

**Staff Diversity**

**Equality and diversity was promoted within the organisation. There was a draft strategy in place, which was still being progressed at the time of the inspection, although this had not been developed in conjunction with any staff networks.**

As of June 2018, West Hertfordshire Hospitals NHS Trust employed 4,316 people, of which 32% were from Black Minority and Ethnic Communities. *(Source: Routine Provider Information Request (RPIR) – P6 WRES reporting document)*

The executive lead for equality and diversity was the director of human resources and organisational development. There was a part-time equality and diversity lead, who reported to the director of human resources and organisational development.

The trust’s equality and diversity strategy had not been updated since 2014. However, there was a draft equality and diversity strategy in place, which although had involvement of the senior management team, had not been devised in conjunction with any staff groups or networks. It had been reviewed by one NED, but was still deemed to be ‘work in progress.’ However, there was a combined equality and diversity and Workforce, Race Equality Standards (WRES) annual action plan in place which was comprehensive, up to date and fit for purpose. In addition, there had been a WRES statement of commitment in place since July 2016.

Equality impact assessments were carried out against core trust policies. These identified if there was likely to be any impact on any of the protected characteristics, such as age, gender, race and sexual orientation, and to mitigate the likely impact. We considered the workforce report in board papers dated January and March 2018. Neither paper had any reference to equality and diversity.

From 6 April 2017, employers in Great Britain with more than 250 staff were required by law to publish their gender pay gap information, covering pay and bonuses. They were also required to publish this information on their website and on the designated government website. In accordance with the Equality Act 2010 (Gender Pay Gap Information Regulations 2017), West Hertfordshire NHS Trust had undertaken a gender pay gap review in 2017. The 2017 West Hertfordshire NHS Trust report demonstrated that on average, men were more likely to earn 14.9% more than women. This compares favourably to the Office for National Statistics estimate for the national gender pay gap mean which is 17.4%. The trust acknowledged where gaps could improve, for example, that there could be greater female representation in senior medical roles, and in their action plan stated that they would reassess their recruitment and selection policy and process for internal and external candidates to avoid any potential bias.

The trust had celebrated black history month in October 2018, range of events including dedicating the Schwartz round in November 2018, to a story from The Windrush. There was also a black history month nursing event, which six BME nurses attended. Other events included a maternity-led event, learning events about Windrush era nurses and a visit from the Jamaican High Commissioner.

We held a BME focus group to gather the views of staff. However, no staff attended.

**Workforce race equality standard (WRES)**

The reporting of WRES provides an overview of performance against the nine indicators of the
NHS WRES. The standard came into effect on 1 April 2015 with organisations required to publish their fourth dashboard of data by 10 August 2018. The overall goal of the standard is to improve the representation and experience of Black and Minority Ethnic (BME) staff at all levels of the organisation – particularly senior managers.

The WRES has nine elements, four relate to equality indicators within the NHS Staff Survey, and the other five elements relate to workforce indicators. The latest report covers the period of April 1 2017 to March 31 2018 and was reported to the board on 6 September 2018. BME staff made up 34.2% of the workforce (1,662 of 4,854 headcount of staff) this is higher than the previous year, when it was 32.2% of the workforce (1,494 out of 4,637 staff).

There had been some improvements. The likelihood of BME staff being involved in formal disciplinary cases (Indicator 3), had reduced, from 1.31 in 2017 to 0.78 in 2018. In addition, BME staff were less likely to be disciplined than white staff for the first time in 3 years. In 2016, BME staff were 2.3 times more likely than white staff to enter the disciplinary process.

However, the report showed deterioration in three of the four national NHS Staff Survey indicators:

- Increase in the percentage of BME staff experiencing harassment, bullying or abuse from staff from 24% in 2017 to 28% 2018
- Drop in BME staff believing the organisation provides equal opportunities for career progression from 74% last year to 71% this year.
- Increase in the percentage of BME staff that have personally experienced discrimination at work from Manager/team leader or other colleagues has increased from 12% in 2017 to 16% in 2018.

Performance against Indicator 5 ‘percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public’ and Indicator 9 ‘percentage difference between BME in the overall workforce compared to the board voting membership’, had remained largely the same.

The trust published its fourth WRES data report in September 2018. The metrics presented to the board in the WRES report in September 2018 showed that there had been no significant change over the last 3 years despite several initiatives including training for recruiting managers, guidance and toolkits for managers, health and wellbeing support for staff, publication of equality and diversity data, and support through the BME staff network; Connect.

The WRES action plan was for a two year period November 2018 to October 2020. The actions were based on evidence-based best practice and set out specific initiatives and actions to address the WRES metrics.

Given the limited resources, energy had been targeted to those areas where there was the greatest impact in relation to the representation of BME people in senior leadership positions in the Trust.

The three overarching aims were:

- Strong visible leadership on race
- Education and training for senior leaders on equality, diversity and inclusive leadership
- Clear and consistent communication to promote race equality

The trust’s aim was to build a more inclusive working culture by equipping the senior teams and leaders with the skills to successfully address unconscious bias and defuse difficult conversations and situations. The plan was that unconscious bias awareness allowed individuals and teams to
more accurately understand and effectively adapt to differences. These differences could arise from any aspect of workplace diversity, including the protected characteristics under the Equality Act 2010 as well as other factors, for example, class or socio-economic status. An action plan was being developed and was discussed at a focus group and the workforce equality forum in September 2018. *(Source: Board papers September 2018)*

The action plan included:

- Working with members to strengthen the BME staff network. There was a relaunch event planned for February 2019.
- It was planned that all staff with protected characteristics were to be invited to take part in a formal review for the Equality Delivery System2 in 2019.
- The data contained in the WRES report was planned to be reviewed as part of the EDS2 grading process with staff, patients and members of the community.

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between white and BME staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th></th>
<th>Your Trust in 2017</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KF25</strong></td>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>White 26% BME 28%</td>
<td>26% 28%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>27% 28%</td>
</tr>
<tr>
<td><strong>KF26</strong></td>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White 26% BME 28%</td>
<td>26% 28%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>25% 27%</td>
</tr>
<tr>
<td><strong>KF21</strong></td>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White 67% BME 71%</td>
<td>67% 71%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>87% 75%</td>
</tr>
<tr>
<td><strong>Q17b</strong></td>
<td>In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td>White 6% BME 16%</td>
<td>6% 16%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7% 15%</td>
</tr>
</tbody>
</table>

*(Source: NHS Staff Survey 2017)*

**Friends and Family test**

The Friends and Family Test was launched in April 2013. It asked people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored similar to the England average for recommending the trust as a place to receive care from September 2017 to August 2018.
Sickness absence rates

The trust’s sickness absence levels from June 2017 to April 2018 were better than the England average.

(Source: NHS Digital)

There were mechanisms for providing staff with the development they required such as career development conversations, which we saw featured in staff appraisals. However, the overall appraisal completion rate at the trust from July 2017 to June 2018 was 76.8%, which did not meet the trust target of 90%. The target had only been met by two core services, outpatients and critical care. The lowest appraisal rate was for urgent and emergency care (54.6%). Data by core service was not provided for medical staff, however within data the trust provided, the overall appraisal completion rate for medical staff was 96% from July 2017 to June 2018, which was above the trust target of 90%.

General Medical Council – National Training Scheme Survey
In the 2018 General Medical Council Survey the trust performed worse than expected for one indicator (feedback) and the same as expected for the remaining 17 indicators.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Satisfaction</td>
<td>71.6</td>
</tr>
<tr>
<td>Clinical Supervision</td>
<td>86.4</td>
</tr>
<tr>
<td>Clinical Supervision out of hours</td>
<td>83.6</td>
</tr>
<tr>
<td>Reporting systems</td>
<td>67.2</td>
</tr>
<tr>
<td>Work Load</td>
<td>41.8</td>
</tr>
<tr>
<td>Teamwork</td>
<td>67.3</td>
</tr>
<tr>
<td>Handover</td>
<td>59.5</td>
</tr>
<tr>
<td>Supportive environment</td>
<td>65.3</td>
</tr>
<tr>
<td>Induction</td>
<td>70.7</td>
</tr>
<tr>
<td>Adequate Experience</td>
<td>73.8</td>
</tr>
<tr>
<td>Curriculum Coverage</td>
<td>70.4</td>
</tr>
<tr>
<td>Educational Governance</td>
<td>68.8</td>
</tr>
<tr>
<td>Educational Supervision</td>
<td>82.1</td>
</tr>
<tr>
<td>Feedback</td>
<td>66.2</td>
</tr>
<tr>
<td>Local Teaching</td>
<td>66.9</td>
</tr>
<tr>
<td>Regional Teaching</td>
<td>65.0</td>
</tr>
<tr>
<td>Study Leave</td>
<td>49.3</td>
</tr>
<tr>
<td>Rota Design</td>
<td>46.8</td>
</tr>
</tbody>
</table>

(Source: General Medical Council National Training Scheme Survey)

The trust had a ‘Guardian of Safe Working Hours’ The guardian of safe working has been introduced by the NHS to protect patients and doctors by making sure doctors were not working unsafe hours, that is longer than their contracted hours. The guardian’s role includes recording and monitoring compliance of working hours against terms and conditions and intervention to reduce any identified risks to individual doctors, or patients’ safety. The guardian, who was a consultant within the trust was given a day a week to fulfil this role, which included gathering information, reporting to the board with regards to working hours and supporting junior doctors. We saw from board papers that doctors’ hours were reported quarterly. Additionally, the guardian held focus groups for junior doctors, where concerns were discussed. We saw evidence that improvements to doctors working hours had been made by altering start and finish times of shifts in particular specialties. This had been done so that there was no impact on patient safety.

**Governance**

There were mostly effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services which were regularly reviewed and improved.

Although a significant amount of data went to each subcommittee and there was much duplication.

The trust had a governance committee structure, which had been refined just over a year ago. The board met monthly. Levels of governance and management functioned effectively and interacted with each other appropriately.

There were eight committees, all chaired by a NED, who fed into the board all of which had a routine cycle of meetings.

- Quarterly: audit, charity.
• Every other month: remuneration, patient safety and staff experience, clinical outcomes and effectiveness, safety and compliance.

• Monthly: finance and investment and ICT infrastructure.

Divisional directors and other non-voting directors attended the trust’s board. Voting directors that we interviewed commented that this ensured rounded discussions, enabled informed decision making and did not impede effective decision making.

A good level of information was available at board and committee level and this included a summary of the financial position of the trust. The committees had clear roles and responsibilities and appeared to provide the board with appropriate assurance. Whilst there were no gaps in reporting lines between committees, some commented that too much information and detail came up through the board and should have been dealt with by the respective committee. However, there was also a significant amount of data which went to each subcommittee and there was much duplication. We understood the trust’s desire not to miss issues but the volume of data risked significant issues being missed. The accountability of each committee and individual’s roles at all levels was not clear.

Mortality

The trust’s learning from deaths process, had been established and was part of overall scrutiny of mortality.

Monthly specialty/departmental mortality review meetings were held, cases from which were then referred for structured judgement review (SJR) according to criteria described in the trust’s ‘learning from deaths’ policy.

The Summary Hospital Mortality Indicator’s (SHMI) latest performance (for April 17 to March 18) was 96.45 and ‘as expected’ (band 2).

For the 12-month period (July 2017 to June 2018), the trust’s overall HSMR of 100.9 was in the ‘as expected’ range. As the trust had previously maintained a ‘lower than expected’ rating for a sustained period, each ‘outlying’ primary diagnostic SMR group had undergone a ‘deep dive’ by case note review with a speciality or senior trust consultant and the coding manager. On each occasion, there was reported to have been no lapses of care identified and in a substantial proportion, the clinical coding was deemed to be incorrect. The trust was working on a strategy to improve the accuracy of primary diagnostic coding. It was planned that case note reviews would continue with any subsequent outliers.

Learning from deaths

The trust collected and published on a quarterly basis, specified information related to inpatient deaths which included the following:

• The total number of the trust’s in-patient deaths.

• Deaths subject to case record review, termed Structured Judgement Review (SJR.)

• Deaths judged more likely than not to have been due to issues associated with the care given or potentially avoidable.

• Emerging themes from SJR.

Since January 2018, the trust had implemented a process to ensure that deaths fulfilling the criteria for further review including those deaths where lessons may be learnt were referred for SJR. The aim was to review the death that required further scrutiny, within 15 working days.
following receipt of the medical record by the reviewer. The SJR review is a validated Royal
College of Physicians methodology and there were 26 trained reviewers within the trust,
representing all clinical divisions.

Those reviews that had an overall care score indicating suboptimal care (including those scoring
'satisfactory'), deaths which had been the subject of a serious incident or a complaint were then
independently reviewed at the level 2 tier panel. This multidisciplinary panel determined the
potential avoidability of the death. As the process was deemed to be still maturing, included were
primary diagnoses which demonstrated persistently high mortality metrics (HSMR).

The total number of the deaths of inpatients was 377 in quarter 2, 2018/2019, which is average.

There was a particular focus on deaths that happened to patients who had a learning disability.
There were four deaths reported where the patient had a learning disability. Of the 377 deaths,
7% were referred for further scrutiny for SJR and of these 27, 11 SJR’s were completed by the
reviewers to demonstrate care and avoidability scores. The report stated that all these deaths
were unavoidable and the medical director confirmed at the time of the inspection that there had
been no avoidable deaths in the trust within the last year. However, it could be argued that
deaths arising, for example, indirectly from in hospital falls or sepsis from hospital acquired
infections are avoidable. Additionally, we saw details of two incidents where, one of which may
have delayed death, if different action had been taken and another, where delays in treatment
contributed to a patient’s deterioration and their eventual death. (Source - board papers
September and December 2018.)

We reviewed five SJRs and found that a clear method of reviewing and investigating death had
been set up. Deaths of people with a learning disability were reviewed and investigated to the
same standard as other deaths and it was noted that carer and family involvement was evident in
all cases reviewed.

Board Assurance Framework

The trust provided their Board Assurance Framework, which detailed four strategic objectives
within each and accompanying risks.

- Aim 1: Best quality care
- Aim 2: Great place to work and learn
- Aim 3: Improve our finances
- Aim 4: Strategy for our future

The trust told us within their PIR submission that they were “implementing a programme of review
and improvement against corporate governance, with particular focus on ward to board risk
register assurance. The approach being adopted recognises the principles of good governance
and is intended to build on the findings from the April 2018 internal audit report against the
organisations BAF and risk management processes (RSM reasonable assurance).” (Source:
P106 BAF document called 2018-2020 BAF.pdf)

It was clear that the BAF’s content and structure had been reviewed, improved and refined, since
our last inspection. There were a number of broad objectives in place, which were supported by
more detailed objectives. Each were linked to a strategy and action plan, its system of monitoring
and the individual committee that provided assurance. Each detailed objective had an executive
owner and there were actions, which were RAG rated to address any gaps in controls or
assurance. Finally, all had a date for completion which was mapped against progress.

The BAF and risk registers included financial risks to the organisation. In addition, each division
maintained separate risk registers.

The BAF included a RAG rating of risks and highlighted their owners and executive leads. but some concerns were raised over how the detail of the risks fed into the BAF.

**Management of risk, issues and performance**

Although the trust had systems for identifying risks, planning to eliminate or reduce them, including risk registers and a recently revised risk management strategy there were ongoing areas of concern including financial risk, poor referral to treatment performance and sufficient oversight of issues in the minor injury unit at St Alban’s.

The board members we spoke with could provide examples of how poor performance was being improved. However, some poorer performing areas and identified risks were not always mitigated in a timely manner. There was a lack of pace in relation to some significant issues such as patient risk in the minor injuries unit at St Albans City Hospital (SACH) and the number of patients waiting over 52 weeks for elective surgery, which had been increasing over time.

The majority of patients who had been waiting over 52 weeks for treatment were those who had complex co-existing conditions, which had excluded them from undergoing surgery at St Albans City Hospital, where most of the trust’s elective surgery took place, because there was a lack of facilities there to support complex patients’ needs. In January 2018, 21 patients had been waiting over 52 weeks, but by July there were 124 patients. All patients who had waited over 48 weeks had a harm review undertaken. If harm had been caused it was reported onto the trust’s electronic incident reporting system and a serious incident process was triggered. It had been reported that 6 harms had been caused, (patients waiting in pain.) A tracker of harm reviews was held by the RTT validation team and were reviewed at a weekly access meeting, chaired by the director of performance.

Additional measures to reduce long waits for routine surgery included:

- Reintroduction of elective surgery at Watford General Hospital into one of 13 ring fenced beds.
- A further 12 beds were opened in September 2018.
- An enhanced care pilot scheme commenced in September 2018 at SACH, where patients with higher comorbidities were accepted for surgery.
- Outsourcing planned surgery to other providers.

As a result of these measures, patients waiting over 52 weeks for surgery were gradually reducing. In the November 2018 Board paper it was reported that 111 patients were waiting in September and in December’s Board paper, 87 patients were waiting in October.

All cancer waiting time standards had been achieved with the exception of 31 day referral to first treatment and 62 day referral to first consultation. The target was 85% and although the target was achieved at 89.5% in September 2018, between June and October it ranged between 77-89.5% with an average of 82%. The national average is 79%. *(Source: board papers September, November and December 2018)*

There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. The results of the audits were reported monthly to the trust executive committee (TEC.) The risk-based internal audit report for 2017/18 identified that the organisation had an adequate and effective framework
for risk management. However, it also identified some weaknesses in the framework of internal controls in relation to maternity activity data, consultant leave planning and estates.

We saw the latest report dated October 2018 and saw that since the August TEC meeting, eight management actions had been confirmed as implemented in relation to the Board Assurance Framework, Duty of Candour and fire safety audits. Seven actions had been deferred whilst work was on-going, in relation to the IT asset and configuration management review, as the trust was negotiating a new contract.

Three management actions were overdue but were in the progress of being implemented. Whilst responses had been provided, there was insufficient evidence to enable the TEC to fully close them off. These actions related to the reviews of fire safety.

All other actions were not yet due. Following the inspection, the acting chief executive told us that; “all data was accurate to the best of their knowledge and there has been appropriate clinical engagement in finalising submissions that relate to clinical data”.

Potential risks were taken into account when planning services, for example seasonal and unexpected fluctuations in demand, as well as disruption to staffing or facilities. Additionally, the leadership team were familiar with managing failure of IT systems. There were robust contingency plans in place for when this happened. There were planning meetings in preparation for seasonal demand such as ‘winter pressures’. We saw evidence that reflective sessions had been held which focussed on last winter and senior staff were able to share what they thought had not gone so well and lessons that had been learned. This had been taken into consideration when planning for winter 2018/19.

Incidents were reported through the electronic report system. All the staff we spoke with during the inspection were confident in how to report an incident using the electronic system. There was a system of ongoing training and support for all levels of staff, including managers who were responsible for handling incidents. Incident handlers were given 10 days to accept the incident. At the time of our inspection there were 158 incidents overdue for acceptance, although this had reduced as the system manager pursued any that were almost at the date for acceptance. Additionally, any that were near to the 35-day deadline and had not been fully completed, were actively pursued and escalated if not actioned in a timely manner.

Any serious incidents were the subject of a panel that met three times a week. This panel was chaired by either the medical director, the director of nursing, or the deputy director of nursing. The composition of the panel changed depending on the type of the incident. We saw minutes from these meetings and saw that there was sufficient discussion and challenge. Incidents were then reported up through the divisions, discussed at staff meeting and then through to the board. We saw individual staff meeting and divisional minutes where learning from incidents had been discussed. The board minutes contained incident data, including key performance indicators and details of serious incidents.

We reviewed a number of incidents at random. All those that we saw contained relevant documentation, statements, duty of candour, if appropriate and been thoroughly investigated and closed in a timely manner.

Impact on quality and sustainability was not always assessed and monitored. There were occasions when financial pressures had compromised care.

During June, July and August 2018, VTE assessment compliance rate had not improved and pressure ulcer numbers had increased. Overall there had been a decrease in the safety thermometer’s harm free care indicators. However, there had been some actions put into place,
which were being monitored by the clinical outcomes and effectiveness committee and scrutinised by the board. These included:

- Clinical areas with high numbers of falls - identifying opportunities for quality improvement and share learning.
- RCA for all falls with moderate harm and above completed prior to review at the SI panel.
- Sharing learning from RCAs.
- Harm free education study day.
- Promoting awareness around the safe and appropriate use of bed rails.
- Bed safety rail audits were planned.
- Developing a heel awareness campaign for all staff, utilising the provision of training and heel mirrors for all clinical staff involved in skin assessment.
- Increasing the tissue viability team establishment to enable improved capacity for teaching and support.

Waits for routine maintenance had the potential to impact on the safety of care for patients on the medical wards. We identified some instances when nursing staff had been waiting for maintenance work to be completed for some time after it had been reported. For example, a non-flushing toilet in a male bay on AAU had been reported two days prior to our inspection visit. In the meantime, patients were using the toilet at the end of the female bay, impacting on privacy and dignity. We also identified issues with the security of the environment in the emergency department (ED). The senior leadership team informed us that this was being rectified and maintenance work was being completed. However, during our second unannounced inspection of ED, and our inspection of medicine in the following weeks, we found these issues had not been improved.

There was a new five-year contract in place as part of a new NHS supply chain. One of the board members advised that the impact of this contract was not known at the time of the inspection, however, assured the board that the new contract would be closely monitored by the finance and investment committee.

Finances Overview

The trust was in a challenging financial position with a continued financial deficit in 2018/19. Board members believed the financial plan would be delivered for 2018/19 but a large proportion of the cost improvements plans were non-recurrent.

Board members that we interviewed had a consistent understanding of the trust’s financial position.

The trust had processes in place to manage financial risk and performance operationally. Divisions were held to account at monthly performance meetings. In addition, divisions not meeting their financial plan underwent a dedicated monthly finance performance meeting. Weekly CIP meetings were also held to track CIP delivery on a divisional basis.

Month-end and year-end processes were clear and had not historically resulted in large and unwarranted adjustments. The chair and a number of NEDs were involved in a monthly “working day 9” meeting which is used as a finance review board to compare forecast to actual financial performance each month.
### Historical data

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£313.7m</td>
<td>£321.1m</td>
<td>£332.0m</td>
<td>£340.5m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£38.4m)</td>
<td>(£46.3m)</td>
<td>(£52.9m)</td>
<td>(£36.2m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£352.1m</td>
<td>£367.4</td>
<td>£385.0m</td>
<td>£376.7m</td>
</tr>
<tr>
<td>Budget (deficit)</td>
<td>(£34.6m)</td>
<td>(£25.7m)</td>
<td>(£52.9m)</td>
<td>(£36.2m)</td>
</tr>
</tbody>
</table>

Two years ago, and last financial year plan, actual income and deficit figures were exclusive of the effect of sustainability and transformation funding. *(Source: Routine Provider Information Request (RPIR) – Finances Overview)*

The trust had significant financial challenges over many years, reporting a deficit of £25.7 million for the 2017/18 financial year. The trust’s vision included reflecting the financial risk and their strategic plan demonstrated the trust were committed to reducing the deficit and improving the trust’s financial position.

In June 2018, the trust had a base forecast of a £57.5m deficit.

There was a £4.2m deficit in August 2018, which was £0.8m worse than budget due to lower than expected pay and non-pay costs. The chief financial officer advised that the year to date deficit at August 2018 of £25.9m which was £1.0m worse than budget and emphasised that to deliver the budgeted full year deficit of no more than £52.9m for the year would require the monthly deficit to reduce to an average of £3.9m for the remaining months of the 2018/19. It was expected that as part of the trust’s recovery the £52.9m target would be reached by the end of the financial year.

The trust had forecast to reach its CIP challenge (target £15.9m). This meant the identification and delivery of a further £3m worth of CIPs before year end. A further £1.55m worth of recovery actions was required in order to deliver the financial plan for 2019/20. The board were concerned about achieving the £52.9m deficit, particularly with forthcoming winter pressures and reminded the Board of the importance of identifying the full cost improvement programme and underpinning the CQUINs.

The chief financial officer assured the board that the cash flow position had improved.

The process for monthly financial forecasting had improved and was now considered rigorous and robust. A divisional forecast was prepared monthly and aggregated to create the trust’s base forecast. This was used to quantify the amount of recovery actions required to meet the financial plan.

*(Source – board papers September 2018)*

In both 2017/18 and 2018/19, given the scale of the financial challenges faced by the trust, they devised in-year financial recovery plans seeking to bring their forecast position back to plan. Although the trust did not deliver its 2017/18 in-year financial recovery plan, it demonstrated effective control over financial factors within its control. For 2018/19, there was a consensus amongst board members interviewed that the trust’s financial plan should be delivered albeit that concerns were raised over the non-recurrent nature of a large proportion of CIPs.
The trust’s ability to innovate and become financially sustainable was hampered by the poor condition of the fabric of the buildings. Estate redevelopment plans were under way, with a refreshed strategic outline case expected during 2019.

Processes to plan and improve the quality and safety of services with the use of capital funding were unclear. Only two million pounds had been spent at the time of our inspection from a total of £14 million capital funding.

We raised this with the senior leadership team who provided an overview of their agreed capital programme for this financial year and next. The acting chief executive was confident that the trust planned to spend the full allocation by March 2019, with the exception of spending the financial support for IT as this was being carried over to the 2019/20 to support the re-procurement of a new IT system.

Trust corporate risk register

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. There was clear alignment between the recorded risks and what the board members said was ‘on their worry list’. However, the pace at which risks were mitigated was a concern.

The trust provided a document detailing their 22 highest profile risks. Each of these had a current risk score of 15 or higher.

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
<th>Last review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/07/2014</td>
<td>3120</td>
<td>Patient medical notes missing, delayed or poor condition.</td>
<td>20</td>
<td>6</td>
<td>31/08/2018</td>
</tr>
<tr>
<td>01/06/2016</td>
<td>3741</td>
<td>Risk of not achieving financial sustainability</td>
<td>20</td>
<td>6</td>
<td>09/08/2018</td>
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<tr>
<td>01/06/2016</td>
<td>3742</td>
<td>Failure to achieve sufficient efficiencies to support annual and longer-term plans</td>
<td>20</td>
<td>12</td>
<td>09/08/2018</td>
</tr>
<tr>
<td>09/11/2016</td>
<td>3828</td>
<td>Inability to deliver achievement of RTT performance standard in line with recovery plan</td>
<td>20</td>
<td>10</td>
<td>31/08/2018</td>
</tr>
<tr>
<td>16/01/2017</td>
<td>3845</td>
<td>CCG approach to financial matters and consequent impact on WHHT</td>
<td>20</td>
<td>6</td>
<td>09/08/2018</td>
</tr>
<tr>
<td>12/06/2017</td>
<td>3893</td>
<td>ICT servers reduced availability, poor reliability &amp; performance</td>
<td>20</td>
<td>9</td>
<td>11/10/2018</td>
</tr>
<tr>
<td>12/06/2017</td>
<td>3894</td>
<td>ICT applications reduced availability, poor reliability &amp; performance</td>
<td>20</td>
<td>6</td>
<td>11/10/2018</td>
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<tr>
<td>12/06/2017</td>
<td>3899</td>
<td>ICT trust bleep system</td>
<td>20</td>
<td>5</td>
<td>10/10/2018</td>
</tr>
<tr>
<td>14/07/2017</td>
<td>3912</td>
<td>High turnover rate within Band 5 nursing population</td>
<td>20</td>
<td>6</td>
<td>16/08/2018</td>
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<tr>
<td>30/04/2018</td>
<td>4017</td>
<td>Deteriorating RTT position</td>
<td>20</td>
<td>4</td>
<td>31/08/2018</td>
</tr>
</tbody>
</table>

(Source: P106 Trust Risk Register extracted August 2018)

Identified areas of concern and poor performance featured clearly on local and corporate risk registers. The registers were comprehensive. There was evidence that risks were being reviewed and risk registers were being updated. However, the pace at which risks were mitigated was a concern.
The safeguarding leads demonstrated they had the skills, knowledge and integrity they required and most staff knew who the leads were. They were described as approachable and accessible.

The annual safeguarding report for the period May 2017 to April 2018 was presented to the board in September 2018 following review, comment and sign-off at relevant meetings and committees. The report showed that the trust was committed to protecting children, young people and vulnerable adults. It also outlined their priorities for the following period such as safeguarding related training and compliance.

Information management

The trust collected, analysed, and used information to support its activities and whilst there were large amounts of data available this had not always been translated into clear information. Some IT systems were slow, did not interface with each other and were not fit for purpose.

The trust used a wide number of information systems across the organisation, which captured and recorded relevant clinical and demographic data about patients along their pathway. Together with clinical systems, there were also non-clinical systems in place that captured such areas as incident reporting: this directly contributed to improving the quality of care for patients. However, all staff told us that the IT systems were slow, did not interface with each other and some were not fit for purpose. Where new systems were identified that could enhance the information recorded, business cases were put forward, and rigorous evaluation took place to ensure investment was viable. A new ICT system was due to be implemented for April 2019, however at the time of the inspection, testing prior to commissioning had still not taken place.

Each month the trust board monitored trust-wide performance against the key performance indicators within the integrated quality and performance report (IPR). Performance metrics were reported at all levels of the organisation. Whilst there were examples of board members effectively challenging data and information provided, for example, we saw recorded in the minutes challenges with regards to safeguarding concerns and VTE assessments there was a lack of challenge when there was an increase in pressure ulcers. It was also noted that data such as this increase was not signposted to the reader of the report rather they had to look at the detail. We were advised that there were plans to review the integrated performance report to make it more outcome focused.

High-level summary information was available at board level, with a clear statement of the financial position of the trust. The finance and performance report to the finance and performance committee included a detail including analysis of the income, expenditure, agency spend, cash flow and capital spend.

There were processes in place to ensure any unexpected variation and potential data issues were identified. Externally submitted data was reviewed by the relevant lead director prior to submission. There was a clear sign-off process that allowed the checking of information against previous returns. Data returns were also checked against national guidance to ensure the counting rules were accurate.

The trust had a Caldicott Guardian, a senior information risk officer and a clinical information risk officer.

A Caldicott guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. The Caldicott guardian was the trusts’ medical director.
The information governance toolkit annual assessment is a requirement for NHS trusts. The trust completed the IG toolkit and submitted its results to NHS Digital, but did not attain level 2 for two controls (IG Training and Corporate Records Management). The IG Toolkit has been replaced by the new Data Security and Protection Toolkit from April 2018, with completion required by March 2019. This was part of the trust’s GDPR plan. At the time of our inspection, information governance training compliance was 88%. This did not meet the trust target of 95%.

Data security risks were managed well. A programme had been initiated by the ICT, Information Security and Emergency Planning and Resilience teams to review the existing business continuity plans. Identified gaps had been addressed. The trust was developing plans to complete a Disaster Recovery test in 2019.

Each month the trust board monitored trust-wide performance against the key performance indicators within the integrated quality and performance report (IPR). Performance metrics were reported at all levels of the organisation. For example, deaths, RTT, breaches, delayed transfer of care and safer staffing reports were reviewed from the wards and departments through to the trust board.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. The trust worked with providers and commissioners, to support transformation of the health and social care system and understand the needs of people within Hertfordshire.

People’s views and experiences were gathered and acted on to shape and improve the services and culture.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the health and social care system and the needs of the local population.

There was a carers’ lead that had links to all the community carers’ hubs. Within these focus groups feedback was given on the support they and their loved one had received. In addition, there were links with Carers in Hertfordshire and other organisations, to promote the importance of patients keeping active and healthy. The carer support team in children’s services had extended its reach to the step down area of the neonatal services.

A bereavement support group had been commenced where care was offered to bereaved families to enable help where required. Additionally, this group fed back to the trust how they perceived the care that had been received.

There was an active patient’s panel, who took part in audits and were part of the accreditation of care environment scheme. For example, one member of the patient’s panel, who used a wheelchair, took the chair on a tour of the main building at Watford General Hospital to demonstrate how difficult it was, in some areas for wheelchair users to gain access.

Within critical care unit a ‘getting to know you’ scheme had been commenced, which built a picture of the patient as a person. This included pictures of them before their illness to help staff see them as individuals. Additionally, the critical care unit offered the option of a patient diary, which has been shown to help in the rehabilitation of the patient, in being able to reflect on lost time. Previous patients and carers were invited attend coffee mornings to reflect on their ITU experience.

A joint school and a spine seminar was in place for those patients having joint replacement and
spinal surgery respectively, where patients could meet members of the multi-disciplinary team.

The Enhanced Recovery programme, whose ethos was: “No decision about me without me.” helps people to recover sooner from surgery. From patient feedback surveys has shown better patient experience, with hospital stays being reported as less stressful.

A discharge quality planning group was in place from those patients who had complained about their discharge plans. They had worked on initiatives such as discharge checklist, improved prescribing and dispensing of medications to take home and discharge letters.

The empathy project in the Children’s ED supported by volunteers from Youth Connexions Hertfordshire and had provided outreach to older children and their families in ED.

Within the endoscopy unit the bowel screening service had a specific patient feedback questionnaire. These results are regularly scrutinised and presented at the clinical governance meeting that influences decisions on improving the service.

The endoscopy unit also has a separate patient and staff survey that is specific to them and is completed every 12 months. The results again were presented at the clinical governance meetings. In addition, the department displayed the results in a poster presentation at the entrance to the unit is there for all patients and visitors to observe.

Staff were actively engaged and their views were reflected in the planning and delivery of services and in shaping culture.

The trust had identified that their key weaknesses with regards to staff was overall perceptions of the trust as a place to work or be treated. Feedback from the survey suggested that this is because of poor IT, tired infrastructure and proximity to London, meant that staff often felt that the service and facilities available in these trusts was better.

The staff survey result results were in the top quartile nationally. Quarterly staff surveys were undertaken and the results were reported and discussed at the trust executive committee and patient safety committee. A range of other methods were also used to gather the views of staff members; for example, leaver interviews and focus groups.

The board members knew what the issues were in terms of staff feedback and could reciprocate what plans were in place to address risks. Issues included workloads and the requirement to move between clinical areas; IT systems, estates and facilities, career development and feelings of bullying and harassment which some board members told us was often due to their manager’s competency. Additionally, the survey showed that staff do not always believe that there is a level playing field in relation to career development and also a higher than average number of staff felt that they had experienced discrimination at work.

Leaders encouraged the involvement of patients, families and carers in reviews and investigations. For example, complainants would be invited to local resolution meetings to discuss concerns and complaints. The medical director often chaired the meetings and there was appropriate divisional representation.

Clinicians were members of all key bodies and were part of all main decisions. The senior leadership team told us that one of their key strengths was strong clinical leadership and the fact that clinical input was at the heart of all decision-making processes. Divisional clinical directors were non-voting board members which meant they had a clear understanding of performance and quality across the trust.

The senior leadership team were visible and were well known throughout the organisation. However, board members were less well known. Feedback from staff regarding their
relationships with line managers was generally positive, particularly in relation to the support they received.

The trust had a package of health and wellbeing initiatives available to staff. This included workshops, classes, and health MOTs. The occupational health service provided a fast track physiotherapy assessment scheme for staff with the aim of keeping staff fit and healthy, as well as supporting them to return to work following injury or illness. A confidential employee assistance line provided staff members and their immediate family access to information and advisory services such as legal advice, counselling services and financial advisors. Health and wellbeing days were held and included massage and relaxation treatments, as well as lunch time talks on topics chosen by staff.

The trust had volunteers who worked across all three hospitals in various wards and departments. Checks were undertaken before they were permitted to work, including; two references, and occupational health assessment, Disclosure and Barring Service (DBS) check. In the event that a DBS Certificate contained information registering a concern, a request was made to see a copy of the DBS certificate in order to evaluate and complete a risk assessment. The volunteer had the opportunity to discuss the information as part of the risk assessment and where relevant, may be accompanied by a care coordinator. The decision to deploy a volunteer with a positive DBS check, was dependent upon the outcome of the risk assessment in relation to the voluntary placement. An induction programme was in place for all volunteers.

Schwartz rounds are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. The aim was to offer staff a safe environment in which they shared their stories and offered support to one another. These were a regular feature at the hospitals, particularly at Watford General Hospital. The trust reported that there had been 29 rounds since January 2016 with an average attendance of 52 staff of all levels and 493 staff in total had attended at least one round. When staff were surveyed after the October 2018 round, all staff said they found the round ‘exceptional or ‘excellent.’

Watford General Hospital was situated adjacent to a premier league football club and there was a good relationship between the football club and the hospital. For example, the football club’s premises were often used for training and some of the players, who were well known supported some of the hospital’s activities.

During October 2018, members of staff supported a number of national healthcare campaigns, which included:

- The freedom to speak up guardian, visited all three hospitals to raise awareness during national freedom to speak up month.
- Staff from St Albans theatres raised awareness of international infection prevention and control week by dressing up in Hallowe’en costumes for the corridor damp dusting process.
- The Macmillan information and support centre hosted an information table to mark breast care awareness month.
- The resuscitation team supported a restart a heart day and teaching CPR and basic life support skills to members of the public in the Watford shopping centre.
- The infection prevention and control team arranged a host of activities to raise awareness during infection prevention and control week.
• The health and wellbeing team ran mental wellbeing sessions as part of world mental health day.

(Source: November 2018 Board papers)

**Learning, continuous improvement and innovation**

The focus of the trust in recent years has been on operational delivery and improving the quality of patient care. The trust was starting to develop a culture of continuous learning and improvement but this was at an early stage of development.

The focus of the trust in recent years has been on operational delivery and improving the quality of patient care. The trust was entering a new stage of more strategic focus and a more structured approach to continuous improvement. This was being developed through the partnership with a local NHS trust and an independent organisation which provides support to improving care through continuous improvement. Whilst some staff had been trained on methods to deliver continuous this was at a very early stage.

The executive team spoke positively about the developments planned for continuous improvement and the ‘bottom up approach’ they wished to promote however examples provided included directives decided and disseminated by senior leaders.

Mandatory training rates were at the trust target of 90% until November 2017, but gradually dropped, until at their lowest were 80.3% in August 2018. There had been some improvement and at October 2018 they were at an overall rate of 91%. The breakdown is shown below.

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Basic Life Support (CSTF) [1 Year]</td>
<td>82%</td>
</tr>
<tr>
<td>Basic Health, Safety and Risk (CSTF) [3 Years]</td>
<td>95%</td>
</tr>
<tr>
<td>Conflict Resolution (CSTF) [3 Years]</td>
<td>93%</td>
</tr>
<tr>
<td>Equality and Diversity (CSTF) [3 Years]</td>
<td>94%</td>
</tr>
<tr>
<td>Fire Safety (Non-Clinical) (CSTF) [1 Year]</td>
<td>89%</td>
</tr>
<tr>
<td>Fire Safety and Evacuation (Clinical) (CSTF) [1 Year]</td>
<td>84%</td>
</tr>
<tr>
<td>Infection Control (Clinical) (CSTF) [2 Years]</td>
<td>94%</td>
</tr>
<tr>
<td>Infection Control (Non-Clinical) [2 Years]</td>
<td>95%</td>
</tr>
<tr>
<td>Information Governance (CSTF) [1 Year]</td>
<td>89%</td>
</tr>
<tr>
<td>Manual Handling (Non-Patient) (CSTF) [3 Years]</td>
<td>90%</td>
</tr>
<tr>
<td>Manual Handling (Patient Contact - Level 2) [3 Years]</td>
<td>88%</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 (CSTF) [3 Years]</td>
<td>96%</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 (CSTF) [3 Years]</td>
<td>91%</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 (CSTF) [3 Years]</td>
<td>96%</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 (CSTF) [3 Years]</td>
<td>90%</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 (CSTF) [3 Years]</td>
<td>94%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>91%</strong></td>
</tr>
</tbody>
</table>

Therefore, the total average figure above the trust’s target of 90%; with 90% having been reached in all but five individual subjects. It was planned that 90% compliance, or more, for the two subjects that were delivered only by e-learning (Information Governance and Fire Safety (Non-Clinical)) by the end of Q4 2018/2019 and for the other three that require classroom courses (Fire Safety and Evacuation, Manual Handling (Patient Contact) and Adult Basic Life Support) by the end of Q1 2019/2020.

Additionally, the trust had a plan to improve compliance rates for the future:

• Extra classes were planned for the three classroom courses (fire safety and evacuation, adult basic life support and manual handling (patient contact); extra classes so far having
already improved adult basic life support, from 57% in August to 82% at mid December 2018.

- Automated system reminders had been set up to routinely remind staff when their compliance with training is about to, or has already, expired.

- Mandatory and essential training was planned to be, raised routinely at divisional performance meetings (along with all other metrics) and at departmental level within the divisions, with the human resources business partners working with their divisional leads to target areas of low compliance.

- A new mandatory training policy enshrining all the improvements in process and procedure and a new clarity of accountability was in the final stages of ratification, due to be completed in January 2019, subject to endorsement by the joint consultative committee.

Complaints process overview

**Effective systems were in place to manage complaints, although not all complaints were investigated within the trust's own target timescale of 30 days.**

The trust had a clear process in place for dealing with complaints and concerns raised. There was a complaints policy in place, which was in date. A revised version including a complaint grading matrix had undergone internal governance processes. Staff we spoke with were aware of the complaints procedure. Posters and leaflets about how to make a complaint were available throughout the trust. The trust’s website also contained information on making a complaint. The associate chief nurse was the executive lead for managing complaints with support from the Patient Advisory and Liaison Service (PALS) and complaints team.

Complaints could be made in person, by telephone and in writing by letter or email. All complaints were acknowledged within three working days. For all complaints a member of the complaints team would contact the complainant to discuss their concerns and inform them of the process. Complaints were sent to divisional leads to investigate and respond. When medical staff were named in a complaint, they would give a response, which would be checked by the divisional director. Complaints against medical staff were raised during appraisals.

If complaints were also serious incidents (SI), they were dealt with by the SI team. The complaints team engaged with the SI team, contacted the patient and collate the SI and complaint responses.

All complaints and concerns were recorded on the trust’s electronic risk management system, to enable the identification of common themes and ensure learning was shared in response to complaints received. Divisions used a standard template available on the risk management system to produce a formulated response, which was submitted to the complaints team two weeks prior to being sent to the complainant. For each response, an action plan was created to ensure steps were taken to resolve or reduce the chance of reoccurrence and lessons are learned.

The trust had a weekly complaints meeting with the divisions and a monthly safety and quality group which was chaired by the chief nurse. The number of complaints that had been open for more than four months was reducing. In May 2018, there were eight but in August, this had reduced to one.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.
Question | In days | Current performance
--- | --- | ---
What is your internal target for responding to complaints? | 3 | 100%
What is your target for completing a complaint | 30 | average 82% by year end
If you have a slightly longer target for complex complaints please indicate what that is here | 40 | average 82% by year end
Number of complaints resolved without formal process in the last 12 months? | 2,545 | April 2017 to March 2018

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

The response rate for complaints within target was worse than the external agreed trajectory at 72.7%, but was above the national average and the trust’s internal trajectory to reach 82% by year end. (Source: Trust board papers - October 2018)

Number of complaints made to the trust

The trust received 833 complaints from July 2017 to July 2018. The surgery core service received the most complaints with 262. Of which 696 (86% were received about Watford General hospital.)

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>262</td>
<td>31.5%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>192</td>
<td>23.0%</td>
</tr>
<tr>
<td>Medical care (including older people's care)</td>
<td>122</td>
<td>14.6%</td>
</tr>
<tr>
<td>Other</td>
<td>110</td>
<td>13.2%</td>
</tr>
<tr>
<td>Maternity</td>
<td>78</td>
<td>9.4%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>28</td>
<td>3.4%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>20</td>
<td>2.4%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>20</td>
<td>2.4%</td>
</tr>
<tr>
<td>End of life care</td>
<td>1</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

The top three complaints subjects were:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>346</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>149</td>
</tr>
<tr>
<td>Communications</td>
<td>90</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

The chief executive was the signatory on all response letters. We saw that letters were thorough and sympathetic. If the complainant was dissatisfied with the trust’s response, the complaint was returned to the division and reviewed. The trust endeavoured to resolve the issues raised by writing a further letter and/or offering a meeting with the relevant clinicians.

There was a process in place to ensure duty of candour had been applied, where appropriate. We checked a sample of complaints and saw that it had been applied in all cases.
Compliments

From August 2017 to August 2018, the trust received a total of 224 compliments. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>109</td>
<td>48%</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>47</td>
<td>21%</td>
</tr>
<tr>
<td>Surgery</td>
<td>23</td>
<td>10%</td>
</tr>
<tr>
<td>Maternity</td>
<td>12</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>4%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>8</td>
<td>4%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>6</td>
<td>3%</td>
</tr>
<tr>
<td>Gynae</td>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td>Critical care</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>End of life</td>
<td>1</td>
<td>0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments)

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust's services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>West Herts Endoscopy Units situated on both the Hemel Hempstead and Watford sites were successfully reaccredited in May 2018</td>
</tr>
<tr>
<td>Bliss Baby Charter</td>
<td>Neonatal Unit</td>
</tr>
<tr>
<td>NHS England Neonatal Peer Review</td>
<td>Neonatal Unit</td>
</tr>
<tr>
<td>Paediatric Oncology Shared Care Units - Peer Review</td>
<td>Paediatric Oncology Services</td>
</tr>
<tr>
<td>Paediatric Critical Care Peer Review</td>
<td>Paediatrics</td>
</tr>
<tr>
<td>MHRA Manufacturing Specials Licence for Technical Services</td>
<td>(last inspection: October 2016)</td>
</tr>
<tr>
<td>MHRA Wholesale Dealers Licence for Stores and Distribution</td>
<td>(last inspection: October 2016)</td>
</tr>
<tr>
<td>General Pharmaceutical Society Registration for dispensaries on all 3 sites</td>
<td>(last inspection November 2015)</td>
</tr>
<tr>
<td>Home Office Controlled Drugs Licence</td>
<td>(compliance visit May 2016)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).
Acute services

Watford General Hospital

Urgent and emergency care

Facts and data about this service

West Hertfordshire NHS Trust provides urgent and emergency care services to people living in West Hertfordshire and the surrounding areas. The trust’s emergency department (ED) is located at Watford General Hospital. It provides a 24 hour, seven days a week service to the local population. The trust also has a minor injury unit located at the St Albans City Hospital site and an urgent care centre located at the Hemel Hempstead Hospital site.

Details of emergency departments and other urgent and emergency care services

- Watford has an accident and emergency department (A&E).
- St Albans has a minor injury unit (MIU).
- Hemel Hempstead has an urgent care centre (UCC).

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The ED at Watford General Hospital has a reception and waiting area. The majors’ area has nine cubicles, and three side rooms, one of which is the designated mental health assessment room. The minors’ area has six cubicles, and two rooms that are suitable for the assessment of independently mobile patients, but are not large enough to accommodate patients admitted on a trolley. There is a nine-bedded resuscitation area, and a STARR (senior team assessment and rapid response) area, which has seating and five cubicles for the initial assessment of patients. There is also an eight-bedded clinical decision unit (CDU), which includes two side rooms.

Watford General Hospital has a separate children’s ED, which is adjacent to the adult ED. It consists of a waiting area, two side rooms, a bay with four trolleys and two cots, and a resuscitation room, which has two beds and one resuscitaire. There is also a five-bedded children’s observation bay. The children’s ED sees children and young people up to the age of 16 years.

The adult ED forms part of the emergency medicine directorate, and the current leadership structure includes a director of emergency medicine, director of operations, directorate manager, head of nursing for elective and emergency medicine and lead nurse for emergency medicine. The children’s ED is under the women and children’s division, and the current leadership structure includes a divisional director, divisional manager and head of nursing. Both senior leadership teams are supported by clinical leads, matrons, ward managers, specialist nurses, and governance facilitators.
Activity and patient throughput

Total number of urgent and emergency care attendances at West Hertfordshire Hospitals NHS Trust compared to all acute trusts in England, July 2017 to June 2018

From July 2017 to June 2018, there were 137,086 attendances at the trust's urgent and emergency care services as indicated in the chart above.

(Source: NHS England)

Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission remained similar in most recent year compared to previous year. In both years, the proportions were higher than the England averages.

(Source: NHS England)
Urgent and emergency care attendances by disposal method, from May 2017 to April 2018

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Since 2015, we have inspected the urgent and emergency care service at Watford General Hospital three times in April 2015, September 2016, and August/September 2017. At each inspection, we have rated the service as inadequate overall. At the last inspection, we rated three key questions as inadequate (safe, responsive, and well led) so we re-inspected all five key questions.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We used a variety of methods to gather evidence to assess urgent and emergency care services at Watford General Hospital. We visited the adult and children’s emergency departments, the clinical decisions unit and children’s observation bay.

We spoke with 55 members of staff, 11 patients/relatives, five paramedic/ambulance staff, and reviewed 28 sets of patient records and seven drug charts.

We interviewed the clinical lead consultant and lead nurse for emergency medicine. We spoke with the director of emergency medicine, and medical, nursing and support staff, such as consultants, junior doctors, nurses, health care assistants, paramedics and porters. We observed the environment and care provided to patients. We also looked at a range of performance data and documents including policies, meeting minutes, audits and action plans. Some of the performance data provided was only available trust wide and therefore relates to all hospital sites covered by West Hertfordshire NHS Trust. Performance data regarding Watford General Hospital only has been used where available.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff. Most staff were up to date with annual refresher training. While the trust target of 90% completion rate was not met for all training courses, most courses had completion rates of 80% or more. Staff understood the importance of completing mandatory training and applied what they learnt to their practice.

Mandatory training completion rates
The trust set a target of 90% for completion of mandatory training. A breakdown of compliance for mandatory courses from July 2017 to June 2018 for nursing staff and medical/dental staff in urgent and emergency care at Watford General Hospital is shown below:

Nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-patient moving and handling</td>
<td>20</td>
<td>20</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>97</td>
<td>107</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>96</td>
<td>107</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire non-clinical</td>
<td>84</td>
<td>96</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>96</td>
<td>107</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand hygiene</td>
<td>79</td>
<td>107</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>77</td>
<td>107</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient moving and handling</td>
<td>93</td>
<td>107</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire and evacuation clinical</td>
<td>84</td>
<td>107</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control</td>
<td>75</td>
<td>107</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>61</td>
<td>107</td>
<td>74%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff met or exceeded the 90% completion target for six out of 11 mandatory training modules. As of October 2018, 89% of nursing staff had completed basic life support training (Source: Additional Data Requests DR187 Staff List Oct 2018 BLS). This meant the service had completion rates of 85% or more for the further five training modules.

Medical and dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict resolution</td>
<td>16</td>
<td>16</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Non-patient moving and handling</td>
<td>41</td>
<td>44</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>25</td>
<td>30</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire non-clinical</td>
<td>34</td>
<td>42</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire and evacuation clinical</td>
<td>25</td>
<td>33</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>35</td>
<td>48</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>32</td>
<td>48</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>29</td>
<td>48</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control</td>
<td>28</td>
<td>47</td>
<td>79%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene</td>
<td>27</td>
<td>48</td>
<td>78%</td>
<td>90%</td>
<td>No</td>
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<tr>
<td>Patient moving and handling</td>
<td>19</td>
<td>36</td>
<td>76%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Medical and dental staff met or exceeded the 90% completion target for four out of 11 mandatory training modules, with completion rates of 80% or more for a further four training modules. The trust mandatory training covered key areas such as fire safety, infection control, health and safety, manual handling and conflict resolution. Training was provided via e-learning modules or classroom based sessions. Staff within the service understood their responsibility to complete mandatory training, and told us the training was relevant to their roles.

Nursing staff in the children’s emergency department (ED) were required to have paediatric immediate life support (PILS) training. At the time of our inspection, 82% of staff had completed this training. There were five members of staff who had not yet completed this training, four of which were new starters and the other had recently returned from maternity leave. All were
booked to undertake this training at the end of October or by mid-November 2018. All senior nursing staff (band six and seven) and children’s ED consultants had completed advanced paediatric life support training (APLS) (Source: Additional Evidence Requests DR109). This was an improvement from our previous inspection in 2017, when we found 66% of staff had completed this training.

Managers had a system to make sure staff were up-to-date with mandatory training, which they regularly monitored. A practice development nurse had oversight of training needs within the service and of training compliance rates. Their main role was to support staff to complete mandatory training and develop training packages in line with national recommendations. They also supported newly qualified staff and identified any learning needs through audit, incident and complaint themes.

Staff said they had received training to make them aware of the potential needs of people with mental health conditions, learning disability, and dementia. The trust’s safeguarding adults’ level two course included dementia training. In the children’s ED, 22 members of clinical staff (63%) had attended a nationally accredited two-day course for mental health. They planned to offer this to all staff when further courses were available (Source: Additional Data Requests DR112). Staff learned from training and put what they learned into practice.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, not all medical staff had received up-to-date training in safeguarding children level one and two.**

Most nursing staff had received up-to-date training in safeguarding systems, processes, and practices. However, not all medical staff had up-to-date training in safeguarding children level one and two, and safeguarding adults level one. The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from July 2017 to June 2018 for nursing staff and medical/dental staff in urgent and emergency care at Watford General Hospital is shown below:

**Watford accident and emergency**

**Nursing staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 1</td>
<td>99</td>
<td>99</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>95</td>
<td>96</td>
<td>99%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>99</td>
<td>107</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3 - three yearly update</td>
<td>75</td>
<td>83</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>95</td>
<td>107</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff met or exceeded the 90% completion target for four out of the five safeguarding training modules, and almost met the target for safeguarding adults level two training with a completion rate of 89%.
As can be seen from the table above, medical and dental staff did not meet the completion target for three of the five safeguarding modules. However, completion rates were better for higher levels of safeguarding training. They exceeded the 90% completion target for two of the five modules, with completion rates of 80% or more for a further two modules.

Safeguarding training was delivered in line with national recommendations, and included scenario-based discussion and learning from local and national serious case reviews. The training programme included professional responsibilities, categories of abuse, safeguarding processes, female genital mutilation (FGM), child sexual exploitation (CSE), domestic violence and preventing radicalisation. Staff said they learnt from safeguarding training and put what they learned into practice. Safeguarding adults, children, and young people at risk was given sufficient priority within the urgent and emergency care service. There were clear systems, processes, and practices in place to safeguard children, young people, and adults from avoidable harm, abuse, and neglect that reflected legislation and local requirements. Safeguarding policies and pathways were in-date and were accessible to staff.

The trust had named safeguarding nurses for adults and children and a named paediatric safeguarding doctor, who were available to provide support, supervision, training, and updates for staff. A paediatric consultant with child protection experience and skills was available 24 hours a day, seven days a week, to provide immediate advice and subsequent assessment, if necessary. Staff could contact the trust’s safeguarding team if they needed advice and support with any safeguarding concerns. Staff in the children’s ED told us the named nurse for safeguarding children was very visible within the department. Attendances in the main emergency department of all young people aged between 16 and 17 years old were reviewed the next working day by a safeguarding children’s nurse. This was to ensure all safeguarding risks had been considered and followed up with appropriate referrals made, where indicated. Furthermore, the discharge summaries of all patients under the age of 18 years included a safeguarding section. When completed by the discharging clinician, a copy was automatically sent to the trust’s safeguarding team. This enabled them to review the discharges of all children and young people where safeguarding concerns had been identified, and ensure appropriate referrals and arrangements for follow up care were in place.

Staff took a proactive approach to safeguarding and focused on early identification. They took steps to prevent abuse or discrimination that might cause avoidable harm, responded appropriately to any signs or allegations of abuse and worked effectively with others, including people who used the service and other agencies, such as social workers, GPs, the police, and independent domestic violence advisors, to agree and implement protection plans.

Staff demonstrated a good understanding of their responsibilities in relation to safeguarding children and adults in vulnerable circumstances and were confident to make safeguarding
referrals. Staff could explain the process of safeguarding a patient and provided us with examples of when they had done so. From January to October 2018, a sample of audits carried out showed safeguarding concerns were well managed by the children’s ED. The audits found records were completed appropriately, the necessary referrals were made, all relevant professionals were involved, and partnership working was effective (Source: Additional Data Requests DR91).

Staff in the children’s ED had access to the child protection information sharing system, used by GPs and safeguarding teams to alert healthcare professionals to children who may be at risk of abuse. Staff could access current information from both local and out-of-area health and social care services. Staff we spoke with told us they would check this system for every child who attended the ED to see if they were identified as being at risk of abuse. The seven patient records seen confirmed this was routinely done.

Clinical pathways were in place for the mandatory reporting and safeguarding of children and women with known, suspected and/or risk of FGM. Staff we spoke with were aware of their mandatory duty to report all cases of FGM in children and young people under the age of 18, and those under the age of 18 at risk of FGM being performed. Since our previous inspection in 2017, the children’s ED had introduced a nationally recognised sexual behaviours traffic light tool to help staff identify and respond appropriately to sexual behaviours in children and young people. Staff were familiar with doctor’s and nurse’s holding powers under the Mental Health Act and gave examples of when these had been used. Staff said if they were unsure they would speak to a senior member of staff or refer to the trust intranet for advice. ED staff were not permitted to restrain patients. If a patient required restraint, staff would contact the police. During our inspection, we saw that the police had been called to restrain a patient and remove a knife from their possession.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection, such as handwashing and use of personal protective equipment. There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained.

During our 2017 inspection, we observed some staff were not washing their hands as frequently as required. During this inspection, we observed hand hygiene practises in the department had improved.

Reliable systems were in place to prevent and protect people from a healthcare-associated infection. We observed clinical staff adhere to the trust’s ‘arms bare below the elbow’ policy. This is an infection, prevention, and control (IPC) strategy to prevent the transmission of infection from contaminated clothing and enables clinicians to thoroughly wash their hands and wrists. We observed staff washing their hands between patient contact, in accordance with national guidance (NICE Infection prevention and control: QS61, quality statement 3, (April 2014)). Patients and relatives told us they saw staff wash their hands. Monthly audits were carried out to monitor staff compliance with hand hygiene. From April to September 2018, the monthly audit results for the service showed hand hygiene compliance was 100% (Source: Trust Board Papers, Integrated Performance Report May to October 2018). There was access to hand washing facilities, hand sanitising gel, and personal protective equipment (PPE) such as gloves and aprons, in all areas. Hand sanitising gel dispensers were available in corridors, bed spaces, and clinical areas for staff, patients and visitors to use. We observed staff apply hand sanitising gel when they entered and/or exited clinical areas. We saw staff used appropriate PPE and aseptic non-touch technique when
carrying out invasive procedures, such as cannulation (the insertion of a small plastic tube into a vein to enable fluids and or medicines to be given).

Effective systems were in place that ensured standards of hygiene and cleanliness were maintained. Standards of cleanliness were regularly monitored and results were used to improve IPC practices where needed. There was a service level agreement in place between the trust and an external provider who cleaned patient and public areas, in accordance with daily and weekly cleaning schedules. All areas of the ED visited during our inspection were visibly clean and tidy, and we observed domestic staff regularly cleaning them. Bi-monthly IPC audits were carried out within the service, which included the cleanliness of patient equipment and staff knowledge of IPC practices. From February to June 2018, the average compliance score for the children’s ED was 97%. We saw evidence that actions were taken to improve compliance where indicated (Source: Additional Evidence Requests DR86).

Nursing and support staff were responsible for cleaning the equipment. We saw “I am clean” stickers were placed on items of equipment, stating the date and time they were last cleaned. In all areas visited equipment was clean and ready for use.

The lack of side rooms within the ED for patients who required isolation was listed on the service’s risk register. There were two side rooms available in the majors’ area, clinical decision unit and children’s ED, which could be used for patients with a known or suspected infection. However, there were no isolation facilities within the resuscitation area (resus). Actions identified to minimise this risk were to keep the bay next to the patient being nursed in resus empty, where possible. All areas used for isolation required deep cleaning after use. Staff could describe what they would do if a patient required isolation due to infection.

Patients who were being admitted to the hospital for ongoing care and treatment were routinely screened for MRSA (antibiotic resistant bacteria). In the CQC Emergency Department Survey 2016, the trust scored 8.1 out of 10 for the question regarding the cleanliness of the department. This was about the same as other trusts (Source: CQC Emergency Department Survey 2016). Patients and relatives we spoke with during our inspection told us they found the department clean.

**Environment and equipment**

The adult emergency department was generally unsecured. We also found some unsuitable furniture in the dedicated mental health room that could potentially have been used as a weapon. This had been removed when we returned. However, the service generally had suitable premises and equipment and looked after them well. Risk assessments were in place where the security of the environment posed a potential risk to patient safety in the children’s emergency department. Equipment required for resuscitation was available for all age ranges and processes were in place to ensure emergency equipment was checked daily.

We identified some potential security risks in the main ED. The dedicated ambulance entrance did not have staff only access. While it was signed for ambulance use only, the doors were opened by a push pad that could potentially be used by anyone. This meant anyone could access the ED from the ambulance entrance. The main corridor that ran through the ED led into the main hospital. This entrance/exit had a secure double-door, which could only be opened by authorised staff with an electronic fob pass. However, during our inspection, we observed that the door was faulty and did not always fully close. This meant there was a potential risk that unauthorised people could use it to access/exit the ED. We raised this concern immediately and the trust took action to fix the double-door and to ensure it was secure. We did observe some staff challenging...
patients and visitors when found in the corridor and they escorted them to where they wanted to go. However, during an unannounced visit, we found the doors were still unsecure and had been wedged open. This meant we were not assured the trust had taken action to ensure the security of the ED. Following our inspection, we saw the insecure access to the ED had been added to the service’s risk register. Actions identified to reduce the risk included ED staff to ensure doors were kept shut and to monitor and challenge unauthorised use of the corridors, and immediate escalation of any faults in the swipe access or push pad to the estates department (Source: Additional Data Requests DR184 Emergency Medicine RR).

There was an ongoing potential risk to the security of the children’s’ ED due to the limitations of the environment. However, risks had been assessed and mitigated. Senior staff told us that the entrance to the resus area and dedicated ambulance entrance were not secured because of the need for immediate access in an emergency. Staff clearly understood the risk and mitigation was in place to reduce it. For example, staff told us that no child was left unattended within the department, which we corroborated during our inspection.

The main ED had a dedicated mental health room, which was generally compliant with the Psychiatric Liaison Accreditation Network (PLAN) quality standards. It had two doors, which opened outwards and were not lockable from the inside, there were no ligature points within the room, an alarm system was in place, and there was CCTV that could be monitored at the main staff hub in majors. However, we found two non-weighted chairs had been placed in the room, which could potentially have been used as a weapon. We observed one patient had been admitted to the room on a trolley, which had ligature points. This was not in line with national standards. We also found there were ligature points in the toilet near the mental health room, which we also reported at our last inspection in 2017. We raised these concerns with the trust at the time of our inspection. On an unannounced visit, we found the non-weighted chairs and trolley had been removed. We saw environmental suicide, self-harm and ligature point risk assessments had been carried out in the main and children’s ED (Source: Additional Data Requests DR121).

Furthermore, the ligature risk in the toilet opposite the mental health room was listed on the service’s risk register. Controls in place to minimise this risk were identifying whether a chaperone for using the toilet was required via the mental health risk assessment. Door hinges were replaced to allow the door to open two ways (Source: Additional Data Requests DR184 Emergency Medicine RR).

We found one patient call bell in the majors’ area was not working. We raised this with the nurse-in-charge who reported it to the estates’ department. Following our inspection, we saw the unreliability of the call bell system had been added to the service’s risk register. Controls in place to minimise this risk included placing vulnerable patients in view of the nurse-in-charge. Call bell checks were added to the daily checklist and a supply of hand bells would be purchased (Source: Additional Data Requests DR184 Emergency Medicine RR).

During our 2017 inspection, the main waiting area could not be observed due to limited visibility from pillars in the middle of the room. During this inspection, we found visibility of the waiting area had improved due to the positioning of the streaming nurse window. An emergency bell was situated in the reception area and waiting room to enable reception staff to call for help if a patient required immediate assistance. Staff also told us that any patients who were at significant risk of deteriorating and presented with any ‘red flag’ symptoms would immediately be seated in the STARR area rather than the main waiting area. During our last inspection, we saw plans for remodelling the environment within the ED had been approved but not commenced. The aim was to create additional space and improve patient flow. During this inspection, we saw a new eight bedded clinical decision unit had been created and was in use. The previous site of the children’s
observation bay was now being used by the main ED to improve their capacity and flow. The children’s observation bay had been relocated within the department. The trust planned to develop the department further, by creating a dedicated entrance to the children’s ED. Any child attending the emergency department booked into the main ED reception and were then directed to the children’s ED. Staff spoke positively about the additions made to the department and how they had improved patient flow as a result.

The layout and design of the children’s ED was in line with national standards (Royal College of Paediatrics and Child Health (RCPCH) Facing the Future: Standards for children in emergency care settings (June 2018)). It was well designed, with adequate space and separate areas for minor treatments, observation, and resuscitation. Patients in the waiting area and bay could be observed at all times from the nurses’ station.

The layout of the ED supported patient flow to most diagnostics and theatres. Patients who required a computerised tomography (CT) scan were required to have a nurse and porter to transfer them. The clinical lead said that due to the distance from the department to the CT scan, there were plans in place to have a dedicated CT scan within the department.

Effective processes were in place to ensure equipment was well maintained and fit for purpose. Resuscitation equipment was readily available and accessible throughout the main ED and children’s ED. Resuscitation trolleys were clean, clearly organised, secure and well maintained. Areas were fully equipped and included size-appropriate equipment for children. Daily and weekly checks of all resuscitation equipment were carried out. The adult and children’s emergency departments had dedicated resuscitation areas. The adult resus area could accommodate up to nine patients and the resus area for children could accommodate two medical emergencies at one time. The children’s resus also had a resuscitaire, which was used to support babies needing resuscitation. Electrical equipment was regularly serviced, and safety tested, to ensure it was safe for patient use. All equipment we reviewed had been serviced within the date indicated.

We checked a sample of consumable items for expiration dates and all were in-date. Store rooms within the majors’ area and children’s ED were tidy and well organised. In the main ED, we saw all medical consumables such as wound dressings, syringes and cannulas, had the price of each item documented on the front of each drawer. Staff said this prompted them to think about the equipment they needed to undertake tasks and made them more aware of wasting unnecessary consumables. Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste, and sharps. Sharps boxes were clean, dated and were not overfilled. This was in line with trust policy (Source: Additional Data Requests DR116).

**Assessing and responding to patient risk**

For most patients, we found risks were managed and patients generally received assessments, treatment, and observations in a timely way. The service planned for emergencies and staff understood their roles if one should happen. While ambulance turnaround times did not generally meet national recommendations, the service had made significant improvements in regard to this performance indicator. However, we were not assured that adult patients with mental health concerns were appropriately monitored at all times.

Staff knew how to refer patients with mental health concerns to the rapid assessment and integrated discharge (RAID) mental health liaison team. There were policies and procedures in place for extra observations or supervision, but we saw that these were not always adhered to. Staff said the RAID team would provide patients at high-risk of self-harm or suicide with one to one supervision. However, according to the clinical record of one patient, they were described as being
suicidal, but they had not been provided with one to one care. We observed this patient was not routinely monitored via the CCTV screen situated at the main staff hub, which surveyed the mental health room. We also observed that this patient could leave the department unaccompanied and go for regular cigarette breaks. We raised this with the trust immediately and the trust took action to address this.

Patients arriving by ambulance as a priority (blue light) call were taken immediately to the resus area. Such calls were phoned through in advance so that the department was alerted, and preparations were made for the arrival of the patient. We observed members of the multidisciplinary team prepare effectively for an incoming patient following a trauma alert during our inspection. Non-priority patients brought in by ambulance were initially assessed in the ‘STARR’ (senior team assessment and rapid response) area, where a senior clinician saw them. Patients were then transferred to either minors’, majors’, or resus dependent on their clinical need. At this inspection, we found the STARR process was well embedded. We did not observe any ambulance patients waiting long periods of time to be assessed in the STARR area. Patient records showed patients were seen by a nurse within one minute of being brought in. However, staff told us that when there were long waits in the STARR area due to it being at full capacity, patients brought to the ED by ambulance waited in non-treatment areas such as the corridor, awaiting handover. Staff relied on ambulance staff to stay with the patients in the corridor until handover had taken place. This was not in line with best practice guidance as set out in the NHS Improvement Good practice guide: Focus on improving patient flow (2017). If the ED was crowded and several ambulances arrived in close succession, there was not always enough space and/or staff to look after newly arrived patients. When this happened, ambulance crews would stay with the patient until they could handover.

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was better than the overall England median for the seven-month period from December 2017 to June 2018. In the latest month (June 2018), the median time to initial assessment was one minute compared to the England average of nine minutes.

Ambulance – Time to initial assessment from July 2017 to June 2018 at West Hertfordshire Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)

The trust’s low median time to initial assessment data was similar to what was reported at our last inspection in 2017. Previously, staff said there was an issue with how the data was captured, which was related to the timeliness of patients being ‘clicked’ on and off the system. At this inspection, we found this data issue had not been resolved. The time of arrival reported was the time the ambulance crew registered the patient’s arrival at the main reception desk, not the time they arrived at the ED. This meant the time from arrival to initial assessment was often under reported to the trust’s benefit. For example, some of the clinical records we reviewed showed that
patients had received their initial assessment before the time they had arrived in the department. Senior staff were aware of this issue and were looking at ways to improve their data collection. During our inspection, we observed that patients who arrived by ambulance received their initial assessment in a timely manner. Trust data showed for the year-to-date (April to September 2018), 96.5% of patients brought by ambulance were assessed within 15 minutes of arrival (Source: Additional Data Requests DR188 Integrated Performance Report – Emergency Medicine September 2018).

The Royal College of Emergency Medicine (RCEM) recommends that ambulance handover to ED staff should take no longer than 15 minutes. Data showed that year-to-date (April to September 2018), 35.4% of patients were handed over within 15 minutes. This was significantly below (worse than) the trust target of 95% (Source: Additional Data Requests DR188 Integrated Performance Report – Emergency Medicine September 2018). However, the service had significantly improved other performance indicators in relation to ambulance handover times.

**Number of black breaches for this trust**

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. At our inspection in 2017, we found that between July 2016 and June 2017, the trust reported 3,211 black breaches, with an average of 267 reported per month. From July 2017 to July 2018 the trust reported 1,799 black breaches. A monthly breakdown is shown below:

(SOURCE: ROUTINE PROVIDER INFORMATION REQUEST (RPIR ACUTE) - BLACK BREACHES TAB)

As the table above shows, the highest number of black breaches were reported in July 2017 and January 2018, with both months reaching over 230. At this inspection, we found the trust had taken action to reduce their black breaches and that since February 2018; significant improvements in this performance indicator had been made. In February 2018, the trust implemented the ambulance response times project with the development of new ways of working, such as the STARR process. Since then the trust performance improved with a month-on-month decrease in the number of black breaches reported. The trust had been asked to present the work done to reduce black breaches to a regional ambulance working group. According to the integrated performance report for September 2018, the number of black breaches did increase in July and August 2018, with 23 and 30 reported respectively. Since April to August 2018, 107 black breaches were reported, which remains a significant improvement on the previous year’s performance (Source: Trust Board Papers October 2018, Integrated Performance Report September 2018).
Data showed for the year-to-date (April to September 2018), 8.5% of patients who arrived by ambulance waited between 30 and 60 minutes to be handed over to ED staff. This was a significant improvement from our previous inspection, when we reported that 65% to 78% of ambulances experienced a delay of more than 30 minutes to offload a patient between July 2016 and June 2017 (Source: Additional Data Requests DR188 Integrated Performance Report – Emergency Medicine September 2018).

One emergency medical technician told us, “the department has greatly improved over the last 12 months”, and another paramedic said, “the department was one of the better EDs in the area”. During our inspection, we did not observe ambulance crews waiting to handover to ED staff.

There was a clear streaming and triage process in place. From 8am to 10.30pm, patients who self-presented to the ED were initially seen by the streaming nurse. Streaming is the process of allocation of patients to specific patient groups and/or physical areas of the department. Streaming adds value by managing queues, and by matching the patient needs to the practitioner so that the right skills are available to the patient at first point of contact. The streaming nurse carried out an initial assessment of the patient, which included pain. Each patient was then given a document that stated the area they had been streamed to. These areas were STARR/majors, minors, minors action, GP, and GP action. Action indicated that the patient needed an intervention prior to full assessment, such as analgesia, wound dressing and observations. Patients who presented with a limb injury had their neurovascular status checked by the streaming nurse, who would escalate if indicated. If a patient required immediate medical attention, the streaming nurse would summon assistance from nursing staff in the STARR/majors area. Outside of these hours, patients would book in at the main reception and would be called into STARR for initial assessment, and transfer to the appropriate area. Any patient the receptionists were worried about would be escalated immediately to nursing staff. From April to September 2018, data provided by the trust showed the median time from arrival to initial assessment was one minute in the main ED and six minutes in the children’s ED (Source: Additional Data Request DR127).

Patients who self-presented to the emergency department or arrived on an ambulance in a wheelchair were assessed using a nationally recognised triage system. This process was followed appropriately. The triage system was in line with Royal College of Emergency Medicine guidance. Patient early warning scores were used during triage and throughout the patient’s admission to the department. The National Early Warning Score (NEWS) was used for adults and age appropriate Paediatric Early Warning Score (PEWS) charts were used for children and young people. Neurological observations such as level of consciousness and pupil check were carried out on all patients admitted with suspected head injury. These observation charts were designed to allow early recognition of deterioration in patients by monitoring physical parameters such as blood pressure, heart rate and temperature. Each chart detailed action that should be taken if any parameters were outside of the normal range. Pain assessments were completed during the initial clinical assessment for both children and adults, in line with national guidance. The completion of NEWS and PEWS charts was regularly monitored. From May to October 2018, an average of 98% of PEWS charts were completed and scored correctly (Source: Additional Data Requests DR85).

We reviewed twelve NEWS and seven PEWS charts during our inspection and found they were completed, scored and escalated, where indicated, in line with national and trust guidance.

There was a screening tool and pathway for the management of suspected sepsis. Sepsis is a potentially life-threatening illness and is when the body’s response to infection injures its own tissues and organs. Early recognition and prompt treatment has been shown to significantly improve patient outcomes. Sepsis Six is an initial resuscitation bundle designed to offer basic intervention within the first hour of recognition. From April to September 2018, an audit of sepsis
and NEWS documentation showed completion of the sepsis screening tool, NEWS score recorded, NEWS calculated correctly, and hourly observations recorded (unless clinically indicated) was generally 90% to 100%. The exception was in July 2018, when performance declined to 67% for NEWS score recorded and 80% for NEWS calculated correctly (Source: Additional Data Requests DR93). There was an escalation policy in place for patients with presumed sepsis. From April to September 2018, the audit of sepsis and NEWS documentation showed evidence of referrals to the critical care outreach team or medical staff when the patient had a NEWS score of six or more during their admission, scored 100% completion for all months, except July 2018 when compliance was 0% (Source: Additional Data Requests DR93). Risk assessments for sepsis were completed in the patient records we reviewed.

Risk assessment for venous thromboembolism (VTE) (used to determine a patient’s risk of developing a blood clot) was not routinely required for patients in the ED, unless the patient had a decision to admit. This was in line with national guidance (NICE NG89 - Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism, 2018). The medical records we saw for patients in the CDU who were awaiting admission or had been in the department for 24 hours or more had VTE risk assessment forms completed. Data showed that year-to-date (April to August 2018), 93.1% of VTE risk assessments were completed for patients in the CDU (Source: Additional Data Requests DR188 Integrated Performance Report – Emergency Medicine September 2018).

The children’s ED had acute paediatric support for the investigation of sudden unexpected death in infancy, children, and young people. The clinical decisions unit (CDU) was part of the emergency department but was located off a separate corridor to the main department. There was a clear standard operating procedure (SOP) and admission criteria for each different clinical condition. All patients met the CDU criteria for admission during our inspection. However, some patients were cared for in CDU for longer than 24 hours, when the hospital was busy, which was not in line with the CDU SOP.

The service planned well for emergencies and staff understood their roles if one should happen. Emergency scenarios were held to maintain and improve the skills needed in the event of an emergency, such as a major chemical, biological, radiological, and/or nuclear contamination incident. These also involved external agencies where appropriate, such as the local police and ambulance provider. Porters, healthcare assistants, and/or nurses escorted patients attending and waiting for diagnostics, where appropriate.

Emergency Department Survey 2016

The trust scored about the same as other trusts for all five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?

9.6 About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and abuse and to provide the right care and treatment. Nurse staffing levels and skill mix were planned in line with guidance on safe staffing in emergency settings. Patient needs were met at the time of inspection with staff of the right skill level and experience.

We found improvements had been made since the last inspection. The trust had completed a full review of the nursing establishment and skill mix within the ED and the staffing establishment had been increased to ensure each area was sufficiently staffed. The trust reported the following nurse staffing numbers for urgent and emergency care from 2017 and June 2018. Watford General Hospital A&E was over established in June 2018, which meant more nursing staff were employed in the department than planned.

<table>
<thead>
<tr>
<th>Location</th>
<th>June 2017</th>
<th></th>
<th>June 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned staff – WTE</td>
<td>Actual staff – WTE</td>
<td>Fill rate</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Watford A&amp;E</td>
<td>88.2</td>
<td>74.7</td>
<td>84.7%</td>
<td>87.8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

Vacancy rates

From April 2017 to March 2018, the average vacancy rate at the trust for nursing and midwifery staff was 3.19%; this was lower (better) than the trust target of 9%. Watford General Hospital had a negative vacancy rate as it was over established. This meant more nursing staff were employed in the urgent and emergency care service than planned.

- Watford: -12.2%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From July 2017 to June 2018, the average turnover rate at the trust for nursing and midwifery staff was 19%, this was higher (worse) than the trust target of 12%.

- Watford: 20%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From July 2017 to June 2018, the average sickness rate at the trust for nursing and midwifery staff was 3%, this was lower (better) than the trust target of 3.5%.

- Watford: 2.5%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage: Qualified nursing staff
From April 2017 to March 2018, the trust had a total of 212,254 nursing staff shifts in urgent and emergency care. A breakdown of bank and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Unfilled rate (%)</th>
<th>Bank use rate (%)</th>
<th>Agency use rate (%)</th>
<th>Total bank and agency Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watford General Hospital</td>
<td>10.8%</td>
<td>8.7%</td>
<td>19.8%</td>
<td>28.5%</td>
</tr>
</tbody>
</table>

The table shows that over a quarter of qualified nursing shifts (28.5%) were covered by bank or agency staff.

Non-qualified nursing staff

From April 2017 to March 2018, the trust had a total of 212,254 nursing staff shifts in urgent and emergency care. A breakdown of bank and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Unfilled rate (%)</th>
<th>Bank use rate (%)</th>
<th>Agency use rate (%)</th>
<th>Total bank and agency Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watford General Hospital</td>
<td>8.8%</td>
<td>35.6%</td>
<td>13.5%</td>
<td>49.1%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

The table above shows that almost half of non-qualified nursing staff shifts were covered by bank or agency staff. From July to September 2018, the service reported an average 33.8% of nursing and/or clinical support worker shifts were filled by bank or agency staff. This was lower (better) than the figures reported above. Particularly for the time of year, when annual leave is at its highest (Source: Additional Data Requests DR185 Use of agency bank nurses).

Staffing levels of nursing staff and healthcare assistants were displayed publicly in all clinical areas. We saw actual nurse staffing levels met the planned nurse staffing levels for each area of the ED. For example, the planned and actual staffing levels in the resus bay was five registered nurses for the day and night shift. In the CDU, the planned and actual nurse staffing levels were two registered nurses during the day and one at night with a healthcare assistant at all times. The skill mix of staff was suitable for the needs of the patients. Senior staff had oversight of activity within the department and moved staff around when needed, to ensure all areas were safely staffed and breaks were covered. We reviewed the planned staffing levels for the corridor for when it was in use. The maximum number of patients in the corridor at any one time was 12. This was staffed by two registered nurses and two healthcare assistants. On one day of our inspection, we did observe patients being cared for in the corridor. We saw the appropriate number of nursing and support staff had been allocated to look after these patients.

Senior staff told us the nurse vacancy rate in the children’s ED was around 20%. Recruiting paediatric trained nurses to vacant positions was challenging due to a national shortage. They had trialled the recruitment of adult nurses with paediatric competencies and experience in emergency care, to varying degrees of success, with one of the three employed adult nurses having left the service. Patient needs were met at the time of inspection with staff of the right skill level and experience. A safe care tool was completed twice a day, which mapped activity and patient acuity with staffing levels. During periods of high activity and/or lack of staff, paediatric nurses could be flexed between the children’s departments when needed. The children’s ED was staffed with a minimum of two children’s nurses on duty per shift and there was always at least one member of staff with advanced paediatric life support training. There was an overall nursing lead for the children’s ED. This was in line with national standards (Source: RCPCH Facing the Future: Standards for children in emergency care settings, June 2018).
An escalation plan was in place to address staffing issues. This included the redeployment of staff from other areas to support the department where needed. Staffing levels were reported at the trust-wide bed management meetings four times a day. A staffing co-ordinator attended these meetings so that nurse staffing across the hospital could be reviewed and bank or agency staff would be requested to fill shifts where needed. A traffic light system was used to rate and flag staffing issues. A green rating showed staffing levels were safe. An amber rating indicted staffing levels were not as expected, and minor adjustments were needed to meet workload and acuity, or staffing levels were as expected but given workload and acuity, additional staff were needed. A red rating indicated staffing numbers were inadequate to cope with workload and patient acuity.

We reviewed the nurse staffing RAG returns for July, August and September 2018, which showed 83% of shifts in the main ED were green rated and 17% were amber rated. In the children’s ED, 55% of shifts were green rated and 45% were amber rated. Neither department had any red rated shifts during this period (Source: Additional Data Requests DR79 Rag Count).

Bank and agency staff were offered unfilled shifts to ensure establishment was met. They received an induction and orientation before they commenced duties. This was corroborated by agency staff we spoke with. They told us they regularly worked in the department and were familiar with local working practices.

Nursing handovers took place at the change of each shift. This included a safety huddle, which took place in the staff room, away from the noise and activity in the department. The safety huddle included a brief overview of activity, staffing, current breaches in the department, as well as any updates in guidance, and learning from incidents and complaints. Staff then dispersed to their allocated area and received a detailed handover of the patients they had been assigned. Senior nurses co-ordinated the activity for each shift. They were mostly supernumerary, which enabled them to have oversight of the department and support staff as needed. A senior nurse who was supernumerary co-ordinated the children’s ED four days a week. We observed appropriate handovers from ambulance staff to nursing staff. Staff gave comprehensive handovers when transferring patients to other departments within the hospital. Student nurses were supernumerary and not included in the nurse-staffing establishment. Every student was assigned a nurse to work with on shift.

**Medical staffing**

**Medical staffing levels within the urgent and emergency care service were sufficient to keep patients safe from avoidable harm and abuse and to provide the right care and treatment.**

At our previous inspection in 2017, medical staffing levels were not consistently sufficient to provide safe care. The medical staff vacancy rate for the department was 23.2% for consultant level and 8.6% for other medical staff grades. The department was particularly short of staff at consultant and middle grade level. At this inspection, we found improvements had been made. As with nurse staffing, the directorate had carried out a full medical workforce review since our last inspection, to ensure the service was resourced appropriately. This had led to an increase in establishment.

The service had increased its consultant establishment by one whole time equivalent (WTE) position. The service employed 13 consultants, two of which worked exclusively in the children’s ED. This meant there were 12.5 WTE consultants in post at the time of our inspection (October 2018), and 10 of these participated in the on-call rota. Their rota ensured consultant presence in the department from 8am to midnight, seven days a week. This was in line with national
standards, which recommends 16 hours of consultant presence a day (*RCEM Emergency Medicine Consultants Workforce Recommendations, April 2010*). Outside of these hours, a consultant was on-call from home.

Staffing was planned to meet hourly, daily and seasonal variations in demand. The service ensured a minimum of a senior doctor (ST4 level or equivalent) in the department 24 hours a day, seven days a week. There were six middle grade doctors rostered to work Monday to Friday, over a 24-hour period; two middle grade doctors were on duty from 8am to 5pm, one from 11am to 8pm, one from 4pm to 1am, one from 8pm to 6am, and one from 10pm to 8.30am. At weekends, there were six middle grade doctors on duty; one from 8am to 6pm, two from 10am to 10pm, one from 4pm to 2am, one from 8pm to 6am, and one from 10pm to 8.30am. The consultants and middle grade doctors were supported by senior house officers (SHOs) and junior doctors. We saw there were 14 SHOs / junior doctors rostered to work Monday to Friday, over a 24-hour period; three were on duty from 8am to 5pm, three from 12pm to 9pm, three from 4pm to 1am, and five from 9pm to 8am. There were also two enhanced nurse practitioners, who supported the ED from 7.15am to 22.30pm and two advanced nurse practitioners, who supported the ED from 8am to 10.30pm. At weekends, there were 13 SHOs / junior doctors on duty; three from 8am to 8pm, two from 10am to 10pm, three from 2pm to 2am, and five from 9pm to 8.30am.

Staffing returns for July to September 2018, showed the medical staffing fill rate was generally 90% or more. This meant we were assured there were sufficient medical staff to keep people safe and provide the right care and treatment.

<table>
<thead>
<tr>
<th>Staff Grade</th>
<th>Fill rate % - Day</th>
<th>Fill rate % - Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANP</td>
<td>96.2%</td>
<td>N/A</td>
</tr>
<tr>
<td>Consultant</td>
<td>101.4%</td>
<td></td>
</tr>
<tr>
<td>ENP</td>
<td>92.4%</td>
<td>N/A</td>
</tr>
<tr>
<td>Junior</td>
<td>99.8%</td>
<td>91.7%</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>91.5%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Paediatric ENP</td>
<td>82.6%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Additional Data Requests DR189 DR80 Data re shifts)

While medical staffing remained a risk within the ED, we saw that the trust had taken action to reduce this risk such as the increase in establishment and ongoing recruitment. The service now had a consultant lead for retention and recruitment, and interviews had been scheduled for two middle grades and two SHO positions. The risk level was graded at eight (moderate), which was an improvement from our previous inspection when it was graded as 20 (high). The clinical lead told us that if there were unfilled middle grade shifts they would try and fill these with their own staff or locum staff wherever possible. If this was not possible, consultants would stay late and/or come in early to ensure there was sufficient senior medical cover within the department.

Arrangements for using locum doctors kept patients safe from avoidable harm. A folder was kept at the nursing station and contained completed local induction checklist forms for locum doctors. Inductions included ensuring staff had read relevant policies, awareness of emergency contacts, location of the resuscitation equipment and use of IT systems. Medical staffing handovers took place three times a day, at 8am, 4pm and 10pm. These were appropriate and efficient. There was a consultant-to-consultant handover at 4pm, which included the middle grade doctors and nurse-in-charge. At 10pm, the consultant handed over to the night team. Care was assessed and planned, and work was allocated to appropriate staff.
The children’s ED had five consultants who were rostered to work in the department; two were consultants in paediatric emergency medicine, two were paediatric consultants, and the other was an emergency medicine consultant with special interest in paediatrics. They worked on-site from 8am to 10pm Monday to Thursday, 8am to 8pm Friday, and 11am to 7pm or 12pm to 8pm on Sunday (Source: Additional Data Requests DR123). This rota had been developed to best meet the needs of patients with the resources they had, as the department’s busiest times were generally at the beginning of the week. Outside of these hours, a consultant was available on-call. They were supported by the ED middle grade doctors, SHOs and junior doctors. All consultants had completed advanced paediatric life support (APLS) training. There was also a middle grade doctor with APLS on site 24 hours a day, seven days a week (Source: Additional Data Request DR109).

On-call arrangements were in place and worked well. Staff we spoke with did not have any concerns about contacting the on-call consultant when needed. Junior doctors spoke positively about working in the ED. They told us that consultants were supportive and accessible. We observed consultants supporting junior staff during our inspection. The medical staffing numbers for urgent care and emergency services in June 2017 and June 2018 at Watford General Hospital are shown below. The hospital’s fill rate was above 90% in both periods. In June 2018, the service’s fill rate exceeded planned staffing levels by 18.5%.

<table>
<thead>
<tr>
<th>Location</th>
<th>June 2017</th>
<th></th>
<th>June 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned</td>
<td>Actual</td>
<td>Fill rate</td>
<td>Planned</td>
</tr>
<tr>
<td>Watford General Hospital</td>
<td>38.9</td>
<td>37.7</td>
<td>96.8%</td>
<td>39.7</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

Vacancy rates

From April 2017 to March 2018, the average vacancy rate at Watford General Hospital for medical and dental staff was -18.4%, this meant the trust was over establishment.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From July 2017 to June 2018, the average turnover rate at Watford General Hospital for medical and dental staff was 58%, this was higher (worse) than the trust target of 12%. However, this figure is inflated due to the inclusion of trainee doctors. If excluded, the turnover rate for medical and dental staff in emergency medicine was 24.5%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From July 2017 to June 2018, the average sickness rate at the trust for medical and dental staff was 1.7%, this was lower (better) than the trust target of 3.5%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Medical agency and locum staff usage

From April 2017 to March 2018, the trust had a total of 83,476 medical staff shifts in urgent and emergency care.

A breakdown of bank and agency usage and unfilled shifts is shown below:
The table shows that medical agency and locum staff usage within the service was low, with less than 1% of medical staff shifts covered by temporary staff.

**Staffing skill mix**

In March 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average whereas the proportion of junior (foundation year 1-2) staff was higher.

### Staffing skill mix for the 40 whole time equivalent staff working in urgent and emergency care at West Hertfordshire Hospitals NHS Trust.

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>26%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>3%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>22%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>49%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

### Records

Appropriate records of patients’ care and treatment were not always kept. Records were not always up-to-date and were sometimes completed retrospectively. Mental health risk assessments completed by the mental health provider were not available to ED staff. However, staff in the children’s emergency department kept appropriate records of patients’ care and treatment.

Individual care records were not always completed to demonstrate that patients were kept safe. For example, we reviewed 16 patient records and found that not all information required to deliver safe care and treatment was recorded. In the clinical decision unit (CDU), we observed three out of six patients who had not had their intentional rounding documentation completed. When we raised this, the documentation was completed retrospectively. This was not in line with national guidance, which states that records should be completed at the time or as soon as possible after an event (NMC The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, (updated October 2018)). In addition, we saw that the intervals in which
rounding should be undertaken in the CDU was not always calculated correctly. For example, we observed a patient who should have had one hourly rounding completed, only being reviewed four-hourly.

Two patients’ in the CDU who were at risk of falls did not have their falls assessment documentation completed, despite staff informing us that a falls assessment had been done. During our unannounced inspection, staff told us they did not have the correct proformas to carry out a falls assessment. However, a further two patient records we reviewed in the CDU had all nursing care plans completed, which included risk assessments for pressure ulcers, nutrition and hydration, falls, manual handling, sleep, mental capacity, infection prevention and control, and continence.

In resuscitation, we saw staff carrying out the hourly checks but not always documenting them. We reviewed six sets of patient records during our unannounced inspection and found all safety checklists for patients were completed hourly.

A risk assessment for a mental health patient was completed by a consultant but was not present in the notes. We raised this during our inspection and found the risk assessment was added to the notes retrospectively. Risk assessments for mental health patients that were completed by the rapid assessment and integrated discharge (RAID) mental health liaison team were not accessible to staff in the emergency department. Patient records were not always updated with the outcome of the mental health risk assessment. This meant there was a risk that staff in the emergency department did not have the relevant information to keep patients with a mental health condition safe.

All clinical records for adults and children contained a risk assessment tool aimed at quickly identifying any safeguarding concerns. In November 2017, an audit found safeguarding record keeping in the children’s ED was mostly compliant. The use of the head injury proforma had improved from 75% in 2016, to 100% in 2017. We found safeguarding risk assessments were completed in the children’s clinical records we reviewed. However, when staff undertook this risk assessment in the adults’ ED, it was generally not documented in the patients’ clinical record if no safeguarding concerns had been identified. From eight records seen, the safeguarding “think family” risk assessment was only completed once. The November 2017 safeguarding audit reported poor completion of the “think family” risk assessment, with 50% compliance. When a patient was identified as having safeguarding concerns, we saw this was documented in the patient’s clinical record and appropriate referrals were made. We raised this with the lead nurse who was taking action to address this. We were told the trust’s safeguarding leads were redesigning the form to make it clearer for staff to complete.

Venous thromboembolism (VTE) and sepsis screening risk assessments were completed, where appropriate. The service routinely audited compliance with the completion of sepsis risk assessments. From April to September 2018, average compliance was 97% (Source: Additional Data Request DR93).

We reviewed seven patient records in the children’s ED and found these included a detailed clinical history, observations, examination and clinical decision making for each patient. The records showed a clear timeline of care and treatment given within the department.

We found records were generally stored securely. We found computer terminals were locked when not in use.

The ED used ‘patient safety at a glance’ (PSAG) white boards to display patient’s names, their location and key information. The PSAG boards were located at nursing stations throughout the ED. Staff had trialled using patients’ initials instead of their surname to protect their confidentiality.
but found this challenging to identify patients’ quickly. Confidentiality was managed by ensuring minimal information was included on the boards. Coded and abbreviated terms that were known to staff were used to describe the reason for a patient’s admission.

**Medicines**

The service generally prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time. There were effective governance arrangements in place to ensure controlled medicines and storage temperatures were checked daily and that out-of-range temperatures were acted upon, when indicated. However, we found patients were not always weighed prior to being prescribed weight-dependent anticoagulant medicine.

Emergency paediatric and adult medicines were stored securely in tamper proof boxes. Checks were in place to ensure emergency medicines were available and safe for use. Medicines were securely stored in all clinical areas we visited. The nurse in charge of each department held the keys for medicine cupboards and fridges. This prevented unauthorised personnel from accessing medicines. We found medicine storage areas were well organised and tidy, with effective processes in place to ensure stock was regularly rotated.

All medicines were within the use by date. The date liquid medicines such as oral morphine was opened was recorded on each bottle to reduce the risk of out of date medicines being given to patients. This is important because the shelf life of liquid medicines is reduced once opened.

Controlled drugs (medicines subject to additional security measures) were stored correctly within wall mounted locked cupboards and the keys were held separately from the main keys. Two registered members of staff were required to check the physical stock against the stock level recorded in the controlled drug register once daily. We reviewed the controlled drug register in the main ED and children’s ED and found stock levels were reconciled daily and every time they were administered. Controlled drug destruction kits were available. Controlled drugs brought in by patients were stored securely and there were adequate controls in place to prevent misuse. Patients’ own controlled drugs were recorded in a separate controlled drug register on admission to the department and were reconciled daily and every time they were administered.

Blank NHS prescription pads (FP10 prescriptions) were stored securely and monitoring systems were in place to ensure all prescriptions were accounted for. The audit record detailed each prescription issued and included the name of the doctor who issued the prescription, the date it was issued, the patient name and prescription number. This was in line with national guidance (Department of Health Security of prescription form guidance, August 2013).

Medicines that needed to be kept below a certain temperature were stored in locked fridges. The treatment rooms where medicines were stored were air-conditioned, which meant the temperature could be maintained within the recommended range (below 25°C). Ambient and fridge temperatures were checked daily to ensure medicines were effective and safe for patient use, and all were within the recommended range. Staff we spoke with knew what action to take if temperatures were outside the recommended range.

There were local microbiology protocols for the administration of antibiotics and prescribers used them. Microbiological samples were taken from patients prior to the commencement of treatment, such as blood cultures prior to antibiotics in cases of suspected sepsis.

Medicine incidents were reported via the trust’s electronic reporting system. From July 2017 to June 2018, the service reported 92 medication incidents through the national reporting and learning system. This equates to approximately 7% of total incidents reported by the service. All
incidents were graded as having caused ‘no harm’ (93%) or ‘low harm’ (7%). Common themes included the administration of contra-indicated medicines, missed, and/or delayed administration and wrong frequency. Actions were taken and learning from medication incidents was shared with staff. Staff we spoke with gave us examples of learning from recent medication incidents.

In the CQC Emergency Department Survey 2016, the trust scored 8.8 out of 10 for the question regarding whether staff explained the purpose of new medication to them in a way they could understand. This was about the same as other trusts.

We reviewed seven prescription charts and found they were all signed, legible, patient allergies were clearly documented, and medicines were given as prescribed. However, we observed one patient without an allergy wristband to alert staff of their allergy. We raised this concern with staff who took immediate action to correct this. Patients at risk of VTE or a pulmonary embolism (PE) were not always weighed prior to being prescribed prophylactic (preventative) medicine. An anticoagulant (blood thinner) is used to prevent and treat VTE and PE and the appropriate dose is dependent on a patient’s weight. We raised this during our inspection and were told that patients should be weighed prior to the prescribing of enoxaparin. Nursing staff in the CDU took immediate action to weigh patients who did not have a weight documented in their records. We were assured that all patients in CDU had been prescribed and administered the correct weight-based dose.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. The service undertook mortality and morbidity reviews to learn from them.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From July 2017 to June 2018, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - StEIS)

**Breakdown of serious incidents reported to StEIS**

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in urgent and emergency care, which met the reporting criteria set by NHS England from July 2017 to June 2018.

The types of incidents reported were:

- Treatment delay meeting SI criteria: one incident.
- Sub-optimal care of the deteriorating patient meeting SI criteria: one incident.
- Surgical/invasive procedure incident meeting SI criteria: one incident.

(Source: NHS Improvement - StEIS)

We reviewed the investigation reports for these three serious incidents and one that had been reported in July 2018 and found comprehensive investigation, with recommendations and actions taken to minimise the risk of recurrence (Source: Additional Data Request DR115). We saw that the serious incident investigations were completed in a timely manner.
From July 2017 to June 2018, the service reported 1,300 incidents through the national reporting and learning system. Incidents were graded from no to low harm, or moderate to severe harm, or death. The majority of incidents were graded as having caused no or low harm (91% and 8% respectively). Of the remaining incidents, 0.7% were graded as having caused moderate harm, 0.2% as having caused severe harm and 0.07% as having caused death (Source: National Reporting and Learning System (NRLS)).

The hospital used an electronic system for reporting incidents. Staff we spoke with said they were encouraged to report incidents and felt confident to do so. Staff received direct feedback when they had been involved in any incidents. Staff said that feedback from incidents, including lessons learned, were cascaded in a variety of ways, such as the daily staff huddle, handover, team meetings, the trust and department newsletters and closed social media pages. We corroborated this during our inspection. Staff were able to provide examples of learning from incidents. For example, a nurse in the children’s department told us there had been a medicines incident and upon investigation, it was identified that trust guidelines had not been updated in line with the British National Formulary guidance. The guideline was updated, and staff were encouraged to report any gaps identified in national guidance and trust guidance as an incident, so they could be promptly updated. Another example told to us by a consultant was in response to two incidents where a junior doctor missed a fractured neck of femur and fractured femur on x-ray. In response, the trust introduced a policy that required senior medical review of the x-ray before the patient is discharged.

Incidents reported were reviewed daily, Monday to Friday, and where necessary investigations were initiated to identify any themes and actions needed to minimise recurrence. Incidents were a standing agenda item at the monthly emergency medicine directorate governance meeting.

Recently, a new clinical governance newsletter had been produced and circulated to staff. This included a section on the number of incidents reported that month and incident trends.

During our inspection in 2017, the minutes of mortality and morbidity meetings were not routinely recorded for the emergency department and examples of minutes provided related only to mortality and morbidity reviews relevant to the acute assessment unit. At this inspection, we found improvements had been made. Minutes of the emergency department clinical governance meeting showed that mortality and morbidity was a standing agenda item. We saw that individual cases of mortality that had occurred within the department were presented for discussion and any learning was identified, where indicated (Source: Additional Data Requests DR89).

When things went wrong, staff apologised and gave patients honest information and support. The trust had a duty of candour policy, which staff could access via the trust intranet. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff we spoke with were aware of the importance of being open and honest with patients and those close to them when something went wrong, and of the need to offer an appropriate remedy or support to put matters right and explain the effects of what had happened. Duty of candour was followed in the incident reports we reviewed. Patients and their families were involved in the investigation process and informed of the outcomes. The investigation report was shared with patient, family, and/or representatives on completion.

Safety thermometer
The service collected and monitored safety information and shared it with staff. Information was used to improve the service.

The emergency department was not required to undertake the NHS Safety Thermometer, because of the transient nature of patients who attended the department. The NHS Safety Thermometer is a national tool used to record the prevalence of patient harm such as patient falls, pressure ulcers, and catheter-acquired urinary tract infections. It provides information for staff to monitor their performance in delivering ‘harm-free care’.

The service did however, monitor safety performance using information from a range of sources such as incidents, complaints, infection prevention and control compliance, VTE assessments, and hospital acquired pressure ulcers. Action was taken to improve safety performance where indicated.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

From our review of patient records, guidelines and clinical pathways, and discussions with staff, we found that care was delivered in line with national guidance and standards. This included National Institute for Health and Care Excellence (NICE) guidance, the Royal College of Emergency Medicine (RCEM) standards, and the Royal College of Paediatrics and Child Health (RCPCH) standards. Clinical pathways were in place for patients presenting with head injuries, sepsis, stroke, myocardial infarction (heart attack), fractured neck of femur (broken hip), trauma and abdominal aortic aneurysm (a swelling in the aorta, the main blood vessel that runs down from the heart through the chest and stomach).

Sepsis screening and management was done effectively and in line with national guidance. The service used the ‘sepsis six’ care bundle, which is the name given to a bundle of medical therapies designed to reduce the mortality and morbidity in patients with sepsis. Audits to monitor compliance with the sepsis care bundle were carried out and actions were taken to improve where indicated.

The stroke pathway ensured a coordinated approach to the care and treatment of patients who had suffered a stroke. Prior to arrival, the ambulance crew would inform emergency department (ED) staff that they were bringing in a patient with suspected stroke. ED staff would alert the stroke consultant and specialist stroke nurse, so they were available to assess and review the patient as soon as possible. Out of hours, when a stroke consultant was not available on site, the ED staff used telemedicine facilities to speak directly to a stoke consultant at another NHS trust, so that prompt treatment was initiated when indicated, such as thrombolysis (the breakdown of blood clots using medication). The resus area had a dedicated cubicle for patients with suspected stroke, which contained telemedicine and thrombolysis equipment. The trust’s pathway was in line with national guidance (NICE Stroke and transient ischaemic attack in over 16s: diagnosis and initial management: CG68, (March 2017)).

Mental health assessments, interventions and treatments were offered in line with national guidance (NICE Depression in adults: recognition and management (CG90), (April 2018)). Patients who were suspected to be experiencing depression were referred to the RAID mental health liaison team. In collaboration with a local NHS trust, the children’s ED had developed standardised clinical pathways. These included pathways for head injury, jaundice, the wheezy child and croup (a respiratory infection that is usually caused by a virus).
The service was involved in national and local audit programmes, and collated evidence to monitor and improve care and treatment. Recent audits carried out by the service included the RCEM fractured neck of femur, procedural sedation, and pain in children (moderate and severe pain) audits. There was an audit schedule for April 2018 to March 2019, with seven national and nine local audits. This was an improvement from our previous inspection in 2017, when we found there was limited local audit activity. The local audit schedule included the management of children presenting with seizure, RCEM standards for mental health, dislocated shoulder and radiology. We saw that action plans were put in place to improve compliance where indicated.

Older people who may be frail or vulnerable received a comprehensive assessment of their physical, mental or social needs because of their contact with the service. Staff followed best practice for assessing and monitoring the physical health of people with severe mental illness. We reviewed the records of three patients with severe mental health illness and saw that staff routinely monitored their physical health. Patients emotional and psychological needs were referred to during staff handovers, as well as their relatives or carers when appropriate. Trust policies were assessed to ensure guidance did not discriminate because of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation and/or age.

**Nutrition and hydration**

**Staff generally gave patients enough food and drink to meet their needs while in the ED. They used special feeding and hydration techniques when necessary.**

There were food and drink arrangements in place for patients and accompanying friends and family, who were in the department for any length of time. This included the provision of healthy food and drink options, and foods that met patients cultural and religious needs,

Staff conducted care and comfort rounds that included offering patients' food and drink. We saw these were completed in the ED. However, they were not always carried out in the clinical decision unit (CDU). The malnutrition universal scoring tool (MUST) was used to assess the nutritional needs of patients admitted to the CDU. Most patients and relatives said they had been offered something to eat or drink. One patient told us they had been provided with “lots of fluids and lunch”. However, we spoke with two patients, one of which had been in the department for two hours and the other for three, who had not been offered anything.

Following assessment, intravenous fluids were prescribed, administered and monitored when clinically indicated. Glucose preparations were available in the department for patients with diabetes, when needed. Glucose preparations are recommended when a patient has a ‘hypo’ and needs to increase their blood glucose levels rapidly (a ‘hypo’ is commonly used to describe hypoglycaemia). Staff could access dietitians for support and advice when needed. For example, if patients required parenteral nutrition (the feeding of a patient intravenously). Water stations were situated throughout the department. These could be used by patients and visitors.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6.5 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Pain relief**
Pain was assessed and managed on an individual basis and was generally monitored by staff. In the most recent national pain in children audit, the service generally performed better than the national average.

Staff monitored patients’ pain regularly and used tools to assess pain in patients with communication difficulties, such as people with a learning disability or those with dementia. The service conducted monthly pain assessment audits. From April to September 2018, we saw compliance was variable and ranged from a low of 62% in May to a high of 100% in June. The latest compliance score for September was 92%. Action was taken to improve compliance where indicated (Source: Additional Data Requests DR85).

Effective pain relief was given in a timely manner and its effects were generally monitored. Patient records we reviewed showed that patients’ pain levels were assessed and recorded using pain scores. We saw nursing staff administering pain relief in a timely manner when they assessed patients who had self-presented to the department and those who had arrived by ambulance. Patients said they had been asked about their pain and had been given pain relief promptly, if required. Staff documented instances where patients had refused pain relief.

Nursing staff who had completed the appropriate competency assessments were able to administer certain pain relief medicines such as over the counter pain relief medicines, against a patient group direction (PGD). PGDs are written instructions that allow healthcare professionals who are not prescribers to supply or administer medicines to defined groups of patients. This meant they could offer simple pain relief to patients without waiting for a doctor to prescribe them.

The children’s ED used a recognised pain assessment tool with smiley and sad faces for younger children, children with a learning disability, and children for whom English was not their first language. The service participated in the RCEM pain in children clinical audit 2017/18, which benchmarked the trust’s performance against the five RCEM standards and the national average. The service met one of the RCEM standards, and generally performed better than the national average in all standards. The audit also showed that 91% of patients were offered analgesia in the children’s ED. This was better than the national average of 71%. The pain in children audit results are shown below; in green where the ED performed in the highest 25% of emergency departments and amber where they performed similar to other departments. The children’s ED did not score in the lowest 25% of departments for any of the standards.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Patient group</th>
<th>This ED</th>
<th>National standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard 1</td>
<td>Pain is assessed within 15 minutes of arrival (100%)</td>
<td>59%</td>
<td>100%</td>
</tr>
<tr>
<td>Standard 2</td>
<td>Patients in severe pain should receive appropriate analgesia:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a)</td>
<td>50% within 20 minutes of arrival or triage, whichever is the earliest</td>
<td>29%</td>
<td>50%</td>
</tr>
<tr>
<td>b)</td>
<td>75% within 30 minutes</td>
<td>50%</td>
<td>75%</td>
</tr>
<tr>
<td>c)</td>
<td>100% within 60 minutes</td>
<td>75%</td>
<td>100%</td>
</tr>
<tr>
<td>Standard 3</td>
<td>Patients with moderate pain should receive appropriate analgesia:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a)</td>
<td>50% within 20 minutes of arrival or triage, whichever is the earliest</td>
<td>66%</td>
<td>50%</td>
</tr>
<tr>
<td>b)</td>
<td>100% within 60 minutes</td>
<td>72%</td>
<td>100%</td>
</tr>
<tr>
<td>Standard 4</td>
<td>90% of patients with severe or moderate pain should have documented evidence of re-evaluation and action within 60 minutes of</td>
<td>0%</td>
<td>90%</td>
</tr>
</tbody>
</table>
receiving the first dose of analgesic

<table>
<thead>
<tr>
<th>Standard 5</th>
<th>If analgesia is not prescribed and the patient has moderate or severe pain the reason should be documented in the notes (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: RCEM Pain in Children Clinical Audit 2017/18; Additional Data Requests DR92 Pain in Children 2017/18)

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 4.7 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was the same as other trusts. The trust scored 7.2 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. While they did not generally meet national standards, performance was mostly comparable with national averages. Action plans were developed to improve performance where indicated.

The department took part in the RCEM national annual clinical audit programme. This enabled them to benchmark their service against national standards and other emergency departments, and identify areas in need of improvement. Results were varied. Although they did not generally meet RCEM performance standards, there were areas where the trust performed similar or better than the national average, and areas where they performed worse than the national average.

RCEM Audit: Moderate and acute severe asthma 2016/17

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Watford General Hospital emergency department failed to meet any of the seven fundamental national standards. When compared to other hospitals the department was in the lower UK quartile for one standard:

- Standard 1a (fundamental): O2 should be given on arrival to maintain sats 94-98%. This department: 7.4%; UK: 19%.

The department’s results for the remaining six fundamental standards were between the upper and lower UK quartiles.

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 37.9%; UK: 26%.
- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 15.8%; UK: 25%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 73.3%; UK: 77%.
- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV.
• Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV.
• Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV.

• **Standard 5a (fundamental):** within 60 minutes of arrival (acute severe). This department: 15.4%; UK: 19%.

• **Standard 5b (fundamental):** within 4 hours (moderate). This department: 21%; UK: 28%.

• **Standard 9 (fundamental):** Discharged patients should have oral prednisolone prescribed as follows:
  • Adults 16 years and over: 40-50mg prednisolone for 5 days.
  • Children 6-15 years: 30-40mg prednisolone for 3 days.
  • Children 2-5 years: 20mg prednisolone for 3 days.

This department: 58.2%; UK: 52%.

(Source: Royal College of Emergency Medicine)

**RCEM Audit: Consultant sign-off 2016/17**

In the 2016/17 RCEM Consultant sign-off audit, Watford General Hospital emergency department did not meet any of the four national standards. When compared to other hospitals the department’s results for three standards were in the lower UK quartiles.

• **Standard 1 (developmental):** Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 0%; UK: 11%.

• **Standard 3 (fundamental):** Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 5.9%; UK: 12%.

• **Standard 4 (developmental):** Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 4%; UK: 10%.

The department’s results for one standard was between the upper and lower UK quartiles.

• **Standard 2 (developmental):** Consultant reviewed: fever in children under 1 year of age. This department: 9.8%; UK: 8%.

(Source: Royal College of Emergency Medicine)

**RCEM Audit: Severe sepsis and septic shock 2016/17**

In the 2016/17 Severe sepsis and septic shock audit, Watford General Hospital emergency department met four of the 13 national standards. These were:

• Standard 3a: Oxygen given to 50% of patients within one hour of arrival.
• Standard 4a: Serum lactate measured within one hour of arrival for 50% of patients.
• Standard 5a: Blood cultures obtained within one hour of arrival for 50% of patients.
• Standard 7a: Antibiotics administered within one hour of arrival for 50% of patients.

When compared to other hospitals the department’s results for five standards were in the upper UK quartiles.

• **Standard 3:** O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. This department: 72.5%; UK: 30.4%.
• **Standard 4:** Serum lactate measured within one hour of arrival. This department: 82.2%; UK: 60%

• **Standard 6:** Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 58.1%; UK: 43.2%.

• **Standard 7:** Antibiotics administered: Within one hour of arrival. This department: 66.7%; UK: 44.4%.

• **Standard 8:** Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 39.5%; UK: 18.4%.

The department’s results for three standards were all between the upper and lower UK quartiles.

• **Standard 1:** Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 88.9%; UK: 69.1%.

• **Standard 2:** Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 57.8%; UK: 64.6%.

• **Standard 5:** Blood cultures obtained within one hour of arrival. This department: 60%; UK: 44.9%.

(Source: Royal College of Emergency Medicine)

**RCEM Audit: Fractured neck of femur 2017/18**

In the 2017/18 Fractured neck of femur audit, Watford General Hospital did not meet any of the nine national standards. The department’s results for four standards were in the lower UK quartiles.

• **Standard 2c:** 100% of patients in severe pain receive analgesia within 60 minutes of arrival / triage. This department: 2%; UK average score; 4%.

• **Standard 3b:** 100% of patients in moderate pain should receive analgesia within 60 minutes. This department: 2%; UK average score; 4%.

• **Standard 4:** 75% of patients should have an x-ray within 120 minutes of arrival / triage. This department: 24%; UK average score; 71%.

• **Standard 5:** 95% of patients should be admitted within 4 hours of arrival. This department; 4%; UK average score; 41%.

The department’s results for five standards were all between the upper and lower UK quartiles.

• **Standard 1:** Pain score is assessed within 15 minutes of arrival. This department; 21%; UK average score; 29%.

• **Standard 2a:** 50% of patients in severe pain receive analgesia within 20 minutes of arrival / triage. This department: 0%; UK average score 0%.

• **Standard 2b:** 75% of patients in severe pain receive analgesia within 30 minutes of arrival / triage. This department; 1%; UK average score 2%.

• **Standard 3a:** 75% of patients in severe pain should receive analgesia within 30 minutes. This department; 2%. UK average score; 2%.
- Standard 5: 90% of patients with severe or moderate pain should have documented evidence of re-evaluation and action within 30 minutes of receiving the first dose of analgesic. This department; 0%; UK average score; 0%.

(Source: Royal College of Emergency Medicine, Additional Data Requests DR89 NOF Presentation)

The service had taken steps to improve performance in the standards measured by the RCEM audits. For example, recommendations made by the RCEM in response to the fractured neck of femur audit had been initiated. A hip fracture lead within the department had been selected. They were responsible for leading improvement and championing standards of care. Staff had been re-educated in the protocols and pathways for suspected fractured neck of femur and were reminded of the importance of ensuring pain assessments were documented and re-evaluated. Further examples of actions taken included the development of a sepsis advice leaflet for patients; a change in consultant shop floor presence to enable more consultation time between junior and senior staff, and staff were re-educated regarding patients that required consultant sign-off (Source: Additional Data Requests DR89).

The service participated in the trauma audit and research network (TARN), which was established to improve care and outcomes for patients admitted with trauma related injuries. In June 2018, the ED was peer reviewed by the national trauma network team. The peer review reported that there were many notable areas of good practice and clear progress since the previous year’s review. This included the support from all relevant major trauma specialties within the unit, which appeared strong and proactive, and there was effective general surgical and orthopaedic cover. The times from computerised tomography (CT) scan to provisional report were well within the one-hour target, and times to review the final report were 30% better than the national average for all patients. The review found there were no immediate risks but it did identify two serious concerns, three concerns and some general concerns. The service had responded to these concerns and had acted to improve where indicated (Source: Additional Data Requests DR106).

Unplanned re-attendance rate within seven days

The rate of patients re-attending the ED did not meet the national standard. Re-attendance rate within seven days for the same condition is used as an indicator of patient outcomes and the Department of Health states this should be no more than 5% of patients. From July 2017 to June 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and generally worse than the England average. However, we saw that trust performance had improved. Data showed the unplanned re-attendance rate year-to-date (April to September 2018) was 7.6%. This was similar to the England average (Source: Additional Data Requests DR188 Integrated Performance Report Emergency Medicine October 2018). Senior staff told us they had reviewed unplanned re-attendance rates within seven days, and no common themes had been identified. Patients’ generally re-attended the department with a different medical complaint. They also found that some re-attendances were planned returns, but these had not been coded correctly. The table below shows the ED performance compared to the national standard and the England average performance over this time.

Unplanned re-attendance rate within seven days - West Hertfordshire Hospitals NHS Trust
Competent staff

The service made sure staff were competent for their roles. Staff were encouraged and supported to develop their knowledge, skills and practice. Competency frameworks were in place to ensure staff gained the skills and experience relevant to their grade. However, managers did not always appraise nursing and support staff’s work performance annually.

All staff underwent a trust induction programme, which included mandatory and role specific training. Staff told us they had received a good induction. All nurses who were new to the service worked in a supernumerary capacity alongside an experienced nurse for a period of two weeks or until they were competent to work alone. A practice development nurse was also available to support staff as needed. Newly qualified nurses completed a comprehensive 12-month preceptorship programme to support and structure their transition. The programme included progress reviews, reflections on practice, mandatory and role specific training, and competency assessment. They were assigned a ‘buddy’ to work alongside during their supernumerary period. The buddy system remained in place once the supernumerary period was over, to ensure newly qualified staff were supported and had a named colleague to discuss their development and any challenges they had. The newly qualified nurses we spoke with felt their preceptorship programme met their learning needs and had enabled them to develop their confidence and skills. At the time of our inspection, the service was in the process of introducing the Royal College of Nurses (RCN) competency framework for emergency nursing level one and two. This was being developed in collaboration with the local university. Senior band five nurses who were working towards band six would be expected to undertake level two competencies, which would include advanced life support training (Source: Additional Data Requests DR187 Staff List Oct 2018 BLS).

The service provided development opportunities for staff. All staff we spoke with told us they were encouraged and supported to develop their knowledge, skills and practice. For example, one nurse told us they were being supported to undertake their masters in contemporary nursing. Nursing staff undertook competency assessments to ensure they had the appropriate clinical skills and knowledge to manage patients safely and effectively. These included pain management, end of life care, venepuncture, cannulation and medicines management, as well as competencies for dealing with specific conditions such as patients with head injury. The staff competency booklets we reviewed confirmed staff had up-to-date competencies.
Nursing staff were required to complete trauma level one training. Level two training was also available. Nursing staff who were put in charge of the resuscitation area were expected to have this higher level of training. As of October 2018, 89% of staff had completed level one and 55% had completed level two trauma training (Source: Additional Data Requests DR141).

The service employed four advanced nurse practitioners who were expected to have completed advanced life support (ALS) training. As of October 2018, 50% had completed this training and the remaining two were booked on an upcoming course. A further five nurses in the ED had also completed ALS training. Band six and seven nurses were expected to complete intermediate life support (ILS) training. As of October 2018, 64% of staff had completed this training. The practice development lead told us it was difficult to book staff on the ILS course because only one was held a month, with limited places available. A fixed number of places had been set aside in the coming year to ensure ED staff could complete this training. A further eight band five nurses had also completed ILS training (Source: Additional Data Requests DR187 Staff List Oct 2018 BLS).

Trainee doctors were assigned a clinical supervisor, whom they met with regularly during their placement. Junior doctors also attended protected weekly trust teaching sessions. In addition, they attended weekly departmental teaching sessions. Trainee and junior doctors we spoke with told us they were well supported by senior medical staff and could approach them for advice at any time. Middle grade doctors also attended weekly teaching sessions led by an emergency medicine registrar. We saw a junior doctor being supported by a consultant while preparing to cannulate a baby for the first time. The consultant was encouraging and knowledgeable, which meant they were able to answer any questions the junior doctor had. Past experiences were discussed, and the consultant provided advice and stayed with the junior doctor throughout. There were processes in place to ensure medical and nursing staff were registered with their professional body and had completed revalidation as required.

Appraisal rates

Arrangements were in place for supporting and managing staff. Staff were required to complete an annual appraisal as part of their personal development review. Staff told us they found the appraisal process useful and they were encouraged to identify any learning needs they had, and any training they wanted to undertake. Poor or variable performance was identified through the appraisal process, complaints, incidents and feedback. Staff were supported to reflect, improve and develop their practice. However, appraisal completion rates for staff were below the trust target of 90%. From July 2017 to June 2018, 152 members of staff were eligible to receive an appraisal in urgent and emergency care, they achieved a 55% completion rate against a trust target of 90%. The medical staff appraisal rates provided were at trust-wide level. From April 2017 to March 2018, 98.8% of eligible medical staff had received an appraisal. From April to August 2018, 95.9% of eligible medical staff had received an appraisal (Source: Routine Provider Information Request (RPIR) P39 Appraisal Dr’s). This was higher (better) than the trust target.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisal eligible</th>
<th>Appraisal completed</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>3</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>1</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>97</td>
<td>53</td>
<td>54.6%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>51</td>
<td>31</td>
<td>60.8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)
As of October 2018, we found appraisal completion rates had improved but were still below the trust target. The appraisal completion rate for nursing and support staff within the main ED and children’s ED was 74% and 82% respectively.

**Multidisciplinary working**

The multidisciplinary team worked together to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

All nurses, doctors and healthcare assistants supported each other throughout our inspection. Doctors were responsive to questions asked by nurses. We also observed a consultant helping a nurse wheel a bed through the department. This was an improvement from our previous inspection, when we observed disjointed working between some doctors and nurses. Staff spoke of good working arrangements with other departments including oncology, children’s services, safeguarding teams, diagnostic services and critical care. Nursing and medical staff in the resuscitation (resus) area told us the imaging teams were very responsive. Radiographers often attended the department to perform bed-side x-rays in the resuscitation area when it was clinically unsafe to move patients. We observed nursing staff supporting a radiographer and the patient when performing a bed-side x-ray. Staff reported good working relationships with the local NHS mental health trust who provided adult, child and adolescent mental health services.

The multidisciplinary team worked effectively together following a cardiac arrest within the department. The resuscitation officer for the trust attended promptly to support the team as needed. The emergency was dealt with expertly and calmly. We also observed the multidisciplinary team manage a trauma alert within the resus area. Personnel present included the ED consultant, resuscitation officer, anaesthetist, surgeon, nurse and orthopaedic specialist. Members of the team all introduced themselves before the ambulance arrived with the patient, to ensure everyone knew who was who and their role. The consultant effectively led the team and ensured the ambulance handover was listened to by all the hospital team. Patients who were acutely unwell with frailty were assessed by clinicians who were competent to identify the most appropriate care pathway. For example, there was clear criteria for referring patients into the frailty service. The criteria were based on the Rockwood clinical frailty scale.

Physiotherapists and occupational therapists assessed patients in the clinical decision unit. We spoke with a physiotherapist who told us they felt appreciated by the emergency department staff and described working relationships as positive and professional. We spoke with two porters who told us they enjoyed working with ED staff and regularly asked if they needed any equipment moving out of hours due to pressures in the ED. Senior managers in the department confirmed this. Ambulance staff we spoke with reported positive and effective working with ED staff, which we saw during our inspection. They said that there had been a reduction in the number of long waits for them to hand over patients to staff in the department. This was an improvement from our previous inspection in 2017, when there continued to be long waits. During our inspection, we attended the trust’s bed management meeting. These meetings took place four times a day and was where members from the trust-wide senior management team liaised with leads from the emergency department and the wards to review current activity. We saw that the team worked together to help improve the patient flow in the ED.

**Seven-day services**

Both the adult and children’s ED were operational 24 hours a day, seven days a week.

Seven-day medical cover was provided with the minimum of resident middle-grade doctors. Dedicated consultant presence in the main ED was from 8am to midnight, with on-call
arrangements out of hours. This was in line with national recommendations (*RCEM Emergency Medicine Consultants Workforce Recommendations, April 2010*).

Radiology services operated seven days per week and offered computerised tomography (CT) scanning, plain imaging services, magnetic resonance imaging (MRI) and ultrasound. On-call services were available for emergencies when needed. Pathology services were available 24 hours a day, seven days a week. The department used pathology forms specific to the ED and acute assessment units, which indicated to pathology staff that these samples should be processed without delay. Staff confirmed that blood test results were usually available within one hour, where appropriate. The rapid assessment, interface and discharge (RAID) team were available 24 hours a day, seven days a week for adult patients with mental health concerns. Children were referred to the children’s crisis assessment and treatment team (CCATT) between the hours of 9am and 9pm. Outside of these hours, the RAID team were available to assess children and young people and they had access to the on-call children and adolescent mental health service (CAMHS). The ED had access to an emergency and trauma theatre as per national guidance, 24 hours a day, seven days a week. The frailty service was available from 8am to 6pm, Monday to Friday. A geriatrician (consultant who specialises in care of the elderly) was available for advice and review 24 hours a day, seven days a week.

**Health promotion**

*Patients who used urgent and emergency care services were supported to live healthier lives and manage their own health, care and wellbeing.*

National priorities to improve the population’s health were supported within the department. For example, there were posters and information about infection prevention, hand-washing and avoiding the common cold. Information was displayed about microbial resistance and how to prevent resistance to antibiotics. Display boards in the children’s ED were regularly updated with relevant seasonal information. For example, in the summer they displayed information about keeping children safe in the sun and advice about safety when playing in water. Staff took the opportunity, if it arose and was appropriate, to discuss smoking cessation, weight reduction, and drug and alcohol misuse with patients. Staff could refer patients with any substance misuse concerns to ‘Spectrum’. This was an integrated misuse service, who provided psychosocial interventions such as counselling and cognitive behaviour therapy, alongside clinical interventions such as substitute prescribing and detox. They supported patients to detox at home, wherever possible.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

*Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.*

The trust had up-to-date policies regarding consent and the Mental Capacity Act 2005. Staff could access these via the trust intranet. Staff were able to describe the relevant consent and decision-making requirements relating to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS) and gave us examples of where they had applied them in order to protect patients’ best interests. Staff in the children’s ED had a sound working knowledge of the guidance for gaining consent from a child. They were aware of the legal guidelines that meant children under the age of 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so (Gillick competency). If not appropriate, consent would be sought from the child’s parent or guardian. Patients’ consent was obtained in line with trust policy and statutory requirements. We saw staff gaining verbal consent from patients’ before they undertook
interventions, such as clinical observations and blood tests. Staff reported that restraint was not used in the department and that physical violence was uncommon. If physical violence occurred, security and/or the police would be contacted.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion

Clinical staff were required to complete Mental Capacity Act and Deprivation of Liberty Safeguards training every three years. As of October 2018, 91% of eligible staff in the children's ED and 89% of staff in the main ED had completed MCA and DoLS training. The trust target was 90% (Source: Additional Data Requests DR110). Staff we spoke with confirmed they had received MCA and DoLS training.

Is the service caring?

Compassionate care

Staff cared for patients with compassion, kindness and respect. Feedback from patients and those close to them was positive about the way staff treated them. Patients felt supported and cared for by staff.

Patients’ told us they felt their privacy and dignity was respected. We saw staff asking for patients’ consent prior to entering their cubicle area, and we saw curtains were drawn in cubicles and doors to side rooms were closed when care and treatment was taking place.

Staff interacted with patients and their relatives in a polite, friendly and respectful manner. Staff introduced themselves to patients and made them aware of their roles and responsibilities. We spoke with 11 patients and five family members during our inspection. All spoke positively about the care they had received and praised staff for being caring, reassuring and respectful. We read one letter from a relative that said, “I write to let you know how impressed, pleased and thoroughly thankful I am to all the nurses, doctors, reception staff, everyone who we crossed paths with yesterday when I brought my mother to A&E. Staff were friendly, warm and welcoming and my mother and I could not have asked for any better service”. We read another letter that was sent in September 2018, which said; “The A&E team were professional, friendly and caring, treating [my husband] with such dignity, doing everything possible for the best outcome – absolutely faultless. They also showed me and my family such patience, gentleness and guidance throughout. They made the worst possible situation, at the worst time in somebody’s life as easy as they could”.

Staff displayed an understanding and non-judgemental attitude towards, or when talking about, patients in vulnerable circumstances, such as those with mental health concerns, learning disabilities and dementia diagnoses. We read one compliment from a patient thanking staff for, “the support given over the years getting detoxed from drink and drugs, am now on a 12-step program of recovery”. Staff confirmed that when they assessed patients’ needs they considered personal, cultural, social and religious needs. Patients we spoke with and patient records we reviewed corroborated this. Staff in the children’s ED interacted and treated children, young people and parents in a friendly, caring and compassionate manner at all times, and did all they could to make children and young people feel safe and comfortable in the hospital environment. We observed nurses prepare equipment required for administering medicines by injection and wound dressings out of sight of children. A nurse told us they felt this decreased children’s anxieties.

Friends and Family test performance

The service obtained patient feedback via the Friends and Family Test (FFT), which allowed patients to give feedback on their experience of emergency care provision and state whether they
would recommend the service to others. From July 2017 to June 2018, the trust’s urgent and emergency care FFT performance (% recommended) was better than the England average. A comparison of FFT performance for the trust and the England average from July 2017 to June 2018 is shown below.

**A&E Friends and Family Test performance - West Hertfordshire Hospitals NHS Trust**

![FFT Data Chart]

(Source: NHS England Friends and Family Test)

FFT data is also available at hospital site level and from September 2017 to August 2018, the FFT performance (% recommended) for Watford General Hospital was again generally better than the England average. The hospital’s average FFT performance for the 12-month period was 90%, while the England average was 86%.

**Emotional support**

Staff provided emotional support to patients to minimise their distress. Patient’s emotional and social needs were seen as being as important as their physical needs.

Staff gave emotional support to patients and their families. They gave open and honest answers to questions and provided as much reassurance as possible. Nursing staff were aware when patients required time to talk with them and they went out of their way to provide this. Parents of children were regularly provided with reassurance. Staff acknowledged that parents were worried about their child and that they needed emotional support as well. One parent wrote, “Having to put your trust in a stranger to look after your baby is such a hard thing to do, but [the nurse’s] care, knowledge and experience shone through”. Another parent wrote, “Everyone was simply amazing, there is no other word for it, and I am grateful to all of them”. Staff could direct patients, relatives and carers to services that provided counselling and support for people living with chronic conditions as needed. For example, clinical nurse specialists for patients living with a diagnosis of dementia would attend the department at the request of staff. Adults, children and young people who were experiencing mental or emotional distress had access to care, support and treatment from the rapid assessment, interface and discharge (RAID) team, the children’s crisis assessment and treatment team (CCATT) and the child and adolescent mental health service (CAMHS). Staff could also refer young people to a new community based service called ‘Supporting You’. This was set up to offer cognitive behavioural therapy to young people experiencing some emotional difficulties but who did not meet the criteria for mental health services.

**Bereavement policies and pathways were in place to support the relatives of patients who passed away in the department.** We found the bereavement care and support provided by the
children’s ED was outstanding. **Staff were especially caring and responsive to parents who suffered the loss of a child or young person. They were committed to continually improving the care and services they provided for bereaved parents.** Parents and relatives who suffered the loss of a child were supported by staff and the bereavement team. Staff in the children’s ED showed a clear understanding of how to support families and carers after the loss of a child and could explain the process. Children’s ED nurses were able to provide examples of how they had supported families. For example, accompanying them to the mortuary instead of using a member of staff that the parents were not familiar with.

Staff who had been involved in distressing cases gave examples of how they were supported by their colleagues and managers. For example, immediate debriefs were provided and ambulance staff were also encouraged to stay. Time away from their clinical duties was offered along with refreshments. They were also invited to the formal debrief four to six weeks after the incident had taken place. A senior nurse told us their wellbeing had been followed up with a call whilst they were at home. Relatives’ rooms were available in the main ED and children’s ED. Staff said they took distressed relatives to these rooms in order to provide a private environment where they could talk openly and give emotional support. We were told the service had recently secured funding to refurbish their relatives’ rooms. They were also creating a viewing room as part of the building works planned within the department. The children’s ED was supported by volunteers, who were available to provide practical and emotional support to patients and their carers. The trust had a chaplaincy service, which provided spiritual care and religious support for patients and relatives as needed. Multi-faith options were available. The chaplains were available to respond quickly to the department to support patients who were dying or those close to a patient who had passed away in the department. They were available 24 hours a day, seven days a week.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them in decisions about their care and treatment.**

All of the patients and relatives we spoke with felt involved in their care and had received the information they needed to understand their treatment and enable them to make informed decisions about their care. Staff explained planned care and treatment with patients. Patients told us they did not feel rushed when they were speaking to the doctors and nurses and they could ask questions if they were unsure about the information given. We read one letter from a patient that said, “They contacted my daughter [overseas] and kept her informed of my diagnosis and treatment. I cannot stress enough how well I was treated. My daughter was also given direct numbers to be able to contact me. She found staff sincere and they calmed her down, giving her the necessary information she needed. She knew I was in good hands from the very first conversation…Please pass on my total respect and appreciation for their utmost care”. Staff modified their language, tone and pace of speech to communicate with patients and those close to them, so they understood their care and treatment. Staff in the children’s ED used language appropriate to the age of the child and their level of understanding. One parent wrote, “All staff spoke to my son as if he was the most important person”. Children and their parents were given the opportunity to speak with staff, to ask questions and were kept informed about what was happening regularly. We saw that staff spoke directly to the child, wherever possible, and ensured they understood what was happening and encouraged them to ask questions.

**CQC Emergency Department Survey 2016**

People aged 16 years and older who attended an emergency department in September 2016, were invited to share their experience of the care and treatment they received in the CQC Emergency Department Survey for 2016. The survey involved 137 acute and specialist NHS trusts...
and consisted of 35 questions, which covered areas such as waiting times, doctors and nurses, tests, hospital environment and facilities, and overall experience. Each question was scored out of 10 (the higher the score the better). Each trust also received a rating, which showed whether their performance was ‘better’, ‘about the same’ or ‘worse’ than most other trusts that took part in the survey. The trust performed ‘worse’ than other trusts for one question in the CQC Emergency Department Survey 2016 relevant to the caring domain.

The trust performed similar to other trusts for all other questions in the CQC Emergency Department Survey 2016 relevant to the caring domain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Question | Trust 2016 | 2016 RAG
---|---|---
Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand? | 8.8 | About the same as other trusts
Q39. Did a member of staff tell you about medication side effects to watch out for? | 5.5 | About the same as other trusts
Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car? | 5.3 | About the same as other trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department? | 4.4 | About the same as other trusts
Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home? | 5.6 | About the same as other trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department? | 7.1 | About the same as other trusts
Q45. Overall... (please circle a number) | 7.6 | About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust was undertaking work to develop the local services. They planned and provided services in a way that generally met the needs of local people. However, signage in the emergency department was not always clear to patients and visitors. Waiting times displayed were not always up to date. The service was taking action to address this, with the installation of a television in the main reception area.

During our inspection, waiting times that were displayed in the streaming window and at the main reception desk were not always accurate or kept up to date on a regular basis. This was not in line with Royal College of Emergency Medicine (RCEM) standards (RCEM Best Practice Guideline: Emergency Department Care, quality standard 5 (July 2017)). This meant that some patients waiting were not always kept informed of delays in the department. However, patients who self-presented were often informed verbally of up to date delays when they registered at the reception desk. The streaming nurse was also able to provide waiting times of the trust’s minor injuries unit and urgent treatment centre to patients who were safe to travel and would be seen quicker at a more appropriate location. Most patients told us they had been kept informed of waiting times. The service planned to install a television in the waiting area that would display current waiting times in the department, as well as other information such as the patients’ pathway through the department and health promotion advice. Patients and visitors had access to the trust’s Wi-Fi, which meant they could keep in touch with their friends and family while in hospital (RCEM Best Practice Guideline: Emergency Department Care, quality standard 5 (July 2017)).

Signage on the hospital site directing patients to the emergency department was clear. However, signage in the department was observed to be unclear. Patients and visitors often asked staff members where to go and how they could access inpatient areas via the ED.

Planning for service delivery was made in collaboration with internal departments, external providers, commissioners and local authorities to meet the needs of local people. A new winter
plan had been developed, which described how the trust would ensure safe patient flow through the ED and hospital during the winter months when there was usually peak demand. This included the increased number of majors’ assessment cubicles. During our unannounced inspection, we saw building work had commenced to use what had historically been the children’s observation bay and clinical decision unit. Another example of forward planning for winter was the relocation of the ambulatory care unit. This would allow for an increase in inpatient side rooms and was aimed at ensuring patients did not spend longer than required in ED due to waiting for an inpatient bed.

Since 1 October 2018, the trust had introduced a GP service. This service was available in the ED from 10.30am to 8.30pm, seven days a week. Patients attending the ED with conditions more suited to assessment and treatment in a primary care setting could be seen by a GP, thereby reducing demand on the main ED. This was in line with national guidance (NHS Improvement Good practice guide: Focus on improving patient flow, July 2017).

Facilities were mostly appropriate to the needs of patients. The service was compliant with some of the RCEM quality standards (QS) (RCEM Best Practice Guideline: Emergency Department Care, July 2017). The department was clean and well-lit and was generally in good order (QS1, QS3). There was mostly adequate space and seating for patients and relatives in the reception and waiting areas (QS5, QS6). Reading materials were available. During busy periods when the waiting area was full and there was no seating available, staff told us patients were able to wait in the fracture clinic reception area where appropriate. However, we found there were no seats suitable for patients or visitors with reduced mobility, such as chairs with a higher seat and with arms to make sitting and rising from a chair easier. There was a separate dedicated psychiatric assessment room within the majors’ area (QS8). The department did not meet RCEM QS7, which recommends that a message such as, “You are in the emergency department at Watford Hospital” is displayed on the ceiling for recumbent patients in the resus area. The children’s ED and children’s observation area had a wide range of age appropriate toys, games, television and books for children and young people to occupy and distract themselves with while in the department.

The trust had developed and continued to work on admission avoidance provision. Since our inspection in 2017, ‘hot clinics’ had been established in a range of specialities such as respiratory, cardiology and dermatology. Patients who did not require admission but needed follow-up care were referred to a hot clinic where they were seen by a specialist either the same day or generally within 72 hours. From April to September 2018, 191 patients had been referred to hot clinics from the ED (Source: Additional Data Requests DR107). There was also an ambulatory care unit (ACU) open 12 hours a day, seven days a week. There were plans to increase this to 14 hours a day in line with national guidance. Staff in ED were familiar with the types of patients that were suitable for admission to the ACU. The consultants in the ACU were supportive of the ED and told us they often reviewed patients who were suitable for ambulatory care but did not have a clear pathway assigned. The frailty service worked closely with the ED team. This met the needs of the older, frail, vulnerable population. They would be holistically assessed by a multidisciplinary team of physiotherapists, occupational therapists and a specialist frailty consultant. A plan of care and decision was made to either admit the patient or discharge home with social input, or to another community service.

The trust worked collaboratively with the local NHS mental health trust, which provided the rapid assessment, intervention and discharge (RAID) team and the children’s crisis assessment and treatment team (CCATT). The RAID team were available 24 hours a day, seven days a week to meet the needs of patients with mental health concerns. The CCATT were available from 9am to 9pm. Outside of these hours, RAID assessed children and had access to the on-call children and adolescent mental health service (CAMHS).
Meeting people’s individual needs

The service generally took account of patients’ individual needs. Patient confidentiality was not always protected due to the layout of the main reception area and location of the streaming window.

Patient confidentiality was not always protected due to the layout of the main reception area and location of the streaming desk. We observed that patients attending the streaming nurse could be overheard by others waiting to be seen. There were notices asking queuing patients to wait behind the line, to try and reduce conversations being overheard. We raised this concern during our inspection and were told the service was taking action to address this, with the provision of privacy screens or hoods. However, during our second unannounced inspection, we found that no action had been taken. Senior staff told us that the estates’ department were looking at ways in which patients’ privacy could be improved but they were restricted due to the physical layout and limited space within the department.

Staff had received training in the care of patients with a learning disability, mental health concerns and dementia. They were able to speak confidently about the differing needs of these patients and prioritised their care where possible. Adjustments were made for patients who attended with complex needs and these patients were prioritised. Children who presented with learning disabilities or regularly accessed the service due to a long-term condition were provided with health passports. The passports had recently been implemented and included an overview of the child’s medical history and social and emotional needs. This meant staff could meet patients’ needs immediately and that parents or carers did not have to repeat their circumstances. Other adjustments included giving children the choice in where they were cared for in the department and accessing the play specialist when required.

Frailty was identified and measured on arrival in the STARR (senior team assessment and rapid response) area. Staff used the Rockwood clinical frailty scale. We saw guidance on assessing frailty displayed throughout the department. Nurses were clear on how and when to refer a patient to the frailty team. Staff wore badges with their first name clearly displayed in large font against a yellow background. This made the name badges easier for visually impaired patients, visitors and staff and promoted open communication across all levels of staff. This initiative was developed by the ED team and had subsequently been rolled out across the trust.

There was a bereavement file in the main and children’s ED that contained information and advice regarding what steps and arrangements to take following a death. In the children’s ED, a nurse with a keen interest in bereavement had developed and collated many resources for parents and carers following the death of a child. This included clothing items for when it was necessary to cut a child’s clothing. There were keepsake boxes that had been donated to the trust. The boxes contained hand and foot print equipment, poetry, cuddly toys and keepsake storage for hairlocks and ID wristbands. Patients and families who attended the children’s ED were provided with practical and emotional support by two volunteer groups, known as the ‘Empathy Project’ and the ‘Carer Support Team’. The Empathy Project was launched in October 2017 and provided practical and emotional support to patients in the ED by volunteers aged between 16 and 21 years of age, ensuring they had a clearer idea of the range of support and activities available to them in their community. The Carer Support Team was set up in 2014 by a mother who spent a lot of time in hospital with her own children. They provided practical and emotional support to parents and carers, such as information about the hospital, or offered to sit with the child if a parent or carer needed a break. Both groups had been shortlisted for categories in the Helpforce Champions National Awards for volunteers.
There was wheelchair access to all parts of the department and the reception desk had a hearing loop for those with hearing difficulties. Access to the department had improved since our last inspection. For example, work had been completed to widen doors. The service employed a number of staff who had the ability to speak other languages. The service utilised their language skills to speak with patients for whom English was not their first language where appropriate. If the language needs of the patient could not be met by staff, interpreter services were available. These were provided face-to-face or via a dedicated telephone translation service. There was a range of leaflets relating to illnesses and injury advice in the main and children’s emergency departments, such as road traffic collision, pain relief and head injury. These could be printed in other languages if needed.

There was a clinical decision unit (CDU) to allow periods of observation, investigation and treatment prior to discharge. This was led by a consultant, which was in line with NHS Improvement guidance. Patients who were identified with a medical or surgical need were reviewed by the appropriate teams. There was also a children’s observation bay for the same purpose. At the time of our second unannounced inspection (November 2018), the children’s observation bay was temporarily closed due to building works being carried out. Children who required ongoing observations were being cared for in the children’s ED or children’s ward.

CQC Emergency Department Survey 2016

The trust performed about the same as other trusts for all three CQC Emergency Department Survey questions relevant to the responsive key question.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Access and flow

Not all patients could access the service promptly when they needed it. Waiting times to be seen for treatment were generally higher (worse) than the England average. More patients waited longer than four hours for a decision to admit, treat or discharge than the England average. However, the number of patients who left the department without being seen was lower (better) than the England average. Performance in the children’s ED was consistently close to and at times did meet the national four-hour standard. Staff were working collaboratively with other hospital departments to improve patient flow in the ED.

Median time from arrival to treatment (all patients)

RCEM recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for five months over the 12-month period from July 2017 to June 2018. From April 2017 to June 2018, the trust’s performance was higher (worse) than the national trend and standard. In the latest month June 2018, the median time to treatment was 71 minutes compared to the England average of 62 minutes.

Median time from arrival to treatment from July 2017 to June 2018 at West Hertfordshire Hospitals NHS Trust
Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From August 2017 to July 2018, the trust failed to meet the standard and performed worse than the England average. This was similar to what we found at our last inspection in 2017, when we reported that between June 2016 and May 2017 the percentage of patients in the department for more than four hours was consistently higher than the national average.

Four-hour target performance - West Hertfordshire Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)

Percentage of patients waiting more than four hours from the decision to admit until being admitted

(Source: NHS England - A&E Waiting times)

From April to September 2018, an average 91% of patients who attended the children’s ED were admitted, transferred or discharged within four hours. The service met the national target of 95% in August 2018 (Source: Additional Data Requests DR108).

From April to September 2018, an average 92% of patients seen in the minors’ area were admitted, transferred or discharged within four hours. This area met the national target of 95% in April and May 2018 (Source: Trust Board Papers, Integrated Performance Report).

Percentage of patients waiting more than four hours from the decision to admit until being admitted
From August 2017 to July 2018, the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average. This was similar to what we found at our previous inspection in 2017. However, as can be seen from the graph below, the service’s performance had significantly improved since April 2018 and was more in line with the England average.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - West Hertfordshire Hospitals NHS Trust

![Graph showing percentage of patients waiting more than four hours from the decision to admit until being admitted](image)

(Source: NHS England - A&E SitReps)

Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from August 2017 to July 2018, no patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over four hours were in January 2018 (1,450), February 2018 (1,375) and March 2018 (1,300).

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>731</td>
<td>0</td>
</tr>
<tr>
<td>September 2017</td>
<td>816</td>
<td>0</td>
</tr>
<tr>
<td>October 2017</td>
<td>742</td>
<td>0</td>
</tr>
<tr>
<td>November 2017</td>
<td>668</td>
<td>0</td>
</tr>
<tr>
<td>December 2017</td>
<td>1,026</td>
<td>0</td>
</tr>
<tr>
<td>January 2018</td>
<td>1,450</td>
<td>0</td>
</tr>
<tr>
<td>February 2018</td>
<td>1,375</td>
<td>0</td>
</tr>
<tr>
<td>March 2018</td>
<td>1,300</td>
<td>0</td>
</tr>
<tr>
<td>April 2018</td>
<td>389</td>
<td>0</td>
</tr>
<tr>
<td>May 2018</td>
<td>602</td>
<td>0</td>
</tr>
<tr>
<td>June 2018</td>
<td>444</td>
<td>0</td>
</tr>
<tr>
<td>July 2018</td>
<td>554</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment
From April 2017 to June 2018, the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was generally lower (better) than the England average. In the latest month June 2018, the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 0%, compared to the England average of 2.4%. This was an improvement from our previous inspection in 2017, when we found between April 2016 and March 2017 the percentage of patients who left the service before being seen was worse than the England average.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - West Hertfordshire Hospitals NHS Trust

![Graph showing percentage of patients leaving urgent and emergency care services before being seen](image)

(Source: NHS Digital - A&E quality indicators)

Median total time in the emergency department per patient (all patients)

From July 2017 to June 2018, the trust’s monthly median total time in the emergency department for all patients was generally in line with the England average. In the latest month June 2018, the trust’s monthly median total time in the emergency department for all patients was 150 minutes compared to the England average of 148 minutes. This was similar to what we found at our previous inspection in 2017.

Median total time in A&E per patient - West Hertfordshire Hospitals NHS Trust

![Graph showing median total time in A&E per patient](image)

(Source: NHS Digital - A&E quality indicators)

Staff had access to the RAID mental health liaison team 24 hours a day, seven days a week. The RAID team standard was to review all mental health patients within one hour of referral. Data showed that from April to September 2018, 97.3% of patients on average were seen within one hour (Source: Additional Data Requests DR143). However, staff we spoke with told us that patients’ who needed admitting to a mental health provider often had to wait in the ED until a bed
could be found. We were also told that patients’ who needed a mental health act assessment sometimes had to wait up to 17 hours for this to take place. This was because of ongoing difficulties with accessing a second psychiatrist.

ED staff could bleep the duty psychiatrist if an urgent mental health assessment was required. While performance in terms of national indicators had not generally improved since our previous inspection in 2017, we found actions were being taken to improve performance and patient flow. Staff we spoke with told us that the issues with capacity and patient flow in the department were now seen as a hospital-wide concern, and staff from all areas were now working together to improve ED performance and the patient experience. We saw evidence of a hospital-wide approach in the minutes of patient flow transformation meetings we reviewed (Source: Additional Data Requests DR122). The shared responsibility of patient flow was an improvement since our previous inspection.

The senior managers in the ED were knowledgeable about the flow through the department and identified areas where access and flow required improvements. They were also knowledgeable about where the surge areas were each day and the pressures on capacity and flow within the wider hospital, particularly admission areas. The divisional management team provided examples of when they had used the Royal College of Emergency Medicine (RCEM) Emergency Department Care (2017) guidance to improve flow through the department. There was a monthly patient flow transformation group meeting and RCEM guidance was referred to prior to trialling or implementing new ideas to improve flow. There were systems in place to manage the flow of patients through the ED to discharge or admission to the hospital. The clinical site team had oversight of the length of time patients had been in the ED, who had breached the four-hour performance target and who required admission. The system enabled the clinical site team to have an overview of bed availability and the demands within the ED. Patient activity and capacity in the ED was discussed at bed meetings, which were held four times a day and plans were made to accommodate patients’ needs.

The service worked well with the bed management team. We observed a bed management meeting during our inspection and saw the requirements of the ED such as patients waiting for medical or surgical beds, was discussed and plans were agreed in a timely manner to support flow through the department and into the inpatient areas. For example, consultants carried out earlier ward rounds so that medically fit patients could be discharged promptly to release beds for patients waiting admission. Patients waiting for an inpatient bed in the ED were managed using an electronic system. Once a plan of care had been agreed for a patient, they were allocated to the most appropriate specialty to enable them to be reviewed by the relevant team of doctors. A bed was requested electronically, and the bed management team allocated the most appropriate bed when one became available. All patients in the clinical decision unit had been allocated to the surgery or medical teams when they had been in the clinical decision unit for over 24 hours. Patients who were waiting for admission to the hospital were managed appropriately in the ED. Medication was prescribed and administered, risk assessments were carried out, observations were completed, and food and drink was provided.

Since our inspection in 2017, a performance manager role had been created to help manage patient flow in the department. The aim of this role was to ensure patients were seen, assessed, treated and admitted or discharged in a timely manner, while ensuring they received appropriate, effective and high-quality care. This role was undertaken by a senior ED nurse. They maintained oversight of patients in the department and worked collaboratively with staff in the ED and other hospital departments to ensure patient flow was prioritised where needed (Source: Additional Data Requests DR124). The role of site practitioners had also been introduced since our last inspection.
They worked collaboratively with the site management team at nights and weekends. Part of their role was to support patient flow in the ED out of hours, by liaising and constructively challenging other departments in the hospital when patients breached wait times due to lack of available beds or long waits for specialty review. A new administrative post was being recruited to at the time of our inspection to manage and update the electronic live bed-state system to support flow. They would report directly to the performance manager. Staff were in favour of this as it would allow nursing staff to focus on their clinical duties (Source: Additional Data Requests DR82).

Patients were electronically tracked from admission to discharge or transfer. Staff had constant oversight of activity in the emergency department via an electronic system. This was live data and included the number of attendances, four-hour breaches, current trust performance against the four-hour national standard and the number of patients waiting for a bed.

The children’s ED worked proactively with the children’s ward to ensure patients who required hospital admission were admitted in a timely manner wherever possible. The paediatric emergency medicine consultants could admit patients directly to the children’s ward, which promoted effective patient flow. A new children’s observation bay was in use at the time of our inspection and was located just outside of the ED footprint. This facility meant that children with acute illness or injury could be assessed, investigated, observed and treated with an expectation of discharge in less than 24 hours.

Patients with the most urgent needs were prioritised. There was a clear process in place for streaming staff to assess patients’ suitability to be transferred to a chair to await treatment. For example, patients who arrived by ambulance but were in a wheelchair were not immediately triaged in the STARR area. They were directed to the streaming nurse who would assess their suitability and transfer them to a chair if appropriate. This was in line with the NHS Improvement Good Practice Guide: Focus on improving patient flow (2017) “fit to sit” assessment recommendations. At times of overcrowding, which is when ambulance crews cannot offload patients into the majors’ area, the corridor was used to accommodate patients. A maximum of 12 patients could be offloaded to the corridor, with two registered nurses and two healthcare assistants assigned to look after them. During our first visit, we did not observe any patients being cared for in the corridor. When we returned on our second visit, we observed three patients being cared for in the corridor. We saw the appropriate number of nursing and support staff had been allocated to look after these patients.

Senior staff told us that patients who were clinically stable and had been referred by a GP were not always able to access the surgical or medical assessment units within 30 minutes of arrival. This was due to the areas being used as surge areas for inpatients because of the demand for beds within the hospital. This meant that patients referred by their GP often remained in the emergency department for their medical or surgical review.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. However, some complaints were not always dealt with in a timely manner.

At our previous inspection in 2017, we found the trust took an average of 71 working days to investigate and close complaints. At this inspection, we found the average response time had improved to an average of 44 days. However, this still exceeded the trust target.

**Summary of complaints**
From April 2017 to March 2018, there were 192 complaints about urgent and emergency services at the trust, the majority of which were in relation to Watford General Hospital (92%). The trust took an average of 44 days to investigate and close complaints. This was not in line with their complaints policy, which stated that complaints should be completed within 30 working days, or 40 working days if the complaint was complex.

The site level breakdown is below:

- Hemel Hempstead General Hospital; 10 complaints.
- St Albans City Hospital; five complaints.
- Watford General Hospital; 177 complaints.

(Source: Routine Provider Information Request (RPIR) – Complaints tab).

The majority of complaints received were about patient care (46%), which involved poor care and communication from staff. The table below outlines the complaints received by theme:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>88</td>
<td>45.8%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>27</td>
<td>14.1%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>24</td>
<td>12.5%</td>
</tr>
<tr>
<td>Communications</td>
<td>22</td>
<td>11.5%</td>
</tr>
<tr>
<td>Appointments</td>
<td>11</td>
<td>5.7%</td>
</tr>
<tr>
<td>Other (specify in comments)</td>
<td>9</td>
<td>4.7%</td>
</tr>
<tr>
<td>Transport (ambulances)</td>
<td>5</td>
<td>2.6%</td>
</tr>
<tr>
<td>End of life care</td>
<td>4</td>
<td>2.1%</td>
</tr>
<tr>
<td>Admin/policies/procedures (including patient record)</td>
<td>2</td>
<td>1.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>192</strong></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR))

The service had processes in place to ensure complaints were dealt with effectively, including prompt acknowledgement of the complaint, a written response to the complaint and whether any changes had been made as a result of the concerns raised. Face-to-face meetings were also offered, where needed. The clinical lead for emergency medicine was able to describe the complaints process clearly. They were responsible for allocating a clinician to investigate each complaint.

Staff were aware of the complaints process and told us that where possible, informal complaints were resolved immediately. If issues could not be resolved informally, patients and/or those close to them were supported to make a formal complaint. Learning from complaints and feedback was shared with staff through a variety of means such as newsletters, the daily safety huddle, team meetings, closed social media forums, and noticeboards. Staff confirmed they received feedback on complaints.

Action was taken in response to complaints received, in order to improve patient experience and care provision. This was an improvement since our last inspection when we were not assured the service was learning from complaints. For example, plans to install a television in the waiting room with information regarding patient wait times was in response to a complaint received. At the time of inspection, the television had been ordered and the service was waiting for it to be delivered and installed. The safety checklist was also introduced in response to a complaint received.
Information was displayed in the emergency departments explaining how patients could raise concerns or complaints. Leaflets were available for patients and those close to them, and details of how to make a complaint was also published on the trust’s website. Patients and parents were signposted to the trust’s patient advice and liaison service (PALS). PALS provided advice and support to patients (and those close to them) who wished to raise a concern or complaint.

Number of compliments made to the trust

From April 2017 to March 2018, there were 32 compliments received for urgent and emergency services at Watford General Hospital. Common themes from the compliments we read were in relation to the positive behaviours and attitude of staff.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

The urgent and emergency care service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Staff spoke positively about the senior management team and department managers, and felt well supported.

At our inspection in 2017, we raised concerns regarding the leadership of the service. We found the directorate leadership to be dysfunctional. This was caused by differences in opinions between the leaders within the service. At this inspection, we found improvements had been made.

The main emergency department (ED) was previously managed as part of the trust’s unscheduled care division. In December 2017, the trust created the directorate of emergency medicine to enable a greater focus on the first 24-hours of patients’ time in the hospital. The directorate was responsible for the main ED, acute admissions unit, medical assessment unit, ambulatory care, operations and resuscitation, as well as the urgent treatment centre at Hemel Hempstead Hospital and minor injuries unit at St Albans City Hospital. There was a clear management structure with defining lines of responsibility and accountability. The leadership structure included a director of emergency medicine, director of operations, directorate manager, head of nursing for elective and emergency medicine and lead nurse for emergency medicine. The children’s ED remained under the women’s and children’s division. The leadership structure included a divisional director, divisional manager and head of nursing. Both senior leadership teams were supported by clinical leads, lead nurses, matrons, ward managers, specialist nurses and governance facilitators.

During our previous inspection, it was reported that the nursing leadership role was vast and stretched. This was because it covered urgent and emergency care services at Watford, Hemel and St Albans. We found that the trust had acted to implement clinical middle management roles, which ensured the lead nurse was supported across the three sites. While urgent and emergency care services for adults and children came under different directorate/divisional leadership teams, they worked closely together as a team to deliver safe, effective and quality care, which we observed during our inspection. This was an improvement since our last inspection. For example, we saw senior staff from the children’s ED attend a cardiac arrest call in the main ED to see if there was anything they could do to help support the department. The consultants within the children’s ED reported to the clinical lead for the main ED. All staff spoke positively about the new directorate structure and felt that leadership in the ED had improved. The director of emergency medicine had direct access to the trust board. Senior staff told us the change in structure and leadership had enabled them a seat at the board table, which they did not feel they had before.
The local leadership team for the main ED consisted of the director for emergency medicine who was previously the clinical lead, a clinical lead, who was a consultant in emergency medicine, and a lead nurse for emergency medicine. The director, clinical lead and lead nurse were highly visible in the department and often worked clinically to maintain their skills and support their staff. They demonstrated the skills, knowledge, integrity and experience needed for their responsibilities. We found they were enthusiastic and passionate about their roles, the department and their staff, and were focused on delivering high-quality person-centred care. The senior leadership team were knowledgeable about the issues and priorities for the quality and sustainability of services. They understood what the challenges were and were taking action to address them, such as improving patient flow and performance. For example, since our previous inspection in 2017, site practitioners had been employed to support patient flow within the ED out of hours. This was a senior role (band eight), which worked collaboratively with the site management team. They maintained oversight of activity and performance within ED, and worked proactively with other departments to minimise patient waits and breaches.

The adult and children’s emergency departments were co-ordinated by experienced senior nursing staff who, wherever possible, were supernumerary to the staffing numbers so they could maintain oversight of activity and acuity within each department, and support staff as needed. There were consultant leads for sepsis and mental health. The service had also appointed a consultant lead for medical recruitment and retention, as part of the service’s ongoing commitment to fill staffing vacancies and foster a stable workforce.

The trust provided development programmes for staff that supported them to develop leadership and management skills, which staff we spoke with corroborated. National and local delivered courses were available to all staff, whether they were new to a managerial role, an experienced manager or were interested in further development. For example, the trust’s management skills programme consisted of modules specifically targeted at staff who were new to supervising or managing a team. Topics covered included recruitment and selection, appraisal, planning, leading and implementing change, and enhancing quality. Senior staff told us they were also looking at developing a bespoke leadership course for ED staff. All staff we spoke with were overwhelmingly positive about the senior management team and local managers. They told us they were very visible, approachable and they felt well supported. We observed this during our inspection. Staff were confident to raise any concerns they had.

**Vision and strategy**

*The service had a vision for what it wanted to achieve and workable plans to turn it into action. The vision and strategy were developed with involvement from staff and key groups representing the local community.*

The service had a clear vision and values, which were focused on providing safe, high quality, sustainable care for all. The trust vision was to provide; “The very best care for every patient, every day”. The service had developed a mission statement that was aligned to the trust’s vision, which was; “Right person, right place, first time, every time”. Staff confirmed they were involved in developing the service’s mission statement.

The values for the service were consistent with the trust’s, which were:

- Commitment.
- Care.
- Quality.
The values had been created with the help of patients and set out the standards by which patients, their partners, family and friends, should expect from all staff. The appraisal process incorporated the trust’s values, whereby each member of staff had to evidence how they demonstrated the values at work. We saw the trust’s vision and values publicly displayed in the ED.

The vision, mission and aims of the service were part of the emergency medicine strategy plan 2018 to 2020, which was in draft form at the time of our inspection. The priorities for the service were aligned to the trust’s strategic objectives. These were:

- Excellent high-quality care 24/7.
- Streaming to the right pathway.
- Rapid initial assessment.
- Supporting and developing the workforce.

The strategy outlined the service’s performance, workforce, quality and environmental priorities. These included: delivering the four-hour performance standard; streaming to appropriate pathways; ambulance offload within 15 minutes; delivering the career development programme; providing a safe environment for patients with mental health issues; ensuring suitable services for patients with dementia, learning difficulties and complex needs, and; providing a fit for purpose, clean and safe environment (Source: Additional Data Requests DR101). The strategy included the children’s ED, and all other departments involved in the first 24-hours of a patient’s journey. This was an improvement from our previous inspection, when we found there was a lack of integrated vision and strategy between the two divisions to support the service’s future strategy. Staff we spoke with were aware of the key priorities for the service and understood their role in achieving them. They were committed to providing safe, high-quality care and improving the patient experience.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were committed to improving the quality of care and patient experience and worked together to do so.

At our inspection in 2017, we found the culture amongst the medical staff remained a significant concern. At this inspection, we found considerable improvements had been made.

We observed a positive culture within the department. All staff we met were welcoming, friendly and helpful. It was evident that staff were passionate about the services they provided and told us they loved working in the emergency department. Staff were committed to providing the best possible care for patients. They were proud to tell us of the improvements they had made since our previous inspection. Medical and nursing staff we spoke with felt the culture within the ED had improved, and reported collaborative, supportive and effective team working, which we observed during our inspection. They shared responsibility and worked together for the benefit of patients.

Staff also felt there had been an improvement in the way in which the ED was supported by the trust’s senior management team and other areas of the hospital. For example, during our last inspection staff told us there was an emergency department escalation group meeting that took place monthly to discuss patient flow. This had been changed to a patient flow transformation group meeting, which was attended by lead clinicians from all areas of the hospital and focused on how the ED could be supported to improve patient flow. Staff told us they felt this was a more joined up supportive approach, rather than the previous approach of the emergency department attempting to solve any patient flow issues that prevented patients from being admitted to an
inpatient area. We saw that actions had been taken to improve the culture. For example, medical, nursing and support staff of all grades were involved in the service’s “projecting warmth and openness” improvement project. As part of this, all staff wore first name badges in large font on a yellow background. These were designed to help make staff more visible and approachable to patients and those close to them and promote a culture of staff openness by helping to break down the barriers of hierarchy. The service held regular away days and team events. These gave staff an opportunity to get to know each other better, strengthen team working and look at ways in which they could improve.

Multidisciplinary teams worked collaboratively and were focused on improving patient care and service provision. During our inspection, we observed positive and respectful interactions, which were focused on meeting patients’ needs and providing safe care and treatment. The clinical lead and lead nurse promoted an open, “no blame” culture and encouraged staff to tell them how they could make things better. They wanted staff to be happy because they knew that happy staff gave better care. Staff said they felt well supported, respected and valued by their managers and the senior management team. They were encouraged to raise concerns and share ideas for service improvement. We observed positive and supportive relationships between the leaders and staff of all levels, including porters and housekeepers.

There were arrangements in place to promote the safety and wellbeing of staff. Staff carried personal alarms and the department had access to the trust’s security team 24-hours a day, seven days a week. A counsellor visited the department monthly and could be accessed at any time. Wellbeing services such as yoga, mindfulness sessions and a confidential employee helpline were available to staff. Staff also received training in how to deal with aggressive behaviours. For example, as of October 2018, 83% of staff in the children’s ED had completed breakaway training. The remaining staff were booked to complete this training in December 2018 (Source: Additional Data Requests DR111).

The urgent and emergency care service celebrated staff success. For example, staff were invited to nominate a colleague who had been particularly helpful, and once a week one of the nominees was selected and that member of staff was given a bag of sweets as a thank you. We saw that compliments were shared with staff at the daily safety huddle, team meetings, newsletters and staff social media forums. The clinical lead posted photographs of ‘thank you’ cards received, which all staff could view. The trust also ran a monthly ‘celebrating excellence staff award’ scheme, which recognised a member of staff who had gone the extra mile. A nurse from the emergency department won this award in December 2017, following nomination from a colleague for consistently going above and beyond. There were development opportunities in place for staff across the department. For example, in the children’s ED nurses told us that there were opportunities for band six nurses to develop into an emergency nurse practitioner role. We spoke with a healthcare assistant who had recently become a trainee nursing assistant and had plans to complete their nursing degree once they were qualified in the nursing assistant role. There were six nursing assistants in total within the emergency department. All of which had developed and trained for this role from becoming healthcare assistants.

**Governance**

The service used a systematic approach to continually improve the quality of its services and safeguard high standards of care. The arrangements for governance were clear and operated effectively. Staff understood their roles and accountabilities.

There were effective governance structures, processes and systems of accountability in place. We found these arrangements supported the priorities of the emergency medicine strategic plan.
Governance and management functioned effectively with each other, including integrated governance arrangements for the adult and children’s emergency departments. This was an improvement since our last inspection. For example, the leadership team were knowledgeable about performance within the children’s ED. The consultants in the children’s ED reported to the clinical lead for emergency medicine. Nursing staff within children’s ED were knowledgeable about developments within the main ED, even when they did not have a direct impact on children’s services.

Monthly clinical governance meetings were held at department, directorate and trust-wide level. These included the emergency department clinical governance meetings and emergency medicine governance meetings. The meeting minutes we reviewed confirmed that performance, incidents, risks, guidelines, audits, clinical issues and training compliance were discussed. Meeting minutes were detailed and included copies of relevant reports, audit presentations and individual case reviews (Source: Additional Data Requests DR89, DR105).

As part of the governance structure, senior staff also met regularly with other departments and we saw a range of cross divisional meetings were held. These included bi-weekly meetings with representatives from the acute assessment unit and ambulatory care unit, bi-weekly meetings with the emergency surgical assessment unit, and monthly meetings with women’s and children’s services (Source: Additional Data Requests ED Governance Structure).

Staff from the urgent treatment centre and minor injuries unit were given the opportunity to work within the adult and children’s ED. This provided staff with the understanding of how governance and performance was managed and reported at the main site. Staff of all levels we spoke with were clear about their roles. They had a clear understanding of their accountabilities and who they reported to. There were clear governance procedures for managing and monitoring service level agreements (SLA) with third parties. For example, an NHS ambulance trust. The SLA was monitored against service provision and meetings were regularly held. The department held monthly meetings with the local NHS mental health provider. Meetings of minutes we reviewed showed that information sharing, incidents, individual cases and training were discussed (Source: Additional Data Requests DR118).

The sepsis lead for the trust was an ED consultant. They oversaw sepsis management across the trust and within the ED. The lead for governance within the division was an ED consultant. They led the ED clinical governance meetings where discussions were held about complaints received, incidents reported, and audit results. There were joint governance arrangements in place to discuss and agree streaming processes to the GP. This was in line with the NHS Improvement Good Practice Guide: ‘Focus on improving patient flow’ (2017). The appropriateness of patients being streamed to the GP was reviewed and discussed regularly because the GP service had recently been reinstated. Nursing staff and managers told us they felt this was working well.

The service monitored performance against key indicators, such as the Friends and Family Test (FFT) and patient safety and experience indicators, which included four-hour waits, ambulance turnaround times, infection control and medication. The senior management team were required to produce an exception report for areas of concern and/or decline in expected performance. These included details of corrective actions to be taken to address the issues identified. The exception reports were reviewed at directorate and trust-wide governance meetings (Source: Trust Board Papers, Integrated Performance Report and Additional Data Requests DR83).

All staff were invited to attend clinical governance meetings. The department’s monthly newsletter included the date of the next meeting and welcomed all to attend. Meeting minutes were saved on a shared drive. This meant staff who were not able to attend the meetings could read the minutes.
Effective governance processes were established at shop-floor level. We were assured that emergency equipment and controlled medicines were checked daily. Staff were committed to improving the quality of service provision and safeguarding high standards of care. Staff were aware of how to complete incident reports and were encouraged to do so.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The service had arrangements in place for identifying, recording and managing risks. The directorate risk register included a description of each risk, alongside mitigating actions and controls in place. An assessment of the likelihood of the risk materialising, its possible impact and the lead person responsible for review and monitoring was also detailed. Risks were reviewed regularly at monthly departmental and directorate governance meetings (Source: PIR P106).

Improvements had been made since our last inspection, when we found the addition of zones in the department had not been risk assessed in terms of the impact these had on staffing. At this inspection, we found a full departmental staffing review had been carried out and significant investment had been made to increase the staffing establishment and ensure each area was sufficiently staffed.

Staff we spoke with were aware of the main risks within the service, which included equipment failure of the machine used to store patient records in the ED, ambulance turnaround times, staffing and the increase in mental health patient attendances. Information regarding risks within the emergency departments were shared with staff in a variety of ways, such as team meetings, the safety huddle and staff noticeboards. All incidents reported via the electronic incident reporting system were reviewed daily, Monday to Friday, and where necessary investigations were initiated to identify any themes and actions needed to minimise recurrence. Any potential serious incidents were reviewed by members of the senior team and were escalated to the trust’s serious incident panel, which met three times a week to review all potential serious incidents. We reviewed the investigation reports of four serious incident investigations and found detailed root cause analyses had been completed, which included the involvement of patients and relatives, care and service delivery problems, contributory factors, recommendations and actions to be completed to reduce the risk of recurrence.

Staff told us they received feedback on risk, incidents, issues and performance in a variety of ways, such as daily safety huddles, noticeboards, newsletters and social media platforms. The service participated in national and local audits, which were used to monitor quality systems and identify where actions should be taken to improve performance. Findings from audits were shared with staff at monthly governance meetings, newsletters and noticeboards. Staff we spoke with demonstrated knowledge of audits that had been completed.

**Information management**

The service did not have effective arrangements in place to ensure information used to monitor, manage and report on performance was accurate. However, electronic systems used were secure with security safeguards in place.

There were not effective arrangements in place to ensure that all information used to monitor, manage and report on performance was accurate. We found the time of arrival recorded for patients who arrived by ambulance was not always accurate. For example, we saw that most patients had been handed over to ED staff before the time of their recorded arrival. This was because the handover was completed in the clinical area, but time of arrival was recorded when
the ambulance crew registered the patient’s arrival at the main reception desk. The ambulance system accurately recorded the time of arrival, but the service did not have access to this data. The newly appointed performance manager was aware of this issue and was looking at ways in which this could be recorded more accurately. This was not yet on the risk register.

We also saw issues with the recording of time to initial assessment in the children’s ED. The triage time was not routinely recorded on the electronic system, which meant the time from arrival to initial assessment performance data was not accurate. The department was monitoring the time from arrival to the time in which the child presented at the reception desk and was visualised by a nurse. The time from arrival to the time in which the child had a full set of observations undertaken and a pain score was not routinely recorded. The consultants and the matron were aware of the reporting issues. Staff were being encouraged to record the triage time on the system. The lead nurse had undertaken audits in this area. From January to September 2018, an audit of triage assessment times found 83% of initial assessments were carried out within 15 minutes of arrival. The audit found there was a small degree of inaccuracy in reported data. This was not a significant issue as the figure was within 5% of the reported data (Source: Additional Data Requests DR125).

The service submitted data to external bodies such as the Trauma Audit and Research Network (TARN). In the 2017 TARN annual peer review, the report found TARN data completeness had been low for a sustained two-year period and was a cause for serious concern. The most recent report at that time indicated 50.3% TARN data completeness. The service had acted to address this and in the service’s 2018 TARN annual peer review, TARN data completeness was recognised as an area of good practice. The service had for the first time reached greater than the 80% target for the year.

Staff generally had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. There were arrangements in place to ensure the confidentiality of patient information held electronically and we found staff were aware of how to use and store confidential information. Computer terminals were locked when not in use to prevent unauthorised persons from accessing confidential patient information.

**Engagement**

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services. However, the emergency department’s Friends and Family Test response rate was worse than the England average.

People’s views and experiences were gathered and acted on to shape and improve the services and culture. Service user feedback was sought to inform changes and improvements to service provision. People who used urgent and emergency care services were encouraged to give feedback on the quality of service they received. The NHS Friends and Family Test (FFT) for A&E was used. From September 2017 to August 2018, the FFT response rates for the service were consistently lower (worse) than the England average. Over this 12-month period, the average response rate for the trust was 1.8%, whilst the England average was 12.7%. The service was taking action to improve this. They had recently purchased tablets, to encourage patients to complete the FFT electronically. We saw the response rate in August 2018 had improved and was the highest it had been for the 12-month period at 5.1%, but this was still lower than the England average.

Information about the complaints’ procedure and patient advice and liaison service was available in the department. Feedback was also gathered through social media forums, such as NHS Choices, Facebook and Twitter. The range of engagement and support options available through the children’s ED remained positive and was similar to our last inspection. The service worked with
a volunteer network of parents who provided voluntary support to parents of children in the department. The department also worked with a youth organisation, which brings volunteers aged between 16 to 21 years into the hospital to speak with young people about matters they might require support with such as sexual health awareness, cyber bullying, mental health and suicide awareness.

The ED had developed a monthly newsletter entitled “Voicebox A&E Newsletter”. We reviewed a number of these publications and found they were very well produced and engaging to read. They contained a wide-range of information including news from the Royal College of Emergency Medicine, a summary of performance, safety alerts, feedback from patients, as well as dates of that month’s religious festivals, A&E related jokes, a word search and interviews with staff members. They also produced a quarterly emergency medicine newsletter, which included information about the directorate, performance, team and staff development news, and wellbeing support for staff (Source: Additional Data Requests DR102, DR113).

From the conversations we had with staff and observations we made during our inspection, it was evident that staff were engaged in the service. They told us they felt confident to raise concerns and were encouraged to come up with ways in which the service could be improved. Increased use of an instant messaging application on mobile phones was the preferred method of communication with staff of all levels. In addition, information was provided at meetings, handovers, via email and on notice boards. A patient forum was held quarterly. The ED had been discussed. For example, seating and signage. This showed that the forum had a good understanding of some of the issues experienced by patients within the ED. The chair of the meeting had good links with the trust’s director of nursing and was able to track actions taken in response to issues discussed. The clinical lead for ED had ensured each consultant had a lead role aside from their clinical duty. For example, there was a consultant who led on recruitment and retention, and another who led on governance. Nurses and medical staff told us they felt this had improved the medical staffing engagement within ED. Consultants told us this gave them a sense of ownership.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

The service had focused on addressing the concerns we reported at the September 2017 inspection. We found many improvements had been made. These included:

- There had been significant investment in medical and nurse staffing. Full reviews of both medical and nurse staffing and skill mix had been carried out and the staffing establishment had been increased.
- There was a positive culture within the department. We observed collaborative, supportive and effective team working between medical, nursing and support staff. Staff were passionate about the services they provided and were committed to providing the best possible care for patients.
- Issues with capacity and flow in the department were now seen as a hospital-wide concern, and staff from all areas were working together to improve ED performance and the patient experience.
- The service had significantly reduced the number of black breaches that occurred within the department. The clinical lead had been asked to present how they had achieved this at a winter planning summit.
• The environment had been remodelled to increase capacity and improve patient flow, this included the development of a clinical decision unit. Further works were being undertaken at the time of our inspection, which included a dedicated entrance for the children’s emergency department, a viewing room and refurbishment of the relatives’ rooms.

• Leadership was strong, supportive and visible. The trust had established the directorate of emergency medicine to enable a greater focus on the first 24-hours of patients’ time in the hospital. Staff spoke positively about the senior management team and department managers, and felt well supported.

• There was an integrated vision and strategy for the directorate of emergency medicine, which included both the adult and children’s emergency departments.

• The number of patients who left the department without being seen was better than the England average.

• Staff compliance in advanced paediatric life support training had increased.

• Hand hygiene and infection control precautions were consistently carried out.

• The STARR (senior team assessment and rapid response) was fully embedded.

However, there was some ongoing work still required and we identified a number of concerns. These included:

• Waiting times to be seen and the number of patients who waited longer than four-hours for a decision to admit, treat or discharge were generally worse than the England average.

• Not all risk assessments were documented. These included fall and safeguarding risk assessments. Intentional rounding and safety checklists were not always completed in line with trust policy. We also found patient records were not always contemporaneous and some entries were written retrospectively.

• Mental health patients were not appropriately monitored at all times. Patients' mental health risk assessments carried out by the RAID team were not available to ED staff.

• The emergency department was generally unsecured.

• Appraisal completion rates were below the trust target.

• Effective arrangements were not in place to ensure information used to monitor, manage and report on performance was accurate.

• There was a lack of patient confidentiality in the main reception and streaming desk.

• Signage in the ED was not always clear to patients and visitors.

• The Friends and Family Test response rate was worse than the England average.

The service was committed to training and staff development. Courses supported by the trust included the advanced nurse practitioner master’s programme, emergency nurse practitioner course, contemporary nursing master’s programme, trainee nurse associate programme and an accident and emergency course. All staff told us they were encouraged and supported to complete additional training.

The Empathy Project and Carer Support Team, who volunteered in the children’s emergency department had both been shortlisted for categories in the Helpforce Champions National Awards for volunteers.
**Medical care (including older people’s care)**

**Facts and data about this service**

The medical care service at West Hertfordshire Hospitals NHS Trust provides care and treatment for a range of specialities. There are 390 medical inpatient beds that are provided at Watford General Hospital

*(Source: Routine Provider Information Request P2 - Sites)*

The trust had 48,774 medical admissions from June 2017 to May 2018. Emergency admissions accounted for 25,819 (53%), 502 (1%) were elective, and the remaining 22,543 (46%) were day cases.

Admissions for the top three medical specialties were:

- General medicine 20,467
- Gastroenterology 12,956
- Clinical haematology 4,231

*(Source: Hospital Episode Statistics)*

The medical service was previously inspected in September 2017 when we rated it as requires improvement overall. It was rated as requires improvement for safe and responsive and as good for effective, caring and well led.

We carried out an inspection from 6 November 2018 to 8 November 2018. Our inspection was unannounced. Prior to the inspection we reviewed information we had about the service and information from stakeholders.

The medical inspection team consisted of an inspector, an assistant inspector (from 4 November to 6 November 2018) and two specialist advisors (for one day). We visited the following areas at Watford General Hospital:

- Acute Admission Unit (AAU) which is on three levels
- AAU level 3 Coronary bay cardiac, green and purple
- Aldenham ward - Respiratory medicine
- Bluebell ward- Dementia care unit
- Cassio ward - Gastroenterology
- Croxley ward - Care of the elderly
- Dick Edmunds stroke unit
- Heronsgate/Gade ward – Haematology, rheumatology and endocrinology
- Medical assessment unit
- Patient lounge - Discharge area
- Sarratt ward - Care of the elderly
- Winyard ward - Care of the elderly
During the inspection visit the inspection team:

- Spoke with 18 patients who were users of the service.
- Spoke with the managers or the nurse in charge for each of the wards and clinical areas.
- Spoke with 45 members of staff including senior managers, doctors, nurses, health care assistants, advanced clinical practitioners, administrative staff, housekeeping staff, housekeeping assistants and allied health professionals.
- Reviewed parts of 10 patient care records relating to assessments, care plans, medicines administration and observation charts.

Following the inspection, we reviewed additional performance data and other information provided by the trust.

**Is the service safe?**

**Mandatory training**

Mandatory training in key skills was provided to all staff. Data initially reported a low level of completion of mandatory training by nursing and medical staff, however, data provided following the inspection showed substantial improvement.

The trust set a target of 90% for completion of mandatory training. Following the inspection, a senior manager reported that the overall compliance for mandatory training had improved to 91%.

**Watford General Hospital**

A breakdown of compliance for mandatory training courses from July 2017 to June 2018 at Watford General Hospital for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-patient moving and handling</td>
<td>87</td>
<td>87</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>419</td>
<td>466</td>
<td>90%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient moving and handling</td>
<td>409</td>
<td>466</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>408</td>
<td>466</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire non-clinical</td>
<td>386</td>
<td>443</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>406</td>
<td>466</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene</td>
<td>366</td>
<td>466</td>
<td>79%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire and evacuation clinical</td>
<td>349</td>
<td>466</td>
<td>75%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control</td>
<td>341</td>
<td>466</td>
<td>73%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>336</td>
<td>466</td>
<td>72%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>317</td>
<td>466</td>
<td>68%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 90% target was met for one of the 11 mandatory training modules for which qualified nursing staff were eligible. Adult basic life support had the lowest completion rate with 68%.

A breakdown of compliance for mandatory training courses from July 2017 to June 2018 at Watford General Hospital for medical staff in medicine is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-patient moving and handling</td>
<td>197</td>
<td>211</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>173</td>
<td>240</td>
<td>72%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>169</td>
<td>240</td>
<td>70%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient moving and handling</td>
<td>122</td>
<td>184</td>
<td>66%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire non-clinical</td>
<td>141</td>
<td>214</td>
<td>66%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene</td>
<td>158</td>
<td>240</td>
<td>66%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control</td>
<td>156</td>
<td>240</td>
<td>65%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>152</td>
<td>240</td>
<td>63%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>118</td>
<td>188</td>
<td>63%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire and evacuation clinical</td>
<td>90</td>
<td>146</td>
<td>62%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>55</td>
<td>109</td>
<td>50%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 90% target was met for one of the 11 mandatory training modules for which medical staff were eligible. Conflict resolution had the lowest completion rate with 50%.

A senior manager reported that they had identified issues with the accuracy of the reports from mandatory training and action had been taken to address this. However, in August 2018, medical staff showed a combined compliance figure across all subjects for medical staff was 73% and adult basic life support was 49%. As a result of actions taken by the trust the overall compliance had increased to 85% and compliance for adult basic life support had improved to 79% by 12 November 2018. In addition, the overall compliance for mandatory training for all staff had increased to 91%.

Completion of mandatory training was recorded on an electronic system and managers told us they were able to monitor their staff’s attendance, as they could see the training records online. Most of the mandatory training modules were provided online using the electronic training system. Staff on some wards told us it was difficult to access a computer on their wards to complete the training, and this, along with the activity on the ward, meant they found it was difficult to complete the training while they were at work. In addition, some ward managers told us of difficulties in staff access to the online training, due to issues with the system. For example, a ward manager said registered nurses had previously had difficulty in accessing a module, as the system did not recognise them as being a registered nurse.

Ward managers said they checked staff compliance and expiry dates for training and reminded staff of the need to complete it. Some wards had a greater number of computers and ward managers said they tried to allocate time on the rota, to complete training. Managers had appointed some practice development nurses for the medical wards and these staff had a remit to oversee mandatory training, in addition to providing ongoing clinical training and updates for staff.

The trust reported there was no discrete sepsis training in the trust and said it was included in infection prevention and control training. As such, they reported an overall medical division compliance of 93% in October 2018. The completion rate for individual departments ranged from 70% to 100% and completion rates for wards ranged from 86% to 100%.

88% of staff in the medical wards had completed dementia training. Completion rates for individual wards ranged from 86% to 100%.
Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had a good knowledge of their responsibilities to report safeguarding concerns and make referrals. They were supported by the trust safeguarding team to do this.

However, only 74% of medical staff had attended trust adult safeguarding training at level 2 as compared with a trust target of 90%.

The trust had policies in place for safeguarding adults and children and these were available to staff on the trust intranet. Staff were supported by the trust’s safeguarding team, who provided advice and support to staff. Staff we spoke with had a good knowledge of safeguarding issues and said they would be confident to report any concerns.

Staff initially used the trust incident reporting system to report a safeguarding concern and the trust safeguarding team were notified. The trust safeguarding team liaised with the local authority safeguarding team. Several staff told us of referrals they had made and said the safeguarding team had responded promptly. For example, a junior doctor said they had made several referrals and the trust’s safeguarding lead had been helpful and supportive and ensured the appropriate referrals were made. Staff told us of the close links they had with the social services teams, who were represented at ward board rounds.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from July 2017 to June 2018 at trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3 - three yearly update</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>422</td>
<td>436</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>433</td>
<td>448</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>424</td>
<td>488</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>420</td>
<td>488</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 90% target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible. Safeguarding children level 3 - three yearly update was only eligible for nine staff compared to all other safeguarding modules. The lowest with 86% was safeguarding children level 2.

A breakdown of compliance for safeguarding training courses from July 2017 to June 2018 at trust level for medical staff in medicine is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
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<th>Completion rate</th>
<th>Trust Target</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3 - three yearly update</td>
<td>98</td>
<td>98</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>202</td>
<td>237</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>202</td>
<td>239</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>175</td>
<td>229</td>
<td>76%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>166</td>
<td>225</td>
<td>74%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 90% target was met for one of the five safeguarding training modules for which medical staff were eligible.

Watford General Hospital

A breakdown of compliance for safeguarding training courses from July 2017 to June 2018 at Watford General Hospital for qualified nursing staff in medicine is shown below:

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<th>Trust Target</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3 - three yearly update</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>401</td>
<td>415</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>411</td>
<td>426</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>402</td>
<td>466</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>399</td>
<td>466</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 90% target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible. Safeguarding children level 3, the three yearly update was only eligible for nine staff compared to all other safeguarding modules. The lowest with 86% was safeguarding children level 2.

A breakdown of compliance for safeguarding training courses from July 2017 to June 2018 at Watford General Hospital for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3 - three yearly update</td>
<td>98</td>
<td>98</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>202</td>
<td>237</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>202</td>
<td>239</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>175</td>
<td>229</td>
<td>76%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>166</td>
<td>225</td>
<td>74%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 90% target was met for one of the five safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Trust training included PREVENT awareness. PREVENT is one of the arms of the government’s anti-terrorism strategy. It addresses the need for staff to raise their concerns about individuals being drawn towards radicalisation.

Awareness of female genital mutilation (FGM) was included in safeguarding training and staff had knowledge of the issue. FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

During the inspection we saw staff had displayed posters about adult abuse and safeguarding for the public, on patient information boards on some wards, and at the entrance to some of the patient bays on the acute assessment unit.

Cleanliness, infection control and hygiene

Risks associated with infection prevention and control were controlled well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. Audits were completed to ensure staff adhered to national guidance.

From October 2017 to September 2018, the trust reported 15 Clostridium difficile (C. difficile) infections in medicine at Watford General Hospital. There was one Methicillin-Resistant Staphylococcus aureus (MRSA) bacteraemia reported in the same period. MRSA is a type of bacteria that is resistant to a number of widely used antibiotics.

MRSA screening is recommended for specific groups of patients at high risk of MRSA. This helps detect patients who may be carrying the organism, in order to minimise the risk of the patient becoming infected and to reduce the risk of transmission to other vulnerable patients. From October 2017 to September 2018 on average 90% of patients eligible for screening were screened within the recommended time frame. This was in line with the trust target.

The trust monitored staff compliance with procedures that were recognised as having a high impact on the prevention of healthcare associated infections. These are procedures that should be followed when inserting and caring for peripheral and central venous cannulae and urinary catheters. Data was not submitted by all the medical wards, however, those that submitted data showed 100% compliance with the procedures in September 2018.

Patient records we reviewed, showed staff completed an intravenous access care plan when patients had a cannula inserted and this included a record of twice daily checks of the cannula site for signs of inflammation and infection (VIP scores), and a record of the insertion of the cannula with batch number of the cannula used.

At our last inspection in 2017, we saw variable compliance with handwashing or use of hand sanitising gel, by staff across all clinical areas. This included some staff not washing their hands after the use of personal protective equipment, following direct patient care and not using hand sanitiser when entering or exiting a ward. At this inspection, we found improvements.

Hand sanitising gel was available at the entrance to every clinical area and at each bedside. Hand wash basins were also readily available. Personal preventative clothing and equipment (PPE) was also available within the clinical areas. During the inspection visit, we observed staff showing good compliance with hand hygiene procedures and they used PPE appropriately.

Staff followed the trust’s bare below the elbows policy and we observed them washing their hands or using the hand gel between patient contacts. Most patients we spoke with, told us staff cleaned their hands before attending to them and two patients mentioned staff wore gloves when dealing with their intravenous cannula, or when replacing their wound dressing. However, one patient said they had not seen staff using hand gel and their relative commented on differences between the
hospital and the specialist hospital they had recently attended, with regards to adherence to infection control procedures. They said staff did not always use protective clothing when attending to the patient, who was particularly at risk of infection. Hand hygiene audits were completed monthly by the trust on all the medical wards and clinical areas. Results for September 2018 showed between 95% and 100% compliance.

Wards and clinical areas were visibly clean at the time of the inspection. We checked the cleanliness of a range of bathroom and toilet facilities, bed areas and equipment. Curtains surrounding each bed space were disposable and were dated to indicate when they had been changed. All those we checked had been changed within the previous six months in line with current recommendations. Patients told us housekeeping staff were efficient and thorough. Housekeeping staff were knowledgeable about the procedures required when a patient had an infection. During the inspection, the managers of the housekeeping team were on one of the wards, completing an audit of the environment to monitor cleanliness.

The trust participated in the Patient Led Assessment of the Clinical Environment (PLACE) audit during 2017. Nine medical wards and departments were assessed for the cleanliness section of the audit and results showed a good level of cleanliness with a pass for the criteria assessed.

Waste was appropriately segregated and sharps were disposed of in the correct receptacles that were labelled with the location and date they were put into service.

There were a number of side rooms available in most wards to enable the segregation of patients with an infection, or suspected as having an infection. We observed staff used signs at the entrance to these rooms, when visitors and staff needed to take specific precautions to prevent infection. We observed staff using PPE appropriately when entering these rooms.

The endoscopy department had achieved accreditation with the Joint Advisory Group (JAG) for endoscopy. This indicated there were appropriate procedures in place for the decontamination of instruments and endoscopes and traceability of items used for the procedure.

**Environment and equipment**

The environment in which medical services were provided were not always designed and managed to ensure the safety of patients using them. We found measures to improve the safety of the environment for patients with delirium and dementia were not fully implemented and learning was not transferred to other wards. Staff said that they reported maintenance issues appropriately, however, they were not always addressed in a timely manner.

Staff gained access to wards and clinical areas with electronic swipe cards. Visitors gained access using a call bell, which enabled staff to monitor visitors and patients entering the wards. In most cases, people could exit the ward by pressing a button, or switch, near to the exit.

Bluebell ward had reported incidents when a patient with confusion or dementia had left the ward unattended, when they were not safe to do so. On one occasion, this was via the exit door to the ward and at other times, via the fire exits from the ward. Staff had been alerted to this, however, the patient had inadvertently put themselves at risk prior to staff reaching them. The incidents had happened in October 2017. As a result alarms were installed on the fire doors to alert ward staff when the fire doors were opened. The action plan from the incidents also included the installation of a controlled exit system from the ward. We found the exit system was installed a week prior to the inspection, one year after the incidents. A further incident occurred on Croxley ward in June 2018 and it was identified that alarms were not in place on the fire exit doors. Croxley ward is also a care of the elderly ward and some of the patients cared for on the ward, lived with dementia.

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Learning from the issues on Bluebell ward had not been extended to other wards caring for people with delirium and dementia.

When we visited Bluebell ward we examined the fire doors and the exit system. The layout of the ward was such that the large double fire doors were clearly visible at the end of the two bays. The doors were painted in the same colour as the walls to make them less obvious, although the exit bars were dark. Patients living with dementia sometimes have difficulty in recognising doors if they blend with the surroundings and this can be used to distract attention from areas, they are not safe to access. Likewise, using colour contrasting doors or door frames can help them identify areas or objects to improve their safety. Staff told us they were investigating the use of screening with murals to further distract patients from the exits. This was being done in conjunction with fire safety officers. However, the alarm on one set of fire doors was turned off on the day of the inspection. This fire door led to a small garden area, with some wooden fence panelling and a wooden door secured by a lock. The fence panels and door was flimsy and a planter was placed in front of the gate. As a result, a patient may have tried to exit via this route. We were not confident the security arrangements were adequate to prevent a patient leaving the building.

Winyard ward was on the first floor, immediately above Bluebell ward and had the same layout. Here, the fire doors on this ward were dark grey in contrast to the surrounding walls. This made them more obvious than on Bluebell ward. Alarms had been installed on the fire doors to alert staff if the doors were opened. At the time of the inspection, several patients with dementia or delirium were being cared for on the ward. The fire doors opened to a metal staircase with a further fire door at the bottom. This posed a safety risk to people who were unsteady on their feet.

Some wards had a lack of storage space and we found equipment stored at the end of corridors and in side corridors near side rooms. Two surplus beds, bedside lockers and patient chairs were found at one end of Aldenham ward. It is likely they had been moved to create a four bedded bay for patients requiring non-invasive ventilation, however, they should have been moved from the ward. The ward manager told us that a lack of storage space on the ward was on the risk register.

We also saw a hoist and a stand aid stored in a corridor. On Croxley ward, two hoists partially blocked the exits from the ward. We also found visitors chairs stacked in front of the fire exit on Winyard ward. The ward manager immediately removed them when we brought this to their attention.

Waits for routine maintenance had the potential to impact on the safety of care for patients on the medical wards. We identified some instances when nursing staff had been waiting for maintenance work to be completed for some time after it had been reported. For example, a non-flushing toilet in a male bay on AAU had been reported two days prior to our inspection visit. In the meantime, patients were using the toilet at the end of the female bay, impacting on privacy and dignity. A medicines cupboard inside a treatment room, had a broken lock and this had been reported several days previously. During the inspection, we noticed a support for a curtain rail surrounding a bed on Heronsgate ward, had come adrift and there was no support for one corner of the rail. Staff told us it had been reported the previous day and a member of maintenance staff had been to the ward to look at it. However, no action was taken to put in a temporary or permanent fix for the rail. As a result, there was a risk the curtain rail might fall down when the curtains were being pulled around the bed. A patient was being cared for in the bed. Ward staff were unaware of any risk assessment being completed to ensure patient safety in the interim. We escalated this to the trust leadership team and it was repaired within 24 hours.

Oxygen cylinders were not always secured safely when they were being stored on the wards. We noticed this was the case on the medical assessment unit and Cassio ward and some were so loosely chained in other areas, they could have been knocked and may have toppled over. We
notified the ward managers of the wards where they were unsecured and they took immediate action to move them. We also noted the gauge on an oxygen cylinder on the resuscitation trolley on Cassio ward was not functioning correctly; this was escalated to the medical engineering department.

The trust had arrangements for the maintenance of medical devices in accordance with the Medicines and Healthcare Products Regulatory Agency (MHRA) Managing Medical Devices (April 2015), and other national guidance. Equipment we checked showed evidence of electrical safety checks and required maintenance. Most sterile supplies and consumables we checked were within their use by date. However, we found over 30 blood sample bottles on Croxley ward were past their expiry date, with a significant number having expired a year previously. The nurse in charge removed them when they were brought to their attention and the ward manager outlined the actions they would take to ensure this didn’t happen in the future.

On Aldenham ward we observed an unattended trolley used by the domestic services staff. It contained some substances hazardous to health which are subject to regulations regarding their storage and availability (COSHH). We spoke with the member of staff and asked them to ensure that the trolley was not left unobserved and unattended in future, to ensure a vulnerable patient did not access it.

There was mostly sufficient equipment such as vital signs observation equipment, commodes and moving and handling equipment, on medical wards to meet patient’s needs. However, a member of staff on the acute assessment unit told us they frequently spent time looking for the ECG machine, as it was not returned to the allocated storage area and was needed by staff in other bays. Alternating pressure mattresses and pressure relieving cushions were used for patients at risk of developing pressure ulcers. Staff told us they were supplied in a timely manner and we saw there were arrangements in place for the receipt of new mattresses and return of them when patients no longer required them.

Emergency resuscitation trolleys were available on each ward and clinical area. Equipment on the trolleys was mostly checked in line with trust requirements. There were tamper proof tags on the drawers used to store some of the equipment. Staff checked equipment on the top of the trolley daily and also checked that the tamper proof tags were undisturbed. On a weekly basis, the tags were broken to check the full contents of the trolley and a new tag inserted. We found there were some occasions when the full weekly checks were not undertaken; however, daily checks were consistently completed.

**Assessing and responding to patient risk**

Staff completed and in most cases updated risk assessments for each patient. They kept clear records of the assessments.

However, staff did not always escalate or refer patients when their clinical risk score (NEWS) indicated a deterioration in their condition.

Medical staff completed an initial admission assessment for patients, that included their presenting problem, past medical history and physical assessment. The admissions proforma also included a “Think Sepsis” section to ensure medical staff considered the possibility of sepsis and a venous thrombo-embolism (VTE) risk assessment. Initial assessments and a plan for the management of each patient was completed. Consultant cover for the admission assessment unit (AAU) ensured all patients were reviewed by a consultant within 12 hours of admission.

NICE guidance (NG89) published in March 2018 states that all medical patients should be assessed to identify the risk of VTE (venous thrombo-embolism or blood clots), as soon as
possible after admission to hospital, or by the time of the first consultant review and that reassessments for VTE should be at the point of consultant review, or if their clinical condition changes. At our last inspection in September 2017 we found inconsistent patient risk assessments of VTE on admission and the reassessment after 24 hours.

At this inspection, the patient records we checked, contained evidence of an initial VTE risk assessment on admission; however, the documentation used did not prompt a reassessment and did not provide space to record a reassessment. Although it is acknowledged that guidance with regards to reassessment had been reviewed, an assessment, appropriate to the patient’s condition, should still take place. A junior doctor we spoke with said they remembered to do the initial VTE risk assessment most of the time and they were aware of the need for a review, however explained there was no area on the form to complete to say the re-assessment had been completed. Another junior doctor said there had been a drive to improve and junior doctors were auditing compliance. Staff on some wards told us they highlighted those patients who required a VTE risk assessment on the ward patient white boards. However, they said no one monitored re-assessments. Monthly data provided by the trust indicated over 95% compliance with VTE screening in medicine from October 2017 to September 2018. They did not provide any data for reassessment.

Discussion at the trust board meeting for October 2018, identified the continued challenges in ensuring VTE risk assessments were consistently completed. The trust had appointed a VTE compliance support worker, in an attempt to improve completion of VTE risk assessments. However, measurable improvements had not been achieved following this. We also saw evidence of discussion about it at the divisional governance meetings.

Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. The trust had a sepsis protocol and used the national “Think Sepsis” pathway to identify and treat sepsis. This was included in the medical assessment proforma and we noted it was completed fully in the care records we reviewed.

The trust produced a sepsis newsletter, which was displayed in the sister’s office on one ward. A patient told us they had been admitted with a suspected infection and staff had reacted very quickly to prescribe and administer antibiotics and complete the required investigations.

Nursing staff used an assessment booklet to assess patient’s risk of developing pressure ulcers, falls, nutritional risk and risks associated with moving and handling. These risks were reviewed regularly. Where patients were identified as being at risk, plans to reduce the risks were in place. For example, when patients were at risk of developing a pressure ulcer, pressure relieving equipment was used and the patient was assisted to change their position on a regular basis. The trust used an intentional rounding document to record individual checks of the patient and interventions such as re-positioning. However, records we reviewed showed staff recorded they had re-positioned the patient, although they did not record the position the patient had been placed in. This meant that there was not a systematic approach to regular re-positioning. In addition, we found some instances when records of intentional rounding and re-positioning were not completed contemporaneously.

Ward staff used the national early warning score (NEWS) when they completed vital signs observations. This was done to identify deteriorating patients and is in line with national guidance. The NEWS documentation included clear directions for staff on the action they should take if the NEWS score increased, indicating the patient’s condition was deteriorating. We checked the observation charts for six patients and found the NEWS score was recorded with every set of observations. In instances when the score had increased, staff had taken action to alert the
doctors or critical care outreach team to the issue. Notes written by medical staff and the critical care outreach team, indicated the patient was reviewed in a timely manner following escalation.

Nursing staff we spoke with were aware of the NEWS escalation process and said they received a prompt response when they contacted the medical staff or critical care outreach team.

The trust audited the completion of patient observations of vital signs and as part of this, monitored whether there was evidence of referral or escalation when the NEWS rose to above four, in accordance with the criteria for escalation. From October 2017 to September 2018 there was variable compliance, with regards to appropriate escalation, for the medical wards. However, the compliance in some months was as low as 65% and there was no evidence of continuous improvement over the 12 month period.

Staff completed fire safety training as part of their mandatory training. Nursing and medical staff spoken with knew what the evacuation procedures were including how to evacuate patients and meet at their allocated meeting points. We observed evacuation aids were available within the clinical areas.

**Nurse staffing**

There were mostly enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm. However, the skills and deployment of staff sometimes impacted on the timeliness and responsiveness of care.

The trust used a nationally recognised tool twice a year, to review and set nurse staffing levels for inpatient wards. They told us that most inpatient ward areas worked on a 60%/40% ratio for registered/unregistered nursing staff. We noted the ratio of registered nurses was increased in some specialties, such as respiratory and cardiology wards and slightly reduced in care of the elderly wards. Establishments were reviewed by ward sisters, matrons, heads of nursing and finally approved by the chief nurse. The establishment reviews used recognised tools such as the safer nursing care tool (SNCT) and the National Quality Board guidance (NQB).

The trust monitored staffing levels against acuity on a daily basis, using the electronic roster system. Information was inputted by senior staff twice per day, that incorporated reviewing the staffing numbers, staffing skills and acuity for the patients on the ward. Matrons for each area had oversight and managed any safety issues that arose.

The trust reported their staffing numbers, as shown below, for the period June 2017 and June 2018 for medicine.

The overall fill rate for nursing staff at the trust has increased between the two periods with 39.9 WTE more nursing staff in place in June 2018.

<table>
<thead>
<tr>
<th>Location</th>
<th>June 2018</th>
<th></th>
<th>June 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>Watford General</td>
<td>640.9</td>
<td>773.0</td>
<td>82.9%</td>
<td>676.1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 19% in medicine; this is higher than the trust target of 9%
- Watford General Hospital medicine department: 20%
- Hemel Hempstead medicine department: 3%

(Source: Routine Provider Information Request (RPIR) – Vacancies)

Turnover rates
From July 2017 to June 2018, the trust reported a turnover rate of 19% in medicine; compared to a target of 12%
- Watford General Hospital medicine department: 19%

(Source: Routine Provider Information Request (RPIR) – Turnover)

Sickness rates
From July 2017 to June 2018, the trust reported a sickness rate of 2.9% in medicine compared to the trust target of 3.5%
- Watford General Hospital medicine department: 2.8%

(Source: Routine Provider Information Request (RPIR) – Sickness)

Bank and agency staff usage
From April 2017 to March 2018, the trust reported a bank and agency usage rate of 19.8% for qualified nursing in medicine;

<table>
<thead>
<tr>
<th>Total Hours available/ Establishment</th>
<th>Total hours unfilled</th>
<th>Total Bank Hours</th>
<th>Total Agency Hours</th>
<th>Unfilled rate (%)</th>
<th>Bank use rate (%)</th>
<th>Agency use rate (%)</th>
<th>Total bank and agency Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>996,108</td>
<td>89,747</td>
<td>88,391</td>
<td>108,832</td>
<td>9.0%</td>
<td>9%</td>
<td>10.9%</td>
<td>19.8%</td>
</tr>
</tbody>
</table>

A breakdown of bank and agency use by site is provided below

Watford General Hospital medicine department reported a bank and agency usage rate of 20.4% from April 2017 to March 2018.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Total Hours available/ Establishment</th>
<th>Total hours unfilled</th>
<th>Total Bank Hours</th>
<th>Total Agency Hours</th>
<th>Unfilled rate (%)</th>
<th>Bank use rate (%)</th>
<th>Agency use rate (%)</th>
<th>Total bank and agency Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified</td>
<td>954774.6</td>
<td>88770.3</td>
<td>86581.2</td>
<td>107959.0</td>
<td>9.3%</td>
<td>9.1%</td>
<td>11.3%</td>
<td>20.4%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Nursing bank agency)

Staffing levels were discussed at the daily meetings in AAU that considered capacity and flow. The service had access to a pool of staff who were allocated to wards where there were shortfalls in staffing, or where patients required one to one observation. Staff were also moved to other wards when required, to meet patient need. Staff we spoke with on most wards, told us that when they achieved their planned staffing levels, there were sufficient staff available to meet patients’ needs.

Staff told us vacancies were being managed through an ongoing central recruitment programme and they were mostly able to recruit staff when there were vacancies. However, an experienced member of staff on AAU identified that staff retention was a problem on the unit and as the new recruits were generally newly qualified staff, or staff from overseas who needed to pass the required examinations in their first few months of employment, there was an imbalance in the skill
mix. They told us that a lot of their day to day work was in explaining and advising junior staff. They felt the risk to safe care was increased due to this imbalance. Other staff told us the staffing levels on AAU were good.

We identified some staffing concerns on Heronsgate and Gade ward. Previously, the ward was two separate wards and the trust had combined the wards and staffed it as one ward, with one ward manager supported by an experienced band 7 nurse from another ward area three days a week. When we visited the ward, we had some concerns about the pressures on staff on the part of the ward that was previously Gade ward. The ward was very busy and several patients required frequent monitoring and adjustment of their diabetes medicines. The registered nurses were constantly interrupted whilst doing one task, by other staff requiring information, advice or assistance. A patient needed escorting to another department for a scan and another patient left the ward for another procedure. We raised this with the trust and they reported that the ward was appropriately staffed for the acuity of the patients. A patient on the ward said that while staff were attentive, they were ‘rushed off their feet.” A senior clinical nurse told us they felt the number of staff were adequate, however there were three new staff who were not yet registered with the Nursing and Midwifery Council and therefore were working at the level of a healthcare assistant. A ward manager from another ward was providing support to staff on the ward in the absence of the usual ward manager. Two practice development nurses were also providing support in the form of training to staff on the ward. The layout of the ward, resulted in the division of staff into two teams; one for Heronsgate and one team for Gade. A member of staff said they adhered to their assigned bays and did not cross over and support each other. Given the layout of the ward, staff in some bays may not have been aware of the workload of staff in the other part of the ward. This suggested the deployment of staff and the organisation of the workload required review. The impact of the layout of the ward on the staffing requirements also required consideration.

Staffing levels on Bluebell ward had been increased to allow for the additional monitoring required to care for patients living with dementia or with delirium. The staffing levels allowed for a member of staff to be present in each of the two bays 24 hours a day, seven days a week. Staff told us that as a result they did not normally need to request additional support when a patient required one to one observation. We saw patients received a good level of attention and support.

A member of staff on Winyard ward, expressed a concern about the staffing levels. We identified that a registered nurse and a health care assistant were allocated to each of the two bays and during the day, an additional registered nurse acted as the coordinator and had a smaller patient caseload. We observed there were occasions during the morning when one member of staff was alone in a bay for significant periods and some patients required two staff to assist them. A member of staff identified the housekeeper was absent that day and therefore they were only able to offer patients a cold drink in the middle of the morning, as they were not able to leave the bay to prepare the hot drinks when they were on their own.

Staffing levels were being reviewed on Aldenham ward to prepare for a planned increased in beds in the acute respiratory care unit, caring for patients requiring non-invasive ventilation (NIV). The unit provided one registered nurse or assistant practitioner for every two patients receiving non-invasive ventilation. At the time of the inspection there were four designated NIV beds and the intention was to provide eight beds. British Thoracic Society Quality Standards for acute non-invasive ventilation in adults (2018) state that 1:2 nursing care should be provided for all patients treated with acute NIV, until NIV requirements reduce to nocturnal use only.
Medical staffing

There were enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Medical staffing was appropriate with effective out of hours and weekend cover. Medical staffing within the acute admission unit was in line with national guidance from the Society for Acute Medicine and West Midlands Quality Review Service in the publication, “Quality Standards in the AMU” dated June 2012.

The trust has reported their staffing numbers below for the period June 2017 and June 2018 for medicine.

The medical staffing numbers have increased by total of 16.4 WTE staff and in June 2018 the medicine department is over established compared to the planned number.

<table>
<thead>
<tr>
<th>Location</th>
<th>June 2017</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Watford</td>
<td>195.0</td>
<td>212.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of -4% in medicine; this is lower than the trust target of 9% indicating they have an over-establishment of medical staff

- Watford General Hospital: -4%

(Source: Routine Provider Information Request (RPIR) – Vacancies)

Turnover rates

From July 2017 to June 2018, the trust reported a turnover rate of 44% in medicine; compared to a target of 12%

- Watford General Hospital medicine department: 44%

(Source: Routine Provider Information Request (RPIR) – Turnover)

Sickness rates

From July 2017 to June 2018, the trust reported a sickness rate of 1% in medicine compared to the trust target of 3.5%

- Watford General Hospital medicine department: 1%

(Source: Routine Provider Information Request (RPIR) – Sickness)

Bank and locum staff usage

From April 2017 to March 2018, the trust reported a bank and locum usage rate of 26.5% in medicine;

The breakdown of unfilled, bank and agency hours for medical staff in the medicine.
<table>
<thead>
<tr>
<th>Total Hours available/Establishment</th>
<th>Total hours unfilled</th>
<th>Total Bank Hours</th>
<th>Total Agency Hours</th>
<th>Unfilled Rate (%)</th>
<th>Bank use rate (%)</th>
<th>Agency use rate (%)</th>
<th>Total agency and bank use rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>385,103.0</td>
<td>12,632.0</td>
<td>70,747.5</td>
<td>31,295.0</td>
<td>3.3%</td>
<td>18.4%</td>
<td>8.1%</td>
<td>26.5%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

**Staffing skill mix**

In May 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the 207 whole time equivalent staff working in medicine at West Hertfordshire Hospitals NHS Trust**

![Staffing Skill Mix Chart]

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (STR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce Statistics - Medical (01/05/2018 - 31/05/2018))

All patients were seen by medical staff on a daily basis. In the acute medical specialties, consultants carried out ward rounds daily whilst in others, the consultant completed a ward round three times a week and a registrar completed the ward rounds on other days.

Teams of specialty and junior doctors were available to support each specialty. At the time of the inspection, we were told there were no rota gaps for the first and second year foundation doctors, however, there were gaps at registrar level, due to reduced Health Education England allocations. Cover was achieved on a temporary basis and the trust were exploring ways to fill the shortfall including the use of overseas medical staff. As a result, we were told it was sometimes difficult to contact a registrar between 5pm and 9pm. However, staff told us the consultants were very supportive and there were some very good junior doctors. In some areas, physician’s assistants were assigned to a team to support junior doctors in inserting cannulas, preparing discharge summaries and routine clerking.

All medical staff we spoke with said they received a good level of support from their consultants who were approachable and able to be contacted at any time. Junior doctors reported they had been allocated an educational supervisor and clinical supervisor. They said they were able to attend the weekly teaching sessions which were ‘bleep free’ periods for junior doctors.
Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Information needed to deliver safe care and treatment was available to staff in a timely way. Records of nursing assessments and daily nursing care were stored separately in folders by each patient’s bed. Therapists and other staff documented daily care in the medical records. This meant staff were able to access the information they required to provide safe care and treatment.

We reviewed 10 patient records. Entries were legible, dated, timed, signed and the designation of the person making the record was recorded, in line with required practice. Medical staff completed an admission assessment, including details of the presenting problem, past medical history, physical assessment and risk assessments. Daily ward round notes were completed, to document the patient’s progress and the plan for their care and treatment.

Nursing assessments and care plans were completed. When risks to patient’s health and safety were identified, a care plan was in place to reduce this risk. For example, a falls care plan was used to identify additional measures to reduce patients’ risk of falling, such as reviewing foot wear and observing them more closely. Nursing staff completed intentional rounding charts to record care interventions such as hydration, toileting and continence care and re-positioning. Intentional rounding is a structured process, where nurses on wards in acute hospitals, carry out regular checks with individual patients at set intervals. We saw staff completed intentional rounding at hourly or two hourly intervals. However, records were not always completed contemporaneously. On some wards records were not completed for several hours in the morning and staff told us they completed them at the end of the morning. This meant the records were not always reliable.

Observation charts were completed accurately and consistently and care bundles were used to record interventions to reduce risks of patients developing pressure ulcers. This showed patients were being monitored and reviewed regularly.

Patients had paper medical administration record charts and records seen were legible.

Discharge summaries were completed when the patient left hospital and were sent to the patient’s GP.

Medicines

Best practice was mostly followed when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time. However, when antibiotics were prescribed, there was no evidence of a review date or rationale for continuing the medicines in the medicines administration record.

Medicines were stored safely in locked cupboards and refrigerators behind locked doors, or in medicines trolleys that were secured to the wall, when not in use. Staff recorded the temperature of the rooms and refrigerators used to store medicines daily. Records showed the temperatures were recorded consistently and were within recommended limits. Nursing staff completed regular checks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse), and recorded their use in line with requirements.

We observed pharmacists were based on some of the acute medical wards and during the week a clinical pharmacist visited all the wards daily. They reviewed medicines prescribing and administration records, completed medicines reconciliation and provided advice to staff. Medicines reconciliation is a process of checks of the patient’s medicines prior to admission to hospital and
their current medicines they are prescribed on admission to hospital, to ensure that patients received the correct medications.

We reviewed six medicines administration records and found medicines were mostly prescribed in line with best practice and records of administration were consistently completed. Staff recorded patients’ allergies and all records were legible, clearly dated and signed. However, we identified an issue with antibiotic stewardship. When antibiotics are prescribed, a review date should be recorded, to ensure antibiotics are not continued for any longer than is necessary. The medicines chart prompted a review date, or stop date, after three days. However, this was not completed by staff in four records we reviewed, although the pharmacist had circled the prompts to encourage medical staff to complete it. We did not see evidence of stop dates, or a review of the need for the antibiotic, when they were continued over a longer period. At our last inspection in 2017, we found inconsistencies in the review of intravenous antibiotics after the initial 48 hours of administration as stated in national guidance.

Incidents

Staff recognised incidents and reported them appropriately. Managers investigated incidents and action was taken to prevent recurrence. However, staff did not always receive feedback about incidents and lessons learned from them. We found examples of actions taken in response to incidents in one area, in which lessons from the incident were not applied in other similar areas.

In accordance with the Serious Incident Framework 2015, the trust reported 16 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from August 2017 to March 2018.

The breakdown of by type of incident is provided below

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>6</td>
<td>37.5%</td>
</tr>
<tr>
<td>HCAI/Infection control incident meeting SI criteria</td>
<td>3</td>
<td>18.8%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>3</td>
<td>18.8%</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by staff</td>
<td>1</td>
<td>6.3%</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by third party</td>
<td>1</td>
<td>6.3%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>1</td>
<td>6.3%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>1</td>
<td>6.3%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>

The trust used an electronic reporting system for recording incidents and accidents and action taken as a result. Ward staff told us there was an open culture in relation to incidents; they were encouraged to report incidents and they were all able to enter the details of incidents onto the electronic reporting system. However, most junior nursing staff said they reported incidents to the nurse in charge of the shift and the nurse in charge completed the electronic report.

The trust carried out a root cause analysis (RCA) in relation to serious incidents and identified preventative actions. Ward managers told us they were involved in completing the RCA for pressure ulcers and falls and identification of learning. A band six nurse on one ward, said the band six staff on their ward completed the investigation, together with an action plan; then their ward manager went to the RCA meeting with the tissue viability nurse. They said that most of their learning from incidents had come from doing the RCAs.
We received varying responses from nursing staff about learning from incidents. Some staff told us they received feedback from their ward manager or by email. However, some staff said the trust communicated learning by email and they did not have access to a computer at work, as they were constantly in use by medical staff, or that they did not have time to access their emails at work. Medical staff told us they heard about incidents and learning from incidents at governance meetings and morbidity and mortality meetings. A junior doctor told us they also received feedback about incidents at the junior doctors forum. A ward manager said the governance department sent out information about incidents and learning to all staff, however, they could not identify any learning from incidents from other wards. Other staff said they received information about incidents at the morning safety huddles or briefing sessions.

We were aware of several incidents when patients had left wards when they were unsafe to leave and had put themselves at risk. We reviewed some incidents that had occurred in October 2017 for a patient being cared for on Bluebell ward. We had some concerns that the improvement of safety in relation to the main exit door, had only been put into place shortly before this inspection, one year after the incident. In addition, alarms to the fire exits were put into place, but were not installed for other wards in the main building caring for similar patient groups.

From November 2014, trusts were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to the person. Staff we spoke with were aware of the duty of candour legislation and the importance of being open and transparent with patients and families when mistakes had been made. The trust provided us with examples of incidents when the duty of candour had been applied and the letters sent to patients in line with the requirements.

The trust reported that awareness of being open and the duty of candour requirements was provided to staff at a number of training sessions. They said compliance was reported to divisions and specialties to increase awareness of the duty or candour requirements. Information was also available online.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 46 new pressure ulcers, 18 falls with harm and 16 new urinary tract infections in patients with a catheter from August 2017 to August 2018 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at West Hertfordshire Hospitals NHS Trust**

1
The trust ran ‘Harm Free’ study days to raise awareness of ways in which the safety of care could be improved.

Staff told us there had been a focus on reducing pressure ulcers and falls within the trust. They said they completed a root cause analysis (RCA) to look at the care provided when patients developed a pressure ulcer and ways in which they could be prevented. The tissue viability nurse was involved to ensure an independent approach was taken. On Sarratt ward, staff told us they now checked patient’s heels daily, as this had been identified as an area where pressure ulcers developed on their ward. Staff told us they had skin champions to promote pressure ulcer prevention. Staff on Aldenham ward had identified issues with pressure ulcers developing on patient’s noses from the oxygen masks, so had changed the type of mask and were looking at ways in which they could protect the skin on the nose when patients wore masks.

In relation to falls, staff told us they placed patients at risk of falls in beds near to the bathroom facilities and where they could be observed easily. Where necessary, they requested an additional member of staff to provide one to one care of the patient.

**Is the service effective?**

**Evidence-based care and treatment**

Care and treatment provided was based on national guidance and evidence of its effectiveness. Audits were completed to make sure staff followed guidance.

We reviewed a small sample of trust policies and guidelines and found these referenced national, best practice, guidance relevant to the subject. Staff were able to access clinical guidelines from [Source: NHS Digital - Safety Thermometer](#)
the National Institute of Health and Care Excellence (NICE) and trust policies from the trust intranet. However, a doctor said they had experienced some difficulties in locating some guidelines on the intranet. The emergency guidelines were easy to find, but for others, they tended to call another member of staff within the specialty e.g. cardiology. Medical staff also had access to phone apps to access guidance, for example, microguide, which provided antibiotic guidance.

The trust reported that the clinical audit department sent NICE guidelines directly to the divisions, logging each set of guidance onto the trust’s NICE database. This was then used to monitor and track progress until completion. Our review of the minutes of clinical governance meetings and audit meetings showed that NICE guidelines were regularly discussed.

Examples of recently a completed audit to assess compliance with NICE guidance included an audit to assess compliance with NICE guideline, NG12 - Suspected cancer: recognition and referral, in relation to suspected upper gastrointestinal cancer completed in September 2018. The trust rated the audit as green using the red, amber, green (RAG) rating system, indicating the audit was completed and action plans and learning identified. The trust also provided us with details of other audits to assess compliance with NICE guidance that were being undertaken.

Staff told us of local audits that had been completed in medicine to monitor practice. One person told us the diabetic ketoacidosis protocol had been revised and there was a clear flow chart for staff to follow, as a result of a local audit. Another member of staff spoke about an audit of blood sampling that had resulted in new labelling, and audits of VTE prophylaxis. A third member of staff said the management of pneumonia had been audited using national criteria and improvement actions identified.

The trust provided us with a list of local audits completed in medicine during 2017/2018 and this demonstrated that the results were reviewed and changes to practice discussed as a result. They had a forward programme of audits for the current year.

We found a range of information on best practice displayed on the wards and in areas staff used. For example, Clostridium difficile and MRSA information, sepsis guidance, and falls prevention information.

The service had advanced care pathways in place for some medical conditions such as stroke, pneumonia, pneumothorax, and chest pain. This standardised interventions and ensured a systematic approach to investigation, diagnosis and treatment based on best practice guidance.

### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary and monitored the amount they ate and drank when necessary. The service made adjustments for patients’ religious, cultural and other preferences.**

Staff measured each patient’s nutritional status on admission to hospital, using a national screening tool (MUST) and a nutritional care plan was put into place, based on the results of this. The screening score was reviewed and recalculated on a weekly basis. Patient’s care records showed they were referred to a dietitian, when staff were concerned about their food intake. A patient with swallowing difficulties was also referred to a speech and language therapist. Another person had been reviewed by a dietitian and a plan was put into place for the patient. Food and hydration charts were completed to record patient’s intake, when staff identified an issue with their intake. The trust completed monthly audits of nutrition as part of the “Test your Care” ward performance dashboard.
We spoke with a patient who had a condition which they told us affected their energy levels. They said that as a result of their condition, they did not have the energy to eat much and had lost weight. However, they were seen by the dietitian and had been prescribed high energy nutritional drinks and offered snacks between meals.

We also spoke with three people who had individual dietary needs, for example one person required gluten free food, another was a diabetic and vegetarian. They told us they were offered a choice of food which met their needs.

We spoke with a person who was receiving nutrition through a tube into their stomach. They told us there had been a delay of 24 hours after the tube was inserted, before any food or fluids were given, due to a delay in the position of the tube being confirmed. This meant the patient was without additional nutrition for longer than was necessary. We checked the patient’s care records and saw the dietitian had advised on the nutritional regime and staff were following this, to ensure the patient received the correct nutritional supplements. A nasogastric checklist and ongoing plan were completed, to ensure the correct safety checks were completed prior to the administration of the nutrition.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

The patient records we reviewed, showed that nursing staff assessed patients’ pain regularly, as part of their routine observations, using the National Early Warning Score (NEWS). Staff said they would observe patients’ facial expressions, body language and a change in behaviour, if they were unable to communicate with them.

Patients who were experiencing pain had a care plan for the management of their pain. This identified when medicines were prescribed and when they were to be taken. Most patients we spoke with, did not have problems with pain. However, one patient we spoke with said they received pain relief when they asked. They told us that initially staff had offered them tablets for their pain, but they were unable to swallow them and it had taken a while for their normal liquid pain relief to be prescribed and provided.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. Performance in national outcome audits was variable, with good outcomes in the national stroke audit and results below the aspirational standards for the national audit of inpatient falls. There was a lower than expected risk of re-admission to hospital for medicine overall.

Relative risk of readmission

Trust level

From May 2017 to April 2018, patients at the trust had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Elective admissions

- Patients in gastroenterology, clinical haematology and cardiology had a lower than expected risk of readmission for elective admissions
Non-Elective admissions

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine and endocrinology had a higher than expected risk of readmission for non-elective admissions

Elective Admissions – Trust Level

![Graph showing ratios of observed to expected emergency readmissions for different specialties.](image)

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

Non-Elective Admissions – Trust Level

![Graph showing ratios of observed to expected emergency readmissions for different specialties.](image)

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics - HES - Readmissions (01/05/2017 - 30/04/2018))

Watford General Hospital

From May 2017 to April 2018, patients at Watford General Hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in gastroenterology, clinical haematology, cardiology and general medicine had a lower than expected risk of readmission for elective admissions
- Patients in geriatric medicine and endocrinology had a higher than expected risk of readmission for non-elective admissions

Elective Admissions - Watford General Hospital

![Graph showing ratios of observed to expected emergency readmissions for different specialties.](image)

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top
Non-Elective Admissions - Watford General Hospital

A respiratory consultant told us about the work they were doing across acute and community services to deliver integrated care and reduce re-admissions. They had introduced acute respiratory clinics, and there was increased community nurse input. This had impacted favourably on the length of stay of respiratory patients, and reduced re-admissions. An electronic referral management system was being introduced and it was felt this would lead to improved data quality as it was identified that the way in which coding of admissions was done, made it appear that patients were discharged without a specialty review, when this was not the case.

Sentinel Stroke National Audit Programme (SSNAP)

The Watford General Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade A in latest audit, August 2017 to November 2017.

The stoke unit in both patient and team centred performance has scored lower compared to the other metrics in the audit whereas multi-disciplinary team working has improved between the last two audit periods.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>A</td>
<td>B↓</td>
<td>B</td>
<td>A↑</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C</td>
<td>D↓</td>
<td>C↑</td>
<td>D</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>B</td>
<td>C↓</td>
<td>B↑</td>
<td>C↓</td>
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<tr>
<td>Domain 4: Specialist assessments</td>
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<td>B↓</td>
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</tr>
<tr>
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<td>Domain 6: Physiotherapy</td>
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<td>Domain 7: Speech and language therapy</td>
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<td>A↑</td>
<td>A</td>
<td>A</td>
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<td>Domain 8: Multi-disciplinary team working</td>
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<td>C</td>
<td>C</td>
<td>B↑</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>B↓</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
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<tr>
<td>Domain 10: Discharge processes</td>
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<td>A↑</td>
<td>B↓</td>
</tr>
<tr>
<td>Patient-centred total key indicator level</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>
### Team centred performance

| Domain 1: Scanning | A | B↑ | B | A↑ |
| Domain 2: Stroke unit | C | D↓ | C↑ | C |
| Domain 3: Thrombolysis | B | C↓ | B↑ | C ↓ |
| Domain 4: Specialist assessments | A↑ | A | B↓ | B |
| Domain 5: Occupational therapy | A | A | A | A |
| Domain 6: Physiotherapy | A | A | A | A |
| Domain 7: Speech and language therapy | A↑ | A | A | A |
| Domain 8: Multi-disciplinary team working | B↑ | C↓ | C | B↑ |
| Domain 9: Standards by discharge | B↓ | A↑ | A | A |
| Domain 10: Discharge processes | A↑ | A | A | B↓ |
| Team-centred total key indicator level | A | A | A | A |

### Overall Scores

<table>
<thead>
<tr>
<th></th>
<th>Aug-Nov 16</th>
<th>Dec 16</th>
<th>Apr 17</th>
<th>Aug 17</th>
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</thead>
<tbody>
<tr>
<td>SSNAP level</td>
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<td>Case ascertainment band</td>
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<td>Audit compliance band</td>
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<tr>
<td>Combined total key indicator level</td>
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<td>A</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

(Source: Royal College of Physicians London, SSNAP audit)

### Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 60.9%, which did not meet the audit minimum standard of 90%. The 2016 figure was 64.7%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 17.3%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 73.8%. This is within the expected range. The 2016 figure was within the expected range the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 51%. This is within the expected range. The 2016 figure was significantly worse than the national level.

The one year relative survival rate for the trust in 2016 is 31.4%. The 2016 figure was /not significantly different to the national level.

(Source: National Lung Cancer Audit)
We spoke with the senior management team about the proportion of patients seen by a cancer nurse specialist. They raised concerns about the accuracy of the data and results in this respect and said patients were seen by a specialist nurse. They told us they were exploring within the trust factors that impacted on the results of the audit. They told us they normally have 2.8 WTE lung cancer nurse specialists, although they had a short-term vacancy which was being filled.

**National Audit of Inpatient Falls 2017**

The crude proportion of patients who had a vision assessment (if applicable) was 0%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 0%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 7%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 89. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

The trust was participating in the NHS Improvement (NHSI) falls collaborative to explore ways in which falls could be reduced. Senior staff told us they had looked at the use of anti-hypertensive drugs on the acute assessment unit and learning from this was being rolled out to other wards. They identified that the falls assessment and checklist was too lengthy and as a result was not being fully completed. Therefore, this was being reviewed. They were also planning a “Deep Dive” exercise on Tudor ward.

A respiratory consultant told us about actions as a result of the chronic obstructive pulmonary disease (COPD) audit. In order to improve care across the acute and community setting, there had been a focus on a discharge care bundle and the community nurses were coming to the ward to take forward an integrated approach.

**Competent staff**

Managers made sure staff had access to training and assessed their skills and competence for their role.

However, managers did not always appraise staff’s work performance to provide support and monitor the effectiveness of the service. We also identified some concerns with the skill levels of some staff when dealing with the particular needs of patients living with dementia.

Staff told us they received a comprehensive induction when they commenced work at the trust. This included a trust wide induction and local induction. The local induction included orientation to the area and support to complete local competencies. We spoke with three nurses who were undertaking a transition programme, after training in other countries. They told us they had received support to undertake the examinations and competencies required, to allow them to be registered as nurses in the United Kingdom. They were positive about the support they had received from other staff within their area and from managers. A newly qualified nurse said they had a monthly review meeting with their ward manager and had been able to access additional training as they needed.

New band 5 nurses completed a competency assessment framework that was common to all staff in the trust. In addition, individual specialties had developed their own competencies for new staff when specific skills were required. For example, nurses in cardiology, spent a week in the cardiac
catheterisation laboratory and completed a competency in caring for patients following angiography.

Notice boards displayed training for nurses to attend, for example, nasogastric tube insertion training and infection prevention and control awareness. The ward manager on Winyard ward had developed a social media group for staff to inform them of training courses and training opportunities.

Practice development nurse posts had been introduced in medicine to support staff to undertake training and oversee completion of training. They were targeting their time on wards that the management team had identified as requiring additional support. They provided some short intensive training sessions for commonly required training and to improve staff awareness of quality issues such as prevention of pressure ulcers, or nutrition and worked alongside staff to develop their competencies.

All band six and seven nurses on the Dick Edmunds stroke unit were competent to undertake swallowing assessments. This was important to ensure patients who might experience swallowing difficulties following a stroke, were able to eat safely and were not without food and drink for an unnecessarily long period.

Staff on Bluebell ward and some of the other elderly care wards that cared for people living with dementia, told us they had completed breakaway training to help keep patients safe when they showed signs of anxiety and aggression.

We overheard a series of exchanges between staff and a patient receiving care behind curtains on Winyard ward, that gave us some concerns about staff’s knowledge of managing patients with dementia and/or delirium, who were agitated and confused. The patient was shouting loudly and protesting vigorously as staff were providing care. The staff with the patient, tried to explain in an impatient way, why they needed to provide care, however, they did not speak to the patient in a way that might calm the patient, or provide the reassurance necessary to gain their cooperation. They also appeared to continue, despite the patient’s protests, rather than refraining from providing the care for a few minutes and then trying again to gain their cooperation. We did not have the opportunity to speak to the staff involved afterwards, however, other staff spoke about using distraction and other techniques described above when patients were resistive of care they required. The ward manager was present and we spoke with them about our concerns; they told us they would address it.

Junior medical staff said they were able to access their weekly teaching sessions and were allocated an educational supervisor and clinical supervisor. Medical and nursing staff told us that they had sufficient support to undertake revalidation. Revalidation is a process by which doctors and nurses can demonstrate they have undertaken continuing professional development and maintained their competence to practice safely. Compliance with revalidation for medical staff was 100%.

We spoke with some therapy staff who told us they had good access to continued professional development and training. One member of staff said the department had in-service training each week and they utilised their own staff to provide updates on their areas of expertise.

**Appraisal rates**

From July 2017 to June 2018, 78% of staff within the medicine core service at the trust received an appraisal compared to a trust target of 90%.

The trust did not provide us with medical staffing appraisal rates.
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>43</td>
<td>42</td>
<td>98%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>16</td>
<td>15</td>
<td>94%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>93</td>
<td>87</td>
<td>94%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>455</td>
<td>347</td>
<td>76%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>386</td>
<td>287</td>
<td>74%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>73</td>
<td>51</td>
<td>70%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>4</td>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>1</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Appraisal rates varied for nursing staff according to individual ward. Some wards reported a completion rate of almost 100% while others identified they were not meeting the trust target and were trying to plan the appraisals into the rota in order to catch up.

Staff we spoke with said their appraisals were generally constructive and they had the opportunity to discuss their training and development needs. The trust monitored appraisal rates and reported them to the trust board.

**Multidisciplinary working**

Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

We observed effective multi-disciplinary working. Therapy staff were based on some wards and staff communicated well with each other.

We observed good multidisciplinary attendance at daily board rounds, which are an important tool to facilitate multi-disciplinary communication and effective care planning. A board round we attended on Sarratt ward had representation from medical staff, nurses, social workers, physiotherapists and occupational therapist. Each patient was discussed in terms of the plans for their care.

We also observed a daily MDT board round on the stroke ward. This was attended by medical, nursing, therapy and operational staff. Staff of all levels had a good knowledge of patients’ progress during rehabilitation.

Staff of all professional groups described very good multi-disciplinary teamworking (MDT) and we observed staff communicating well with each other and ensuring they had the required information about each patient.

A junior doctor on Bluebell ward told us the team work was exceptional. During our time on the ward we saw occupational therapists, physiotherapists, medical staff and nursing staff working seamlessly together. An occupational therapist told us they took a coordinating role in gathering information about patients on the delirium recovery pathway and went out with patients to their own home. They continued visits on a weekly basis for three weeks after discharge.

There was a team of therapists based on the stroke ward with the aim of rehabilitating patients who had had a stroke and preparing them for discharge. The team worked well together. Nursing and medical staff were complimentary of the therapy team.
Full weekly MDT meetings were held for each specialty and there was a full discussion of patients and plans for discharge.

The diabetes service worked closely with podiatrists and there was a twice weekly MDT foot round with attendance from podiatry, an endocrine consultant, vascular consultant and the diabetes specialist nurses. The service also had access to a psychiatrist and psychologist for patients with diabetes, who were experiencing psychological problems.

We saw evidence in patient records, of the involvement of dieticians, physiotherapists, occupational therapists, speech and language therapists, pharmacists and specialist nurses in addition to medical staff and ward nurses.

Pharmacists were present on the medical wards daily and out of hours there was an on-call service for advice and support.

**Seven-day services**

**Staff were working towards the provision of seven-day services.** Consultants completed ward rounds at the weekend in the acute medicine specialties although care of the elderly consultants were not present on site at the weekends. In the same way, allied health professionals were present in acute specialties at the weekend and provided an on-call service to other areas.

Consultants on the acute assessment unit were available seven days a week and all new patients were seen at the weekend. Consultants in acute medicine were on site seven days a week and completed ward rounds at the weekend. Each day, the on-call medicine rota was provided by the acute physicians from 8am to 5pm. From 1pm to 9pm Monday to Friday, a consultant geriatrician provided direct on-call reviews for all elderly patients over 80 years. A further on-call consultant physician supported the take from 5pm to 9.30pm and then was on call overnight.

At weekends there were two consultant physicians seeing patients post take from 9am to 12pm providing on-call review for newly admitted patients. From 12pm to 9.30pm one of these physicians continued to work a long day and then on call from home.

There was a further consultant physician covering the acute admissions unit, seeing sick patients and those for potential discharge on Saturday and Sunday mornings.

On Saturday and Sunday mornings two consultant physicians carried out discharge ward rounds throughout the general medical and care of the elderly wards seeing patients for discharge, to ensure patients were discharged in a timely manner over the weekend.

Out of hours, two registrars were available and were supported by a team of junior doctors and an advanced nurse practitioner. Consultants provided on-call cover at night.

The critical care outreach team and the hospital at night team provided a good level of cover and staff told us they were very responsive to requests for assistance.

Consultants for some specialties, including care of the elderly, completed ward rounds on three weekdays and their registrars led the daily ward round on other days. Cardiology, haematology and respiratory consultant wards rounds were undertaken seven days per week in addition to a 24 hour, non-invasive ventilation advice service.

A thrombolysis service was available 24 hours a day seven days a week, overseen by the stroke consultants on a rotational basis. There was daily stroke specialist nurse review.
The gastroenterology department provided a seven day service for acutely unwell gastroenterology patients. They ran a Sunday endoscopy list and saw new referrals on the acute admissions unit.

Physiotherapists and occupational therapists provided a service seven days a week and were available to respond to emergencies at the weekend.

Staff reported good access to diagnostic and interventional radiology out of hours and at the weekend.

Pharmacy operated a weekday 9am to 5pm weekday service, with an evening and weekend pharmacist available for dispensing urgent medicines. There was a weekend dispensing service at the hospital.

**Health promotion**

A range of information leaflets were provided for patients, in a variety of formats. These included locally produced leaflets and leaflets provided by national organisations and charities. We did not see any of these available in other languages or easy read format, although some of the leaflets gave a telephone for people to call if they required it in another language, Braille or audio format.

The trust displayed a range of health promotion information near the main entrance and other public areas. These included leaflets about Hertfordshire Health Walks, “Positive Movement” (a wellbeing programme for older people), and preventing blood clots. We also observed some health promotion information was displayed on the wards. For example, the respiratory ward had posters encouraging people to stop smoking and other wards had information about healthy eating. Information leaflets were also available about dementia and delirium, support for carers, discharge from hospital, sepsis and a range of other topics.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Most staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They were able to explain how they acted in patients’ best interests when they were unable to make decisions for themselves; however, mental capacity assessments and best interest decisions were not always documented as required.

We saw staff obtained consent for medical procedures and documented this. For example, when a chest drain was required.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible.

Staff we spoke with were aware of the requirement to complete a mental capacity assessment and to act in the patient’s best interests when patients were unable to make a specific decision for themselves. They described how they involved their relatives and other professionals in the decision making process. Some nursing staff were very knowledgeable and could provide examples of when it might be necessary to complete a capacity assessment and document the best interest decision, such as if a patient required a urinary catheter or an intravenous cannula. The trust provided a form for staff to complete to aid the documentation process.
We saw evidence of mental capacity assessments and best interest decisions, in relation to “do not attempt cardio-pulmonary resuscitation” (DNACPR) orders, when patients could not be involved in the decision making process. We also observed that a decision specific approach was taken in line with the legislation, when a person with a learning disability was able to make some decisions about their care, but not others.

However, we also found mental capacity assessments had not been undertaken for other patients who were unable to make their own decisions and decisions were taken in their best interests. We also identified two patients where we would have expected a DoLS application to have been submitted and they had not been. We discussed this with the ward managers of the wards and they told us they would address this immediately. Deprivation of Liberty Safeguards (DoLS) protect patients who are subject to restrictions that deprive them of their liberty and are unable to make decisions when they are in hospital and care homes.

Mental Capacity Act and Deprivation of Liberty training completion

The trust did not specifically provide training data against mental capacity act or deprivation of liberty.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Patients we spoke with, were very positive about the care and kindness they experienced from staff. One patient said, “The nurses here are better than anywhere else I have been cared for. They ask how I am feeling, if I am ok and try to help.” The patient also commented positively about the patience of nurses with patients living with dementia, or with mental health problems. Another patient said, “Nurses are always happy to help and very attentive. They always offer to help especially with trips to the toilet and shower.” Other patients described both nurses and doctors as excellent.

We were told about one exception to this, by a patient who had experienced a very poor and uncaring attitude from an agency nurse, towards them in particular, and also described the nurse’s attitude to other patients in their bay as “cutting.” They told us they had reported the issue to PALS and had received a profuse apology. We asked the senior leadership team about this and they told us the issue was being investigated.

A patient told us they had observed staff caring for a patient with autism. They said staff had been very caring and attentive when caring for the patient and showed an understanding of the needs of the patient.

Patients told us they were treated with dignity at all times and their privacy was respected. Staff were able to explain the steps they took to protect people’s dignity during care. For example, they spoke about assisting them at meal times and ensured they had a serviette and wipes to mop up any spillages. They also spoke about offering them choice and ensuring patients were nicely presented, as this was important to patients.

We observed a range of staff as they interacted with patients, reassuring them and explaining what they needed to do. For example, we observed two phlebotomy staff enter a bay and take blood samples from four patients. They greeted each person by name, and each step was explained during the procedure. They made the patients feel comfortable and provided
reassurance to those who were confused. We witnessed several other similar situations with other member of staff and patients.

Friends and Family test performance

The Friends and Family Test response rate for medicine at the trust was 25% which was similar to the England average of 25% from August 2017 to July 2018.

**Friends and Family Test – Response rate between 01/08/2017 to 31/07/2018 by site.**

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Tot ReSp</th>
<th>ReSp Ra</th>
<th>Percentage recommended</th>
<th>Ann Per</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aldenham Ward</td>
<td>73</td>
<td>62</td>
<td>94%</td>
<td>91%</td>
</tr>
<tr>
<td>Sarratt Ward</td>
<td>34</td>
<td>45</td>
<td>96%</td>
<td>56%</td>
</tr>
<tr>
<td>Stroke Unit</td>
<td>39</td>
<td>44</td>
<td>94%</td>
<td>90%</td>
</tr>
<tr>
<td>Red Suite</td>
<td>42</td>
<td>40</td>
<td>94%</td>
<td>88%</td>
</tr>
<tr>
<td>Cassio Ward</td>
<td>31</td>
<td>31</td>
<td>94%</td>
<td>84%</td>
</tr>
<tr>
<td>Endoscopy - Watford</td>
<td>29</td>
<td>34</td>
<td>28%</td>
<td>99%</td>
</tr>
<tr>
<td>AAU 1 Yellow</td>
<td>22</td>
<td>17</td>
<td>5%</td>
<td>81%</td>
</tr>
<tr>
<td>Key ( Highest score to lowest score)</td>
<td>10</td>
<td>4</td>
<td>0%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Note: sorted by total response

(Source: NHS England Friends and Family Test)

Staff told us they tried to obtain Friends and Family Test feedback from as many patients as possible and this was monitored on the ward quality dashboard. The ward managers on some of the care of the elderly wards, said the percentage of patients responding, was affected by the number of patients living with dementia or delirium, who could not give feedback. The ward
manager on Bluebell ward was trying to overcome this by arranging for a member of staff to contact the patients and/or close relative following discharge.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.**

Patients told us they received emotional support from nurses and other health professionals during their admission. Patients told us they found time for them when they were distressed or anxious and provided them with support and reassurance. However, one patient told us they had become very tired and distressed as a result of the other patients in the bay. They told us another patient was verbally aggressive and used 'foul' language when addressing staff and other patients made continuous noise throughout the night. They said they were eventually moved to another bay, however, they felt staff had been slow to respond to their concerns and were slow to intervene when patients were being disruptive.

Patients with diabetes had access to a psychologist and psychiatrist to support them in the management of their condition. Specialist nurses were also available in some medical specialties and provided ongoing emotional support to patients. Examples included respiratory clinical nurse specialists and lung cancer nurse specialists.

The chaplaincy team provided specialist religious care, spiritual and pastoral support to patients, visitors and staff of all religions, beliefs and world views, including those with no religious belief. The chaplaincy lead had qualifications in counselling and was supported by two part-time chaplains and a team of volunteer chaplains/pastoral support workers from a range of different religions, cultures and backgrounds that was reflective of the local population.

**Understanding and involvement of patients and those close to them**

**Staff mostly involved patients and those close to them in decisions about their care and treatment.**

However, we spoke with three patients who expressed concerns about a lack of communication between staff and departments which impacted on their confidence and trust in the care provided.

Most patients were aware of plans for their care and treatment and said they had been provided with the information they needed to help them make decisions about their care. One patient said they saw a different doctor each day, however, they were consistent in the information they provided. The patient said, “They are all singing from the same hymn sheet.” Another patient said doctors were always happy to explain and listened to their views.

However, we spoke with three patients on different wards, who expressed concerns about a lack of communication between staff and departments, which impacted on their confidence and trust in the care provided. They felt they were not listened to or involved in the plans for their care. Two of these patients told us they didn’t have the opportunity to ask questions during the daily ward round and didn’t feel their questions were properly answered. One said they were approached by five or six doctors and the doctors conducted their review without involving them, which made them feel quite intimidated. The other patient said doctors did not give them enough information or specific information. They went on to say, “They say they are doing the best they can and that they have already explained. It is all very woolly.” A third patient told us about concerns they had about their transfer from another hospital. They said they were transferred in the late evening and they had been informed of the ward they were being transferred to, but the ambulance staff had been given the name of another ward. They were taken to both wards, where staff said they were not expecting them and sent them to the emergency department. They eventually went back to the...
ward they had been told they were going to and staff said the message had not been passed from day to night staff. They were concerned that hospital staff did not listen to them and that communication was poor. They also had been told they would be going for a biopsy and the plan was changed twice and they felt “in limbo.”

Is the service responsive?

Service delivery to meet the needs of local people

Medical services were planned and provided in a way that met the needs of local people. They worked collaboratively with stakeholders to develop services to benefit the local population.

However, we identified a lack of shower facilities and single sex toilet facilities on the medical assessment unit, which was being used to care for inpatients at the time of the inspection.

Managers gave us a range of examples, which demonstrated collaborative working with the clinical commissioning group (CCG) and the strategic transformation programme (STP) for Hertfordshire. The rheumatology service had worked with the CCG to provide integrated pathways and services, reducing duplication and enabling patients to access less complex rheumatology services in the community. The respiratory service had worked in partnership with the CCG to agree a referral management system and pathway. Integrated diabetes services were also in place across acute and community services. The trust was part of the STP work being carried out around frailty.

Managers and clinicians from the dermatology service, attended project board meetings for skin health in conjunction with the Hertfordshire & West Essex STP. They attended regular meetings to discuss an integrated STP model and were working together to find a solution to the issues currently being faced within skin health. Meetings included representatives of the CCG, GPs, consultants, and the British Association of Dermatologists.

Tele-dermatology services, launched in September 2017, had reduced the number of patients attending the hospital for dermatology services. The aim of tele-dermatology was to allow the majority of patients to be treated by their own GP, following a suitable management plan suggested by the specialist, but without having to attend hospital. This helped to optimise resources across the health economy, as well as providing patients with an earlier outcome. Analysis over six months showed 63% of patients were given a management plan without face to face consultation and it resulted in a very positive response from the 2018 GP survey.

There was a clinical partnership group with another NHS trust looking at the management of pneumonia, anaemia, and heart failure. There was close working between the hospital and tertiary centres for the management of cardiology patients.

The cardiology department held an annual GP educational event to improve the referral and management of patients across acute and community services.

Medical services were provided in an environment which, on the whole, was suitable for patient’s needs. Wards were divided into single sex bays and there were a small number of side rooms that were mainly used for patients with infections. Bathrooms and toilets were designated as single sex, and the service was compliant with Department of Health guidance on single sex accommodation. A patient’s lounge was staffed to provide an area for patients on the day of their discharge. Refreshments were available along with a cooked lunch, sandwiches and snacks for
patients waiting for discharge. However, the medical assessment unit was used as a surge area, when the trust faced capacity issues. This was the case at the time of the inspection, when the area was being used to care for inpatients. No single sex toilet facilities and no shower facilities were available on the unit. The trust did not report any single sex breaches for patients in the medical assessment unit from July 2017 to June 2018.

Meeting people’s individual needs

Staff took account of most patients’ individual needs. Most staff showed a good awareness of the needs of patients with some complex needs such as those with a learning disability or autism. Interpretation and translation services were available for people who were unable to speak English.

However, adaptations to the environment on care of the elderly wards were not consistently or fully implemented to improve the experience of patients living with dementia.

The trust employed a specialist nurse for dementia care and staff were able to refer patients if they required support or advice in caring for patients living with dementia. Patients were screened for dementia on admission to hospital using prompts on the admission assessment proforma. If a cognitive impairment was identified they completed a further assessment. The trust had identified a patient with a diagnosis of dementia with a blue clasp on the patient’s wrist band and a “Forget me not” magnet on the ward whiteboard alongside the patient’s name.

Bluebell ward was a dementia assessment ward and the environment contained some adaptations to meet the needs of patients living with dementia or recovering from delirium. There was an area on the ward where patients could sit to do activities and have their meals. In addition, there was a kitchen to enable patients to undertake daily activities with the support of the occupational therapists and physiotherapists, who were based on the ward. We were told the trust employed an activities coordinator to provide activities for patients. The post was vacant at the time of the inspection, although a new appointment had been made. However, there were limited adaptations to improve the safety of people with dementia, on most of the care of the elderly wards. We saw one ward had contrasting toilet seats and contrasting colour toilet doors for example, however, this was not replicated on other wards.

A ‘Tiptree box’ (a box containing everyday items and activities to provide distraction for people with dementia) was available for staff to use with patients. However, there were limited other items to orientate or hold the attention of people living with dementia. The ward managers on Bluebell ward and Winyard ward told us they were hoping to purchase clocks with large numbers and other items specifically designed to improve the experience of people living with dementia, from charitable funds. There did not appear to be a trust wide approach to this and it was reliant on the enthusiasm of individual ward managers and their ability to raise funds or obtain funding from charitable sources.

Staff and patients had access to an acute liaison team employed by the county council to provide support for patients with a learning disability during an acute hospital admission. Staff told us the team were supportive and a good source of advice. Some patients with a learning disability were admitted with a purple folder which gave more information about the patient’s preferences and support needs. Staff on AAU told us they tried to obtain additional information about the patient from their carers or relatives to enable them to personalise care around the patient’s individual needs. In addition, staff used “This is me” booklets to provide further information about patients with a learning disability and those living with dementia, including their life history and things which interested them or were important to them.
A junior doctor told us they had found the learning disabilities liaison team supportive in a situation, when a patient with learning disabilities was admitted at the end of their life. They said the team were able to obtain information about the person’s preferences and things that upset them.

A patient on Cassio ward told staff that nursing staff were aware of their sensitivity to light and their anxiety towards people and crowds. Staff made adjustments for this by drawing the curtains and dimming the light above the patient’s bed space. However, they said consultants came to review them with several junior doctors in attendance and this made them feel uncomfortable.

Interpretation and translation services were available for people who were unable to speak English. Staff told us they could access interpreters through the hospital switchboard or the patient advice and liaison service (PALS). However, they did not have access to any other communication aids to assist them when patients could not understand English or had communication difficulties.

The trust had completed a range of initiatives to improve patient experience through the involvement of carers. They had appointed a carers lead for the trust who was the first point of contact for carers who could have instant feedback on the service provided. The trust website provided information for carers and we saw information leaflets for carers available in the wards and by the main entrance to the hospital. This provided information about the concessions and facilities available to carers. The website contained a link to the ‘Carers in Herts’ website. The trust had developed a carers agreement to support carers and staff to understand the contribution of the carer within the hospital environment. Carers were able to visit at any time and concessions on parking and refreshments were available.

We received varying feedback on the quality of the food. For example, two people told us the food was excellent with plenty of choice, while another said it was ‘dreadful’ being overcooked, ‘sloppy’ and potatoes were ‘soggy’. Another person told us the food was ‘hit and miss’.

We observed staff serving lunch on one of the medical wards. We observed them providing support to enable patients to eat and we also observed staff on an elderly care ward encouraging patients to drink between meals. Ward whiteboards provided information for staff on patients with special dietary requirements and those that needed assistance. The wards observed protected mealtimes by restricting access to the ward.

**Access and flow**

Patients could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

However, there were no agreed criteria for the use of the medical assessment unit as an inpatient area in times of capacity issues.

At our previous inspection in 2017 we identified that clinical specialities did not always meet the national average referral to treatment times. At this inspection we found improvements.

Referral to treatment (percentage within 18 weeks) - admitted performance

From July 2017 to June 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was better than the England average. For the most recent month of June 2018 the trust scored 94.3% compared to the England average of 88.7%.
Referral to treatment (percentage within 18 weeks) – by specialty

Five specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>100.0%</td>
<td>96.4%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>100.0%</td>
<td>97.0%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>100.0%</td>
<td>94.5%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>98.2%</td>
<td>93.7%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>96.3%</td>
<td>93.0%</td>
</tr>
</tbody>
</table>

Two specialties were below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>68.5%</td>
<td>82.2%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>61.8%</td>
<td>82.1%</td>
</tr>
</tbody>
</table>

The senior management team told us the referral to treatment time for cardiology was currently 92%. A significant improvement on the data provided above.

Patient moving wards per admission

From July 2017 to June 2018, 61% of individuals did not move wards during their admission, and 39% moved once or more. However, data was provided for one medical ward which was Red suite ward. Red suite was an acute admissions area and most patients would expect to be moved from there to a medical or care of the elderly ward if they required an admission to hospital.

(Please note: Red suite was not included in the data above as they were not a WGH ward.)

Patient moving wards at night

From July 2017 to June 2018, there were 324 patient who moved wards at night within medicine. The Red suite ward was the highest reporter of patient moves at night accounting for 23% of the total. There was no trend over time with the most reported in March 2018, there was 44 moves at night during this month.

Calls from patients referred to medical services by their GP, and patients requiring admission from the emergency department, were accepted by a nurse coordinator/navigator from 8am to 8pm and they allocated patients to the most appropriate area. Outside these hours the registrars took
referrals from GPs. Twice daily multi-disciplinary board rounds were undertaken on AAU to review patients and plan their next steps.

Most patients were admitted via the AAU or the medical assessment unit (MAU). The medical assessment unit was primarily used for the assessment of patients and the aim was for patients to stay no longer than four hours. Staff escalated to senior staff, when patients stayed longer than four hours, in order that an inpatient bed could be identified for them. There was a consultant presence in MAU for 15 hours a day and all patients were reviewed twice daily. However, at the time of the inspection, MAU was being used to accommodate inpatients, due to a lack of bed capacity elsewhere in the hospital. There was no clear operating policy that identified the criteria for patients that could be safely cared for on the MAU, when it was used to provide inpatient care. When we visited MAU, we had concerns about the suitability of the environment for a patient on the unit and escalated our concerns to the senior management team. They immediately arranged for the patient to be moved.

Most patients requiring non-invasive ventilation were admitted directly to Aldenham ward. Standard operating procedures had been developed to prioritise patients requiring care on the ward. Plans were in place to increase the number of acute respiratory beds on the ward to enable the ward to care for all patients requiring non-invasive ventilation.

The trust used the SAFER patient flow bundle developed by the NHS Improvement team to track patient’s progress from admission, through the wards to discharge. This used a red to green traffic light system. Discharges before 10am, 12midnight and 4pm were monitored. Staff told us there had been increased emphasis on patient flow and highlighting delays to discharge, in order that they could be managed more effectively. During our inspection the divisional director and associate divisional director visited the wards to review capacity as there were challenges with patient flow.

The patient lounge was open from 8am to 8.30pm Monday to Friday and from 10am to 5pm Saturdays, Sundays and Bank Holidays. This area accepted patients on the day of their discharge when they were ready to go home. Some patients waited in the patient lounge for their discharge medicines, whilst others had already been provided with these. The trust used a checklist to ensure all the required arrangements had been made and the patients could be safely discharged. The intention was that this should be completed prior to their move to the patient lounge. However, data provided by the trust showed that in most cases the discharge checklist had not been completed prior to transfer. From 1 November 2018 to 5 November 2018 inclusive, 117 patients were cared for in the discharge lounge. Of these, 88 patients did not have a discharge checklist completed prior to transfer. This meant there was an increased risk of an unsafe discharge.

The trust reported that the average time for the provision of patients’ medicines to take home was one hour 45 minutes in 2017 against a one hour target. A review of staffing and processes in pharmacy had resulted in improved times and achievement of the one hour target.

Staff on the medical wards highlighted issues with their ability to discharge complex patients in a timely way when they required care packages or oxygen at home for example. Staff told us they worked closely with social services staff and completed the required referrals in a timely way, however, delays happened. A central assessment team were in place to reduce the need for staff from residential and nursing homes to come to the hospital to assess patients.
Average length of stay

Trust Level

From June 2017 to May 2018 the average length of stay for medical elective patients at the trust was 5.4 days, which is lower than the England average of 6.0 days. For medical non-elective patients, the average length of stay was 6.1 days, which is lower than the England average of 6.4 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gynaecological oncology and gastroenterology is higher than the England average.
- Average length of stay for elective patients in cardiology is lower than the England average.

Elective Average Length of Stay – Trust Level

[Bar chart showing average length of stay for elective specialties at the trust compared to England average.]

Note: Top three specialties for specific trust based on count of activity.

Average length of stay for non-elective specialties:

- Average length of stay for elective patients in general and geriatric medicine is lower than the England average.
- Average length of stay for elective patients in endocrinology is higher than the England average.

Non-Elective Average Length of Stay – Trust Level

[Bar chart showing average length of stay for non-elective specialties at the trust compared to England average.]

Note: Top three specialties for specific trust based on count of activity.

Watford General Hospital

From June 2017 to May 2018 the average length of stay for medical elective patients at Watford General Hospital was 5.5 days, which is lower than England average of 6.0 days. For medical non-elective patients, the average length of stay was 6.1 days, which is lower than England average of 6.4 days.

Average length of stay for elective specialties:
• Average length of stay for elective patients in gynaecological oncology and general medicine is higher than the England average.

• Average length of stay for elective patients in cardiology is lower than the England average.

**Elective Average Length of Stay - Watford General Hospital**

![Graph showing Elective Average Length of Stay](image)

*Note: Top three specialties for specific site based on count of activity.*

**Average length of stay for non-elective specialties:**

• Average length of stay for non-elective patients in general and geriatric medicine is lower than the England average.

• Average length of stay for non-elective patients in endocrinology is higher than the England average.

**Non-Elective Average Length of Stay - Watford General Hospital**

![Graph showing Non-Elective Average Length of Stay](image)

*Note: Top three specialties for specific site based on count of activity.*

The senior leadership team told us of work they had been undertaking to reduce length of stay. There was a clinical lead for the SAFER programme (a national NHSi programme) to improve patient discharge and reduce delays. A multi-disciplinary team reviewed all patients staying over 14 days twice weekly and in October 2018, they had shown a 30% reduction in the number of patients staying over 14 days in comparison to March 2018. They also completed “Fresh Eyes” ward rounds as a multi-disciplinary team to improve patient flow.

Senior clinicians identified some issues with patients who were at the end of life and required a “fast track” discharge. This was managed by the integrated discharge team, however, they told us the process was lengthy and did not achieve a timely discharge for patients.

**Learning from complaints and concerns**

Concerns and complaints were treated seriously, investigated and lessons were learned from the results, and shared with staff.

At our last inspection in 2017, we found that complaints were not always managed effectively, with frequent delays in response to complainants. At this inspection we found improvements had taken place. The senior leadership team told us they had weekly reviews of complaints to check on their
progress and monitor response rates. The matrons now took a lead role in drafting the responses to complaints.

The trust had a complaints policy and a complaints and Patient Advice and Liaison Service (PALS) team. We saw some information about these was available in the clinical areas.

Summary of complaints

From July 2017 to June 2018 there were 122 complaints about medical care. The trust took an average of 25 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be completed with 30 days.

The most common themes included patients care reported 62 times followed by appointments reported 17 times.

Site level breakdown is provided below:

- Watford General Hospital: There were 111 complaints, 60 related specifically to patient care.
- Hemel Hempstead General Hospital: There were eight complaints, most related to appointments.
- St Albans City Hospital: there was three complaints associated to medicine at this site

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From August 2017 to July 2018 there were 68 compliments within medicine all reported at the Watford General Hospital site.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Staff told us they would try and resolve any concerns raised with them and would refer patients to PALS, if they wanted to make a complaint.

Ward managers were generally aware of the complaints for their ward and told us they tried to address any issues directly. They communicated learning from complaints to staff, in a variety of ways, including feedback at handovers and putting information about complaints in the staff communication folder.

Information about feedback from patients and relatives was provided on display boards on each ward, alongside other quality indicators. Comments from patients were listed and actions taken to address areas of concern were also given.

Is the service well-led?

Leadership

Managers had the right skills and abilities to run a service providing high-quality sustainable care. There was some variability of experience and skills at band seven level; however, the nursing leadership team were aware of the issues and providing support and development to staff.

Following a divisional restructuring exercise, the acute assessment unit and medical assessment unit were managed within the division of emergency medicine, whilst the rest of medical services were managed in the division of medicine. Each division was led by a divisional director, divisional manager, clinical director and head of nursing. The leadership team were supported by clinical leads, matrons and governance facilitators. There were clear lines of responsibility and
accountability. The senior leadership team told us there was less “silo” working and more cross divisional meetings. During the inspection, we observed staff within the two divisions, working seamlessly together, to manager patient flow and achieve the best outcomes for patients.

We met with the divisional director, associate divisional director, divisional manager, clinical director, head of nursing and deputy head of nursing for the division of medicine. They had a clear understanding of the performance of the division and the challenges to performance. They told us the divisions worked well together and said there was a now a better flow of information and daily conversations, to improve patient flow and address capacity issues. They were exploring what they could do differently, in relation to winter planning and working with stakeholders to achieve this. We witnessed divisional leaders visiting the wards during the inspection, when capacity and flow issues were identified. A member of staff in AAU said, “We can escalate any issues at the morning meetings; the chief operating officer, or the chief nurse attends the meetings most days.”

Each speciality had a medical clinical lead. Medical staff including junior medical staff, told us the medical director was visible and they found the clinical leads supportive.

Matrons and the head of nursing were visible in the clinical areas during the inspection and staff told us this was routine. Ward managers told us they saw their matron on a daily basis and they were approachable, supportive and in touch with what was happening at clinical level. We saw evidence that when issues were identified with a ward, the head of nursing and matrons had put in a series of supportive measures to review practices and bring about improvements. When we visited the ward, staff were very positive about the changes and the ongoing improvement initiatives. We visited a second ward where we identified some concerns about leadership, staff skill mix and deployment. The nursing leadership team had taken some steps to provide some additional support to the ward and told us they were monitoring the situation.

Ward managers were supernumery, to allow them to provide clinical support and supervision, and undertake their managerial role. Ward managers we spoke with, were generally enthusiastic and keen to improve. They were aware of their ward’s performance against the quality performance indicators, although we saw limited evidence of learning from each other and the spread of new practice across the division. The exception to this, was the coronary care team’s nightingale project on the coronary care unit, that was introduced to reduce patient harm from pressure ulcers on Sarratt ward.

AAU had a band seven sister for each area. We obtained varying responses from staff in AAU as to whether they felt supported and appreciated. From the feedback we obtained, this reflected the differing leadership skills of the band seven staff. An experienced member of staff said, “I have a good relationship, but some staff can feel intimidated. There are some quite strong characters among the band sevens.” Another member of staff spoke about a band seven nurse not tackling issues with some staff and people not always being treated equally. We spoke with a senior nurse who said there was some variability in the experience of the band seven staff and they were aware of this and providing support and training.

**Vision and strategy**

Managers had a vision for what they wanted to achieve and workable plans to turn it into action. The vision and strategy were developed with involvement from staff and key groups representing the local community.

The trust vision was, “To deliver the best care for every patient, every day.” They had identified four key strategic aims:

- Best quality care
• A great place to work and learn
• A strategy for the future
• Improving our finances

This was underpinned by the trust’s core values which were: Care, Commitment, and Quality.

The values had been created with the help of patients and set out the standards by which patients, their partners, family and friends, should expect from all staff. The appraisal process incorporated the trust’s values, whereby each member of staff had to evidence how they demonstrated the values at work.

The medical service had an outline strategy for the next two years. A member of the senior leadership team described how it took into account the interface with the division of emergency care and the interface with the community. The trust provided us with a diagrammatic overview of the strategy for medical services for 2018 to 2020. This identified four areas of focus:

• The interface with the emergency department and AAU
• Inpatient care and patient flow
• Integrated care and outpatient services
• Future developments

Workstreams were identified for each of these areas providing an outline of the priorities for the division.

**Culture**

**Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**

The senior leadership team told us the culture had changed over the last two years. They said there was now a clear understanding of acceptable behaviours and the way in which things should be done in the organisation. They told us it was about valuing people and listening to them.

All staff we met were welcoming, professional, friendly and helpful. Staff were enthusiastic about their area or specialty and were committed to providing the best possible care for patients. A member of staff who had recently been appointed to a post on a ward that had struggled to meet the trust’s ward quality performance indicators, said staff were now very involved in the improvement projects and had responded very positively, whereas previously they had felt blamed and demotivated. A junior doctor told us they found the service a supportive place to work and all their senior colleagues were helpful. The exception to this positive feedback from staff, was a small minority of nursing staff working in AAU, who said they only received negative feedback and felt unappreciated. A member of staff identified issues with staff retention in AAU, which they blamed on the type of service and the lack of praise and positive feedback.

Staff spoke about the excellent teamwork within each specialty and we witnessed this in the clinical areas. Staff were proud of their teams and told us they were encouraged to put forward ideas to further develop the services.

Staff we spoke with did not know who the freedom to speak up guardian was for the trust; however, they were aware there was one and said they had seen posters about it, so it would be easy to find the information. Some identified there was a link on the trust intranet where they could access the information.
Staff said they were encouraged to be open and honest. The understanding of the duty of candour was variable amongst staff, however, they were able to explain the basic principles of openness and apologising to patients when things went wrong. The trust provided us with evidence that they were adhering to the requirement of the duty of candour.

**Governance**

A systematic approach was used to continually improve the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. We found examples of discussion at department and divisional level to identify improvements to the quality, safety and effectiveness of care.

Medical services had an established clinical governance framework at divisional and department levels. At divisional level, there was a monthly divisional governance meeting and departments were represented at this committee. We reviewed the minutes of a meeting and found there was good attendance from clinical leads, governance leads, and the senior management and leadership team for the division. There was a discussion of incidents, audits and NICE guidance and other issues affecting the quality and safety of care. We did not see evidence of a discussion about the risk register or complaints at this meeting, suggesting there wasn’t a standard agenda; however, we saw these issues were discussed at department or specialty level.

We reviewed the minutes of clinical governance meetings held at specialty level and whilst the agenda was not consistent across the different specialties, there was evidence of a discussion of incidents, risks, audits and ongoing operational challenges to the quality of the services. Each specialty had a nominated audit or governance lead.

The senior leadership team told us they had joint audit half days four times a year with the emergency medicine division. At these meetings departments shared audit findings and learning from incidents and complaints.

**Management of risk, issues and performance**

There were effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Risks were clearly identified in the divisional risk registers.

There were daily meetings to review all incidents, harms and actions and ward based daily safety huddles.

Divisional risk registers identified the key risks within each division. We reviewed the risk registers and found the risks we had identified during the inspection were generally identified on the risk register. We spoke with the senior leadership team about the main risks within the division of medicine and the actions they were taking to mitigate the risks. For example, they spoke about the safety of the acute medical take due to the number of registrar vacancies. They said they were working on a major rota re-design, involving the speciality doctors and recruiting overseas trainees. They were providing a programme of induction and supernumery working.

Ward key quality performance indicators were measured and reported monthly to the trust board. They covered a wide range of quality indicators, including number of pressure ulcers and falls, infection control indicators including hand hygiene, and friends and family test results. Ward managers were aware of their monthly performance and they told us of actions they were taking to improve. We were told of a quality improvement programme on Sarratt ward, where quality issues had been identified previously. Staff told us of the focus on the deteriorating patient, pressure ulcer prevention, infection prevention and control and medicines management.
All the medical wards had a display board visible to visitors and staff, with details of their performance in relation to some of the ward quality indicators and also their planned and actual staffing levels.

Root cause analysis (RCA) was completed for hospital acquired grade 3 and 4 pressure ulcers and injurious falls. Nursing staff told us they completed an investigation and an action plan. They said the falls specialist nurse or the tissue viability nurse was involved and a root cause analysis was undertaken.

The division showed evidence of a planned approach to clinical audit in that each specialty had an audit plan for 2018/19 and monitored progress against it.

The trust had a major incident plan dated September 2017. Staff could access the plan on the trust intranet. Major incident training was included within the trust induction. The trust had a business continuity plan released in May 2017, which provided guidance on maintaining services and dealing with business interruptions, which might disable services or require special arrangements to be put in place to allow them to continue.

**Information management**

The trust collected, analysed, managed and used information well to support its activities. Most records were paper based and when electronic systems were used, security safeguards were in place.

However, the trust information technology systems were slow and access to computers was an issue for staff in some areas. We also found some areas had patient names displayed on white boards in areas visible to visitors walking onto the ward.

Data was collected and audits completed; the information gained was used to improve the service provided. A range of information was available at divisional level, to enable managers to assess and understand performance in relation to quality, safety, patient experience, workforce, operational performance, and finances. The trust had identified targets for the performance indicators and rated performance using the traffic light, RAG (red, amber, or green) rating system. This allowed managers to assess their performance at a glance and identify those areas which required further improvement or investigation.

Most clinical information about each patient was paper based. Patients’ care records were stored in lockable trolleys, with keypad access. We found most of the trolleys were locked when we checked, however, we found a trolley was unlocked on Gade ward and Aldenham ward. Nursing daily records of care such as vital signs observations and food and fluid balance charts were stored at the end of each patient’s bed.

Discharge letters were sent electronically to their GP and a copy was given to the patient. Medicines to take home were prescribed electronically, then printed out and given to pharmacy.

Wards had white boards identifying the initial and last name of patients in each bed, although there was no other information about the patient, such as their diagnosis. Some of these were in full view of visitors entering the ward, while others were in areas less visible to the public.

Computers used on the wards to access patient information, such as results of investigations, discharge letters and medicines systems, were always logged out when we observed them unattended, thus protecting patient information. Medical staff told us there were major problems with the information technology as the computer systems were very slow. Nursing staff in some areas told us they could not access the computers, as they were in constant use by junior doctors and pharmacists. The number of computers each ward or unit had access to, varied and therefore...
we observed this was more of an issue in some areas than in others. Staff spoke about not being able to access the computer to track pharmacy medicines requests, for example. They told us they had to book training electronically. In addition, some training was through e-learning; this made accessing training difficult. Staff also told us they did not have the opportunity to check their work emails and as most information from the trust, particularly in relation to learning from incidents, etc. was sent by email, they weren't able to access the information in a timely way or missed out on it.

Trust policies and clinical guidelines were available on the trust intranet. Some staff told us they found it easy to access policies and guidelines whilst others told us they had experienced difficulties in finding individual policies.

**Engagement**

**Staff engaged well with patients, staff, the public and local organisations to plan and manage appropriate services.**

The senior leadership team told us of patient and stakeholder involvement in the development of planned care initiatives.

The respiratory service provided examples of several developments in which they had involved patient groups in evaluating and developing the service. For example, interstitial lung disease (ILD) is an umbrella term for a large group of disorders that cause scarring (fibrosis) of the lungs. The scarring causes stiffness in the lungs which makes it difficult to breathe. The service was discussed with patient groups and GP groups and feedback obtained to shape the future provision of the service.

The gastroenterology specialty engaged with patients with inflammatory bowel disease. The consultants and specialist nurses ran regular patient group meetings. They were praised by the National Association for Crohn's and Colitis for this. The team also managed patients in the community and developed a support service for individuals to phone, if they required advice. Feedback from patients was that this service was vital in managing their condition but the time frame for contact was too long. As a result, they increased the resources allocated and patients were contacted within 24 hours, helping to improve the safety of patients.

The cardiology physiology service held twice yearly meetings for the benefit of our complex device (implanted cardioverter defibrillator) patients. These were called Energy meetings and all the patients who had these complex devices were invited. They told us the usual number of attendees was approximately 50-60 patients and friends; and feedback was always very positive. They were sponsored by one of the two companies supplying the devices and they frequently provided an educational element to the afternoon, as well as a patient story and other topics requested by the patients themselves, which had included nutrition and mental health issues. Attendees were encouraged to put forward ideas to help improve the device service and make the meetings as positive as possible., as a lot of these patients would have had a cardiac arrest or arrhythmia requiring intervention.

Cardiology consultants were honorary presidents of each of Watford, Hemel Hempstead and St Albans patient heart groups and attended at least once a year their meetings to discuss cardiac issues.

The stroke unit had produced an information booklet and personal record to guide patients and family through their care. The feedback given was very positive and to improve this even further the unit were looking at condensing the booklet.
Within the endoscopy unit, the bowel screening service had a specific patient feedback questionnaire. These results are regularly scrutinised and presented at the clinical governance meeting that influences decisions on improving the service.

The endoscopy unit also had a separate patient and staff survey that was completed every year. The results were presented at the clinical governance meeting and a poster presentation was displayed at the entrance to the unit.

The trust undertook leaver surveys and focus groups to engage with staff and there was an annual trust survey. They also undertook quarterly staff surveys which was made up of 11 questions including questions on FFT, relationship with managers, day to day issues and feeling pride.

Our discussions with staff indicated they were positively engaged and confident to raise concerns. In many instances they said they were asked for their ideas and listened to.

**Learning, continuous improvement and innovation**

Managers were committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation. We found numerous examples of continuous improvement and development of services to sustain them into the future.

However, we found that learning identified in one area did not always result in changes in others and some areas of concern we identified at our inspection in September 2017 had not significantly improved.

During our inspection we reviewed areas identified as concerns in our inspection in September 2017. We found most of these had improved. For example, staff adherence to good hand hygiene practices, referral to treatment times, same sex breaches and response times to complaints. However, some aspects had not improved, such as inconsistencies in the review of antibiotics, and re-assessment of the risk of venous thrombo-embolism (VTE).

We also identified that learning from some incidents when patients had left the wards, risking their own safety took an extended timeframe for action to be completed and learning was not extended to other wards that might experience similar issues.

However, we saw numerous examples of actions take to sustain, improve and further develop the service.

The rheumatology service ran a televised MDT for complex rheumatology patients that allowed tertiary care management of patients without the patients moving to the tertiary care centre. It had won a best practice award.

The endoscopy service had achieved Joint Advisory Group (JAG) accreditation and had a new endoscopy suite.

The trust participated in the NHSi falls collaborative project and AAU was one of the pilot areas. They identified issues with patients on blood pressure lowering medication and elderly patients who were on a range of medicines which might impact on their risk of falling. As a result of the project there was an emphasis on recording lying and standing blood pressures, withholding blood pressure lowering medicines when patients had a low blood pressure and medicines reviews.

A nurse endoscopist led telephone assessment service, was commenced April/May 2018. All gastrointestinal patients who had been placed on the two week pathway, were assessed, triaged, the patient phoned and offered straight to test, for example, endoscopy, an appointment in the clinic, or a scan. The results were then followed up and the patient was informed. The trust told us
this system was working effectively and had reduced the length of time patients were on the pathway considerably.

There has been an appointment of a Parkinson’s disease nurse who conducted ward referral reviews and held a dedicated nurse led clinic.

Cardiology had introduced cardiac CT scanning and MRI in the last 12 months. The local cardiac CT service was fully compliant with NICE CG 95 and Watford General hospital were the first hospital within the M25 to be up and running with Heartflow, as part of the NHS Innovation and Technology Payment (ITP) programme. The HeartFlow technique enabled the assessment of coronary artery disease with CT coronary angiography aimed at giving a timely and accurate assessment of the extent of coronary artery disease. This had reduced unnecessary investigations and enabled patients to receive definitive treatment at a much earlier stage. The funding was allocated from NHS England.
Facts and data about this service

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

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

Watford General Hospital has five main operating theatres covering general surgery, trauma, and orthopaedics. Theatre one was dedicated for emergency trauma operations. Theatre five was dedicated for low risk, and day case surgery. The theatre suite comprises of five theatres and the post operation recovery area. The hospital has six inpatient wards (Cleves, Flaunden, Langley, Letchmore, Ridge and Elizabeth) with a total of 163 beds, a pre-assessment unit, an emergency surgical admissions unit (ESAU) and an admissions area combined with a day surgery unit (Surgical Admission Unit/Surgical day case area). Fracture and orthopaedic clinics were also held at this site.

Watford General Hospital provides a range of elective (planned) and emergency (unplanned) surgery services for the community it serves. The trust had 28,905 surgical admissions from June 2017 to May 2018. Emergency admissions accounted for 7,035 (24.3%), 17,959 (62.1%) were day case, and the remaining 3,911 (13.5%) were elective.

(Source: Hospital Episode Statistics)

During our unannounced inspection on 16 to 18 October 2018, we visited all areas providing surgery services at the hospital, spoke with 13 patients or their relatives, observed patient care and treatment and looked at 25 patient care records. We spoke with 70 members of staff including nurses, doctors, surgeons, therapists, healthcare assistants, administrators, theatre staff, ward managers, matrons, and senior managers. We also considered the environment and held focus groups attended by trust staff prior to the inspection and reviewed the trust’s surgery performance data.

Surgery was previously inspected in September 2017 and was rated good for effective, caring and well-led, and required improvement for safe and responsive. The overall rating was requires improvement.

Is the service safe?

Mandatory Training

The service provided mandatory training in key skills to staff and generally made sure everyone completed it. There was improving compliance with the trust target of 90% completion.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training.

Watford surgery department

A breakdown of compliance for mandatory courses from July 2017 to June 2018 for qualified nursing staff in the surgery department at Watford is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-patient moving and handling</td>
<td>33</td>
<td>33</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>161</td>
<td>184</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient moving and handling</td>
<td>159</td>
<td>184</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>148</td>
<td>184</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>148</td>
<td>184</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire non-clinical</td>
<td>139</td>
<td>174</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene</td>
<td>138</td>
<td>184</td>
<td>75%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control</td>
<td>130</td>
<td>184</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>130</td>
<td>184</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire and evacuation clinical</td>
<td>123</td>
<td>184</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>113</td>
<td>184</td>
<td>61%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Watford surgery department the 90% target was met for one of the 11 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory courses from July 2017 to June 2018 for medical staff in the surgery department at Watford is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire and evacuation clinical</td>
<td>86</td>
<td>92</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Non-patient moving and handling</td>
<td>141</td>
<td>167</td>
<td>84%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>142</td>
<td>198</td>
<td>72%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>139</td>
<td>198</td>
<td>70%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire non-clinical</td>
<td>116</td>
<td>193</td>
<td>60%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>117</td>
<td>198</td>
<td>59%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene</td>
<td>111</td>
<td>198</td>
<td>56%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>43</td>
<td>77</td>
<td>56%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control</td>
<td>110</td>
<td>197</td>
<td>56%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>89</td>
<td>170</td>
<td>52%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient moving and handling</td>
<td>69</td>
<td>157</td>
<td>44%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Watford surgery department the 90% target was met for one of the 11 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Mandatory training was an annual cycle for all staff. There was a structured induction programme in place for all new staff. All trust staff were expected to complete mandatory training modules. Trust training was both face-to-face and elearning. Staff were allocated dedicated time to complete ‘face to face’ mandatory training.

A new staff member’s mandatory training profile was identified at their induction to meet the needs of their role, using the trust’s standard matrix. Any individual specific requirements were identified, and this training profile added. Staff were informed as to their requirements via induction processes and could see their own training profiles via their own electronic training records. Training was completed and entered onto the trust’s electronic system where any competences achieved through training completion could then be awarded. A new electronic
system had been recently introduced. This allowed staff to access their own training details whilst at home. Band 7 nurses could access training details for the whole trust.

The induction process for each new staff member was reviewed monthly as part of the service’s routine reporting process. Individual service area reports were sent to managers for validation and action and overview shared at group meetings for local action. Senior staff said there had been work undertaken to improve the compliance rates across the mandatory training portfolio with steady progress being made. The diversity and inclusion mandatory training for staff included information about protected groups, and what needs to be taken into account to provide high quality services.

Data provided by the trust prior to the inspection, indicated that both nursing and medical staff reached the trust target for completion of mandatory training in only one of 11 mandatory training topics listed. For some topics, compliance was significantly lower than target. For example, adult basic life support (ABLS) training was at 61% for the nursing staff and 52% for the medical staff. Senior managers were aware of poor compliance and recognised this as a risk. They put on more training sessions. The service had an action plan in place to improve compliance with this mandatory training. This was also on the service risk register. We found sufficient staff on duty with relevant life support training and this was factored in when rotas were planned. Updated figures provided by the trust on inspection showed that ABLS had increased to 85% for nursing staff and to 74% for medical staff.

The service provided updated training figures for the three months prior to the inspection:

<table>
<thead>
<tr>
<th>All Mandatory Training for All Staff in the Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of July 2018 (Reported on 8/8/18)</td>
</tr>
<tr>
<td>End of August 2018 (Reported on 31/8/18)</td>
</tr>
<tr>
<td>End of September 2018 (Reported on 31/10/18)</td>
</tr>
<tr>
<td>Most Recent Report Available (Reported on 15/10/18)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adult Basic Life Support Compliance for Registered Nursing Staff in the Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of July 2018 (Reported on 8/8/18)</td>
</tr>
<tr>
<td>End of August 2018 (Reported on 31/8/18)</td>
</tr>
<tr>
<td>End of September 2018 (Reported on 31/10/18)</td>
</tr>
<tr>
<td>Most Recent Report Available (Reported on 15/10/18)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Moving and Handling Compliance for Medical Staff in the Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of July 2018 (Reported on 8/8/18)</td>
</tr>
<tr>
<td>End of August 2018 (Reported on 31/8/18)</td>
</tr>
<tr>
<td>End of September 2018 (Reported on 31/10/18)</td>
</tr>
<tr>
<td>Most Recent Report Available (Reported on 15/10/18)</td>
</tr>
</tbody>
</table>

(Source: DR 65)

<table>
<thead>
<tr>
<th>Date of Report</th>
<th>% of Doctors Compliant in ABLS for Surgery and Anaesthetics Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>16/07/2018</td>
<td>58%</td>
</tr>
<tr>
<td>08/08/2018</td>
<td>52%</td>
</tr>
<tr>
<td>16/08/2018</td>
<td>53%</td>
</tr>
<tr>
<td>31/08/2018</td>
<td>50%</td>
</tr>
<tr>
<td>17/09/2018</td>
<td>58%</td>
</tr>
<tr>
<td>24/09/2018</td>
<td>60%</td>
</tr>
<tr>
<td>01/10/2018</td>
<td>71%</td>
</tr>
<tr>
<td>08/10/2018</td>
<td>73%</td>
</tr>
<tr>
<td>15/10/2018</td>
<td>74%</td>
</tr>
</tbody>
</table>

(Source: DR 167)

As of 15 October 2018, overall compliance for all staff had improved to 84% from 71% in June 2018.
On Ridge ward, the nurse in charge demonstrated the electronic training system. As it was updated monthly, not all recent training had been captured. For example, we looked specifically at ABLS training for nurses on the ward. The system showed 37 eligible staff with eight not recorded as having completed the training as of 18 September 2018. Three staff were on long-term absence/maternity leave, two had done the training in the past month, and two more had training booked. The compliance rate was 92% as 31 staff had done the training out of 34 eligible staff at work.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Most nursing staff had received training on how to recognise and report abuse and they knew how to apply it. However, medical staff compliance with annual refresher was 72% at the time of inspection.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.

**Watford surgery department**

A breakdown of compliance for mandatory courses from July 2017 to June 2018 for qualified nursing staff in the surgery department at Watford is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3 - three yearly update</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>149</td>
<td>158</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>155</td>
<td>165</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>153</td>
<td>184</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>147</td>
<td>184</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Watford surgery department the 90% target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible. A breakdown of compliance for mandatory courses from July 2017 to June 2018 for medical staff in the surgery department at Watford is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3 - 3yr update</td>
<td>96</td>
<td>96</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>153</td>
<td>189</td>
<td>81%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>136</td>
<td>177</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>152</td>
<td>198</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>129</td>
<td>187</td>
<td>69%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Watford surgery department the 90% target was met for one of the five safeguarding training modules for which medical staff were eligible. Overall compliance for medical staff was 81%.

(Source: Routine Provider Information Request (RPIR) – Training tab)
The service provided updated safeguarding training for doctors which showed compliance had not improved. The overall compliance for medical staff at the time of inspection was 72%.

<table>
<thead>
<tr>
<th>Safeguarding Adults Level 2 Compliance for Doctors in the Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of July 2018 (Reported on 6/8/18)</td>
</tr>
<tr>
<td>End of August 2018 (Reported on 31/8/18)</td>
</tr>
<tr>
<td>End of September 2018 (Reported on 31/10/18)</td>
</tr>
<tr>
<td>Most Recent Report Available (Reported on 15/10/18)</td>
</tr>
</tbody>
</table>

(Source: DR 65)

There were 16 safeguarding referrals made within the surgical services between July 2017 and June 2018. The service had effective systems and processes in place for child protection and vulnerable adult safeguarding including mandatory staff training. Appropriate arrangements were in place to ensure patients were kept safe from avoidable harm. The service had safeguarding policies and procedures available to staff on the intranet, including out of hours’ contact details for staff. There were posters displayed with contact details of the trust’s safeguarding team and for the local safeguarding authority teams. Nursing staff, healthcare assistants and ancillary staff could explain safeguarding arrangements, and when they were required to report issues to protect the safety of vulnerable patients. Relevant information and relevant contact numbers for safeguarding were seen on staff noticeboards and in public areas.

Nursing staff described how they identified children at risk of harm who may be visiting the wards and how they would make a safeguarding referral. Staff understood how to protect patients from potential abuse. They were aware of their responsibilities to report safeguarding concerns and knew whom to contact for advice. Most staff knew how to find out who the safeguarding leads were within the trust. Staff described examples of when they would raise a safeguarding concern. For example, a patient had been admitted and staff found some unexplained injuries. Staff made a safeguarding referral, and a protection plan was in place, pending investigation. We also saw that staff reported a pressure ulcer (grade two) as a safeguarding concern. The nurse told us that this was routine, for any ulcer of a grade two or above.

Prevent awareness training, which explains how to safeguard vulnerable people from being radicalised into supporting terrorism, or becoming terrorists themselves, was included within the adult safeguarding training. There was an overall compliance of 89%.

All surgical wards displayed a poster highlighting chaperoning to patients. Leaflets on safeguarding adults at risk from the Hertfordshire safeguarding adults’ board were readily available. They detailed what types of abuse there were, what behaviour to look for and contact details to report the abuse.

Female Genital Mutilation (FGM) was included in level two safeguarding children training, which all clinical staff completed. Staff were aware that they had a mandatory reporting duty to report any cases of FGM in females under the age of 18 years of age, including those females who had given birth to a female infant. This awareness may come from physical examination or from a verbal disclosure. Staff knew their responsibility to report this to the police within 24 hours ideally but certainly within 28 days after being made aware of the FGM.

Child Sex Exploitation (CSE) was included in level two and three safeguarding training. CSE is a form of child abuse and reportable to children’s social services in line with safeguarding
procedures. Staff were aware of the potential indicators of abuse, the toolkit to use and how to complete an interagency referral. The trust policy for safeguarding children included FGM and CSE.

Cleanliness, infection control, and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained. We observed the wards, reception areas, and treatment areas to be visibly clean during our inspection. Staff said that the cleaners did a ‘great job’ and that there were no concerns. Cleaning staff were seen cleaning the ward areas during the time of the inspection. There was a sticker system in place, which indicated equipment had been cleaned and we observed that stickers had been placed on equipment. Two patients we spoke to stated that the ward area was very clean.

Staff received training about infection prevention and control (IPC) and hand hygiene training during their initial induction and annual mandatory training. The trust’s training record for June 2018 showed that 75% of nursing staff and 56% of medical staff had completed this training. The trust provided up to date compliance following the inspection that showed that clinical staff within the division compliance was now 90% combined. This met the trust target of 90%. Most staff showed good hand hygiene on inspection and either used hand gel or washed their hands at the appropriate time. In theatres, staff were seen washing or gelling their hands on 11 out of 15 identified opportunities.

All staff were ‘arms bare below the elbows’ and they wore personal protective equipment as required and this was available throughout the service. Trust policies were adhered to and staff wore minimal jewellery in line with the trust’s infection prevention and control policy. Personal protective equipment (PPE) such as gloves and disposable aprons were used in accordance with the trust’s infection control policy. Two patients we spoke to said staff used PPE when examining them. Hand hygiene gels were available for use at the entrance and exit of the wards, bays, theatres and the pre-operative assessment clinic. There was also a verbal prompting system and hand hygiene advice at the entrance to the wards, which reminded staff, visitors, and patients to decontaminate their hands prior to entry. We observed all staff using alcohol hand gel when entering and exiting the wards and theatres. This included staff carrying out the ward rounds observed on Cleves and Langley wards. This was in line with the National Institute for Health and Care Excellence (NICE) quality standard (QS) 61, statement three. This standard states people should receive healthcare from staff who decontaminate their hands immediately before and after every episode of direct contact or care. Handwashing facilities were appropriate and accessible.

The service had side rooms available to isolate patients suspected of having an infection. Specific care plans were also used for these patients. This enabled staff to take extra precautions and help prevent the spread of infection. Wards had side rooms available to provide appropriate isolation facilities for those patients with an infectious disease. We saw effective use of the trust’s isolation protocols being followed by staff on Ridge ward.

Deep cleans were arranged following the discharge of patients with an infection. There were notices in the dirty utility rooms advising staff what type of cleaning to organise when a patient was discharged. Staff in the theatre department had systems in place to ensure theatres were cleaned appropriately following surgery on an infected patient.

Monthly hand hygiene audits were undertaken in all areas. The trust’s IPC team conducted
monthly code of practice audits on the surgical wards. The areas audited included: correct storage and cleaning of equipment, safe management of sharps and staff awareness of IPC procedures. Hand hygiene audit compliance for September was 100% on Ridge ward, 100% on Letchworth ward, 100% on Flaunden B ward, 95.5% for Langley ward, and 100% on Elizabeth ward. When compliance did not meet trust targets, or areas of consistent non-compliance were identified, the ward managers implemented action plans.

Cleaning audits were also carried out and consistently achieved compliance of 95% or above. Cleaning audit compliance for September 2018 was 99% on Ridge ward, 96% on Letchworth ward, 99% on Flaunden B ward, and 97% on Elizabeth ward. These were displayed on the 'matrons' board' in each area.

The trust infection control team completed monthly infection control audits on each surgical ward. The areas audited included: correct storage and cleaning of equipment, safe management of sharps and staff awareness of IPC procedures. We saw copies of the audits for August 2018. During this period, the audit results ranged from 69% (Flaunden A Ward) to 100% (Theatre recovery and Ridge wards). All the surgical wards displayed the audit results. There was no action plan attached to the audit, but the infection control team made notes highlighting areas of good and poor practice. We saw a communication from Flaunden A ward manager who informed staff of the poor IPC audit result of 69%. They asked staff to focus on improving the infection control standards and stated that the sister would be completing twice-weekly compliance audits. Managers stated that they also discussed audit results in their morning handovers or at team meetings.

Wards reported performance information monthly and this was displayed on the large noticeboards in each area. These were called the matron’s board. For example:

<table>
<thead>
<tr>
<th>As of September, 2018</th>
<th>Elizabeth ward</th>
<th>Ridge ward</th>
<th>Cleves Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days since last acquired <em>E. coli</em> blood stream infection</td>
<td>250 days</td>
<td>394 days</td>
<td>Over 1000 days</td>
</tr>
<tr>
<td>Days since last acquired <em>MRSA</em> blood stream infection</td>
<td>3 years 66 days</td>
<td>Over 1000 days</td>
<td>Over 730 days</td>
</tr>
<tr>
<td>Days since last <em>clostridium difficile</em> infection</td>
<td>206 days</td>
<td>258 days</td>
<td>270 days</td>
</tr>
</tbody>
</table>

The hospital outsourced the decontamination and sterilisation of equipment from theatres to an accredited supplier. The supplier had three designated times for collection, and delivered throughout the day. The standard turnaround time for equipment was 24 hours, but if theatre staff required this equipment sooner, the supplier offered an accelerated and priority service. The trust completed an annual site inspection of the outsourced supplier to monitor the quality and reliability of the service. Theatre scrub areas had been appropriately cleaned with approved cleaning agents. Control of substances hazardous to health (COSHH) risk assessments in place to support staff’s exposure to hazardous substances.

No patients had developed a surgical site infection (SSI) following their hip replacement surgery from April 2018 to June 2018 and 1.7% developed a SSI in the last time period. This is slightly higher than national baseline of 0.6%. There were no reported SSIs for patients following knee replacement surgery for the same period.

Trust policy was to screen patients having elective surgery for MRSA at their pre-operative
assessment. If the result was positive, staff informed the patient and provided them a course of
treatment. During this inspection, we observed staff adhering to the trust guidelines.

All patients who were admitted to surgical wards as an emergency had to be MRSA screened. In
August 2018, five out of nine wards achieved below 80% for this and in September 2018 this
improved and only two wards achieved below 100%. Cleves ward improved their compliance
from 78% to 100% within one month. Senior staff discussed compliance within their ‘daily three’s’
which reminded staff of the trust policy. The daily threes were three things that the ward manager
wanted to highlight to staff each day at handover time. Each three topics were highlighted for a
week to ensure that all staff were captured.

Clinical waste was appropriately stored and disposed of. In all clinical areas, there was correct
segregation of clinical and non-clinical waste into different coloured bags. This was in line with
the Health Technical Memorandum 07-01, ‘Control of Substance Hazardous to Health, and the
Health and Safety at Work Regulations’. There was a chemical spill kit in place in theatres.
Sharps bins were labelled and the bins were not overfilled. Specimens were stored in line with
trust policy, and staff called the trust's porters to collect patient specimens and transport them to
the laboratory. If the specimen required urgent testing and there was a delay with the porters, the
staff took them directly to the laboratory themselves.

The NICE 2008 guidance states that all personnel entering or leaving the operating department
should wear specific non-sterile theatre wear. The trust had a uniform policy, which followed the
standards and recommendations of the Association for Perioperative Practice (AfPP). All theatre
staff knew the trust’s policy regarding theatre attire and the procedures to follow when leaving the
perioperative environment. Staff informed us they could wear their theatre attire within clinical
areas only and were not allowed in retail areas. There was a red line on the floor in theatre that
symbolised no outside clothing beyond that point. During our visit, theatre staff were adhering to
this and we did not see theatre staff wearing theatre attire in non-clinical areas.

Theatre five (emergency theatre) had no clean preparation area and had a small dirty area
(where used equipment is taken). This meant that there was a risk of the clean/dirty flow being
compromised. Staff who worked in that theatre stated it was “not fit for purpose” and “we have to
work very hard to ensure the scrub up sink does not splash our sterile trolleys”.

The day surgery unit had difficulty in controlling infection prevention on the ward due to the poor
environment and lack of space. We were informed that staff were not always aware of a patient
infection until the day of their admission. They sometimes admitted patients who had an infection,
for example, MRSA, but cared for them by the lift, outside of the ward area, to reduce the spread
of infection. There was no risk assessment available for this. However, we saw plans for the
refurbishment of the unit, which was planned to create more space for patients and reduce the
risk of this happening.

Environment and equipment

The service did not always have suitable premises. There had been a delay in the service’s
theatre refurbishment plans. Managers were actively working on revised plans. Equipment
was looked after well.

Senior managers recognised that the environment of theatres, day surgery unit and the recovery
unit were not compliant with national guidance. There were actions to mitigate some of the risks
that were documented on the divisional risk register. This was a concern at the last inspection.
The trust’s executive and finance board had approved a theatre refurbishment business case to
address the compliance and space issues. Senior management informed us that NHS
Improvement (NHSI) had approved the initial proposal but that building scoping works had revealed structural issues in the fabric of the building that mean the original plans could not be carried out. A revised plan had now been prepared and was due to be discussed at trust board. The anticipated delivery of the revised refurbishment plan was now autumn 2019.

Theatre five and the recovery area were cramped and staff said they were doing the best they could to mitigate this. Theatre five was previously a plaster room and it did not comply with national standards. This was documented on the divisional risk register. The scrub facilities were inside the theatre and not recessed. Due to the poor facilities in theatre five, it was not suitable for major emergencies and therefore, surgeons completed these procedures in the other four theatres. Theatre five was suitable for minor emergency procedures only. The theatre did not have sufficient dirty utility rooms or an anaesthetic room. Senior managers were fully aware of this issue and had carried out a risk assessment and put mitigations into place. Staff said they did what they can to manage with the cramped conditions. The recovery area did not have space for the separation of children and adults, as recommended in the Royal College of Anaesthetists (RCoA) guideline, the provision of paediatric anaesthesia (2017). The service acted to mitigate risks by grouping children together on a list, where possible, and screening off an area of the existing recovery. The provisional plans for the refurbishment of theatres had a separate recovery area for paediatric patients.

During our last inspection, we found that the day surgery unit was small and did not provide appropriate facilities. There were three cubicles used by both men and women and toilet facilities were in the corridor outside the area. Plans were due to start imminently for the refurbishment of the unit. There would be an additional three cubicles and the unit would segregate males and females.

The emergency surgical assessment unit (ESAU) had six trollies. These were set out in two areas, one with four trollies, and one with two. There were male and female toilets with no shower facilities. The unit policy excluded patients with limited mobility or who were acutely ill due to lack of space and lack of facilities. The manager informed us that this policy was developed after a patient with poor mobility was transferred to the department and they had to complete a trolley to bed transfer in the middle of the ward due to lack of space.

The maintenance of facilities and the checks on electrical equipment protected people from avoidable harm. Staff kept fire exits clear and free from obstruction in all surgical areas, and evacuation slides were accessible, where necessary. Wards were secure. Visitors were required to use the intercom system outside the wards to identify their arrival before they could access wards.

There was sufficient equipment on the wards and in theatres to maintain safe and effective care, including hoists for assisting patients, blood pressure and temperature monitors, air mattresses (used to minimise the risk of patients acquiring pressure ulcers), commodes and bedpans. Nursing staff we spoke with also said there was an adequate supply of equipment to meet the needs of the patients. Checks of the oxygen and suction were completed on ESAU. There was access to bariatric equipment when needed, for example bariatric beds, hoists, and wheelchairs. Equipment was serviced internally and a record of the maintenance was kept centrally within the hospital. The trust rated items on a scale of one to four, with four being low risk and one being high risk. We found that 47 out of the 1,462 medical devices in surgery were overdue for their service. Five of these were high-risk items such as electric hoists, theatre headlamp, and hemodynamic monitor. The majority of these had been arranged and had dates for engineers to attend site.
Single use sterile instruments were stored appropriately and kept within their expiry dates. Surgical procedure packs, implants, and consumable items were stored in a tidy and organised manner. The hospital used a sterile service offsite for decontamination and sterilisation of surgical instruments. The equipment trays were very well organised. Each set was photographed to assist staff with instrument management. Staff reported that they had good turnaround times and did not usually have any difficulties obtaining equipment.

There were adult resuscitation trolleys on all surgical wards, theatres and in the pre-operative assessment clinic. Checklists showed that registered healthcare professionals checked the resuscitation equipment daily and documented the equipment was ready for use. There was a paediatric resuscitation trolley for use in the recovery department, which staff also checked regularly. Equipment and supplies in the trolleys we examined was fit for use and within use by dates. There was a difficult airway trolley available in theatres and an arrest ‘grab bag’, both of which were checked daily.

The airflow systems in the theatres were revalidated regularly by an external organisation. Leaders stated that validation of theatre ventilation was recently completed across both sites. This was confirmed as compliant with the current mitigations in place therefore met the standards set out in the national guidance, Health Technical Memorandum (HTM) 03-01: ‘Specialised Ventilation for Healthcare Premises’. Theatres one to four were operational and compliant at 21 changes per hour that was at 75% of full capacity. The ventilation in theatre preparation rooms was not compliant with these standards. However, there was adequate dilution of gases in the anaesthetic rooms to be compliant with these standards. Staff prepared the sterile equipment in the theatres as a precaution. This caused delays to the lists as it took longer to prepare and clean up following surgery therefore decreased the theatre utilisation.

The issue with the ventilation in theatre preparation rooms was documented on the estates’ risk register and was to be addressed in the theatre refurbishment plan.

Patients were not always wearing printed wristbands as we were informed that there was a lack of facilities to provide these. This meant that staff were using patient stickers on the wristbands and these often wore off. There were patients with worn stickers seen on inspection.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. Improvements had been made in venous thromboembolism (VTE) assessments but still did not meet trust targets. Compliance with staff debriefs post-surgery was variable. Oversight of risk to patients on a waiting list was effective.

Risk based pre-operative assessments were carried out in line with national guidance. Patients for elective surgery attended a nurse led pre-operative assessment clinic prior to their operation. During the assessment all required tests were undertaken, for example, MRSA screening and blood tests. This was in line with NICE guidance NG45: ‘Routine preoperative tests for elective surgery’ (April 2016) and guidance from the Modernisation Agency. Patients that were identified as being a higher risk were referred for further review with a consultant or anaesthetist against a strict criterion. An anaesthetist attended three times a week to see patients when required.

The service used the American Society of Anaesthesiologists (ASA) grading system to pre-assess patients’ level of risk for general anaesthesia. There were five grades within the ASA system. Grade one patients were normal healthy patients and grade five patients were patients not expected to survive more than 24 hours with or without surgery. The hospital had level two and three critical care facilities for critically ill patients to recover in following surgery. This allowed
them to treat patients of all ASA grades safely.

The surgical service met the Association for Perioperative Practice (AfPP) guidance for assessing and responding to patient risk for all surgical areas. This included ward admission, anaesthesia, surgery, and recovery. There were, and the records showed, sufficient staff on duty during the patient’s surgical procedure, which included surgeons, anaesthetists, and operating department practitioners. This was in line with AfPP guidance, which meant the service had assessed the risk to patient’s undertaking surgery.

Nursing staff on the surgical wards had three daily ‘safety huddles’. We observed the safety huddle on Ridge and Langley wards. Staff highlighted workload issues, patients due for discharge, and high-risk patients who required extra monitoring. This included patients with pressure ulcers, patients with safeguarding issues and patients at high risks of falls. This ensured staff were continually updated on the plan of care for every patient on the ward and the nurse in charge maintained an effective oversight of the patients in their care. Each ward recorded the meeting in a logbook.

The trust had implemented the ‘Safer’ checklist, which all wards completed three times a day in the mornings, afternoon and evening/night. This was now recorded electronically. The checklist helped to highlight the number of deteriorating patients or patients that required monitoring on each ward. For example, the checklist assessed the number of falls the ward had in the previous 24 hours, the number of patients with nasogastric tubes, and the number of patients with enhanced care needs. The senior nurse for each ward presented their checklists at the hospital bed management meeting. This initiative ensured all senior staff had oversight of what was happening on each ward.

All wards visited completed a daily safety check. We saw all had been completed daily on Ridge and Langley wards. Examples of areas covered included:

- Safe care update, which included the acuity of staff and the staffing register.
- Environment clean and tidy and uncluttered, corridor exits clear and good availability of personal protective equipment.
- Patients with infection control risk were isolated correctly.
- Medicine cupboards were locked, and weekly medicine stock checked.

Members of the pharmacy team reviewed patients’ medical history and commenced a medicine reconciliation to ensure their medicines were available and up to date.

Comprehensive risk assessments were also carried out on patients when they were admitted to the surgery service. Nursing staff used nationally recognised tools to assess patient’s risk of developing for example, pressure ulcers, nutritional risks, falls, as well as risks associated with moving and handling. These were reviewed regularly. Patients identified at risk were placed on care plans and were monitored more frequently by staff to reduce the risk of harm. The ‘test your care’ audit was completed monthly which looked at these care plans and risk assessments. The results across surgery were generally between 90 to100%.

The National Early Warning Score (NEWS) was used for adults when required, dependent on the presenting condition. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Clinical observations such as blood pressure, heart rate, and respirations were recorded and contributed to a total score. Once a certain score was reached a clear escalation of treatment was commenced. Any patients with a NEWS of three or more was automatically screened for sepsis (a serious infection of the blood). NEWS scores were audited monthly as part
of the service’s ‘test your care’ audits. Wards regularly score 90 to 100% on these audits. There was an action plan to implement NEWS 2 across the trust that was due to be completed in November 2018. Our review of the NEWS 2 charts showed correct calculation of the score and appropriate action taken where needed.

NICE guidance (NG89) for March 2018 states that all surgical and trauma patients should be assessed to identify the risk of venous thromboembolism (VTE) and bleeding as soon as possible after admission to hospital or by the time of the first consultant review. Reassessments for VTE and bleeding should be at the point of consultant review or if their clinical condition changed. Medical staff documented the initial VTE assessments on admission and all patients had VTE prophylaxis (preventative treatment) prescribed. VTE assessments and prophylaxis were reviewed at the daily ward rounds. We found that eight out of the ten notes reviewed had a completed VTE risk assessment. The other two were completed, but had not been signed by a consultant. The most recent audit completed in August 2018 showed a decrease in compliance from 94% to 91%; the trust target is 95%. The overall compliance since April was 94% with 868 out of 13,379 patients not having their VTE assessed.

(Source: DR 48)

The compliance was discussed in the trust board meeting in September 2018 and they are considering modifying the drug chart to include a full VTE assessment and reassessment. The medical clerking document had been adapted to include prompts in red bold letters to encourage the completion of VTE assessments. Senior managers had full oversight of compliance and discussed at monthly integrated performance reviews. They also stated that if a clinical incident was related to VTE, this would automatically become a serious incident. We asked for evidence of an action plan for the surgical division to increase compliance following the inspection. The trust provided us with a table showing compliance with VTE assessments, by ward, which showed that overall, compliance with the trust target had not been met. However, there was no associate action plan to effect improvements.

The trust had a hospital wide approach to managing deteriorating patients. This involved a critical care outreach service this team provided services to patients outside the unit. These included visiting surgical patients on wards to help with interventions to stabilise them and prevent them becoming more ill. There was 24-hour access to emergency surgery teams, including theatres and doctors. During the night, there was a registrar, senior house officer and junior doctor present, who covered the surgical wards and was supported by the on-call consultant for surgery. Records showed that patients had received a daily weekday review, which was also confirmed by the patients.

The trust used the ‘Five steps to safer surgery’, World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency (NPSA) guidelines. The theatre staff
completed monthly WHO audits to establish if the five steps to safer surgery were being completed in line with the recommendations. These audits were not observational audits and only looked at the completion of the checklist. Senior staff informed us that they had just started completing observational WHO audits and had only completed six. The audit results were 94% for September, 96% for August, and 95% for July. Action plans were created to make improvements. The results were seen on the staff board; the main area of poor compliance was with the debrief. We observed the WHO checklist being completed four times during inspection and found it to be completed professionally and in line with national guidelines. However, we found inconsistencies in the application of the safety checklist regarding the briefing and debriefing process. We checked the brief and debrief forms in theatre one and found that six out of 17 debriefs had not been completed. This was also in line with what we found when looking at patient records. Two out of five sets of notes for patients who had had surgery did not have a debrief completed on the WHO checklist. We also found that the brief was not always done for every list. For example, if a second consultant used the theatre later in the day, the brief would not always be done for their list. We looked at five days and for two out of the five days, there were lists that did not have a completed brief or debrief. We raised this with the trust at the time of inspection. They stated their current compliance with debrief was variable at around 70 to 80%. They had put the following actions in place to make improvements:

- They were looking to include the debriefs on the ‘test your care’ audits within theatres so that compliance could be monitored monthly.
- They would review the five steps to safer surgery policy to ensure that it had adequate detail regarding brief and debrief standards.
- They would focus on debriefs within the theatre clinical governance sessions in November 2018.

Anaesthetised patients are not able to regulate their body temperature, which means there was a danger of patients being at risk of unintended hypothermia. The surgical team had access to ‘bair huggers’ that are temperature management systems to maintain a patient’s core body temperature. The ‘bair hugger’ system consists of a reusable warming unit and a single-use disposable warming blankets for use before, during and after surgery.

The trust supported the delivery of a sepsis campaign. Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. This incorporated the red and amber flag system to enable staff to detect the deteriorating patient. The trust had launched teaching days to train link staff in the usage of the sepsis tools, 74 members of the surgical staff had this ward based training. The treatment and escalation plan was outlined on the sepsis tool being used. The tool also enabled staff to record when they had not followed the plan and used alternative treatments. The tool had been fully completed and reviewed on those patients who had become unwell with a possible indication of sepsis. Staff spoken with had a good understanding of the actions required. Nursing staff on surgical wards confidently described the signs of sepsis and what action they would take, for example, completing the sepsis six pathway in the patient’s notes and immediate escalation to medical staff. Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. It consists of three diagnostic and three therapeutic steps to be delivered within one hour of the initial diagnosis. A trust wide audit completed between April 2018 to June 2018 showed that timely treatment for sepsis was 93.5%.

The trust had implemented discharge checklists to improve the quality of discharges. We reviewed seven discharge checklists and saw they had been completed appropriately.
checklist data included details of the patient’s stay as well as medicines prescribed.

The divisional managers had oversight of the RTT times and were taking measures to address it. Clinical harm reviews had been completed on patients who were waiting over 48 weeks from referral to treatment (RTT) for surgery. Harm reviews were implemented as part of the trust’s RTT recovery programme to determine whether there was a risk of harm to patients due to the length of wait for a procedure. All patients received a letter, which informed them of the long waits for treatment and details of who to contact if their condition deteriorated. The trust had a process of prioritising patients on the waiting lists and brought patients back to a clinic appointment when required.

105 patients were waiting more than 52 weeks at the time of the inspection. 33 of these were elective orthopaedic patients. Senior managers said six patients had been identified as potentially having harms so harm review processes were being carried out to validate this and to ensure no further harms were caused. The service was undertaking harm reviews for every patient who had been waiting over 48 weeks for surgery. Each review was to be completed prior to the waiting time exceeding 50 weeks. The trust had implemented the following to mitigate the harm to patients waiting for treatment:

- A week-by-week tracker across all specialities. There was an early warning system, which enabled the trust and specialities to see the total number of patients waiting. This could be refreshed daily to include all new referrals.

- The completion of a root cause analysis (RCA) for all patients who were waiting for surgery over 48 weeks. These RCAs were presented by each specialty team at the divisional governance meetings.

- Harm review data was included within the bi-monthly quality and safety report. This meant that the executive team saw the levels of harm patients received due to delayed treatment.

There was a standard operating procedure for identifying harm and to ensure that the reviews were all completed consistently. There were six patients who had experienced harm in orthopaedics. All other patients from other specialities had come to no harm due to the delays in treatment. There were 69 outstanding harm reviews at the time of inspection.

The service had an emergency plan and staff could direct us to the policy on the trust’s intranet. Each ward had a major incident box available with relevant documents and guidance. Major incident training was included within the trust induction. The theatres had an area specific business continuity plan, which outlined clear actions staff needed to take in the event of an electric failure or other major incident. The hospital had back-up generators to ensure an uninterrupted power supply if the mains supply failed.

Staff completed fire safety training as part of their mandatory training. Nursing and medical staff spoken with knew what the evacuation procedures were including how to evacuate patients and meet at their allocated meeting points. However, in the wards visited, staff did not routinely allocate a fire marshal to take charge of an emergency if required. Although, we did see staff messages for Flaunden Ward in August 2018 where the ward manager asked for volunteers to be the fire marshal. We raised the lack of allocated fire marshals on shift with senior managers who have provided assurances that this will be looked into. Staff were aware of evacuation processes, and evacuation plans were clearly visible at the nurses’ stations in all wards. All fire safety equipment checked on Letchworth and Flaunden wards was fit for use. Clear guidance posters were on display for staff informed them of what to do if the fire alarm sounded. Staff fire training compliance rates were below the trust target.
Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and to provide the right care and treatment. Staffing levels were appropriate to meet patients’ needs during our inspection.

The trust reported their staffing numbers below as for June 2017 and June 2018. The overall fill rate of nursing staff had improved by 4.8% since last year.

<table>
<thead>
<tr>
<th>Location</th>
<th>June 2017</th>
<th></th>
<th></th>
<th>June 2018</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------</td>
<td>------------------</td>
<td>------------</td>
<td>-------------</td>
<td>------------------</td>
<td>------------</td>
</tr>
<tr>
<td>St Albans</td>
<td>70.5</td>
<td>87.7</td>
<td>80.4%</td>
<td>66.4</td>
<td>86.0</td>
<td>77.2%</td>
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<tr>
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<td>24.2</td>
<td>27.9</td>
<td>1.7</td>
<td>28.6</td>
<td>28.4</td>
<td>100.7%</td>
</tr>
<tr>
<td>Watford</td>
<td>155.9</td>
<td>197.3</td>
<td>79.03%</td>
<td>170.7</td>
<td>198.7</td>
<td>85.9%</td>
</tr>
<tr>
<td>Grand total</td>
<td>250.7</td>
<td>312.9</td>
<td>80.1%</td>
<td>265.7</td>
<td>313.2</td>
<td>84.9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

Vacancy rates

From March 2017 to April 2018, the trust reported a vacancy rate of 16% in surgery: this did not meet the trust target of 9%. At the time of inspection, this had reduced and it was in target at 9%.

- St Albans 23%.
- Watford 15%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From July 2017 to June 2018 reported a turnover rate of 24% in surgery this did not meet the trust target of 12%.

- St Albans 14%.
- Watford 20%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From July 2017 to June 2018 reported a sickness rate of 3.1% in surgery: this met the trust target of 3.5%

- St Albans 2.7%.
- Watford 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From April 2017 to March 2018, the trust reported a bank and agency usage rate of 14.3% in surgery.
The service planned, and reviewed staffing levels and skill mix so that levels were in line with relevant tools and guidance. Senior staff used the national safer nursing tool to assess, identify, and plan staffing levels. The safer nursing care tool is an evidence-based tool developed to help hospitals measure patient acuity and dependency and determine workforce levels. The matrons reviewed these to ensure staffing risks were addressed and any safety issues that arose were managed. This process was in line with the NICE in relation to its guidelines for Safe Staffing (SG1). This tool also worked out the utilisation of the wards daily. For example, the utilisation on Cleves ward on 17 October 2018 was 98.6% and the previous day was 66.6% and 101% overnight. This meant that senior managers could see gaps in staffing levels and act upon this appropriately. This could involve moving staff from another area to cover if their utilisation allowed. There was a senior nurse on call seven days a week, out of hours to assist with any staffing issues that may occur.

Staffing levels were appropriate to meet patients' needs during our inspection. The planned levels of staff and the actual levels were displayed on each ward/unit and updated daily. For example, Elizabeth ward had five registered nurses on duty and four healthcare assistants, which met the planned levels. At night, this was to be four registered nurses and four healthcare assistants. Cleves ward had three registered nurses and two healthcare assistants on duty for 22 patients. This met the planned levels. Staffing to patient ratios were generally one to seven during the day and one to 10 at nights, in line with trust staffing plans. We discussed the staffing levels with the nurses in charge of each area. Whilst they did not always achieve the planned staffing levels, they were able re-allocate staff according to the needs of the patient on the ward and they felt they had sufficient staff to meet the needs of patients. To ensure safe staffing levels, nursing staff were often moved between surgical wards to cover vacant shifts. Staff understood the reasons for ward moves and spoke positively about it. If the nurse in charge had concerns about the staffing on a particular day they could ring the matron and they would ensure they received support.

The trust had implemented the ‘Safer’ checklist, which all wards completed three times a day in the mornings, afternoon and evening/night. This included the staff skill mix and patient acuity for each area. Senior staff used this at the bed management meetings three times a day to determine appropriate and safe staffing levels for each ward and clinical area. We observed one bed management meeting at 8.30am, and we saw a structured and focused approach to ensure each ward had the appropriate staffing levels. Nursing handovers happened at the change of each shift and were well structured, concise and used a standardised handover sheet. This included information about patients going to theatre, discharges, and home circumstances.

At our last inspection, recruitment of theatre staff was a challenge for the trust and this remained on the local and directorate risk register. During this inspection, the theatre manager told us about initiatives to improve theatre nurse recruitment and retention. This included offering rotational placements to junior nurses, which allowed them to work in several rotational
placements before deciding on a preferred speciality. The trust had a trust wide rotational programme, for newly qualified nursing staff, where they would rotate between A&E, theatres, and critical care. This programme started in February 2018. One nurse who had completed the rotation said that they had really enjoyed it and gave them a chance to refresh their skills in different areas.

The most up to date data received showed that between December 2017 and March 2018 theatres used between 10 to 20% agency per month. At the time of inspection, we were informed that they used two to three agency staff per day. The manager stated that she had successfully recruited a few agency staff onto the bank which had reduced the agency spend.

A yellow ‘nurse in charge’ badge identified the nurse in charge of each area. This meant they were easily identifiable to staff, visitors and patients. We found that the nurses in charge had a clear knowledge of their area and the status of patients and staff.

Staff said there were enough suitably skilled staff on duty in the wards. There had been improvements in recruitment and retention of staff in the service since the last inspection. Most staff said this had made work pressures more manageable and were positive about the staffing position. The trust had worked hard to recruit and support transitional nurses (overseas nurses, who were not registered nurses in the UK until they had completed an induction and competency-based programme). The transitional nurses we spoke with told us they referred to the nurse in charge or a qualified nurse when they needed support or advice. We observed fully qualified nurses on wards at all times.

New bank and agency staff received a local induction to each area on their first shift. This ensured staff were familiar with ward layouts and emergency procedures. Staff showed us an induction booklet used for new agency staff and we saw copies of signed induction sheets in wards visited. Managers generally used the same agency nurses on each ward whenever possible. This ensured continuity of care for patients and ensured agency staff were in a familiar environment, with staff they knew. The hospital had access to a hip fracture lead nurse who supported patients and their families on the hip fracture care pathway.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust had reported their staffing numbers below as of June 2017 and June 2018. The overall fill rate of staff had dropped by 5.5% since last year.

<table>
<thead>
<tr>
<th>Location</th>
<th>June 2017</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Watford</td>
<td>202.5</td>
<td>227.5</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From March 2017 to April 2018, the trust reported a vacancy rate of 15% in surgery: this did not meet the trust target of 9%

- Watford 15%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
The trust provided data detailing their vacancies and they had a high number in general surgery, urology, and orthopaedics. They stated that the job was being advertised and they were covering with locum bank shifts or agency.

**Turnover rates**

From July 2017 to June 2018 Watford surgery department reported a turnover rate of 38%. This did not meet the trust target of 12%.

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness rates**

From July 2017 to June 2018 reported a sickness rate of 0.9% in surgery: this met the trust target of 3.5%

- Watford 0.9%

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Bank and locum staff usage**

From April 2017 to March 2018, the trust reported a bank and locum usage rate of 21.4% in surgery. We asked the trust for up to date data on this but they did not supply it.

<table>
<thead>
<tr>
<th>Total Hours available/ Establishment</th>
<th>Total hours unfilled</th>
<th>Total Bank Hours</th>
<th>Total Agency Hours</th>
<th>Unfilled Rate (%)</th>
<th>Bank use rate (%)</th>
<th>Agency use rate (%)</th>
<th>Total agency and bank use rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>831,135</td>
<td>28,477</td>
<td>113,876</td>
<td>63,718</td>
<td>3.4%</td>
<td>13.7%</td>
<td>7.7%</td>
<td>21.4%</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)*

**Staffing skill mix**

From June 2018 to June 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was lower.

**Staffing skill mix for whole time equivalent staff working at West Hertfordshire Hospitals NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>46%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>20%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>25%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>9%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
After 8pm and at weekends, a registrar, senior house officer and junior doctor covered the surgical wards. An on-call registrar and consultant for surgery were available to provide support and advice, if required. A medical registrar was also available for support. The hospital at night team, staffed by a senior nurse and an assistant practitioner, was available from 8pm to 8am to support junior doctors. There was also a surgical consultant based on ESAU from 8am to 8pm every day who supported the junior doctors.

Doctors ward rounds occurred twice daily, one in the morning and one again in the afternoon. The morning ward round was led by a consultant surgeon and the afternoon ward round led by the registrar of the week. At both handovers and ward rounds, the medical staff reviewed surgical patients who were on a non-surgical ward (outliers). We observed a morning handover and it was well structured, informative with good engagement from all staff. It prioritised those patients in need of an urgent review. Surgical outliers were also discussed.

The service was working towards ensuring consultant led treatment and decision-making. A consultant was on call for emergencies 24 hours a day, seven days a week. Junior doctors told us that the consultants were supportive and accessible, even out of hours. Consultant led ward rounds took place on Saturdays and Sundays. Senior staff told us every patient was seen daily at ward rounds. Nurses said access to on call consultants was effective and reported very positive working relationships with them.

Medical staff informed us that there were gaps in the rota for senior house officers. This put pressure on the registrars. Locum doctors mainly covered the gaps. This was less time efficient and the locums were less independent in their working. On inspection the teams worked well together. For example, the operating surgeon sought out the on-call team to offer them theatre space for an emergency patient. One consultant said that there was a robust system in place if a surgeon was not available due to sickness or if they were operating. They stated that colleagues were very supportive and covered services for each other. We observed the consultant on ESAU interacting well with the junior doctors and offering support to them with patient management.

**Records**

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.

Patients’ individual care records were managed, written, legible, and stored correctly according to best practice. Records were paper based. All entries were dated and signed, and included the clinician’s bleep number, when appropriate. Each patient had two sets of records: a nursing risk assessment and care plan folder, and a medical notes folder.

We looked at 25 sets of records, which included pre-operative assessments, consent forms, theatre records, risk assessments, and care plans identifying the patients’ needs. Most records reviewed were legible, accurate and up-to-date. Most of the notes were up to date, contained appropriate care plans and were regularly reviewed, however, we found that five out of ten care rounding records were not up to date. We raised with senior staff, who took action to address this. Nurses and allied health professionals contributed to information in patients’ medical records and medical staff completed a review of the patient at least daily and a plan documented. There was a record of discussions with the patient and/or their close relatives and records demonstrated the input of the multi-disciplinary team. Monthly audits were carried out as part of the ‘test your care’ audits that looked at all aspects of the patient’s nursing documentation. The below table shows the ‘test your care’ results from the last three months.
### Ward area | July 2018 | August 2018 | September 2018
---|---|---|---
Cleves Ward | 75.8% | 95.5% | 97.2%
Elizabeth Ward | 92% | 94.1% | 97.7%
Flaunden Ward | 96.8% | 94.7% | 91.2%
Langley Ward | 91.3% | 100% | 99.5%
Letchmore Ward | 91.3% | 100% | 99.5%
Ridge Ward | 99.5% | 96.2% | 98.1%

(Source: DR 76)

Ward managers stated that these audits were displayed on notice boards, discussed in meetings or at daily three’s. For example, meeting minutes from Flaunden ward showed that the ‘test your care audit’ results were 95% and the manager thanked the staff.

The initial risk assessment on admission was largely ‘tick box’ with small sections for additional written information. When nursing staff identified a risk, they completed a more detailed risk assessment, for example a falls risk assessment. A nursing assessment provided more detail about individual needs. Staff recorded preoperative assessments on a standardised form based on national guidance. Nursing and theatre staff completed a pre-operative checklist on the ward and on entry to theatre to ensure safety issues such as allergies, dentures and other safety factors were considered and recorded. There was a four-point check that the site for the operation was marked on the patient.

Patients’ medical and nursing notes were stored away from public view in lockable trolleys in the ward corridors or bays. The trust used trolleys with the same access code to enable all clinicians to access notes in an emergency.

The surgical wards used ‘Patient Safety at a Glance’ (PSAG) white boards to display patient names, their location on the wards and some treatment information. Hospital wards use PSAG boards to display important information such as the patient’s infection risk, mobility, discharge readiness, and lead consultant. The PSAG boards were visible to staff, patients and visitors to the ward. We raised this with senior staff who told us the boards should not contain patients’ full names. The PSAG board on Letchmore Ward had a cover that staff folded over the patient names to improve confidentiality. At the last inspection, the service planned to change all other PSAG boards to the same style as the board on Letchmore Ward, but this had not been carried out. We raised this with senior managers who told us that they were piloting an electronic board on one ward.

Discharge summaries were sent to patients’ GPs to ensure continuity of care in the community.

Records in pre-assessment were managed by dedicated administrators. They ensured that as many patients as possible were seen with their notes. They stated that it was very rare for a patient to be seen without their notes and it was usually if the pre-operative assessment was close to their consultant outpatient appointment.

### Medicines

The service followed best practice when prescribing, giving, recording, and storing medicines. Patients received the right medication at the right dose at the right time.

Suitable arrangements were in place for the safe management of medicines. This included obtaining, prescribing, recording, storage and security, dispensing, safe administration and disposal. Medicines within the wards and theatres were stored safely behind locked doors or cupboards and were only accessible to appropriate staff. Controlled drugs (CDs) (a medicine that
is controlled under the Misuse of Drugs legislation 2001), were stored appropriately in a locked cupboard and the keys held separately from the main keys. We checked two controlled drugs and the controlled drugs register and found the required records were correctly maintained. Staff carried out and recorded checks of controlled drugs twice daily. However, it was not noted within the CD book that theatre areas were closed at weekends. All CD records checked were accurate and up to date.

Medicines that required refrigeration were kept at the correct temperature and staff checked and recorded the fridge temperatures daily in both theatres and the surgical wards. This ensured that medicines that were temperature sensitive were stored correctly. The recording sheets indicated the acceptable temperature range for the fridges and treatment rooms. When a fridge temperature was above the recommended maximum temperature, the nurse reported it as an incident, informed the ward sister and transferred the medication to another medicines fridge within the department. Most areas recorded and controlled the temperature of the treatment room where medications were stored. We found however that ESAU were recording the temperature of the ward area rather than the temperature of the room that the medicines were being stored in. We raised this with senior staff, who took action to address.

We checked 10 medicines’ administration records and found medicines were prescribed in line with best practice and records of administration were consistently completed. Staff recorded patient’s allergies and all records were legible, clearly dated and signed. We saw one missed dose from ten charts and this was discussed with the ward manager at the time. They stated that this was rare as they did a ‘check and challenge’ at each shift. This was where staff challenged any missed doses they had seen during their shift at handover times.

On some wards such as Letchmore and ESAU, patients were discharged with pre-pack medication to reduce delays waiting for medication from pharmacy. This was checked by two nurses and logged including expiry date and batch numbers.

Patients’ own medicines were stored in locked bedside cupboards and nurses looked after the cupboard keys. Staff checked and recorded these medicines daily. An audit of controlled drugs confirmed staff were storing them safely.

During the week, a clinical pharmacist visited the ward daily, monitored, and reviewed patients’ prescribed medicines, and was readily available for advice about medicines. The pharmacist had completed a comprehensive medicines’ reconciliation for each patient record we reviewed. This included the pharmacist taking a patient’s medical history and checking for any medicine contraindications. Medicine reconciliation is a check to ensure that people receive the correct medicines on admission to hospital. The pharmacist also stated that she reviews time-specific medicines and ensures they were prescribed at a time appropriate for the patient and the nursing staff. They said that if the patient was able, they would self-administer and gave an example of when this had happened and ensured that the medication and patients’ symptoms were well managed. Pharmacist support was available during pre-operative assessments to ensure patients received the correct medicines on admission to hospital. The pharmacy team also reviewed any medicines that patients needed to stop prior to surgery, for example, blood-thinning medicines. All medicines we checked during inspection were in date.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
The service had processes in place to prevent harm to patients. Staff understood their responsibilities to raise concerns, to record safety incidents and to report them internally and externally. The hospital used an electronic online system for reporting incidents. Ward and theatre staff in surgery services described the process for reporting incidents and gave examples of when they had done this. They told us their managers encouraged them to report incidents and supported them with this process. Incidents were reviewed promptly, and initial feedback given to the person raising the incident. Only a few staff stated that they did not receive feedback from incidents. Learning was identified and cascaded throughout all staff teams at handovers and safety huddles. The service used the ‘top three’ themes each week at every handover and huddle to embed learning. For example, pressure area care themes. Each ward had ready access to all recent root cause analysis (RCAs) reviews of incidents and staff read and signed to say they had understood the actions required to improve services.

Lessons learned from incidents were cascaded to the team during ward and theatre handovers. Staff confirmed the service shared learning through individual feedback, handovers and the trust newsletter enclosed with their payslip. There were boards in staff areas that displayed details of incident investigations and learning from all surgical areas across the trust. Cleves ward staff informed us that they had learned from another area’s grade three pressure ulcer incident. The manager shared the divisional RCA with the staff, arranged training on the equipment, and appointed a skin champion. As a result, the pressure area care improved on the ward and they had a reduction in pressure ulcers. The wards also displayed the serious incidents on their governance board. For example, Cleves ward had no SI’s but there were five within the surgery division for September 2018 and the details of these were given with the relevant learning.

Consultants and junior doctors informed us that there was effective learning from incidents and that all incidents were discussed at their monthly meetings. Serious incidents were reviewed at the divisional governance meetings and the whole department was involved in the feedback and learning from mistakes. A serious incident action plan review group that met quarterly reviewed all the action plans from each serious incident to ensure that they were being completed. There was good oversight of the serious incidents.

There was evidence of learning from incidents. For example, in the vascular catheter laboratory, an agency nurse had prepared a patient incorrectly which led to a non-sterile skin incision being done. As a result, they developed a detailed proforma for agency staff for their induction that involves observation of their first few cases. We also saw a newsletter from Ridge ward stating there had been an increase in pressure ulcers. The manager had put staff on extra training days and asked junior staff to work with senior staff when checking patient’s pressure areas.

Each surgical speciality held monthly mortality and morbidity meetings to discuss patient deaths and other adverse events and review the care provided. The mortality and morbidity meeting minutes for general surgery included presentations from different specialities, such as breast and vascular surgery. They gave a brief overview of the cases discussed and if required, made learning points to prevent reoccurrence. However, there was little evidence of action and tracking of these learning points. There was no action plan, dates for completion or ownership of these. This made it difficult to know if improvements had been made from the learning that was identified.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a
never event. From August 2017 to July 2018, the trust reported one incident classified as a never event for surgery, which was a surgical/invasive procedure that occurred on the 19th May 2018. *(Source: Strategic Executive Information System (StEIS)).* The never event was a wrong side implant. The theatre team learned from this and changed the storage of their prosthesis.

Staff of all levels across the surgical service confirmed they were aware of the never events which had occurred. Most staff could describe the learning from the most recent never event. Staff we spoke with said they had been made aware of never events at handovers and safety huddles. Action plans were in place to prevent the likelihood of the incident re-occurring.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in surgery that met the reporting criteria set by NHS England from August 2017 to July 2018. Of these, the most common types of incident reported were:

- Surgical/invasive procedure incident meeting SI criteria with three (25.0% of total incidents).
- Medication incident meeting SI criteria with three (25.0% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with two (16.7% of total incidents).
- Pressure ulcer meeting SI criteria with two (16.7% of total incidents).
- HCAI/Infection control incident meeting SI criteria one (8.3% of total incidents).
- Treatment delay meeting SI criteria with one (8.3% of total incidents).

Site-specific information can be found below:

- St Albans: one.
- Watford: 11.

*(Source: Strategic Executive Information System (STEIS))*

From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires
providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person. Nursing and medical staff understood their responsibilities regarding the duty of candour legislation. They said they were open and honest with patients and applied this to all their interactions. Staff said they would discuss any identified concerns with the patient and provide a full apology. Staff understood their responsibilities with regard to the duty of candour regulation and were aware of the trigger for the application of duty of candour, which was for moderate harm and above. Staff described a working environment in which any errors in a patient’s care or treatment were investigated and discussed with the patient and their relatives. We saw from investigations that the service had applied duty of candour following serious incidents.

We looked at incidents reported prior to the inspection and found that there was an increase in reported incidents in urology. We looked at this on inspection and were confident that the divisional managers had oversight of this. They gave us assurance that the incidents were due to over reporting and could evidence that the urology service was safe.

Safety Thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date. Data from the Patient Safety Thermometer showed that the trust reported 21 new pressure ulcers, five falls with harm, and one new catheter urinary tract infection from August 2017 to August 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at West Hertfordshire Hospitals NHS Trust
Total CUTIs (1)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

The board report for September 2018 stated that they had implemented a bi-weekly harm free panel to review, analyse, and learn from pressure ulcers and falls. The trust had also recruited skin champions who had attended training to drive improvements. Each ward displayed safety information on the matron's boards. For example:

<table>
<thead>
<tr>
<th>As of September, 2018</th>
<th>Cleves ward</th>
<th>Ridge ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days since last fall</td>
<td>6 days</td>
<td>26 days</td>
</tr>
<tr>
<td>Days since last</td>
<td>105 days</td>
<td>1 day</td>
</tr>
<tr>
<td>pressure ulcer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall compliance</td>
<td>95%</td>
<td>98%</td>
</tr>
<tr>
<td>with nursing standards</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers assessed staff compliance with guidance and identified areas for improvement.

Policies were up to date and followed guidance from the National Institute for Health and Care Excellence (NICE) and other professional associations. Local policies, such as the resuscitation and management of deteriorating adult policy were written in line with national guidelines. Policies were available on the trust intranet and clinical staff we spoke with knew how to access them.

The surgery, anaesthetics, and cancer division worked with the trust governance team to ensure policies were up-to-date by allocating authors to review policies. The authors took account of publications from the National Institute of Health and Care Excellence (NICE), guidance from professional bodies and good practice from other NHS trusts. They presented the policies to the trust’s policy review group for ratification. The trust had reviewed the policies that needed to be updated in line with NICE guidelines. At the time of inspection, there were 16 that had been completed, 10 that were in progress and one that had not been started and was not within timescale.

The trauma and orthopaedic team continually reviewed their practice in the care of patients with fractured neck of femur to improve the effectiveness of the treatment pathway. Weekly multidisciplinary team meetings, attended by consultants, doctors, nursing staff and therapists, discussed patients and reviewed whether their pathway adhered to best practice. There was a dedicated ward for orthopaedic patients. The trauma coordinator ensured that these patients had a good and coordinated pathway. The coordinator attended ward rounds and worked with
members of the multi-disciplinary team, to make sure all patients had the treatment, therapy, and care they needed and were prepared well for discharge. The trauma coordinator called each patient after discharge to give them support and check they were managing at home. These patients were cared for using the enhanced recovery pathway (ERP) to accelerate their recovery. There was no dedicated enhanced recovery nurse for orthopaedics at the time of inspection. This meant that no data was captured for Watford General site.

The service had enhanced recovery pathways for colorectal, upper gastro-intestinal patients and patients who had hip or knee replacement surgery. This standardised interventions and involved the multi-disciplinary team working together to optimise the rehabilitation process and reduce the time patients spend in hospital. At the time of inspection, there was no enhanced recovery nurse in either the colorectal and upper gastro-intestinal role. This meant that these patients did not always receive specialist advice to optimise their recovery. The trust was unable to show whether the enhanced recovery programme improved patient outcomes, as they were incapable of retrieving the information due to technical difficulties. At their pre-operative assessment, patients saw all members of the multidisciplinary team including nurse, anaesthetist, and pharmacist. All ERP patients for joint replacements and spinal surgery were offered a ‘joint school’ and ‘spinal school’ following their pre-operative assessment. At the school, they attended a seminar where all aspects of their surgery such as mobility, pain, and nutrition were discussed. The ERP involved patients mobilising on the day of surgery at four hours after surgery, and standardising medication. The aim was to discharge the patient within three days of surgery. The ERP was in use on the wards, but it was not always fully completed. We raised this with the senior nurse at the time of the inspection. Checking the pathways was part of the enhanced recovery nurses role that was being recruited to. The successful candidate was due to start in November. The manager also stated that they would bring this lack of compliance at the ‘daily three’s’ for the following week.

Medical staff followed professional guidance and recorded medical device implants using the National Joint Registry (NJR). The NJR collects information on joint replacement surgery and monitors the performance of joint implants. This ensured traceability at national level, if concerns were raised about the quality of joints or any adverse effects.

There was a wide range of information on best practice was displayed in staff areas such as the treatment room and staff room. This included hydration and fluid balance, pressure ulcer prevention, the wound dressing formulary and selection guide, and falls prevention and management information.

There were audits and checks in place on the wards to monitor the processes that helped to keep patients safe. These included audits of tissue viability care, medicines administration and early warning scores. The hospital used, ‘test your care’, a national audit tool to check adherence to care standards on wards. Matrons and senior nurses reviewed the care received by 10 patients in a ward in a different division. They collected data from patient experience questions and nursing care indicators, such as missed doses of medication and nutritional assessments. A recent audit found a 99% compliance rate to standards on surgical wards.

The pre-operative assessment clinic assessed patients in accordance with NICE NG45 ‘Routine pre-operative tests for elective surgery’ (2016). For example, MRSA screening and blood tests were undertaken following this guidance.

Surgery services used the American Society of Anaesthesiologists (ASA) grades as a guide regarding a patients’ fitness to undergo an anaesthetic. This was in line with NICE guidance. The ASA physical status classification system is a simple scale describing fitness to undergo an
anaesthetic. For example, ASA1 or ASA2 are relatively low risk patients. ASA3 patients have a higher risk of complications during anaesthesia due to other comorbidities they may have.

The theatre department audited its use of the World Health Organisation (WHO) safer surgery checklist. However, this was not a qualitative audit and did not look at compliance to WHO guidance. The theatre manager told us they had just started a qualitative WHO audit, which looked at compliance to guidance, and they had audited six times. Since the audit had been started recently we were not assured about the quality checks and governance surrounding compliance to WHO safer surgery.

The surgery service contributed to some national audits and benchmarked their performance against other healthcare organisations to ensure they were following best practice. This included the National Hip Fracture Database audit, the National Emergency Laparotomy Audit (NELA) and Patient Reported Outcome Measures (PROMS).

There was a range of integrated care pathways and protocols to standardise practice and improve outcomes for patients. These included a urinary catheter pathway, guidance on the prevention of venous thrombo-embolism (blood clots following surgery, often referred to as VTE), and a fractured hip care pathway. The trust had adopted the guidance produced by the association of anaesthetists of Great Britain and Ireland (AAGBI) for fasting prior to surgery to ensure patient safety whilst reducing the overall time patients were not able to eat and drink. For example, in pre-assessment, a patient was given a high carbohydrate drink to drink two hours prior to fasting. This is proven to aid wound healing and enhanced post-operative recovery.

We saw relevant policies in use in ward areas, including the ‘enhanced recovery integrated care pathway for spinal surgery’ (2012) and ‘enhanced recovery integrated care pathway – total knee replacements’ (2015). Both were within review by dates.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural, and other preferences.

Following assessment of patients, intravenous fluids were prescribed, administered, and recorded when clinically indicated. A system of intentional care rounds was carried out. This aimed to ensure that patients felt comfortable and had been offered food and drink. Most records showed that patients had been offered food and drink on a regular basis, although not all were completed in a timely manner.

Patient’s nutrition and hydration needs were assessed on admission, monitored, and recorded using the Malnutrition Universal Screening Tool (MUST). This was in line with NICE guidance QS15 statement 10: ‘Physical and psychological needs’ (2012). When staff identified medium risk, they introduced food and drink intake charts. They also allocated a red tray to the patient to indicate the need for support with eating. In addition, they referred high-risk patients to a dietitian. We saw these actions had implemented in the records we reviewed. During our inspection, we observed MUST assessments were completed for all sets of notes we looked at. Reassessments were completed regularly. Matrons also completed ‘test your care’ audits monthly. These included the completion of the nutrition assessments and implementation of care plans. Ward managers stated that they created action plans to improve compliance for lower audit results. A sample of the results for the wards can be seen below:
<table>
<thead>
<tr>
<th>Ward area</th>
<th>July 2018</th>
<th>August 2018</th>
<th>September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleves Ward</td>
<td>95%</td>
<td>78.9%</td>
<td>81.3%</td>
</tr>
<tr>
<td>Elizabeth Ward</td>
<td>94.4%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Flaunden Ward</td>
<td>95%</td>
<td>94.1%</td>
<td>83.3%</td>
</tr>
<tr>
<td>Langley Ward</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Letchmore Ward</td>
<td>100%</td>
<td>100%</td>
<td>95.5%</td>
</tr>
<tr>
<td>Ridge Ward</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Staff used fluid balance charts to monitor patients’ fluid intake and output. Fluid balance charts were inconsistently completed and not totalled up every 24 hours.

Staff managed mealtimes on the wards to support patients to eat well. The whiteboard had information marked next to the patient so that staff had a quick overview of the patients needing support with nutrition. Patients with a red tray had nutritional needs, and that patients living with dementia had a blue tray indicating they needed support to eat their meal. The wards observed protected mealtimes by restricting access to the ward.

Patients with nausea or vomiting were prescribed antiemetic medicine (a drug effective against vomiting and nausea). Patients had jugs of water within reach. These were regularly refilled. Spill cups were provided to help patients drink independently. Intravenous fluids were prescribed when necessary.

Prior to surgery patients were kept ‘nil by mouth’ and fasted in accordance with national safety guidance to reduce the risks of aspiration during general anaesthesia. Elective patients were given clear instructions about fasting prior to admission and formulated drinks were provided to patients at their pre-assessment appointment. Information was given verbally at the pre-operative assessment and in writing. For example, patients were told not to eat for six to eight hours before a general anaesthetic and were encouraged to drink clear fluids up to two hours prior to a surgical procedure. However, we found that not all patients’ fasting prior to surgery was well managed. We spoke to two patients who had long fasting times. One patient had been fasted since 6am, attended at 11am and had their operation cancelled at 8pm. They returned the following day, fasted from 6am, attended at 11am and their operation at 6pm.

Patients at risk of malnutrition, with a MUST score of two or had a pressure sore of grade two and above were referred to a dietitian. The dietitian informed us that they look at handover sheets and saw patients with an increased output from their stoma, post-operative complicated bowel surgery, and special diets such as high potassium diets. Dietitians reviewed patients who had been referred to them, made treatment plans and recommendations. There were a number of supplements available to patients and if these were needed for discharge, the dietitian would write to the patients’ GP.

Patients were also given nutrition support via total parenteral nutrition (TPN). This is the feeding of nutritional products to a patient intravenously. There was a nutrition support team. They did ward rounds three times a week. The team comprised of a pharmacist, consultant, two nurses, and a dietician. They reviewed all patients who were receiving feed via TPN or a nasogastric tube. The nutrition specialist nurses also trained and supported the nurses on the ward. Protected meal times were in operation for wards, for example, on Flaunden B, lunch was 1 to 2pm and supper 6 to 7pm.
**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

The patient records we reviewed showed that ward staff assessed patients’ pain regularly as part of their routine observations using the National Early Warning Score (NEWS). Staff said they would observe patients’ facial expressions, body language, and a change in behaviour if they were unable to communicate with them. The surgical services had access to a pain team for advice and support with patients in pain. In two patient’s notes, there was evidence of review by the pain nurse and medication was changed to suit the needs of the patient. Patients were provided with pain relief in a timely manner. Patients told us ward staff regularly asked them about their pain, both before and after the administration of pain relief. They said pain relief was prompt and effective.

We listened in to a multi-disciplinary board round on Cleves ward. The staff discussed a patient’s pain and made a plan to refer the patient to the pain team. Staff chose appropriate pain relief using the ‘pain hierarchy’ (starting with common medicines and moving to more powerful medicines, some of which were controlled drugs). Commonly used painkillers were prescribed routinely but if these were not effective, staff asked the pain team for advice and for additional medicines to be prescribed to ensure patients were pain free and comfortable. We saw recovery staff monitoring patients' pain well post-surgery and administering appropriate analgesia promptly.

**Patient outcomes**

Managers monitored the effectiveness of care and treatment but did not always use the findings to improve them. Outcomes were mainly good with the trust performing better than national average for most indicators. They compared local results with those of other services to learn from them.

The service took part in national audits, such as the elective surgery patient recorded outcomes (PROMs) programme. PROMs and other national audits were reviewed by the clinical lead for the relevant speciality. The service acted to improve services and made recommendations following analysis of the results. For example, the divisional surgical director stated that they look at the actions for the audits monthly. They had done a business case for another nurse who specialises in fractured hips as the outcomes showed that there is a need for further support at the weekends.

The hospital benchmarked patient outcomes with other trusts and presented findings to speciality teams. For example, the trust audited its ability to get patients with hip fractures to theatre within 36 hours, which is the national standard. Audit results showed that 75% of patients did receive surgery the day of or day after admission. This was within the middle 50% of trusts. These results were below the national aspirational standard of 85%. This had decreased by 7% since 2016. The average length of stay for hip fracture patients has increased from 15.0 days in 2016 to 22.4 days. This falls within the middle 50% of trusts. We asked the trust for clarification of why the outcomes were getting worse for hip fracture patients and whether there was an action plan for improvements. It was stated that they were in line with national average therefore offered no improvement plan.

**Relative risk of readmission**

**Trust level**

From May 2017 to April 2018, all patients at the trust had a lower expected risk of readmission for
elective admissions when compared to the England average.

- Urology patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a slightly lower expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

![Graph showing elective admissions](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity*

All patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

**Non-Elective Admissions – Trust Level**

![Graph showing non-elective admissions](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity*

(Source: Hospital Episode Statistics - HES - Readmissions (01/05/2017 - 30/04/2018))

**Watford General Hospital**

From May 2017 to April 2018, all patients at Watford General Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

- General surgery patients at Watford General Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.
• Urology patients at Watford General Hospital had a much higher expected risk of readmission for elective admissions when compared to the England average.

• Colorectal surgery patients at Watford General Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

A senior manager told us that trauma patients (that is, non-elective patients) were seen in the emergency surgical assessment unit on the day of their injury and then, if their clinical condition allowed, they were sent home to wait for a planned surgical date. When they returned for surgery, this was recorded as a readmission.

Elective Admissions - Watford General Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

All patients at Watford General Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

• General surgery patients at Watford General Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

• Trauma and orthopaedics patients at Watford General Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

• Urology patients at Watford General Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions - Watford General Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

National Hip Fracture Database

The trust participated in the National Hip Fracture Database. The patient outcomes were within the expected range but had decreased since 2016 quite significantly.

• In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 8.0%, which was within the expected range. The 2016 figure was 3.9%.

• The proportion of patients having surgery on the day of or day after admission was 75.2%,
failed to meet the national standard of 85%. This was within the middle 50% of trusts. The 2016 figure was 82.1%.

- The perioperative medical assessment rate was 99.8%, which failed to meet the national standard of 100%. This was within the Top 25% of trusts. The 2016 figure was 99.2%.
- The proportion of patients not developing pressure ulcers was 97.8%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 97.8%.
- The length of stay was 22.4 days, which falls within the middle 50% of trusts. The 2016 figure was 15.0.

(Source: National Hip Fracture Database 2017)

Bowel Cancer Audit

The trust participated in the National Bowel Cancer Audit. The audit results showed that the trust was generally achieving patient outcomes within the expected range. The trust provided a response to this data. They stated that this was because the theatre lists were at the end of the week and the specialist nurses who were trained in stoma care did not work weekends. The divisional manager stated that they had put in a business case for another specialist nurse who would offer this cover at the weekend and reduce the patient length of stay.

- In the 2017 Bowel Cancer Audit, 73.7% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than expected. The 2016 figure was 70.7%.
- The risk-adjusted 90-day post-operative mortality rate was 2.3%, which was within the expected range. The 2016 figure was 5.6%.
- The risk-adjusted 2-year post-operative mortality rate was 17.1%, which was within the expected range. The 2016 figure was 23.1%.
- The risk-adjusted 30-day unplanned readmission rate was 9.4%, which was within the expected range. The 2016 figure was 10.9%.
- The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 42.9%, which was within the expected range. The 2016 figure was 44.9%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

The trust participated in the National Vascular Registry (NVR) audit. The 2017 audit results showed the trust were not always achieving patient outcomes within the expected range or the national standard. The trust provided a response to this data. They said that they were aiming to get patients onto the next available operation lists and hoped this would reduce the time to surgery to 14 days.

- In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 1.6% for Abdominal Aortic Aneurysms. The 2016 figure was 1.3%.
- Within Carotid Endarterectomy, the median time from symptom to surgery was 16 days, worse than the audit aspirational standard of 14 days.
- The 30-day risk-adjusted mortality and stroke rate was 3.4%; this was within the expected
range.
(Source: National Vascular Registry)

Oesophago-Gastric Cancer National Audit

The trust participated in the National Oesophago-Gastric Cancer Audit. In the 2016 National Oesophago-Gastric Cancer Audit, the age, and sex adjusted proportion of patients diagnosed after an emergency admission was 3.5%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 9.2%.
(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

The trust participated in the National Emergency Laparotomy Audit (NELA). The national Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80%, and red ratings indicate performance under 50%. In the 2016 National Emergency Laparotomy Audit (NELA), Watford hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 225 cases.

- The site achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 152 cases.
- The site achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 121 cases.
- The site achieved an amber rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 98 cases.
- The risk-adjusted 30-day mortality for the site was within the expected range, based on 225 cases.
(Source: National Emergency Laparotomy Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias.
- Varicose veins.
- Hip replacements.
- Knee replacements.

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2016/17, performance on groin hernias was about the same as the England average.

For varicose veins, performance was worse as the England average. The proportion of patients reporting they felt worse was higher than the England average.

For hip replacements, performance was about the same as the England average.

For knee replacements was about the same as the England average.

(Source: NHS Digital)

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Staff received a comprehensive induction when they commenced work at the trust. This included a trust-wide induction and local induction. The local induction included orientation to the area and support to complete local competencies. Newly qualified nurses were placed on a preceptor programme. Preceptorship is a period of structured transition for newly qualified healthcare professionals lasting up to one year, during which support is given by a preceptor who provides supervision, mentoring, and support to develop confidence and refine skills. Each nurse completed a competency booklet, which prompted reflection on their practice. Nurses carried out tasks, such as insertion of intravenous lines, when they had received training and demonstrated competency. Notice boards displayed training for nurses to attend: such as nasogastric tube insertion training and infection prevention and control awareness.

In the last inspection, the trust had addressed the shortage of nursing staff by recruiting overseas. These ‘transitional nurses’ worked on the wards as non-qualified staff until they passed nursing competencies and language tests to register in the UK. They received an induction and the practice development nurse attended wards to support them. All the overseas nurses we spoke with said the trust provided good training and support and helped them to pass their exams.

Theatre staff said they were responsible for completing their own development folders. They had good access to training and said they were encouraged and supported to develop. The theatre manager had introduced a theatre coordinator role and had developed the band 6 staff to run their own lists. Senior nurses took part in the trust’s leadership course. Ward sisters had completed the band seven leadership course. We spoke to two ward managers who were new into their role and they both said they had been invited to complete the band seven leadership course. We observed staff providing care to patients competently and confidently. Patients told
us they had complete confidence in the skills of staff and their knowledge. They said, “Staff are very good at their job and it is very hard”. Junior doctors praised the nurses on ESAU, said that they were highly skilled, and were able to fully support the doctors in their role. Staff in pre-assessment completed the pre-operative course. The sister said that the manager facilitated practice scenarios for listening for heart and chest sounds to ensure staff were competent and skills were maintained.

A consultant reported that they had good training and a supportive environment for surgical trainees at the trust. A consultant felt that junior surgical trainees and anaesthetists were being taught in a ‘safe supervised fashion’. Medical and nursing staff told us that they had sufficient support to undertake revalidation. Revalidation is a process by which doctors and nurses can demonstrate they have undertaken continuing professional development and maintained their competence to practice safely. Compliance with revalidation for medical staff was 100%.

Appraisal rates

Staff received an annual appraisal, which they told us was constructive and provided a formal opportunity to review their progress and identify further training needs. From July to June 2018, 68% of staff within surgery care at the trust received an appraisal compared to a trust target of 90%. At the time of the inspection, the divisional managers informed us that the appraisal rate had improved significantly to 91%. The medical staff were 97% compliant with appraisals at the time of inspection.

A table showing appraisal rates:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2017 - March 2018</th>
<th>July 2017 - June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Required</td>
<td>Complet ed</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>30</td>
<td>25</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>213</td>
<td>190</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>220</td>
<td>191</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff</td>
<td>46</td>
<td>35</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. Staff always had access to up-to-date, accurate, and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update.
Effective multidisciplinary team working practices were established and teams worked well together to improve the effectiveness and timeliness of care. Relevant staff teams and services were involved in assessing, planning and delivering patient’s care and treatment and worked together to understand and meet the range and complexity of patient’s needs. We observed patient care on surgical wards was supported by a variety of teams. This included pharmacists, a pain management team, and physiotherapists.

Daily huddles were held on each ward with nursing staff and members of the multi-disciplinary team, including occupational therapists and physiotherapists. During the huddles, important information was shared to ensure each patient received the required level of support for that day. The intervention needed for that patient was then updated on the whiteboard. For example, if a patient needed physiotherapy, a yellow ‘P’ was put next to their name; once this had been completed, it was changed to a green ‘P’.

Staff reported effective and positive working relationships between doctors and nurses and this was evident during our inspection. There were daily ward rounds on all surgical wards. Nursing staff, pharmacists, specialist nurses, and therapists joined the ward round when appropriate. However, staff told us it was sometimes difficult for ward sisters or their senior staff to accompany every consultant’s ward round. For example, Flaunden B Ward often had five or more consultant teams with patients on the wards.

Patient care was planned in several specialities through MDT meetings, for example, in trauma and orthopaedic. There were daily meetings between the emergency department and the ESAU and trauma and orthopaedic teams to discuss patients. There was effective MDT working for patients who had a fractured neck of femur. The orthogeriatrician, who specialised in the care of older orthopaedic patients, worked with the surgical team and did a ward round three days a week. They worked alongside the ward staff to make sure patients received optimum care and treatment.

Care pathways were multi-disciplinary and staff of all disciplines developed and supported the enhanced recovery programme. Each professional group recorded their assessments in patient’s medical notes. It was therefore easy to access information about outcome of the valuation and the ongoing care of the patients from each professional’s perspective.

Staff could access dieticians, occupational therapists, safeguarding teams and the critical care outreach team who were able to provide support and advice when required. Allied healthcare professionals told us that things had improved since the last inspection, especially as there were more occupational therapists working at the hospital now. Theatre and ward staff worked well together and we observed this enabled theatre lists to run efficiently. Patients were brought to and from theatre in a timely manner and there was good handover between the teams. Theatre staff informed nurses on the wards of any theatre delays.

Discharge planning started at pre-operative assessment when a patient’s expected discharge date was discussed so that a plan could be put into place for requirements at home. The wards had a red to green system to record on the whiteboard the post-operative tasks that were outstanding or had been completed. The service had access to a discharge team, which included patient flow coordinators. They provided support with discharge planning for complex discharges and when patients required a care package in the community to enable them to return home safely. The ward manager completed a daily status report, which had an estimated discharge date, length of stay and reasons for delayed discharge. This was flagged up to the discharge team and bed management who offer support where possible. On Cleves ward, they stated the main theme for delays to discharge was therapy needs and failed ‘trial without catheters’.
Seven-day services

The service was working towards being a seven-day service.

The surgery directorate provided most services seven days a week. Seven day ward round and seven day emergency operating was available. There was a registrar on duty seven days a week and 24-hour registrar and consultant on call cover. Consultants could be contacted out of hours by junior staff if required. Junior doctors and middle grade doctors we said the on-call consultants were responsive. At the weekend, a rota of senior trust doctors carried out a full ward round of elective patients. All patients in ESAU and surgical outliers were seen by a consultant daily. This complied with national guidance for seven-day services (NHS: Seven day Services Clinical Standards, 2017) priority clinical standard 6. Diagnostic services were available seven days a week, with imaging, pathology, and endoscopy available out of hours in an emergency. Staff confirmed they could access diagnostic tests out of hours.

Patients who had been admitted in an emergency were seen by the on call team, which included a consultant or registrar. The ESAU team were available 24 hours a day, seven days a week and staffed by a consultant 8am until 8pm. When the unit was closed because the beds were used for inpatients, the team reviewed patients in the emergency department instead of in ESAU. Patients who had been admitted for elective (planned) surgery were seen daily by a registrar grade or equivalent, or a consultant.

There was a dedicated emergency surgery theatre (known as a CEPOD theatre) on site. An anaesthetic consultant was on site 24 hours per day. Theatre nursing staff were available 24 hours per day, seven days per week. This included anaesthetic scrub and recovery staff. Consultant surgeons were available with additional staff on call, in case of unexpected demand in an emergency.

The consultant on ESAU informed us that during winter pressures, an additional registrar was provided between 5pm until 10pm to assist the on call team during these busy hours. The doctors had an internal professional standard which measured how quickly they answer within 30 minutes and this went from 60% to above 90% with the additional resources. The divisional managers stated that this was something they would like to bring in again to assist in the winter period.

Ward staff could contact the critical care outreach team directly from 8am to 8pm for advice or for review of a deteriorating patient. After 8pm, staff contacted the hospital at night team who called the member of the outreach team on call when needed. Pharmacy operated a weekday 9am to 5pm weekday service, with an evening and weekend pharmacist available for dispensing urgent medicines. There was a weekend dispensing service at the hospital. Physiotherapists were available at weekends and visited surgical wards for urgent patients only. The physiotherapists on a Friday categorised their patients according to risk level and these patients were seen first. There was an occupational therapist and assistant who covered the surgical wards at the weekend. However, dietitians and speech and language therapists were not available at weekends for surgical patients. The service also employed physician assistants who assist at the weekends in certain specialities such as vascular surgery. The discharge lounge was open seven days per week.

Health Promotion

Staff took opportunities to promote healthy lifestyle options for patients.

Staff took the opportunity, if it arose and was appropriate, to discuss smoking cessation, weight reduction, and drug and alcohol misuse with patients. Staff identified patients who may need
extra support. There was health promotion information and materials on display on the wards. There were leaflets and contact details of relevant organisations that may be able to offer support and advice to patients, including cancer care charities. We observed a pre-assessment taking place and the nurse advised the patient to stop smoking prior to surgery and offered advice around different ways to cut down.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 (MCA). They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Nursing staff knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Nurses understood when a person might need to be assessed for a Deprivation of Liberty Safeguard (DoLS) and understood what might constitute a deprivation of liberty. Some staff knew how to submit an urgent and a routine request for authorisation for DoLS. Staff we spoke with knew where to get advice on DoLS. The ‘safer’ checklist on wards, which staff referred to several times a day, included a check on whether there was anyone on the ward who might lack mental capacity and whether they might need to have their liberty restrained, for example to prevent them from leaving the ward.

Medical staff supported patients to make decisions in line with relevant legislation and guidance. Doctors we spoke with were aware of MCA and DoLS requirements and told us they had received training. Nursing staff were aware of processes of how to support medical staff to assess and record decisions about care and treatment if patients lacked mental capacity and how to make ‘best interest’ decisions. We saw completed records where staff had undertaken mental capacity assessments, and best interest decisions in line with NICE guidance. Examples of assessments completed included decisions around the use of bed rails; consent to help with personal care; medical interventions resuscitation and decisions around surgery. We also saw a referral for an independent mental capacity advocate (IMCA) for a patient who had no independent voice, family members, or friends who was able to represent them.

Consent was consistently undertaken in line with the trust consent procedure. The trust had a consent policy to guide staff. Consent was completed in line with guidelines. Consultant surgeons or members of their teams informed patients about the risks and benefits of surgery in the outpatient clinic. Patients either signed the consent form at that time or were asked to consider their decision and sign the consent form before surgery. There were checks that the consent form was signed before the patient went to theatre and after they arrived in theatre. We viewed seven consent forms, which were completed appropriately and showed evidence of informed consent.

Nursing, therapy, and medical staff understood the principles of different forms of consent. They took verbal consent, when a patient verbally agrees to treatment after they have received information, and implied consent, when they assume permission to do something from the patient’s actions. They always checked with patients before they undertook tasks such as administering medicines or taking bloods, regardless of the type of consent obtained. There were procedures in place for patients who were assessed as not having mental capacity to consent to treatment. There was a specific consent form to be used that required two doctors’ signatures which was used for patients who were unable to consent themselves. Doctors we spoke with had a good awareness of the different types of consent and told us when they had completed
‘consent 4’, for patients unable to consent for themselves. We saw this had been completed for a patient who had dementia, alongside a mental capacity assessment. These were double-checked during the WHO checklist process. Elective patients with a learning disability or those living with dementia were involved in a pre-operative meeting with their carer to put a plan in place for their admission. Staff in pre-assessment were aware of MCA and DoLS. Carers were encouraged to stay with the patient and operating lists were adjusted to suit patient need.

The trust audited the consent forms on an annual basis. The consent annual report showed that 43 consent forms were audited in 2017 and 16 of these were from the surgery division. It found that a large proportion of the patients were unable to recall discussing benefits, risks and alternatives and they were not provided with any written information. The trust had an action plan for improving the compliance, which was on track for completion.

The trust wide policy met the requirements of all relevant national guidance.

Mental Capacity Act and Deprivation of Liberty training completion

This information is routinely requested within the universal provider information request, completed within a standard template. However, the trust did not provide any data relating to Mental Capacity Act and Deprivation of Liberty Safeguards training completion.

During our inspection, we asked staff about training they had received in MCA and DoLS. Most nursing staff said they had attended this training. A trust representative told us MCA and DoLS training was covered in safeguarding training. Current compliance for level one safeguarding training was 94% for nurses and 72% for doctors.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

There were many examples of patients treated with compassion, dignity, and respect. Staff spoke in a respectful and friendly manner and maintained patient’s confidentiality always. Staff greeted people reassuringly and with courtesy. Ward clerks were friendly and helpful to visitors. Staff displayed a gentle and reassuring manner towards all patients and family members. We spoke with 13 patients and their family members. They all reported a positive experience. One said, “The care here is excellent. They work so hard.’ On Cleves ward, there were many thank you cards. They included comments such as ‘My care on your ward has been professional with compassion and consideration’ and ‘I would like to express my heartfelt thanks for the wonderful care I have received during my stay’. We heard staff updating relatives about patients’ progress whilst maintaining confidentiality. Feedback from patients confirmed that staff treated them well and with kindness.

Staff respected patient privacy and dignity during the two ward rounds we observed on Cleves and Langley wards. Staff ensured curtains were drawn around patients’ beds and conversations were respectful. Staff on the combined admissions unit and day surgery unit made sure that despite the limited space patients did not change into the theatre gown until their procedure was due and they had a private space to change.

We observed staff treating everyone with kindness and respect. Staff welcomed people onto the ward and to theatre and put them at their ease. Staff answered call bells in all areas visited. We observed that staff explained what they were proposing and responded well to people’s questions.
and concerns. Staff quickly recognised when someone might need some extra reassurance or support and provided it tactfully.

Staff showed an understanding and a non-judgemental attitude when caring for or talking about patients with mental health needs, learning disabilities, autism, or dementia.

**Friends and Family Test performance**

The Friends and Family Test response rate for surgery at West Hertfordshire Hospitals NHS Trust was 33%, which was better than the England average of 27% from July 2018 to July 2018.

There were varied response rates from the division. For example, ESAU/Letchmore had an 8% response rate in July 2018 whereas on both Flaunden and Cleves ward for September 2018 it was 65%. Ward managers attended monthly matron’s meetings and at the September meeting, the lead for FFT was invited to speak to the senior staff and assist with improving their scores. Managers said that this was useful and they had some ideas on how to improve the ward scores following the meeting. A breakdown of response rate by ward can be viewed below.

<table>
<thead>
<tr>
<th>Ward</th>
<th>July 2018</th>
<th>August 2018</th>
<th>September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleves Ward</td>
<td>15%</td>
<td>30%</td>
<td>65%</td>
</tr>
<tr>
<td>Elizabeth Ward</td>
<td>16%</td>
<td>26%</td>
<td>24%</td>
</tr>
<tr>
<td>Flaunden Ward</td>
<td>64%</td>
<td>56%</td>
<td>65%</td>
</tr>
<tr>
<td>Langley Ward</td>
<td>57%</td>
<td>42%</td>
<td>61%</td>
</tr>
<tr>
<td>Ridge Ward</td>
<td>30%</td>
<td>55%</td>
<td>40%</td>
</tr>
<tr>
<td>ESAU/Letchmore Ward</td>
<td>8%</td>
<td>13%</td>
<td>12%</td>
</tr>
</tbody>
</table>

The percentage of these scores where the patient said they were either likely or extremely likely to recommend was overall positive. For September, Cleves ward was 99%, Ridge ward was 94%, Flaunden ward was 86%, and Elizabeth ward was 88%.

**Friends and family test response rate at West Hertfordshire Hospitals NHS Trust, by site.**

(Source: NHS England Friends and Family Test)

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.**

Ward staff were sensitive to the impact of hospital admission on patients and their relatives. Staff were able to provide appropriate support to patients and their families and signposted them to appropriate services outside the hospital if required. Staff understood the impact that a patient’s care, treatment, and condition had on them and the impact it could have on their wellbeing and on those close to them, both emotionally and socially. Staff provided emotional support whilst caring for patients. Staff said there was a psychologist support available to provide counselling to...
patients. Staff could seek support for patients and their relatives from the trust's chaplaincy and bereavement services where required. We observed a consultant spending time with a patient on the ward round who was terminally unwell. They listened to the patient, were compassionate, and gave them time to respond to any questions.

**Understanding and involvement of patients and those close to them**

*Staff involved patients and those close to them in decisions about their care and treatment.*

Patients were aware of plans for their care and treatment and said they had been provided with the information they required. Staff introduced themselves and explained what was about to happen to all patients. All staff wore name badges. This helped to ensure that patients were aware of the professionals involved in their care. Staff talked to them in a way that patients could understand and described what they were going to do. They checked that patients had understood what they had been told and what needed to happen next. The trauma coordinator also followed patients up after discharge with a phone call to check they had the support they needed and to answer any questions. We saw feedback from a patient who said, ‘you have been the most amazing consultant, explaining the procedure clearly but also your kindness you have shown and your understanding’.

We observed a pre-operative assessment, with the patients’ permission, and observed the nurse communicating well, and answering questions clearly and precisely. The nurse discussed post-operative arrangements and set an expected date of discharge. We saw feedback from a patient who stated that they were ‘very pleased with the pre-operative information’.

The service offered a joint school for patients having joint replacement and a spine seminar for patients having spinal surgery. Patients and their relatives learn all about their surgical journey. They meet the following health professionals: physiotherapist, occupational therapist, anaesthetist, pain specialist nurse, surgeon, and enhanced recovery nurse. Patients told us they were very satisfied with the care they received and the staff who provided it. They had been involved in how and where their ongoing treatment took place. They said they had plenty of opportunity to ask questions and staff listened to them and were happy to answer any questions they had. Patients and their families said they were kept informed of all care and treatment due to be carried out. Patients told us the surgeon and nurses who were responsible for their care.

**Is the service responsive?**

**Service delivery to meet the needs of the local people**

*Services were planned in a way that met the needs of local people.*

The trust worked with commissioners, the local authority, and health services in West Hertfordshire to plan services for local people. Surgery services worked within strategic clinical networks in the region to ensure patients received the most effective care. These included the trauma network and cancer networks.

During the inspection, patient privacy was clearly important to the service and patients were nursed in single sex bays with designated toilets and bathrooms except for the day surgery unit. The day surgery unit was due for refurbishment with works due to start November 2018 to create single sexed occupancy. The service confirmed there had been no single sexed occupancy breaches from July 2017 to June 2018. Single sexed occupancy means that male and female patients do not share the same bay.

An enhanced recovery programme was in place to support patients prior and during their
procedure. The aim of the programme was to:

- Ensure patients were as healthy as possible for their treatment.
- Ensure patients received the best care during their surgical procedure.
- Ensure patients received the best care while recovering post-operatively.
- Encourage early mobilisation to avoid complications such as pressure tissue damage or a chest infection.

Adjustments were made for patients living with a physical disability, which included wheelchair access, lift, patient moving, and handling equipment and facilities for bathing. The main hospital had disabled access in the main reception areas. The wards were open to visitors most of the day. The wards protected mealtimes to ensure patients could eat their meals without interruption. Although the hospital building was old, the trust was making a full business case to refurbish theatres, the recovery area, and the day surgery area. Work was estimated to start autumn 2019. All wards had a welcome to your ward sign for people visiting. This included the number of staff on duty and nurse in charge, meal times, shift patterns and an explanation that staff could be approached and involved in discussions.

**Meeting people’s individual needs**

*Patients’ individual needs were taken into account. The service had a person-centred care approach to meeting the needs of patients living with a dementia.*

Patients were assessed on admission to identify any additional support or needs, and this was provided when required. For example, a skin integrity assessment identified any needs for pressure relieving equipment. Patients’ needs were assessed, and appropriate equipment used to ensure patient safety. Wards reported that equipment was readily available. This included mobility aids, pressure relieving cushions and mattresses, bariatric equipment and communication aids.

There were arrangements in place for patients with complex social health and social care needs. Staff said patient’s individual needs were identified during their pre-operative assessment and the theatre lists were arranged to reduce the amount of time patients waited. This was also highlighted on the theatre list so that staff were aware in advance.

Staff received mandatory training as part of their induction to the hospital. This included basic sessions around caring for patients living with dementia, learning disabilities, and mental health.

Effective care and responsiveness to patients with complex needs such as those living with a dementia or a learning disability was provided. There were dementia champions present on the wards. A specialist nurse for learning disabilities was available to provide support and advice if required. The service promoted the use of the local ‘purple star’ awareness campaign for care of patients with a learning disability. The “forget-me-not” scheme was used to identify patients living with dementia. The trust had also adopted the blue clasp on wristband scheme for patients who required additional care and support. Staff could access specialist dementia nurses who gave expert practical, clinical, and emotional support to families of patients living with dementia. Staff had access to the advanced care team who they said played a vital part in supporting patients living with dementia or other mental health challenges. Patient passports and “This is me” documents were used which enabled staff to provide individualised care to patients. We saw three of these fully completed during our inspection. Patient passports included information about patients’ likes and dislikes, eating and drinking preferences, special requirements and personal information such as what the patient enjoyed doing in their spare time and information about their
family and pets. Communication requirements and preferences were documented.

The acute liaison psychiatric service (RAID) based within the hospital provided psychiatric support to patients. Staff knew how to contact the mental health team when required and were aware that this was a 24-hour service. For example, a patient had been transferred from a psychiatric unit and was detained under the mental health act. The RAID team advised staff on how to care for the patient while they received treatment on the ward. Adjustments were made for patients living with a physical disability. The hospital had disabled access across all areas of surgery. Most wards had a family room or a confidential space that could be used for difficult conversations.

The trust had stopped using the online system that staff had used to get information leaflets for patients, but had not replaced this system. Pre-operative assessment clinic staff said they now had a limited number of leaflets and there was no longer access to written information in different languages. There was a face-to-face and telephone interpretation service for spoken languages. Staff had access to picture communication aids when they were required. Interpreters were usually pre-booked for the pre-operative assessment and prior to surgery. Staff stated that if interpreters were not available they would use a family member during the pre-operative assessment. Interpreters were booked by the surgical secretaries, but staff could use a telephone translation service if translation was needed urgently. Display boards were visible on all wards, which provided details of support networks to enable people to improve their health and well-being, for example, carer support groups and chaplaincy services.

Leaflets informing the public about sepsis were displayed on the wards. These included:

- “What is sepsis?".
- The signs and symptoms of sepsis.
- Where to find more information on sepsis.

Wards had long periods of time when they were open to visitors, usually from 1pm to 9pm. The wards protected patient mealtimes (at lunchtimes and supper times) to ensure they could eat their meals without interruption. Family members were encouraged to attend at lunchtime if the patient required assistance with eating so that they could provide extra support. Patients could choose their meals from a menu with a choice of hot and cold options. A menu we reviewed provided a good variety of meals and a balanced diet. One patient informed us that the food was very good. Medicines were not routinely administered during mealtimes to allow patients time to eat without interruption.

**Access and flow**

Patients could not always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit treat and discharge patients were not in line with good practice. Cancelled operations were still higher than the national average.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From July 2017 to June 2018, the trust’s referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average. The trust performed better than the England average in June 2017, however for the rest of the year the trust performed worse than the England average by at least 8.1%.
Referral to treatment (percentage within 18 weeks) – by specialty

One specialty was above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral surgery</td>
<td>73.6%</td>
<td>60.5%</td>
</tr>
</tbody>
</table>

Eight specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>69.7%</td>
<td>76.8%</td>
</tr>
<tr>
<td>General surgery</td>
<td>64.1%</td>
<td>72.7%</td>
</tr>
<tr>
<td>ENT</td>
<td>50.5%</td>
<td>63.2%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>50.0%</td>
<td>60.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>25.5%</td>
<td>69.0%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>0.0%</td>
<td>79.8%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0.0%</td>
<td>70.3%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>0.0%</td>
<td>81.4%</td>
</tr>
</tbody>
</table>

During our last inspection, we found patients did not always have timely access to treatment. Referral to treatment times (RTT) and the cancellation rates for surgery were both worse than the national average for surgical specialities. During this inspection, we found that the trust’s position for RTT had not significantly improved. There were 105 patients waiting over 52 weeks for treatment. 33 of these patients were elective orthopaedic patients. Leaders said the trust’s elective flow had recommenced in September 2018 and that the number of operations carried out was now improving, but understood further work was required to maintain this improvement. We discussed this with the divisional managers who stated that this was largely due to the clean orthopaedic ward closing due to winter pressures and national directives. This was highlighted on the corporate risk register in April 2018. An action plan had been implemented to reduce the number of patients waiting over 52 weeks for their treatment.

The service had recently recommenced elective orthopaedic surgery, following a national directive to stop such surgery to relieve bottlenecks caused by winter pressures. They had an elective ward, Flaunden A, with seven beds, which had been re-established for orthopaedic patients only. Since this had opened in May 2018, they have reduced the number of orthopaedic patients waiting. At the time of inspection, 33 patients were over the 52-week waiting time for...
orthopaedic surgery. The service was looking at opening Castle ward with 12 beds and ring fencing these for elective admissions. The elective flow for both general surgery and urology had started in mid-September 2018 and managers said they had started to see an improvement. The division were liaising with the clinical commissioning group (CCG) and independent providers with the view that they would outsource procedures to the surrounding independent hospitals and in turn reduce the patient load and RTT at the trust.

The service was also looking at restructuring the elective beds and using St Albans City Hospital for more complex cases. The pre-operative assessment criteria had been revised to enable admission of patients with more complex co-morbidities. The pilot started 17 September 2018 with the orthopaedic speciality.

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. The trust had no surgical patients who had not been seen within 28 days of their cancellation.

Over the two years, the percentage of cancelled operations at the trust showed a worse than the England average for seven out of eight quarters. The trust rates reaching as high as 35% in Q4 2017/18. In Q4 2016/17, the trust performed slightly better than the England average.

The service provided data which showed that the percentage of cancellations for elective operations was 2% in July 2018, 3% in August 2018 and 2% in September 2018.

Cancelled Operations as a percentage of elective admissions - West Hertfordshire Hospitals NHS Trust

Over the two years, the percentage of cancelled operations at the trust performance was similar to the England average in Q2 and Q3 2016/17. The trust performed slightly worse than the England average from Q4 2016/17 to Q1 2018/19. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Trust Level – elective patients

From June 2017 to May 2018, the average length of stay at the trust was:

- For all elective patients at the trust was 3.4 days, which is lower compared to the England average of 3.9 days.
- For trauma and orthopaedics elective patients at the trust was 3.8 days, which was as
expected compared to the England average of 3.8 days.

- For general surgery elective patients at the trust was 3.5 days, which is lower compared to the England average of 3.9 days.
- For urology elective patients at the trust was 2.1 days, which is lower compared to the England average of 2.5 days.

Elective Average Length of Stay – Trust Level

![Bar chart showing elective average length of stay for different specialties at trust level compared to England average.]

Note: Top three specialties for specific trust based on count of activity.

Trust Level – non-elective patients

- The average length of stay for all non-elective patients at the trust was 4.6 days, which is lower compared to the England average of 4.9 days.
- The average length of stay for general surgery non-elective patients at the trust was 3.0 days, which is lower compared to the England average of 3.8 days.
- The average length of stay for trauma and orthopaedics non-elective patients at the trust was 8.7 days, which was as expected compared to the England average of 8.7 days.
- The average length of stay for urology non-elective patients at the trust was 2.4 days, which is lower compared to the England average of 2.9 days.

Non-Elective Average Length of Stay – Trust Level

![Bar chart showing non-elective average length of stay for different specialties at trust level compared to England average.]

Note: Top three specialties for specific trust based on count of activity.

Watford General Hospital - elective patients

- From June 2017 to May 2018, the average length of stay for all elective patients at Watford General Hospital was 4.4 days, which was higher compared to the England average of 3.9 days.
- The average length of stay for general surgery elective patients at Watford General Hospital was 4.6 days, which is higher compared to the England average of 3.9 days.
- The average length of stay for urology elective patients at Watford General Hospital was 2.3 days, which is lower compared to the England average of 2.5 days.
- The average length of stay for trauma and orthopaedics elective patients at Watford
General Hospital was 5.8 days, which is higher compared to the England average of 3.8 days.

**Elective Average Length of Stay - Watford General Hospital**

![Graph showing elective length of stay comparison](image)

*Note: Top three specialties for specific site based on count of activity.*

**Watford General Hospital - non-elective patients**

- The average length of stay for all non-elective patients at Watford General Hospital was 4.6 days, which is lower compared to the England average of 4.9 days.
- The average length of stay for general surgery non-elective patients at Watford General Hospital was 3.0 days, which is lower compared to the England average of 3.8 days.
- The average length of stay for trauma and orthopaedics non-elective patients at Watford General Hospital was 8.7 days, which was as expected compared to the England average of 8.7 days.
- The average length of stay for urology non-elective patients at Watford General Hospital was 2.4 days, which is lower compared to the England average of 2.9 days.

**Non-Elective Average Length of Stay - Watford General Hospital**

![Graph showing non-elective length of stay comparison](image)

*Note: Top three specialties for specific site based on count of activity.*

(Source: Hospital Episode Statistics)

The average length of stay for emergency surgical patients was 3.4 days, which was better than the England average. The average readmission rates were 27.3% within 28 days for emergency patients, which was better than the England average of 28.2%. However, the re-admission rate for elective orthopaedic patients was slightly worse than the England average at the hospital.

Pre-operative assessment appointments were readily available. Patients with suspected or diagnosed cancer were seen within 48 hours of their consultant appointment. All other pre-operative assessments were seen within 10 days where possible. The administrators said that they made the appointments closest to the patient’s homes, as there were several locations that they could have their assessments.

Services were planned in way that ensured elective surgical patients were allocated a surgical bed. At the time of the inspection, there were surgical outliers. Surgical outliers is a term used
when there were not enough surgical beds for surgical patients meaning these patients were cared for in another speciality bed, usually on a medical ward. These patients were discussed in the surgical handover and seen by a surgical team daily. There were no medical outliers on the surgical wards during our inspection. Since April 2018, there had been 583 medical patients in surgical beds across the hospital. The service did not demonstrate what the impact of this was on the surgical service.

Staff said they felt that the service supported the flow of patients expecting surgery. There was a dedicated emergency surgery theatre (known as a CEPOD theatre) on site but staff stated that there was a lack of capacity and this could sometimes lead to the elective list being cancelled. This happened during the inspection. Two patients we spoke to had been waiting over six hours for their procedure and felt the considerable length of time in the waiting area did not help with their anxiety or stress. One of them had previously been cancelled for the same surgery. They were cancelled late in the day due to the emergency theatres overrunning. Senior staff made sure the patients had been kept informed.

Surgery services managed the demand for emergency surgery well. The emergency surgical assessment unit (ESAU) functioned well as an assessment unit. It operated 24 hours seven days a week to prevent unnecessary admissions and to reduce the demand on the emergency department. The role of the department was to assess patients directly from the emergency department (ED) following nurse triage. This ensured that there was effective patient flow through the departments of patients and reduced waiting times in ED. However, if there was a lack of surgical beds, this meant that ESAU was used as a surge area and patients were kept in the area on beds. This meant that due to the lack of facilities, they had to ring-fence the gender within the ward. This limited the patients that could be accepted onto the assessment area. The ESAU consultant team reviewed patients referred by their GP, the emergency department and the acute assessment unit. The latest average length of stay for patients was 1.8 hours, which included their investigations. The nursing team also reviewed patients for daily dressings and post-operative care to reduce the strain on the wards. Staff confirmed that the ESAU team improved the flow of patients coming to the hospital for unplanned care. When the unit closed because beds were used for admitted patients, the team attended the emergency department to review patients. This meant that they saw a high volume of patients and assisted with the flow of surgical patients through the hospital. ESAU staff told us that patients were regularly admitted overnight to the unit when there were no beds available on the wards. They stayed in the four-bed area that was curtained off from the rest of the unit. ESAU staff continued to review patients referred to them in the two-triage cubicles. When patients were admitted, the unit changed to a single sex unit, which reduced the flow for the other gender through ED. Because of this, the patients could have long waits on a trolley in ESAU before bed management agreed a bed, as they did not want to impact on the flow in ED. There were currently no standards or breach times for trolley waits in ESAU. At the time of inspection, the average length of stay for a bed was 9.5 hours. This means that patients could be at risk of developing skin damage due to long trolley waits.

There was a criterion for patients that were accepted onto ESAU. All patients had to be independently mobile, have full cognitive ability and must have a NEWS score of below three. There was an escalation policy in place regarding the admissions to the unit. This outlined plans for when all six beds were utilised on ESAU; elective surgery would be cancelled and the day surgery unit would become the assessment unit. This was also the estimated plan for winter pressures and there was evidence in team meeting minutes from September 2018 that this had been discussed with the team. When more than four patients stayed overnight, the unit was closed because the other two beds were not in the separate curtained off area. On inspection,
ESAU had one male patient who had stayed on the unit overnight. This meant that only men could be admitted to the unit. The patient’s staying in the unit overnight were cared for as an extension of the neighbouring ward and had access to the ward’s facilities.

Discharge planning was started on admission to the ward. This included an estimate of the patient’s length of stay, together with any additional required support following their procedure. Whiteboards on the wards displayed the estimated discharge date (EDD) for each patient, which was discussed during safety huddles. This was also recorded electronically and patients who had delayed discharges were followed up by bed management. The service had appropriate discharge arrangements for people with complex health and social care needs. There were surgical patient flow coordinators who assisted with the complex discharges. They attended board rounds and referred patients to social services and intermediate care. Ward staff carried out board rounds at around 11am each day with the focus on appropriate discharge. Meetings were attended by the nurse in charge and the allied health professionals involved in the patients’ care. The hospital’s discharge lounge (called the ‘Patient Lounge’) was open at weekends. The hospital also had a dedicated discharge team Mondays to Fridays who liaised with ward staff regarding timeliness of discharges. One of the main delays to discharge was getting the patients’ ‘To Take Away’ (TTA) medicines ready. Nurses said doctors did not write up the TTA prescriptions in advance. This meant some delays occurred as patients were fit for discharge but had to wait for the TTA medicines to be prepared. There was also a weekly ‘fresh pair of eyes’ meetings held on Thursdays when social workers and discharge planners would discuss those patients with a delayed discharge to help ensure timely and appropriate discharges.

Hospital wide bed meetings took place at 8.30am and 12.30pm and senior staff attended these meetings. Hospital bed capacity and patient flow risks were discussed. Any escalation areas in sue the previous night were also discussed and we saw suitable arrangements in place regarding the management of any outlaying patients.

Theatre usually operated for elective surgery until 8:30pm and aimed to finish emergency surgery by 10pm. There was 24-hour availability of an emergency theatre. There was a theatre team and recovery nurse on site at all times, with consultant surgeons and four anaesthetists on call out of hours. There was a process to open and staff a second emergency theatre. The theatre escalation policy listed the steps to take when the numbers of trauma and emergency general surgery patients was high, including stopping elective surgery lists.

Staff in the recovery area confirmed that patients from intensive care (ITU) occasionally stayed overnight in recovery, however this was staff by ITU staff. Staff also stated that recovery was open at nights, at times, due to the unavailability of beds and staff. Staff sometimes work for up to 17 hours to ensure patient safety. Staff confirmed they could access food and drink for patients when required but there was a lack of privacy for patients as there were no toilets or showers readily available.

The service used an electronic system to plan and monitor theatre utilisation. This programme allowed theatre managers to filter by location, speciality and for each consultant surgeon. Daily reports were produced and used to plan theatre lists. In the four weeks prior to the inspection, overall theatre utilisation was 71%, slightly lower than the national average of 80%.

When an operation was cancelled on the day, staff would record the reasons why on the electronic system. Operations cancelled by the patient were not reportable to the local commissioners. When operations were cancelled for all other reasons, a root cause analysis form was completed. This specified the reason, for example, non-availability of a surgeon. A weekly draft summary report was prepared on Mondays for and distributed for comment. The finalised weekly report was circulated to all relevant staff. Elective operations were planned on the
weekend operating lists and generally, when there was theatre capacity; two or three elective operations were completed each day. Theatre staff discussed list order within the team brief and changes to the list were made at this point. The theatre coordinator communicated these verbally but the list was not reprinted on different coloured paper, which would be best practice. The theatre coordinator was easily identified as they wore a red hat.

The trauma coordinator (TC) managed the attendance of emergency and elective trauma patients. If there was no bed availability and the patient was stable, for example upper limb fracture, the patient would be sent home and the TC would arrange their readmission and keep the patient informed. The patient would be added onto the emergency list so there was a chance that their operation would be cancelled. The TC stated that there was limited theatre time available. They said that elective patients go first and then the trauma patients follow which means there could be cancellations. There was a patient on Ridge ward whose operation was cancelled whilst we were on site. It had been cancelled the previous day as well.

Since the last inspection, there had been a reconfiguration of the surgical wards. Flaunden A ward now had a dedicated seven beds for elective orthopaedic patients. Staff said this worked better to protect the elective operation programme. All patients referred to fracture clinic from the emergency department were reviewed by a consultant within 72 hours.

## Learning from complaints and concerns

Concerns and complaints were taken seriously, investigated and learned lessons from the results and shared with all staff.

### Summary of complaints

From July 2017 to June 2018, there were 262 complaints about trust wide surgical care. The trust took an average of 38.5 days to investigate and close complaints; this was not in line with their complaints policy, which stated complaints should be completed in 30 days. In part, this was due to the complexity of some of the complaints. Managers wrote to patients if there was going to be a delay in progressing their investigation.

At Watford General Hospital, there were 204 complaints:

- 94 for patient care.
- 59 for admissions and discharges (excluding delayed discharge due to absence of care package).
- 17 for communications.
- 15 for values & behaviours (staff).
- 14 for appointments.
- Four for other (specify in comments).
- One for transport (ambulances).

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Complaints were investigated and addressed by the senior staff who described their approach to complaints. Where appropriate, early contact with complainants was made to apologise and gain more information about the events surrounding the complaint. They asked the complainant whether they would prefer a written or verbal response. Following completion of the investigation, they would offer a face-to-face meeting with the complainant to explain and apologise. We looked at a recent complaint and found that this approach had been followed and that the complainant
appreciated the early contact. Letters of response were discussed with one of the service's senior managers. All complaints were discussed at monthly quality improvement meetings and learning from complaints was discussed at staff safety huddles and staff meetings. For example, in Ridge wards newsletter for August they discussed a recent complaint and actions that needed addressing. Staff said that there was more focus on resolving complaints as early as possible, so a local resolution process was used in all areas visited. Patients we spoke with were aware of how to raise a concern if necessary. Managers said there had been an increase in complaints about waiting times in the past few months, due to the cessation of elective operations because of winter pressures at the start of the year.

Information was available for patients on how to raise concerns or make a complaint. Leaflets and the information contained on the website sign posted patients and carers to advocacy services and the Parliamentary Health Service Ombudsman. There were posters on display and the service liaised with the hospital’s Patient Advisory Liaison Service (PALS) officer, and all wards received information on monthly complaints and compliments. The matrons’ boards in each area gave information on complaints and what actions staff had taken to improve services. For example, staff had introduced ear plugs, turned the volume of telephones down and made sure lights were turned down to help patients’ sleep better at nights on Cleves, Letchmore and Elizabeth wards.

All feedback received was reviewed. Staff discussed and agreed their actions in response to patient and carer feedback.

Number of compliments made to the trust

From August 2017 to August 2018, there were 23 compliments within surgery.

- Watford: 14 compliments.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Each ward had a compliments folder with thank you cards and letters. Staff were kept informed of these compliments.

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

The service was managed within the trust’s surgery, anaesthetics, and cancer division. A divisional director, divisional manager, and head of nursing led the division. There were clinical leads and managers for each surgical speciality and for theatres. The leaders reported a positive working relationship with each other and were dedicated to their role and responsibilities. They understood the division’s performance, the challenges they faced and the actions needed to address those challenges. For example, the division identified a busy period in winter last year between 5pm and 10pm and did a business case for an additional registrar. This was approved and the consultant informed us that this improved their outcomes and patients were seen much quicker. The divisional managers stated that they were considering whether this is something, they would need again this winter.

Each surgical speciality had a clinical director. Each speciality and the theatre department had a matron who was supported by the ward and theatre manager. Matrons were visible in the surgical areas. Staff described matrons and the wards and theatre managers as approachable and supportive. Staff told us the matron would come to the ward if they asked and often
supported them when they were busy. We observed the constant presence of the matron for surgical wards and theatre. The ward managers confirmed the matron had a detailed knowledge of the pressure on the wards and took prompt action to address any problems. The divisional manager's offices were on Flaunden A ward. This meant they were visible and staff told us that they were supportive and approachable.

Senior staff used a number of methods to communicate with junior staff. Managers sent information to ward and theatre staff by email, produced newsletters with key items of information, and had folders of information for staff. Information on noticeboards in theatres and on wards was up to date at the time of our visit. Most managers did not hold monthly team meetings. They stated that they did not feel these to be the most effective way of keeping staff informed. Managers said that not all staff could make them and it was difficult to find a time, especially during the previous year when there had been a high number of vacancies. Senior staff disseminated information to their teams by newsletters or within their ‘daily threes’. The daily threes were three things that the ward manager wanted to highlight to staff each day at handover time. Each three topics were highlighted for a week to ensure that all staff throughout different shifts were kept up to date.

We met with ward managers and registered nurses during the inspection and found they were organised, passionate, and demonstrated strong and supportive leadership. They were knowledgeable about the ward’s performance against the trust priorities and the areas for improvement. When we raised issues with them, they responded to address them immediately. There were examples of initiatives on the wards to improve patient care, such as sharing the root cause analysis (RCA) following a grade three pressure ulcer with all staff. Staff on Cleves ward said that this was effective in reducing the number of pressure ulcers. Ward staff were aware of their roles and took responsibility for adhering to expected standards.

The trust had specific leadership training available to ensure leaders could carry out their role effectively. For example, there was band 6 and band 7 leadership training courses. Senior nurse leaders we met had undertaken leadership training. There were good examples of where the division had developed their staff to become leaders. One ward manager had worked their way up from a healthcare assistant to their current position in a short period. They stated that it was due to the support of managers who recognised potential and encouraged progression.

Managers had started planning for resilience against winter pressures with fortnightly meetings. They looked at what the impact was the previous year and created a surge policy to reduce the effect on the department. For example, ESAU would move to the day surgery unit and run out of one bay enabling ESAU to open as a six bedded unit. There are also plans to move pre-operative assessment to St Alban’s City Hospital and utilise the rooms for ambulatory care.

**Vision and strategy**

**The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and patients.**

Staff in all the areas we visited emphasised their commitment to providing safe care and improving patients’ experience of care. They demonstrated they understood the trust's vision to provide the very best patient care for every patient, every day, and the values of commitment, care, and quality. The values also formed part of the appraisal process.

Surgery services were working to meet the priorities set out in the trust's clinical strategy and operational plan. They had made progress towards reducing the referral to treatment times by redesigning pathways, providing additional clinics and reorganising theatre lists.
Divisional managers had a clear strategy and vision for their service. The main points within their strategy for the next two to three years were:

- Centralising the orthopaedic services and moving it primarily to St Alban’s City Hospital (SACH). They were piloting this at the time of inspection and testing the support and infrastructure prior to full implementation. They were aiming to complete the restructure in a two-phased approach to ensure that there was adequate capacity at SACH to manage the increase in complexity and number of operations; and

- Completion of theatre refurbishment. The original business case was approved but the surveyors said that the design was not possible with the age of the building and therefore had to be redesigned. The current plans solved all risks that were present within the theatre such as lack of space in theatre 5 and lack of segregation of paediatrics within recovery.

There were plans to increase the proportion of patients who received day surgery at the SACH by expanding and developing the facilities at the site, which would reduce demand for surgery at Watford General Hospital. These plans were at an early stage.

Staff were aware of the overall plans for development of the service and generally felt they were kept informed of what was happening. Senior staff said the chief nursing office met with them regularly and meetings were open and positive. The lead nurses spoke positively about the reconfiguration and move of the orthopaedic clinic to the SAHC site. This meant facilities for the fracture clinic at Watford would be improved and better support the emergency department.

The division had an emergency surgery care pathway through effective use of ESAU. It provided surgical and medical cover out of hours and ensured surgical patients had fast and efficient reviews. They had started to develop key performance indicators for the unit to improve monitor the effectiveness of the service. These included:

- Initial presentation to nursing- triage within 30 minutes – 95%.
- Initial presentation to first medical assessment within 1 hour – 95%.
- Initial presentation to consultant review within four hours (0800-20:00) (or review by ST3+ between 20:00-08:00).
- Referral for imaging to results of imaging within 3 hours – 80%.
- Decision to admit to admission within 4 hours – 80%.
- Decision to admin to admission with 12 hours – 95%.

**Culture**

**Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**

Leaders promoted an inclusive, positive culture that supported and valued staff, creating a sense of common purpose based on shared values. All staff that we spoke with told us that they trusted the local leadership team and felt able to raise concerns with them. Morale had improved across the service since the last inspection, especially due to the successful staff recruitment programme. One manager told us that they were very proud of their staff. They felt that the morale in the last six months had improved dramatically. This was through giving them praise, involving them in decisions, and supporting them. Almost all staff told us that they felt respected and valued by their colleagues and the leadership team within the trust. There was a strong
sense of teamwork, which encouraged candour, openness, and honesty. Staff told us that the support that they received from their colleagues helped them cope with the pressures, which sometimes arose when the service became very busy. Senior staff spoke highly of the trust’s directors and executives. Staff spoke with pride about the ‘team working, compassion and care’ the service delivered.

The culture within the department was centred on the needs and experience of people who used the service. When something went wrong, patients received a sincere apology and were told about any actions to prevent something similar happening in the future. Staff told us the service operated in an open, friendly, and inclusive manner. Staff all told us they enjoyed working there.

We saw positive professional interactions between staff and effective communication with patients and their families. There was a no-blame approach used with respect to complaints, incidents, and errors. Nurses felt confident in applying duty of candour principles when incidents had occurred. Whilst staff were confident in raising concerns, and felt they would be acted upon, no staff were able to tell us the name of the trust’s Freedom to Speak Up Guardian (FSUG). We raised this with senior managers during the inspection. However, we did see posters throughout the hospital promoting the FSUG.

The managers told us that the past year had been challenging for the culture of the hospital. There had been several bed reconfigurations, which had been very difficult for the staff, and there was an increase in vacancies because of this. They had been able to improve on this and the band 5 vacancies were at 9% at the time of inspection. The managers felt that these changes were necessary and had been beneficial. For example, they had protected the clean flow for orthopaedic patients due to the extra capacity on Flaunden A. All staff told us that the culture was good within the department and this was evident at the time of inspection.

Wards held safety huddles three times a day at around 9.30am, 3pm and during the evening/night and staff used these meetings to share information and learning. These were well documented in each area visited. Some wards did not have regular minuted staff meetings given the pressures in the service, but all staff reported the safety huddles were more effective in shared key messages quickly.

Governance

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The division had developed an effective clinical governance framework and there was clear accountability for managing risk and making service improvements. Departments and specialties within the division, such as trauma and orthopaedics, general surgery and urology, held monthly clinical governance meetings, which combined mortality and morbidity discussions, presentation of audits and a review of activity data, risks, complaints, and incidents. Consultants, senior nursing, and theatre staff attended quarterly divisional clinical governance meetings. There was good representation from across the surgical division in attendance at the meetings. Minutes from these meetings showed incidents being discussed but there was limited evidence of learning and actions from these.

The service had designated governance lead staff:

- Clinical governance lead.
- Divisional governance lead.
- Divisional governance facilitator.
• Divisional governance co-ordinator.

The dedicated governance facilitator developed a quarterly governance newsletter that went to all staff and all consultants. This included lessons learnt from complaints, updates on the division, shared learning and details of the serious incidents, patient feedback and head of nursing headlines. The governance facilitator reviewed every incident reported within a day and discussed with the reporting staff. This included all low and no harm reported incidents. Immediate learning was identified and duty of candour was applied whenever required. The governance facilitator called relatives direct to explain what had happened and whether there was to be an investigation.

There was an effective process for management of serious incidents (SI). Each SI had a separate file with a list of actions. There were three meetings per week to review incidents and specialty staff were asked to present RCAs and participate in the learning from these. The RCAs were completed by other specialities that were not involved in the incident to remove bias. Completed investigations were then presently to the trust SI review group monthly. The RCAs were shared with all staff within the division to encourage improvements. We saw signed RCAs on the wards whilst on inspection. The governance lead stated that they were looking to audit RCAs soon to ensure actions were being carried out effectively. They looked at the themes of the SIs. For example, they identified poor epidural infusion management. Although the patients came to no harm, all staff members were retrained on how to use an epidural and compliance for this was now above 90%. Wards with poor training compliance were not able to use epidurals for pain relief until compliance had been achieved through retraining of staff. They have had no more incidents relating to epidurals since. There were no current themes with the SIs. At the time of the inspection, we saw that six SIs were in progress. 215 incidents had been reviewed and closed off in September 2018. Learning had been identified and shared. Staff gave us examples of how some issues regarding reporting incidents within the urology service had been identified and actioned.

Consultant staff we spoke with commented on the open discussions at the departmental and divisional meeting. Multiple consultants were involved in the governance within the division with attendees contributing their views and expertise. They felt there was a strong governance structure and no blame culture that encouraged improvement and accountability. Consultants were very engaged with the governance team and sought the team out for assistance with SIs. The quality governance facilitator stated they were proud of the changed culture and the candour around incidents and learning.

The leaders of the division had access to safety, quality, activity, and financial information. The integrated performance report for the division provided summary data on a variety of key indicators, including whether targets were met. However, we found that when targets were not met, there was not always action to improve performance. For example, there was no action plan for the improvement of the VTE compliance within the surgical division. In some cases, such as the ventilation within the theatre department, when the division was unable to fully resolve the issue, the item was entered on the divisional risk register.

The divisional director of nursing for surgery held regular meetings with matrons. Surgical ward managers and sisters had monthly meetings with matrons to discuss vacancies, incidents, complaints and local audits. Nursing staff confirmed they had feedback from their managers and received learning from incidents, complaints, audits and other quality improvement initiatives. These were communicated to them in a variety of ways such as handover meetings, quality safety meetings, e-mails, and information on the notice board. These notice boards showed monthly ‘you reported, we learnt’ messages. For example, staff had reported an increase in
omission of medicines and they have learned to query any missing medications at each handover and ensure that all staff followed the medicines’ management policy.

There were some arrangements in place with partners and third parties. For example, another local independent hospital provided some elective surgeries to assist in reducing the hospitals RTT. The monitoring of service level agreements with third parties was managed by the contracts’ department and any issues identified were highlighted to the divisional board.

Local audits were completed on each ward and theatre including hand hygiene and test your care audits. There was evidence of action plans displayed on notice boards and being completed where audit results showed poor compliance. For example, theatres September 2018 ‘test your care’ audit showed pre-operative temperature was not always monitored. There was an action for managers to remind staff to record this and that it would be re-audited in October 2018.

On the last inspection, we were not assured that surgery services were fully engaged in the implementation of the National safety standards for invasive procedures (NatSSIPs), which were published in September 2015 to support hospitals to provide safer surgical care. All NHS organisations were expected to develop their own Local safety standards for invasive procedures (LocSSIPs) and to allocate responsibility for each clinical speciality that carried out procedures. Compliance with LocSSIPs includes consideration of human factors and how teamwork, tasks, equipment, workspace, culture, and organisation affect human behaviour. The service called them standard operating procedures (SOP). We reviewed two of these and they referenced national guidelines and were appropriate. They did not however have a review date on them. This meant that there was a risk that they could contain out of date guidance. There was an effective action plan for the implementation of the NatSSIPs and LocSSIPs which showed that many of the SOP’s had been written.

**Management of risk, issues, and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The service maintained a divisional risk register, which defined the severity and likelihood of risks causing harm to patients or staff. It documented the measures to be taken to reduce the risk. The risks that were described accurately reflected the concerns described by staff throughout the service. The leadership team reviewed the risk register monthly and severe risks were escalated to the board when necessary, via the corporate risk register. Clear actions, mitigations, timescales for action, and risk owners were in place for the risks identified. One of the main risks was the environment, especially the theatre suite. Risks seen on inspection had been recognised, assessed, and included on the register, together with mitigating actions being put in place. An example was the separation of Flaunden A and B wards, with the lack of sluice facilities on Flaunden A ward. Clear mitigations were in place including fitting a second macerator. The risk was regularly reviewed and there was a plan for a full segregation of the wards and a new sluice to be added to Flaunden B. Other risks included the ventilation in the preparation rooms in theatres. The theatre team mitigated this by preparing their instruments within the theatres. This was on the risk register and to be addressed in the new theatre redevelopments. Senior staff were clear about the challenges the service faced and they were all committed to improving the patients’ journey and experience.

All risks were inputted onto the electronic system by the governance team to ensure they had full oversight of them. Risks were owned by senior staff and the risks we reviewed were managed effectively. Risks were discussed and agreed at the divisional governance meetings before a risk was put on the register. The minutes from September 2018 quality governance meeting showed
new risks had been discussed and added onto the register. They also do ‘check and challenge’ with the leads of services and ask them to present current risks at the meetings. This ensured that managers were aware of the risks and were continuously mitigating them. The divisional risk register recorded the key risks, the controls in place, and any gaps in controls. The register listed the assurances to address these gaps and any further action planned. The division had successfully made a business case to address some of the gaps in assurance, such as the improvement plans for theatre, which were going through the final sign off of phases. The quality governance facilitator met with managers monthly to discuss their risks and to offer support with the management of risk where needed. Not all risks had been identified by the service. For example, managers had not identified that wards did not routinely allocate a fire marshal on every shift to take charge of an emergency if required. Following our inspection, the trust advised us that now all bleep holders have been trained to act as a fire marshal, including out of hours. The trust stated that they were developing a training programme to ensure all sisters and senior sisters were trained to be a fire marshal and this would be fully implemented by December 2018.

Managers and staff had an effective knowledge of the risk register. Copies of the main risks of the service were displayed on staff noticeboards. There was risk register available for all staff and concerns and risks were discussed at team’s safety huddles. Each week, there was a ‘top three’ themes emerging from incidents and complaints and learning was shared at the safety huddles. Pressure area care was a theme discussed at these huddles. Where national audits had demonstrated a weakness in clinical practice, the senior clinical team did not always ensure that action plans were developed and monitored. There was a clear cyclical audit programme specific for surgery.

A bi-monthly quality and safety report was produced. This included risks in the service and linked quality and performance information so areas for improvement could be identified.

The trust had a major incident plan released in September 2017 and developed by the trust’s emergency planning steering committee. Staff could access the plan on the trust intranet. Some staff had attended practice events in the past year. Major incident training was included within the trust induction. The trust had a business continuity plan released in May 2017, which provided guidance on maintaining services and dealing with business interruptions, which might disable services or require special arrangements to be put in place to allow them to continue.

**Information management**

The service collected, analysed, managed, and used information well to support all its activities, using secure electronic systems with security safeguards.

The service had a wide range of information available to enable managers to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance, and finances. Each of the indicators were given an equal rating. The trust produced specialty scorecards for each division, which listed performance against all performance indicators monthly. Trust targets were set in relation to these indicators and performance was rated using the traffic light, RAG (red, amber, or green) rating system. This allowed managers to assess their performance at a glance and identify those areas, which required further improvement or investigation. The scorecards were discussed at the trust board and at divisional meetings and actions to improve were discussed and agreed. Themes were then cascaded to each ward and clinical area by matrons and senior sisters. There were arrangements in place, which ensured some data was submitted to external providers as required. For example, serious incidents and never events. Information technology systems were used effectively to monitor and improve patient care. Staff received helpful data daily, which
supported them to adjust and improve performance as necessary. The newly implemented ‘Safer’ staffing computer system displayed the service’s staffing position and was used three times a day at bed management meetings to inform decisions about staffing levels. Staff had access to up-to-date, accurate, and comprehensive information on patients’ care and treatment. Staff were aware of how to use and store confidential information.

**Engagement**

The service engaged well with patients and staff to plan and manage appropriate services and collaborated with partner organisations effectively.

The leadership team engaged with staff and aimed to ensure that their voices were heard and acted on to shape services and culture. The service gathered feedback from staff through discussions. For example, meeting minutes from ESAU showed the manager asking the team for their vision of the unit and where they would like to see it in five years. Whilst there had been some staff meetings in the past year, the service used the daily safety huddles held in all areas as the main method to share important messages. All staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and managers.

There was some evidence that the views and experiences of patients and those close to them were gathered and acted on to shape and improve the service. For example, a patient’s relative was attending the divisional half day to give feedback about their relative’s death. They wanted to help the staff learn from it and see it from the relative’s perspective. They were sharing this half day with the emergency care division, as they were also involved in the incident. This promoted shared learning as a trust. All staff were invited attend the divisional half day from consultants, junior doctors, specialist nurses and ward nurses. Leaders knew public engagement was an area to develop. Leaders recognised that there was more to do in capturing public feedback from the engagement activities undertaken to help shape services at the hospital. System wide, the trust was engaging in planning the services needed to meet local demand with all partners in the STP. Posters were displayed in public areas encouraging people to complete the Friends and Family test (FFT). Results were also on display in public and staff areas on the matrons’ boards.

Ward managers did daily walk arounds of the patients to gain feedback. This meant any negative or positive feedback could be acted on quickly. There was no documentation of the conversations that the managers had with the staff as it was completed informally. We saw ‘you said we did’ boards in clinical areas during our inspection. Some examples displayed were positive feedback, which had been given to the trust, as well as changes the service had made in response to patient feedback. For example, Cleves ward had ‘improved how we keep patients informed’ and ‘turned telephones down to reduce noise at nights’.

Matrons held a sister’s meeting once a month where complaints, SIs, RCAs and clinical governance feedback were discussed. At the previous month’s meeting, the lead for FFT was invited to speak to the senior staff and assist with improving their scores. Managers said that this was useful and they had some ideas on how to improve the ward scores following the meeting. The enhanced recovery nurses were looking to get patients involved with the development of the pathway to make sure it was patient focussed and adapted to suit their needs. The lead nurse for the fracture and orthopaedic clinics had been actively involved in the planning of the new clinic services at both site and held weekly meetings with staff regarding the planned changes.

The trust staff completed a staff survey and this gave them five key actions to focus on. The division staff had created five key priorities. They had allocated one to each month and this started in June 2018. This was detailed in the surgical division in the quality and governance newsletter. Their key priorities were:
Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research, and innovation. Recruitment had improved which had in turn improved the culture and morale of the staff.

The divisional leaders and ward leaders took decisive action to make improvements in the running of the surgery services. They had regular meetings where learning was discussed in a variety of forums. For example, matrons’ meetings and quality and governance meetings. There was strong evidence of improved culture across the service and there was strong leadership.

During our inspection, we found some areas of concern that were highlighted in our last inspection and had not improved. For example:

- Ensuring that patient personal identifiable information was not displayed.
- VTE assessments.
- Ensuring that patients were not nursed in ESAU overnight.

There were areas of improvement, which included:

- The service had taken steps to improve the facilities for the day surgery patients and the work was due to start on the day surgery unit in November 2018.
- Theatres had taken steps to ensure that they were complaint with national standards, such as recovery and the theatre ventilation. They had redesigned the theatres and were awaiting final approval. Managers expected the work to start in autumn 2019. The service had mitigated the risks as best they could with the environment they were working with.
- Recruitment had improved which had in turn improved the culture and morale of the staff.

Whilst the RTT recovery scheme was well embedded and progress had been made, it was recognised that the number of patients waiting over 52 weeks was still high despite it decreasing in the last few months. Staff understood the importance of ensuring all patients waiting had their risk of harm reviewed.

A pressure ulcer review group met once a month. Staff from all divisions attended to ensure shared learning.

The trust had a virtual fracture clinic in place for the past three years. This clinic was now fully electronic with an e-referral process that patients accessed themselves. Consultant reviews were held daily and feedback from patients had been very positive.

The recent introduction of an electronic system designed for use on mobile telephones was seen as a great improvement by staff. This would allow them immediate access to staff rosters and support effective rota planning.

The recent introduction of an electronic staff training database system was also a big improvement as it allowed all staff, and their managers, to view in real time staff training needs.
and compliance rates.

The safe care system was also now an essential hospital wide tool for assessing patients’ needs and the staffing levels and skill mix to ensure the delivery of safe, high quality care each shift.

All staff spoke positively about the trust’s ongoing support programme for transitional nurses and how these nurses had significantly improved the staffing vacancies position in the service.

Senior managers were very proud of the improvements on staff recruitment and retention. In the past year, vacancies at band 5 level had reduced from 25% to 9%. They said this ‘was a fantastic achievement’ and that it had stabilised the workforce and reduced pressures on all staff, at all levels.
Facts and data about this service

The trust has 71 number maternity beds at the Watford General site.

There are community midwife teams at Hemel Hempstead and St Albans Hospitals

(Source: Trust Provider Information Request – P2 sites)

Maternity inpatient services are provided on one site (Watford) with outpatient services provided on three sites (Watford, Hemel and St Albans). There are approximately 1,100 deliveries per annum in the Alexandra birthing centre.

(Source: Trust Provider Information Request – Acute context)

From April 2017 to March 2018 there were 4,653 deliveries at the trust.

A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at West Hertfordshire Hospitals NHS Trust – Comparison with other trusts in England.

A profile of all deliveries and gestation periods from April 2017 to March 2018 can be seen in the tables below.

Proportions of deliveries by recorded delivery method (April 2017 to March 2018)

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>West Hertfordshire Hospitals NHS Trust</th>
<th>England</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections$^1$</td>
<td>1,328</td>
<td>28.6%</td>
<td>28.3%</td>
</tr>
<tr>
<td>Instrumental deliveries$^2$</td>
<td>694</td>
<td>14.9%</td>
<td>12.4%</td>
</tr>
<tr>
<td>Non-interventional deliveries$^3$</td>
<td>2,628</td>
<td>56.5%</td>
<td>59.3%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>4,650</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

1 Includes elective and emergency caesareans
2 Includes forceps and ventouse (vacuum) deliveries
3 Includes breech and normal (non-assisted) deliveries

(Source: Hospital Episode Statistics, April 2017 to March 2018)
Gestation periods (April 2017 to March 2018)

<table>
<thead>
<tr>
<th>Gestation period</th>
<th>West Hertfordshire Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>271</td>
<td>5.8%</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>4,356</td>
<td>94.0%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>Total number of deliveries with a valid gestation period recorded</strong></td>
<td><strong>4,636</strong></td>
<td><strong>498,704</strong></td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics, April 2017 to March 2018
Notes: This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’. To protect patient confidentiality, figures between 1 and 5 have been suppressed and replaced with ‘***’ (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

Number of deliveries at West Hertfordshire Hospitals NHS Trust by quarter.

(Source: Hospital Episode Statistics - HES Deliveries (April 2017 - March 2018))

Is the service safe?

Mandatory training

Although the service provided mandatory training in key skills to staff, they did not ensure all staff completed it. Mandatory training compliance in maternity services was variable as staff were not meeting the trust target of 90% for the majority of mandatory training courses. However, the trust had recently reviewed its mandatory training arrangements in order to simplify the process and improve accuracy of reporting.

The service received monthly reports which identified compliance against core mandatory topics reported to the board. Reports were also sent to managers which identified individuals who needed to update their training. Mandatory training data for maternity services showed that nursing and medical staff had not met the trust 90% target for key skills such as patient moving and handling, equality and diversity and infection control. This meant that nursing and medical staff were not meeting the trust standard for mandatory training compliance in 2017/2018.
Staff confirmed new mandatory training arrangements had recently been implemented. Senior staff reported the new arrangements would ensure staff were compliant with their mandatory training requirements and electronic records were used to record staff attendance. Training schedules were on display across maternity the services. Staff said they received monthly updates regarding their compliance and one to one support was available if required. Staff confirmed mandatory training was covered during their annual appraisals.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training.

Watford General Hospital maternity department

A breakdown of compliance for mandatory training courses from July 2017 to June 2018 for qualified nursing staff in the maternity department at Watford General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-patient moving and handling</td>
<td>24</td>
<td>24</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>151</td>
<td>161</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>145</td>
<td>156</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>147</td>
<td>161</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire and evacuation clinical</td>
<td>141</td>
<td>161</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire non-clinical</td>
<td>135</td>
<td>161</td>
<td>84%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient moving and handling</td>
<td>130</td>
<td>160</td>
<td>81%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene</td>
<td>127</td>
<td>160</td>
<td>79%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>124</td>
<td>161</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>109</td>
<td>150</td>
<td>73%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control</td>
<td>116</td>
<td>160</td>
<td>73%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Watford General Hospital maternity department the 90% target was met for four of the 11 mandatory training modules for which qualified nursing staff were eligible. The lowest completion rate was 73% for infection control.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire and evacuation clinical</td>
<td>18</td>
<td>18</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Non-patient moving and handling</td>
<td>26</td>
<td>33</td>
<td>79%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>29</td>
<td>38</td>
<td>76%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>27</td>
<td>38</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire non-clinical</td>
<td>21</td>
<td>38</td>
<td>55%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>17</td>
<td>31</td>
<td>55%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene</td>
<td>19</td>
<td>38</td>
<td>50%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>18</td>
<td>38</td>
<td>47%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control</td>
<td>17</td>
<td>38</td>
<td>45%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient moving and handling</td>
<td>8</td>
<td>26</td>
<td>31%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Watford General Hospital maternity department the 90% target was met for one of the 11 mandatory training modules for which medical staff were eligible. Patient moving and handling had the lowest completion rate with 31%.
The trust were unable to provide us with medical staff for maternity alone, the numbers provided here are for all medical staff across maternity and gynaecology services. The trust did not provide us with medical staff at this location.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies. The trust target of 90% completion was met for the majority of safeguarding training courses.

Nursing staff were meeting the trust standard of 90% for level 1, 2 and 3 safeguarding training for children and adults. However, the trust was unable to supply us with data for medical staff for maternity services alone and numbers were combined with gynaecology services. Medical staff were compliant with level 3 safeguarding training for children but were not compliant with safeguarding children and adults training at levels 1 and 2. This meant medical staff were not meeting all the safeguarding training requirements as outlined in the trust mandatory training policy.

Staff were aware of the different types of abuse and the procedure for reporting a concern. Appropriate arrangements were in place to ensure patients were kept safe from avoidable harm. The trust had safeguarding policies and procedures available to staff on the trust intranet including out of hours contact details for hospital staff. The trust safeguarding policies reflected relevant legislation and local requirements for safeguarding.

The trust reported in the annual safeguarding report 2016/17, that safeguarding activity remained a high priority and often involved complex and challenging cases. Safeguarding activity in maternity services remained high and there were 981 safeguarding referrals, 737 mental health referrals for maternity cases and 90 unborn babies were on child protection plans. The reporting period identified that staff had been dealing with emerging national safeguarding issues such as trafficking, female genital mutilation (FGM) and domestic abuse.

The trust had recently introduced a lead nurse for safeguarding to manage the safeguarding team and coordinate safeguarding across the trust. The trust had a named midwife for safeguarding. The service also had a designated team of midwives (known as the Lavender team) who provided care, support and treatment for women in vulnerable circumstances, such as those who had a history of substance misuse, those with perinatal mental health concerns, teenagers, travellers and asylum seekers. The team liaised with other professionals and agencies, such as social workers, the police, independent domestic violence advisors and the community perinatal mental health team.

Midwives (in the Lavender team) were allocated to locality areas which were linked to the local health visiting service and children's centre. Working in defined areas had helped to promote continuity of care and good communication between other health professionals and multiagency working at a local level. Women were allocated a named midwife (from the team) to provide continuity, emotional and social support and individualised care and robust multi-agency liaison. The team had a secure database of all women with safeguarding concerns under their care. Information held on the database was reviewed regularly and updated as required. Each woman was graded as low, medium or high risk. The database provided midwifery and medical staff with up-to-date details of the care plan for each women, so that if they were admitted and/or discharged from the hospital, appropriate actions were taken by staff to protect women and/or their babies.
The trust had a specialist female genital mutilation (FGM) midwife who ran clinics for pregnant women who had experienced FGM. Staff were aware of the mandatory reporting of FGM for under 18 years of age. All cases of FGM were recorded via an enhanced data collection process that was shared with the informatics department and reported to NHS England. Female genital mutilation was covered in all levels of safeguarding training and additional training was available following the introduction of mandatory reporting. Midwives received an hour of FGM training annually on their mandatory study days.

Entry to the maternity unit was protected by keypads and buzzers to ensure the safety of babies. We observed staff were vigilant when relatives wanted to gain entry and answered buzzers promptly. A security guard was present by the main reception desk (situated by the entrance of the Women and Children’s unit), from 5pm to 8am, seven days a week. Ward staff would inform the security guard of visitors not allowed to visit.

A baby tagging system was in place and every baby had an identity tag applied to each ankle shortly after birth, which contained the baby’s name, date of birth and the mother’s name. Identity tags were checked on admission to the postnatal ward and following transfer from the delivery suite, and were part of daily postnatal checks. The trust had an up-to-date abduction policy and measures and controls were in place to minimise the risk of a baby being abducted from the unit. The trust had carried out two simulations of an abduction of a baby in 2018 to test the effectiveness of controls.

The trust set a target of 90% for completion of safeguarding training. The Intercollegiate Document (March 2014) states that: “Any clinician who is responsible for planning or assessing the needs of children who may be vulnerable or at risk of harm, require level 3 safeguarding training”. This included clinicians whether a doctor, nurse or allied health professional. Therefore, level 3 safeguarding training is the expected level for people caring and assessing the needs of children (and young people).

The trust set a target of 90% for the completion of safeguarding training. At the time of the inspection the target was being met by qualified nursing staff for levels 1, 2 and 3 safeguarding children and adults training. However, although medical staff in the maternity unit were meeting the trust target for level 3 safeguarding children training, they were not compliant with levels 1 and 2 safeguarding children and levels 1 and 2 safeguarding adults training. The trust was unable to provide us with medical staff for maternity alone and numbers included medical staff from gynaecology.

Watford General Hospital maternity department

A breakdown of compliance for safeguarding training courses from July 2017 to June 2018 for qualified nursing staff in the maternity department at Watford General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3 - three yearly update</td>
<td>146</td>
<td>152</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>153</td>
<td>161</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>152</td>
<td>161</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>151</td>
<td>161</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>151</td>
<td>161</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At Watford General Hospital maternity department the 90% target was met for all safeguarding
training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from July 2017 to June 2018 for medical staff in the maternity and gynaecology at Watford General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3 - three yearly update</td>
<td>27</td>
<td>29</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>30</td>
<td>36</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>28</td>
<td>35</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>30</td>
<td>38</td>
<td>79%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>26</td>
<td>36</td>
<td>72%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Watford General Hospital maternity department, the 90% target was met for one of the five safeguarding training modules for which medical staff were eligible. The lowest completion was safeguarding adults level 2 with 72%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

Infection risks were well controlled. Staff kept themselves, equipment and the premises clean and used control measures to prevent the spread of infection. However, staff in maternity services were not meeting the trust infection control training standard of 90% at level 1 and 2.

At the time of the inspection all areas in the maternity service were seen to be visibly clean and clutter free. There were no reported cases of MRSA or Clostridium difficile in the period July 2017 to June 2018. Dispensers of hand sanitising gel or foam were available at entrances to each department and within clinical areas. We observed staff adhering to good hand hygiene practices. In the period July 2017 to June 2018. Results of hand hygiene audits in maternity services scored above 98% which showed full compliance against the trust standard. Results were displayed on patient safety boards and posters promoting hand hygiene were visible to staff.

We observed staff complied with trusts policies for infection prevention and control. This included wearing the correct personal protective equipment (PPE), such as gloves and aprons. We observed that staff adhered to the trust uniform policy and were ‘arms bare below the elbow’. Cleaning schedules were clearly displayed in all ward and department areas. Monthly cleaning audits were carried out across the service. In the period June to August 2018, the average compliance rate in maternity services was 98%. Waste was appropriately segregated in clinical areas with separate colour coded arrangements for general waste, clinical waste and sharps (needles). Bins were clearly marked and were pedal operated and within safe fill limits.

At the time of the inspection staff told us they had completed the required infection control training at level 1 and level 2. However, in the period July 2017 to June 2018, data provided by the trust showed nursing and medical staff in maternity services at Watford hospital were not compliant with infection control training compliance rates which were (45%) and therefore were not meeting the trust standard of 90%.

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

We reviewed the processes for cleaning the birthing pools. Each birthing pool was cleaned and flushed daily and following every patient use. The estates department carried out a weekly thermal disinfection. We reviewed the daily decontamination and flushing records from July to September 2018 and all were complete. Water quality was tested monthly which included screening for legionella bacteria. Trust board papers indicated that no legionella had been identified in the birthing pools.

Environment and equipment

Premises and equipment were suitable for purpose and and looked after well. Equipment was checked at regular intervals to ensure it was safe to use. The service continued to review the security arrangements of its premises to ensure the safety of women and babies.

The design, maintenance and use of facilities and premises were suitable for purpose. Since our previous inspection in 2017, the service had undertaken two simulation exercises to test security controls within maternity services. Access to the delivery suite and wards was by swipe cards or an intercom buzzer system to gain both entry and exit from the wards. This meant staff could identify visitors and ensure women and their babies were kept safe. Two simulation exercises in 2018 identified it was possible for an unauthorised person to enter the delivery suite which posed a risk to women and their babies. Changes to security arrangements were made and we saw additional surveillance equipment and signage about the risks of tailgating into the unit. The risks were entered onto divisional risk registers. A plan to create a purpose built and manned reception to increase the security of the unit had been commissioned by the trust. This meant the trust was continuing to ensure the safety of women and their babies was a high priority for the service.

Adult resuscitation equipment was available on delivery suite, the Alexandra Birthing Centre (ABC), wards, theatres and outpatient areas. Resuscitation trolleys were checked daily to ensure they were stocked, equipment was in working order and medicines were up to date. All trolleys were tamper evident and were checked daily. Resuscitaires (used to support newborn babies who may need resuscitation after delivery) were available on all maternity inpatient areas and obstetric theatres. Daily checks to ensure they were in working order and fully stocked were carried out. We reviewed the checklists for three resuscitaires on the delivery suite in the month of September. There was one day where checks had not been completed. This was an improvement from our previous inspection where on 11 occasions, they had not been checked.

All equipment across the maternity service had been electrically tested; we saw stickers on equipment which confirmed this had been completed in a timely way. Staff said equipment repairs were undertaken promptly and equipment failures immediately addressed. This meant that risks to mothers and babies from unsuitable equipment was reduced.

Assessing and responding to patient risk

Risks to both women and babies were not always managed well, however the majority of patients received assessments, treatment and observations in a timely manner. Staff in triage and the Maternity Day Assessment Unit (MDAU) were not aware of best available evidence and plans for the management and care of women with reduced fetal movements.

At the initial antenatal booking appointment, community staff were responsible for carrying out full risk assessments of women. These included medical, mental health and social assessments and referral as necessary. Other assessments included tobacco and drug use and family and
obstetric history. The findings from risk assessments were used to help women choose their preferred place of delivery, recommend further investigations, and inform plans of care. This included whether a woman required midwife or consultant-led care.

Midwives continued to complete risk assessments throughout the antenatal, intrapartum and postnatal period. We reviewed ten sets of maternity records and saw evidence that risk assessments were generally well completed. Women identified as being unsuitable for midwifery-led care were referred to the obstetric team for review and management. Women with high-risk pregnancies, for example, due to a multiple pregnancy, diabetes and pre-eclampsia, were regularly monitored and reviewed by an obstetrician. Women who were at high-risk of gestational diabetes were referred for glucose tolerance testing.

The service completed venous thromboembolism (VTE) risk assessments (used to determine a patients’ risk of developing a blood clot) in line with national recommendations (RCOG, ‘Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium’: Green-top Guideline No 37a, April 2015). In the ten patient records we reviewed, the necessary VTE assessments had been completed. These findings were also corroborated with the divisional performance indicator summary (scorecards) which identified the maternity service was performing below trust standard of 95%. The year to date position in August was 85.2%. In the minutes of the August Quality Safety Meetings, actions were discussed to ensure VTE compliance met the trust target. This meant the service was taking appropriate actions to address service shortfalls.

Women were routinely asked about their baby’s movements at each antenatal contact. Written information regarding fetal movements was also given to women by 16 weeks gestation and again if they experienced episodes of reduced fetal movements. This was in line with national guidance (NHS England ‘Saving Babies’ Lives: A care bundle for reducing stillbirth’, 2016. Women were advised to contact the MDAU if they had any concerns about their baby’s movements. However, following two recent serious incidents, learning had been identified relating to the advice and management of reduced fetal movements. In the August 2018 maternity staff newsletter, serious incident investigations had identified women were not given the best available evidence and plans following admission to Triage and MDAU. This meant women were at increased risk of a poor perinatal outcome. The newsletter reminded staff of the importance of following guidelines for the management of reduced fetal movements (2017) and based on RCOG (2011) guidance, which state ‘any women with recurrent reduced fetal movements of two or more episodes MUST be reviewed by the obstetric registrar/consultant on call and should be followed up in the next consultant antenatal clinic for further management plan. Cardiotocography (CTG) monitoring to review fetal heart rate and uterine contractions should be performed and supplemented by further investigations such as an ultrasound scan. The newsletter contained the reduced fetal movement leaflet, flowchart and checklist. Throughout our inspection we saw displays of ‘reduced fetal movement’ information posters across maternity services. This demonstrated that the service was learning from incidents to improve the care of women and babies.

At our previous inspection the maternity service were not using customised fetal growth charts to help identify babies not growing as expected and a plan to introduce the charts by September 2016 had not been implemented by 2017. During our inspection we saw the service had continued to implement the NHS England ‘Saving Babies’ Lives: A care bundle for reducing stillbirth’, 2016, which included an element of risk assessment and surveillance for fetal growth restriction (FGR). The service had implemented the Gap/Growth Assessment Protocol, shown to significantly increase the detection of FGR and help prevent stillbirth. However, following
implementation in 2017, the service identified there was a lack of capacity for scan slots and skilled sonographers available to undertake the required scans and print off the customised growth charts. The lack of capacity was impacting on the service’s ability to deliver the Gap/Grow initiative and was entered on the divisional risk register. At the time of the inspection we saw actions had been taken by the service to mitigate the risks and included: a review of the criteria for scan requests in maternity services, review of scanning arrangements to accommodate additional scans and development of a business case for Gap/Grow capacity and appointment of a maternity lead. This meant the trust was aware of the impact on the quality of care for women and babies and was taking steps to mitigate the risks.

The unit used the ‘fresh eyes’ approach to CTG monitoring which is a technical means of recording the fetal heartbeat and uterine contractions during pregnancy and is widely used to assess fetal wellbeing. This meant a second midwife checked the interpretation and classification of the CTG recording of fetal heart and uterine contractions during labour. This ensured the CTG trace was correctly interpreted and appropriate actions were taken when indicated. This was in line with national guidance (NHS England ‘Saving Babies’ Lives’: A care bundle for reducing stillbirth’, 2016. Fresh eye reviews were generally carried out hourly and non-reassuring and pathological CTG traces were appropriately escalated.

The maternity service used an adapted version of the World Health Organisation’s (WHO) surgical safety checklist. This was in accordance with national recommendations (NPSA ‘Patient safety alert: WHO surgical safety checklist’, January 2009). The checklist was used for women having a caesarean section or other surgical procedure relating to childbirth, for example, a manual removal of the placenta. Completion of the checklists were audited from July to September 2018 and compliance rates were 100% for the obstetric theatre. This meant the service could be assured that the team worked well together to keep women safe from avoidable harm.

Maternity used the modified early obstetric warning score (MEOWS) assessment to detect signs of deterioration (in mothers). This included a pain score and a full set of vital signs (heart rate, respiratory rate, temperature, blood pressure and oxygen saturations). Staff plotted the observations against pre-determined parameters. There were clear actions to take when the MEOWS increased and indicated a woman was deteriorating. The maternity service monitored compliance with MEOWS documentation and escalation. The audit report presented in October 2018 showed there was good compliance with the use of MEOWS. However, only 50% of the 25 charts audited, had met the criteria for escalation and were escalated appropriately. There was evidence women had been reviewed but not always in a timely manner. This meant that although MEOWS offered the opportunity to intervene before a woman becomes seriously ill, by not complying with local and national guidance the service was not providing assurance regarding surveillance of women. Findings from the audit were presented at the service QSG meetings and shared with staff through message of the week and were place in learning folders in all areas of maternity services. An action plan was implemented following the recommendations highlighted in the report. For example, a complete set of observations to be competed on all women, escalate and document a plan for any abnormal observations and ensure that women who trigger are reviewed in a timely manner and in accordance with the policy, particularly if doctors fail to respond within 30 minutes.

There was a clear pathway for the management of sepsis. Midwifery and medical staff confidently described the signs of sepsis and what treatment should be initiated in line with national and local guidance. Staff received annual training on the recognition, escalation and management of sepsis during their maternity training updates.
There was a designated three-bedded triage (emergency assessment) unit on the delivery suite which provided 24-hour assessment, review and ongoing care planning for women over 20 weeks gestation and postnatal women up to 10 days post delivery. Women could telephone for advice or present to the triage unit if they had any concerns or health issues such as pain, reduced fetal movements or vaginal bleeding. Staff told us the unit was cramped and the service was considering relocating the unit to provide a better experience for women.

There were up-to-date policies in place for transfer arrangements to ensure women and/or their babies received care and treatment in the most appropriate location. These included transfer from homebirth to hospital, transfer from the emergency department to delivery suite and transfer to another hospital. Standard operating procedures were in place with the ambulance service for attendance at emergencies, such as babies born unexpectedly at home.

**Midwifery and nurse staffing**

Although the service had sufficient midwifery staff with the right qualification, skills, training and experience at the time of the inspection, staff raised concerns about staff shortages due to high vacancy and turnover rates. However, suitable measures were in place through the appropriate use of bank and agency staff known to the service which kept women and babies safe from avoidable harm and abuse and provided the right care and treatment. Staff levels were safe across maternity services at the time of the inspection and we saw evidence of this in all the areas we visited.

The maternity service had commissioned a formal workforce review in December 2016 to determine the midwifery establishment required to deliver high quality safe care. Birthrate Plus was used which is the national tool used to calculate the level of midwifery staff needed based on the trust’s activity, case mix and demographics. According to Birthrate Plus, the midwife to birth ratio required to provide safe care was one midwife to 26 births. However, according to data provided from April 2017 to March 2018, the trust had one midwife to 29.13 births which was below the England average of 26.68 births. In November 2017, the chief nurse (CN) presented to the trust executive committee, an updated midwifery workforce analysis report in line with Birthrate Plus which said the midwifery service was depleted of at least 35 WTE (whole time equivalent) midwives due to an average of 5% sickness, 6.2% maternity leave and an 8.8% vacancy rate. The CN proposed the over recruitment of 15 WTE midwives to help limit the high use of bank and agency staff and improve the quality of care to woman and babies.

The service employed two WTE consultant midwives which exceeded national recommendations (RCOG Safer Childbirth; Minimum Standards for the Organisation and Delivery of Care in Labour, 2007. The director, consultant midwives and matrons for maternity services were aware of the challenges and risks associated with failure to recruit to full establishment and retain and engage staff and had recorded it on the maternity risk register. Recruitment and retention remained a key focus for the service across all nursing grades and plans for 2019 were being developed. The service had recruited 28 new midwives as part of their rotational preceptorship programme that would join the trust in November 2018. The programme would enable midwives to experience all aspects of the service and had attracted newly qualified midwives from the trust and nationally. The service had appointed a dedicated midwife to support recruitment and retention across the service who was working closely with the human resources department to support the trust by attending schools and university job fairs and careers events to promote the diversity the trust could offer.

The service consistently achieved one-to-one care in labour and the average compliance score was 100%. Staff said during periods of high activity/lack of available staff, midwives were
deployed from other areas to support delivery suite. The director of maternity service told us staffing levels on the delivery suite were under review and there would be an increase from seven to eight WTE midwives per shift by December 2018. This was in addition to two midwives allocated to Triage. To ensure delivery of safe patient care, staffing was used flexibly across maternity services and was dependent on the acuity of patients and staff skill mix. Staffing numbers were displayed on white boards at the entrance to each unit and were assessed on a shift by shift basis. Multi-professional operational meetings were held throughout the day where patient’s requirements were reviewed and planned for. Actions were taken in line with the trust safe staffing policies which identified the escalation processes and outlined the risk assessment and communication required in the maternity unit. The trust had introduced an electronic staff rota system that took into account patient numbers, acuity and patient dependency to ensure the right staff was in the right place at the right time. This supported the escalation policy for maternity services where there was a midwifery manager who was on call 24 hours a day, seven days a week; they were the point of escalation for staffing concerns.

Midwifery handover took place at the change of each shift. We observed nursing handover on the delivery suite which were detailed and effective and appropriate information was shared and discussed. Women were encouraged by staff to participate in handovers by the bedside.

**Planned vs actual staffing**

The trust has reported their staffing numbers below for the period June 2017 and June 2018.

The midwifery and nursing staff have increased from June 2017 to June 2018 by 18.99 more WTE staff. The trust had an over establishment of staff with a fill rate of 117% in June 2018.

<table>
<thead>
<tr>
<th>Location</th>
<th>Jun-17 Actual WTE staff</th>
<th>Jun-17 Planned WTE staff</th>
<th>Jun-17 Fill rate</th>
<th>Jun-18 Actual WTE staff</th>
<th>Jun-18 Planned WTE staff</th>
<th>Jun-18 Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemel Hempstead</td>
<td>10.91093</td>
<td>14.23</td>
<td>76.68%</td>
<td>14.23</td>
<td>11.28093</td>
<td>126.14%</td>
</tr>
<tr>
<td>St Albans</td>
<td>10.17332</td>
<td>10.28</td>
<td>98.96%</td>
<td>10.78</td>
<td>9.71666</td>
<td>110.94%</td>
</tr>
<tr>
<td>Watford</td>
<td>168.2858</td>
<td>190.81</td>
<td>88.20%</td>
<td>183.36</td>
<td>156.4992</td>
<td>117.16%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>189.3701</td>
<td>215.32</td>
<td>87.95%</td>
<td>208.37</td>
<td>177.4968</td>
<td>117.39%</td>
</tr>
</tbody>
</table>

*Source: Routine Provider Information Request (RPIR) – Total staffing tab*

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 16% in maternity; which is higher than the trust target of 9%.

- Watford General: 15%.
- Hemel Hempstead: 21%.
- St Albans: 10%.

*Source: Routine Provider Information Request (RPIR) – Vacancy tab*

**Turnover rates**

From July 2017 to June 2018, the trust reported a turnover rate of 14% in maternity; which is higher than the trust target of 12%.

- Watford General: 16%
- Hemel Hempstead: 9%
• St Albans: 0%  
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From July 2017 to June 2018, the trust reported a sickness rate of 4% in maternity which is similar to trust target of 3.5%

• Watford General: 4%
• Hemel Hempstead: 6%
• St Albans: 9%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From April 2017 to March 2018, Watford General Hospital reported a bank and agency usage rate of 21% in maternity;

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Total Hours available/Establishment</th>
<th>Total hours unfilled</th>
<th>Total Bank Hours</th>
<th>Total Agency Hours</th>
<th>Unfilled rate (%)</th>
<th>Bank use rate (%)</th>
<th>Agency use rate (%)</th>
<th>Total bank and agency Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified</td>
<td>291,106.9</td>
<td>10,816.7</td>
<td>34,774.8</td>
<td>26,379.4</td>
<td>3.7%</td>
<td>11.9%</td>
<td>9.1%</td>
<td>21.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

Midwife to birth ratio

From April 2017 to March 2018 the trust had a ratio of one midwife to every 29.13 births. This was worse than the England average of one midwife to every 25.68 births.

(Source: Electronic Staff Records – EST Data Warehouse)

**Medical staffing**

There was enough medical staff with the right qualifications, skills and expertise to keep people safe from avoidable harm and to provide the right care and treatment.

Medical staffing levels and skill mix were planned in advance and were in accordance with relevant guidelines to ensure women and babies received safe care and treatment. The service provided 98 hours of consultant obstetric cover on delivery suite per week. This was in line with Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (RCOG, 2007), which recommends that units with between 4,000 and 5,000 births a year should provide at least 98 hours a week of consultant presence. On-call arrangements worked well and staff told us they did not have any concerns about contacting the on-call team when needed. There were three multidisciplinary ward rounds each day on delivery suite and a consultant-led ward round of all other wards each day, seven days a week. We observed a morning handover on delivery suite, which included structured discussions on all maternity patients and overnight deliveries and appropriate guidance was provided for junior medical staff. Women told us they were encouraged to participate in ward rounds and told us they were included in the care of their child.

Planned vs actual staffing
The trust were unable to provide us with medical staff for maternity alone, the numbers provided here are for all medical staff across maternity and gynaecology services.

The trust has reported their staffing numbers below for the period June 2017 and June 2018. The trust had an over establishment of staff for both time periods with a fill rate of 103% in June 2018.

<table>
<thead>
<tr>
<th>Location</th>
<th>Jun-17</th>
<th>Jun-18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Watford</td>
<td>35.9</td>
<td>34.1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates
From April 2017 to March 2018, the trust reported an over establishment of 3% in maternity; which is lower than the trust target of 9%

- Watford General: -3%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates
From July 2017 to June 2018, the trust reported a turnover rate of 33% in maternity; which is higher than the 12% trust target.

- Watford General: 33%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From July 2017 to June 2018, the trust reported a sickness rate of 1% in maternity which is lower than the trust target of 3.5%

- Watford General: 1%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage
From April 2017 to March 2018, the trust reported a bank and locum usage rate of 40% in maternity.

<table>
<thead>
<tr>
<th>Total Hours available/Establishment</th>
<th>Total hours unfilled</th>
<th>Total Bank Hours</th>
<th>Total Agency Hours</th>
<th>Unfilled rate (%)</th>
<th>Bank use rate (%)</th>
<th>Agency use rate (%)</th>
<th>Total bank and agency Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>33,224</td>
<td>3,603</td>
<td>7,705</td>
<td>5,621</td>
<td>10.8%</td>
<td>23.2%</td>
<td>16.9%</td>
<td>40.1%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

Staffing skill mix
In May 2018, the proportion of consultant staff reported to be working at the trust was about the same as the England average as was the proportion of junior doctors (foundation year 1-2).

Staffing skill mix for the 39.4 whole time equivalent staff working in maternity at West Hertfordshire Hospitals NHS Trust.
Records

Staff kept records of patient’s care and treatment and individual records were mostly managed according to best practice. However, not all records on the delivery suite were written clearly by medical staff and signatures were not always printed and were not legible. The delivery suite notes trolley did not correspond with the patient’s white board. This was addressed at the time of the inspection. Records were stored securely in all areas we visited in maternity services.

The maternity service used the standardised maternity notes developed by the perinatal institute for antenatal, labour and postnatal care. Women carried their own pregnancy records which they were advised to bring to each antenatal appointment and on occasions they attended the hospital. The handheld records were supported by hospital-held information to ensure staff had access to essential patient information. This meant staff could make informed decisions on patients’ care, management and treatment. We reviewed 10 maternity records and they were mostly completed to a satisfactory standard. Records completed by the midwifery team were comprehensive, fully completed, legible, dated and signed. Records completed by the medical team on delivery suite were not always written clearly and signatures were not printed and were not always legible. The named consultant / midwife were documented.

Regular clinical assessment was evident in the handheld antenatal records. Clinical assessments such as blood pressure and urinalysis were clearly documented. There was chronological recording of all contacts and events and evidence of multi-agency working. Antenatal screening results and ultrasound scan findings were included in handheld records. This was in line with national recommendations (NICE) for uncomplicated pregnancies. Medical records included care plans and referrals to specialist services when indicated. For example, the coagulation nurse specialist.

Mothers were given the national personal child health record (often called the ‘red book’), before they were discharged home. The red book is a national standard health and development record and is used to monitor the child’s health and development up to the first four years of life. Discharge summaries were sent to health visitors and GPs. The summary included information about the woman’s pregnancy, labour and postnatal care, and any medications they had been prescribed and any ongoing risks and/or follow-up care needed. On post natal discharge from the unit women were given written information and relevant contact details in case they needed extra support.

Community midwives told us they did not always have computerised access to patient’s
screening and blood results. This meant they had to telephone staff at the hospital to obtain results which was laborious and time consuming. During our inspection, we saw records in the delivery suite notes trolley did not correspond with the patients white board. This was raised at the time of the inspection and was addressed by the midwife in charge. Records were stored in locked trolleys and in offices behind public areas which were secured at night.

**Medicines**

**Best practice was followed when prescribing, giving, recording and storing medicines.**

Patients received the right medication at the right dose at the right time.

Medicines (including controlled drugs) were stored securely and there were appropriate disposal facilities. A controlled drug (CD) register was used to record the details of CDs received and administered as well as CDs that had been disposed of. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. Stricter legal controls apply to controlled medicines to prevent them being misused, being obtained illegally and causing harm.

Medicines and equipment for use in emergencies were stored in tamper proof boxes and were checked regularly. Medicines were stored securely in all the areas we visited. Medicines that needed to be kept below a certain temperature were stored in locked fridges and keys were held by the midwife/nurse in charge. This meant unauthorised personnel were prevented from accessing medicines. We sampled ambient and fridge temperatures to ensure medicines stored kept patients safe from avoidable harm. The fridge temperature records for delivery suite and the antenatal ward were within the recommended range, were clearly documented and there were no omissions on the documented checklists. This was an improvement from our last inspection where there were omissions on the temperature checklists in the same clinical areas.

The prescription charts we reviewed were signed, legible, and patient allergies were clearly documented and medicines were given as prescribed. Medicine incidents were reported via the electronic incident reporting system. A clinical pharmacist supported staff during weekdays and monitored the prescribing of medicines and was available to provide advice and support to staff and patients as needed.

**Incidents**

**Staff recognised incidents and reported them appropriately. Managers investigated incidents and provided feedback to staff. Lessons were learnt as a result of incidents and actions monitored. When things went wrong, staff apologised and gave patients honest information and suitable support. During our inspection we identified a potential theme within the incident reporting system which we brought to the attention of the service who undertook a thematic review.**

During our inspection, we observed staff understood their responsibilities to report incidents and patients were informed when things went wrong. Incidents were reported and investigated and were subject to high quality review by matrons and senior managers in maternity services. Evidence of decisions and discussions at safety and team meetings were consistent and learning outcomes were recorded in the minutes of team meetings and on safety boards across the service. The trust used an electronic reporting tool to record incidents. Staff were confident in the use of the system and said they always reported incidents. Staff said they were given feedback about incidents at handovers at the start of each shift, safety and team meetings, safety alert messages, message of the week and email and governance meetings. Learning folders were available in all areas of the service and contained messages of the week, lessons learnt,
maternity safety alerts, complaints, serious incidents and divisional investigations. All incidents were reviewed daily at the patient safety meeting. The meeting we attended had 12 members of the multidisciplinary team in attendance. We observed all incidents were discussed and where necessary investigations were initiated.

A patient who had undergone a caesarean section in the previous 24 hours was diagnosed as having a paralytic ileus (PI) following abdominal surgery. This meant there was an obstruction of the intestine due to paralysis of the intestinal muscles which can be a side effect of surgery. We were told a number of women had experienced the same complication following recent caesarean sections. Therefore, we requested incident reports for the previous 12 months. We reviewed seven incident reports for the period November 2017 to October 2018. Three incidents were graded as ‘no harm’ three as ‘low harm’ and one as ‘moderate harm’. The trust undertook a thematic analysis following our inspection to identify the commonalities within seven cases of PI reported on the incident reporting system between the period November 2017 and October 2018. During this period the service reported there had been approximately 4,700 deliveries. The average lower section caesarean section rate was 30.6% and the reported PI rate was 0.10% of total deliveries. There is no comparable national rate but it is recognised that 3% of total abdominal hysterectomy patients (handling of pelvic organs) would develop a PI regardless of the enhanced recovery pathway. On review of the cases only five were confirmed PI. This meant the PI rate was very small when compared to available data.

There was no identifiable trend with demographics (of the patient) grade of surgeon and intraoperative management. Postoperatively the analgesia was considered best practice and evidence based and the obstetric care in most cases was considered appropriate and timely. There was one case where a delay occurred in the consultant obstetric review. There were no care service delivery issues identified in all cases to meet the criteria for a SI.

Of the two surgical interventions; one was undergoing a root cause analysis (RCA) investigation, the second had completed an RCA with individual learning and actions specific to that case. This was monitored through the divisional governance process. The service was continuing to monitor the incidence of PI through daily multidisciplinary team review and ongoing monitoring of the data base This ensured trends and themes were identified and learning implemented. An action plan confirmed the service had taken appropriate actions to address concerns raised during the inspection.

Divisional performance was reported on the monthly indicator summary (dashboard). This provided the women and children’s service with safety and performance data to enable the identification of themes and trends and to take appropriate actions as necessary. Actions were monitored locally and overseen at monthly governance and unit meetings and we saw evidence of this in the July to September 2018 QSG meetings.

Monthly perinatal and maternal mortality and morbidity meetings were attended by clinicians from across the women and children’s division. Minutes indicated a full discussion of cases took place and learning points were identified. For example, serious incidents, themes, stillbirths and neonatal deaths were discussed. Lessons were learned and actions were taken to improve the outcome of care for women and their babies. The maternity service reported all premature births between 22+0 and 23+6 weeks gestational age who did not survive the neonatal period. This was in line with national recommendations (MBRRACE-UK, 2015).

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify parents (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of
the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medical and nursing staff understood their responsibilities regarding the duty of candour regulation and were aware of the trigger for application of duty of candour for moderate harm and above. All staff received training in duty of candour at induction which included the principles and how to apply them. It focussed on the ‘Saying Sorry’ messages outlined in the NHSR leaflet which provided reassurance to staff that saying sorry is not an admission of liability.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From August 2017 to July 2018, the trust reported no incidents which were classified as never events for maternity.

*(Source: Strategic Executive Information System (StEIS))*

**Breakdown of serious incidents reported to StEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from August 2017 to July 2018. Of these, the most common types of incident reported were:

- Seven maternity/obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant).
- One maternity/obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant).
- One maternity/obstetric incident meeting SI criteria: mother only.
- One operation/treatment given without valid consent.
- One VTE meeting SI criteria.

All 11 incidents took place at Watford General Hospital. *(Source: Strategic Executive Information System (STEIS))*

We reviewed the investigation reports for the 11 serious incidents and found comprehensive investigations, lessons learned and actions taken to mitigate future risk. For example, a women with grade three (severe) FGM was not identified antenatally or during labour until the second stage of labour. All staff were reminded to ask women at their antenatal booking appointment ‘if they have been cut’ or similar terminology which they understood. We saw reports were completed within 60 days and were shared with the clinical commissioning group and the parents. Key learning was shared with staff when reports were completed and action plans developed. As duty of candour was an essential part of the process, the trust identified a lead person to liaise with parents.

**Safety thermometer**

The maternity service used the national maternity safety thermometer designed to support improvements in patient care and experience.

The thermometer records the percentage of mothers who have experienced harm free care. It also records harm associated with maternity such as perineal trauma, infection and women’s psychological perception of safety.

The trust’s combined harm free score was 87.5% which was considerably better than the England
average of 69.3% in a snapshot of the maternity safety thermometer for August 2018. This was an improvement from our last inspection when the score was 79% compared to the England average of 74%. The August snapshot showed the trust scored better than the England average in five of the six indicators including maternal infection, post-partum haemorrhage (excessive blood loss of more than 1,000mls following delivery) and concerns about safety during labour and birth not taken seriously. This was an improvement from our previous inspection where the trust had scored worse than the England average for women who were left alone at a time that worried them. However, the number of babies born with an Apgar score of six or less at five minutes. The Apgar score is an evaluation of the condition of a newborn infant based on a rating of 0, 1, and 2 for each of the five characteristics of colour, heart rate, response to stimulation, muscle tone and respiration, with 10 being the optimal score. The trust had scored 14.3% which was worse than the England average of 6.7%. We saw evidence that the trust had taken action in response to these results.

**Is the service effective?**

**Evidence-based care and treatment**

Care and treatment was provided that was based on national guidance and there was evidence of its effectiveness. Managers checked to make sure staff followed guidance. Local and national audits were completed and actions were taken to improve care and treatment when indicated.

Women and babies care was consistently planned and delivered in line with evidenced based guidance. Staff followed National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) and other professional guidelines regarding the treatment of women and babies. For example, Mothers and Babies: Reducing the Risks through Audits and confidential Enquiries across the UK (MBBRACE-UK) and Baby Friendly (Unicef). NICE guidelines relating to maternity care were reviewed and incorporated into locally specific guidelines.

There was an effective system in place to ensure policies and guidelines reflected national guidance. The maternity service held a monthly forum for review of maternity guidelines and led by a consultant obstetrician and consultant midwife. Updated guidelines were ratified at monthly women and children’s quality and safety group (QSG) meetings and evidenced in meeting minutes. For example, in the minutes of the September 2018 meeting the Gap and Grow guidelines had been ratified. This was in line with national recommendations (RCOG Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007). We reviewed 30 guidelines on the trust intranet and saw they had been reviewed in the last three years which was in line with national recommendations.

The trust reviewed reports published by MBBRACE-UK, a collaboration that runs the national maternal and newborn and infant clinical outcome programme review programme. The trust benchmarked themselves against key areas of Saving Lives, Improving Mothers’ Care (2016) and Perinatal Confidential Enquiry: Term, singleton, normally-formed, antepartum stillbirth (2015). The trust was compliant with the majority of recommendations from these reports and had action plans to improve non/partial compliance.

Maternity services were actively involved in national and local clinical audit programmes and collated evidence to monitor and improve care and treatment. The clinical audit schedule for 2017/18 included 26 national clinical audits and 53 local clinical audits. National clinical audits included, Every Baby Counts, Saving Babies Lives, National Maternity and Perinatal Audit and
Maternity Surveillance (part of MBBRACE). Local clinical audits included, reduced fetal movement in pregnancy, consent for caesarean section, third and fourth degree perineal tear audit and the triage waiting time audit. The service undertook additional audits in response to incidents and clinical performance data for example, MEOWS and PEWs, medication, documentation and pain. Audit reports were presented monthly at women and children’s services QSG meetings and minutes showed where audits had been discussed.

**Nutrition and hydration**

**Women’s and babies’ nutrition and hydration needs were identified, monitored and met. There was access to an infant feeding specialist to assist women and babies when needed, and the trust’s breast feeding initiation rate was better than the national average.**

Women received support and advice for feeding their babies, including positioning and attachment, hand expression and preparing infant formula. Women told us how ‘supportive and helpful’ staff were. They told us they were never pressurised to breastfeed and they were assisted with feeding their babies whatever method they chose. Breastfeeding initiation rates were monitored monthly. From October 2017 to September 2018 the average breast initiation rate was 79%. This was higher (better) than the national target of 75%. Breastfeeding information was displayed throughout the service. The service had a team of infant feeding specialist midwives who provided education and support to women and staff and led the implementation of the Unicef baby friendly initiative awards. The awards are based on evidence-based interlinking standards for maternity, health visiting, neonatal and child centred services and are awarded to services that actively promote breastfeeding. The service had achieved level 1 at our last inspection and was making good progress towards achieving level 2. All staff had received additional training to support mothers who wished to breastfeed and the service was supported by a team of breastfeeding volunteers.

**Pain relief**

**Whilst pain was assessed and managed well on an individual basis and was regularly monitored by midwifery and nursing staff, A theme from complaints was the delay in administration of pain relief.**

Pain was assessed and managed well on an individual basis and was regularly monitored by midwifery and nursing staff. Pain levels were routine assessed during the completion of patient observations and were recorded on observation charts.

Maternity staff provided pregnant women with evidenced-based information about the availability and provision of different types of analgesia, in line with national recommendations (OAA/AAGBI ‘Guidelines for Obstetric Anaesthetic Services’, 2013). For example, midwives provided information and advice on pain relief options during their antenatal parent craft classes.

Pharmacology methods of pain relief were readily available and included nitrous oxide (gas and air), opioids (such as pethidine and oral morphine) and epidural anaesthesia, which were available 24-hours a day. Non-pharmacological methods of pain relief were also available. In the Alexandra Birthing Centre (ABC) there were two birthing pools available for women to use in labour and/or birth. From April 2017 to March 2018 the maternity service facilitated 198 water births; this equated to 20% of all deliveries in the ABC.

All staff we asked told us anaesthetists responded promptly to requests for epidurals. Women we asked did not have any concerns with timeliness of pain relief. Midwives told us regular analgesia was prescribed for post-operative women, including opioids, paracetamol and non-steroidal anti-inflammatory drugs (NSAIDs). Women were routinely given local anaesthetic prior to perineal
suturing, unless contraindicated. This was in line with national recommendations (NICE 'Intrapartum care for healthy women and babies': CG 190, last updated February 2017). Women, who had undergone surgery including caesarean section, were given pain relief for use at home when discharged.

Patients we spoke with throughout the inspection told us they had received effective pain relief. Three patients told us they were asked regularly if they required pain relief. Two patients told us they had requested an epidural in labour which was given without delay. However, a theme from patient complaints was the delay in the administration of pain relief. The service was taking appropriate steps to address concerns and action plans were in place.

Concerns raised by patients on the postnatal ward were recorded on the safety board and shared with staff at each handover. The matron told us intentional rounding (comfort rounds) had been implemented to ensure patients were offered regular pain relief throughout their stay. We saw action plans were in place to patients concerns. This meant staff were aware of the concerns raised by patients and had taken steps to address them.

**Patient outcomes**

The effectiveness of care and treatment was monitored and findings used to improve it. Local results were compared with those of other services to learn from them. Prompt action was taken to address any patient outcomes that were not in line with trust thresholds or national averages, for example, the service was working to address its higher than average perinatal mortality rate and caesarean section rates.

The service maintained a monthly maternity indicator summary (dashboard), which reported on birth activity, workforce, and obstetric and neonatal outcomes, such as normal vaginal births, instrumental and caesarean section deliveries, third and fourth degree tears and intrauterine deaths. The dashboard tracked monthly performance against locally agreed thresholds and national targets, where available. A traffic light system using red, amber and green (RAG) ratings was used to flag most of the performance against agreed thresholds. We saw exceptions (red flags) reported on the maternity dashboard identified areas that required action in order to maintain safety and restore quality.

For example, in the maternity dashboard review for August 2018 the top five trigger areas were, category 1 crash caesarean section, instrumental delivery (unexpected difficulty), massive obstetric haemorrhage, third degree tear and retained placenta. The maternity degree of harm for July and August 2018 was reviewed. There were 367 incidents of no harm, 35 of low harm, no moderate harm, three of severe harm and one death/ catastrophic harm. The severe and death/ catastrophic harm were investigated as serious incidents (SI) and learning was reported on dashboard reports. For example, staff were reminded to document the delivery position of the woman and patients waiting to go to theatre for any procedure should be nil by mouth.

According to the maternity dashboard for the period April to July 2018, the elective caesarean rate was 11.1% which was above the red flag of 10% and the trust target of 9.8%. Water births in the ABC were 20.2% and were above the trust target of 16% and there were no shoulder dystocia resulting in neonatal injuries. For the same period the service generally met the threshold for normal delivery rates. We saw that the service had taken actions to monitor, investigate and address any issues related to the clinical indicators reported on the dashboard.

The trust participated in the Antenatal and Newborn Screening programme overseen by Public Health England. The programme aimed to ensure that all women and babies have access to high quality antenatal and newborn screening programmes. The trust had adopted the national service
specifications for antenatal and newborn screening. For example, antenatal screening for infectious diseases such as HIV and hepatitis B, fetal anomaly and newborn physical examination. Of the 12 key performance indicators (KPIs) (across six screening domains), the trust had scored the highest rating of ‘achievable’ which scored 99%, for five of the KPIs. The trust scored ‘acceptable’ for three KPIs and performed below the threshold for four KPIs. An ANNB multiprofessional screening operational group met quarterly to review progress of the screening programme and audits were undertaken monthly to highlight trends and incidents. There were six screening incidents in the 2017/18 screening programme. Learning from incidents was identified and priorities had been set for the next 12 months. For example, to improve KPI compliance of the three domains, which had been highlighted at the previous inspection, develop a training needs analysis for screening staff and develop a process to gather user feedback.

The trust had commissioned an external review of nine non-randomly selected cases of stillbirth and brain damage as a result of oxygen deprivation. This was to obtain an impartial view of the standard of care to women and their babies by the maternity and neonatal services after an internal review of all SIs in 2016/17. Since our last inspection maternity services had received the report and we saw the draft action plan dated October 2018 of the recommendations from the external review. For example, the service needed to develop a clear and well-resourced pathway for referral of women at risk of small for gestational age babies (SGA) and patients at risk of mania who require medication which can be a risk to the baby (FGR). This would require sufficient resources to undertake fetal scanning during regular hours and within 24 hours for women who presented out of hours. The director of midwifery and the clinical director were responsible for delivering the action plan which would be monitored by the women and children’s QSG.

National Neonatal Audit Programme

In the 2017 National Neonatal Audit Watford General Hospital performance in the two measures relevant to maternity services was as follows:

- Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 133 eligible cases identified for inclusion, 91% of mothers were given a complete or incomplete course of antenatal steroids.

This was better than expected when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

The hospital met the audit’s recommended standard of 85% for this measure.

- Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

There were 20 eligible cases identified for inclusion, 15% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

This was lower than the national aggregate of 43.5%, and put the hospital in the bottom 25 of all units. An action plan was in place to address this and was monitored by the maternity quality safety group.

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

Standardised Caesarean section rates and modes of delivery

From April 2017 to March 2018 the total number of caesarean sections was as expected. The standardised caesarean section rates for elective sections as expected and rates for emergency
sections as expected.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>WEST HERTFORDSHIRE HOSPITALS NHS TRUST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.4%</td>
<td>550</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.9%</td>
<td>778</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>28.3%</td>
<td>1,328</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics, April 2017 to March 2018)

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries. Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery from April 2017 and March 2018 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Profile of all deliveries (April 2017 to March 2018)</th>
<th>WEST HERTFORDSHIRE HOSPITALS NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Single or multiple births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>4,580</td>
<td>98.5%</td>
</tr>
<tr>
<td>Multiple</td>
<td>70</td>
<td>1.5%</td>
</tr>
<tr>
<td>Mother's age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>69</td>
<td>1.5%</td>
</tr>
<tr>
<td>20-34</td>
<td>3,213</td>
<td>69.1%</td>
</tr>
<tr>
<td>35-39</td>
<td>1,125</td>
<td>24.2%</td>
</tr>
<tr>
<td>40+</td>
<td>243</td>
<td>5.2%</td>
</tr>
<tr>
<td>Total number of deliveries</td>
<td>4,650</td>
<td>596,828</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics, April 2017 to March 2018)

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.

Maternity active outlier alerts

As of September 2018, the trust has one active maternity outlier related to emergency caesarean section (CS) delivery rates. This meant the trust had a significantly higher than expected number of emergency caesarean deliveries when compared to other trusts and was similar to findings at our last inspection.

In 2017, the trust had implemented an action plan to reduce CS rates and improve the quality of care and experience for women. The CS rate had declined and by August 2017 the combined rate was 24% which was below the England average of 27%. During this inspection the combined CS rate was 28.6% and was similar to trusts of a similar size and complexity in England. However, data provided by the trust during the inspection showed the combined CS had increased from 28.8% to 38.4% in the period April to June 2018. This was higher than the
England average (28.3%) for a trust of similar size and complexity in England. The trust was continuing to monitor the local improvement plan and had added additional actions for 2018. For example, the introduction of centralised (CTG) monitoring on delivery suite to facilitate the effective review of fetal heart rate and the monitoring of uterine contractions to support decision making regarding CS.

We saw in the minutes of the quality, safety and governance meeting in September 2018, an audit to look at trends in practice had been undertaken in May 2018. Of the 150 completed audit forms, 138 CS were identified as being necessary and 10 CS were identified as being avoidable. Abnormal CTG recordings were the main reason for an emergency CS. Concerns had been raised as 11 cases had not involved the consultant in the decision making process. It was suggested consultants should work with registrars in decision making to enable them to work more effectively. Discussions in the minutes identified the possible benefits of learning from other trusts. A previous visit to another hospital had identified a system where consultants were able to view live CTG monitoring which had helped to reduce the trusts CS rates. This demonstrated the service was continuing to monitor the higher than average CS rate and was taking steps to address current concerns.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.00. This is more than 10% higher than the average for the comparator group rate of 4.95. Performance was worse than expected for stabilised and risk-adjusted extended perinatal mortality rate. There is currently no national aspirational standard for this audit.

(Source: MBRRACE UK)

Data from the trust for 2017, reported lower than the England average for stillbirth, neonatal mortality and extended perinatal rates and were within the 10% of the average percentage for a unit of similar size and complexity. Data completeness overall had been extremely good (100% complete) and post-mortems had been offered to 100% of stillbirths and neonatal mortality cases. The trust had identified the need to improve statistics for stillbirths and neonatal mortality, the ration of post-mortems obtained versus post-mortems offered and improvement in the 30 day reporting to MBRRACE in respect of the 2018 target. The service had an action plan in response to the MBRRACE-UK audit report which included the implementation of the ‘Saving Babies’ Lives care bundle which had mainly been completed within agreed timescales. This meant the service was continuing to monitor higher than average perinatal mortality rate and was taking steps to address concerns.

Competent staff

Staff were proactively supported and encouraged to acquire new skills and use their transferrable skills and share best practice. Maternity services recognised the continuing development of staff was integral to ensuring high-quality care.

The majority of staff in maternity services told us they had an annual appraisal as part of their personal development review. Staff said they had completed an appraisal in the previous year and had found it a helpful and constructive process.

There were systems and processes in place to ensure that staff had the necessary qualifications, skills, knowledge and competencies to do their jobs. The service enabled staff to take on new responsibilities on a continual basis. Trust induction programmes included mandatory training...
and competency based ward skills. New staff were inducted to the clinical area. Student midwives spoke highly of their mentors and felt well supported. Newly qualified midwives were supported through preceptorship programmes which offered role specific training and support. Preceptorship packages were individualised and provided a framework to develop midwives from band 5 to band 6. The programme included competency assessments in perineal suturing, cannulation, venepuncture, CTG interpretation (electronic monitoring of babies during labour) and medicines management. Preceptorship midwives were rotated to work in all areas of the maternity service during their 12-month programme. Staff told us they felt well supported during preceptorship programmes. We spoke with bank and agency staff who told us they had received a good induction before they commenced clinical duties.

Midwifery staff were given the opportunity to undertake additional training courses such as Mentorship, obstetric high dependency care and non-medical prescribing. Senior managers said that developing and supporting midwives and maternity support workers practice was fundamental to the safe delivery of care to women and their babies. The maternity practice development team worked closely with the trust practice development team to incorporate elements of mandatory and role specific training into the two/three midwifery training days each month. All training days were facilitated by midwives and doctors who were practising in their area of speciality demonstrating clinical credibility.

The role of supervisor of midwives (SoM) was discontinued in April 2017 following changes to legislation. The trust had appointed professional midwifery advocates and was implementing the new A-EQUIP (advocating for education and quality improvement) model of midwifery supervision. A-QUIP is a continuous improvement process that aims to build personal and professional resilience, enhance quality of care and for women and babies and support preparedness for professional revalidation (NHS England, 2017).

The service had implemented mandatory annual CTG competency assessment for all practising midwives and obstetricians. This was in line with national recommendations (NHS England ‘Saving Babies’ Lives: A care bundle for reducing Stillbirths) 2016. This meant failure to achieve adequate mandatory training would mean staff may lack the required knowledge to successfully assess fetal wellbeing using CTG equipment. Staff were able to undertake a yearly update or undertake the e-learning (k2 training packages) and/or CTG masterclasses. Ensuring mandatory compliance for CTG training was recorded on the divisional risk register and training compliance was presented at monthly divisional QSG meetings. In August 2018 training compliance in midwifery was 80% overall (100% in delivery suite) and doctors were 55%. This was due to training having expired in May/June 2018. We saw staff were advised directly through emails, minutes of meetings and divisional newsletters to undertake their CTG mandatory training updates.

The results of the General Medical Council (GMC) National Training Scheme Survey 2018 for doctors in training showed the trust was ‘within expectations’ and overall there was an improvement on the 2017 survey. For example, supportive environment, workload and teamwork. The trust scored ‘below expectations’ for reporting systems. The service had monitoring processes in place to ensure doctors were working within the GMC revalidation guidelines and would be able to revalidate in line with the scheduled date. Medical revalidation was introduced in 2012 to ensure all doctors were up to date and ‘fit to practice’. All of the consultants working in obstetrics had either been revalidated or were working towards revalidation in line with the timescale notified to them by the GMC. Nursing revalidation was supported by the hospital working within the nursing and midwifery council guidelines and nurses would be able to revalidate in line with the scheduled date. Nursing staff told us they were given assistance and
support to complete the appropriate reflective accounts and training to complete this.

**Appraisal rates**

From July 2017 to June 2018, 79% of staff within maternity care at the trust received an appraisal compared to a trust target of 90%. Data provided by the trust at the time of the inspection showed 87% of midwifery and nursing staff and 100% of medical staff had an up to date appraisal. This meant the majority of staff were compliant with the trust target of 90%. Midwives and nursing staff told us their appraisal gave them an opportunity to discuss their individual training needs and the requirements of the department.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>8</td>
<td>7</td>
<td>88%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>17</td>
<td>13</td>
<td>76%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>145</td>
<td>121</td>
<td>83%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>87</td>
<td>71</td>
<td>82%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>3</td>
<td>2</td>
<td>67%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

**Multidisciplinary working**

Maternity services were committed to working collaboratively. Medical staff, midwives, anaesthetists and other health care professionals supported each other to provide good care.

Staff in all areas of the maternity service told us they worked closely together to make sure women received person-centred and effective care. This included working with healthcare professionals outside the trust and patient records we reviewed corroborated this. Community staff reported good relations and communications with other professionals and/or agencies. They described effective multidisciplinary working between health visitors, GPs and social services. Staff confirmed they were advised when a woman had suffered a pregnancy loss or had safeguarding concerns.

Multidisciplinary handovers took place three times a day on delivery suite and included an overview of maternity patients. The obstetrics medical team, anaesthetists and delivery suite co-ordinator attended handover. We observed good interactions between medical staff and midwives on the delivery suite during multidisciplinary handovers. Meeting minutes confirmed regular multidisciplinary meetings were held and were well attended. These included perinatal morbidity and mortality meetings and speciality quality meetings. Midwifery staff told us there was good communication with the neonatal unit. The delivery suite coordinator would inform the neonatal unit of the acuity within the maternity service, including potential admissions to the neonatal unit. For example, women who had been admitted in pre-term labour, and when an emergency caesarean section was performed.

Women referred for a caesarean section, were reviewed to assess if they were suitable for a vaginal birth. If the women agreed with the multidisciplinary team’s recommendation, they were offered an appointment at the birth options clinic. Women with multiple pregnancies were cared for by a multidisciplinary team which included fetal medicine specialist obstetricians. Women who needed higher levels of care were referred to neighbouring trusts with tertiary fetal medicines centres. In the maternity records we reviewed, we saw detailed discharge letters to the mothers’ GP informing them of their current medical situation for the mother and their baby.
Seven-day services

Women had access to midwifery, obstetric and anaesthetic support seven days a week. Arrangements were in place to keep women and their babies safe out of hours.

Access to medical support was available seven days a week throughout the service. Consultant obstetricians and anaesthetist cover was provided seven days per week with on-call arrangements out of hours. Local diagnostic services were available daily with out of hour’s facilities for emergency procedures such as x-ray, computerised tomography (CT), ultrasound sonography and pathology out of hours. Women were able to report to the hospital in an emergency by telephoning the triage midwives. Community midwives were on call over a 24-hour period to facilitate home births. Antenatal and postnatal services were available to community-based mothers in emergencies.

Health promotion

Women who used the maternity service were supported to live healthier lives and manage their own health, care and wellbeing. In 2017, the hospital was accredited with the Unicef baby friendly initiative stage one.

In 2017 the hospital was accredited with the Unicef baby friendly initiative stage one. This meant the trust was committed to support and promote mothers to initiate breastfeeding and educate staff about infant feeding. At the time of our inspection the hospital was working towards stage two. Maternity services offered women and babies a comprehensive immunisation programme which included, influenza (flu) and pertussis (whooping cough) and BCG vaccinations and was in line with national pregnancy recommendations. Smoking rates at booking were on average 7% and community midwives recorded the smoking status for each pregnant woman at the booking appointment and provided them with information on smoking cessation services.

The maternity service supported women who wanted to reach a healthier weight during their pregnancy. The service worked with colleagues to in dietetics and the community to provide nutritional and physical activity guidance for women. The trust website contained a wide range of information to support women and their babies. For example, parent education courses and breast feeding support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Patients’ consent was obtained in line with hospital policy and statutory requirements. Staff received specific training in the relevant consent and decision-making requirements relating to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DOLS). Staff understood their responsibilities in relation to consent and we saw consent was undertaken in line with the trust consent policy. We observed midwifery staff asking for consent before they provided care or treatment, for example, taking clinical observations or giving medication. All women we spoke with told us staff always asked permission before providing care.

Medical staff informed women of about the risks and benefits of obstetric procedures, such as emergency caesarean sections. Written consent was obtained from women prior to surgery and we saw evidence of this in the maternity records we reviewed. At our previous inspection the consent audit for elective and emergency caesareans in June 2017 was found to be inadequate and inconsistent. Frequent risks such as pain/discomfort following surgery, hospital readmission...
and repeat caesarean sections, and serious risks such as hysterectomy and future scar rupture were not consistently documented. This meant there was no evidence that these risks were discussed with women. Since our last inspection the service had implemented a pre-filled consent form that was in line with national guidance RCOG Caesarean Section (Consent Advice). An audit of the consent form was undertaken in June 2018 and sampled 25 consent forms each for elective and emergency caesarean sections. The audit demonstrated the consent process for caesarean delivery had significantly improved and had scored 100% for the majority of mandatory fields. This meant there was evidence that risks had been discussed with women prior to surgery.

Mental Capacity Act and Deprivation of Liberty training completion

The MCA and DoLs training were included in mandatory safeguarding training. Staff we spoke with confirmed they had received MCA and DoLS training and understood their responsibilities to ensure patients were protected. Staff had access to specialist midwives and nurses (the Lavender team) that had particular expertise in dealing with women in vulnerable circumstances, such as those with learning disabilities and mental health concerns.

Is the service caring?

Compassionate care

Staff cared for women and babies with compassion and they were motivated to provide care that promoted women’s privacy and dignity. Feedback from women and relatives confirmed staff treated them well and with kindness.

Women, their birthing partners and families told us they were very happy with the care and support they received and feedback was consistently positive throughout the inspection.

Staff were very kind and caring towards patients on all interactions we observed. Women and those close to them were very happy with the care and support they received and feedback was consistently positive throughout the inspection. One woman and their partner told us their experience had “been really amazing and exceeded their expectations from the first smile from our midwife to the birth of our child”. Another woman and their partner told us their experience had “been amazing compared to our experience here there years ago. We felt really cared for and listened to and nothing was ever too much trouble throughout the whole experience”.

All staff we spoke with were passionate about their roles and were committed to making sure women and their babies received the best patient-centred care. We observed all staff respecting the privacy and dignity of women at all times during the inspection. We observed staff knocking on doors, politely asking before opening curtains and waiting to be invited into rooms and cubicles. We saw constant positive interactions by staff that were kind and caring to both parents and their families.

Thank you cards were displayed throughout the unit commending the friendliness, supportiveness and professionalism of staff. For example, “All staff were amazing and wonderful and made me and my partner feel really special”, and “This unit is just superb, this is my third delivery here and would recommend the hospital every time” and “Always had time for me as a new mum and whatever else was going on, me and my baby were always made to feel special”.

Women told us they had a named midwife and we saw evidence of this in the patients records we reviewed. Staff confirmed that when they assessed a woman’s needs they considered personal, cultural, social and religious needs. Women we spoke with and patient records we reviewed confirmed this.
The maternity service obtained patient feedback via the NHS Friends and Family Test (FFT), which allowed women to give their feedback on their experiences and state whether they would recommend the service to others. Service performance for antenatal, birth, postnatal ward and community postnatal provision performance was similar to the England average in the period July 2017 to July 2018. In July 2018 and community postnatal provision performance (100%) was above the England average (98%). This was a similar performance to our previous inspection in 2017.

Friends and Family test performance

Friends and family test performance (antenatal), West Hertfordshire Hospitals NHS Trust

From July 2017 to July 2018 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average. In the most recent period of July 2018 the England average performance for antenatal was 95% whereas the trust was 90%.

Friends and family test performance (birth), West Hertfordshire Hospitals NHS Trust

From July 2017 to July 2018 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally similar to the England average. In July 2018 the trust performance for birth was 92% compared to the England average of 97%.

Friends and family test performance (postnatal ward), West Hertfordshire Hospitals NHS Trust

From July 2017 to July 2018 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average. The trust’s performance for postnatal wards was 93% for July 2018 compared to the England average of
From July 2017 to July 2018 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average. In July 2018 the trust performance for postnatal community provision was 100% compared to 98% for England average.

(Source: NHS England Friends and Family Test)

CQC Survey of women’s experiences of maternity services 2017

Women who gave birth in February 2017 were invited to share their experience of the maternity care they received in the CQC maternity survey for 2017. The survey involved 130 NHS trusts in England and consisted of 16 questions, which covered labour and birth, staff during labour and birth, and care in hospital after the birth. Each question was scored out of 10 (the higher the score the better). Each trust also received a rating, which showed whether their performance was ‘better’, ‘about the same’ or ‘worse’ than most other trusts that took part in the survey.

The trust performed similar to other trusts for 15 out of 16 questions in the CQC maternity survey 2017. They performed worse than other trusts in one question, which related to women being involved enough in decisions related to care in labour and birth. The trust had performed similar to other trusts in the CQC maternity survey 2015, and worse for the same question regarding women being involved enough in decisions related to care in labour and birth. Following the publication of the survey, the maternity service developed a series of recommendations, including the implementation of Better Births: Improving outcomes of maternity services in England: A Five Year Forward View for maternity care (2017), to improve continuity of care throughout the birth pathway.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.97</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.10</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.44</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.52</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during</td>
<td>Did the staff treating and examining you introduce</td>
<td>9.03</td>
<td>About the same</td>
</tr>
</tbody>
</table>
labour and birth

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>7.73</td>
<td>About the same</td>
</tr>
<tr>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.58</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.48</td>
<td>About the same</td>
</tr>
<tr>
<td>If you used the call button how long did it usually take before you got the help you needed?</td>
<td>8.59</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.00</td>
<td>Worst performing trusts</td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.28</td>
<td>About the same</td>
</tr>
<tr>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>8.94</td>
<td>About the same</td>
</tr>
</tbody>
</table>

Care in hospital after the birth

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.02</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>7.86</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>8.68</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>8.76</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?</td>
<td>8.45</td>
<td>About the same</td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

Emotional support

Staff provided emotional support to women and their families to minimise their distress and we were provided with many examples of this. Women’s emotional and social needs were as important to staff as women’s physical needs, and there were ongoing support for bereaved women and their families.

Staff demonstrated an awareness and understanding of women with complex needs and when to provide them with additional support to minimise the potential of them becoming anxious or distressed. For example, staff regularly checked the emotional wellbeing of a mother whose baby was being cared for in the special care baby unit. There was ongoing assessment of women’s mental health during their antenatal and postnatal period. The maternity unit had an established team of specialist midwives and consultants, including a psychiatrist, who provided care, support and treatment for women in vulnerable circumstances, such as those with mental health concerns.

Since our previous inspection in 2017 the maternity service was about to incorporate video clips of babies receiving care twice a day to support the “iSeeU” initiative. The “iSeeu” initiative uses face-time technology to enable mothers separated from their babies at birth the opportunity to see their baby receiving care and treatment in the neonatal intensive care unit (NICU). Staff told
us the use of video clips twice a day would enable mothers to see how their babies were progressing in the NICU. Women were offered emotional support when trying to establish breastfeeding. Staff told us they had received training in how to support all mothers and babies to initiate a close relationship with their baby and feeding soon after birth. Women we spoke with were complimentary about the breastfeeding support and encouragement staff provided.

The maternity service offered a ‘birth reflections’ clinic, which provided women and their partners with the opportunity to discuss any unresolved concerns or issues they had regarding their pregnancy or birth experience. A dedicated counsellor for women’s services was also available.

Maternity staff followed the bereavement policies and guidelines to support mothers and their family in the event of a pregnancy loss, such as miscarriage, still birth or neonatal death. The maternity service had a specialist bereavement midwife who supported families from their initial loss throughout their time in hospital and their return home. The trust had a chaplaincy service which provided spiritual care and religious support for patients, carers and relatives as needed and multi-faith options were available. Staff signposted women and their families to national and local advisory groups when required such as the stillbirth and neonatal deaths charity (Sands) and the community perinatal team for women experiencing or at risk of significant perinatal mental health disorders. The trust held an annual service of remembrance for all babies and children who had died before, during or after birth. The service was held at a local church and anyone affected by such circumstances were invited to attend.

Understanding and involvement of patients and those close to them

Staff involved women and those close to them in decisions about their care and treatment. They provided women and their partners the opportunity to ask questions and raise concerns throughout the care pathway.

Women were involved in the choice of birth location at booking and throughout the antenatal period. This was important for the women who had a complicated pregnancy, for example those who had diabetes, hypertension (high blood pressure), or were at risk of pre-term birth.

Women and relatives we spoke with told us they felt involved in their care and their babies care and received the information they needed to understand their treatment. Women said they were supported by midwives and doctors to make informed decisions and the choices open to them and were given options of where to have and when to have their baby safely.

Women told us they were encouraged to ask questions and raise concerns and said they were given the opportunity to speak with staff and were kept informed about what was happening regularly. All partners said they felt involved in the care and treatment of their partner and felt able to ask questions. A partner of a women commented, “All staff we were involve with made me feel part of the team at the antenatal appointments and made sure I understood what was happening throughout my partners pregnancy”.

Senior midwifery staff and the consultant team were involved in supporting plans of care for women who made birth choices outside of the trust and national guidance, such as women who requested a waterbirth or homebirth with either a current or previous high-risk pregnancy.

Birthing partners told us they were included and involved in the care of their partner/relative and newborn baby, including being offered the option to cut their baby’s cord at delivery. Birthing partners accompanied women into theatre for caesarean sections carried out under regional anaesthesia (epidural and/or spinal) and could sit beside their partner/relative and could sit beside their partner/relative and support them throughout the procedure. This helped alleviate anxiety and distress for the women.
Is the service responsive?

Service delivery to meet the needs of local people

Service were planned and delivered in a way that met the needs of local people. The importance of choice and continuity of care was reflected in future maternity care provision. The service worked closely with local commissioners and neighbouring trusts to ensure future planning covered recommendations laid out by NHS England and the Department of Health.

The service worked closely with local stakeholders and neighbouring trusts to establish the local maternity system (LMS) to improve the maternal and neonatal safety across the clinical network. This collaborative working ensured future planning covered recommendations laid out in ‘Better Births’ (NHS England, 2016, the ‘Maternal and Neonatal Health Safety Collaborative’ (NHS Improvement (2017). Through working with the LMS, the service had been able to fund a ‘Better Births’ project midwife and a Healthy Lifestyle midwife which were shortly to be advertised.

Women’s Services at West Hertfordshire Hospitals NHS Trust were in the process of reviewing its maternity strategy which was expected to be completed by March 2019. The strategy would be the result of a co-production between commissioners, service providers, user representatives and women and their families and would incorporate national and local drivers to inform the strategy.

Representatives from the service attended the Maternity Voices Partnership (MVP) meetings which were held quarterly. The MVP provided a forum for people who used services, health professionals and the local clinical commissioning group to work in partnership to plan, monitor and improve maternity provision in the local area. For example, in the minutes for June 2018, the MVP was working with facilities to improve parking and signage outside the Women and Children’s Unit, a virtual feedback tour of the maternity service was being developed, and double beds for the Alexandra Birthing Centre (ABC) and reclining chairs for the postnatal ward were being considered in support of a business case to improve facilities for partners staying overnight.

A named midwife and/or consultant cared for women throughout their pregnancy. This was confirmed from the maternity records we reviewed and the women we spoke with. This was in line with national guidance National Institute for Health and Care Excellence (NICE) ‘Antenatal care’ (April 2016). Women were given an informed choice about where they gave birth, in conjunction with consideration of their potential risk. Low risk women were encouraged to deliver at home or at the ABC which provided midwifery-led care. Women who had an existing medical condition, complication of pregnancy or had experienced previous complications in pregnancy and / or labour, were advised to have their baby on the delivery suite, which were obstetric-led. A birth options clinic was available for women who did not meet the criteria for low risk birth but who wished to consider alternative options for delivery. This included women who planned to have a vaginal birth after a previous caesarean section.

At our previous inspection the trust had implemented a team home birth pilot scheme. This was in line with the recommendations outlined in the National Maternity Review: Better Births (NHS England 2016). The service had piloted the Phoenix Team; a team case loading integrated approach in partnership with the ABC, for women with uncomplicated pregnancies who wanted to give birth at home or at a birth centre. The pilot had proved to be successful and there were now six geographically based community teams across the trust.
Bed Occupancy

A total of 6,231 women booked to have their babies in the unit during 2016/2017. Of which 4,877 gave birth within the trust in 2017. The attrition rate was 22.5% which was attributed to miscarriages, relocations and birthing in neighbouring maternity units. Within the trust, births took place in a variety of settings, including the consultant-led delivery suite, the ABC, and home settings where women had chosen to access homebirth services. On average, 77% of babies were born on the consultant-led delivery suite, 19% were born in the ABC and 5% of births were at home (planned and unplanned). In the period March 2017 to June 2018, the bed occupancy levels for maternity were generally lower than the England average, the attrition rate was 19.1% and 430 less births were predicted for 2018/19. The trust had a maternity marketing strategy which included promotional events in the local community to showcase maternity services and development of a promotional video. The maternity services website was being updated and supported by a project group to make it more engaging and accessible to women. From March 2017 to June 2018 the bed occupancy levels for maternity were generally lower than the England average.

The chart below shows the occupancy levels compared to the England average over the period.

![Occupancy chart]

(Source: NHS England)

Meeting people’s individual needs

The maternity service took account of women’s individual needs, including those who were in vulnerable circumstances or had complex needs. Bereavement care provision was in place to support families from their initial loss, throughout their time in hospital and return home.

The maternity service had arrangements to support women in vulnerable circumstances, such as those with learning disabilities, substance misuse and teenagers. These were managed by specialist midwives and/or consultants and included a joint endocrinology and obstetric clinic for women with diabetes, perinatal mental health clinic, fetal medicine clinic and female genital mutilation (FGM) clinic.
Women were offered information so they could make an informed choice about where to give birth depending on clinical need. The maternity service offered home birth; the maternity led Alexandra Birthing Centre (ABU) or obstetric led care on the delivery suite. Two birthing pools were available on the ABC for women who wished to use water immersion for pain relief in labour. Antenatal and community midwifery services were provided by six geographically based teams. The service was continuing to work on the induction of labour pathway to ensure that women did not remain on the postnatal ward when their clinical need was to be in the delivery suite. Quality improvement methods were being used to monitor service improvement.

The Lavender team provided individualised care and support to vulnerable women in the antenatal and postnatal period and worked collaboratively with children’s centres. Combined obstetric and psychiatric clinics were available for women with complex mental health needs and the Lavender team saw women with mental health needs for up to 28 days after the birth of their baby. Care was then transferred to the perinatal mental health team. The team worked closely with GPs, health visiting teams, the community perinatal team, children’s social services and women’s counselling services to support women and their babies. The team was able to access local support groups, for example, local women’s centres and postnatal support illness groups.

The service ran a programme of parent education courses which were available at Watford, Hemel Hempstead and St Albans. For example, preparation for labour and birth for first time parents, a course for couples expecting twins, refresher sessions for women that have had a baby previously and breastfeeding workshops. A midwifery-led pregnancy club was available at children’s centres designed to support women through pregnancy.

Patient information posters were displayed in the antenatal department and delivery suite. For example, supporting women in labour, the power of skin to skin and advice from 20 weeks for women experiencing adverse symptoms in pregnancy. A reduced fetal movement leaflet and information poster to support the learning from two SIs where women had not been given the latest and best available evidence following admission to triage (emergency assessment) and the Medical Day Assessment Unit for the management of reduced fetal movements. The information was also provided for women for whom English was not their first language.

A specialist diabetic midwife had been appointed to help streamline diabetes services for women through the development of an evidenced-based pathway to promote continuity of care and provide a better service to women.

During our previous inspection, we saw there were limited facilities for partners staying overnight to rest comfortably. Although the service was aware of the issue and were in the process of procuring reclining chairs, this was raised as a concern in the Maternity Voices Partnership (MVP) survey undertaken in June 2018. A bereavement midwife was employed by the trust to provide support to parents and to train and educate staff in bereavement care. There was a dedicated room in the delivery suite to ensure bereaved parents had time with their baby. Staff created memory boxes for parents who had suffered a pregnancy loss and parents were supported with making funeral arrangements and counselling services where arranged where necessary. The chaplaincy service offered support to parents who had lost their baby and were able to provide chaplains of various denominations and faiths on request.

Access and flow

Patients were able to access the service when they needed it. The maternity service had not closed the unit on any occasion from July 2017 to June 2018. Delays were reported in antenatal clinic waiting times (ANC) and triage waiting times which had continued to be a
theme in patient complaints. There were issues with data collection in triage which the service had plans to address.

Women could access the maternity service via their GP, local children’s centre or by contacting the community midwife directly. Community postnatal care was arranged as part of the discharge process from hospital and an electronic discharge letter was automatically sent to the women’s GP.

The maternity service had not closed the unit on any occasion from July 2017 to June 2018. Contingency plans were in place if the unit was required to close due to lack of capacity. From April to July 2018, the service had consistently achieved above the 90% goal of women who had booked for antenatal care by 12 weeks and six days. The National Institute for Health and Care Excellence (NICE) recommends that women should ideally be able to access antenatal care by 10 weeks so that antenatal screening tests can be provided in a timely manner. The service had achieved 86.5% which was an improvement from our previous inspection when the service had achieved 66%. Routine antenatal appointments for nulliparous women (women who have never given birth) and parous (women have given birth) women were scheduled in line with NICE ‘Antenatal care for uncomplicated pregnancies’: CG 62. There was a policy to ensure women who did not attend appointments (DNA) were followed up. At the end of each antenatal clinic, the clinic midwife followed up all women who did not attend their appointment. The midwife informed the clinic administrative staff who contacted the women and rearranged her appointment. If the women did not attend three consecutive appointments a community midwife was sent to visit the women at home to check her wellbeing. If the women were vulnerable the Lavender team were immediately informed.

The antenatal clinic (ANC) was staffed from 8am to 6pm, Monday to Friday. Staff advised women if the clinic was running late when they arrived. There was also a white board which midwifery staff updated with clinic waiting times. At our previous inspection delays in ANCs were reported and an action plan was developed. During this inspection we found there were similar delays and little appeared to have changed to address the service shortfalls.

In October 2018, a snapshot audit of waiting times was undertaken. Of the 45 women seen in clinic, 37 had completed an audit form. Waiting times showed 15 women waited under 30 minutes to an hour, and women said, “Incredibly satisfied with level of care and information given”. Of the 17 women who had waited between one and two hours, said “Waiting time better than last time” and “Waited an hour but happy as the consultant helped with all my queries” and “Not really, too long to wait”. Five women waited over two hours and said, “Two hours not great” and “It’s a long wait but the doctors and nurses are doing a wonderful job”. The average waiting time was 68 minutes. The majority of women were satisfied with the waiting time (49%) and 19% were not satisfied with the waiting time. However, 33% of women did not comment on waiting times. Comments were received to improve the service, for example, more information about current waiting time, more midwives and consultants to have additional rooms to see women, additional clinics and not booking three women to each time slot, waiting area could be more comfortable.

An action plan had been implemented and immediate actions taken regarding the updating of the white board. For example, a review of clinic timetables and patient templates with a view to a combined weekly clinic every week, early escalation of absent clinicians and delays to the maternity bleep holder, waiting room improvements and ongoing audits of ANC waiting times. The service was planning to pilot an innovative approach to ANC called “Pregnancy Circle” to help improve waiting times. This meant that although the service was listening to issues expressed by women and were planning to take steps to address concerns, the service needed
to ensure changes to practice were sustained.

Women could telephone the maternity triage unit for advice 24 hours a day and attended the unit for review if indicated by the symptoms/ concerns they described. A traffic light system, using red, amber and green, (RAG) ratings was used to ensure women were assessed and reviewed in a timely way. There were 577 attendances recorded in the triage audit of waiting times for the period September to October 2018. The time women arrived was recorded for 100% of attendances. However, only 51% of attendances had the time they were seen recorded. This meant a large proportion of data was not available for analysis.

The findings of the 51% of women (where data had been recorded) attending the unit showed the majority of women were seen within the RAG rating guidelines. Out of 21 women in the red category, 17 (81%) were seen immediately as per the guideline. Out of 154 women in the amber category 148 (96%) were seen within 30 minutes as per the guideline. Out of 93 women in the green category 93 (100%) were seen within 45 minutes as per the guideline. The audit identified that on days when a health care assistant was not on duty or when there were peaks in activity, data was not always completed. The audit had identified there was no place to document the time the doctor had been called to review the patient. It was noted from verbal and written complaints there were often delays in waiting for a medical review following a midwifery assessment. Where patients had waited for over an hour, staff followed the escalation policy and informed the maternity bleep holder and the consultant covering the delivery suite as per the guideline. However, this was not reflected on the triage form which the service planned to amend before the next audit. Recommendations following the audit identified:

- Audit form to be updated to ensure doctor waiting times are incorporated in future monthly audits,
- Optimal staffing in triage to include HCA to assist with data entry,
- Staff to be made aware of the importance of completing data in triage, and
- The importance of completing data to be raised at safety huddles and displayed on posters in triage.

Women who presented at the triage unit with imminent delivery were red rated and were admitted directly to the delivery suite. If direct admission to delivery suite could not be facilitated, one private room with a delivery bed and birthing equipment was available on the triage unit.

The hospital had identified an increase in the number of birth before arrival (BBA) of a midwife and/or an in-transit birth during 2017/2018 and highlighted by the maternity dashboard. A total of 31 BBAs / in transit births had occurred during this period. The service undertook an audit to identify the factors that led mothers to experience the birth of their baby before arrival of a midwife and /or in transit birth so these could be minimised and areas of commendable practice could be embedded. Eight sets of notes were audited supported by maternity hand-held, telephone and computerised records.

The audit identified all eight women had booked at the hospital and had regular access to a midwife and / obstetric care. The audit identified there were inaccuracies in the way information was recorded, stored and retrieved in Triage and there could be benefits from the wider use of computerised contact systems to help facilitate monitoring and future audits. Further analysis was required on the large number of BBAs who had originally booked to give birth in the ABC. This would be undertaken by reviewing incident reports to identify learning points. Women who had built close relationships with their midwife as part of the community team may feel empowered to contact their midwife directly. The completion of a holistic telephone assessment could enable
them to access help in a timely manner.

The audit tool did not take into account the details of women’s labour and changes to the audit form were recommended to capture this in an attempt to positively influence labour diagnosis and minimise preventable BBAs. As midwives are the coordinators of care and experts in normal birth, the audit emphasised the importance that every attempt is made to ensure midwifery presence is readily available at every single birth as well as identify any hindrances to this happening. The aim of future audits would be to closely monitor BBAs to help identify barriers and plans could be instigated to minimise their occurrence. An action plan had been implemented and learning had been shared with through the divisions QSG meetings and in audit presentations.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results and shared them with staff.

There were processes in place for responding to complaints and information was available to women and their families of how to complain. Leaflets informing patients how to make a complaint or how to contact the patient advice and liaison service (PALS) were available in all areas of the maternity service.

Women and their partners told us they knew how to make a complaint and if they had concerns about this care would discuss it with the midwife in charge. Complaints were recorded on monthly performance dashboards and circulated with minutes of the divisions QSG. Governance meeting detailed the number of complaints received in a month, the number ongoing and detailed if there had been any delays in responding to the complainant and the learning that had taken place including changes to practice which were shared at meetings and safety huddles.

**Summary of complaints**

From July 2017 to June 2018, there were 78 complaints about maternity. The trust took an average of 30 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be investigated and closed within 30 days.

- Hemel Hempstead General Hospital: There were three complaints.
- St Albans City Hospital: There were seven complaints, appointments were the main compliant raised.
- Watford General Hospital: There were 68 complaints, the main themes were patient care (32), followed by staff values and behaviours (17).

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

During the inspection staff told us when a complaint was received staff were encouraged to be proactive and manage patients concerns at the earliest opportunity. Local resolution meetings were held which enabled staff to meet with patients and their families at the earliest opportunity to explore in detail issues around complaints. Complaint themes were recorded in action plans in the maternity service. For example, communication with women and families and feedback to women on their birth experience. A robust process had been developed to ensure cases were reviewed and actions followed through and we saw this recorded in the minutes of QSG meetings from June to September 2018.

**Number of compliments made to the trust**

From July 2017 to June 2018 there were 12 compliments within maternity.
The breakdown by site is shown below.

- Hemel Hempstead General Hospital: There were one compliment.
- Watford General Hospital: There were 11 compliments.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leadership at senior level in maternity services demonstrated a high level of experience and capability to deliver high quality sustainable care. Leaders led their service and supported the wider development of maternity services across the trust. Leadership at local level was experiencing a period of change and transition and some staff reported the findings to be unsettling and leaders less visible in some parts of the division.

The maternity service was managed through the trust’s women and children’s division. The director of midwifery (and gynaecology) had joined the service in May 2018, following an interim role since January 2018. There was a clear senior management structure with defining lines of responsibility and accountability. The service’s leadership team consisted of a divisional director who had overall responsibility for the division, a separate clinical director for obstetrics, a divisional manager and the director of midwifery. Medical and midwifery leads worked collaboratively to improve service provision. For example, the clinical director for obstetrics was the lead consultant for the Phoenix team community initiative, designed to promote normal birth, improve women’s experiences and reduce the caesarean section rate.

The senior leadership team spoke with pride about maternity services and the commitment and passion demonstrated by staff on a daily basis. The team were aware of all aspects of the service’s performance and the challenges they faced and were clearly motivated to continue on their journey of service improvement. The team were working to address performance issue in obstetrics and had met the duty of candour requirements in relation to patients that had been affected. The leadership team had direct access to the trust board and trust board oversight was clearly documented in the board minutes we reviewed.

New midwifery leadership had prompted staff to comment on differences in leadership style but this was not necessarily seen (by staff) as a bad thing. Some staff said (the director of midwifery) was a less visible presence and there was less communication. This was not the experience of all staff and was dependent on location. Staff also said there was a lack of clarity around changes to matron’s roles and responsibilities which had led to a lack of maternity leadership at local level. Staff reported they were in turmoil until the new roles were established. Leadership within community teams was praised by staff, women and their families. Performance of postnatal community provision was similar to or above the England average. During our inspection, we observed matrons attending wards to support staff, discuss activity and issues that had arisen. The delivery suite was co-ordinated by an experienced senior midwife who was mainly supernumerary to the staffing numbers required for the provision of one-to-one care in labour. There were consultant leads for specific services such as perinatal mental health, diabetes audit and clinical risk.

Vision and strategy

Maternity services had a clear vision and set of values which focused on quality and safe care. The service was reviewing its vision, values and maternity strategy which were expected to be completed by March 2019. Plans were in place to ensure engagement with
commissioners, service providers, staff, and women and their families.

Maternity services had a clear vision and set of values which focused on quality and safe care. The vision for the maternity services was, “exemplary care; where little things matter”. The service was in the process of reviewing its vision, values and maternity strategy and the process was expected to be completed by March 2019. The strategy would be the result of a co-production between commissioners, service providers, user representatives and women and their families. The service had a plan to integrate national and local drivers to inform the strategy.

The draft strategy was based on maternity data intelligence information from West Herefordshire Hospital’s NHS Trust which had highlighted areas that needed to be progressed. It also identified a number of schemes that had been launched or were in the process of being designed to address this. Local drivers and areas in need of improvement were:

- To promote and deliver women-centred personalised care, that takes into consideration the needs of family and partners.
- Develop collaborative working to deliver high quality and safe care.
- Working with the Local Maternity Service (LMS) to implement the ‘Better Births’ strategy.
- Reducing the Caesarean Section Rate.
- Developing a Normal Birth Strategy.
- Delivery of a sustainable workforce model across all areas to include the development of new roles.
- Clinical Leadership Development.
- The co-production of services with women and families.
- Development of a marketing strategy.
- Continuing to contribute to the Clinical Pathway Group in partnership with an acute trust.

The strategy plan identified how the service was working with commissioners, service providers and service users. For example, under staff engagement, monthly sessions to ‘speak to management’ were in progress and a ‘Whose Shoes’ listening event for service users was planned. The work plan was RAG rated (red, amber and green) and was on track to meet the March 2019 strategy deadline.

Culture

Leaders had a shared purpose and strived to deliver and motivate staff to succeed. Although there were high levels of satisfaction among the majority of staff we spoke with staff satisfaction and morale amongst some staff was mixed. This was due mainly to changes in local leadership and increasing workloads in some areas of the division.

Staff of all roles and levels of seniority we met were welcoming, friendly and helpful. Staff talked with pride about providing the best care for women and their babies and it was clear staff were proud to work in the service and really cared about the standard of care they delivered to patients.

Feedback received from staff pre, during and post our inspection indicated the majority of staff enjoyed working in the service although satisfaction and morale was variable in some parts of the division. Staff told us they felt well supported, respected and valued by their managers, colleagues and the senior leadership team. They said the director of midwifery and the clinical director for obstetrics were approachable and staff felt able to raise concerns and issues with
them and knew they would be listened to.

At focus groups staff reported they could not always provide enough care to patients which was mainly due to capacity issues and sometimes staff from community teams were required to support the birthing centre at night. Staff reported they were unable to meet the conflicting demands of work which meant staff were not always meeting the conflicting demands on their time which could impact on the care of patients and staff morale. Staff said the provision of information technology (IT) in the hospital and community caused staff to feel they were not always able to deliver care to the correct standard. For example, difficulty accessing blood results for patients in the community. However, according to the results from the trust staff survey (2017), the trust was in the top 20% of comparable trusts in England for staff who looked forward to going to work. The findings were supported in the maternity survey 2017 where 73% of staff reported they were enthusiastic about their job which was similar to the trust and comparable organisations. We found staff were supportive of each other and there was a strong culture of collaborative team work. Different parts of maternity services worked well together with strong leadership support from senior managers all focusing on improving health outcomes for mothers and babies. Junior medical staff and newly appointed midwives told us they had returned to the service as they had been so well supported and felt it was an environment that promoted excellence.

The Maternity Voices Partnership (MVP), is a voluntary organisation which enables mothers to discuss their experiences of maternity care and promotes multi-agency working. The MVP undertook a ‘Walk the Patch’ survey in June 2018 which identified the behaviours of staff towards each other and towards women and their families. Themes from the survey were, raising awareness of communication, negativity, respect, allowing people to speak and not listening to women and women feeling they were not in the room at handover. The service had shared the findings at QSG meetings and staff education days and in the maternity newsletter and there were plans to create a Maternity Behaviour Charter. However, positive feedback was also received and 94% of women felt they were treated with compassion and care. Following the staff survey senior leaders in the division had taken action to improve staff well-being and improve team working through a programme of bi-monthly divisional walk rounds, team building sessions and a wellbeing programme that included stress and resilience, mindfulness and nutrition workshops and an onsite counsellor and pilates. Staff were encouraged to report incidents and highlight any concerns and told us they felt confident that if concerns were raised in relation to patient safety, action would be taken. We saw examples where actions had been taken and improvements made as a result. This was evidenced in the no blame approach regarding SIs.

The health and wellbeing of staff was a high priority for the trust and the division and staff told us they received a good level of support from senior managers and occupational health services.

**Governance**

*Governance arrangements were proactively reviewed and reflected best practice. The service used a systematic approach to improving the quality of its services and safeguarding high standards by creating an environment in which the quality of care could flourish.*

Maternity services reviewed the quality of care through attendance at daily and weekly safety review meetings and ongoing reviews of ward and department quality data about their service. During our inspection, we identified maternity services had an effective governance structure and risk management framework to support the delivery of high quality care. All incidents reported via the incident reporting system were reviewed daily at patient safety meetings. This was to ensure the service was safe and identify any immediate actions required to address safety concerns. We
attended a patient safety meeting during our inspection which was well attended by members of the multidisciplinary team. We observed immediate actions were identified to reduce the risk of reoccurrence and were included in safety huddles and ‘messages of the week’ at staff handovers.

Potential serious incidents were reviewed in more depth at the clinical incident review group (CIRG) and were escalated to the trust serious incident review panel. Monthly governance, quality and safety group meetings were held and reported to the divisional quality and safety group who reported to the trust quality safety group. In the three sets of minutes we reviewed we saw incidents, patient safety alerts, complaints, clinical audit and mandatory and staff appraisal were discussed and actions agreed to address current service shortfalls.

The governance framework ensured staff responsibilities were clear and quality and performance risks were understood and managed. Senior staff understood their roles in relation to governance and their level of accountability regarding providing a safe service to mothers, babies and their families. Staff were able to describe the governance structure across all levels of the service and believed communication, on the whole was good. There were systems to review the National Institute for Health and Care Excellence (NICE) guidelines and other nationally recognised guidance.

The maternity service used a clinical performance dashboard to monitor activity, outcomes and performance. The dashboard was used to help identify patient safety and quality issues. This was in line with national recommendations (Royal College of Obstetrics and Gynaecology (RCOG) ‘Maternity Dashboard: Clinical Performance and Governance Score Card, Good Practice No7’, 2008). The dashboard tracked monthly performance against locally and nationally agreed performance measures. The maternity dashboard was regularly discussed at speciality and divisional quality meetings and we saw timely and appropriate actions were taken to address areas where performance was not met. This was confirmed in meeting minutes we reviewed. The dashboard was displayed on noticeboards throughout the service.

Each area had their own key performance measures, which were reported monthly and discussed at the speciality governance meetings. These included the Friends and Family Test (FFT) results, the number of complaints and incidents, staffing and infection prevention and control. Medical staff told us they attended regular half day clinical governance meetings every month which included progress on clinical audit programmes, risks attributed to the maternity service, education and infection control and prevention issues. Information from governance meetings was cascaded to staff via emails, staff handovers and safety briefings. Information was recorded on safety boards in ward and department areas to ensure that staff that had missed a safety briefing were able to receive feedback. There were patient safety and ward and unit newsletters which included safety messages, incidents and learning opportunities.

Management of risk, issues and performance

There were effective systems in place for identifying risks, planning to eliminate or reduce them, coping with both the expected and unexpected. The women and children’s division had a divisional risk register which identified key risks and was regularly reviewed. During the inspection we did not identify any risks that were not recorded on the risk register.

The women and children’s division had a divisional risk register which identified key risks and was reviewed monthly at the women and children's board meetings. Maternity services had its own risk register which identified each risk with a description of the mitigation and assurances in place and the nominated risk owner. Risks included staffing shortfalls, security of the entrance to maternity services, the management of elective and emergency caesarean sections, the perinatal
mortality rate and the communications technology infrastructure. During our inspection we did not identify any risks that were not on the risk registers. The service had investigated the 11 serious incidents in the period June 2017 to July 2018 in line with national and trust requirements. We reviewed all of the root cause analysis reports which demonstrated clear actions and changes to practice.

Patients received care and treatment according to national guidelines and the service had a comprehensive audit programme to ensure practice was current and based on sound evidence. The service was able to demonstrate quality outcomes as evidenced by MMBRACE and NNAP and where shortfalls were identified actions were taken to address them. There were monthly staff meetings to share learning from incidents and complaints and compliments. Where specific actions were required they were fed back at daily handovers and safety meetings. For example, at the delivery suite safety meeting, delays in women seeing the consultant about their scan results (on the previous day) were discussed and actions were agreed to minimise future delays. Staff were aware of the duty of candour requirements which identified the importance of sharing information with parents and families when an incident had occurred which involved them.

Information management

Overall, the service collected, analysed and used information well to support its activities. However, the functionality and interface of information technology systems was not robust and impacted on the quality of care and staff morale and could not be used effectively due to a lack of information technology support (in the hospital) and connectivity issues in maternity teams in the community. This was impacting on the quality of care due to delays in inputting patients’ information and obtaining test results and on staff morale.

The maternity service had clear performance measures and key performance indicators (KPIs), which were robustly monitored. These included the maternity dashboard and clinical area KPIs. Performance results were reported at ward to board level and were used to challenge and drive forward improvements in care where indicated. For example, the parameters had been set in agreement with local and national thresholds which allowed the service to benchmark themselves against other NHS trusts.

During our inspection, we saw the arrangements in place to ensure confidentiality of maternity patient records were robust. We found trolleys where patient records were stored were locked in all areas we visited. Computer terminals were also locked when not in use to prevent unauthorised persons from accessing confidential information. The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBBRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

Throughout our inspection staff told us the functionality and interface of the information technology (IT) systems was not robust and was a longstanding problem in the trust. Staff said this was impacting on patient care and staff morale as they were unable to complete routine monitoring requirements, particularly in community teams. We raised this with the senior team at the time of the inspection. We were told a plan had been agreed with IT and a project lead was shortly to be appointed.

Engagement

Staff recognised the importance of engaging with women, their families and local organisations and involved them in the development of their service. Staff felt they were generally kept informed and consulted about changes to service provision.
People’s views and experiences were gathered and acted on to shape and improve the service and culture. For example, the service contributed to the CQC’s national maternity survey as well as the national friends and family test (FFT) which was used across maternity services and in the community. We saw examples of actions the service had taken in response to feedback from surveys which were displayed on public notice boards, entitled “you said, we did”. We saw examples of positive and negative feedback on notice boards in the delivery suite. For example, the establishment of midwifery led debriefing clinic following concerns raised by women following a traumatic birth who had requested feedback on their experiences’.

Since our previous inspection, the service had acted upon the variable FFT response rate across maternity service as it had been below the England average for seven of the 12 months in the 2016/17 reporting period. During our inspection we saw the service performed significantly above the agreed (trust) response rate of 25% and were above the England average of 20.8% in the period June to August 2018. In the same period 81 of the 85 comments received were positive. For example, “I found the care I received from admission out to discharge and babies care amazing. I was informed of every step of decision made and the staff were exceptional” and “My midwife was amazing. I started to deliver whilst my midwife was on lunch, I screamed for her and the second midwife went to get her. Amazing care from all involved in my birth. Including special care doctors who were present”.

The service took account of the views of women through the Maternity Voices Partnership (MVP). Minutes from the meetings showed patient experience of clinic appointment waiting times, maternity triage and antenatal education were discussed including suggestions for improvement to service provision. Women who had complained about their care were invited to speak to staff on mandatory training days. In the maternity survey (2017), 23% of staff were unable to meet all conflicting demands on time at work, 54% of staff had felt unwell due to work related stress in the last 12 months and only 40% met often to discuss team’s effectiveness compared to the trust findings of 63%. In the 2018 maternity ‘temperature check’ staff survey, the majority of staff gave a positive response to the question “What is it like to work in maternity at West Herts?” For example, “Hard work but rewarding, good learning environment” and “Labour ward in spite of being very busy they look after each mum with excellent one-to-one care” and “Difficult at times, but good team relationships” and “Staffing challenges and constant battling with triage make it stressful. There is no effective team working with other units”. Following the survey, the trust implemented five survey actions (one per month) for the trust and divisions in the period April to August 2018. For example, under the heading ‘Your wellbeing’ the division had introduced a programme of emotional and physical wellbeing and support throughout the year for staff. This meant the trust and the division were listening to staff and had put plans in place to help address concerns.

During our inspection, we saw effective team working across all clinical areas. There was a positive and collaborative relationship with external partners and stake holders to build a shared understanding of challenges within maternity and the needs of the local population, and delivery of services to meet those needs. The service was working collaboratively with service users, neighbouring trusts and commissioners via the LMS to ensure national recommendations for maternity care were implemented across the region.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things went well and when things went wrong, promoting training, research and innovation.

The service had implemented the following improvements since the last inspection:
• A women’s service newsletter was launched in June 2018.
• The appointment of a professional midwifery advocate to support midwives in their clinical practice and act as an advocate for women.
• Implementation of Wave 2 Maternity and Neonatal Health Safety Collaborative in conjunction with NHS Improvement to improve the safety outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies and families across England.
• Detection and management of neonatal hypoglycaemia (low blood sugar in premature babies).
• Implementation of a midwifery-led debriefing clinic for mothers who had experienced a traumatic birth experience.
• Lavender team midwives (safeguarding) working at weekends and attending daily patient safety meetings.
• Appointment of a lead midwife for recruitment.

The service was continuing to work on the following areas which had been highlighted during our last inspection:

• Multidisciplinary team working in the Women and Children’s Service.
• IT functionality and interface.
• Elements of Saving Babies Lives – Gap and Grow
• Emergency and elective caesarean rates
• Perinatal mortality rates.

There was a culture of continuous learning, improvement and innovation across maternity services and managers encouraged staff to look at different ways to improve their service.
Facts and data about this service

The Urgent Care Centre (UCC) at Hemel Hempstead hospital is open every day from 8am to 11pm seven days a week.

The UCC is staffed by emergency nurse practitioners (ENPs), emergency care practitioners (registered paramedics), and administrative support staff. A general practitioner was supporting the unit at the time of the inspection, due to changes being made to the GP service which was co-located with the UCC. The UCC also acted as a referral and treatment point for the trust’s deep vein thrombosis (DVT) service (assessment of blood clots in veins).

The co-located general practitioner service was commissioned separately and provided by a third party and so did not fall within the scope of this inspection.

The UCC provides a service for children and adults with minor injuries and acute illnesses. All patients are assessed by a nurse. Those with minor injuries or minor illnesses are treated by emergency nurse practitioners (ENP) or an emergency care practitioner.

Between October 2017 and September 2018, the UCC accommodated 31,317 attendances.

Patients who attend the UCC should be expected to be assessed and admitted, transferred or discharged within a four hour period in line with the national target for all accident and emergency and unscheduled care facilities.

The UCC forms part of the trust’s emergency care division, which includes the emergency department at Watford General Hospital and the Minor Injuries Unit at St Albans City Hospital. All three services are managed by the same division and have the same overall managers.

We carried out an unannounced inspection of the UCC on 6 November 2018. During our inspection, we spoke with seven members of staff and four patients, and we looked at ten sets of patients’ records.

Details of emergency departments and other urgent and emergency care services

- Watford has an accident and emergency (A&E)
- St Albans has a minor injury unit (MIU)
- Hemel Hempstead has a urgent care centre (UCC)

(Source: Routine Provider Information Request (RPIR) – Sites tab)
Activity and patient throughput

Total number of urgent and emergency care attendances at all West Hertfordshire Hospitals NHS Trust compared to all acute trusts in England, July 2017 to June 2018

From July 2017 to June 2018 there were 137,086 attendances, of which 31,317 were to the UCC, at the trust’s urgent and emergency care services, as indicated in the chart above.

(Source: NHS England)

Is the service safe?

Mandatory training

Mandatory training completion rates

Mandatory training rates remained low and below the trust target.

The trust set a target of 90% for completion of mandatory training.

A breakdown of compliance for mandatory courses from July 2017 to June 2018 for nursing staff/medical and dental staff in urgent and emergency care is shown below:

Hemel Hempstead Urgent Care Centre

Nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-patient moving and handling</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient moving and handling</td>
<td>14</td>
<td>15</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>14</td>
<td>15</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>13</td>
<td>15</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>13</td>
<td>15</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire and evacuation clinical</td>
<td>13</td>
<td>15</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>12</td>
<td>15</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire non-clinical</td>
<td>12</td>
<td>15</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Nursing and midwifery staff failed to meet the 90% completion target for eight out of 11 mandatory training modules. This was in part due to long term staff leave such as maternity or sickness.

**Safeguarding**

**Staff understood how to protect patients from abuse. Staff had completed training on how to recognise and report abuse and they knew how to apply it.**

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training from July 2017 to June 2018 for nursing staff/ medical and dental staff in urgent and emergency care is shown below:

**Hemel Hempstead Urgent Care Centre**

**Nursing staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3 - three yearly update</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>15</td>
<td>15</td>
<td>100%</td>
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</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>15</td>
<td>14</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff exceeded the 90% completion target for all five safeguarding training modules.

*(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)*

Staff were aware of their roles and responsibilities regarding safeguarding, both adults and children. We reviewed four sets of notes specifically relating to the care of children. We noted that in all cases, reception staff had recorded they had accessed an electronic child protection information sharing system which allowed the trust to share and receive information from other authorities responsible for safeguarding children. This enabled healthcare staff to be aware of any child categorised as being vulnerable, or those who had been the subject of a protection plan. We noted the reception staff also recorded the number of previous attendances any child had to the emergency department, in order staff could consider previous presentations or to identify any trends or patterns which may have had cause for concern.

Staff had a good understanding of the national, “Think Child” campaign, and could provide examples of when a child may be vulnerable. Furthermore, staff could describe examples of what may constitute a vulnerable person, including those at risk of neglect, financial abuse, child sexual exploitation, female genital mutilation, domestic violence and abuse.

Monthly audits took place which confirmed a consistent approach to applying the trust’s safeguarding protocols:
Cleanliness, infection control and hygiene

Infection risks were not always well controlled. Some areas of the department were visibly unclean with dust and debris visible. There was a lack of assurance to demonstrate clinical areas were cleaned daily.

Staff were observed to use best practice techniques including being bare below the elbow, five moments of hand cleaning and aseptic techniques for dressings and wound care.

There had been no reported incidents of healthcare-associated infections reported against this service in the preceding twelve months.

There was no evidence in the department, of daily cleaning checklists having been completed, to demonstrate regular cleaning of the department. Some areas of the department were visibly unclean with dust and debris visible.

A review of the integrated performance report and ward scorecard for September 2018 (most recently available via board papers for November 2018) reported cleaning scores as being, “not applicable”.

We observed staff using antibacterial hand gel appropriately and washing their hands regularly after patient contact. There was no evidence of hand hygiene audits conducted in UCC; staff told us that it was difficult to conduct these audits as they were in enclosed environments and it would be difficult to measure practice.

The integrated performance report for emergency care included a section for hand hygiene audit results for the UCC however this section was marked as “not applicable”. The matron informed us they had received a directive from the Director of Infection Prevention and Control that such audits should be instigated in the UCC, however, there was no time scale as to when these audits were to recommence.

‘Bare below the elbow’ policies were adhered to and staff wore minimal jewellery in line with the trust infection control policy. Personal protective equipment such as gloves and disposable aprons were used according to the trust’s infection control policy.
Staff adopted appropriate aseptic non-touch techniques when undertaking wound dressings. Infection control audits were undertaken monthly and reported against the “Test your Care” metric.

<table>
<thead>
<tr>
<th>Grouping</th>
<th>Name</th>
<th>01/05/2018</th>
<th>01/06/2018</th>
<th>01/07/2018</th>
<th>01/08/2018</th>
<th>01/09/2018</th>
<th>01/10/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Alcohol gel</td>
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<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Appropriate curtains</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Bed space clean</td>
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<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Commodores clean/green sticker</td>
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<td>100</td>
<td>100</td>
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<td></td>
<td>Hand hygiene audits</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>HD space clean, working oxygen/suction</td>
<td>100</td>
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<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>mattress/frame cleaning</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Modestly clothed</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
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<td>100</td>
</tr>
<tr>
<td></td>
<td>Stores/boxes/IV fluids off the floor</td>
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<td>100</td>
<td>100</td>
<td>100</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Uniform</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>90</strong></td>
<td><strong>81.8</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

(Source DR191 – test your care audit results)

The trust submitted a number of documents which confirmed that local, “code of practice checklist audits” had been undertaken in February, April and June 2018. The audits considered a range of areas including the general cleanliness of the clinical setting; that linen was stored appropriately and that personal protective equipment was appropriately stored. In addition, staff knowledge was tested, specifically about the best techniques to wash their hands and handling spillages of bodily fluids. Compliance in audits was consistently reported as 100%.

<table>
<thead>
<tr>
<th>Months/Year</th>
<th>February 2018</th>
<th>April 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall compliance</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Data Request 176 – code of practice for infection control audit)

Environment and equipment

There were some processes in place to ensure equipment was checked regularly and maintained.

Not all equipment or consumable items were checked regularly.

Staff had easy access to a resuscitation trolley, which was appropriately stocked with equipment for adults and children. Adults and children’s resuscitation equipment had been checked on a daily
and weekly basis and staff had highlighted equipment and medicines that were nearing expiry date.

We identified a range of consumable equipment stored in the treatment room which had exceeded its expiry date. We informed the senior emergency nurse practitioner during the inspection who removed the equipment from the clinical environment.

Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Sharp bins were not overfilled and had been correctly labelled.

<table>
<thead>
<tr>
<th>Grouping</th>
<th>Name</th>
<th>01/05/2018</th>
<th>01/06/2018</th>
<th>01/07/2018</th>
<th>01/08/2018</th>
<th>01/09/2018</th>
<th>01/10/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Checked daily</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Checks signed and initialled</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Correct checklist being used</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Defibrillator</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Drug box</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>O2 cylinder</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Other equipment present and in date</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Suction machine</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Trolley clean within service dates</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>90</td>
<td>100</td>
</tr>
</tbody>
</table>

(Source Data request 191)

We found a glucometer (a device used to test for the level of glucose present in blood). Whilst it was not clear whether the glucometer was frequently used, we noted the calibration testing solution had expired in February 2018. This meant staff could not be assured the machine provided accurate results had it been used to test blood samples. We informed the senior emergency nurse practitioner who removed the device from service. The senior emergency nurse practitioner informed us more current devices were used which required staff to scan their user ID and to input patient details which provided greater traceability for when samples were assessed.

Assessing and responding to patient risk

There was a formal process for clinically assessing patients presenting to the department and for ongoing monitoring of them.

Standards jointly developed by the Royal College of Emergency Medicine, the Emergency Nurse Consultant Association and the Faculty of Emergency Nursing state: “All patients should be assessed in a timely manner. If there are delays in a healthcare professional assessing the patient then some form of initial assessment will be required to detect those at risk of deterioration or potentially serious conditions.” (Unscheduled Care Facilities 2009). At previous inspections we found patients could expect to wait up to periods of two hours before being initially seen. At our inspection in 2017 and again at this recent inspection we found the department had made and sustained improvements. A triage nurse was present at the front door to assess and prioritise patients, dependant on their clinical needs.
The department had undertaken audits to determine their effectiveness at triaging children within 15 minutes from arrival. We asked the trust to provide us with the audit data which is included below. Whilst the data was dated between November and January 2017/2018, the department was able to demonstrate that whilst some children waited longer than 15 minutes to be triaged, approximately 70% of children were assessed within 30 minutes.

### November 2017

<table>
<thead>
<tr>
<th></th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;15 mins</td>
<td>9</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>15 - 30 Mins</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>30 - 60 mins</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>&gt;60 mins</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

### December 2017

<table>
<thead>
<tr>
<th></th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;15 mins</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>17</td>
<td>34</td>
</tr>
<tr>
<td>15 - 30 Mins</td>
<td>3</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>30 - 60 mins</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>&gt;60 mins</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

### January 2018

<table>
<thead>
<tr>
<th></th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;15 mins</td>
<td>8</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>22</td>
<td>44</td>
</tr>
<tr>
<td>15 - 30 Mins</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>30 - 60 mins</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>16</td>
<td>34</td>
</tr>
<tr>
<td>&gt;60 mins</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

(Data request DR178).

We asked the trust to also provide data for the number of adults clinically triaged within fifteen minutes, however, this was not provided.

Reception staff had been provided with a clear guide to ‘red flag’ conditions such as chest pains, difficulty breathing, and severe bleeding, in line with the RCEM: triage position statement (2011) ‘guidance for non-clinical staff.’ Reception staff that we spoke with were familiar with this guidance and we observed clinical staff being rapidly alerted when a patient arrived with a red flag condition.

Staff had been trained in the use of the national early warning system (NEWS) and the paediatric early warning system (PEWS). This was a quick and systematic way of identifying patients whose clinical condition was at risk of deteriorating. This system was being used appropriately. We reviewed ten records of patients who had recently attended the centre and who should have had an early warning score calculated. Eight of the ten sets of records had appropriate scores. Where
patients required escalating, there was evidence that this had happened. The trust monitored completion of PEWS charts monthly. Details of those audits are as follows:

<table>
<thead>
<tr>
<th>Observations</th>
<th>01/05/2018</th>
<th>01/06/2018</th>
<th>01/07/2018</th>
<th>01/08/2018</th>
<th>01/09/2018</th>
<th>01/10/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAS card</td>
<td>100</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Name, Ward, PID</td>
<td>100</td>
<td>100</td>
<td>0</td>
<td>100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEWS aged &lt;=4/Presenting with illness</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEWS assessed against normal range for age</td>
<td>0</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEWS Score</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>66.7</td>
<td>100</td>
<td>100</td>
<td>66.7</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

(Source Data request 191)

We saw evidence that staff were aware of the process for managing sepsis and had appropriate risk assessments and guidance, which was on display in all areas. They were able to describe patients who had presented in the department, that had recently been diagnosed and the rapid transfers to an emergency department that had resulted. We reviewed two sets of notes related to patients who presented with symptoms of sepsis. In both cases, staff used the local risk assessment tool and commenced appropriate therapy in line with national recommendations.

**Nurse and allied health staffing**

**Nursing staff had the right qualifications, skills and experience to enable them to provide the right care to patients.**

Patients were treated by emergency nurse practitioners (ENP) and emergency care practitioners (ECP). These were ambulance paramedics who had gained further qualification, in order to treat patients, in a hospital setting. In addition, there were qualified nurses who carried out wound care, administered medication and measured patients' vital signs. They were supported by health care assistants and receptionists.

We reviewed the staffing rota for the month prior to our inspection. This demonstrated that there was always a minimum of one emergency nurse practitioner (ENP) and one other qualified nurse on duty. In the middle of the day staffing levels rose to three ENPs and ECPs with two qualified nurses and a health care assistant. Since our previous inspection, the department had mapped the activity of patients to determine peak times and had adjusted staff rotas accordingly. This meant there were more staff available during peak times.

All of the ENPs and ECPs had undertaken further training in the assessment and initial treatment of children.

Staff had access, always, to specialist children’s nurses at the emergency department at Watford General Hospital.

The trust reported the following nurse staffing numbers for the three urgent care and emergency sites in June 2017 and June 2018. The fill rate remained below 90% in both periods for the MIU and Urgent Care Centre. Watford A&E was over established in the June 2018.
<table>
<thead>
<tr>
<th>Site</th>
<th>Unfilled rate (%)</th>
<th>Bank use rate (%)</th>
<th>Agency use rate (%)</th>
<th>Total bank and agency Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemel Hempstead</td>
<td>0.5%</td>
<td>2.3%</td>
<td>0.0%</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

(Weighted annual staffing averages for Hemel Hempstead for nursing and midwifery staff)

### Vacancy rates

From April 2017 to March 2018 the average vacancy rate at the trust for nursing and midwifery staff was 3.19%, this was lower than the trust target of 9%. However, Watford had a negative vacancy rate as it was over established. At Hemel Hempstead, the vacancy rate was 10.3%, which was above the trust target.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

### Turnover rates

From July 2017 to June 2018 the average turnover rate at the trust for nursing and midwifery staff was 19%, this was higher than the trust target of 12%. At Hemel Hempstead, the average turnover rate was 7.4%, which was below the trust target.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

### Sickness rates

From July 2017 to June 2018 the average sickness rate at the trust for nursing and midwifery staff was 3%, this was lower than the trust target of 3.5%. At Hemel Hempstead, the average sickness rate was at 3.9%, which was lower than the trust target.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

### Bank and agency staff usage

#### Qualified nursing staff

From April 2017 to March 2018 the trust had a total of 212,254 nursing staff shifts in urgent and emergency care. A breakdown of bank and agency usage and unfilled shifts is shown below for Hemel Hempstead:

<table>
<thead>
<tr>
<th>Site</th>
<th>Unfilled rate (%)</th>
<th>Bank use rate (%)</th>
<th>Agency use rate (%)</th>
<th>Total bank and agency Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemel Hempstead</td>
<td>0.5%</td>
<td>2.3%</td>
<td>0.0%</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

#### Non-qualified nursing staff

From April 2017 to March 2018 the trust had a total of 212,254 nursing staff shifts in urgent and emergency care. A breakdown of bank and agency usage and unfilled shifts is shown below for Hemel Hempstead:

<table>
<thead>
<tr>
<th>Site</th>
<th>Unfilled rate (%)</th>
<th>Bank use rate (%)</th>
<th>Agency use rate (%)</th>
<th>Total bank and agency Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemel Hempstead</td>
<td>0.8%</td>
<td>17.5%</td>
<td>0.0%</td>
<td>17.5%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

### Records

Staff kept detailed records of patient’s care and treatment, which complied with best
practice guidelines. However, there was an isolated incident where records were stored that did not protect patients’ confidentiality.

The department used a range of electronic and paper based records to record care and treatment. Records were written and managed according to best practice, and respected patient’s confidentiality. Patients’ registration details were recorded on the unit’s computer system which then produced a paper record for staff to use.

We looked at ten patient records and found that information regarding the patient’s care and treatment was well-documented, with appropriate information to understand the treatment delivered. We did note that paper based records such as observation charts did not always have three patient identifiable information recorded. This meant there was a risk paper records could be misfiled or staff may not have been able to link the paper record to electronic records.

Paper records were stored behind a locked door in secured cabinets in the reception area after patients were discharged.

Records containing confidential personal information were stored in an unlocked dirty utility area. Located within the dirty utility room was a log-book detailing pregnancy screening results for patients. In the majority of cases staff used only a patient hospital ID number and their test result, that is whether their pregnancy test was positive or negative. However, we found a number of examples where staff had recorded the patient’s name, the date of their test and the test result.

<table>
<thead>
<tr>
<th>Grouping</th>
<th>Name</th>
<th>01/05/2018</th>
<th>01/06/2018</th>
<th>01/07/2018</th>
<th>01/08/2018</th>
<th>01/09/2018</th>
<th>01/10/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation</td>
<td>Name, PID, date</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Triage score including priority</td>
<td>90</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>95</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

(Source Data request 191)

**Medicines**

**Best practice was followed with regards to the storage of medicines.**

**Nursing staff continued to use patient group directions despite them not being duly authorised in line with trust policies.**

Medicines were stored in line with the trust’s medicines management policy and fridge and room temperatures were regularly checked and temperatures recorded. The recording charts showed the fridge and room temperatures were in an acceptable range. The keys were held by the nurse in charge on the day and stored overnight in a keypad locked safe. Controlled drugs were kept secure and checked on a regular basis to ensure they were present and correct.

A small proportion of emergency nurse practitioners were qualified non-medical prescribers. This meant they had the legal authority to supply and administer a range of medicines without the need for a doctor to authorise the prescription. The remaining emergency nurse practitioners operated under the auspices of a patient group direction. We reviewed seven patient group directions and found that whilst they were all in date, expiring in July 2020, only one member of staff had signed a small number (two) of the “Agreement to Practise” logs contained within each PGD. However, whilst on the rare occasion when the member of staff had signed the PGD, this had not been countersigned by a “senior representative authorising health professional”. This meant the staff member was not authorised to administer medicines against individual PGDs as they had not
been duly authorised by a trust representative. We raised this with the senior emergency nurse practitioner at the time of the inspection.

<table>
<thead>
<tr>
<th>Grouping</th>
<th>Name</th>
<th>01/05/2018</th>
<th>01/06/2018</th>
<th>01/07/2018</th>
<th>01/08/2018</th>
<th>01/09/2018</th>
<th>01/10/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>Administrations signed/dated</td>
<td></td>
<td></td>
<td></td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Allergy box completed and signed</td>
<td></td>
<td></td>
<td></td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CDA keys separate</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Children weighed before medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Daily checking of CDs</td>
<td>0</td>
<td>0</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Fridge temperature documented</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>IV fluids secured</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Prescription legible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Secure medicines</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>80</td>
<td>80</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

(Source Data request 191)

**Incidents**

Staff were aware of their responsibility to report incidents both internally and externally and used the hospital's electronic reporting system.

Reporting levels were lower than expected, as some incidents were not reported consistently.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From July 2017 to June 2018, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - STEIS)

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from July 2017 to June 2018. None of these incidents were attributable to Hemel Hempstead Urgent Care Centre

(Source: NHS Improvement - STEIS)

Incidents and accidents were reported using a trust wide electronic system and were graded in severity from low or no harm to moderate, severe harm or death. The trust had a comprehensive
incident reporting policy, which described the process for grading and reporting incidents. Staff were able to access this on the trust’s internal website.

Staff were aware of their responsibility to report incidents both internally and externally and used the hospital’s electronic reporting system. Whilst staff could describe the types of incidents they would report, there was a general consensus amongst the management team that incident reporting rates were lower than expected. For example, staff would not routinely report incidents where patients had experienced delays in their initial assessment. Between 1 May 2018 and 31 October 2018 the department reported 19 incidents. The main cause for incidents being reported was a lack of a general practitioner being available in the main department. This was raised with the service commissioned to provide the service to ensure mitigations were in place.

<table>
<thead>
<tr>
<th>Description of Incident</th>
<th>UCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication between teams</td>
<td>1</td>
</tr>
<tr>
<td>Communication between Staff and Patients/Carers</td>
<td>1</td>
</tr>
<tr>
<td>Human Resource Availability</td>
<td>0</td>
</tr>
<tr>
<td>Injury of Unknown Origin</td>
<td>0</td>
</tr>
<tr>
<td>Other Communication Incident</td>
<td>0</td>
</tr>
<tr>
<td>Other Investigations</td>
<td>1</td>
</tr>
<tr>
<td>Other Service Disruption*</td>
<td>8</td>
</tr>
<tr>
<td>Referrals</td>
<td>0</td>
</tr>
<tr>
<td>Uncontrolled crowds</td>
<td>0</td>
</tr>
<tr>
<td>Monitoring/On-going Assessment of Patient Status</td>
<td>1</td>
</tr>
<tr>
<td>Other Administration Incident</td>
<td>0</td>
</tr>
<tr>
<td>Administration to Patient</td>
<td>1</td>
</tr>
<tr>
<td>Diagnostic Conclusions</td>
<td>1</td>
</tr>
<tr>
<td>Other Therapeutic Incident</td>
<td>1</td>
</tr>
<tr>
<td>Non-invasive Treatment Processes</td>
<td>1</td>
</tr>
<tr>
<td>Other Medical Devices, Equipment, Supplies</td>
<td>1</td>
</tr>
<tr>
<td>Other Documentation Incident</td>
<td>1</td>
</tr>
<tr>
<td>Safeguarding/Protection</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19</strong></td>
</tr>
</tbody>
</table>

(Source: Data request DR172 & 173)

Lessons learnt from previous incidents were on display in the urgent treatment centre. Examples on display were current and demonstrated good cross site learning. We observed that staff had changed their practice and complied with new models of care including the instigation of trauma calls for patients who had sustained an injury following falls from height.

Providers are required to comply with Regulation 20 (duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Staff had a good understanding of these regulations and spoke confidently about when they should be applied. However, because there had been no incidents that met the threshold of the duty of candour regulation it was not possible to fully assess compliance against this regulation for this core service.

**Safety thermometer**

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering
harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the hospital reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from July 2017 to July 2018 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

In addition to the safety thermometer, the trust also undertook monthly “Test your care” audits. These audits assessed a range of metrics including infection control measures, safeguarding procedures, medicines management and the readiness of resuscitation equipment. Results for these audits, which included Hemel Hempstead were:

<table>
<thead>
<tr>
<th>Grouping</th>
<th>Name</th>
<th>01/05/2018</th>
<th>01/06/2018</th>
<th>01/07/2018</th>
<th>01/08/2018</th>
<th>01/09/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care</td>
<td>96.2</td>
<td>96.9</td>
<td>100</td>
<td>97.7</td>
<td>88.1</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Data request DR182)

Is the service effective?

Evidence-based care and treatment

There was a local audit programme in place, but there remained a lack of audits. This had previously been identified by the Care Quality Commission as an area which required improvement.

Staff in the urgent treatment centre had access to evidence based clinical guidelines via the trust’s intranet. For example, we saw that there were clinical pathways for chest pain and complex fractures, which were based on National Institute for Health and Care Excellence (NICE) guidelines.

Nursing staff that we spoke with were familiar with them and could speak confidently about any actions that needed to be taken. There was a clearly defined clinical treatment criteria for the urgent treatment centre and included exclusions.

There was a folder in the treatment room which referenced historical clinical guidance. This included the management of children requiring advanced life support; the algorithm within the folder was dated 2010. This algorithm had been updated by the UK resuscitation council in 2015 but was not readily available to staff. We raised this with the senior emergency nurse practitioner at the time of the inspection who took action to print the latest available version.

During our last inspection, in August 2017, we found there whilst there was a local audit programme, no audits had taken place. At this recent inspection there was a very small amount of audit activity being undertaken. Two audits were included on the emergency division annual audit programme: “Triage assessment in the UCC” and “Audit of oversight of patients waiting to be seen in the UCC”. A number of local audits relating to safeguarding and record keeping had been undertaken and reported through the “test your care” audits which were undertaken monthly. We have reported the performance against test your care within the safe domain.

Staff had initially audited the number of children assessed within 15 minutes of their arrival, however, this was last audited in January 2018. No further audits had been undertaken.
There was no clinical audit activity undertaken to ascertain how well the department performed against compliance with national best practice or evidence based care and treatment.

There was no peer review programme for emergency nurse practitioners or ECPs. It was therefore not possible for the trust to provide assurances that ENPs and ECPs were acting within scope of their remit; that their clinical decision making skills were up-to-date and relevant, and that treatment decisions were aligned to national and local best practice protocols.

Whilst there was a process for ensuring all requested radiology images were reviewed and reported by a radiologist within five working days. there was very limited assurance to support staff who may have missed fractures or other deformities or misinterpreted x-ray images. This was acknowledged as an area for improvement by the senior emergency nurse practitioner.

**Nutrition and hydration**

Due to the nature of the service, meals were not provided to patients. Water was accessible to the public in the waiting area.

Staff were able to describe the action they would take in the event of a patient presenting with malnutrition concerns or who were dehydrated for example.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

We observed staff routinely assessing patients for pain. Where patients required analgesia, this was offered in a timely way. Staff were observed reassessing patients to ensure any pain relief provided had been effective.

Pain management formed part of the departments “test your care” monthly audit programme in which the department performed consistently well.

<table>
<thead>
<tr>
<th>Grouping</th>
<th>Name</th>
<th>01/05/2018</th>
<th>01/06/2018</th>
<th>01/07/2018</th>
<th>01/08/2018</th>
<th>01/09/2018</th>
<th>01/10/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>Assessed on arrival</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Pain status before/after analgesia</td>
<td>100</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pain status with every set of observations</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

*(Source: data request 191)*

**Patient outcomes**

There remained a lack of monitoring of patient outcomes and compliance with evidence-based protocols. This had previously been identified by the Care Quality Commission as an area which required improvement.

As we have previously reported there continued to be no formal audit programme within the urgent treatment centre to assess patient outcomes.

Patients attending the UCC were not included in relevant national audits that were being conducted in the emergency care division such as treatment of feverish children.
Staff reported that whilst they were identified leads for specific areas, they had no protected management time to undertake any audit activity. There was no robust action plan or timeline in place which could provide the Commission assurance that this lack of audit activity was likely to be resolved and so we have judged the provider to be in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

**Competent staff**

Managers made sure staff had access to training and assessed their skills and competence for their role.

**Appraisal rates**

From July 2017 to June 2018, 152 members of staff were eligible to receive an appraisal in urgent and emergency care, they achieved an 55% completion rate against a trust target of 90%.

The trust did not provide us with medical and dental staff appraisal rates as no medical or dental staff were employed for this service.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisal eligible</th>
<th>Appraisal completed</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>3</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>1</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>97</td>
<td>53</td>
<td>54.6%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>51</td>
<td>31</td>
<td>60.8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff who were new to the department underwent an initial induction programme. We spoke with one member of staff who was relatively new to the department. They confirmed they had completed an induction programme and had completed a range of competencies.

Those new to the role of emergency nurse practitioner or ECP undertook rotational posts across the minor injuries service at Watford General Hospital and the MIU at St Albans City Hospital. This ensured individuals gained a range of experience managing different conditions, alongside other health professionals such as general practitioners, before working independently at the UCC.

**Multidisciplinary working**

Staff worked together as a team to benefit patients.

We observed good working relationships with the co-located GP service and nursing staff working in the UCC. We observed staff discussing individual patient cases and treatment options. This demonstrated staff were willing to seek alternative clinical opinions before discharging a patient.

There was a process in place for ENPs to discuss or refer complex or urgent cases with the duty emergency department consultant at Watford General Hospital.

A clinician from the main emergency department had adopted the role as lead clinician for the UCC and so was scheduled to provide clinical oversight to the department.

Pathways existed for the timely referral of patients to specialists including orthopaedics and ophthalmology.

**Seven-day services**

The UCC was open seven days a week from 8am to 11pm.
X-ray facilities were available throughout the opening hours of the UCC.

There was an on-site pharmacy available at the hospital from Monday to Friday 9am to 5pm and staff had access to a weekend pharmacy at the Watford General Hospital from 10am to 4pm.

Outside of these hours staff had access to an on-call pharmacist for advice.

A stock of frequently required medication was kept in the unit which could be dispensed to patients when the pharmacies were closed.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Patients had their consent obtained in line with national guidance. We observed that consent, both written and verbal, was obtained for any procedures undertaken by the staff. Written guidance on consent, and assessing mental capacity was available via the trust’s intranet.

Consent forms were available for people with parental responsibility to consent on behalf of children. The nursing staff that we spoke with had a good working knowledge of the guidance for gaining valid informed consent from a child. They were aware of the legal guidelines which meant children under the age of 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so, often referred to as being Gillick competent. Staff were aware that should a child not be considered Gillick competent, consent would be sought from the child’s parent or guardian. Staff could also describe the scenarios in which an individual would be deemed to have parental responsibility. The staff we spoke with had sound knowledge about consent and mental capacity.

Staff were aware of the processes and mechanisms in place should the need arise. This included gaining telephone advice from the unit’s senior emergency nurse practitioner or local psychiatric crisis teams if this was necessary. Training against mental capacity act and deprivation of liberty safeguard awareness was reported as follows:

<table>
<thead>
<tr>
<th></th>
<th>Number of trained staff July 18</th>
<th>number of eligible staff July 18</th>
<th>MCA Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCA &amp; DOLS (Feb 18)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>MCA &amp; DOLS (Jul 18)</td>
<td>20</td>
<td>22</td>
<td>90.9%</td>
</tr>
</tbody>
</table>

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Friends and Family test performance
The trust’s urgent and emergency care Friends and Family Test performance (% recommended,) which included Hemel Hempstead, was better than the England average from July 2017 to June 2018.

**A&E Friends and Family Test performance - West Hertfordshire Hospitals NHS Trust**

Confidentiality was maintained at the reception desks by means of signs asking people to stand back from the desk when someone was being registered.

The UCC had examination and treatment rooms with doors to ensure privacy when patients were being examined. We saw that staff knocked and waited to be called before entering.

We observed staff introducing themselves and explaining what was about to happen before examining patients.

All staff wore name badges which clearly stated their name and role. This helped to ensure that patients were aware of the professionals involved in their care.

We saw several examples of patients being treated with compassion, dignity and respect. Staff spoke in a respectful but friendly manner and made allowances when people were stressed or worried.

Practitioners took time to distract and comfort children during examinations and wound cleaning. Parents were involved in the assessment and treatment of their children and clear explanations were given.

We spoke with four patients and their families. They all reported a positive experience.

Results from the Friends and Family test for the year ending August 2018 were consistently good. They showed that between 96% and 99% of people would recommend them.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress and involved patients and those close to them in decisions about their care and treatment.**

Staff were able to spend time with patients to explain their treatment options. Where patients were anxious or apprehensive, staff supported them, spending additional time to provide care.

We saw staff involve both patients and those close to them in their own care, allowing time to answer any questions.

Patients we spoke with said they felt involved and were aware of their plan of care.
Understanding and involvement of patients and those close to them

Staff were available to speak with family members to explore treatment options where appropriate, including the use of ‘do not attempt cardiopulmonary resuscitation’ orders. One family we spoke with told us both they and their loved one had been involved in the decision-making process and that staff had been responsive to their anxieties and concerns about making the right decision.

Is the service responsive?

Service delivery to meet the needs of local people

In most cases, patients could access the service when they needed it.

The service had recently transitioned from being an urgent care centre to an urgent treatment centre. This meant staff had access to additional points of care terminals; this allowed staff to undertake additional immediate blood sampling to aid in clinical decision making. This also allowed staff to manage more acutely unwell patients although processes remained in place for ensuring sick patients were transferred without delay to the emergency department at Watford General should the need arise.

Meeting people’s individual needs

Patient’s needs were considered, with the expectation of those who were hard of hearing; there had been no environmental adaptations or consideration given to this cohort of patients.

The unit was well signposted from the main road and throughout the hospital. There was drop-off point immediately outside and wheelchairs were available just inside the entrance. This meant that people with leg injuries or limited mobility could access the unit easily.

Staff that we spoke with demonstrated a good understanding of the requirements of patients with complex needs. There were close links with community services to provide support. A local navigation team had been commissioned as part of a trial. The role of the navigation team was to support patients who presented to the urgent treatment centre who potentially required social support. The team worked with nursing and medical staff to support patients who may have been homeless for example, or those patients who reported living in poverty or who were subject to domestic violence.

All nursing staff had undertaken training in the specific needs of people with dementia and learning disabilities and the involvement of families was encouraged.

Staff were able to describe the care and treatment of patients with a learning disability or dementia, who had recently attended the department. Priority was given to patients living with dementia or those with learning disabilities. This ensured such patient cohorts remained in the department for as little time as possible.

The computer system featured a flagging system for people with learning disabilities so that staff could be alerted to their special needs.

Staff had compiled 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 computer system featured a flagging system which alerted staff to people whose first language was not English. It recorded which language the patient preferred to use. Translators could be accessed via the telephone translation system provided by the hospital.

We observed that staff adapted their practice and communication styles to meet the needs of individuals who attended the unit.

Staff gave information leaflets to patients that clearly stated who they should contact if they had any concerns or worrying symptoms after treatment. There was information throughout the department relating to support groups for patients with specific conditions to access local support networks.

The UCC was on a single level and there was sufficient space for wheelchair users to move around easily. There was designated disabled parking bays outside the unit and there was always one available during our inspection.

There was a small children’s play area located in the main waiting room. This was not audio-visually separate from the main waiting area as recommended by the Emergency College of Emergency Medicine.

**Emergency Department Survey 2016**

The trust, which included the Hemel Hempstead site, was about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Access and flow**

**Most patients transitioned through the department in a timely manner as 99% of patients were admitted, transferred or discharged within four hours.**

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust, which included Hemel Hempstead, did not meet the standard for five months over the 12 month period from July 2017 to June 2018.

From April 2017 to June 2018 the trusts performance was higher than the national trend and standard. In the latest month; June 2018 the median time to treatment was 71 minutes compared to the England average of 62 minutes.

**Median time from a arrival to treatment from July 2017 to June 2018 at West Hertfordshire Hospitals NHS Trust**

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.
The department consistently met the national target that at least 95% of patients were seen, admitted or discharged within four hours of presentation. Between October 2017 and September 2018, 99.6% of all patients were seen, admitted or discharged within four hours. 

(Source: NHS England - A&E SitReps).

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From April 2017 to June 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was generally lower than the England average. This is data for the whole trust. Separate data for Hemel Hempstead was not available.

In the latest month June 2018 the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 0%, compared to the England average which was 2.4%.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - West Hertfordshire Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)

Learning from complaints and concerns
Staff investigated complaints and provided patients with an apology. Lessons learnt were evidenced through changes to practice.

Complaints were not always responded to in line with the trust's target however the trust was able to demonstrate improvements against a recovery plan.

The UCC received few formal complaints annually. Where complaints were made, these often related to poor communication and delays in care and treatment. Staff could describe the action they took to resolve complaints and to consider improved ways of working. For example, staff undertook hourly patient comfort checks for those waiting in the main waiting area in response to patients complaining about a lack of information on waiting times. Staff asked patients about their pain, whether they required a drink as well as proving approximate waiting times.

Summary of complaints

From April 2017 to March 2018 there were 192 complaints about urgent and emergency services at the trust. The trust took an average of 44 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 40 days.

The site level breakdown is below:

- Hemel Hempstead General Hospital: 10 complaints
- St Albans City Hospital: five complaints
- Watford General Hospital: 177 complaints

45% complaints related to patient care which involved poor care and communication from staff.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From April 2017 to March 2018 there were no compliments recorded for urgent and emergency services at the trust.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Whilst there had been changes to the leadership team with the addition of a senior emergency nurse practitioner to oversee and manage the urgent care centre (UCC), there remained little oversight of the service at divisional level.

The UCC was a part of the emergency care division, which also included the emergency department (ED) at the Watford General hospital and the MIU at St Albans City Hospital. The overall management of the division included a divisional director, divisional general manager, and divisional lead nurse. During the inspection we interviewed the senior emergency nurse practitioner and the lead nurse responsible for the UCC. A clinical lead had recently been appointed with protected time as part of their job plan to strengthen management, professional and clinical leadership of the UCC. The divisional management team retained overall responsibility and accountability for the services.

Whilst staff reported the lead nurse was visible on occasions, they had not met with the divisional director; this was consistent with our findings from our previous inspection in 2017. Staff described the nursing leadership as being visible however there was an element of feeling isolated from the wider emergency care community at the trust.
The senior emergency nurse practitioner was aware of the challenges and risks associated with the service. Action had been taken following previous inspections and other external visitors to address shortfalls. There did however remain a gap in the level of clinical audit being undertaken by the department.

There were limited development programmes in place for local leaders.

**Vision and strategy**

**There was no formalised strategy for the department.**

The lack of a formal strategy was consistent with previous inspections. However, staff welcomed the expansion and development of services to enable them to become an urgent treatment centre.

**Culture**

**Staff reported a culture which was open and transparent. Members of the management team were described as approachable.**

The team consisted of a range of health professionals including ENPs, ECPs and medical practitioners. Staff told us they felt the morale of the department was starting to improve. They told us nurse leaders had engaged with them and that they, “had been heard”. Managers told us they strived to promote a culture which was free from bullying and harassment and which was directed towards promoting and achieving a good service, geared towards patient safety.

Incident reporting was encouraged although it was recognised there was scope for improvement; clinical leaders acknowledged when things had gone wrong. There was a focus on learning from incidents; changing practice or reviewing existing protocols and consideration of human factors were all acknowledged as key to promoting a safe culture.

**Governance**

**There lacked a systematic and robust approach to governance and the management of risk. Despite our previous inspection findings, we found that service enhancements and improvements had not been sustained.**

Whilst the emergency care division had formalised governance arrangements, representation of the UCC was poor. A review of governance meeting minutes reflected little or no discussion regarding the performance of the UCC.

The emergency care division integrated performance report made only one reference to the UCC; it appeared the only key performance indicators considered by the divisional team were linked to the four hour ED target, staff sickness, vacancy rates, number of incidents reported, complaints received, mandatory training completion rates and results from the friends and family test. Elements such as hand hygiene and cleaning scores were marked as not applicable. Whilst the integrated performance report considered elements such as accident and emergency clinical indicators (including time to initial assessment), there was no reference to the UCCs performance. It was therefore difficult to ascertain the level of oversight afforded to the delivery of quality services within the minor injuries unit.

The senior emergency nurse practitioner and lead nurse both acknowledged the need for greater oversight of governance within the MIU at ST Albans City Hospital and UCC collectively. Whilst individuals had been given key roles to support the concept of governance, such as undertaking local audits, staffing challenges meant staff felt they did not have sufficient time to complete the audit programmes.
There was no scope or avenue to consider information in greater detail. There was no reference made to the performance of the UCC or the associated limited key performance indicators for the MIU within the governance meeting and so we were not assured sufficient focus was placed on considering quality in any significant detail. This was consistent with the result of conversations with staff. Band seven nursing staff had a high-level appreciation of quality issues within the department, however they lacked any significant understanding of the work underpinning any improvement plans.

There was a lack of recognition for the need for there to be a formalised audit programme. Audits were reactive as compared to being proactive. For example, the emergency care division had set two specific audits for the UCC for 2017/18 as reported within the effective domain. There were no further audits suggested. This included a lack of audit to determine the clinical making decisions of ENPs or ECPs to ensure their practice was aligned to local and national best practice guidance. There had been no formalised programme for reviewing missed fractures to determine whether any individual required on-going support in the interpretation of x-rays. There was no formal review to determine whether local protocols were applied in practice; for example, there was no audit of care records to ensure early warning systems were consistently used.

**Management of risk, issues and performance**

The UCC had a risk register which contained one risk. This was a historical risk relating to the lack of skilled ENPs to manage children. The trust had worked with the ENP workforce and the children’s ED to manage this risk which was now graded as a risk of two.

There was a lack of insight into wider risk management strategies. For example, there had been no consideration to the risks associated with the lack of clinical audit programmes to support the wider assessment of patient safety and quality within the department.

**Information management**

Information was of a poor quality with a reliance on manual processes to extract data; this was labour intensive and did not allow for real-time reporting. Information was not considered holistically to enable the divisional management team to assess the safety and effectiveness of the service.

The trust had a number of information management technologies in use at the time of the inspection. The UCC used a system which was used in almost isolation to the rest of the trust. A lack of interface between existing trust computer systems meant operational staff at Watford General hospital were required to contact the UCC via telephone for an assessment of current departmental occupancy and performance.

There was a reliance on using paper records for some patient interventions including physical observations of vital signs. These records were held locally for a period of twelve months and so could not be easily accessed by the wider health community within West Hertfordshire Hospitals NHS Trust.

The lack of functionality of the IT system meant it was a burden for staff to undertake audits of patient activity as staff were required to manually review patient treatment cards.

Staff working in the UCC reported they could access GP based care records in a timely way. This enabled staff to have a better understanding of the medical history of local patients who presented to the UCC.

**Engagement**
Little work had been undertaken by the department to assess the needs of the population it served.

The trust had worked with local commissioners at a time when a neighbouring service was decommissioned.

There were questionnaires in the waiting and reception area of the unit asking patients to provide feedback about their experience at the UCC.

Patients, carers, and relatives were able to leave feedback using the trust’s public website.

**Learning, continuous improvement and innovation**

There was no active quality improvement strategy for the service at the time of the inspection.

Staff spoke about looking at different ways of working. However, the team were inward looking and had not considered new models of care.

A lack of governance or corporate oversight meant service developments had not progressed. There was little in-sight amongst staff as to how they could make changes. Quality improvement models were an unfamiliar concept for the team.
St Albans City Hospital

Urgent and emergency care

Facts and data about this service

The Minor Injuries Unit (MIU) at St Albans City hospital is open every day (except Christmas Day) from 9am to 8pm.

The MIU is staffed by emergency nurse practitioners (ENPs) and administrative support staff. It provides a service for children and adults with minor injuries such as lower limb and minor head injuries. The unit has five treatment rooms, a resuscitation room, and access to on-site x-ray facilities Monday to Friday from 9am to 5pm.

Patients who attend the MIU should be expected to be assessed and admitted, transferred or discharged within a four hour period, in line with the national target for all accident and emergency and unscheduled care facilities.

The MIU forms a part of the trust’s emergency care division, which includes the emergency department at Watford general hospital and the Urgent Care Centre at Hemel Hempstead hospital. All three services are managed by the same division and have the same managers.

We carried out an unannounced inspection of the MIU on 7 November 2018. During our inspection, we spoke with four members of staff and six patients, and we looked at fifteen sets of patients’ records.

As a result of the inspection on 7 November 2018, the Care Quality Commission opted to utilise its urgent enforcement powers. We imposed conditions on the trust’s registration, requiring them to instigate, with immediate effect, an effective process which ensured that all patients who presented to the MIU were initially assessed by a suitably qualified member of staff within fifteen minutes of arrival. This was to ensure that in the event an extremely sick patient presented to the department, they would be assessed and managed in a timely way.

Activity and patient throughput

Total number of urgent and emergency care attendances at West Hertfordshire Hospitals NHS Trust compared to all acute trusts in England, July 2017 to June 2018

![Graph of urgent and emergency care attendances](image)
From July 2017 to June 2018 there were 137,086 attendances at the trust’s urgent and emergency care services as indicated in the chart above.

(Source: NHS England)

Total number of all patients attending the Minor Injuries Unit at St Albans City Hospital between October 2017 and September 2018. There were a total of 13,926 attendances.

(Source: Data Request DR193).

Total number of children attending the Minor Injuries Unit at St Albans City Hospital between October 2017 and September 2018. During this period, there were 3,697 attendances.

(Source: Data Request DR193)

Is the service safe?

Mandatory training

Mandatory training was provided in key skills to all staff, however completion rates remained low.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training.
A breakdown of compliance for mandatory courses from July 2017 to June 2018 for nursing staff in the Minor Injuries Unit is shown below:

St Albans MIU

Nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-patient moving and handling</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>6</td>
<td>7</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>6</td>
<td>7</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>6</td>
<td>7</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene</td>
<td>6</td>
<td>7</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire non-clinical</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>4</td>
<td>7</td>
<td>57%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control</td>
<td>4</td>
<td>7</td>
<td>57%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire and evacuation clinical</td>
<td>3</td>
<td>7</td>
<td>43%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient moving and handling</td>
<td>2</td>
<td>7</td>
<td>29%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff failed to meet the 90% completion target for 10 out of 11 mandatory training modules.

The senior emergency nurse practitioner responsible for the MIU reported that on-going sickness had been a contributory factor to the poor completion rates for mandatory training.

**Safeguarding**

Staff understood how to protect patients from abuse. Staff had completed training on how to recognise and report abuse and they knew how to apply it.

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from July 2017 to June 2018 for nursing staff for the MIU is shown below:

St Albans MIU

Nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults level 1</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3 - three yearly update</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>6</td>
<td>7</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff exceeded the 90% completion target for three of the five safeguarding training modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff were aware of their roles and responsibilities regarding safeguarding both adults and children. We reviewed seven sets of notes specifically relating to the care of children. We noted
that in all but one case, reception staff had recorded they had accessed an electronic child protection information sharing system which allowed the trust to share and receive information from other authorities responsible for safeguarding children. This enabled healthcare staff to be aware of any child categorised as being vulnerable, or subject to a protection plan. We noted the reception staff also recorded the number of previous attendances any child had to the emergency department in order staff could consider previous presentations or to identify any trends or patterns which may have had cause for concern.

Staff had a good understanding of the national “Think Child” campaign, and could provide examples of when a child may be vulnerable. Further, staff could describe examples of what may constitute a vulnerable person including those at risk of neglect, financial abuse, child sexual exploitation, female genital mutilation, domestic violence and abuse.

<table>
<thead>
<tr>
<th>Grouping</th>
<th>Name</th>
<th>01/05/2018</th>
<th>01/06/2018</th>
<th>01/07/2018</th>
<th>01/08/2018</th>
<th>01/09/2018</th>
<th>01/10/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding</td>
<td>Accompanying adult documented</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>0</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CPPIP checked and documented</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Immunisation history documented</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>0</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>(Paediatric)</td>
<td>parental responsibility</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient information checked/verified</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Referrals to CSF</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reporting safeguarding concerns</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td></td>
<td>awareness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>71.4</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Data Request DR191)

Cleanliness, infection control and hygiene

Infection risks were not always controlled well. Whilst staff were observed to use best practice techniques including being bare below the elbow, five moments of hand cleaning and aseptic techniques for dressings and wound care, patients were not always isolated in a timely way then they posed a possible infection risk to others.

There was a lack of assurance to demonstrate clinical areas were cleaned daily.

There were no reported incidents of healthcare-associated infections against this service in the preceding twelve months.

The pathway for isolating possibly infectious patients was poorly embedded within the department. Due to a lack of clinical prioritisation or triaging protocols, potentially infectious patients (such as those with norovirus) could be asked to wait in a waiting area until they were called to be seen by an emergency nurse practitioner. We did note however, that due to the presence of the senior emergency nurse practitioner on the day of inspection, two patients who presented to the department having been in contact with an infectious disease were asked to wait in a clinical room as compared to the waiting area. The senior emergency nurse practitioner reported that further
work was required to ensure there was a consistent approach to isolating patients upon arrival to the department.

Whilst the two patients were held in a clinical room, away from other patients, there were no precaution signs placed on the door of the clinic room.

The department was visibly clean. We observed housekeeping staff undertaking cleaning duties during the inspection. This included a clean of a clinical room used to accommodate patients who were possibly infectious.

A review of the integrated performance report and ward scorecard for September 2018 (most recent available from board papers for November 2018) reported cleaning scores as being “not applicable”. There was no evidence on the ward of daily cleaning checklists having been completed to demonstrate regular cleaning of the department. Local staff were not aware of the existence of the scorecard.

Following the inspection, we asked the trust for information or audit activity relevant to the management and prevention of infections, specifically for the MIU. The trust submitted a number of documents which confirmed that local “code of practice checklist audits” had been undertaken in May and August 2018. The audits considered a range of areas including the general cleanliness of the clinical setting; that linen was stored appropriately; personal protective equipment was appropriately stored as well as considering staff knowledge specifically about the best techniques to wash their hands and handling spillages of bodily fluids. Compliance in both audits was at least 95% compliance against the 44 individual metrics.

We observed staff using antibacterial hand gel frequently and washing their hands regularly after patient contact. There was no evidence of hand hygiene audits conducted in MIU; staff told us that it was difficult to conduct these audits as they were in enclosed environments and it would be difficult to measure practice. The integrated performance report for emergency care included a section for hand hygiene audit results for the MIU however this section was marked as “not applicable”. The senior emergency nurse practitioner informed us they had received a directive from the director of infection prevention and control that such audits should be instigated in the MIU however there was no time scale as to when these audits were to recommence.

‘Bare below the elbow’ policies were adhered to and staff wore minimal jewellery in line with the trust infection control policy. Personal protective equipment, for example, gloves and disposable aprons were used according to the trust’s infection control policy.

Staff adopted good aseptic non-touch techniques when undertaking wound dressings.

Infection control audits were undertaken monthly and reported against the “Test your care” metric.

<table>
<thead>
<tr>
<th>Grouping</th>
<th>Name</th>
<th>01/05/2018</th>
<th>01/06/2018</th>
<th>01/07/2018</th>
<th>01/08/2018</th>
<th>01/09/2018</th>
<th>01/10/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control Privacy and Dignity</td>
<td>Alcohol gel</td>
<td>100</td>
<td>100</td>
<td></td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Appropriate curtains</td>
<td>100</td>
<td>100</td>
<td></td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Bed space clean</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Commmodes clean/green sticker</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hand hygiene audits</td>
<td>100</td>
<td>100</td>
<td></td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HD space clean, working oxygen/suction</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inserted PVCs documented</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100</td>
</tr>
</tbody>
</table>
Environment and equipment

Although there were processes in place to ensure equipment was checked regularly and maintained, some substances hazardous to health including bleach based liquids were easily accessible.

A range of disposable items including swabs and scissors remained in stock despite having expired their use-by dates.

Staff had access to a resuscitation trolley, which was appropriately stocked with equipment for adults and children. Adults and children’s resuscitation equipment had been checked on a daily and weekly basis and staff had highlighted equipment and drugs that were nearing expiry date.

Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Sharp bins were not overfilled and had been correctly labelled.

Emergency resuscitation equipment was readily accessible. Checklists confirmed the equipment was checked daily. The resuscitation trolley was equipped with items suitable for the management of all ages of patients.

<table>
<thead>
<tr>
<th>Grouping</th>
<th>Name</th>
<th>01/05/2018</th>
<th>01/06/2018</th>
<th>01/07/2018</th>
<th>01/08/2018</th>
<th>01/09/2018</th>
<th>01/10/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Checked daily</td>
<td>100</td>
<td>100</td>
<td></td>
<td>100</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Checks signed and initialised</td>
<td>100</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Correct checklist being used</td>
<td>100</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Defibrillator</td>
<td>100</td>
<td>100</td>
<td></td>
<td>100</td>
<td></td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Drug box</td>
<td>100</td>
<td>100</td>
<td></td>
<td>100</td>
<td></td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>O2 cylinder</td>
<td>100</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Other equipment present and in date</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>0</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suction machine</td>
<td>100</td>
<td>100</td>
<td></td>
<td>100</td>
<td></td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Trolley clean</td>
<td>100</td>
<td>100</td>
<td></td>
<td>100</td>
<td></td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>within service dates</td>
<td>100</td>
<td>100</td>
<td></td>
<td>100</td>
<td></td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>80</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Data Request DR191)

A range of disposable items including swabs and scissors remained in stock despite having expired their use-by dates.
The dirty utility area was unlocked. We found a bottle of disinfectant granules in an unlocked cabinet. A bottle of a different disinfectant had been prepared and was stored on top of a cistern and so was within easy reach of children and vulnerable adults. Both items are potentially hazardous if ingested and so posed a risk to people because they were not stored in locked cabinets. We reviewed the Control of Substances Hazardous to Health (COSHH) folder which did not contain any information relating to the storage of either the disinfectant granules or the solution.

Assessing and responding to patient risk

There remained no formalised process for clinically assessing patients presenting to the minor injuries unit, outstanding from previous inspections. Patients were advised of waits of up to three hours before being seen by a healthcare professional.

Standards jointly developed by the Royal College of Emergency Medicine (RCEM), the Emergency Nurse Consultant association and the Faculty of Emergency Nursing state; “All patients should be assessed in a timely manner. If there are delays in a healthcare professional assessing the patient, then some form of initial assessment will be required to detect those at risk of deterioration or potentially serious conditions” (Unscheduled Care Facilities 2009). During our inspections in 2015 and 2016, we found delays of up to two hours before patients were assessed. We noted there had been some minor improvements, specifically relating to the timely assessment of children, during our previous inspection in 2016. The trust provided the commission with information as part of the 2016 inspection which included ensuring a qualified band five nurse overseeing all patients presenting to the minor injuries reception. However, we found this was not in place at the time of this inspection. The trust has since reported that no such role had existed within the MIU at St Albans City Hospital.

Patients who arrived at the MIU were initially seen by the unit’s reception staff who took a brief description of the patient’s condition or symptoms. Reception staff we spoke with were aware of the ‘red flag’ conditions such as chest pains, difficulty breathing, and severe bleeding in line with the RCEM: triage position statement (2011) guidance for non-clinical staff. Reception staff told us that any patient presenting with these symptoms would be immediately highlighted to the nursing staff and actions would be taken to prioritise the patient.

However, during the inspection we noted that two patients who had been involved in separate road traffic incidents presented to the department with head, neck and back pain and back pain respectively. National Institute of Health and Care Excellence guideline 176 states all patients with presenting with a head injury should be assessed within 15 minutes. Further guidance from the National Institute of Health and Care Excellence (NICE 41 – spinal injury: assessment and initial management) recommends undertaking a comprehensive assessment of patients to determine whether they are at high or low risk of cervical spine injury. Low risk criteria includes those patients involved in minor rear-end motor collision, are comfortable in a sitting position, ambulatory at any time since the injury, no midline cervical spine tenderness and delayed onset of neck pain. The guidance also suggests a patient is low risk if they are unable to actively rotate their neck 45 degrees to the left and right. High risk criteria includes those individuals who report having spinal pain alongside other criteria. Where any high risk criteria is identified, or where a patient has at least one low risk indicator and cannot rotate their neck 45 degrees, the patient should be managed in a full in-line spinal immobilisation pathway until such time clearance has been provided that no cervical spine injury is present. Due to the lack of triaging protocols, both patients were asked to wait in the waiting area. We noted one patient had still not been clinically assessed at 1 hour 5 minutes following their initial presentation.
We reviewed the care record for a second patient who presented with a head injury. They waited more than one hour before an initial assessment or pain assessment was undertaken. There were no recorded neurological observations, (assessment of function, movement and cognitive ability, which may have indicated the presence of a head injury requiring rapid treatment) undertaken when the patient first presented to the department despite the patient having sustained a visible head injury.

We therefore considered that patients presenting with possible trauma injuries, either acute or delayed, were at risk of further harm due to a lack of timely initial assessment.

Whilst we observed nursing staff briefly viewing the waiting room when they collected their next patient they did not have line of sight of all waiting patients when they did this.

Data provided by the trust (DR181) demonstrated the median time patients could expect to be seen was 40 minutes. The longest wait was reported as a median time of 139 minutes between May and October 2018.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Attend Year</th>
<th>Month</th>
<th>Time to Seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIU (SACH)</td>
<td>2018</td>
<td>May</td>
<td>36</td>
</tr>
<tr>
<td>MIU (SACH)</td>
<td>2018</td>
<td>June</td>
<td>40</td>
</tr>
<tr>
<td>MIU (SACH)</td>
<td>2018</td>
<td>July</td>
<td>51</td>
</tr>
<tr>
<td>MIU (SACH)</td>
<td>2018</td>
<td>August</td>
<td>25</td>
</tr>
<tr>
<td>MIU (SACH)</td>
<td>2018</td>
<td>September</td>
<td>42</td>
</tr>
<tr>
<td>MIU (SACH)</td>
<td>2018</td>
<td>October</td>
<td>48</td>
</tr>
<tr>
<td>MIU (SACH)</td>
<td>2018</td>
<td>May-Oct</td>
<td>40</td>
</tr>
</tbody>
</table>

(Source: Data Request DR181 MIU Median, 25% and 95% length of time to be seen.)

We had previously raised concerns that children were also not being clinically assessed within 15 minutes of arrival to the MIU. At this inspection, we found that improvements had been made. On presentation to the MIU, reception staff took basic information from the patient or their parent and then alerted nursing staff by pressing a bell. Nursing staff were observed leaving their consulting room to assess the child. Whilst there was improved oversight of children, we judged this process to be inefficient as we observed nursing staff having to leave other patients, mid-consultation to review children. These interruptions led to delays and increased waiting times.

A standard operating procedure (SoP) was in place to support the delivery of the MIU. There was a requirement for emergency nurse practitioners to undertake an initial triage and to calculate a national early warning score for any patient presenting with an acute illness. There were escalations defined in the SoP where patient’s acuity was of a level which could not effectively be managed at the MIU. During the inspection we observed one patient being transferred to the emergency department at Watford General Hospital because of their presenting condition. Whilst the ENPs stabilised the patient, they did not utilise an early warning scoring tool. Staff had been trained in the use of the national early warning system (NEWS) and the paediatric early warning system (PEWS). This was a quick and systematic way of identifying patients whose clinical condition meant that they were at risk of deteriorating. Whilst it was reported by staff they
consistently used PEWS for children who presented with acute illnesses, NEWS was used less consistently.

<table>
<thead>
<tr>
<th>Grouping</th>
<th>Name</th>
<th>01/05/2018</th>
<th>01/06/2018</th>
<th>01/07/2018</th>
<th>01/08/2018</th>
<th>01/09/2018</th>
<th>01/10/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observations</td>
<td>CAS card</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Name, Ward, PID</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>PEWS aged &lt;=4/Presenting with illness</td>
<td>100</td>
<td></td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PEWS assessed against normal range for age</td>
<td>100</td>
<td></td>
<td>100</td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>PEWS Score</td>
<td>100</td>
<td></td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Data Request DR191)

Nurse staffing

Nursing staff had the right qualifications, skills and experience to enable them to provide the right care to patients.

There were minimal vacancies within the team, but there had been little consideration to how staff were deployed to meet the needs of patients in a timely way.

The trust reported the following nurse staffing numbers for the MIU in June 2017 and June 2018.

<table>
<thead>
<tr>
<th>Location</th>
<th>June 2017</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned staff – WTE</td>
<td>Actual staff – WTE</td>
</tr>
<tr>
<td>St Albans MIU</td>
<td>6.8</td>
<td>6.5</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

We reviewed that staffing rota for the month prior to our inspection. The minimum planned staffing for the department was for there to always be two emergency nurse practitioners (ENP) on duty. A third ENP worked on Mondays as this was the day that most patients attended. A third ENP was also rostered to work Tuesday – Friday between 09:00 and 15:00 however we found this was rarely achieved due to staff sickness.

Although staffing levels met the minimum standards recommended by the Royal College of Emergency Medicine (Unscheduled care facilities 2009), there had been no analysis of patient waiting times compared to staffing levels. On the day of our inspection the senior emergency nurse practitioner was present to support the CQC inspection team and was not rostered to provide patient care. On the day of our inspection, two ENPs were rostered to work the full duration of the opening hours of the MIU. At its peak, patients were advised of a three hour wait to be seen by an ENP. We observed the senior emergency nurse practitioner responded proactively by seeing and treating patients to improve waiting times. However, had the senior emergency nurse practitioner not been present on the day, it was not clear how staffing levels had been planned to ensure the needs of patients was met in a timely way.

Vacancy rates

From April 2017 to March 2018 the average vacancy rate at the trust for nursing and midwifery staff was 3.19%, this was lower than the trust target of 9%. However, the vacancy rate at St Albans was reported as 17.8%, in part due to two staff recently having retired from their roles.
Turnover rates

St Albans MIU was a significant outlier for staff turnover. The senior emergency nurse practitioner reported this was in part due to the retirement of two members of staff who had been working in the department for a significant period of time. Additionally, because the staff numbers were small, two people leaving had an inordinate impact.

- St Albans: 29.7%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Sickness rates

From July 2017 to June 2018 the average sickness rate at the trust for nursing and midwifery staff was 3%, this was lower than the trust target of 3.5%. However, at St Albans MIU, the staff sickness rate was over double that of the trust average. The senior emergency nurse practitioner reported that staff with chronic conditions contributed significantly to the sickness rate. We reviewed staff rotas during the inspection and found multiple occasions when individual members of staff reported in sick. The senior emergency nurse practitioner told us she was receiving support from her human resources business partner to manage individual sickness performance thus supporting the needs of individual members of staff.

- Hemel Hempstead: 3.9%
- St Albans: 7.5%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Bank and agency staff usage

Qualified nursing staff

From April 2017 to March 2018 the trust had a total of 212,254 nursing staff shifts in urgent and emergency care. However, only a small percentage of these related to the MIU. A breakdown of bank and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Unfilled rate (%)</th>
<th>Bank use rate (%)</th>
<th>Agency use rate (%)</th>
<th>Total bank and agency Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemel Hempstead</td>
<td>0.5%</td>
<td>2.3%</td>
<td>0.0%</td>
<td>2.3%</td>
</tr>
<tr>
<td>St Albans</td>
<td>1.4%</td>
<td>7.1%</td>
<td>0.0%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Watford General Hospital</td>
<td>10.8%</td>
<td>8.7%</td>
<td>19.8%</td>
<td>28.5%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>8.8%</strong></td>
<td><strong>7.8%</strong></td>
<td><strong>15.9%</strong></td>
<td><strong>23.7%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Records

Records were stored and managed confidentially, written legibly and according to best practice. Patients’ registration details were recorded on the unit’s computer system, which then produced a paper record for staff to use.

We looked at fifteen sets of records and found that information regarding the patient’s care and treatment was methodically documented. There was appropriate information to understand the treatment delivered including any required follow up or onward referral to fracture clinic, for example.
Paper records were stored behind a locked door in secured cabinets in the reception area when they were no longer required. Patient records were retained for a period of one year before being sent to a central record depository. This meant that whilst the trust retained clinical records, these were individual care events and so could not be accessed in a timely way by staff from other departments across the trust. For example, if a patient presented to the MIU for clinical care and then subsequently attended either the Hemel Hempstead urgent treatment centre or Watford General emergency department out of hours, clinical staff would not be able to review the care provided at the MIU with the exception of a very high level coding entry on the computer system.

Records were audited on a monthly basis via the “Test your care” audit programme:

<table>
<thead>
<tr>
<th>Grouping</th>
<th>Name, PID, date</th>
<th>01/05/2018</th>
<th>01/06/2018</th>
<th>01/07/2018</th>
<th>01/08/2018</th>
<th>01/09/2018</th>
<th>01/10/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation</td>
<td></td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Triage score</td>
<td></td>
<td></td>
<td></td>
<td>100</td>
<td>100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>including priority</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Data request DR191)

We found the dirty utility room, which was located in the main department was unlocked and so could be accessed by members of the public. Located within the dirty utility room was a log-book detailing pregnancy screening results for patients. In the majority of cases staff used only a patient hospital ID number and their test result, that is whether their pregnancy test was positive or negative. We found an example where staff had recorded the patient’s name, the date of their test and the test result. The senior emergency nurse practitioner also reported that the department was unlocked before 9am by security staff and there had been examples when patients had been found by reception staff in the reception area, waiting for the department to open. There was therefore a risk that patient’s confidentiality was at risk of being breached due to the easy access of the logbook, should members of the public had unchallenged access to the department.

**Medicines**

Medicines were stored in line with the trust’s medicines management policy and fridge and room temperatures were regularly checked and temperatures recorded.

Patient Group Directives were in place, but were not used in line with best practice or trust policy.

The recording charts showed the fridge and room temperatures were in an acceptable range. The keys were held by the nurse in charge on the day and stored overnight in a keypad locked safe. Controlled drugs were kept secure and checked on a regular basis to ensure they were present and correct.

A small proportion of emergency nurse practitioners were qualified non-medical prescribers. This meant they had the legal authority to supply and administer a range of medicines without the need for a doctor to authorise the prescription. The remaining emergency nurse practitioners operated under the auspices of a patient group direction (PGD). We reviewed seven PGDs and found that whilst they were all in date, expiring in July 2020, only one member of staff had signed a small number (two) of the “Agreement to Practise” logs contained within each PGD. However, whilst on the rare occasion when the member of staff had signed the PGD, this had not been countersigned by a “senior representative authorising health professional”. This meant the staff member was not authorised to administer medicines against individual PGDs, as they had not been duly authorised.
by a trust representative. We raised this with the senior emergency nurse practitioner at the time of the inspection.

We noted that a PGD for Clarithromycin had been amended in ink on 8 May 2018. A comment at the top of the PGD entry stated “250mg Clarithromycin TTA pack was discontinued by the microbiologists. Rec (recommend) dose 500mg BD”. There was no record or version control to confirm that this change of dose had been verified via the trust governance protocol, due to the changes being made in ink.

The service completed monthly “test your care” audits against a range of indicators relating to medicine safety. Compliance was seen to be consistently good across the nine assessed metrics, with the exception of controlled drugs not being checked daily during September. This omission had been addressed locally.

<table>
<thead>
<tr>
<th>Grouping</th>
<th>Name</th>
<th>01/05/2018</th>
<th>01/06/2018</th>
<th>01/07/2018</th>
<th>01/08/2018</th>
<th>01/09/2018</th>
<th>01/10/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>Administrations signed/dated</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Allergy box completed and signed</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>CDA keys separate</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Children weighed before medication</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Daily checking of CDs</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>0</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Fridge temperature documented</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>IV fluids secured</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Prescription legible</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Secure medicines</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>80</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

(Source: Data Request DR191)

**Incidents**

Staff could describe the types of incidents they should report.

There was a consensus amongst the management team of a culture of under-reporting of incidents.

There were limited examples of learning from incidents and staff relied on historical examples, despite more recent incidents having occurred across the emergency medicine division, where lessons had been learnt which were applicable to the minor injuries unit.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From July 2017 to June 2018, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - STEIS)

Breakdown of serious incidents reported to STEIS
For year ending July 2018 there had been no serious incidents reported to the Strategic Executive Information System (STEIS) for the MIU.

(Source: NHS Improvement - STEIS)

Incidents and accidents were reported using a trust wide electronic system and were graded in severity from low or no harm to moderate, severe harm or death. The trust had a comprehensive incident reporting policy, which described the process for grading and reporting incidents. Staff were able to access this on the trust’s internal website.

Staff were aware of their responsibility to report incidents both internally and externally and used the hospital’s electronic reporting system. Whilst staff could describe the types of incidents they would report, there was a general consensus amongst the management team that incident reporting rates were lower than expected. For example, staff would not routinely report incidents where patients had experienced delays in their initial assessment. For the period 1 May 2018 and 31 October 2018, 13 incidents had been reported within the MIU. A breakdown of the incidents are as follows:

<table>
<thead>
<tr>
<th>Description of Incident</th>
<th>MIU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication between teams</td>
<td>0</td>
</tr>
<tr>
<td>Communication between Staff and Patients/Carers</td>
<td>0</td>
</tr>
<tr>
<td>Human Resource Availability</td>
<td>1</td>
</tr>
<tr>
<td>Injury of Unknown Origin</td>
<td>1</td>
</tr>
<tr>
<td>Other Communication Incident</td>
<td>2</td>
</tr>
<tr>
<td>Other Investigations</td>
<td>1</td>
</tr>
<tr>
<td>Other Service Disruption*</td>
<td>2</td>
</tr>
<tr>
<td>Referrals</td>
<td>1</td>
</tr>
<tr>
<td>Uncontrolled crowds</td>
<td>1</td>
</tr>
<tr>
<td>Monitoring/On-going Assessment of Patient Status</td>
<td>0</td>
</tr>
<tr>
<td>Other Administration Incident</td>
<td>1</td>
</tr>
<tr>
<td>Administration to Patient</td>
<td>0</td>
</tr>
<tr>
<td>Diagnostic Conclusions</td>
<td>0</td>
</tr>
<tr>
<td>Other Therapeutic Incident</td>
<td>0</td>
</tr>
<tr>
<td>Non-invasive Treatment Processes</td>
<td>1</td>
</tr>
<tr>
<td>Other Medical Devices, Equipment, Supplies</td>
<td>2</td>
</tr>
<tr>
<td>Other Documentation Incident</td>
<td>0</td>
</tr>
<tr>
<td>Safeguarding/Protection</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

(Source: Data request DR 172 and 173)

Lessons learnt from previous incidents were on display in the MIU. However, the examples used were historic, dating back to incidents having occurred in 2017. More recent serious incidents had occurred across the emergency care division, including an incident at Watford General Hospital, whereby a possible spinal trauma patient had not been managed in the most effective way possible. The trust had established key learning from that incident and whilst these learning events had been disseminated and were on display at the Urgent Treatment Centre in Hemel Hempstead, they were not on display at the MIU. We spoke with two members of nursing staff who said that whilst they were aware of the incident, they did not know what had changed or if any new protocols had been introduced as a result.
Providers are required to comply with Regulation 20 (duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Staff had a good understanding of these regulations and spoke confidently about when they should be applied. However, because there had been no incidents that met the threshold of the duty of candour regulation it was not possible to fully assess compliance against this regulation for this core service.

**Safety thermometer**

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the patient safety thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from July 2017 to July 2018 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

**Major Incident Planning**

The major incident plan for the Minor Injuries Unit was poorly developed as staffing models meant there were not always sufficient numbers of staff available for the plan to be instigated in full. There was confusion regarding the major incident plan. Various copies of different plans were available across the department.

A number of documents were available across the minor injuries unit which referenced current and historic major incident plans. For example, in the main reception area, a folder labelled “CBRN Protocol” contained details of what actions reception and nursing staff should take in the event a patient presented to the MIU who may have been in contact with chemical, biological, radioactive or nuclear material. These action cards were dated August 2006. A second folder was also located in reception and included a major incident plan dated 2016 and a CBRN and “Hazmat Plan” dated 2015. A third major incident folder was located in the clean utility area, and included a range of equipment including high visibility vests, torches and patient categorisation cards. A copy of the trust’s major incident plan was included in the major incident box and was dated January 2016.

The major incident plan suggested that St Albans MIU would be a centre designated for managing “P3” (delayed priority/walking wounded) patients. In the event of a major incident, there was an expectation, that in order for the major incident plan to be effective, four emergency nurse practitioners would be required to support the patient pathway. Two ENPs were allocated to triage and initial assessment, one ENP located in the fracture clinic and a fourth in the outpatient treatment area. Daily staffing of the minor injuries meant that the maximum number of ENPs on shift at any one time was three (Mondays), with 2.5 ENPs rostered for the remainder of the working week and two at weekends. This meant there was insufficient resource to enable the major incident plan to be instigated effectively.

Is the service effective?
Evidence-based care and treatment

There was a local audit programme in place, but there remained a lack of audits. This had previously been identified by the Care Quality Commission as an area which required improvement.

Staff had access to guidelines and policies via the trust’s intranet which were up-to-date and relevant. However, a range of printed policies and procedures which reflected clinical guidance that had been superseded was present across the department.

Staff in the MIU had access to evidence based clinical guidelines via the trust’s intranet. For example, we saw that there were clinical pathways for chest pain and complex fractures, which were based on National Institute for Health and Care Excellence (NICE) guidelines. Nursing staff that we spoke with were familiar with them and could speak confidently about any actions that needed to be taken. There was a clearly defined clinical treatment criteria for the minor injuries unit. This included a description of the types of injuries, ailments and illnesses which could be treated within the MIU. The protocol also included exclusion criteria, including those presenting with severe pain, or overdose of medicines/illegal drugs. However, whilst staff reported they opted to use the intranet as their main source for information, a policy folder was located in the clean utility room. A number of clinical guidelines were presented and dated back to 8 February 2001 for antibiotic therapy for meningitis. Whilst the doses and first line drug suggested within the reference document remained in line with national standards (NICE clinical guideline 102: Meningitis (bacterial) and meningococcal septicaemia in under 16s: recognition, diagnosis and management,) the dated policy made reference to secondary medicines for those individuals who may have been hypersensitive to Penicillin. Advice regarding secondary antibiotics has evolved with alternative suggestive therapies. Whilst the suggested secondary drug was included in national guidance, had staff opted to refer to the 2001 guidance, they may not have been providing the most up-to-date evidence based care or treatment. In addition, the local policy folder also contained guidance relating to advanced life support techniques for children which was dated 2001. This guidance was dated and had been superseded in 2005, 2010 and 2015 and so the existing version did not reflect current best practice techniques.

There was a policy for the management of hypoglycaemia (low blood sugar). The policy made reference to the administration of Lucozade as an initial management strategy for the conscious patient. However, a sign located in the clean utility advised staff of a “product change”. The trust policy position was for staff to administer “60 ml Gluco Juice” instead of Lucozade. Whilst the sign directed staff to the adult diabetes guideline, local staff had not printed the policy so that the most up-to-date policy was available.

A guide for the preparation of intravenous medicines was noted to contain guidance dating back to 2003 and 2004. This meant there was a risk staff could be relying on outdated guidance to prepare medicines.

During our last two inspections we found there was no local clinical audit programme to check that treatment given to patients followed best practice. There continued to remain a lack of clinical audit activity in 2018 with the exception of “test your care” audits which were undertaken monthly. We have reported the performance against test your care within the safe domain.

Staff had initially audited the number of children assessed within 15 minutes however this was last audited in April 2018. No further audits had been undertaken. There was no clinical audit activity undertaken to ascertain how well the department performed against compliance with national best practice or evidence based care and treatment.
There was no peer review programme for emergency nurse practitioners. It was therefore not possible for the trust to provide assurances that ENPs were acting within scope of their remit; that their clinical decision-making skills were up-to-date and relevant and that treatment decisions were aligned to national and local best practice protocols.

Whilst there was a process for ensuring all requested radiology images were reviewed and reported by a radiologist within five working days. there was also very limited assurance frameworks to support staff who may have missed fractures or other deformities or misinterpreted x-ray images. This was acknowledged as an area for improvement by the senior emergency nurse practitioner.

**Nutrition and hydration**

Water was not always available as it was kept behind the reception desk which was not always staffed.

Due to the nature of the service, meals were not provided to patients. Water was available from the receptionist. Due to the water fountain being located next to the receptionist, in a secure area, patients could not help themselves to drinks. We observed the receptionist being responsive to patients when they asked for water. However, during periods of time when the receptionist was away from their desk, such as during their lunch break, the reception area was left unattended and so patients were required to wait for a member of nursing staff to return to the reception area before they could get a drink.

Staff were able to describe the action they would take in the event of a patient presenting with malnutrition concerns or who were dehydrated for example.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain.**

Following our previous inspections, we raised concerns about the lack of pain assessments for patients presenting to the MIU. The trust had responded by including pain scoring as a criterion for audit on a monthly basis via the “test your care” audit programme. The latest audit results for pain assessments was as follows:

<table>
<thead>
<tr>
<th>Grouping</th>
<th>Name</th>
<th>01/05/2018</th>
<th>01/06/2018</th>
<th>01/07/2018</th>
<th>01/08/2018</th>
<th>01/09/2018</th>
<th>01/10/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>Assessed on arrival</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pain status before/after analgesia</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pain status with every set of obs</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

We reviewed fifteen sets of notes during the inspection. In six of the seven records we reviewed relating to children, pain assessments were undertaken and there were entries recorded where analgesia had been offered, administered or declined. Within the remaining care records, pain assessments were recorded in five of the eight adult care records. Therefore, there remained an inconsistent approach to the initial assessment of pain scores despite there being positive assurances provided from the “test your care” audit programme.

**Patient outcomes**

There remained a lack of monitoring of patient outcomes and compliance with evidence-based protocols.
As we have previously reported there continued to be no formal audit programme within the minor injuries unit to help assess patient outcomes.

Patients presenting at the MIU, were not included in relevant national audits that were being conducted in the emergency care division, for example, treatment of feverish children.

Staff reported that whilst they were identified leads for specific areas, they had no protected management time to undertake any audit activity. There was no robust action plan or timeline in place which could provide the Commission assurance that this lack of audit activity was likely to be resolved and so we have judged the provider to be in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Competent staff

Staff were given opportunities to rotate around the trust's different sites to build up their confidence and competence.

Appraisal rates

From July 2017 to June 2018, 152 members of staff were eligible to receive an appraisal in urgent and emergency care, they achieved an 55% completion rate against a trust target of 90%. Information relating to the MIU was not available.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisal eligible</th>
<th>Appraisal completed</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>3</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>1</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>97</td>
<td>53</td>
<td>54.6%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>51</td>
<td>31</td>
<td>60.8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff who were new to the department underwent an initial induction programme. We were not able to assess the effectiveness of the induction programme as the two staff on duty during the inspection had worked in the department for some years and so were well-established.

Those new to the role of emergency nurse practitioner undertook rotational posts across the minor injuries service at Watford General Hospital and the urgent treatment centre before moving across to the MIU at St Albans City Hospital. This ensured individuals gained a range of experience managing different conditions, alongside other health professionals such as general practitioners, before working independently at the MIU.

Multidisciplinary working

Staff worked together as a team to benefit patients.

There was a process in place for ENPs to discuss or refer complex or urgent cases with the duty emergency department consultant at Watford General Hospital.

A clinician from the main emergency department had adopted the role as lead clinician for the MIU and so was scheduled to provide clinical oversight to the department.

Pathways existed for the timely referral of patients to specialists including orthopaedics and ophthalmology.

Seven-day services
The MIU was open seven days a week (except for Christmas Day) from 9am to 8pm.

X-ray facilities were only available at St Albans City Hospital, Monday to Friday 9am to 5pm. During the evening, at weekends and bank holidays, patients who required X-rays had to travel to Hemel Hempstead or Watford. If further treatment was required, for example if a fracture had been identified on X-ray, the patients sometimes had to return to St. Albans for treatment to be carried out. Between August 2018 and October 2018, 40 patients were required to return to the MIU for an X-ray because the X-ray department had been closed during their initial visit.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

The trust did not specifically provide training data against the Mental Capacity Act or Deprivation of Liberty Safeguards.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

Patients had their consent obtained in line with national guidance. We observed that consent, both written and verbal, was obtained for any procedures undertaken by the staff. Written guidance on consent, and assessing mental capacity was available via the trust’s intranet.

Consent forms were available for people with parental responsibility to consent on behalf of children. The nursing staff that we spoke with had a good working knowledge of the guidance for gaining valid informed consent from a child. They were aware of the legal guidelines which meant children under the age of 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so, often referred to as being Gillick competent. Staff were aware that should a child not be considered “Gillick competent”, consent would be sought from the child’s parent or guardian. Staff could also describe the scenarios in which an individual would be deemed to have parental responsibility. The staff we spoke with had sound knowledge about consent and mental capacity. Although no formalised training had been provided to ENPs to undertake mental capacity assessments staff were aware of the processes and mechanisms in place should the need arise. This included gaining telephone advice from the unit’s senior emergency nurse practitioner or local psychiatric crisis teams if this was necessary.

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

**Friends and Family test performance**

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was better than the England average from July 2017 to June 2018.

A&E Friends and Family Test performance - West Hertfordshire Hospitals NHS Trust
Confidentiality was maintained at the reception desk by means of signs asking people to stand back from the desk, when someone was being registered.

The MIU had examination and treatment rooms with doors to ensure privacy when patients were being seen and examined. We saw that staff knocked and waited to be called in before entering.

We observed staff introducing themselves and explaining what was about to happen before examining patients. Staff took time to explain treatment options to patients, providing choices where clinically relevant and supporting patients to make informed decisions.

Emergency nurse practitioners took time to distract and comfort children during examinations and wound dressings. Parents were involved in the assessment and treatment of their children and clear explanations were given. Distraction techniques were used where applicable as an aid to supporting children.

We spoke with five patients and one family. Each patient spoke positively about the attitude of staff. Patients consistently reported good experiences with nursing staff during consultations. We reviewed completed “I want great care” questionnaires which further supported the positive feedback regarding staff attitude, communication skills and their caring approach.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.**

Staff were able to spend time with patients to explain their treatment options. Where patients were anxious or apprehensive, staff supported them, spending additional time to provide care.

We saw staff involve both patients and those close to them in their own care, allowing time to answer any questions.

Patients we spoke with said they felt involved and were aware of their plan of care.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them in decisions about their care and treatment.**

*Emergency Department Survey 2016*

The trust scored about the same as other trusts for all 24 Emergency Department Survey questions relevant to the caring domain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be</td>
<td>3.3</td>
<td>About the</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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<td>--------------------------------------</td>
</tr>
<tr>
<td>examined?</td>
<td></td>
<td>same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>4.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Initial assessment services had been planned around the needs of the local population.

The local clinical commissioning group was reported to have undertaken a scoping activity to determine the suitability of the service currently provided at St Albans City Hospital. The senior emergency nurse practitioner reported the CCG was seeking to enhance the service provision from the location, and was working with the trust to extend clinical services so they were more aligned to that of an urgent treatment centre specification. This would mean more acute patients could be seen and treated within the existing service. However, there were some concerns over the staffing of the new service, with suggestions of increased operating hours having also been discussed. The trust had not, at the time of the inspection, finalised any changes to the service provision and had not commenced modelling a new service.

X-ray facilities were not always available. The X-ray department closed at 5pm during the week and was not open at weekends or bank holidays. This meant that some patients had to travel nine miles to Hemel Hempstead Hospital, or further to Watford, for an X-ray. Between August 2018 and October 2018 forty patients had been required to reattend the MIU in order for them to access X-ray services.

**Meeting people’s individual needs**

The service took account of people’s needs with the exception of patients who were hard of hearing.
Emergency Department Survey 2016

The trust about the same as other trusts for all three emergency department survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

The unit was well signposted from the entrance to the hospital site. Patients told us that it was easy to find. There was drop-off point immediately outside and wheelchairs were available just inside the entrance. We did observe one patient who had sustained an ankle injury having to walk with difficulty, behind a nurse, despite wheelchairs being available in the reception area. The MIU was on a single level and there was sufficient space for wheelchair users or those who had limited mobility, to move around easily. There were designated disabled parking bays outside the unit and we saw that there was always one available during our inspection.

The computer system featured a flagging arrangement for people with a learning disability so that staff could be alerted to their special needs.

Staff reported any patient living with dementia, who had learning disabilities or complex physical disabilities would be prioritised for treatment. However, we noted one patient who had sustained a head injury and who had a confirmed diagnosis of dementia was in the department for a period of one hour and twenty minutes before they were seen.

The unit was not equipped with any hearing loop systems. This meant it may have been difficult to communicate with individuals who were hard of hearing and who relied upon hearing aids to help them.

There was a small children’s play area located in the main waiting room. This was not audio-visually separate from the main waiting area as recommended by the College of Emergency Medicine.

The computer system featured a flagging system for people with a learning disability so that staff could be alerted to their special needs.

Staff gave information leaflets given to patients that clearly stated who they should contact if they had any concerns or worrying symptoms after treatment. There was information throughout the department relating to support groups for patients with specific conditions to access local support networks.

Access and flow

Patients were admitted, transferred or discharged within four hours.

Median time from arrival to treatment (all patients)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour.
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Attend Year</th>
<th>Month</th>
<th>Time to Seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIU (SACH)</td>
<td>2018</td>
<td>May</td>
<td>Median (50%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>MIU (SACH)</td>
<td>2018</td>
<td>June</td>
<td>Median (50%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>25%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>MIU (SACH)</td>
<td>2018</td>
<td>July</td>
<td>Median (50%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>25%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>MIU (SACH)</td>
<td>2018</td>
<td>August</td>
<td>Median (50%)</td>
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<td></td>
<td></td>
<td></td>
<td>25%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>MIU (SACH)</td>
<td>2018</td>
<td>September</td>
<td>Median (50%)</td>
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<td></td>
<td></td>
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<td>25%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>MIU (SACH)</td>
<td>2018</td>
<td>October</td>
<td>Median (50%)</td>
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<td>25%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>MIU (SACH)</td>
<td>2018</td>
<td>May-Oct</td>
<td>Median (50%)</td>
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<td></td>
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<td>25%</td>
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<td></td>
<td></td>
<td></td>
<td>95%</td>
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</tbody>
</table>

Median time from arrival to treatment from May 2018 to October 2018 at St Albans City Hospital Minor Injuries Unit.

The table shows that 95% of patients were seen and treated within an hour of arrival.

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

![Graph showing MIU (Total Attendees) and MIU (Seen, admitted or discharged within 4 hrs) from Oct 2017 to Sep 2018]

The department consistently met the national target that at least 95% of patients were seen, admitted or discharged within four hours of presentation. Between October 2017 and September 2018, 99.6% of all patients were seen, admitted or discharged within four hours.

Learning from complaints and concerns

Whilst staff investigated complaints and provided patients with an apology, lessons were not always learnt. Complaints were not always responded to in line with the trust’s target however the trust continued to make improvements on its previous response times.

The MIU received few complaints annually. Where complaints were made, these often related to poor communication and delays in care and treatment. There had been limited action to resolve
recurring themes in a sustainable way. There had been no review of the activity of the department and its associated staffing establishment to determine whether long waiting times could be resolved through better deployment of staff.

Summary of complaints

From April 2017 to March 2018 there were 192 complaints about urgent and emergency services at the trust. The trust took an average of 44 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 40 days.

The site level breakdown is below:

- Hemel Hempstead General Hospital: 10 complaints
- St Albans City Hospital: five complaints
- Watford General Hospital: 177 complaints

It was unclear whether the five complaints regarding the MIU had been responded to within the trust’s timescale.

45% complaints related to patient care which involved poor care and communication from staff.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From April 2017 to March 2018 there were no compliments recorded for urgent and emergency services at the trust.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Whilst there had been changes to the leadership team with the addition of a senior emergency nurse practitioner to oversee and manage the minor injuries service, there remained little oversight of the service at divisional level.

The MIU was a part of the emergency care division, which also included the emergency department (ED) at the Watford General hospital and the urgent care centre (UCC) at Hemel Hempstead. The overall management of the division included a divisional director, divisional general manager, and divisional lead nurse. During the inspection we interviewed the senior emergency nurse practitioner and the lead nurse responsible for the MIU. A clinical lead had recently been appointed as part of their job plan to strengthen management, professional and clinical leadership of MIU and UTC, working with the senior emergency nurse practitioner.

Whilst staff reported the lead nurse was visible on occasions, they had not met with the divisional director; this was consistent with our findings from our previous inspection in 2017. Staff described the nursing leadership as being visible however there was an element of feeling isolated from the wider emergency care community at the trust. Staff working in the MIU were aware of the divisional governance meetings, however they were not clear on the outputs of the meeting. They could not describe what decisions had been made or what risks and issues were explored. A review of minutes of the governance meetings for emergency care confirmed varied attendance of the MIU senior emergency nurse practitioner, in part because they had been away on leave for a period of time.
The senior emergency nurse practitioner was aware of the challenges and risks associated with the service. However, there was a significant lack of insight in to how the risks were being addressed. For example, we explored the long-standing issue of the department having no formalised, timely triage process in place. The senior emergency nurse practitioner could describe the need for a band five nurse to be present during opening hours, who could assume the role of triage nurse. However, there was no clearly defined strategy or timescale for introducing the role. There had been no formalised review of the establishment to determine whether the additional role could be funded from existing departmental funds, or whether additional business cases were required to fund new roles.

There were limited development programmes in place for local leaders.

**Vision and strategy**

The vision and strategy for emergency services within the trust was not well established or widely known about amongst staff we interviewed.

Local commissioners were reported to be considering an uplift to the existing service provision offered within the minor injuries unit at St Albans City Hospital.

There was an ambitious drive to increase services in order the service could meet a wider range of clinical presentations including acute illnesses. Staff reported this level of service would be provided by the existing workforce. Some staff felt this was not possible without additional training and development. The senior emergency nurse practitioner was aware of the need to up-skill the workforce and was looking to rotate staff from the Hemel Hempstead Urgent Care Centre to support the department however plans remained very much at the provisional planning stage whilst commissioning decisions were finalised.

**Culture**

There was a commitment from the leadership team to resolve long standing cultural challenges within the department.

With the appointment of a new senior emergency nurse practitioner, the local leadership team were committed to addressing concerns within the department. This included improving the morale of the team, stabilising the workforce, addressing the basics with regards to reviewing the policies and procedures of the department and upskilling the workforce. This approach was acknowledged and well received by those members of staff we spoke with. There was a commitment from the leadership team to resolve long standing cultural challenges within the department. Staff sickness was amongst the highest across the emergency division. Whilst chronic health conditions and an ageing workforce was identified as being contributory factors to the high sickness rate, the senior emergency nurse practitioner was liaising with their local human resources partner to manage sickness within the team.

There was some anxiety amongst the workforce regarding the transition of services to more of an acute treatment centre. In part, the anxiety was linked to a need for individuals to be clinically upskilled. Contributory factors included a need to increase the operating hours of the department, to include all bank holidays; this was a new proposed way of working for the local team.

**Governance**

Whilst the emergency care division had formalised governance arrangements, representation of the Minor Injuries Unit was poor.

A review of governance meeting minutes reflected little or no discussion regarding the performance of the minor injuries unit.
The emergency care division integrated performance report made only one reference to the minor injuries unit; it appeared the only key performance indicators considered by the divisional team were linked to the four hour ED target, staff sickness, vacancy rates, number of incidents reported, complaints received, mandatory training completion rates and results from the friends and family test. Elements such as hand hygiene and cleaning scores were marked as not applicable. Whilst the integrated performance report considered elements such as accident and emergency clinical indicators (including time to initial assessment), there was no reference to the MIUs performance. It was therefore difficult to ascertain the level of oversight afforded to the delivery of quality services within the minor injuries unit.

The senior emergency nurse practitioner and lead nurse both acknowledged the need for greater oversight of governance within the MIU and UCC collectively. Whilst individuals had been given key roles to support the concept of governance, such as undertaking local audits, staffing challenges meant staff felt they did not have sufficient time to complete the audit programmes.

There was no scope or avenue to consider information in greater detail. There was no reference made to the performance of the minor injuries unit or the associated limited key performance indicators for the MIU within the governance meeting and so we were not assured sufficient focus was placed on considering quality in any significant detail. This was consistent with the result of conversations with staff. Band seven nursing staff had a high-level appreciation of quality issues within the department, however they lacked any significant understanding of the work underpinning any improvement plans.

There was a lack of recognition for the need for there to be a formalised audit programme. Audits were reactive as compared to being proactive. For example, the emergency care division had set two specific audits for the MIU for 2017/18. These included an audit to consider the time it took for an initial assessment for children waiting to be seen in the MIU and an audit of oversight of patients waiting to be seen in the MIU. There were no further audits suggested. In addition, there was lack of audit to determine the clinical making decisions of ENPs to ensure their practice was aligned to local and national best practice guidance. There had been no formalised programme for reviewing missed fractures to determine whether any individual required on-going support in the interpretation of x-rays. There was no formal review to determine whether local protocols were applied in practice; for example, there was no audit of care records to ensure early warning systems were consistently used for adults.

**Management of risk, issues and performance**

There was no effective process for identifying risks or plans to eliminate or reduce such risks.

The minor injuries unit had a risk register which contained one risk. This was a historical risk relating to the lack of skilled ENPs to manage children. The trust had worked with the ENP workforce and the children’s ED to manage this risk which was now graded as a risk of two. There was a lack of insight into wider risk management strategies. For example, there had been no consideration to the risks associated with the lack of initial timely triage and assessment at the front door of the MIU despite this being a cause for concern for local staff and the senior emergency nurse practitioner. Additionally, there was no consideration to the risks posed by relying on historical policies which were located in the department.

**Information management**

Information was of a poor quality with a reliance on manual processes to extract data; this was labour intensive and did not allow for real-time reporting. Information was not
considered holistically to enable the divisional management team to assess the safety and effectiveness of the service.

The trust had a number of information management technologies in use at the time of the inspection. The minor injuries unit had opted to use a system which was used almost exclusively within the trust, which meant that it did not interface with other trust systems. There was a reliance on using paper records which were initially stored locally for a period of twelve months and so could not be easily accessed by the wider health community within West Hertfordshire Hospitals NHS Trust. The lack of functionality of the IT system meant it was onerous for staff to undertake audits of patient activity as staff were required to manually review patient treatment cards.

**Engagement**

Little work had been undertaken by the department to assess the needs of the population it served.

There were questionnaires in the waiting and reception area of the unit asking patients to provide feedback about their experience at the MIU.

Patients, carers, and relatives were able to leave feedback using the trust’s public website.

Staff were invited to nominate colleagues for the monthly Celebrating Excellence Awards.

Whilst the main commissioner engaged with the wider community to determine the future needs of the population, little work had been undertaken by the department to assess the needs of the population it served.

**Learning, continuous improvement and innovation**

There was no active quality improvement strategy for the service at the time of the inspection.

Staff spoke about looking at different ways of working. However, we considered the team were inward looking with little consideration to new models of care. A lack of governance or corporate oversight meant service developments had not progressed. There was little in-sight amongst staff as to how they could make changes. Quality improvement models were an alien concept for the team.

Commissioners were seeking to extend clinical services at St Albans City Hospital however there had been no planning or review of staffing establishments and staff skill-sets to determine whether such an extension of services was feasible in the time-scale given. In part, this was because commissioners had not finalised a service specification to enable the trust to consider the full impact on staffing.