West Hertfordshire Hospitals NHS Trust
Evidence appendix
Trust Headquarters
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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

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. Overall, the population served by the trust is relatively affluent, but there are some areas of deprivation.

The trust also provides a range of more specialist services to a wider population, serving residents of North London, Bedfordshire, Buckinghamshire and East Hertfordshire.

As an employer of almost 5,000 people, the trust is one of the biggest employers in the area and sees nearly a million patients each year.

The trust has three sites:
- Watford General Hospital: The main acute site, which includes an accident and emergency department.
- Hemel Hempstead Hospital: Outpatient services with an urgent care centre and Simpson Ward which is a discharge to assess ward.
- St Albans City Hospital: An elective care centre with a minor injury unit.

In West Hertfordshire, local services cater for a changing population with complex health and care needs, which reflected the national picture and challenges described by the NHS Five Year Forward View. The trust's host commissioner, Herts Valley Clinical Commissioning Group (CCG) has developed Your Care, Your Future. This looks at how health and social care services can be provided more effectively in the future and can respond to ensure local people receive the right care at the right time and in the right place. As the CCG’s principle provider of acute healthcare services, the trust is committed and engaged with this process.

The trust is also an active contributor in the Hertfordshire and West Essex Sustainability and Transformation Plan (STP). The local STP shows how services across the area will evolve over the next five years in delivering better local health and social care services, including prevention, in an efficient and sustainable way.

The trust is actively involved and either leads or is a partner in multi provider single pathways for diabetes and gynaecology. Open market tendering by the CCG for a range of services including ophthalmology, ear, nose and throat (ENT) and dermatology will see further key provider changes for local care similar to those seen by the re-provision of community musculoskeletal care.

(Source: Trust website; Routine Provider Information Request – Acute context tab)
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 executive and non-executive directors, and spoke with senior managers across the hospital. We met and talked with a wide range of people to ask their views on the leadership and governance of the trust. Over the previous 12 months, we have observed board meetings and risk review group meetings. We looked at a variety 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

The trust board had the appropriate range of skills, knowledge and experience to perform its role. The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience. The leadership team had an appropriate level of operational and financial experience and expertise and good oversight of the operational and financial pressures within the trust. The board was largely stable with some changes since our last inspection in November 2018. The chairman had been recruited to an interim post in March 2019, however was familiar with the trust following five years in the vice chair role and eight years as a non-executive director before that. The chief executive officer (CEO) had been substantively recruited at the time of our last inspection. The other changes to the board included the recruitment of an associate non-executive director (ANED) and chief information officer (CIO) in 2019.

The trust was managed overall by a trust board consisting of non-executive (NED) and executive directors as set out below:

- Chairman - interim post since March 2019
- Chief executive officer (CEO), substantive since March 2019.
- Chief medical officer (CMO), appointed 2013, having worked in the trust since 2000.
- Chief nursing officer (CNO), appointed 2014
- Chief operating officer (COO), appointed April 2016, having worked in the trust since 2015.
- Chief financial officer, appointed 2014.
- Chief people officer appointed in May 2015.
- Chief information officer, and senior information risk officer, appointed in 2019.
- Deputy chief executive.
- Four non-executive directors who had been in post for four to eight years.
- One associate non-executive director, in post since 2019.
- Divisional directors of medicine and surgery, anaesthetics and cancer.
- Director of environment appointed in December 2017.
- Director of Strategy (interim) appointed in June 2018.
- Director of communications appointed in April 2016.
- Director of integrated care, appointed January 2017.
- Director of performance, appointed March 2015

Of the executive board members at the trust, 20% were Black and minority ethnic (BME) and 60% were female as of November 2019.
Of the non-executive board members, 16.7% were BME and 33.3% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME%</th>
<th>Female%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>20.0%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>16.7%</td>
<td>33.3%</td>
</tr>
<tr>
<td>All board members</td>
<td>18.2%</td>
<td>45.5%</td>
</tr>
</tbody>
</table>

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

The trust operated a clinically led model of leadership at divisional level which encouraged local decision making and collaboration between medical, clinical and managerial staff.

Clinical leadership was provided through individual divisions according to the speciality. Since our last inspection the divisional structure had changed. The trust now had five directorates:

- Surgery, Anaesthetics and Cancer
- Clinical Support
- Women’s and Children’s
- Emergency Medicine
- Medicine

Divisional leadership consisted of a divisional director, supported by a head of nursing, a divisional manager, speciality leads and business partners from finance and human resources. Divisional directors were line managed by the chief operating officer with professional accountability to the chief medical officer. Divisional directors were positive about their relationship with the board and felt that their position on the trust board helped to focus on clinical quality. There was evidence that this change in divisional leadership was having a positive impact on service delivery in some areas. For example, the multi-disciplinary approach to the management of patients attending the accident and emergency department as highlighted in the urgent and emergency care core service report.

Leaders understood the challenges to quality and sustainability and could identify actions needed to address them. All leaders were familiar with the challenges faced by the trust and there was clear understanding on how the trust was going to address the challenges and what were the priorities. For example, the trust had received funding in October 2019 to address the significant estates and infrastructure that have also been reported on in previous CQC reports. The trust was working with all relevant stakeholders to ensure that any future build and potential pathway reconfiguration was designed and developed in line with system wide sustainability plans. However, in the meantime whilst plans were being developed the board acknowledged the need to continue to make essential changes. For example, high cost equipment replacement plan, rebuild of the theatres and the introduction of an urgent care centre at the Watford General Hospital site.

The trust leadership team had a comprehensive knowledge of current priorities and challenges across all sectors and took action to address them. For example, the trust was continuing to work with partners in the STP to improve mental health care provision and develop new pathways. Members of the safeguarding team were working jointly with the specialist police teams, local authorities and other services to improve access to healthcare for vulnerable groups such as victims of modern slavery. The board had started to develop a quality improvement (QI) approach to manage challenges and projects which had been trialled in specific areas with success. The board were using the QI methodology to enable teams to focus on the overall improvements to ensure that they were both effective and sustainable. There was an understanding that the QI approach was immature, however, there was a consistent feeling that this was the right approach.
Leaders understood the unique qualities and needs of their team. Our interviews with leaders at all levels confirmed that leaders had a shared vision which was based on the trust’s priority for ensuring patients received the best care every day. Leaders worked collectively and supported and offered constructive challenge when necessary. Changes to the leadership team had resulted in a shift in accountability where individuals were beginning to be held to account for their performance. Staff were clear that there had been a change in culture over the last 18 months. The non-executive directors (NEDs) and executive directors spoke positively about their working relationship. The board met formally once per month, although all acknowledged regular/frequent contact. Directors described positive challenges from the NEDs and felt that the level of challenge was appropriate.

The trust reviewed leadership capacity and capability on an ongoing basis. Senior leaders were clear that staff capacity and capability was reviewed regularly. Leadership development opportunities were available, including opportunities for staff at all levels. There was clear consideration of staff development into management roles. When senior leadership vacancies arose the recruitment team reviewed capacity and capability needs. Within the board, the chair had made the decision to include associate non-executive director in the board to offer development opportunities to the individual and for succession planning. Executive directors were supported to complete leadership and development programmes where appropriate as part of their own professional development and career planning. Across the trust, there had been a focus on developing ward managers and matrons. This had given staff the support network to develop skills and share experiences. Succession planning was now in place throughout the trust.

Leaders were visible and all were described as approachable. There was now a formal programme for visits to wards, departments on all the trust’s sites, by individual board members. Staff we spoke with were positive about the leadership team, describing them as approachable, knowledgeable and inclusive. During the core service inspections, we were given examples of where leaders had visited clinical areas out of normal working hours and staff had viewed this as being above the normal. There was a programme of board visits to services and staff fed back that leaders were visible and approachable. The executive and non-executive directors regularly attended clinical areas prior to board meetings. Small groups of board members would visit several clinical areas to speak to patients and staff. All board members we spoke with reported that this enabled an understanding of the pressures experienced in clinical areas and the type of care being provided. On return to the board meeting, the team gave an update on what they had seen, experienced and what staff and patients had fed back to them. Board meetings were held at all sites which enabled the board to visit clinical areas outside the main Watford general hospital site.

There were trust wide leads for learning disabilities, dementia, safeguarding and mental health. We saw that although individuals worked in these specific lead roles, responsibility was held by one of the directors. For example, the chief nursing officer was the named lead for safeguarding. There was not a flagging system for patients with dementia, however, any patient flagged as having a cognitive impairment had a dementia form completed which was uploaded onto a database. This was accessed daily by the dementia team to identify those patients that had been admitted to hospital with a potential diagnosis. There was a trust wide flagging system for patients with learning disabilities. This was maintained by the safeguarding team and updated every three months. When a patient was admitted to hospital, or attends a department, there was an automatic alert to inform the staff member of them being on the register. This enables staff to ensure that they can make any reasonable adjustments to their care.

**Fit and proper person Requirement**

Fit and Proper Person checks were in place. 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 a fit and proper person checklist in place which was used for 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.

We reviewed six 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**

**There was a clear vision and strategy for what the trust wanted to achieve and a workable plan to turn it into action. This was developed with involvement from staff, patients, key groups representing the community. The vision and strategy were embedded across the organisation.**

The trust had a clear vision and set of values with quality and sustainability as the top priorities. The trust vision was for ‘the very best care for every patient, every day’. This was supported by four main aims:

- **Best care** - reflects our vision: the very best care for every patient, every day.
- **Great team** - recognises the importance of career development, staff morale and team work.
- **Great place** - reflects our ambition to provide better buildings and also better IT.
- **Best value** - recognises the need to make the very best use of every NHS pound.

The trust vision and aims were clearly displayed across all areas as a colourful poster. Staff had been involved in the development of the vision, having completed several events where staff could give suggestions and opinions on the vision and aims. Staff we spoke with were familiar with the vision and felt that it accurately represented the trust.

There was a robust and realistic strategy for achieving trust priorities and developing good quality, sustainable care. The trust had just launched its strategy for 2020 to 2025. This was clearly aligned to the trust vision and aims. Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. The trust had encouraged feedback from patient users, GPs and community healthcare providers to identify the main areas for focus. Local providers and people who use services had been involved in developing the strategy.

Staff knew and understood the trust’s vision, values and strategy and how achievement of these applied to the work of their team. The wider team had been involved with the development of the strategy and there was a sense of ownership across clinical teams. Clinical leads told us that the strategy reflected the aims of the organisation and accurately reflected the wider objectives with regards to developing services and redeveloping the site. Staff were using the strategy to give clear guidance on how they should work.

The trust embedded its vision, values and strategy in corporate information received by staff. Staff were familiar with the trusts vision although the strategy had only recently been launched. There were clear plans to measure progress against the trust strategy through quality improvement. Each aim was divided into themes which were the responsibility of suitable committees. For
example, best care was divided into the themes of Quality improvement programme, integrated care, partnership/ service development and access improvement programme. The quality committee was responsible for ensuring the delivery of the quality improvement programme and the integrated care, partnership/ service development themes.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans.

The trust had planned services to take into account the needs of the local population. The trust were familiar with the future pressures within healthcare and knew that there was a need to address some concerns now in order to improve delivery of services in the future. The trust had a robust plan for the development of the site and the rebuild of parts of the hospital. This plan was the incentive to review and amend future services to ensure that the trust was able to meet the capacity and demands of healthcare in coming years. This included the involvement of community providers and the wider sustainability transformation plans. When discussing the plans for the trust, there was a cohesive understanding by all senior leaders and a recognition that the strategy and aims would not be achieved independently.

The trust had a strategy for meeting the needs of patients with a mental health, learning disability, autism or dementia diagnosis. The trust was working collaboratively with partners in the STP in the different areas. The majority of this work was being led by the divisions with support at trust wide and executive level. For example, the emergency medicine division was leading on the mental health strategy as the emergency department was normally the first point of contact for patients in mental health crisis. A multi-disciplinary health and social care professional team from the STP met on a monthly basis. The mental health trust with an onsite team for adults and children attending the hospital in need of mental health support. The mental health team worked 24 hours per day and were responsive to needs. Staff across the hospital told us that there was effective partnership working. The mental health team were responsive to calls for help and they reported that staff sis not refer patients inappropriately and therefore they were confident that staff had a good understanding of the roles and responsibilities of the team. There was a clear pathway outlined for the management of children (under 16 year olds) who presented with a mental health issue. This outlined escalation processes and timelines of responses.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The leaders worked hard to promote equality and diversity in daily work and provided opportunities for career development. The trust had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt respected, supported and valued. Staff we spoke with felt positive and proud to work for the organisation. We saw improvements in the culture, although during our inspection we were made aware that some concerns had been flagged to the trust in relation to maternity services. The trust was open about the concerns raised and acted in a timely manner to assess the concerns and support staff within the department.

The trust’s strategy, vision and values underpinned a culture which was patient centred. It was clear that the vision and strategy was focused on the patient and culture. Each aim included key cultural traits such as listen, communicate, be kind and speak up. The patient was identified as the centre of the vision.

Staff felt positive and proud about working for the trust and their team. The positivity of staff had significantly improved since our last inspection. Staff were positive about their work, took ownership of their work and wanted to share their experiences with the inspection team. On
reflection, senior leaders felt that staff engagement had improved over the last 18 months. This was felt to be in response to the engagement work completed. The impact of the shift in culture had resulted in a reduced vacancy rate, particularly for junior nursing staff.

The trust recognised staff success by staff awards and through feedback. The senior leaders were proud of the wider teams’ achievements since our last inspection. The trust had been named “best UK employer of the year” by the Nursing Times, the safeguarding team had won the NHS parliamentary awards in 2019 for their joint work with the police regarding sex trafficking. Internally the trust had introduced a ‘stars of Herts’ award scheme to recognise individuals or teams across the trust.

The trust worked appropriately with trade unions.

Managers addressed poor staff performance where needed. Leaders were clear that poor performance was addressed where necessary following the relevant policy. Directors were confident that behaviour that was not in line with the trusts vision was challenged at all levels. The culture encouraged openness and honesty at all levels, including people using the service.

**Freedom to Speak Up Guardian**

The trust had appointed a Freedom to Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns. 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 addition to the FTSG the trust were in the process of appointing a lead who would work trust wide.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. Staff were aware of the FTSG and knew how 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 FTSG reported that there was a small number of calls however, these tended to be complex in nature.

Trust data showed that there had been 20 whistleblowing cases from September 2018 to September 2019. Breakdown of the data showed that 12 of these related to the behaviours of management, four were linked to bullying and harassment and four were safety concerns. Actions taken by the trust included working with individuals to improve working relationships, mediation, monitoring and supervision of clinical practice and formal meetings. The trust confirmed that all cases were managed informally and did not require changes to clinical practice.

The local guardian met regularly with the head of employee relations and shared information obtained from the National Guardian Office.

The FTSG had recruited 20 freedom to speak up champions who worked across all clinical and non-clinical areas and all sites. These individuals acted as a local link for staff. Training was provided and clear guidance on their roles and responsibilities. The FTSG was clear of the roles and responsibilities of the champions and they were supported to make decisions, escalate concerns and manage any concerns raised with them. Some of the champions attended a board meeting to discuss their roles and why they had chosen to take on the additional role.
The handling of concerns raised by staff always met with best practice. The FTSG and champions managed any concerns in line with local policy. Where necessary, concerns were escalated to the human resources team or board members. We were told that the chief nursing officer was the usual link, and that they took concerns raised seriously acting as soon as possible. There was a clear process for managing concerns.

Staff felt able to raise concerns without fear of retribution. Staff we spoke with told us that they felt that they could discuss concerns with either their line managers or with the FTSG.

The trust applied Duty of Candour appropriately. The culture encouraged openness and honesty at all levels within the organisation. This included openness with people who used services, and 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. The policy was clear, appropriate and reflected the requirements of the regulation. 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 had 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. Senior clinicians involved at the time of the incident were responsible for duty of candour and consultants or matrons were responsible for maintaining contact with the patient or their relatives. We saw that the trust recorded when duty of candour had been applied. All staff understood the importance of staff being able to raise concerns without fear of retribution and all staff told us they would be happy to raise concerns.

The trust took appropriate learning and action as a result of concerns raised. The FTSG had a small number of cases (between 8-13 per year), however, it was clear that learning had taken place in response to concerns raised. Staff had raised concerns regarding maternity services and in response an external review was requested, and staff were supported through the process.

All staff had the opportunity to discuss their learning and career development needs at appraisal. This was an improvement from our previous inspection. As of October 2019 data supplied by the trust showed that 90% of all staff had an annual appraisal. Appraisals were mostly completed and aligned to professional registrations. Staff had meaningful conversations with their line managers about career developments and opportunities. Directors told us that they had clear objectives and were supported in achieving them. Where necessary staff were supported to attend external training or courses that supported development needs. We also saw that directors met with peers from other organisations to discuss development as well as performance.

Staff had access to support for their own physical and emotional health needs through occupational health. The trust had a package of health and wellbeing initiatives available to staff which included workshops, classes, and health MOTs. The occupational health service provided a fast track physiotherapy assessment scheme to promote ongoing fitness as well as supporting staff returning to work. 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 was a focus of the trust and during the Covid-19 pandemic additional support was provided through pastoral services and debriefing sessions.

Teams had positive relationships, worked well together and addressed any conflict appropriately. Across all areas we saw that teams worked collaboratively. Staff were respectful and listened to
their colleagues. Directors told us that collaborative working had improved with the implementation of the quality improvement methodology for development. This process enabled staff to voiced ideas and thoughts on how services could be improved. This had led to clinicians looking at improvements that could be made to either individual areas or larger patient pathways working collaboratively with external teams.

**NHS Staff Survey 2019 results – Summary scores**

The trust had an improved response to the 2018 staff survey with 44% of staff responding to the survey, in comparison to 45% for the sector. This was improved from the previous year when the response rate was 41%. Directors felt that this showed much better levels of engagement. The Trust increased the overall staff engagement score from 6.93 in 2017 to 7.02 in 2018 and the trust was in the 20 trusts for staff survey results.

The following illustration shows how this provider compares with other similar providers on 11 key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.

The trust’s 2019 scores for all 11 themes were not significantly different when compared to the 2018 survey.

(Source: NHS Staff Survey 2019)
Although the trust saw some improvement in the staff survey, they identified key areas which required additional work. For example, the trust scored less well for advocacy (although an improvement on our 2017 score) which detail the Friends and Family questions about recommending the organisation as a place to work and receive treatment. Recommending the trust as a place to work was the same as the sector. Recommending the trust as a place to receive care had improved from 56% to 59%, although this remained lower than the sector score (68%). This therefore lowered our overall engagement score despite significant improvements in many other areas.

**Staff Diversity**

**Equality and diversity was promoted within the organisation.**

The trust embedded equality and diversity values into its policies and procedures. Board assurance was obtained by the monitoring and reporting on equality objectives, patient and workforce information and via equality impact assessments. Each policy contained a completed equality impact assessment which enabled the trust to evaluate and set actions in response to their obligations.

The executive lead for equality and diversity was the chief people officer. The chief finance officer also had an active role in BME activity across the trust. Our interviews with staff at all levels demonstrated that there was an emphasis on ensuring that the trust was inclusive.

As of December 2019, West Hertfordshire Hospitals NHS Trust employed 5,038 people, of which 36.8% were from Black Minority and Ethnic Communities. (Source: Routine Provider Information Request (RPIR) – P6 WRES reporting document).

The trust provided the following breakdowns of staff by banding and ethnic group as of 2018/19.

<table>
<thead>
<tr>
<th>Banding</th>
<th>BME</th>
<th>White</th>
<th>Undefined ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1</td>
<td>55.6%</td>
<td>44.4%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Band 2</td>
<td>40.2%</td>
<td>53.5%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Band 3</td>
<td>28.9%</td>
<td>62.1%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Band 4</td>
<td>23.4%</td>
<td>70.9%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Band 5</td>
<td>49.2%</td>
<td>41.3%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Band 6</td>
<td>32.1%</td>
<td>60.3%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Band 7</td>
<td>25.3%</td>
<td>69.3%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Band 8</td>
<td>22.9%</td>
<td>70.5%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Band 9</td>
<td>16.7%</td>
<td>83.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Consultant</td>
<td>48.3%</td>
<td>40.0%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Director - Trust board</td>
<td>9.1%</td>
<td>90.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Non-executive</td>
<td>0.0%</td>
<td>100.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other medic</td>
<td>56.5%</td>
<td>25.8%</td>
<td>17.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36.8%</strong></td>
<td><strong>54.8%</strong></td>
<td><strong>8.4%</strong></td>
</tr>
</tbody>
</table>

*(Source: Trust Workforce Race Equality Standard (WRES) report, 2018/19)*
Data from the staff survey is also monitored against protected characteristics and is highlighted within the Workforce Race and Disability Equality Standard action plans. The trust told us that the rights and obligation of each staff member is clearly outlined to promote equality to all employees irrespective of their role, hours of contract or whether they held a substantive post or not.

Staff were expected to outline whether any “new physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more’ had been acquired during the appraisal process. This was to help managers to identify if any adjustments were required to help staff with a disability perform their jobs.

**Workforce race equality standard (WRES)**

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:
- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts’ circumstances.
As of March 2019, two of the four ESR staffing indicators shown above (indicators 1a and 2) showed a statistically significant difference in score between White and BME staff:

1a. In 2019, BME candidates were significantly less likely than White candidates to hold senior (band 8+) clinical roles. The proportion of BME staff remained similar to the previous year, 2018.

2. In 2019, BME candidates were significantly less likely than White candidates to get jobs for which they had been shortlisted. The proportion for BME staff had significantly decreased by 6.9 percentage points compared to the previous year, 2018.

Of the four indicators from the NHS staff survey 2019 shown above (indicator 5 to 8), the following indicators showed a statistically significant difference in score between White and BME staff:

5. A significantly higher proportion of BME staff experienced harassment, bullying or abuse from patients, relatives and the public in the past year when compared to White staff. The proportion of BME staff remained similar to the previous year, 2018.

7. A significantly lower proportion of BME staff believed that the trust provided equal opportunities for career progression and promotion when compared to White staff. The proportion of BME staff remained similar to the previous year, 2018.

8. A significantly higher proportion of BME staff experienced discrimination from a colleague or manager in the past year compared to White staff. The proportion of BME staff remained similar to the previous year, 2018.
As of March 2019, there was one BME voting Board Member at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff.

(Source: NHS Staff Survey 2019; NHS England)

The Workforce Race Equality Standard Report 2018/19 was presented to the board in September 2019 and clearly states the actions taken by the trust in response to results from the Workforce Race Equality Standards from March 2019. The report focused on the ESR staffing indicators detailed above. Results for these indicators showed that BME staff were not as likely to hold senior positions (although this had improved), less likely to be shortlisted for posts, more likely to enter a formal disciplinary and less likely to access training or professional development. There was one director on the board from a BME background, which was not representative of the workforce or local population. The trust had developed plans to address all of these areas and actions were clearly outlined in the board report. For example, the trust held discussions with BME staff to discuss their experiences with recruitment to help identify any themes, the trust were also supporting national initiatives for BME career development and quarterly newsletters specifically to BME staff to encourage engagement and promote awareness of development and progression. During our core service inspections, staff told us they felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression.

There were four areas of improvement in the staff survey. There had been a reduction in the percentage of staff experiencing bullying and harassment with 31.4% BME staff reporting experience of harassment, bullying or abuse from patients, relatives or the public in the last 12 months. This was higher than the benchmark of 29.8% and the previous year’s results. Bullying and harassment from staff had improved (27% compared to benchmark of 29%), as had the percentage of people believing that the organisation provided equal opportunities for career progression or promotion (74% compared to 70% in 2017). The last indicator to show an improvement was the percentage of staff who experienced discrimination.

Staff networks were in place to promote the diversity of staff.

Friends and Family test

Carers, parents, guardians and named relatives were asked to provide feedback on their experiences through the friends and family test (FFT). Patients with a learning disability who were unable to complete the survey were supported to do this either by local staff or the mental health team. The anonymised surveys were available in all clinical areas and collected/collated on a weekly basis and reported nationally monthly.

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 93.0% and 96.5% from December 2017 to November 2019.

The data showed a downward shift from September 2018 to July 2019, although this did not continue.

Two data points (May and June 2019) were outside of the control limits.

West Hertfordshire Hospitals NHS Trust – recommendation rates, December 2017 to November 2019
The chart below shows the response rates at the trust from December 2017 to November 2019.

**West Hertfordshire Hospitals NHS Trust – response rates, December 2017 to November 2019**

(Source: Friends and Family Test)

The results of the FFT were shared with the patient experience group and escalated to the executive team as necessary. This process enabled the patient experience group to focus on any areas where issues were identified and then offer suggestions to the executive team for actions. An example of this was concerns were flagged regarding the standardisation of bathroom and toilet doors to improve the experience for patients with cognitive funding. This issue has been flagged to the executive team and is currently awaiting funding approval.

**Sickness absence rates**
Sickness and absence figures were not outliers. The trusts overall sickness rate was 3.5% for November 2018 to November 2019. This was in line with trust targets.
The trust’s sickness absence levels from October 2018 to September 2019 were consistently lower than the England averages.

![Graph showing sickness absence levels from October 2018 to September 2019](Image)

(Source: NHS Digital)

**General Medical Council- National Training Scheme Survey**

In the 2019 General Medical Council Survey the trust performed worse than expected for one indicator (curriculum coverage) and the same as expected for the remaining 17 indicators.

(Source: General Medical Council National Training Scheme Survey)

**Training Data Summary – trust wide**

Staff told us that training was easily accessible and that they were supported to complete it. Managers kept track of training needs and ensured that staff were booked on training before it expired. Staff completed training according to their role and their responsibility. Training compliance was reviewed at all divisional and trust board meetings and directorate leads were held to account for compliance, and if necessary, outline improvement plans.

The trust set a target of 90% for completion of mandatory training. The compliance for mandatory training modules from April to October 2019 was 92.5% at trust level. Of the training modules provided, 14 achieved compliance and two failed to reach the trust target of 90%.

The overall training compliance for mandatory training reported at the trust during this inspection was higher than the 88.5% reported in the previous year. No modules failed to score above the CQC recommended minimum threshold of 75%.

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

**Guardian of Safe working**

The trust had a ‘Guardian of Safe Working Hours’. The guardian of safe working was introduced by the NHS to protect patients and doctors by ensuring doctors were not working unsafe hours,
(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. Board papers showed that doctors’ hours were reported quarterly. The guardian held focus groups for junior doctors, where concerns were discussed. We were given examples of where issues had been flagged by a junior doctor and action was taken in response. This included changes to staffing levels and responsibilities out of hours. We heard that the trust board were responsive to any concerns raised and acted immediately to reduce any risks.

**Governance**

There were 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.

All levels of governance and management functioned effectively and interacted with each other appropriately. Each speciality, division and directorate followed the same governance structure. There were designated governance leads affiliated to each division who helped to coordinate meetings, reviews and risk responses. These were then fed into the next tier of governance which was a system of steering groups, sub-committees and committees until reaching the board for assurance. This meant that there was complete oversight of governance from ward to board.

The trust’s governance committee structure was well established. Committees had clear roles and responsibilities and were developed to provide the board with appropriate assurance. The accountability of each committee and individual’s roles at all levels was clear. The trust board met monthly and six main committees fed directly into the board which were chaired by the NEDs. These were:

- Audit committee
- Remuneration committee
- Charity committee
- Finance and performance committee
- Quality committee
- People, Education and research committee

Feeding into these six main committees was the trust management committee. This was the central point for all groups to feed into. The groups that fed into the trust management committee included risk review group, patient experience group, quality and safety group, elective care programme board, environmental steering group, divisional performance reviews, patient flow transformation board, medicine management group, surgery, anaesthetics and cancer management group, clinical support management group, women’s and children’s management group and the emergency medicine management group. These groups met regularly to provide scrutiny and ensure delivery of the trusts aims and objectives, whereby the committees were designed to ensure assurance to the board of compliance with the board plans and inform of performance. The frequency of meetings depended on the topic, for example, audit and charity meetings were held quarterly, remuneration, quality committee and finance and performance committee are held monthly, people, education and research committee is bi-monthly

At the time of our inspection, the trust had an acute redevelopment programme board which was responsible for the monitoring the transformation plans and reported directly to the board.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom.
Information reported through governance was reliable, although due to IT infrastructure difficulties, processes for capturing information were not always easy or robust. For example, we were given two accounts for how triage data was captured at Hemel Hempstead hospital. One report was that data was pulled off the electronic system, whilst we were also told that the data was collected manually. The board recognised that IT was one of their biggest risks and had invested considerably in improving the infrastructure and systems across all sites. This risk remained on the trust wide risk register and was cited by all directors as one of the biggest concerns. There was a robust IT development plan which was aligned to the trust strategy and rebuild. There had been an investment in the infrastructure and teams had seen some improvements in accessibility, however it remained a significant issue and we were given examples of IT causing delays in accessing patient records. Despite this, directors felt assured that information was accurate and reflected what was happening trust wide. The board used dashboards to inform decision making and monitor performance. Each division attended monthly performance meetings where dashboards were reviewed and leads were asked to confirm positions against targets, and how the targets would be met. This included the review of performance against complaints and target outliers, for example referral to treatment times.

Learning from deaths

There was an established process for mortality reviews and learning from deaths. Monthly specialty/departmental mortality review meetings were held, and cases 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 July 2018 to June 2019) was 0.99 and ‘as expected’. For the 12-month period (July 2018 to June 2019), the trust’s overall HSMR of 102.11 was in the ‘as expected’ range. Both the SHMI and HSMR were on a gradual upward trajectory following a sustained period of being ‘lower than expected’.

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.

The aim of the SJR was to review the death that required further scrutiny, within 15 working days of receipt of the medical record by the reviewer. The SJR review is a validated Royal College of Physicians methodology completed by specifically trained staff. Reviews that indicated suboptimal care, deaths which had been the subject of a serious incident or a complaint were independently reviewed at the level 2 tier panel. The multidisciplinary panel determined the potential avoidability of the death. We saw that the board had oversight of SJRs, and teams were encouraged to use the review process for all serious incidents not just those that had resulted in a death. This process enabled triangulation of information.

There was a partnership arrangement for the provision of psychiatric liaison services and a service level agreement in place. Mental health liaison meetings were scheduled for every three months; however, we saw that operational pressures sometimes impacted on the ability to complete these. Despite this, directors told us that there was regular contact between the trust and the mental health provider. There was also a multi-agency high intensity user team who met every two weeks to discuss the appropriate approach to manage frequent users of the service. This was chaired by a consultant psychologist.

We spoke with a selection of staff who worked for both West Hertfordshire Hospitals NHS Trust and the mental health trust who told us that there were clear arrangements to manage patients presenting at the hospital with mental health needs. Teams were co-located and responded within
one hour of referrals. Referrals were appropriate and when ongoing or acute mental health needs were identified, patients were swiftly relocated to appropriate clinical areas. The trusts met regularly to discuss pathways. We were given examples of where the trust had acted swiftly to meet the mental health needs of patients requiring supervision in the accident and emergency department. The mental health trust had provided some guidance on the equipment needs of the mental health room and the suggestions had been agreed and implemented without any discussions or reference to costs.

**Board Assurance Framework**

The trust provided their Board Assurance Framework 2019/20, which details 12 strategic objectives and the accompanying risks within each, as of November 2019. The strategic objectives were:

1. To deliver excellent clinical outcomes for the trust's patients
   - mortality
   - harm free care
2. To implement best practice, integrated care pathways and reduce unwarranted clinical variation in care and outcomes
3. To implement and embed the trust’s 'quality commitment' and 'West Herts way' quality improvement methodology
4. To improve patient experience and the responsiveness of the trust's services
5. To further develop the trust's participation in research and development
6. To have happy, healthy, well supported staff who feel able to deliver great care and 'make a difference' in an inclusive environment and to be a clinically led organisation
7. To reduce vacancy rates and reduce the trust's reliance on agency workers
8. To become an excellent organisation for employee development
9. To deliver best value care
10. To improve the trust’s IT and move towards full digitalisation
11. To work with local stakeholders and partner organisations to identify where, by working together, the trust can improve care for its patients
12. To improve the quality of the trust’s estate and implement its service driven estates strategy

(Source: Trust Board Assurance Framework 2019/20, as of November 2019)

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff at all levels contributed to decision-making to help avoid financial pressures compromising the quality of care.

Robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Risks were recorded on a risk register and reviewed regularly. Each division had a process for reviewing risks and there was a trust wide meeting to discuss risks and what actions had been taken to address them. Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. When risks were identified as within a clinical environment, they were recorded along with the mitigating actions to reduce the risks or harm. These were escalated according to the level of risk or harm. The trust board had sight of the most significant risks and mitigating actions were clear. Those risks identified with a risk score greater than 12 were reviewed by the trust. We saw that risks were discussed in detail and staff were held to account for actions being taken to address them.
Recorded risks were aligned with what staff said were on their ‘worry list’. Directors told us that the main risks were staffing, IT infrastructure and the estate. This was consistent across all directors and non-executive directors. Staff concerns matched those on the risk register. Staff we spoke to across the trust had similar ideas of the risks, mostly referring to staffing levels.

**Trust corporate risk register**

The trust provided a document detailing their 25 highest profile corporate risks. Each of these had a current risk score of 15 or higher, as of November 2019. Below are the details of the four risks which had a risk score of 20 (out of 25):

<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>01/10/2018</td>
<td>4082</td>
<td>Potential shortage of spare parts to repair acute admissions unit CT scanner impacting on patient care Information and communications technology (ICT) applications reduced availability, poor reliability and performance</td>
<td>20</td>
<td>4</td>
<td>30/11/2019</td>
</tr>
<tr>
<td>12/06/2017</td>
<td>3894</td>
<td>Information and communications technology (ICT) applications reduced availability, poor reliability and performance</td>
<td>20</td>
<td>6</td>
<td>29/11/2019</td>
</tr>
<tr>
<td>12/06/2017</td>
<td>3899</td>
<td>ICT trust bleep system</td>
<td>20</td>
<td>5</td>
<td>29/11/2019</td>
</tr>
<tr>
<td>09/07/2014</td>
<td>3120</td>
<td>Lack of storage facility for patient medical notes leading to missing, poor condition and delayed location</td>
<td>20</td>
<td>6</td>
<td>10/10/2019</td>
</tr>
</tbody>
</table>

(Source: Trust Corporate Risk Register, November 2019)

The risk register was reviewed every month and we saw that changes were clearly recorded. For example, additions and removals from the register along with clear justification or mitigation.

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The governance team regularly reviewed the systems. Incidents were reported through the electronic report system. All the staff we spoke with were confident in how to report an incident and there was ongoing training and support for staff, including managers who were responsible for handling incidents.

Any potential serious incidents were discussed at review panel that met three times per week. This panel was chaired by either the chief medical officer, the chief nursing officer or the deputy chief nurse. The composition of the panel changed depending on the type of the incident. Minutes from these meetings showed that there were robust discussions and challenge around incidents. Incidents were reported 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. Trust data showed 26 serious incidents across all services from November 2018 to November 2019. Four of these were associated with an unexpected death.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance. The trust were working collaboratively with local partners looking at improving patient pathways and experiences. The trust had held patient focus groups and were in the process of liaising with local health partners to identify areas for development. Specialities were working collaboratively and where appropriate were sharing staff and knowledge to improve services. We were given an
example where a consultant was working across two acute hospitals to provide similar services and access to specialities for the local population. All changes were being completed in line with the trust strategy. Leads were responsible for aligning any trust developments using the quality improvement methodology and the board ensured that it was aligned appropriately though regular review meetings. The strategy gave the board a framework to ensure that performance was managed and reviewed on a regular basis. Referral to treatment times (RTT) and cancer waiting times were a focal point at various performance and quality meetings. Our interviews with senior leaders including the chief operating officer demonstrated that there was a trust wide plan to improve RTT. Performance was reviewed against an agreed trajectory and data available at the time of our well-led inspection showed that there was some improvement.

There was a systematic approach to clinical audit to monitor quality, operational and financial processes, and systems to identify where actions should be taken. There was an audit calendar which included clinical and non-clinical audits. Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed. Audits were generally completed at all levels and then results reported and reviewed. Within specialty and divisional meetings audits were reviewed for themes and trends. The audit committee had oversight of all audits and audits were reported monthly to the trust executive committee. Where audits were not being consistently conducted (for example, the minor injuries unit) leaders were developing plans to address this and we saw some improvements at the urgent care centre.

There were plans in place for emergencies and other unexpected or expected events. For example, adverse weather, a flu outbreak or a disruption to business continuity. At the time of our core service inspections, the trust had commenced emergency planning to manage the Covid-19 outbreak. We saw that there were robust, well-rehearsed plans to manage the current pandemic situation for patients and the public attending hospital during the coronavirus Covid-19 outbreak. For example, the accident and emergency department and inpatient areas had been split into two key areas, one for suspected/infected patients and another for patients who did not display any signs of infection. This meant that there was duplication of services within the accident and emergency department, however ensured patient and staff safety. The plans had been implemented fully supported by all staff within a very short period. Directors felt that the success of the change had been the result of the recent changes to the accident and emergency pathways which encouraged speciality consultants to be based in the department already.

Where cost improvements were taking place there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. Quality assessments were routinely completed prior to any changes, or cost improvements. Clinical leads emphasised that their role on the board was to ensure that patient care remained the focus of the board. All board members spoken with agreed that the quality of patient care was the key focus. Where cost improvements were taking place, they did not compromise patient care. All staff felt that there had been no occasions where quality had been compromised by financial pressures. Non-voting clinical directors attended the trust’s board and voting directors commented that this was a positive step to ensuring a focus on quality and patient care.

**Finances Overview**

The trust was in a challenging financial position with a continued deficit in 2019/2020. Board members were confident that the financial plan would be delivered.

Board members we spoke with had a good understanding of the trusts financial position and knew the plans for recovery. Trust data showed that at month 6 the trust had delivered its planned deficit of £2.14m in-month, with the year to date (YTD) deficit of £17.8m also on-plan. Total income was £161.4m compared to a plan for £162.8m. The shortfall largely due to reduced spend on high cost drugs and devices. Pay costs (at month 6) totalled £22.17m compared to the
plan to spend £21.54m. The overspend was due to medical and nursing staff costs being higher than expected due to emergency activity and costs of 1:1 nursing and training newly recruited nursing staff. The non-pay position showed an underspend of £471k in month.

The trust expected to meet its revenue Control Total of a deficit of £22.7m and the cost improvement programme (CIP) target of £15.0m.

The trust’s capital programme relied on £8.2m of previously approved loans, an emergency capital bid of £4.8m and a £1m energy efficiency loan to top up £7m of internally generated funds. The trust expects to spend £21m on new and replacement assets including improvements for winter, fire safety, enabling refurbishment of Watford General theatres.

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous Year (2017/18)</td>
<td>Last Financial Year (2018/19)</td>
</tr>
<tr>
<td>Income</td>
<td>£324.8m</td>
<td>£333.4m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£42.6m)</td>
<td>(£49.6m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£367.4m</td>
<td>£338.0m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£15.0m)</td>
<td>(£52.9m)</td>
</tr>
</tbody>
</table>

The deficit reported in 2018/19 was higher than the previous year. The projection for 2019/20 indicated that the deficit will decrease, whilst no projection was provided for 2020/21.

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

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 board received holistic information on service quality and sustainability. There was a number of information systems used across the organisation, which captured and recorded relevant clinical and demographic data about patients and their pathways. Clinical and non-clinical systems were used to capture information such as, incident reporting, performance against audits and patients attendance.

Leaders used meeting agendas to address quality and sustainability sufficiently at all levels across the trust. Staff said they had access to all necessary information and were encouraged to challenge its reliability. We saw that information was used effectively to inform decision making at all levels across the hospital. Audit, compliance reports and information from incidents and complaints was used to inform decisions regarding specialty performance and the meeting of targets. The trust was aware of its performance through the use of KPIs and other metrics. This data fed into a board assurance framework. 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.

Team managers generally had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient
care. Systems were in place to collect data from wards/service teams although this was sometimes time consuming for front line staff. Staff did not always have access to the IT equipment and systems needed to do their work. Despite a significant amount of work being completed in the review of the IT systems, staff told us that some IT systems were slow, did not interface with each other and some were not fit for purpose. The new ICT system had been implemented in 2019 and the trust were building on this with new systems and processes to enable an improved user friendly system, however the work was not complete. During core service inspections we were told in several areas that IT systems relied on individual reporting or multiple data entries for example, in the urgent care centre. Another example is discharge letters were not easily accessible within the accident and emergency department and therefore there was a potential risk that follow up was not completed in a timely manner. Staff were aware of these issues and where necessary added systems to support patient flow. The board recognised that IT systems and processes were not as effective as they could be, and there was a plan for redevelopment that was aligned to the trust strategy and in progress. The trust were collaborating with partners where possible to ensure that the new systems would be of a high standard to prevent repeated upgrades. There were plans to ensure that the IT upgrading coincided with the rebuild of the hospital site to prevent repeated work or delays.

The board and senior staff expressed confidence in the quality of the data and welcomed challenge. Directors were happy that information collected was reliable and reflected where the trust was in regard to performance. Where possible, information was triangulated to ensure that it was accurate. For example, board ward visits would be reviewed in line with feedback from complaints and staff and audit results to ensure that information was accurate. The board also worked with external partners to test information and compare findings. Information was in an accessible format, timely, accurate and identified areas for improvement. Internal data was supported by data quality reports which ensured that staff could identify any potential errors and make any necessary amendments on source systems as appropriate. Reports included national waiting times, referral to treatment times, cancer and diagnostic waiting times and clinical coding completeness. Each report had filters designed to flag any potential data issues which made reviews and checks easier. Where possible, information was provided in dashboards to enable the identification of trends or themes.

Leaders submitted notifications to external bodies as required. The trust escalated reports internally and externally as necessary. 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. There was work being completed on IT systems across organisations and the sustainability transformation plan. The commissioning group and trust had set up a local business intelligence group looking at shadowing businesses teams to work across the area.

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 trust was in the process of completing the data protection toolkit and expected completion by the end of April 2020. This was part of the trust’s GDPR plan and included heads of medical records and senior clinicians. The role of this group included the monitoring of board reports and the needs of the organisation to ensure that information was used safely and securely. There were reports to the board every three months which details information sharing and any breaches.

Data security risks were managed well. A programme had been initiated by the ICT, Information Security and Emergency Planning and Resilience teams to review business continuity plans. 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, referral to treatment times, breaches, delayed transfer of care and safer staffing reports were reviewed from the wards and departments through to the trust board. The trust learned from data security breaches. The trust reported minimal breaches, however expressed learning from each. We were given examples of breaches that had occurred and how they had been investigated.

Information governance systems were in place including confidentiality of patient records. The long term plans were to move to electronic patient records, however this was not possible at the time of inspection due to the IT infrastructure. Instead this had been factored into the redevelopment plans of the hospital and aligned to the rebuild. There was a recognition that staff would need to be trained in electronic records prior to moving to a new build and therefore plans for all infrastructure developments were linked to ensure success of the plans.

**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 in the local population.

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives. People’s views and experiences were gathered and acted on to shape and improve the services and culture. Focus groups were held to gather information about the trust, its performance and future plans. Directors told us that they were working across the wider health community to promote understanding of pathways and improve them for patients. This was planned to enable patients to access the most appropriate care in the right location at the right time.

People who use services, those close to them and their representatives were actively engaged and involved with decision making to shape services and culture. The wards, service teams and divisions had access to feedback from patients, carers and staff and were using this to make improvements. 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.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. The board members knew what the issues were in terms of staff feedback. They acknowledged that there had been a shift towards a more positive staff group and felt that this had been the result of a prolonged engagement programme with staff, promoting autonomy and accountability within roles. This was echoed in the core service inspections, where we found staff to be positively engaged and enthused about their roles and responsibilities. Staff were very positive and wanted to share information about their achievements and involvement in plans for the future. Staff we had spoken with at previous inspection told us that they had been given “permission” to do their jobs and were encouraged to come up with ideas on how things could improve.

The board had started to promote a quality improvement (QI) programme across the trust. We saw that although this was an immature process, some results had significantly impacted on the trust, promoting further work and enthusiasm for expanding projects. There were plans for the QI programme to be expanded into other areas to coincide with the strategy pathways. There were five QI projects in progress at the time of our inspection. Which included improving patient
communication, get up, get dressed, get moving, swarming strategy post falls, NHSI Pressure Ulcer collaborative and improving patient hydration. Our interviews with senior leaders involved with QI confirmed that the trust was exploring ways to involve patients in co-design groups for future improvements.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Feedback was encouraged across the organisation, and we saw that patients and carers were encouraged to attend the board meetings to give feedback about their experiences. Feedback was survey results were agenda items on most meeting minutes. FFT results were tracked monthly and reviewed at governance meetings.

The trust sought to actively engage with people and staff in a range of equality groups. The trust had a number of focus groups and equality groups which were used to capture ideas and opinions.

The trust had a structured and systematic approach to staff engagement and staff were involved in decision making about changes to the trust services. Staff told us that they were able to give feedback about services and play a part in changes. An example of this was the accident and emergency department, where the team had agreed to the introduction of the speciality consultants being based in the department. Senior nursing staff told us that they were given the opportunity to make decisions on how this would work and given more autonomy overall since our last inspection. This was replicated across other clinical areas, where staff told us that they were able to make decisions in line with their roles and responsibilities. This had improved job satisfaction and engagement.

Patients, staff and carers were able to meet with members of the trust’s leadership team to give feedback. The leadership team met with staff regularly either at pre-planned groups such as focus groups or whilst completing ward visits. Staff across all sites told us that they would recognise board members and would feel happy to stop them in the corridor and ask questions or speak about their clinical area. We heard staff from all sites report that the board were interested in what was happening within their departments. Patients and their carers were invited to board meetings to share their experiences. This included positive examples of care and experiences which gave the trust opportunities to learn or improve.

The trust was actively engaged in collaborative work with external partners, such as involvement with the sustainability and transformation partnership (STP). The trust had improved its work with the STP and were looking at health system improvements. Directors told us that the focus was on ensuring services were future proof, which meant that the STP needed to work smarter and collaboratively to ensure they met future needs of patients. There was acknowledgment that service needed to be redesigned to meet capacity demands and ensure compliance with targets.

For example, the trust was implementing a range of outpatient service redesign initiatives in collaboration with the STP and commissioners, including implementing a tele-dermatology service, respiratory referral management service, cardiology referral support service and paediatric integrated primary care clinics.

External stakeholders said they received open and transparent feedback on performance from the trust. The trust worked with a large number of stakeholders which included other acute hospital trusts, hospices, independent health providers, national initiative programmes and community volunteer groups. Some were through formal partnership where joint working was outlined and agreed with regular meetings to monitor progress against objectives. Some staff worked across organisations to ensure a seamless provision of care for patients, for example, the palliative care consultant worked within the hospital and local hospice which enabled patients to access appropriate treatment and care in a timely manner.

Learning, continuous improvement and innovation
The trust actively sought to participate in national improvement and innovation projects. The trust had implemented a number of changes since our last inspection.

The trust have implemented performance improvement programmes and recovery trajectories with a view to achieving compliance and a sustainable position against the national access standards for the accident and emergency department, referral to treatment times and cancer targets. There was a focus on improving patient flow with workstreams to improve early discharge, improve timeliness of medicines for patients to take home and embedding of the Red to Green and SAFER hospital projects.

In October 2019, the trust piloted the new medical ‘take model’ in the emergency department (ED) with senior respiratory, cardiology, acute medicine and care of the elderly clinicians providing rapid expert review in ED. Early evaluation suggested that this was having a positive impact on patient experience and supporting improvements in the ED four hour standard, reducing the need for admission, enabling more patients to access expert medical care via ambulatory pathways and reducing length of stay for patients who are admitted by initiating diagnostics and treatment more quickly.

In July 2019 the paediatric assessment service (PAU) opened in close proximity to the children’s emergency department. The PAU provides assessments, investigations, treatment and ongoing management for patients with an urgent and acute illness. The initial evaluation of the service was presented to the trust management committee in October 2019 demonstrating a range of benefits for children and families, improved MDT working, a positive impact on the children’s emergency department waiting times and a reduction in short stay inpatient admissions.

Across the sites, the trust had extended opening hours for diagnostics services at St Albans City Hospital to match the opening hours of the minor injuries’ unit, reducing the need for patients to travel to other sites or re-attend for diagnostic care.

The trust had a planned approach to take part in national audits and accreditation schemes and shared learning. All audits were reviewed by the audit committee which was chaired by a NED. Trust data showed that there were 170 audits across the trust. These included national and local audits, and covered trust wide and speciality audits. Actions from audits were clearly recorded and monitored to ensure compliance prior to closing an action. Divisions were responsible for ensuring audits were completed.

The trust was actively participating in clinical research studies. For example, the critical care were participating in an international trial, in the treatment for sepsis supported by local consultants

There were organisational systems to support improvement and innovation work. Innovation was a focus of the trust’s board. Staff had training in improvement methodologies and used standard tools and methods. Since our last inspection, the trust had employed a quality improvement lead nurse and two improvement leads. A training needs analysis was completed, and 45 staff members had been trained in QI modules through accredited eLearning. An additional 60 members of staff had been enrolled in or completed leadership programmes which include a QI module. There was a trust wide education strategy which outlined aims to ensure that staff engaged in QI and promoting the embedding of QI within divisions.

Effective systems were in place to identify and learn from unanticipated deaths. There was a robust process in place for learning from deaths which followed the trust wide process of review at a mortality meeting and review by the serious incident review panel.

Staff had time and support to consider opportunities for improvements and innovation and this led to changes. Since our last inspection, there had been a number of changes to patient pathways. Within respiratory medicine, a completely virtual pathway had been devised for the management
of patients with pulmonary nodules, which had reduced the number of hospital visits and improved patient experience whilst ensuring they were managed according to national guidelines and enabling the early detection of lung cancer.

Within colorectal surgery, the team were performing better than national comparators for multiple areas of the service. For example, the trust were completing more than 90% of cancer resections laparoscopically which was well above the national average of 66%. This could reduce the proportion of patients who get recurrent disease, and significantly improve long term quality of life reducing symptoms after treatment. There was also a new pathway for anterior resection patients to support patients in pro-active management and prevention of bowel dysfunction symptoms.

Within cardiology, the trust had trained a small number of nurses to independently implant loop recorder devices. This previously was performed by doctors, using antibiotics in the catheter laboratories. This was now a nurse led and antibiotic free service. The trust audited performance to ensure that it was safe to do this.

Within maternity services, the trust was using QI methodology to identify and manage term infants who were at risk for hypoglycaemia. The aim was to reduce term neonatal admissions and reduce mother infant separation. Innovative changes included an alert system for ‘at risk’ babies, glucose gel to manage hypoglycaemia initially instead of intravenous glucose and staff education. There was another project within maternity to look at the administration of magnesium sulphate to mothers within 24 hours of imminent preterm births which could potentially reduce the risk of cerebral palsy in babies by 30%.

External organisations had recognised the trust’s improvement work. Individual staff and teams received awards for improvements made and shared learning. As well as the trust award programme the teams had achieved a number of external awards. Over the course of the year, as well as being shortlisted in numerous national awards, the trust won a significant number of prestigious national awards, including:

- The best UK employer of the year in the Nursing Times workforce awards
- The Nurse of the Year award in the Nursing Times awards
- Chief Nursing Officer award from Dr Ruth May
- The safeguarding team were East of England regional winners of The Health Equalities Award

Complaints process overview

The complaints team and the patient advise and liaison service (PALS) worked in unison, however were managed separately. Both reported that they worked directly with the divisions/specialities to manage written and verbal complaints or concerns.

The trust received 356 written complaints from November 2018 to October 2019. A breakdown of these can be found below. For the same period there were 3343 concerns logged with PALS. The main themes from PALS concerns were communication, concerns with treatment and delays in appointments or admissions. The trust reported that there had been a decrease in the number of formal complaints received with 432 reported for the previous year.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>100%</td>
</tr>
</tbody>
</table>
What is your target for completing a complaint

If you have a slightly longer target for complex complaints please indicate what that is here

Number of complaints resolved without formal process in the last 12 months?

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

Number of complaints made to the trust

From November 2018 to October 2019, the trust received a total of 356 complaints. The highest number of complaints were for medical care, with 26.1% of total complaints, followed by surgery (20.5%), and urgent and emergency care (16.6%).

A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people’s care)</td>
<td>93</td>
<td>26.1%</td>
</tr>
<tr>
<td>Surgery</td>
<td>73</td>
<td>20.5%</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>59</td>
<td>16.6%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>52</td>
<td>14.6%</td>
</tr>
<tr>
<td>Maternity</td>
<td>32</td>
<td>9.0%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>22</td>
<td>6.2%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>9</td>
<td>2.5%</td>
</tr>
<tr>
<td>Provider wide</td>
<td>8</td>
<td>2.2%</td>
</tr>
<tr>
<td>Critical care</td>
<td>4</td>
<td>1.1%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>3</td>
<td>0.8%</td>
</tr>
<tr>
<td>Not core service specific</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total</td>
<td>356</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

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

All complaints were managed by the directorate or speciality and by the most appropriate person. For example, the matron for nursing concerns or the clinical lead consultant if medical in nature. The complaints team supported clinical staff with formatting responses but did not take ownership of the complaints received. The trust was planning to move to a system whereby the complaints team managed the complaints assisted by the clinical teams. The aim was to develop a team of band 5 and band 6 nurses, who could complete complaint investigations.

The trust planned to investigate and respond to complaints within 30 days and 40 days for more complex concerns. Data showed that this was achieved for 80% of complaints. Those outside the timescale were reported to be complex, cross directorates or internal and external services.

All complaints responses were reviewed by the chief nursing officer or chief medical officer and signed off by the chief executive officer. We saw that the board had a good overview of complaints, the themes and the timeliness of responses. Executive leads offered meetings with complainant to help resolve any issues and were proactive in ensuring resolution.

The quality and safety group reviewed complaints and their responses providing feedback and assurance to the quality committee. All complaints were also reviewed to determine if they
included details of a serious incident which was not picked up. We were given examples of where complaints had resulted in safeguarding or incident reporting and investigations.

From November 2018 to November 2019 the trust had two complaints referred to the Parliamentary and Health Service Ombudsman. One of which had been closed as it could not be investigated and the other remained open. No complaint referred to the ombudsman had been upheld for the same period.

Compliments

From January to November 2019, the trust received a total of 165 compliments. The highest number of compliments were for critical care, with 50.3% of total compliments, followed by medical care (34.5%) and surgery (5.5%).

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>Critical care</td>
<td>83</td>
<td>50.3%</td>
</tr>
<tr>
<td>Medical care (including older people’s care)</td>
<td>57</td>
<td>34.5%</td>
</tr>
<tr>
<td>Surgery</td>
<td>9</td>
<td>5.5%</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>4</td>
<td>2.4%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>3</td>
<td>1.8%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Maternity</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>165</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The trust reported that the themes for compliments over the last 12 months had identified that staff were helpful, dedicated to providing good care and committed to being effective in delivering that care to patients. This had been the case for teams as well as for individuals.

(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>Endoscopy departments and endoscopy decontamination units at Watford General Hospital and Hemel Hempstead Hospital</td>
</tr>
</tbody>
</table>

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

Watford General Hospital
Vicarage Road,
Watford,
WD18 0HB
Tel: 01923 244 366
www.westhertshospitals.nhs.uk

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

- Watford General Hospital: Emergency department, including the children’s emergency department
- St Albans City Hospital: Minor injuries unit
- Hemel Hempstead Hospital: Urgent care centre

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

The trust’s urgent and emergency care service is delivered across all three of their sites:

- The emergency department is located at Watford General Hospital. This has a nine bedded resus department which accepts both trauma and stroke patients; an eight bedded (plus chairs) clinical decision unit; a minors area run by dedicated emergency nurse practitioners (ENPs), including triage by a registered nurse; a five space senior team rapid assessment and treatment (STARR) area (plus chairs); a 22 bedded majors area; plus, a mental health room and chair area.
- The trust’s children’s emergency department is adjacent to their adult emergency department. This has a dedicated paediatric resuscitation area and paediatric assessment unit. The
service benefits from both paediatric ENPs and emergency paediatricians.

- At Hemel Hempstead Hospital, the trust has an urgent treatment centre which is supported by both GPs and ENPs. It runs from 8am to 10pm seven days a week, offering radiology services during these times.
- At St Albans City Hospital, the trust has an ENP-led minor injuries unit which runs from 9am to 8pm seven days a week, offering radiology services during these times.

(Source: Acute Routine Provider Information Request (RPIR) – Acute context tab)

Activity and patient throughput

From September 2018 to August 2019 there were 157,177 attendances at the trust’s urgent and emergency care services as indicated in the chart below.

Total number of urgent and emergency care attendances at West Hertfordshire Hospitals NHS Trust compared to all acute trusts in England, September 2018 to August 2019

(Source: Hospital Episode Statistics)

Urgent and emergency care attendances resulting in an admission

The percentage of accident and emergency (A&E) attendances at this trust that resulted in an admission remained similar in 2018/19, compared to the previous year, 2017/18. In both years, the proportions were higher than the England averages.
Urgent and emergency care attendances by disposal method, from September 2018 to August 2019

* 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)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff. However, medical staff compliance for mandatory training was below the trust target.

Mandatory training completion rates

Nursing staff received and mostly kept up-to-date with their mandatory training. Data supplied by the trust showed there were generally good completion rates. Adult basic life support was just short of the 90% target. The target of 90% had not been achieved for fire and safety evacuation training which was at 76%. Managers told us that staff who were not compliant would be supported in achieving training as soon as possible.

We requested information from the trust for compliance data for completion of advanced paediatric life support and it was not supplied. We were unable to make an assessment or a judgement.

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

Watford General Hospital

Nursing staff received and kept up-to-date with their mandatory training.

A breakdown of compliance for mandatory training courses from April to October 2019 for qualified nursing staff in urgent and emergency care at Watford General Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual handling (non-patient)</td>
<td></td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control (non-clinical)</td>
<td></td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic health, safety and risk</td>
<td></td>
<td>130</td>
<td>130</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety (non-clinical)</td>
<td></td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td></td>
<td>129</td>
<td>130</td>
<td>99.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td></td>
<td>127</td>
<td>129</td>
<td>98.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disability (TEACH) (essential)</td>
<td></td>
<td>127</td>
<td>129</td>
<td>98.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood handling (essential)</td>
<td></td>
<td>125</td>
<td>128</td>
<td>97.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In urgent and emergency care at Watford General Hospital, the 90% target was met for 13 of the 16 mandatory training modules for which qualified nursing staff were eligible.

Medical staff had not kept up-to-date with their mandatory training. In urgent and emergency care at Watford General Hospital, the 90% target was met for two of the 15 mandatory training modules for which medical staff were eligible. The lowest completion rate for was fire safety and evacuation which was 47%. This meant there was a significant number of clinical staff who did not have up to date training.

A breakdown of compliance for mandatory training courses from April to October 2019 for medical staff in urgent and emergency care at Watford General Hospital is shown below:
The mandatory training was comprehensive and met the needs of patients and staff. Medical staff had not always completed training available, which was relevant to ensure they were competent to carry out their responsibilities. Staff had the option to access training sessions in a variety of formats, for example, face to face, eLearning or observations. This meant that staff could often have flexible learning. The leadership team told us that they monitored staff to support them in achieving their up to date training.

Staff received training in advanced life support for adults and children. There was a system in place to ensure that there was a minimum of two members of staff on duty at all times with advanced life support training for adults and children. This included medical and nursing staff. In children’s ED there was always at least one nurse and doctor with advanced life support training on duty.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff completed recognising and responding to patients with mental health needs and dementia, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) awareness. Staff received additional mandatory training in learning disability awareness.

Staff received mandatory sepsis training. The sepsis nurse lead and sepsis trust lead clinician spent time with all staff and provided annual mandatory training to staff which was at 80%. Staff told us they were passionate about safe sepsis management.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers ensured training compliance using an electronic flagging system. The system alerted managers to when new starters required training or those in post required updates. We looked at data related to training compliance and checklists which demonstrated monitoring and alerting staff to update their training.

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.

Safeguarding training completion rates

Nursing staff received training specific for their role on how to recognise and report abuse. The majority of staff were up to date with their training, however two of the mandatory modules below were short of compliance.

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

The tables below include Prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

Watford General Hospital

A breakdown of compliance for safeguarding training courses from April to October 2019 for qualified nursing staff in urgent and emergency care at Watford General Hospital is shown below:

| Fire safety and evacuation (clinical) | 8 | 17 | 47.1% | 90% | No |

(Source: Routine Provider Information Request (RPIR) – Training tab)
<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>1</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>1</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>44</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>124</td>
</tr>
<tr>
<td>PREVENT WRAP</td>
<td>114</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>65</td>
</tr>
</tbody>
</table>

In urgent and emergency care at Watford General Hospital, the 90% target was met for four of the six safeguarding training modules for which qualified nursing staff were eligible.

Medical staff received training specific for their role on how to recognise and report abuse. A breakdown of compliance for safeguarding training courses from April to October 2019 for medical staff in urgent and emergency care at Watford General Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>10</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>29</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>38</td>
</tr>
<tr>
<td>PREVENT WRAP</td>
<td>20</td>
</tr>
</tbody>
</table>

In urgent and emergency care at Watford General Hospital, the 90% target was met for three of the four safeguarding training modules for which medical staff were eligible.

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

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff spoke with provided us with examples of when they had identified and escalated the concerns to the appropriate safeguarding staff. We saw documented safeguarding referrals and incident reporting relating to safeguarding.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff worked with trust safeguarding leads and external safeguarding agencies to protect patients from harm. Staff completed safeguarding referrals using an electronic system. The system triggered an alert when a referral was made to the safeguarding lead. The safeguarding lead responded to ensure all steps were completed to assure people were protected against harm.

Staff accessed safeguarding guidance and policies through the trust's intranet system. A safeguarding lead supported the team, provided training and were a source of information and guidance for staff. Staff we spoke with provided us with examples when they had raised concerns with following policy and using the system. We looked at safeguarding referrals for adults and
children recorded in the electronic system from November 2019 until February 2020 and saw a wide range of safeguarding concerns raised, recorded, referrals made and managers comments. The report outlined action taken and lessons learned. All updates for Safeguarding were posted on the intranet which was accessible by all staff.

Children and young people up to the age of 18 years could be referred to the Child and Adolescent Mental Health Services (CAMHS) children’s crisis assessment team. The CAMHS Crisis Assessment Treatment Team (C-CATT) was an integrated multi-disciplinary team. They offered a crisis assessment service, followed, when appropriate, by an intensive, short-term home/community treatment service. The crisis assessment team had a daily presence in the hospital. Staff told us that the team were accessible as they were available from 09.00 until 21.00 hours; there was also an out of hours service. Staff we spoke with told us the information they shared with C-CATT was written up in care records and a verbal handover was also given to the team at point of discharge.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Safeguarding meetings took place in the children’s department every Wednesday morning. This was where staff discussed safeguarding concerns and agreed referrals if needed. For example, issues relating to parents of children who used substances. We saw good examples of urgent care pathways for children. This was when children required a referral to the children’s community nursing team who would follow up or visit a child’s home to provide support for both children and their parents. Staff told us that input from the community nursing team acted as a good safety net to ensure ongoing care and support following discharge. We looked at data over a three month period and saw that referrals had been made to crisis teams, adult social care of appropriate and children’s services.

Staff knew and understood child exploitation and female genital mutilation (FGM). We saw evidence of discussions about FGM and child exploitation in minutes of meetings. Staff understood that they had a duty to inform the police and children’s services if they had identified either concerns.

Leadership staff reviewed children’s safeguarding at monthly meetings. We looked at minutes of meetings and saw a standard agenda item to discuss paediatric safeguarding concerns. Staff discussed a number of items relating to children and young people’s safeguarding. Staff discussed the clinical assessment service (CAS) which was used to ensure that patients were directed to the most appropriate onward care pathway. Staff had introduced an adapted CAS card. The card prompted questions about self-harm, drug related harm, gang related questions, knife crime and sexual exploitation. This meant that staff could gather as much information as possible to help support children and young people accessing the right services to keep them safe.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, we found a small amount of seating which was visibly torn, posing a potential risk of infection.

All ward areas were clean and had suitable furnishings which were clean and well-maintained. Waiting rooms, the clinical decisions unit, senior team assessment and rapid response (STARR), majors, minors and the children’s emergency department areas were visibly clean. Furniture had appropriate coverings and could be wiped clean. However, staff in the resuscitation area had to sit
on chairs that were torn which could present as an infection prevention control issue. Disposable curtains were visibly clean and had installation dates which would indicate when they should be replaced.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Domestic staff were employed to ensure daily, regular cleaning. We looked at cleaning schedules and saw they were signed when completed to demonstrate that all areas had been cleaned and when.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were bare below the elbows at all times and did not wear any watches or jewellery. Staff wore correct personal protection equipment, including the use of gloves and aprons, and we saw staff wash their hands between each episode of patient care.

The emergency department had two cubicles with doors which were used for isolating patients. There were no isolation facilities in the resuscitation area. Patients in resus were nursed in a bay. Staff followed isolation practices as far as possible. We saw staff follow good infection prevention control when patients left the resus area. For example, staff used appropriate personal protective equipment and cleaned all items in the area using appropriate cleaning materials.

The trust had a robust process for the monitoring of flu. Staff were trained and identified on rotas which enabled allocation of roles and responsibilities. Patients admitted with suspected flu were swabbed and test results recorded in their medical notes. The results were reported on nationally and we were told had a positive impact on reducing admissions.

The department responded well to Public Health England instructions to set up a pod to safely manage coronavirus (Covid-19). We saw staff engaged in providing a safe and rehearsed response to those presenting with coronavirus related concerns. The leadership team set up an emergency planning team. A standard operating procedure was available to provide step-by-step instructions to help staff carry out complex and routine response.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff carry out cleaning following patient contact and equipment was labelled to demonstrate the equipment had been cleaned and ready to be used.

Infection prevention control (IPC) audits were carried out weekly. Staff were given IPC responsibilities which included auditing and they could be identified by their different coloured uniforms. Staff were reminded of their responsibility for good infection prevention control in the governance newsletter. We saw examples of how to effectively remove personal protective clothing and reminders of how to safely dispose of different types of waste.

**Environment and equipment**

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, daily checks on resuscitation equipment were not always recorded and staff did not always store cleaning materials covered by control of substances hazardous to health (COSHH) safely and in line with legislation.

The design of the environment followed national guidance. Staff proudly demonstrated plans and an outline business case for a new emergency department; work to start in January 2021. In the meanwhile, the environment met the standards set out in *Health Building Note 15-01: Accident & Emergency Departments* guidance to ensure the layout was suitable. The waiting area was overseen and observed by administrative staff working at large windows. A pillar in the waiting
area could present as a blind spot. The leadership team had piloted and explored a number of ways to reduce risks. Staff managed risks by using a 15 minute triage system which meant patients were seen quickly, referred to an appropriate location to manage their specific risks. For example, patients who were referred to as the ‘walking well’ would wait in the minors area and those assessed to be at higher risk would be referred to majors for clinical oversight and observation.

Managers assessed the emergency department’s waiting room for risks. We looked at a completed risk assessment dated February 2020. The risk assessment demonstrated consideration had been given to the layout and the potential for patients to deteriorate in the waiting room. It also provided control measures to ensure patients were safely managed in that area. We looked at incidents reported from November 2019 to February 2020 and saw no recorded incidents relating to patient deterioration in the waiting room.

Reception staff observed the waiting area for deteriorating patients. However, a central pillar which could present as a blind spot. Staff told us they managed the risk by regular observations. We saw a risk assessment specific to managing patients in the waiting room which helped manage the potential risks.

The children’s waiting room was appropriate in layout and presentation and in line with Royal College of Paediatrics and Child Health (RCPCH) in *Facing the Future: Standards for Children in Emergency Care Settings (RCPCH 2018)*. There was a central nurses station which was situated in the centre of the ward. It was open and had sight of the waiting area and bays. Where there were blind spots there was CCTV which was overseen using a monitor by staff. There were individual rooms with windows that had privacy shutters. The furniture was appropriate, the colours were calming. There was an accessible toilet with nappy changing facilities situated directly from the waiting room.

Patients with mental health concerns had access to an appropriate environment. This met the standards set out in the Royal College of Psychiatrists *Quality Standards for Liaison Psychiatry Services Fifth Edition 2017*. Patients with mental health needs had a dedicated room with an appropriate up to date risk assessment. Staff and patients were protected by ensuring the environment was safe and secure. The room had been assessed as a low ligature risk, ligature cutters were available, and staff could tell us how to manage the space safely.

The department had invested in improving access security. All wards had intercom access. There was CCTV, staff carried pin point alarms that alerted other staff in the event of an emergency.

Children and young people who presented with mental health concerns were seen for assessment in an appropriate environment. The room was located directly opposite the nurses station. Staff had very good visibility and the room was almost arm’s length that meant staff could respond immediately. The room had an observation window and observation panel in the door which meant privacy could be managed. The room was designed with reduced ligature risks and CCTV to help keep children and young people safe.

Patients could reach call bells and staff responded quickly when called. However, staff identified risks associated with call bells which was noted on the risk register. The call bell system in the emergency department required regular repair and maintenance. This meant patients who required assistance may not receive it in a timely manner. The risk register set out mitigation to reduce help avoid call bell incidents. For example, high risk patients were allocated a space which was in clear view of staff and daily checks were carried out to ensure the call bells worked. Staff understood that daily checks may not be sufficient. Staff carried out risk assessments based on the individual’s presentation. An improved system throughout the department formed part of the
re-development plans for the new department which commences January 2021. There had been no incidents recorded or reported relating to call bell malfunction.

A review of access to the emergency department had been undertaken and work carried out. Authorised staff had swipe access to restricted areas, for example, only those with swipe cards could access the resus corridor. There was controlled access to the clinical decisions unit which was based at the end of the resus corridor. Perspex covers were placed in the reception area. Staff told us they felt more secure with the new swipe access wards. All other access was via an intercom system whereby staff would have to buzz people in. Secure access meant patients and staff were provided with a safer environment.

Staff carried out daily safety checks of specialist equipment. We looked at the resus trolleys and saw they were secured with tags. Resus equipment was accessible in all departments. However, not all resus trolleys had recorded checks to ensure they were in date and ready to use in the event of an emergency. The entries on the trolley checklists were inconsistently completed. This meant we could not be assured that trolleys contained in-date, correct equipment for emergency use. We looked at the senior team assessment and rapid response (STARR) area daily equipment check lists and there were some omissions for example, dates were not recorded which meant we could not be assured that the trolley equipment had been checked on those dates. However, resus trolleys in the children’s department and the clinical decisions unit were clearly checked, accurately recorded and ready to use.

The service had suitable facilities to meet the needs of patient’s families. Visitors could use the waiting area to wait. There were accessible toilets. There were vending machines to access food and drinks, a café and a shop. There was a quiet room for families and carers to use for privacy. There was multi-faith prayer room that offered a quiet space where people of all faiths and none could pray or reflect. We were told that staff, patients and relatives used the room regularly.

The service had enough suitable equipment to help them to safely care for patients. However, not all equipment was instantly accessible. For example, the distance to the computerised tomography (CT) scanner which would make accessing the vital equipment easier and improve outcomes for patients. The computerised tomography (CT) scanner was a 40 minute round trip journey. This would be the case until the works for the new computerised tomography (CT) scanner were completed. We saw that works had started for the new CT scanner, which was immediately adjacent to the emergency department. Staff told us that they did not always have access to scales to help them to weigh all patients. Patient weights were not always recorded in patient records. However, scales could be sourced when medication administration indicated a weight requirement.

Staff disposed of clinical waste safely. Clinical waste bins and sharps bins were available throughout all areas of the department, including majors, resuscitation and the children’s emergency department. All sharps bins we looked at were stored, signed, dated and closed correctly. Clinical waste bins contained the appropriate coloured bags to identify the need for safe and appropriate disposal.

Staff did not always store cleaning materials safely in line with national guidance. We saw cleaning materials covered by control of substances hazardous to health (COSHH) accessible to staff on worktops in the drugs room. These substances should have been stored in a locked cupboard to meet legislation requirements. However, the drugs room was locked which meant they were not accessible to patients.

**Assessing and responding to patient risk**
Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. Staff used a range of evidence based tools specific to assess the needs of adults and children. For example, with children they used paediatric early warning score (PEWS), a tool to assess and respond to deteriorating children. Staff used the national early warning score (NEWS2), an equivalent tool for adults. We looked at patient’s NEWS2 scores which were kept at the bedside and updated at appropriate intervals. All were completed fully. We saw that one patient had a NEWS2 score that required escalation which was appropriately managed by a clinician.

Staff carried out a triage of all self-presenting adult patients. Staff managed patient safety at first presentation following a standard operating procedure which provided guidance using the Manchester Triage System in applying best practice standards. This meant that a registered nurse saw patients within 15 minutes of arrival. Patients deemed low risk were managed appropriately. Lower risk patients were asked to sit in the waiting area and those triaged with risks that required more immediate input were directed to the appropriate area.

Staff observed patient wait times using an electronic monitoring system in the nurses station. The system displayed patient details on a large monitor. The visual system acted as a visual prompt for escalation and action. Staff told us that the triage system with a 15 minute target for patients to be seen, worked well. The screen clearly displayed who and how long they had been waiting. It was colour coded and we saw nurses use the monitor to ensure they saw patients within the 15 minute window.

Managers identified that increased ambulance conveyances continued to present as a challenge. Staff collaborated regularly with the local ambulance trust to help minimise handover delays. Performance against the 15 minute standard had slightly improved though this had not been consistent. Ambulance handovers was included in the division’s governance /monitoring framework. We looked at initial assessment performance indicators from December 2019 which had shown an 0.1% increase from the previous month. This was a slight improvement in performance.

Four hour access performance data:

<table>
<thead>
<tr>
<th>MONTH</th>
<th>ALL ATTENDANCES (all sites)</th>
<th>ATTENDANCES &gt; 4 HOURS</th>
<th>% &lt; 4 HOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2019</td>
<td>13955</td>
<td>2483</td>
<td>82.2%</td>
</tr>
<tr>
<td>December 2019</td>
<td>14371</td>
<td>2966</td>
<td>79.4%</td>
</tr>
<tr>
<td>January 2020</td>
<td>13568</td>
<td>2484</td>
<td>81.7%</td>
</tr>
</tbody>
</table>

(source Trust data request DR26)

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We spoke with staff, observed the waiting area, followed the triage process and were assured that patients were being managed well to keep risks low. Patients were booked in at reception. Reception staff directed patients to the right department based on individual circumstances. For example, those who attended with a GP letter could be sent directly to a specific area, those with urgent needs, for example, patients...
complaining of chest pain were directly immediately to the correct area and seen immediately by a clinician.

Staff knew about and dealt with any specific risk issues. We looked at the sepsis policy which was accessible on the intranet. It was up to date, signed and a review date indicated. There was a sepsis nurse lead. Staff told us the sepsis screening process had been updated and adapted in response to national sepsis studies. Ambulance staff provided the department with a pre-alert where sepsis had been suspected so that staff could respond in a timely way. This meant staff would use the sepsis pathway to provide appropriate safe treatment.

Staff in the clinical decisions unit (CDU) completed comprehensive safety checks, risk assessments and used intentional rounding. This was a structured process where nurses carried out regular checks at set intervals. During checks, they carried out scheduled tasks. This included skin assessments and pressure ulcers, pain, nutrition and continence needs. Patient records in CDU had been completed comprehensively. They were accurate, consistently completed with designation, dates and signatures.

Staff were provided with a support to ensure their safety in the department. Staff could access a security team to help with aggressive people in the department. Screens and security doors protected people from threats of violence. Staff told us the security team were very responsive in the event of an incident. Staff used personal pinpoint alarms used to alert an emergency response. These mechanisms ensured staff could respond appropriately to risks in the department.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff completed mental health risk assessments for patients attending the department with mental health needs. Staff told us they could access a registered mental health nurse from mental health trust bank without issue. Staff used the enhanced care team for one to one support. This support helped with clarity of risks, recorded risks, risk assessed for observed toilet and bathroom access.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). All patients identified with mental health concerns were observed and discussed at every bed meeting. There were daily morning system calls that included the local mental health team to discuss patients who would be referred to them or to share information if they had experience of the patient.

Patients with mental health concerns, who did not need to be admitted to the hospital were reviewed and managed at site meetings throughout the day. We looked at the number of mental health patients in the department, who were either awaiting transfer to a mental health facility or those who were awaiting a place of safety. We saw these patients were discussed and managed at the site meeting regularly to ensure transition to ongoing care.

Staff shared key information to keep patients safe when handing over their care to others. Staff shared patient information with consent. We saw examples of good shared care in the clinical decisions’ unit. Staff shared information about patients with dementia with the enhanced care team who would send a member of their team to assess patients. Staff regularly worked with the mental health liaison team and the women and children’s trust to support young people and people with mental health concerns.

Shift changes and handovers included all necessary key information to keep patients safe. Staff attended daily huddles to coordinate safe care for the day. We saw evidence of safety huddles throughout the day, attended by the nurse in charge, departmental managers and the departmental consultant to discuss any emerging issues and concerns, such as waiting times, capacity and demand.
Emergency Department Survey 2018 – Type 1 A&E departments

In relation to type 1 A&E departments, the trust scored worse than other trusts for one of the five Emergency Department Survey questions relevant to safety, question 33. The trust scored about the same as other trusts for the remaining four questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at A&amp;E, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.7</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>5.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the A&amp;E department?</td>
<td>7.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q34. While you were in A&amp;E, did you feel threatened by other patients or visitors?</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 2018)

Emergency Department Survey 2018 – Type 3 A&E departments (urgent care centres, urgent treatment centres and minor injury units)

In relation to type 3 A&E departments, the trust scored about the same as other trusts for the four Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. How long did you wait before you first spoke to a health professional?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. Sometimes, people will first talk to a health professional and be examined later. From the time you arrived, how long did you wait before being examined?</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q30. In your opinion, how clean was the urgent care centre?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q31. While you were in the urgent care centre, did you feel threatened by other patients or visitors?</td>
<td>9.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 2018)

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

The median time from arrival to initial assessment was consistently lower than the overall England median over the 12-month period from November 2018 to October 2019.

In the most recent month, October 2019, the median time to initial assessment was two minutes compared to the England average of eight minutes.
Ambulance – Time to initial assessment from October 2018 to September 2019 at West Hertfordshire Hospitals NHS Trust

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

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Watford General Hospital

From October 2018 to September 2019, the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Watford General Hospital ranged from 60.1% to 76.7%.

In the most recent month, September 2019, 76.0% of ambulance journeys had turnaround times over 30 minutes.

Ambulance: Percentage of journeys with turnaround times over 30 minutes - Watford General Hospital

Ambulance: Number of journeys with turnaround times over 30 minutes - Watford General Hospital
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.

From 29 October 2018 to 27 October 2019 the trust reported 1,828 “black breaches”, with peaks in March 2019 (249 black breaches), January 2019 (235) and May 2019 (215).

*N* The time period in the chart above represents the month at week end. November 2018 includes data from 29 October to 30 November 2019; October 2019 includes data to 27 October 2019.

(Source: Routine Provider Information Request (RPIR) - Black breaches tab)

**Nurse staffing**

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. Shifts were planned
and managed well in advance. For example, in the children’s department, planning was five months in advance to ensure that staffing met nationally recommended minimum requirements. In addition, staffing was managed on a daily basis and adjustments were made to ensure patients were kept safe and staff were supported in providing good quality care. During our inspection, we saw that staffing levels in all areas were appropriate for the needs of patients. This included appropriate staffing in children’s ED in line with Royal College of Emergency Medicine and Royal College of Paediatric and Children’s Health guidelines.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients. Managers on the wards used a daily shift ‘safe care’ staffing system. This was a visual system that matched staffing levels to patient acuity. This helped provide staffing assurances at the start of each shift. It meant that leaders could compare staff numbers and skill mix alongside actual patient demand in real time, allowing them to make informed decisions and create acuity driven staffing.

**Watford General Hospital**

The table below shows a summary of the nursing staffing metrics in urgent and emergency care at Watford General Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Urgent and emergency care annual staffing metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2018 to October 2019</td>
</tr>
<tr>
<td>-------------------------------</td>
</tr>
<tr>
<td>Staff group</td>
</tr>
<tr>
<td>Target</td>
</tr>
<tr>
<td>All staff</td>
</tr>
<tr>
<td>Qualified nurses</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

The ward manager could adjust staffing levels daily according to the needs of patients. Monthly performance reports reported the staffing level risks. Managers carried out daily reviews of shift patterns and monitored unfilled shifts monitored. Escalation processes were followed as appropriate.

The number of nurses and healthcare assistants matched the planned numbers. Staffing levels were displayed publicly in all clinical areas. Each area clearly identified the number of staff planned against set targets. Leaders could flexibly manage staff skills mix to meet the needs of patients.

Nurse staffing rates within urgent and emergency care at Watford General Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and sickness.

**Vacancy rates**
The service had a reducing vacancy rates for nursing staff. Data we looked at showed at December 2019 the year to date vacancy rates were just below the target of 10%.

Monthly vacancy rates over the last 12 months for registered nurses showed an upward shift from May 2019 to October 2019.

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

Turnover rates

The service had a higher that target turnover rate for nursing staff. We looked at December 2019 year to date data which demonstrated a 16% turnover against the 13% target.

The service had reducing turnover rates for nursing staff. Turnover in December had reduced from 16.5% to 15.8%. We looked at an analysis of leavers data which showed that in December 2019, five individuals left the emergency department. The monthly number of leavers remained consistent at five/six per month since July 2019. From January 2019 to December 2019, 76 staff left the department. The main reason for leaving stated was relocation (32 individuals).

Managers checked in with staff at three months and 10 months post appointment to help with staff retention. Staff turnover was recorded on the risk register. Reviews of establishment in the department took place at the end of January 2020. Monthly updates were provided to board and January 2020 reported 90% of posts had been recruited to.

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

Sickness rates

The service had low sickness rates for nursing staff. We looked at December 2019 year to date data which demonstrated 3% sickness rates against a target of 3%.

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

Bank and agency staff usage

Please note that the trust was unable to provide total hours including those covered by substantive staff to allow us to calculate bank and agency usage or unfilled hours for nursing staff
as a percentage of the total hours available.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

The service had increasing rates of bank nurses and decreasing rate of agency nurses.

[Graph showing Bank hours - registered nurses]

Monthly bank use over the last 12 months for registered nurses was not stable and may be subject to ongoing change.

[Graph showing Agency hours - registered nurses]

Monthly agency use over the last 12 months for registered nurses showed a downward shift from May 2019 to October 2019.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The leadership team told us they used predominately bank staff and kept agency staff to a minimum. Bank staff used were familiar with the department to help keep people safe. We looked at bank use against targets. The data for May showed 23% bank use against a target of 12%. The reason was due to significant reduction in agency spend and reliance on bank staff to backfill vacancies and maintain safer staffing levels. Managers reviewed the risks associated to the use of agency staff on a monthly basis which was recorded on the risk register.

Managers made sure all bank and agency staff had a full induction and understood the service.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)
Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Watford General Hospital

The service had enough medical staff to keep patients safe.

The table below shows a summary of the medical staffing metrics in urgent and emergency care at Watford General Hospital compared to the trust’s targets, where applicable:

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<tr>
<td>Target</td>
</tr>
<tr>
<td>All staff</td>
</tr>
<tr>
<td>Medical staff</td>
</tr>
</tbody>
</table>

The medical staff matched the planned number. A consultant in the department had made successful efforts in an ongoing recruitment campaign for medical staff. The division’s risk registers clearly documented the management and regular review of the challenges in recruitment of emergency medicine medical workforce. We looked at recruitment from the last 12 months and saw successful ongoing recruitment of medical staff. A committed consultant had worked on a successful recruitment initiative to improve medical staffing in the urgent and emergency care department. The initiative included recruiting consultants from other departments to work in the emergency department to share and improve their skills. In children's ED, there was a full time equivalent consultant paediatrician in post with the appropriate qualification in emergency care for children. This was in line with national guidance. In addition the service also had two other consultants who had a special interest in paediatric emergency medicine.

Medical staffing rates within urgent and emergency care at Watford General Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover and sickness and locum usage.

The trust provided us with the hours of consultant presence in the department each day. The total hours for consultants in the emergency department, including the children’s emergency department each day was 19 hours; 08.00 to midnight, seven days a week. Sunday sessions were built into a rota. We were told additional hours could be arranged to accommodate surges.

Please note that the trust was unable to provide total hours including those covered by
substantive staff to allow us to calculate bank and locum usage or unfilled hours for medical staff as a percentage of the total hours available.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Vacancy rates
There was not enough variation in vacancy rates over the last 12 months for medical staff to comment on performance of this metric over time. However, we looked at the risk register which indicated insufficient senior medical / clinical decision makers and junior doctor shortages in the department. Plans were in place to address vacancies. A recruitment campaign was ongoing to improve medical staffing issues.

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

Turnover rates
There was not enough variation in vacancy rates over the last 12 months for medical staff to comment on performance of this metric over time.

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

Sickness rates
There was not enough variation in vacancy rates over the last 12 months for medical staff to comment on performance of this metric over time.

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

Bank and locum staff usage
The service had low and/or reducing* rates of bank and locum staff (*Delete as applicable).

Monthly bank use over the last 12 months for medical staff showed an upward shift from April 2019 to September 2019.

Managers could access locums when they needed additional medical staff. We saw this
recorded in up to date minutes from the emergency department directorate performance review meeting. The leadership team and medical staff we spoke with told us that they could access additional medical staff if needed.

The leadership team were working with the procurement team to find an agency to recruit four emergency department consultants. A small group of locum consultants worked regularly in the emergency department. This helped to decrease some risk. Two substantive emergency department consultants were due to return to work following sick leave and maternity leave which would increase consultant cover.

Managers made sure locums had a full induction to the service before they started work.

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

**Staffing skill mix**

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

In September 2019, 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 37 whole time equivalent staff working in urgent and emergency care 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>26%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>0%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>32%</td>
<td>35%</td>
</tr>
<tr>
<td>Junior*</td>
<td>42%</td>
<td>21%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at Senior House Officer (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**

Staff kept secure records of patients’ care and treatment. However, records were not always clear, up-to-date or easily available to all staff providing care.

Patient notes were not always comprehensive, and staff could not always access them easily. Staff could not always access patient notes quickly when we asked for them. We asked for four specific patient records in the majors and the children’s department. Two records could not be located and the other two were not easily located. This could mean that accurate patient
information was not always available as a result.

We looked at 16 patient records and saw most of the records were incomplete and did not contain important information. For example, one record did not record allergies, one patient had delayed pressure area checks recorded and nearly all patients did not have their weight recorded. These omissions could present a risk to patients.

Staff kept a regular attender register and had access to a regular attenders pathway to help them explore ways to reduce presentations. We followed a regular attenders journey in the department and saw they were known to staff. That they were appropriately supported and managed and were highlighted for discussion.

When patients transferred to a new team, there were no delays in staff accessing their records. Records were stored securely. Patients who were transferred from the department were followed by their records. We saw evidence of this in all cases we reviewed. Patient’s records were securely stored in locked cabinets. Staff used a transfer checklist to record details for handing over patients to other departments.

Staff had access to a fractured neck of femur pathway. We saw evidence of when this was used. For example, a learning disability patient seen by orthopaedics commenced the neck of femur pathway following admission. This demonstrated records being shared with the learning disability team to provide a co-ordinated response.

### Medicines

**The service had systems and processes to safely prescribe, administer, record and store medicines. However, there were gaps in the recording of patient weights and not all medicines were stored in line with guidance.**

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. The room for storing medicine was secured, and entry could only be accessed by using a key code. We found non-controlled drugs stored in unlocked cupboards and in an unlocked fridge in the majors area. Staff we spoke with told us that this should not and did not normally happen. We did however observe this practice on three separate occasions. The intravenous cupboard and fridges were not locked when we looked.

Temperature sensitive medicines were appropriately stored in the fridge. For example, insulin had an open and expiry date stated. Medicines cupboards were not well organised with some medicines not put back in original packs, for example, ibuprofen and phenoxymethylpenicillin. This might make it more difficult to locate medicines swiftly and increases the risks of selecting the wrong medicines.

A risk assessment was carried out to assess how injectable medicines were prepared and administered. This was completed with a pharmacist and a staff nurse who normally administered injectable medicines to patients. Monitoring of incidents reported was shared at governance meetings. Pharmacy audited the process annually.

Staff did not always store and manage all medicines and prescribing documents in line with the provider’s policy. We found incomplete and inconsistent completion of patient care records. Weights not always recorded on drug chart for venous thromboembolism (VTE) prophylaxis. Anticoagulation and thromboprophylaxis policy stated to adjust doses of anticoagulation medicine based on patients' weights. We looked at drug charts and patient records. Not all patient drug
charts or records were recorded with full details required to safely prescribe medications. For example, one patient who required anticoagulants did not have their weight recorded. Charts we looked at in the emergency department were not always transcribed properly.

Staff stored controlled drugs in line with guidance. Controlled drugs are those when possession, or use is regulated by the government designated by law that they should be stored in a locked cabinet. Only approved clinical staff could access controlled drugs. Two staff were required to sign for the administration of the controlled drugs and staff maintained a controlled drug register, which was accurately completed and audited by the hospital's pharmacy team.

Staff followed current national practice to check patients had the correct medicines. Staff discussed patient allergies at triage and documented on patient records. Patients with known allergies were supplied with a wristband to alert staff to check a patient records prior to the administration of any medications. Allergies were recorded in patient records.

In May 2020, the service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Monthly reports in the form of scorecards. This scorecard consisted of the results of several audits and checks, including medicine audits. This chart showed staff the number of medicine errors, medicine storage errors, medicine prescribing errors, medicine harms to patients and number of prescription documentation errors that had occurred within the department each month. Each area was rated on a red, amber, green (RAG) scale and this chart was displayed in the department on a public noticeboard, which allowed both staff and patients to see the department’s current performance.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff reported incidents using an electronic incident reporting system. The electronic system automatically sent incidents to managers for review and when appropriate, investigation. Staff we spoke with understood the process for incident reporting. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses. Staff told us they were supported, without blame in reporting incidents. We looked incident reporting data from November 2019 to February 2020. Staff had reported over 1103 incidents during this period. The majority (784) of incidents reported were in adult outpatients; the majority of which were pressure ulcers. Staff reported 308 (178 of which were pressure ulcers) in resus. Two incidents were reported in the paediatric assessment unit; one was communication and the other related to equipment.

Staff raised concerns and reported incidents and near misses in line with trust policy. Shared learning from incidents was cascaded to staff via the internet and newsletters which were published monthly. Staff also told us they shared learning from incidents at huddles and discussions with managers and at meetings.

Staff received feedback from investigation of incidents, both internal and external to the service. We saw recorded incidents of when staff had made mistakes, the feedback they received and
additional learning received to ensure staff were competent and did not make further errors. Managers told us that staff would be observed to ensure competency and may not return to duties until they could ensure lessons were learned and they were safe to practice. Learning was shared with staff in discussions and shared through newsletters.

Staff met to discuss the feedback and look at improvements to patient care. We saw records of incidents feedback, lessons learned, and improvements made as a result. We looked at incident reports from November 2019 to February 2020 and saw there were over 1000 reported incidents, all of which had recorded actions associated and lessons learned. Staff used this information to help avoid future incidents and learn from investigation outcomes.

**Never events**

The service had no 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. **Watford General Hospital**

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in urgent and emergency care at Watford General Hospital which met the reporting criteria set by NHS England from January to December 2019. This was categorised as a treatment delay. the incident was reviewed and learning was identified, shared and with an action plan.

(Source: Strategic Executive Information System (STEIS))

Managers debriefed and supported staff after any serious incident. Managers told us staff affected by serious incidents were offered support and could access a wellbeing support through occupational health if needed.

Security supported staff in managing incidences of combative and challenging patient behaviours. We saw regular reference in the incident reporting data to security supporting staff in managing challenging behaviours. Staff told us that security were very responsive and responding promptly to provide support.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Duty of candour is a requirement under the Health and Social Care Act 2008. We saw evidence of when staff had made errors and applied duty of candour responsibilities to be open and transparent about any mistakes made. Staff we spoke with could explain duty of candour principles and provide examples of when they might apply it.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff and visitors.

Safety thermometer data was displayed on wards for staff and patients to see.

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.

Staff used the safety thermometer data to further improve services. Staff monitored safety performance and managers undertook audits and checks across several areas of the
department each month.

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 November 2018 to November 2019 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

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.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff had access to a process to help prioritise patients where demand was high. A standard operating procedure for triage in the emergency department helped staff prioritise. Triage helped manage patient flow safely ensured patients with immediate medical needs were treated in a timely way. The Manchester Triage System was used in the department so that nurses assigned clinical priority to patients.

Staff used tools adapted using the UK Sepsis Trust’s ‘Sepsis Six’ bundle which was recognised by the Royal College for Emergency Medicine and NHS England. The tool was used to identify and treat patients suspected of having sepsis; including neutropenic sepsis (patients who received chemotherapy). In addition, staff had access to a sepsis resource folder. It contained advice, contact details, risk information, triggers, including triggers for neutropenic patients.

Staff carried out auditing for sepsis. Staff followed guidance to ensure appropriate assessment and access to treatment to reduce mortality and morbidity associated with sepsis. The aim of the audit was to establish how well the trust was doing in ensuring patients received antibiotics within an hour of diagnosis. A baseline audit was completed in June / July 2019 which showed a compliance of 77% to 78%, which was worse than 90% in previous audits. In October 2019, 105 patients were audited and 80% compliance was achieved. In November 2019, 103 patients were audited, of which 78% compliance was achieved and in December 2019 81% compliance was achieved with an audit of 82 patients. Staff looked at the reason for the reduced compliance figures to help improve outcomes. The ED consultant lead for sepsis was exploring pathways and systems including trigger tools.
Patient's living with frailty received coordinated care by accessing the frailty unit connected directly to the department. The trust’s clinical teams worked the clinical commissioning group and local GPs to redesign care pathways. These included a frailty pathway redesign. The frailty unit helped reduce unnecessary hospital admissions by thoroughly assessing whether hospital admission was needed.

Staff protected the rights of patients subject to the Mental Health Act. Staff ensured people who presented with mental health concerns were kept safe. We saw a number of patients kept safe, either in the dedicated mental health assessment room or escorted by police when they had been detained on a Section 136. Police used this section to detain people with suspected mental illness who needed care. Staff gave us many examples of how they cared for patients with mental health concerns. All patients had completed risk assessments documented to ensure care received was appropriate for their needs.

Staff knew and understood how to keep patient’s safe during their stay at the hospital. Staff demonstrated a good understanding of the use of a Section 5 (2) of the Mental Health Act in relation to common law, for example the risk of absconding. Staff could explain that they could stop the patient from leaving if they were worried that the patient may harm themselves or others.

There was an abundance of information leaflets in the department. The information leaflets provided followed the National Institute for Health and Care Excellence guidelines which meant that information provided was evidence based. For example, in the children’s department, parents had access to red flag leaflets with contact details to inform them about child specific issues.

### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs. They used hydration techniques when necessary.**

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients and relatives could purchase food and drinks from vending machines, water machines, café and shop. Patients awaiting admission were given meals and drinks.

Staff did not always fully and accurately complete patient’s fluid and nutrition charts where needed. We looked at 16 patient records and saw there were some gaps in nutrition and hydration recording, for example, one patient had a gap of four hours before records indicated checks were completed. One patient had no nutrition or fluid checks recorded. This meant that were there were omissions, staff could not always be assured that patients were suitably hydrated or if they had nutrition which could help improve outcomes.

### Emergency Department Survey 2018 – Type 1 A&E departments

In the CQC Emergency Department Survey, the trust scored 7.0 for the question “Were you able to get suitable food or drinks when you were in A&E?”. This was about the same as other trusts.

*(Source: Emergency Department Survey 2018)*

### Emergency Department Survey 2018 – Type 3 A&E departments

In the CQC Emergency Department Survey, the trust scored 6.4 for the question “Were you able to get suitable food or drinks when you were at the urgent care centre?”. This was about the same as other trusts.
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. However, pain scores were not always recorded.

Staff assessed patient's pain using a recognised tool however, did not always provide pain relief in line with individual needs and best practice. Patients records demonstrated they had received pain relief soon after requesting it. However, not all patients had pain scores and pain relief documented. One patient had IV pain relief administered, however they had no administration time recorded. This meant that staff would not know when they should receive a safe follow up dose.

Staff assessed patients’ pain level by asking each patient to score their current level of pain out of 10, with zero meaning the patient was experiencing no pain and 10 meaning they were in extreme pain.

Staff in the children’s department used a smiley faces pain score tool. The scale showed a series of faces ranging from a happy face at 0, which meant no pain, to a crying face at 10, which represented worst pain imaginable. Patients unable to speak, for example, adults or children with cognitive impairment were issued with wrist bands to flag additional needs and tools required to communicate, including pain levels.

Emergency Department Survey 2018 – Type 1 A&E departments

In the CQC Emergency Department Survey, the trust scored 7.0 for the question “Do you think the hospital staff did everything they could to help control your pain?”. This was about the same as other trusts.

(Source: Emergency Department Survey 2018)

Emergency Department Survey 2018 – Type 3 A&E departments

In the CQC Emergency Department Survey, the trust scored 6.6 for the question “Do you think the hospital staff did everything they could to help control your pain?”. This was about the same as other trusts.

(Source: Emergency Department Survey 2018)

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. However, sepsis audits showed varied compliance in the administration of antibiotics.

The service participated in relevant national clinical audits, however they did not always perform well. We saw evidence of a number of audits. For example, the Royal College of Emergency Medicine (RCEM) national audits in moderate and acute severe asthma, consultant sign-off audit, severe sepsis and septic shock audit, sepsis pathway, which included time to first dose of antibiotic. and trauma audit and research network (TARN) audit. The TARN audit captured
patients admitted to a nonmedical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults). The audit results were shared with staff in a number of ways. For example, in meetings, in newsletters, on the intranet and via email. Staff completed trust wide audits. Our review of meeting minutes confirmed that audits and action plans were regularly discussed.

Outcomes for patients were positive, consistent and met expectations, such as national standards. However, audit outcomes were often not met, although performance was very similar to national standards. For example, the Royal College of Emergency Medicine (RCEM) national audits in moderate and acute severe asthma performance standards were not met, however they were similar compared to other hospitals.

Managers and staff used audit results to improve patient outcomes. We looked at a triage audit that identified patients who were urgent need of attention were seen quickly. Staff audited those who required immediate assessment on arrival. Patients who were very urgent priority, were to be seen within 10 minutes of arrival, those who were urgent and to be seen within 60 minutes of arrival, standard response within 120 minutes of arrival, and non-urgent, to be seen within 240 minutes of arrival. The outcome of the audit showed that patients seen around at 08:00 hours waited 20 mins on average to be seen. Patients seen around 09:00 hours waited 17 mins on average to be seen. Patients seen around 10:00 hours waited 17 mins on average to be seen and patients seen at 11:00 hours waited 30 mins on average to be seen. This meant the triage system appeared to be working well. Patients did not appear to have long waiting times and that sicker patients were seen quickly.

Staff had not completed an audit cycle of the senior team assessment and rapid response (STARR) area. However, staff who attended regular divisional and departmental meetings monitored the process for effectiveness. Staff monitored 15 minute target to offload ambulances and additional monitoring of ambulances that take over an hour to offload. Staff carried out reviews of the time from initial assessment to clinical assessment. This was a marker for the effectiveness of processes in senior team assessment and rapid response.

RCEM Audit: Moderate and acute severe asthma 2016/17

Watford General Hospital

The table below summarises Watford General Hospital’s performance in the 2016/17 RCEM moderate and acute severe asthma audit.

The audit reports hospital performance in quartiles. In this context, ‘similar’ means that the hospital’s performance fell within the middle 50% of results nationally.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard 1a: O2 should be given on arrival to maintain sats 94-98%</td>
<td>7.4%</td>
<td>Worse</td>
<td>Not met</td>
</tr>
<tr>
<td>Standard 2a: Vital signs should be measured and recorded on arrival at the emergency department</td>
<td>37.9%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
<tr>
<td>Standard 3: High dose nebulised β2 agonist</td>
<td>15.8%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
</tbody>
</table>
Bronchodilator should be given within 10 minutes of arrival at the emergency department.

**Standard 4:** Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy.

73.3% Similar Not met

**Standard 5a:** If not already given before arrival to the emergency department, steroids given within 60 minutes of arrival (acute severe).

15.4% Similar Not met

**Standard 5b:** If not already given before arrival to the emergency department, steroids given within four hours of arrival (moderate).

21.0% Similar Not met

**Standard 9:** Discharged patients should have oral prednisolone prescribed according to guidelines.

58.2% Similar Not met

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

Watford General Hospital

The table below summarises Watford General Hospital’s performance in the 2016/17 RCEM consultant sign-off audit.

The audit reports hospital performance in quartiles. In this context, ‘similar’ means that the hospital’s performance fell within the middle 50% of results nationally.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients from high-risk groups reviewed by a consultant in emergency medicine prior to discharge from the emergency department:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atraumatic chest pain in patients aged 30 years and over.</td>
<td>0.0%</td>
<td>Worse</td>
<td>Not met</td>
</tr>
<tr>
<td>Fever in children under 1 year of age.</td>
<td>9.8%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
<tr>
<td>Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge.</td>
<td>5.9%</td>
<td>Worse</td>
<td>Not met</td>
</tr>
<tr>
<td>Abdominal pain in patients aged 70 years and over.</td>
<td>4.0%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
</tbody>
</table>

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

Watford General Hospital

The table below summarises Watford General Hospital’s performance in the 2016/17 RCEM
Severe sepsis and septic shock audit.

The audit reports hospital performance in quartiles. In this context, ‘similar’ means that the hospital’s performance fell within the middle 50% of results nationally.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard 1:</strong> Respiratory rate, oxygen saturations ((\text{SaO}_2)), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival.</td>
<td>88.9%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
<tr>
<td><strong>Standard 2:</strong> Review by a senior (ST4+ or equivalent) ED medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the ED.</td>
<td>57.8%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
<tr>
<td><strong>Standard 3:</strong> (\text{O}_2) was initiated to maintain (\text{SaO}_2&gt;94%) (unless there is a documented reason not to): within one hour of arrival.</td>
<td>72.5%</td>
<td>Better</td>
<td>Not met</td>
</tr>
<tr>
<td><strong>Standard 4:</strong> Serum lactate measured: within one hour of arrival.</td>
<td>82.2%</td>
<td>Better</td>
<td>Not met</td>
</tr>
<tr>
<td><strong>Standard 5:</strong> Blood cultures obtained: within one hour of arrival.</td>
<td>60.0%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
<tr>
<td><strong>Standard 6:</strong> Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: within one hour of arrival.</td>
<td>58.1%</td>
<td>Better</td>
<td>Not met</td>
</tr>
<tr>
<td><strong>Standard 7:</strong> Antibiotics administered: within one hour of arrival.</td>
<td>66.7%</td>
<td>Better</td>
<td>Not met</td>
</tr>
<tr>
<td><strong>Standard 8:</strong> Urine output measurement/fluid balance chart instituted within four hours of arrival.</td>
<td>39.5%</td>
<td>Better</td>
<td>Not met</td>
</tr>
</tbody>
</table>

(Source: Royal College of Emergency Medicine)

Trauma Audit and Research Network (TARN)

Watford General Hospital

The table below summarises Watford General Hospital’s performance in the 2018 Trauma Audit and Research Network audit. The TARN audit captures any patient who is admitted to a nonmedical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults).
### Case Ascertainment

<table>
<thead>
<tr>
<th>Measure</th>
<th>TARN Report</th>
<th>Hospital EPISODE Statistics</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)</td>
<td>64.7 to 76.5%</td>
<td>n/a</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude median time from arrival to CT scan of the head for patients with traumatic brain injury</td>
<td>59 minutes</td>
<td>Takes longer than the TARN aggregate</td>
<td>Met</td>
</tr>
<tr>
<td>(Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury</td>
<td>66.7%</td>
<td>Lower than the TARN aggregate</td>
<td>n/a</td>
</tr>
<tr>
<td>(Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care</td>
<td>40.0%</td>
<td>Higher than the TARN aggregate</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk-adjusted in-hospital survival rate following injury</td>
<td>0.3 additional survivors</td>
<td>Similar to expected</td>
<td>Met</td>
</tr>
<tr>
<td>(This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix.)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: TARN)

The service contributed to the local trauma network, though was not a receiving service for major trauma. The Trauma Audit and Research Network (TARN) is a national organisation that collects and processes data on moderately and severely injured patients. The TARN report for 2018 identified no immediate risks.

### Unplanned re-attendance rate within seven days

The service had a higher than expected risk of re-attendance than the England average.

From November 2018 to October 2019, the trust’s unplanned re-attendance rate to A&E within seven days was consistently higher than the national standard of 5% and the England average.

In the most recent month, October 2019, the trust’s performance was 11.0% compared to an England average of 8.3%.

Unplanned re-attendance rate within seven days - West Hertfordshire Hospitals NHS Trust
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 development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There was good evidence of staff being supported in achieving relevant up to date skills and development. Staff were qualified to work in an urgent and emergency setting. Skills development sessions were available to staff across all areas. Staff and volunteers who worked in the children’s department had access to a range of relevant training. Managers told us that the local mental health trust had a service level agreement to provide training. For example, training on how to look after young people with mental health concerns.

Staff were supported at all levels to achieve their competencies for their role in the department. Leaders kept a spreadsheet for new starters with training needs. There was a training board with a case of the week to learn from, dates of training and revalidation information. We saw evidence of clinical skills courses, for example, venepuncture courses, administration of intravenous medication. Healthcare support workers had to complete their care skills course within a three month period of commencing post. Staff received conflict resolution and breakaway training. This was provided at regular intervals. Staff at band 5 and above received additional training to ensure they had advanced skills in how to work with challenging behaviour. The evidence demonstrated a culture of learning and development.

Staff were particularly good at identifying and understanding complexities associated with substance misuse. For example, staff were particularly good at identifying and understanding Cannabinoid hyperemesis syndrome. This condition led to repeated and severe bouts of vomiting. It was rare and occurred in daily long-term users of marijuana. This was evidenced in discussion with staff, including the drug and alcohol agency staff who worked alongside staff in the department. This meant they could respond appropriately to the syndrome.

Staff were supported in achieving additional qualifications to improve their competencies in the role. For example, one nurse was completing a masters qualification and focused on Mental Capacity Act for their dissertation. This meant that staff were acquiring knowledge to help improve the quality of their skills.

Managers gave all new staff a full induction tailored to their role before they started work. All staff we spoke with told us they received a good corporate and local induction. All new staff, following induction were supernumerary for two weeks and competencies observed before they took up
their responsibilities independently. Band 5 nurses were supported in achieving a development course and their preceptorship. We saw evidence of good preceptorship courses and senior nurses signed off clinical checks. Staff we spoke with told us confidently that they would not carry out duties without the correct skills.

**Appraisal rates**
Managers supported staff to develop through yearly, constructive appraisals of their work. All staff we spoke with told us they received meaningful annual appraisals. We were provided with examples of when staff had worked with their managers in achieving advanced skills to support them in their role.

**Watford General Hospital**
As of October 2019, 92.5% of staff within urgent and emergency care department at Watford General Hospital received an appraisal compared to a trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>As of October, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>1</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>37</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>35</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>109</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>27</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>209</strong></td>
</tr>
</tbody>
</table>

Medical and dental and registered nursing staff in urgent and emergency care services both met the 90% target.

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

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Senior nurses had a team of nurses who they were responsible for providing regular supervision to. All staff we spoke with told us they received supervision and felt supported in their clinical roles.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers kept a checklist for all new starters that demonstrated appropriate training and skills. The checklist was up to date. All staff had a personal information booklet which was updated with appropriate information. For example, we saw that coronavirus had been added to nurses booklets. Staff could access a number of relevant courses. Health care support workers were given development and study days.
Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Training needs were identified in a number of ways; through supervision, appraisal and observations. For example, infection prevention control nurses carried out hand washing audits and if they observed staff were not compliant, they would ensure further training to support improvement.

Staff were provided with additional learning opportunities. These opportunities were advertised in monthly newsletters, online campaigns and there was evidence of learning and development through social media. For example, groups of staff across the country discussed evidence based and good practice and provided peer support via a telephone app. There was also a closed social media noticeboard for staff where they could access up to date information, for example clinical governance updates and photos of coronavirus trolleys.

Managers made sure staff received any specialist training for their role. The practice development lead provided examples of forward thinking about future training needs for staff. We saw evidence of a clinical leaders programme that started in September 2019. This meant there was formal managerial training. Coaching was available to staff if identified through supervision or appraisal. The practice development lead organised external speakers and trainers when specialist skills were required. For example, equipment specific training in resuscitation mechanical equipment and external end of life training facilitators.

The clinical educators supported the learning and development needs of staff. We saw evidence of a clinical training provided by clinical leads. For example, trauma training was delivered by a clinical lead. This was evidenced in a trauma competency book. There was a trauma agenda which was shared. A paediatric consultant delivered training for children’s trauma. The practice nurse developer linked with the women’s and children’s hospital and invited staff to complete this training. These training opportunities were ongoing and regular to meet the development needs of staff.

Managers identified poor staff performance promptly and supported staff to improve. Managers responsible for staff performance worked with their individual staff members to plan and review actions to help improve performance. Managers provided us with examples of when they had identified performance concerns and actions they took to support improvements.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers were employed from a volunteer network of parents who provided voluntary support to parents of children in the department.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Team meeting minutes were accessible for staff on the intranet, social media noticeboard and email. This meant that staff could catch up on what was discussed at a convenient time.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff provided us with evidence of regular multi-disciplinary meetings. For example, the local trust’s children and adolescent mental health service consultant would meet regularly with children’s emergency department staff and have a formal monthly meeting which was documented. There were weekly safeguarding meetings with open attendance facilitated by the
safeguarding lead.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw examples of excellent seamless care for patients. For example, an elderly, confused and distressed patient in the clinical decisions unit was quickly intubated following a timely response from the appropriate departmental team. Communication between teams were seamless. Effective communication and organisation of transportation to an appropriate local speciality hospital was promptly organised. Staff were quickly identified to undertake the transfer. Good drugs safety checks took place between the consultant and nurse. We saw excellent communication with the family to understand the process of intubation and transfer. The meant there was a well-coordinated care between disciplines and providers to ensure effective and calm processes to support smooth transition of care.

Staff had access to support services required. For example, access to imaging, diagnostics and dietetics and speech and language therapy services.

Staff had access to the mental health liaison team for patients at risk of self-harm or suicide for assessment and intervention. We saw patients in the department receive care from the mental health liaison team. Staff told us they could be accessed quickly either by phone or seen quickly in the department. High risk patients were prioritised and seen quickly. Staff provided us with examples of good access to a drug and alcohol agency to support patients with drug and alcohol conditions. Staff could also access a learning difficulties team to support patients with learning difficulties.

Staff provided good examples of joint work with the clinical psychologist and assistant from the mental health trust to develop and support multiagency care plans for patients who required mental health input, including work with patients with learning difficulties and dementia.

Staff worked alongside Rapid Assessment Interface and Discharge (RAID) team to support patients with mental health concerns. We case tracked one patient in the department who presented with mental health issues. We saw that they had fully completed documentation, including assessment of their physical wellbeing. We saw that the RAID team had attended to them and a mental health proforma had been completed. RAID teams provided an in-reach psychiatric liaison service to prevent avoidable admissions to inpatient wards and reduce length of stay associated with mental illness. The patient had an appropriate follow up review by the RAID team in a timely manner. We looked at the records of a young person with mental health issues who attended the department. A proforma had been completed by the on-duty psychiatrist. The proforma was specifically for young people on the cusp of transition to adult services to ensure an appropriate pathway and intervention.

Ambulance staff worked closely with colleagues in the department to ensure smooth handover from ambulance to the department. We saw this in practice at the senior team assessment and rapid response area and in discussions with ambulance staff. Ambulance staff told us they felt that escalation consistently worked well. That key staff worked to ensure patients were transferred promptly so that ambulance staff could go back to their next patient.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds in all clinical areas, including weekends. Patients were reviewed by consultants depending on the care pathway. Doctors handovers which were consultant led were well attended by the medical team. Handovers included the sharing of
appropriate information such as new admissions and patients transferred to the wards. The consultants discussed workload and delegated actions. Doctors confirmed that consultant support was available seven days a week and that they responded quickly to requests for guidance and assistance.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. For example, access to x-rays, computerised tomography (CT) scans, blood test results from the pathology lab. We saw evidence in patient records, discussions with staff and direct observations of patients accessing mental health support via the mental health liaison service. We saw psychiatrists respond to patients in both the adults and children’s department. Staff told us that mental health staff were accessible and responsive to help meet the needs of patients who were in crisis.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in all departments. Patients could access leaflets and promotional information encouraging healthy lifestyles. For example, we saw leaflets and posters on smoking cessation, healthy young minds services and good sexual health.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff talked with patients about their lifestyle and provided details about services who helped to improve people’s health. Advice and information leaflets were easily accessible to patients, relatives and carers throughout the department. We saw posters displayed that provided supportive information to people with learning disabilities and sepsis. Young people were provided with support in managing self-harm behaviours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients’ liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff had knowledge of the Mental Health Act including doctors and nurses holding powers, and Deprivation of Liberty Safeguards. Staff provided us with examples of joint capacity assessments with mental health staff for complex cases. For example, a patient with a learning difficulty and mental health need who was deemed to have capacity however, was making unwise decisions. Staff supported the patient to fully understand implications of the decision made. We also saw good examples of staff requesting support and involving the mental health liaison team in capacity assessments. We saw evidence of good understanding of fluctuating capacity and staff told us they would review capacity at regular and appropriate intervals.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood that consent should be given voluntarily and explained this to patients as far as reasonably possible before gaining consent to treatment. Patients’ who were unable to consent would have this documented in their care records and escalated to an appropriate
When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. Staff working in urgent and emergency care understood that consent could not always be obtained. Staff could explain to us that medical treatment provided should always be in the patient’s best interests and necessary to avoid deterioration. Staff considered a patients’ wishes when possible.

Staff made sure patients consented to treatment based on all the information available. Staff were trained in understanding gaining consent to treatment. Staff could explain to patients the principles of gaining consent in line with legislation and guidance. We saw examples of staff assessing patients with physical and mental health conditions and ensuring they had consent in verbal and written form at the point of triage.

Staff clearly recorded consent in the patients’ records. Records we looked at had signed consent documented. Staff we spoke could explain the importance of recorded consent.

Staff understood Gillick Competence and supported children who wished to make decisions about their treatment. Young people over the age of 16 were seen in the adults emergency department. We saw young people treated as young adults. All were accompanied by adults; however, we saw staff speak with the young people independently and give them the autonomy and respect expected. Staff could explain to us their understanding of Gillick Competence and Fraser Guidelines. Gillick competency was used to help decide whether a child or young person was mature enough to make their own decisions and determining a child or young person’s capacity to consent.

**Mental Capacity Act and Deprivation of Liberty training completion**

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Compliance for medical staff feel just short of the 90% target at 87%.

The trust set a target of 90% for the completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

**Watford General Hospital**

Compliance for MCA/DoLS (essential) training from April to October 2019 for qualified nursing and medical and dental staff in urgent and emergency care at Watford General Hospital is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April to October 2019</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met  (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>45</td>
<td>45</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Medical and dental</td>
<td>27</td>
<td>31</td>
<td>87.1%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

In urgent and emergency care at Watford General Hospital, the target of 90% for MCA/DoLS (essential) training was met by qualified nursing staff while the completion rate for medical and
dental staff was below the target.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff engaged with patients and their loved ones in the department, listening and being caring. We observed consultants being respectful and compassionate with distressed family members. On one occasion one patient was observed to look dishevelled; staff were alerted and quickly responded to restore the patient’s privacy and dignity.

We spoke with 18 patients and visitors who said staff treated them well and with kindness. One relative told us the care their family member received was excellent. One nurse proudly provided positive feedback forms, completed by people who had used the department the previous night. Staff took pride in providing good quality and kind care.

Friends and Family test performance

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 88.6% and 95.7% from October 2017 to September 2019.

The data shows seven sudden change data points in May, June, July and September 2018, and June, July and August 2019. These sudden change data points indicate that two out of three consecutive data points sit between the upper or lower warning limits and the upper or lower control limits.

Friends and family test performance – West Hertfordshire Hospitals NHS Trust – October 2017 to September 2019
The graph below shows the response rates at the trust over the 24-month time period:

**West Hertfordshire Hospitals NHS Trust – response rate – October 2017 to September 2019**

(Source: Friends and Family Test)

Staff followed policy to keep patient care and treatment confidential. Staff demonstrated an understanding of privacy. We saw this in all areas. For example, in the senior team assessment and rapid response area, where ambulance handovers took place, we saw patients were taken straight to private bay where the curtains were promptly closed and of possible, discreet conversations took place. Staff showed regard for private information in areas that could be accessed by the public. We saw patient records locked securely in cabinets.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We saw patients with mental health needs attend the department and receive the same care, attention, dignity and respect as all other patients. We observed warm and caring engagement between staff and patients. When available and appropriate, a dedicated room was used to assess patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

**Emotional support**
Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw many examples of staff providing emotional support and advice. We saw compassionate interactions between consultants and distressed family members. Staff provided examples of how they were supported and how they supported others when dealing with difficult and highly emotional situations. Staff received debriefs and offered time out if needed. All staff, patients and those involved in their care told us that staff were kind and compassionate. Staff could attend a formal debrief following incidents. Staff wellbeing was valued to ensure they had the emotional resilience to work effectively with patients. Relatives’ rooms were available in adults and children’s areas in the department.

We saw examples of when staff spoke with distressed relatives in the adult and children’s areas. We saw doctors ask questions to help support relatives based on their needs. Rooms were available to provide a private and confidential space. The children’s department was supported by volunteers, who were available to provide practical and emotional support to patients and their carers. We saw staff comfort parents who were struggling to manage their emotions because their children were emotional. We saw them use distraction techniques, for example, using toys and engaging conversations to distract from wounds being looked at.

Spiritual and religious support was available and accessible to all 24 hours a day, seven days a week. Multi-faith options were available. A chaplaincy service was responsive in the event that support was needed for patients who were dying or those close to patient who had died.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We witnessed staff ensure curtains were closed to maintain dignity. Voices were kept low to allow privacy and confidentiality. Staff in the children’s department carried out hourly emotional wellbeing checks which were documented in the patients records. We witnessed one patient’s dignity compromised and staff promptly rectified this when alerted.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We observed staff talking with friends and relatives in a sympathetic and caring manner. We saw consultants clearly relaying difficult information and providing appropriate time and space to people to process the messages being relayed. We saw healthcare support workers providing refreshments, a private space and support.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff took time to understand social care needs of patients, the emotional impact and responded appropriately. We followed a regular attender; a homeless patient through their journey at the department. We saw staff acknowledge the patients personal circumstances and social care needs. Staff spoke with us about the patient’s isolation and anxiety and how the system should support them. They approached the patient with care and warmth. Staff involved other social care agencies and demonstrated compassionate interactions at all times.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
Staff made sure patients and those close to them understood their care and treatment. We spoke with twelve patients and six relatives. All, except two people from the same family who we spoke with. They were unhappy with the level of communication they had received from staff about their loved ones treatment. Staff we spoke with were keen to listen to the family members, however they preferred to relay their concerns through formal channels. Staff told us they would have been more than happy to have resolved concerns with the family and were disappointed they were unable to do so.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff provided dementia patients with a comfort trolley. Staff were seen using the items on the trolley with patients and could be seen replenishing it with fiddle muffs and dementia sensory and fiddle blankets. Staff could access interpreter services to support people where English was a second language. Easy to read versions of patient literature was available support patients and visitors with learning disabilities or autism. Patients with autism were provided with communication books which were autism friendly.

Several staff gave good examples of understanding their patients well, particularly high intensity users of the service. Staff used their knowledge of their patients to provide them with resources specific to their needs. For example, comfort trollies that had toiletries and socks for patients who needed them. Dementia resources including blank “this is me” documents they could give out. Access to fiddle muffs and staff used reminisce aids for people with dementia. In the children’s department, there was carer support for parents who were volunteers.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The two family members who were unhappy with communication received, told us they wanted to make a formal complaint. We saw staff direct them to the patient advice and liaison service. Families were provided with feedback forms. Staff provided us with examples of when they had received feedback. This was used to help with improvements. We saw comments boxes throughout the department where people could complete feedback forms and post them in the boxes.

Staff supported patients to make advanced decisions about their care. We saw evidence of patient involvement in our observations and patient care records. Patients and relatives told us staff kept them informed about their care and treatment.

Emergency Department Survey 2018 – Type 1 A&E departments

The feedback from the Emergency Department survey test was about the same as other trusts.

The trust scored worse than other trusts for four of the 26 Emergency Department Survey questions relevant to the caring domain. The trust scored about the same as other trusts for the remaining 22 questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you informed how long you would have to wait to be examined?</td>
<td>3.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. While you were waiting, were you able to get help from a member of staff to ask a question?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust score</td>
<td>RAG</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
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<td>--------------------------</td>
</tr>
<tr>
<td>Q13. Did you have enough time to discuss your condition with the doctor or nurse?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. While you were in A&amp;E, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. Did the doctors and nurses listen to what you had to say?</td>
<td>8.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q17. 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>Q18. Did doctors or nurses talk to each other about you if you weren't there?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. If a family member, friend or carer wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. While you were in A&amp;E, how much information about your condition or treatment was given to you?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. Sometimes, a member of staff will say one thing, and another will say something quite different. Did this happen to you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q25. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q45. Overall, did you feel you were treated with respect and dignity while you were in A&amp;E?</td>
<td>8.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q16. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Before you left A&amp;E, did you get the results of your tests?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q29. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q30. If you did not get the results of the tests when you were in A&amp;E, did a member of staff explain how you would receive them?</td>
<td>5.7</td>
<td>About the same as 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>9.1</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>4.6</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>4.6</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 A&amp;E?</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 symptoms to watch for regarding your illness or treatment after you went home?</td>
<td>5.3</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 A&amp;E?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Did staff give you enough information to help you care for your condition at home?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q46. Overall</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 2018)
The feedback from the Emergency Department survey test was about the same as other trusts.

The trust scored about the same as other trusts with type 3 A&E departments for the 20 Emergency Department Survey questions relevant to the caring domain.

Please note: Four questions were excluded from analysis due to the low number of responses received nationally (While you were waiting, were you able to get help from a member of staff to ask a question?; Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?; Did a member of staff tell you about medication side effects to look out for?; Did hospital staff take your family or home situation into account when you were leaving the urgent care centre?).

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9. Were you informed how long you would have to wait to be examined?</td>
<td>4.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your condition with a health professional?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the urgent care centre, did a health professional explain your condition and treatment in a way you could understand?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the health professional listen to what you had to say?</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the health professional examining and treating you?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did health professionals talk to each other about you as if you weren't there?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. If a family member, friend or carer wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. While you were in the urgent care centre, how much information about your condition or treatment was given to you?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes, a member of staff will say one thing, and another will say something quite different. Did this happen to you?</td>
<td>9.5</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>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. Overall, did you feel you were treated with respect and dignity while you were in the urgent care centre?</td>
<td>9.3</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 health professional discuss them with you?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q25. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Before you left the urgent care centre, did you get the results of your tests?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q37. 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>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the urgent care centre?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did staff give you enough information to help you care for your condition at home?</td>
<td>8.0</td>
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<td>Question</td>
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</tr>
<tr>
<td>Q43. Overall</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 2018)

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. They worked with others in the wider system to plan care. For example, we saw that staff in the ED had worked closely with system wide partners to improve pathways for mental health care. The service had worked with partners in primary care and commissioning services to develop the urgent treatment centre at Watford General Hospital to help ensure that people received the right care at the right time. The leadership team worked closely with Public Health England to ensure the environment was suitably adapted for outbreaks of new infectious diseases. There were suitable measures in place to ensure the safety of all patients and staff while also ensuring services were available to the public as normal. During our inspection, we saw staff respond to notices of new presentations of patients with infectious symptoms. This included isolation of the area where patients were admitted. For example, patient’s had access to a pod specifically designed to safely manage coronavirus. Staff were observed to follow a very clear process to safely manage these patients in the department.

Patients were triaged in a Senior Team Assessment and Rapid Response (STARR) area before being moved to minors, majors or resuscitation areas as appropriate. The STARR area contained six bays for assessment and initial treatment by a clinical decision maker. We saw that this was a well-managed area with good flow in to appropriate treatment areas. We spoke with a staff nurse in the majors area who reported that the STARR area had made considerable improvements in the department. Patients in the STARR area could be triaged and receive pain relief before being transferred to the appropriate department. We saw patients receiving pain relief quickly following admission to STARR.

Adults and children who attended with mental health illnesses were provided with a safe and appropriate space for assessment. At the time of our inspection, there was one mental health room in each department which meant if more than one person required a space specific to their needs and the room was in use, staff would have to use an alternative space. We saw that space for mental health patients was a risk that was highlighted on the risk register. It was a concern that was discussed regularly at a range of meetings, for example, governance meetings and risk meetings. Senior leaders told us that additional spaces would be considered in the re-design plans and there were control measures in place. Staff told us they risk assessed each patient and mitigated against risks to keep people safe.
Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Due to the nature of the department, most areas did not have gender separation. Patient’s received care and treatment in individual cubicles that had privacy screening.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff accessed a mental health liaison service for adults and Child and Adolescent Mental Health Services (CAMHS) for children and young people. Staff told us that they received a responsive service from the local CAMHS team. An on-call service was available 24 hours a day. Staff told us they could access a CAMHS consultant for support and advice, or to attend to a child in the department. We saw that there was well signed mental health contact details displayed for staff. There was a mental health liaison service bleep number and office extension number and the on-call psychiatrist contact number.

The service had systems to help care for patients in need of additional support or specialist intervention. However, until the new department works were completed, there remained challenges. For example, in resus there was no separate cubicle for patients who required isolation. Redevelopment plans included a proposal for isolation facilities in resus and potential additional room in the main area. In the meantime, mitigation continued. The leadership team informed us that they had started to see a positive impact of the 2018 opening of majors 2 which provided the ability to care for patients in the right setting. We saw that patients who required additional support on the wards had their needs displayed on boards by their beds, for example, we saw patients with dementia highlighted clearly to flag an appropriate response.

The service relieved pressure on other departments when they could treat patients in a day. Patients assessed with specific medical conditions that could be treated in a day were directed to the ambulatory care unit. This meant patients received appropriate care for specific conditions, which simultaneously reduced pressure on the main emergency department. Staff told us there had been no corridor care which was a very different situation to the year before.

**Meeting people’s individual needs**

The service was inclusive and took account of patients’ individual needs and preferences. **Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff worked jointly with specialists employed by the trust and external professionals to provide joint assessments for people with additional complex needs. We spoke with a team leader from the mental health trust who told us that staff were very good at assessing capacity. Patients who were seen by a member of the mental health liaison team had an assessment, care plan and risk assessment accessible to emergency department staff. Staff did not have access to a shared electronic system, however a printed assessment was stored in the patient record. A new mental health proforma had been introduced and could be seen in patient records. Both emergency department staff and the mental health liaison team completed sections of the proforma and worked together to meet the needs of patients.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. Staff provided GP’s with a copy of discharge letters. Copies were also sent to care homes and copies placed in specific “purple file” for patients with learning
disabilities. The department could access psychology services for older age patients who jointly assess, to meet specific needs of older people. Patients with dementia had resources to help them feel comfortable in the environment. Staff provided patients with sensory needs with a ‘comfort box’, which included twiddle muffs, activity blankets and colouring pencils. We saw 1950’s reminiscence laminated cards and passports for people with learning disabilities.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff provided specialist support tools, for example, easy read documents and communication aids. There were hearing loops available throughout the hospital. Staff told us they could access communication aids depending on individual needs.

The service had information leaflets available in languages spoken by the patients and local community. Leaflets were available throughout the departments and staff told us they could access leaflets in other languages online if requested.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff could access a 24-hour translation service for telephone assistance.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff told us patients could request special dietary foods, for example, halal foods.

**Emergency Department Survey 2018 – Type 1 A&E departments**
The trust scored 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>Trust 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>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Overall, how long did your visit to A&amp;E last?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Were you given enough privacy when being examined or treated?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 2018)

**Emergency Department Survey 2018 – Type 3 A&E departments**
The trust scored 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>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the urgent care centre last?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. Were you given enough privacy when being examined or treated?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 2018)
Access and flow

People could not access the service when they needed it and did not always receive the right care promptly. Waiting times and arrangements to admit treat and discharge patients were not in line with national standards.

The first point of contact for people who presented at the urgent and emergency care reception was reception staff. Reception staff were provided with recognising ‘red flag’ symptoms guidance. This meant that they understood when people presented with serious concerns, such as sepsis and chest pains. Reception staff explained to us the process to escalate patients who required immediate access to senior staff. Patients deemed lower risk followed the Manchester Triage System which helped identify the severity patient symptoms. Staff treated and discharged patients at point of triage wherever possible to reduce patient wait times. Staff aimed to carry out a triage of all lower risk self-presenting adult patients within 15 minutes of arrival. Patients referred via their GP were directed to the appropriate area. Patients who were deemed critically ill were directed to the resus area.

A performance manager was employed to work specifically on improving performance, including meeting the four hour target. The data below shows a slight improving picture which could be attributed to the specific role and responsibilities of this manager. The performance manager and leadership staff met throughout the day. They worked consistently to address patient flow and to achieve the four hour target. The performance manager linked directly with leads across the hospital to work jointly to improve communication about patient access to wards. They worked together to improve flow through the department to support efficient transition to an appropriate ward for their ongoing care and treatment.

Ambulance handover performance was monitored to help improve flow in the department. We saw recorded reviews of ambulance handover performance at monthly performance meetings. This also formed a part of the trust’s performance improvement plan which was overseen by the Patient Flow Transformation Group and weekly check-ins with Chief Executive Officer and Chief Operating Officer.

Staff monitored ambulance handover performance at the division’s governance monitoring framework and meeting. We looked at data between 2 and 16 February 2019. There were 78 handover delays in excess of 60 minutes. Performance against the 15 minute standard had slightly improved though improvements were not consistent. Compared to the national average of 2.3%, handover delays in excess of 60 minutes was 6.1%. However, that was not statistically significant.

Managers used a standard operating procedure for boarding patients in exceptional circumstances. Boarding was a patient admission to a ward to wait for an appropriate bed following discharge from the ED. Leaders told us careful consideration was given at daily bed meetings before boarding was considered. Senior nursing staff used a bespoke assessment tool during the bed meetings to discuss the position of the department and identify those who could safely go straight to speciality wards.

Staff used escalation policies to help them manage specific concerns. For example, the leadership team used a full capacity protocol that had an escalation policy to help them manage capacity concerns. Managers used the bed escalation policy to assist with decision making. There was an escalation policy for patients with mental health concerns that required an admission. These policies clearly demonstrated the steps required and people to contact if the four hour decision to admit target had been breached.
Staff managed winter pressures using a robust winter plan. The plan included an extra 18 beds in the department. The extra space was set up as a ward, each division provided a substantive member for staff. Medical cover was sourced. Staff monitored patients, including mental health patients awaiting admission against the national 12 hour standard. We looked at the numbers of incidents recorded for patients waiting for mental health input and saw they were regularly reported. Staff told us that risk remained seasonal. Plans were in place to mitigate winter pressures which included use of surge areas and flexibility in increasing staffing requirements.

Median time from arrival to treatment (all patients)

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The Royal College of Emergency Medicine recommended 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 in any of the 12 months from November 2018 to October 2019 and the median time was consistently higher than the England average.

In October 2019, the trust’s median time to treatment was 74 minutes compared to the England average of 65 minutes. Data showed that over the most recent four months from November 2019 to February 2020 there was still no sign of either improvement or deterioration. Managers worked together with ambulance providers to improve on targets for ambulance handovers. Hospital ambulance liaison officers (HALO) who were employed by a local NHS ambulance trust were based in the senior team assessment and rapid response area of the department. They worked alongside staff to support patient flow through the department. An electronic tracking system was in place to ensure staff were aware of all 999 patients due to arrive at the department. The tracker provided an estimated time of arrival and first response diagnosis. The HALO worked as a co-ordinator alongside the bed manager and departmental co-ordinator for emergency admissions to ensure smooth handover, triage and flow through the department to help meet agreed timeframes and national targets.

Median time from arrival to treatment from November 2018 to October 2019 at West Hertfordshire Hospitals NHS Trust

![Graph](chart.png)

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

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

Managers and staff worked together ensure patients did not stay longer than they needed to. Patients seen in minors could be seen and discharged promptly by a doctor. Patients accessing the senior team assessment and rapid response area were seen promptly, admitted, assessed
and transferred to an appropriate area. Patients had access to multiple hot clinics, which allowed urgent access to secondary care specialist physicians enabling treatments on an urgent outpatient basis and avoiding unnecessary admissions. For example, respiratory, cardiology, neurology, dermatology to help ensure a prompt plan of care with a view to relieving pressure in the department. We followed the journey of a stroke patient who arrived in the department. Clinical staff followed the stroke pathway which included admission to resus and computerised tomography (CT) scan; all completed within one hour.

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 December 2018 to November 2019, the trust failed to meet the standard and performed consistently worse than the England average in all months with the exception of the most recent, November 2019. Performance at the trust ranged from 73% (February 2019) to 83% (September and October 2019), compared to the England average range of 82% to 87%.

In the most recent month, November 2019, 82% of patients at the trust were admitted, transferred or discharged within four hours of arrival in the emergency department which was the same as the England average.

**Four hour target performance - West Hertfordshire Hospitals NHS Trust**

![Graph showing four hour target performance](image)

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

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

From December 2018 to August 2019 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was consistently higher than the England average. However, in the most recent three months, September to November 2019, the percentage was similar to nationally. After our inspection, we reviewed updated information which demonstrated that over the nine months from July 2019 to March 2020 there was some improvement in the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted. Performance was lower than the England average in July and August 2019. However, from September 2019 to March 2020 there was an improvement in performance. Over these seven months performance was either better than or similar to the
England average. However, it was too soon to tell if this was sustained.

**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)

The table below shows the monthly numbers of patients waiting more than four hours to admission:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2018</td>
<td>746</td>
</tr>
<tr>
<td>January 2019</td>
<td>1287</td>
</tr>
<tr>
<td>February 2019</td>
<td>854</td>
</tr>
<tr>
<td>March 2019</td>
<td>979</td>
</tr>
<tr>
<td>April 2019</td>
<td>873</td>
</tr>
<tr>
<td>May 2019</td>
<td>1036</td>
</tr>
<tr>
<td>June 2019</td>
<td>649</td>
</tr>
<tr>
<td>July 2019</td>
<td>716</td>
</tr>
<tr>
<td>August 2019</td>
<td>979</td>
</tr>
<tr>
<td>September 2019</td>
<td>577</td>
</tr>
<tr>
<td>October 2019</td>
<td>669</td>
</tr>
<tr>
<td>November 2019</td>
<td>537</td>
</tr>
</tbody>
</table>

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

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

Over the 12 months from December 2018 to November 2019, no patients at the trust waited more than 12 hours from the decision to admit until being admitted.

(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**

The number of patients leaving the service before being seen for treatments was higher than the England average. From November 2018 to February 2019, the trust did not report any patients...
who left the trust’s urgent and emergency care services before being seen for treatment. However, from March to October 2019, the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was consistently higher than the England average.

In the most recent month, October 2019, the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 3.0%, compared to the England average which was 2.0%.

**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)

**Median total time in A&E per patient (all patients)**

From November 2018 to October 2019 the trust’s monthly median total time in A&E for all patients was similar to the England average.

In the most recent month, October 2019, the trust’s monthly median total time in A&E for all patients was 152 minutes, compared to the England average of 165 minutes.

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

(Source: NHS Digital - A&E quality indicators)
Managers and staff worked to make sure that they started discharge planning as early as possible. Staff worked with other professionals and agencies to ensure patients were safely discharged. We saw evidence of staff working with mental health professionals to support discharge planning for those with enduring mental health and social care needs. Patients could access the hospital’s frailty unit, which was based at the entrance of the department. This meant staff could work closely with frailty colleagues to provide timely specialist frailty support when they were discharged.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. Staff ensured safe discharge arrangements for people with complex needs. For particularly complex discharge they may admit patients to the clinical decisions unit to ensure suitable discharge planning arrangements had been put in place.

Staff supported patients when they were referred or transferred between services. Patient transfers followed national standards and were monitored by staff. Patients transferred between services for clinical need only, for example, for specialist treatment. Staff followed a patient through the transfer journey, for example, an anaesthetist or nurse would accompany a patient during transfer if assessed as appropriate. Managers monitored patient moves between wards and services to ensure they were kept to a minimum and the least disruptive to patients.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. However, complaint response times were sometimes longer than guidance within the trust policy.

Patients, relatives and carers knew how to complain or raise concerns. The service encouraged patients to raise complaints with staff in the department where they were receiving their care, or through the trust’s Patient Advice and Liaison Service (PALS) if they did not feel comfortable to do this or had already left the department. Patients in the waiting areas could access feedback forms and suggestion boxes.

The service clearly displayed information about how to raise a concern in patient areas. The Patient Advice and Liaison Service (PALS) was situated at the main entrance of the hospital and was clearly signposted. PALS was available to people who wanted to raise a complaint or concern. We saw evidence of staff providing a patient with PALS information. Patients could also find information on the trust’s website about how to make a complaint.

Managers investigated complaints and identified themes. We saw complaints were monitored and discussed at monthly performance meetings. We looked at complaints data for November 2019. We saw all complaints had been reviewed by appropriate medical and clinical representatives at every directorate performance review meeting. Complaints were investigated and signed off by a clinical lead. Staff reported 11 open complaints of which five were overdue. Three complaints had been dealt with in a timely manner and eight complaints were new. Staff documented 61% compared to 80% target of complaints responded to within one month or agreed timescales with a complainant. In December 2019, 63% of complaints had been achieved against the target of 80%. This meant there had been a small improvement from the previous
A dedicated team actively focused on overdue complaints to ensure timely responses. Dedicated complaints sessions with divisional complaints advisors took place to support improvement in quality and timeliness of responses. Feedback from complaints was used for improvement purposes and shared with staff.

**Summary of complaints**

**Trust level**

From November 2018 to October 2019, the trust received 59 complaints in relation to urgent and emergency care at the trust (16.6% of the total complaints received by the trust).

For the 55 complaints that had been closed at the time of data submission, the trust took an average of 38.9 working days to investigate and close the complaints. The trust policy states that complaints should be closed with 30 days, with a 40 day or mutually agreed timeframe for more complex complaints.

The four complaints, that had not yet been closed, had been open for an average of 24.5 working days at the time of data submission. This was in line with the trust’s policy.

A breakdown of complaints by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watford General Hospital</td>
<td>48</td>
<td>81.4%</td>
</tr>
<tr>
<td>Hemel Hempstead General Hospital</td>
<td>10</td>
<td>16.9%</td>
</tr>
<tr>
<td>St Albans City Hospital</td>
<td>1</td>
<td>1.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>59</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

**Watford General Hospital**

From November 2018 to October 2019, the trust received 48 complaints in relation to urgent and emergency care at Watford General Hospital (15.4% of the total complaints received by the hospital).

For the 45 complaints that had been closed at the time of data submission, the trust took an average of 38.5 working days to investigate and close the complaints.

The three complaints, that had not yet been closed, had been open for an average of 16.0 working days at the time of data submission. This was in line with the trust’s policy.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical care and treatment</td>
<td>32</td>
<td>66.7%</td>
</tr>
<tr>
<td>Staff attitude</td>
<td>7</td>
<td>14.6%</td>
</tr>
<tr>
<td>Appointments, assessment</td>
<td>3</td>
<td>6.3%</td>
</tr>
<tr>
<td>Complaints</td>
<td>Count</td>
<td>Percentage</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>Communications</td>
<td>3</td>
<td>6.3%</td>
</tr>
<tr>
<td>Admissions, discharge and transfers</td>
<td>2</td>
<td>4.2%</td>
</tr>
<tr>
<td>Privacy and dignity</td>
<td>1</td>
<td>2.1%</td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

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

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We saw complaints information recorded in minutes and completed complaints trackers monitored to monitor performance. The complaints tracker recorded acknowledgements to complaints to ensure compliance.

**Number of compliments made to the trust**

**Watford General Hospital**

From January to November 2019, there were four compliments received about urgent and emergency care at Watford General Hospital (2.4% of the total compliments received by the hospital). Three of these related to the A&E department and the remaining compliment related to the children’s A&E.

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

**Is the service well-led?**

**Leadership**

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The urgent and emergency care department was a part of the emergency medicine division. This division had been introduced formally in January 2019 after a restructure and a trial period. The leadership team worked as a divisional triumvirate, which consisted of a general manager, divisional director and head of nursing. Previously urgent and emergency care were a part of the unscheduled care division which encompassed all urgent and emergency services and more medical wards. The divisional restructure was to help with flow and to streamline management. Staff told us this also meant the leadership team focussed on first 24 hours of care.

Staff told us that the leadership team were approachable and accessible. Staff we spoke with spoke highly of the leadership team. They told us they felt listened to and felt valued by leaders with their contributions appreciated.
Staff with leadership responsibilities were supported in achieving leadership qualifications to equip them for their leadership positions. Staff were encouraged to develop into leadership roles. The performance manager told us that they started as a clinician and were encouraged to progress into leadership and to use their skills to improve performance in the department.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had developed vision and strategy. The vision for the department was ‘the very best care for every patient, every day’, and ‘right place, right care, first time, every time’. We looked at the 2020 strategy. The strategy set out the priorities. The leadership team took us through a visual infographic, which graphically displayed where the journey for improvement started and where the department were heading.

The trust had developed strategies that were embedded in the emergency medicine directorate performance review meetings. Staff from the department who attended the meeting followed a system of monitoring, review and reporting against current performance for each individual work stream. This included actions resulting from additional scrutiny by external agencies. We looked at records from the review meetings outlining an objective headed ‘strategy for the future’. This helped the leadership team focus on strategic themes that were reviewed at regular intervals to ensure compliance.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff worked in a culture of teamwork, respect and value. Staff at all levels worked together putting patients at the centre of their care. We saw this demonstrated from the point where patients checked in with reception staff in the main waiting areas, to healthcare assistant input being respected in resus. There was an open culture. Staff talked highly of managers and colleagues. All staff we spoke with told us they felt supported to raise concerns without reprisal and that their concerns were heard. We saw further demonstrations of a culture of openness messages relayed in the trust’s governance newsletter.

The leadership team proudly demonstrated their commitment to everyone in the department safe from violence and aggression. Reception staff were provided with a safety screen and there were security doors throughout the department which meant only people who were permitted could access restricted areas. Staff told us they had a very responsive security team in the event of an incident. Staff personal pinpoint alarms used to alert an emergency response.
Staff could access advancement and development opportunities. Staff provided us with examples of training and development opportunities supported by the leadership team. For example, masters programmes and leadership studies. Students told us that they were provided with the responsibilities specific to their competencies and were given opportunities to develop at their own individual pace.

The staff survey formal results were not available to review or discuss at the time of inspection. Managers told us that high level feedback fell in line with trust averages.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The leadership team told us they were proud of the work they had completed to improve governance across the department. A term of reference had been completed to support delivery of good governance. There was a clear governance structure that supported the organisation in the delivery of the vision and values and the delivery of high quality care. Governance and risk management arrangements were in place supported by risk registers which had actions in place to manage risks.

The leadership team spoke daily with the governance team and attended monthly governance meetings. We looked at the governance meeting minutes and saw appropriate membership from leaders including consultants and medical team staff. There was an agenda with standard items discussed at every meeting. For example, mortality and morbidity reviews where staff discussed patient deaths in the previous months. Audits were reviewed and a comprehensive safeguarding discussion was recorded.

The department employed a sepsis lead who facilitated good governance relating to sepsis management in the department. They promoted this through various initiatives, including a sepsis month and a social media group where staff could share information about sepsis.

Staff had access to a quality and governance newsletter. The newsletter we looked at, which was the winter issue, provided up to date governance information, including contact details for all staff in the governance team. Staff were provided with incident reporting and performance data. A ‘do you know the reporting procedure?’ guidance page, information on ‘do you know divisional trust risks?’ and shared learning from incidents. For example, equipment failure, an outline of the root cause and lessons learned. Divisional audits with shared learning.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
A performance manager was employed full time from Monday to Friday to provide managerial support operationally and clinically. The manager oversaw key performance indicators and escalation if those targets were not met. Staff could access key performance indicators data and information and associated standard operating procedures with contact details for escalation. The manager attended the department before daily handover, spoke with the nurse in charge to help manage issues. They looked at numbers, attendances, breaches; explored the issues and congratulated good work. All breaches were printed off daily and discussed at daily site meeting.

Staff kept an up to date risk register to manage departmental risks. The emergency department directorate performance review meeting took place on a monthly basis. Staff reviewed the risk register at every meeting. We looked at minutes from the meeting and saw all risks, with associated data and immediate action plans were documented and discussed. For example, ambulance handover delays.

The leadership team had developed a system wide winter and escalation plan. NHS England directed commissioners to provide additional capacity for 40 patients. Managers planned additional assessment bays available for patients in December 2019. Provision was made for an ambulatory care service.

Overall performance against the Emergency four hour standard was variable. We saw that in February 2020 the figure had increased to 83.4%. Minors performance continued to improve month on month achieving 97.3% in October. The director of performance chaired a weekly access meeting to review previous weeks performance and identify required areas of focus. We saw there was a performance improvement plan which included plans relating to ambulance handover. The division saw improvement in the children’s emergency department performance since the opening of paediatric assessment unit in June 2019. The leadership team worked closely with the children’s department. They attended regular meetings where performance was discussed and focussed on areas of improvement. There had been a task and finish group to explore the ambulatory care service to support an increase in patients being streamed away from the emergency department. Staff monitored delays and used the electronic system to capture data which was shared at the patient flow transformation group.

Staff used performance improvement plans (PIP) as a formal and structured way to manage performance problems and take steps for improvement. We saw evidence of a PIP for the implementation of the triage model and senior team assessment and rapid response (STARR) areas. This demonstrated improvements in decongestion of STARR area. The emergency department senior decision maker in STARR along with the specialities were proactively streaming patients away from STARR. This helped improve the ambulance turnaround times. Leaders closely monitored time to clinical assessment to improve on this performance. The consultant leading on the initiative told us they aimed for two discharges before 10:00 from each bay. Staff attended a discharge quality working group to support achieving early discharges. Progress was monitored at the group. Results from initiatives were shared in the meeting.

Full escalation protocols were in place ensuring patients received safe quality care whilst waiting. All mental health patients had a risk assessment undertaken on arrival which included consideration for enhanced care worker support of a registered mental health nurse. A mental health steering group was established to monitor and review issues relating to patients who attended with mental health concerns.
Staff monitored the percentage of discharge summaries that were sent electronically to GP practices within 24 hours. A standardised electronic discharge summary enabled continuous care of patients once they were discharged from hospital, with consistent and relevant information in the right place, quickly. We looked at data and saw 64% of discharge paperwork had been achieved for December against target of 95%. Actions were indicated in performance meetings and progress reviewed at monthly intervals against actions. We saw that email reminders were send to clinicians and performance for individual areas was shared with teams.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. However, IT systems were slow and not user friendly.

Staff used an electronic system for patients. Staff told, and we saw demonstrations of issues using the information technology infrastructure. For example, staff tried accessing patient information and the system was very slow and sometimes could not be accessed when needed.

Staff used real time electronic systems to monitor and analyse performance data. Staff could see real time data to help compare the number of predicted patient attendances against actual attendances. Staff could see patient waiting times, number of ambulance attendances, and patient outcomes. We spoke with the leadership team and the performance manager who demonstrated to us how data supported staff with decision-making in the department and helped work with other teams in the hospital to improve performance, for example, managing bed capacity.

Staff participated in national clinical audits. This included audits by the Royal College of Emergency Medicine. Staff provided data to external bodies and organisations and used the information to help them manage performance.

Staff accessed information needed to help them in their role using an electronic information management system. They could access policies and procedures using the intranet, hard copies kept in reference folders located in the nurses’ stations and in accessible data files. Staff had access to additional PC’s across the department to improve access, for example, senior team assessment and rapid response and Resus. Staff had access to a new electronic board display system in Majors.

**Engagement**

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff attended focus groups and project groups to work together to achieve their key performance indicators. Doctors attended these groups on weekly or monthly basis.
Staff attended various engagement opportunities with colleagues. For example, staff held a “stop the pressure” stall on national pressure awareness day. This was for all members of the multidisciplinary team and was very well attended.

Staff accessed secure social media accounts to engage with professionals and groups where learning and information was shared. Staff accessed online campaigns, speciality WhatsApp groups where staff engaged with each other to share good practice and provided peer support.

Local residents represented the community on a Patients’ Panel. People who participated in the panel helped bring patient’s point of view to help make improvements across the trust. The panel has access to all levels of the trust’s management. They visited wards and clinics and ensured they relayed patients’ care and concerns to encourage improvements.

Staff were recognised for their contribution and received thanks which was shared across the trust. Staff told us how they felt valued and recognised for their contribution. We saw that staff were rewarded by receiving awards which were recognised, acknowledged and shared in the hospital newsletter.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The leadership team were committed to continuous improvement. We saw this demonstrated in the commitment to improve the patient journey. This was outlined in the divisions strategy and vision for the future. Staff proudly demonstrated a visual representation of the planned improvement journey using a laminated infographic. There were established improvements, for example, the security system in the department. Staff excitedly told us about the new computerised tomography (CT) scanner which would make accessing the vital equipment easier and improve outcomes for patients. The government had made a financial investment commitment in improving the department and plans were in motion for a new build.

Staff told us they were invested in improving care and outcomes for patients. We saw examples of medical and non-medical staff being supported in achieving development opportunities. The leadership team proudly told us that a committed consultant had worked on a successful recruitment initiative to improve medical staffing in the urgent and emergency care department.
Medical care (including older people’s care)

Facts and data about this service

The medicine division oversees the care of 320 medical inpatient beds (this excludes acute admission units), the cardiac catheter laboratory and endoscopy services.

In October 2019, a pilot commenced at the trust whereby specialist consultants were integrated in front door management (managing patients presenting at urgent and emergency services), to review patients quickly and identify alternative pathways to admission. The division supports the frailty unit in ambulatory care (a service which aims to identify patients with frailty as soon as possible, to improve outcomes, including reducing avoidable hospital admissions and supporting patients to be cared for in the community), and has been working in partnership with the Emergency Care Improvement Programme (ECIP) on back door flow and enhanced working with the discharge planning team and social care services. Weekly review meetings were in place for patients with long lengths of stay; this includes a work stream on discharge planning. Discharge assessment review teams are also in place for patients with a length of stay over 21 days, whereby they are reviewed on the ward by a clinical team.

The medicine division at the trust works in partnership with general practice and clinical commissioning group colleagues through integrated care transformation pathways and other partners. A series of integrated services were in place within respiratory, diabetes and rheumatology specialities. The trust provided a Joint Advisory Group (JAG) accredited endoscopy unit and provided the bowel scope screening programme.

Simpson ward is located on the Hemel Hempstead site; it was transferred to the trust on 1 October 2019. Nursing leadership is provided by a full-time senior nurse. Beds are allocated to patients who meet pathway three of the South Warwickshire discharge to assess (DTA) model of care or meet flex criteria (point of care) when there is capacity and no pathway three patient identified. A DTA is where people can be assessed and cared for in a non-acute setting and do not require an acute hospital bed. They may still require care services provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.
The integrated discharge team has partnered with the medicine division and work closely with the flow manager to reduce length of stay.

(Source: Acute Routine Provider Information Request (RPIR) – Acute context tab)

The trust had 52,396 medical admissions from September 2018 to August 2019. Emergency admissions accounted for 26,563 (50.7%), 514 (1.0%) were elective, and the remaining 25,319 (48.3%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 21,557 admissions
- Gastroenterology: 15,511 admissions
- Clinical haematology: 4,012 admissions

(Source: Hospital Episode Statistics)

Medical care services were managed within the division of medicine. The last CQC inspection of the medical care service at Watford General Hospital was in November 2018 when the service was rated as good overall. Safe was rated as requires improvement. The remaining four key questions of effective, caring, responsive and well led were rated as good.

We carried out an unannounced inspection from 11 to 13 February 2020, during which we visited the acute admissions unit, medical assessment unit, ambulatory care, metabolic day unit, discharge lounge, endoscopy unit and 12 medical wards.

We spoke with 83 members of staff including nurses, doctors, matrons, senior managers, healthcare assistants, pharmacists, allied health professionals, and administrative staff. We also spoke with 21 patients and relatives. We observed interactions between patients and staff, considered the environment and looked at 19 care records including patients’ medical notes and nursing notes. We also reviewed other documentation from stakeholders and nationally published performance data for the trust.

The inspection team consisted of a lead inspector and three specialist advisors.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff. However, not all medical staff were up to date with mandatory training.

Staff received mandatory training in the safety systems, processes and practices. However, not all medical staff were up to date with their training.

Mandatory training completion rates

The trust set a target of 90% for the completion of mandatory training.
Watford General Hospital

Nursing staff received and kept up-to-date with their mandatory training. A breakdown of compliance for mandatory training courses from April to October 2019 for qualified nursing staff in medicine at Watford General Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Manual handling (non-patient)</td>
<td>1</td>
</tr>
<tr>
<td>Fire safety (non-clinical)</td>
<td>1</td>
</tr>
<tr>
<td>Learning disability (TEACH) (essential)</td>
<td>466</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>466</td>
</tr>
<tr>
<td>Basic health, safety and risk</td>
<td>465</td>
</tr>
<tr>
<td>Venous thromboembolism prevention (essential)</td>
<td>462</td>
</tr>
<tr>
<td>Blood handling (essential)</td>
<td>436</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>461</td>
</tr>
<tr>
<td>Infection control (clinical)</td>
<td>456</td>
</tr>
<tr>
<td>End of life care (essential)</td>
<td>440</td>
</tr>
<tr>
<td>Manual handling (patient contact - level 2)</td>
<td>450</td>
</tr>
<tr>
<td>Information governance</td>
<td>445</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>444</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>412</td>
</tr>
<tr>
<td>Fire safety and evacuation (clinical)</td>
<td>394</td>
</tr>
</tbody>
</table>

In medicine at Watford General Hospital, the 90% target was met for 13 of the 15 mandatory training modules for which qualified nursing staff were eligible.

Medical staff received but did not always keep up to date with their mandatory training. A breakdown of compliance for mandatory training courses from April to October 2019 for medical staff in medicine at Watford General Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Fire safety and evacuation (clinical)</td>
<td>47</td>
</tr>
<tr>
<td>Manual handling (patient contact - level 2)</td>
<td>47</td>
</tr>
<tr>
<td>Basic health, safety and risk</td>
<td>200</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>198</td>
</tr>
<tr>
<td>Infection control (clinical)</td>
<td>197</td>
</tr>
<tr>
<td>Manual handling (non-patient)</td>
<td>149</td>
</tr>
<tr>
<td>Information governance</td>
<td>187</td>
</tr>
<tr>
<td>End of life care (essential)</td>
<td>172</td>
</tr>
<tr>
<td>Fire safety (non-clinical)</td>
<td>134</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>141</td>
</tr>
<tr>
<td>Blood handling (essential)</td>
<td>136</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>137</td>
</tr>
<tr>
<td>Venous thromboembolism prevention (essential)</td>
<td>126</td>
</tr>
</tbody>
</table>
In medicine at Watford General Hospital, the 90% target was met for five of the 15 mandatory training modules for which medical staff were eligible.

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

The mandatory training was comprehensive and met the needs of patients and staff. Training covered key areas such as infection control, information governance, basic health, safety and risk, fire safety and evacuation, manual handling, equality and diversity, and end of life care. Training was provided through e-learning modules and face-to-face sessions. Staff understood their responsibility to complete mandatory training, however, not all medical staff completed it.

Nursing staff told us that they accessed training to meet their competencies for basic and extended skills. Examples of training included; how to insert tubes to feed patients and training in how to take blood and use a canula (access for giving patients intravenous fluids and drugs).

Therapists told us they had access to basic and extended training that was relevant to their job role. This included training on use of specialist assessments and equipment.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff were able to explain how they accommodated patients who had mental health needs. Staff had a good awareness of caring for a patient with dementia and their specific needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. Completion of mandatory training was recorded on an electronic system. Staff were expected to complete mandatory training according to their roles. Training uptake was reported and monitored across the division; staff were encouraged to take responsibility for completing mandatory training themselves. They were sent reminders by email to ensure they completed it on time.

Divisional mandatory training compliance was discussed at monthly divisional performance meetings with executives. Any specific areas of concern were discussed at this forum and an action plan agreed. In addition, mandatory training reports were discussed at monthly divisional governance group meetings and particular areas of concern were fed back to the clinical leads and assistant divisional managers to resolve at departmental level. Mandatory training reports were then reviewed at weekly divisional management team meetings to monitor the progression of the action plans.

Senior leaders were aware of the poor compliance with mandatory training amongst medical staff. They told us middle grade doctor training was an issue due to complicated work rotas. Concerns had been raised at the clinical advisory group meeting and a new process for training introduced. Mandatory training for all middle grade and junior doctors was now linked and fed back to their educational supervisors so clear lines of responsibility were in place.

At our last inspection, 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 whilst they were at work. However, at this inspection access to mandatory training had improved. Staff told us they were able to access and complete online training at home if necessary.
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 were up to date with safeguarding training.

There were clear systems, processes and practices in place to safeguard patients from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements. However, compliance with safeguarding training amongst medical staff did not always meet the trust target.

Safeguarding training completion rates

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

The tables below include Prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

Watford General Hospital

Nursing staff received training specific for their role on how to recognise and report abuse. A breakdown of compliance for safeguarding training courses from April to October 2019 for qualified nursing staff in medicine at Watford General Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>466</td>
<td>470</td>
<td>99.1%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>453</td>
<td>466</td>
<td>97.2%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>PREVENT WRAP</td>
<td>414</td>
<td>446</td>
<td>92.8%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

In the medicine division at Watford General Hospital, the 90% target was met for all four safeguarding training modules for which qualified nursing staff were eligible.

Medical staff received training specific for their role on how to recognise and report abuse, however, not all had completed it. This was a concern we raised at our last inspection. A breakdown of compliance for safeguarding training courses from April to October 2019 for medical staff in medicine at Watford General Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>181</td>
<td>200</td>
<td>90.5%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>163</td>
<td>215</td>
<td>75.8%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>PREVENT WRAP</td>
<td>106</td>
<td>164</td>
<td>64.6%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

In medicine at Watford General Hospital, the 90% target was met for two of the four safeguarding training modules for which medical staff were eligible.
As with poor compliance with mandatory training amongst medical staff, a new process had been introduced whereby all training for middle grade and junior doctors were linked and fed back to their educational supervisors with clear lines of responsibility.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff demonstrated a good understanding of their responsibilities in relation to safeguarding patients in vulnerable circumstances and were confident to make safeguarding referrals. Staff completed patient care plans which had a dedicated section to record safeguarding issues and share key information to safeguard patients. For example, a patient who may need additional monitoring due to ongoing safeguarding concerns or vulnerability due to learning disability. Vulnerable patients, including those living with a learning disability, dementia, or safeguarding were highlighted at daily handover meetings.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service had comprehensive safeguarding policies that reflected relevant legislation and local requirements. Staff liaised with other professionals and agencies, such as health visitors, social workers, the police, independent domestic violence advisors, and the community mental health team, as needed. Multidisciplinary teams worked well together to ensure the safety of their patients.

The trust had up-to-date guidance on female genital mutilation (FGM), which was in line with national recommendations. Clinical pathways were in place for the mandatory reporting and safeguarding of women with known, suspected and/or risk of FGM, which staff could access from the trust intranet.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had a safeguarding lead and team in place who provided support, supervision, training and updates for staff. Staff knew who the safeguarding lead was and had a good understanding of how to recognise safeguarding concerns.

Staff followed safe procedures for children visiting the ward. Staff were aware of how to protect children visiting the wards. Ward areas we visited were locked at all times. Access was gained by using a buzzer. Staff gave clear guidance to visitors on who was allowed into the ward and allowed by the patient bedside.

Processes were in place to support the care of patients who posed a risk of absconding from a ward. The wards were secure with buzzer and swipe card access, this was an additional aid in the event that a patient ‘tailgated’ a relative who may hold the door open despite requests not to do so.

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

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises generally clean.

However, although most of the areas we visited were clean, we observed some wards which had not been cleaned regularly. Cleaning schedules were not always signed and
dated to evidence regular cleaning took place.

Cleaning materials that were covered by control of substances hazardous to health (COSHH) were not always locked and secured in line with legislation.

Ward areas were mostly clean and had suitable furnishings which were clean and well-maintained. Most of the wards we visited were visibly clean and free from clutter. However, we observed some wards with cluttered corridors and bathrooms and window ledges which had not been cleaned regularly.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. ‘I am clean’ stickers showed where staff had cleaned equipment and we observed staff cleaning equipment between use. Examination couches and beds were clean, intact and made of wipeable materials. This meant they could easily be cleaned between patients. Disinfectant wipes were available in all clinical areas to wipe down equipment between patients. White paper rolls were used on examination couches which were changed between patients. Individual rooms and beds were cleaned after each patient.

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.

The service generally performed well for cleanliness. Hand hygiene audits for December 2019 and January 2020 showed most medical wards achieved 100% compliance. Nursing staff achieved 97% compliance with infection prevention control training and medical staff achieved 91% compliance.

Dispensers of hand sanitising gel or foam were available at the entrance to each department, within clinical areas and available in every patient area, alongside handwashing facilities. There were written prompts, which reminded staff, visitors and patients to decontaminate their hands. We observed staff adhering to good hand hygiene practices. We spoke with nursing and medical staff who told us that they felt confident to challenge colleagues regarding hand hygiene.

Disposable curtains were in use around patient beds and examination areas. All were dated with the date on which they were last changed. All curtains we checked had been changed in line with the trust policy.

Spill kits, for the safe cleaning of body fluids, such as blood, were readily available in each of the dirty utility rooms we visited.

Cleaning records were not always up-to-date and did not always demonstrate that all areas were cleaned regularly. Domestic staff cleaned all areas daily, nursing and support staff cleaned between patients. However, cleaning schedules were not always signed and dated to evidence regular cleaning took place. We found old cleaning schedules in the bathroom on one ward which were dated April 2019.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service had access to infection prevention and control nurses for support and advice. Staff were ‘arms bare below the elbow’ and had access to personal protective equipment (PPE), including aprons and gloves.

We saw patients with infections were nursed in side rooms with appropriate signage displayed to reduce the risk of spreading infection. Deep cleans were arranged following the discharge of
patients with an infection. There were apron and glove stations near to all side rooms to ensure that both patients, relatives and staff were protected.

There were processes in place for clinical waste management. Clinical waste bins were foot operated and once bags were full, they were removed to a secured waste area. Waste was separated into different coloured bags to signify the different categories of waste. This was in accordance with the health technical memorandum (HTM) 07-01, control of substance hazardous to health (COSHH), health, and safety at work regulations. All sharp boxes we observed were correctly assembled, labelled, and dated. None of the bins were more than half-full, which reduced the risk of needle-stick injury. This is in accordance with HTM 07-01: safe management of healthcare waste. All sharp bins had temporary closures in place. Temporary closures are recommended to prevent accidental spillage of sharps if the bin was knocked over and to minimise the risk of needle-stick injuries.

From February 2019 to January 2020, the trust reported 23 Clostridium difficile (C. difficile) infections in the medicine division 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 February 2019 to January 2020, on average 95.2% of patients eligible for screening were screened within the recommended time frame. This was in line with the trust target of 95%.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. We observed staff ensuring that patients had call bells within reach as well as other equipment, for example walking aids. Patients we spoke with told us that staff responded to them quickly.

The design of the environment followed national guidance. At our last inspection, we found 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. We were not confident the security arrangements were adequate to prevent vulnerable patients leaving the building. There had been incidents of patients absconding ward areas, however, during this inspection, we found this had improved. The service had a programme in place specifically looking at the environment, particularly for patients living with dementia. Bluebell ward and Winyard ward had painted their fire door exits to look like a bookshelf. Using colour contrasting doors or door frames can help people living with dementia identify areas or objects to improve their safety. In addition, the garden areas had been made secure to prevent vulnerable patients living with dementia or experiencing confusion from absconding. Staff told us there had been no incidents of patients absconding from the wards since December 2018.

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.
Cleaning materials that were covered by control of substances hazardous to health (COSHH) were not always locked and secured in line with legislation. We found sluices where COSHH material was stored were unlocked on some of the wards we visited. We raised this nursing staff who told us a risk assessment had been completed and sluices with COSHH material were not required to be locked as long as COSHH materials were stored in locked cupboards.

Window restrictors were used on the wards to reduce the risk of falls and the blind cords were not a ligature or strangulation risk. Flooring was non-slip and in good condition in all areas we visited. However, some of the areas we visited did not have curved edges. The Department of Health (2013) Health Building Notes (HBN) 00-10 regulation consider floors should have curved edges to prevent bacterial growth. Staff told us plans were in place to replace flooring to ensure it was compliant.

Staff carried out daily safety checks of specialist equipment. Resuscitation equipment, for use in an emergency, was easily accessible. Resuscitation trolleys were available on each ward and clinical areas. Equipment on the trolleys was 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 observed checks across all medical wards were completed daily to confirm that equipment was ready for use. Piped oxygen and suction equipment was available at each bed space, as well as emergency call buttons.

The service had suitable facilities to meet the needs of patient’s families. Medical wards were clearly sign posted from the main reception and throughout the corridors. Wards consisted of multiple bedded bays, generally containing six beds. Patients who required more observation due to their clinical condition were situated in the bays opposite the nurses’ station.

All ward areas were well lit, and most were spacious. However, some ward areas we visited were cluttered with equipment in the corridors, although staff were able to get through with emergency trolleys if needed. The environment around the beds we inspected were uncluttered, and equipment was dated as checked and fit for purpose.

The maintenance and use of equipment kept patients safe. Electrical appliances and equipment we checked during the inspection had been tested and serviced to ensure they were safe to use and had stickers with appropriate dates to show that this had taken place. We checked 43 pieces of equipment and the majority were in date. However, we found testing on an intravenous pump machine in the ambulatory care unit had expired in January 2019. We raised this with a senior nurse who immediately removed it from the service.

There was a range of manual handling equipment available, for example, hoists and turning tables. There was a gym located in the stroke ward for patients who required rehabilitation. Physiotherapists told us they generally had adequate equipment to do their work safely, such as pressure-relief cushions to support patients at risk of pressure ulcers.

The endoscopy service was accredited with the Joint Advisory Group on Gastrointestinal Endoscopy (JAG). JAG is an accreditation scheme that is awarded to endoscopy services following a peer review of standards. JAG awarded a trust with accreditation upon the achievement of a framework of requirements supporting the assessment of endoscopy services and achievement of person-centred care.

All staff we asked showed an appropriate awareness of fire safety protocols throughout the unit, including demonstrating the location of the nearest fire exit.
The service had enough suitable equipment to help them to safely care for patients. Staff could access bariatric equipment (equipment for heavier patients) when requested, for example bariatric beds and wheelchairs. Nursing staff told us syringe drivers, feeding pumps, bariatric and pressure relieving equipment was easily accessible when it was required.

Staff disposed of clinical waste safely. There were arrangements for managing waste and clinical specimens. There were separate colour coded arrangements for general waste and clinical waste. Sharps bins were dated and were not overfilled.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

Appropriate systems were in place to assess risk, recognise and respond to deteriorating patients within the service. Systems were in place to appropriately assess and manage patients with mental health concerns.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used the national early warning score 2 (NEWS2) system. NEWS2 is a point system tool used to standardise the approach to detecting deterioration in a patient’s clinical condition. The NEWS2 was calculated and recorded on a paper based system. The generated NEWS2 score provided a prompt to the staff entering the data, to review if the patient was unwell and/or deteriorating, required a medical review or if the nurse should consider possible sepsis. On review of records, observations were routinely completed and escalated appropriately when needed. The trust had a deteriorating patient policy, which clearly outlined the criteria for escalating the deteriorating patient. All staff we spoke with knew how to escalate deteriorating patients and understood the importance of doing this in a timely manner.

Staff had 24-hour access to onsite level two and three critical care for patients who required additional one to one care for invasive intensive interventions.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Medical staff completed an initial admission assessment for patients, that included their presenting problem, past medical history and physical assessment. Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance. We reviewed 19 sets of patient records and found all were completed, legible and risks were monitored routinely.

Staff knew about and dealt with any specific risk issues. There was a clear pathway for the management of sepsis. Sepsis is a potentially life-threatening illness when the body’s response to infection injures its own tissues and organs. Early recognition and prompt treatment have been shown to significantly improve patient outcomes. Nursing and medical staff confidently described the signs of and what treatment should be initiated in line with national and local guidance. This included completing the ‘Sepsis Six’ pathway 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. Suspected or confirmed cases of sepsis were managed using a sepsis screening tool, in line with National Institute of Health and Care Excellence (NICE) and the UK sepsis guidance.
All wards had sepsis toolkits which were easily accessible, secured and contained all necessary equipment and medicines for treating a patient with suspected and confirmed sepsis.

Further risk assessments were undertaken for venous thromboembolism, falls, malnutrition and pressure ulcers. These were documented in patient records and included actions to mitigate any identified risks. The trust used the malnutrition universal screening tool (MUST) to identify patients, who were malnourished, at risk of malnutrition or obese. We observed that patients identified at risk had a care plan in place and were monitored more frequently by staff to reduce the risk of harm.

The trust had a dedicated falls prevention nurse and tissue viability nurse and staff followed up to date guidance to complete falls and pressure care assessments.

We saw all patients had their skin integrity assessed within six hours of admission in line with national guidance. Pressure ulcers affect an area of skin and underlying tissue and are categorised according to severity from one to four. For example, category one identifies the discolouration of skin, with category four being full thickness skin loss with underlying damage to muscle, bone or tendons. All pressure ulcers reported by the service as a serious incident were category two and above. Patient notes confirmed that referrals were made to a tissue viability nurse for assessment and advice when necessary.

Patients that were at high risk of falls had additional safety measures in place, including enhanced observations. Staff had access to floor lowering beds if needed.

Ward staff carried out intentional care rounding checks every hour on all patients to document that comfort and care needs were met. Records we reviewed showed that these checks had been completed and recorded.

Urgent or unplanned admissions were seen and assessed by a consultant within 12 hours of admission. Patients were admitted to the acute medical unit from the emergency department or by their GP, where there was consultant presence at all times.

There was always at least one registered nurse present within the patient discharge lounge. Processes and procedures were in place should there be an emergency, or the patient deteriorated whilst in the discharge lounge.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). Staff knew how to contact the mental health team when required and were aware that this was a 24-hour service.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff described how they would access the mental health team should they have any concerns, and there was a timely response to assess patients.

Staff shared key information to keep patients safe when handing over their care to others. We saw that safety briefings occurred in all areas at least once a day. Safety briefings included discussion around staffing and skill mix. Appropriate actions were taken following the safety briefing and concerns escalated to senior staff.

All staff participated in ward handovers where key information was shared at regular intervals throughout the day. This information included discharge planning, the patient’s current wellbeing, any safeguarding issues, ongoing clinical needs and additional key information appropriate to the patients care.

Shift changes and handovers included all necessary key information to keep patients safe. Nursing staff on wards held a handover when staffing changed. This included all relevant information on
patients’ needs. We observed handovers between the day teams and night teams and found shift changes and handovers included all necessary key information to keep patients safe.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. The trust used a nationally recognised tool twice a year, to review and set nurse staffing levels for inpatient wards. Most inpatient ward areas worked on a 60% to 40% ratio for registered and unregistered nursing staff. The ratio of registered nurses was increased in some specialties, such as respiratory and cardiology, due to the high acuity of their patients. Matrons for each area had oversight and managed any safety issues that arose.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The trust used a safer staffing bundle to monitor staffing levels and ensured that staff were delegated appropriately across the service. Daily meetings enabled the staff team to identify any areas where staffing shortfalls occurred, and managers delegated staff accordingly.

The ward manager could adjust staffing levels daily according to the needs of patients. An escalation plan was in place to address staffing issues, including the use of flexible rotas to cover staffing gaps. Nurses were redeployed from other areas to support the service when needed and ensure patient acuity needs were met. The trust used a safe staffing tool, which considered nursing activity as well as patient dependency. This enabled senior nursing staff to identify areas with staffing pressures and allocate staffing across the organisation.

The number of nurses and healthcare assistants matched the planned numbers. During our inspection all ward areas we visited displayed the current and expected staffing levels for each shift. All ward areas were staffed in line with expectations. Nursing staffing levels and skill mix were reviewed on a daily basis and adjusted according to patient acuity and dependency to provide safe care.

Staff confirmed that if they had concerns about staffing levels, they would escalate this to senior management for their review. Staff also said that they could call the matron who would put procedures in place to ensure they received the appropriate support.

There were effective nursing handovers at shift change times. Nursing handovers took place at 7:15am and 7:15pm every day. We observed a morning handover. Nursing staff were allocated to care for specific bays, side rooms, or patients who needed one to one care. Each nurse handed over their patients to the specific nurse taking over that area and the nurse in charge had a handover of the whole department. Senior staff provided an overview of all the patients on the ward and highlighted any issues for staff to be aware of. Each staff member was able to access information detailing patient clinical history and updated treatment plans. The nurse handing over discussed each patient, how the patient had been and what changes had occurred. Handovers were concise and gave oncoming staff a clear description of what each patient required.

Watford General Hospital
The table below shows a summary of the nursing staffing metrics in medicine at Watford General Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>November 2018 to October 2019</th>
<th>September 2018 to August 2019</th>
<th>November 2018 to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average establishment</td>
<td>Annual vacancy rate 10%</td>
<td>Annual turnover rate 13%</td>
</tr>
<tr>
<td>Target All staff</td>
<td>1,449</td>
<td>8%</td>
<td>11%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>472</td>
<td>5%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Nurse staffing rates within medicine at Watford General Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and bank use.

Please note that the trust was unable to provide total hours including those covered by substantive staff to allow us to calculate bank and agency usage or unfilled hours for nursing staff as a percentage of the total hours available.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

**Vacancy rates**

The service had reducing vacancy rates for nursing staff. The trust had a comprehensive recruitment programme in place to address shortfalls in the nurse staffing levels. The trust had been successful in attracting nurses from overseas. New nurses were supernumerary on wards until completing the required competencies and conversion processes.

![Vacancy rate - registered nurses](image)

Monthly vacancy rates over the last 12 months for registered nurses showed a downward shift from May 2019 to October 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
Turnover rates

The service had low turnover rates for nursing staff. Managers had a comprehensive recruitment process and were actively seeking to attract staff who were looking for long term careers with the trust. We met a number of staff who had trained within the trust and managers actively promoted opportunities to apply for additional training or roles in order to reduce turnover rates.

Sickness rates

The service had a varying sickness rate but with the exception of July to October 2019 was largely below the trust target of 3.5%.

Monthly sickness rates over the last 12 months for registered nurses showed an upward shift from May 2019 to October 2019.

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

Bank and agency staff usage

The service had reducing rates of agency nurses.

Monthly agency use over the last 12 months for registered nurses showed a downward shift from May 2019 to October 2019.
Managers limited their use of bank and agency staff and requested staff familiar with the service. The service used bank and agency staff to meet planned staffing numbers. Internal bank staff were offered unfilled shifts to ensure staffing establishment was met. Staff told us that the bank staff used were generally the same staff and were known to the service. Managers made sure all bank and agency staff had a full induction and understood the service.

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

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Medical staffing was appropriate with effective out of hours and weekend cover. Rotas were planned to ensure adequate numbers of medical staff. Medical staff we spoke with told us that there were sufficient staffing levels and a willingness for staff to cover each other at times of absence or due to holidays and training.

Each ward had a dedicated consultant who was responsible for patients’ treatment. The number of specialty consultants varied according to the specialty and ward size. Each consultant team had a registrar and two more junior doctors. Junior doctors were easily contacted and responded in a timely manner.

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 (senior medical staff) completed the ward rounds on other days.

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 was protected free time for junior doctors.

We observed three multi-disciplinary board rounds attended by medical staff, therapies staff and nursing staff, as well as a discharge co-ordinator. The board rounds were organised and detailed the patients’ medical history, current treatment plan and any important information, such as; resuscitation status or further clinical reviews required. Discussions also prioritised patients who required a medical review, followed by those patients who could potentially be discharged.

Watford General Hospital

The medical staff matched the planned number. The table below shows a summary of the medical staffing metrics in medicine at Watford General Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Medicine annual staffing metrics</th>
<th>November 2018 to October 2019</th>
<th>September 2018 to August 2019</th>
<th>November 2018 to October 2019</th>
<th>October 2018 to September 2019</th>
</tr>
</thead>
</table>

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<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual locum hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>1,449</td>
<td>10%</td>
<td>13%</td>
<td>3.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>210</td>
<td>2%</td>
<td>9%</td>
<td>0.4%</td>
<td>176,269</td>
<td>80,149</td>
<td>25,272</td>
</tr>
</tbody>
</table>

Medical staffing rates within medicine at Watford General Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and bank use.

Please note that the trust was unable to provide total hours including those covered by substantive staff to allow us to calculate bank and locum usage or unfilled hours for medical staff as a percentage of the total hours available.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Vacancy rates

The service had low vacancy rates for medical staff.

![Vacancy rate - medical staff](chart)

Monthly vacancy rates over the last 12 months for medical staff showed an upward shift from May 2019 to October 2019.

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

Turnover rates

The service had low turnover rates for medical staff.

Sickness rates

Sickness rates for medical staff were low.
Monthly sickness rates over the last 12 months for medical staff showed an upward shift from May 2019 to October 2019.

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

Bank and locum staff usage

The service had reducing rates of bank and locum staff.

Monthly locum use over the last 12 months for medical staff showed a downward shift from April 2019 to September 2019.

Managers could access locums when they needed additional medical staff. Locum staff were used when needed, especially during the winter escalation months.

Managers made sure locums had a full induction to the service before they started work. All locum staff completed a detailed induction to the department prior to commencing duties.

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

Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Managers reviewed medical staffing levels frequently and ensured appropriately qualified medical staff were available.
In September 2019, 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. Locum staff were used to fill any gaps.

**Staffing skill mix for the 199 whole time equivalent staff working in medicine 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>41%</td>
<td>44%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>23%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>31%</td>
<td>20%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at Senior House Officer (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)

The service always had a consultant on call during evenings and weekends. Out of hours, on call consultants were contactable and a defined rota was in place. Medical cover overnight consisted of a team of registrars and junior doctors’ registrars who were responsible for all inpatient areas.

**Records**

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

Patient’s notes were comprehensive, and all staff could access them easily. Throughout our inspection we found staff took great care in securing patient records and maintaining these to a high standard. 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.

For patients living with dementia or learning disabilities, specific additional documents called ‘This is Me’ ‘Forget Me Not’ or ‘Purple Folder’ were used. This presented information in an easy-read format and included details of likes and dislikes, as well as personal information about the patient.

Staff completed and recorded intentional care rounding. Intentional care rounding is a structured process where staff performed regular checks with individual patients at set intervals. For example, we observed HCAs visiting patients every hour during the day to check that call bells and drinks were within reach and they asked if the patient was comfortable or in any pain. We saw these were documented in the patients’ records we reviewed.
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.

We reviewed 19 patient records and found all contained patient reviews, referrals to and from other clinicians and clear treatment plans. All the entries from current admissions were dated, timed and most were signed by staff.

There was clear documentation from physiotherapists, occupational therapists, psychologists and speech and language therapists. There was also a clear record of psychiatric liaison involvement with patients in the notes to ensure staff could see the treatment and advice that was given to patients with mental health conditions.

When patients transferred to a new team, there were no delays in staff accessing their records. The trust had ward administrators who supported staff to access records quickly and ensure records were maintained to an appropriate standard.

Records were stored securely. Records were stored securely. Patient nursing records were stored at the end of the patient’s bed in a closed folder and medical records were stored in a locked cabinet with key pad entry.

**Medicines**

The service generally used systems and processes to safely prescribe, administer, record and store medicines. However, antibiotic prescriptions did not always include review dates and patients weights were not always recorded.

Staff generally followed systems and processes when safely prescribing, administering, recording and storing medicines. We reviewed 19 prescription charts 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, the indication and review dates for patients commenced on antibiotics was not always recorded in charts we reviewed on the acute admissions unit (AAU). This was the case in two out of the 19 charts we reviewed. When antibiotics are prescribed, the indication and a review date should be recorded, to ensure antibiotics are not continued for any longer than is necessary. This was a concern raised at our last inspection.

On the acute admissions unit, patient weights were not always recorded on drug charts for venous thromboembolism prophylaxis. The anticoagulation and thromboprophylaxis policy states to adjust doses of medication based on patients’ weights. We also observed some prescription charts with medications crossed off and not signed by doctors. It is good practice to sign and state the reason why medication was stopped.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. Pharmacists were based on some of the acute medical wards and during the week a clinical pharmacist visited all the wards daily. They reviewed prescription monitoring, 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. The pharmacist undertook clinical checks on patients’ medicines to ensure safe prescribing with any interventions recorded or discussed directly with the
prescriber, and checked elderly patients understood their medications before they were discharged. A quick discharge service was available on a number of acute medical wards.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. 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. All intravenous fluids were stored safely behind locked doors and only accessible to appropriate staff.

Controlled drugs were stored correctly according to the Misuse of Drugs (Safe Custody) Regulations 1973. Controlled drugs are those at risk of misuse and therefore require additional safety measures. We saw that controlled drugs usage was recorded in appropriate secure records, checked and administered daily by two nurses.

All medicines we checked were in-date.

Resuscitation trolleys contained medicines required in an emergency and were accessible. Daily checks were in place to ensure emergency medicines were available and safe to be used. Gases were stored appropriately.

Staff followed current national practice to check patients had the correct medicines. There was a process to monitor and record medication administration on all wards. Staff ensured that the right patient had the right medications. All patients had their name on their wrist bands, these were checked prior to administration to ensure that the right patient was getting the right medicine.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff knew how to report a medicine incident and followed the trust policy. Any known allergies or sensitivities to medicines were recorded on the medicine charts. This information prevented the potential of a medicine being given in error and causing harm. Any medication safety alerts were shared at clinical governance meetings, with the information shared through safety briefings and during staff handovers.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. Staff ensured that patients’ behaviour was not being controlled by inappropriate use of medicines. All medications administered were recorded, to ensure patients were not taking excessive amounts. If patients were given potentially addictive medications, such as some forms of pain relief, to take home, they were only given three days’ supply so as to avoid any overdosing. Patients were advised to see their GP if they required further medication.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Both medical and nursing staff were able to provide examples of when they had appropriately reported an incident. Staff told us they always received feedback when they had requested it on the initial reporting form.
Staff raised concerns and reported incidents and near misses in line with trust policy. Staff were encouraged to report incidents, even when they felt they were not significant. Staff reported all incidents using the trust’s electronic incident reporting system. Staff were confident that action had been taken following incidents they had reported. The electronic incident reporting system was easily accessible to all staff across all clinical areas.

**Never Events**

The service had one never event. 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.

**Trust level**

From January to December 2019, the trust reported one incident that was classified as a never event for medicine. The incident occurred at Watford General Hospital in August 2019 and related to a misplaced naso-gastric (NG) tube.

*(Source: Strategic Executive Information System (STEIS))*

We reviewed the investigation report following the never event, which included actions taken and recommendations to minimise the risk of recurrence. We saw evidence of patient involvement and application of duty of candour principles. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The following actions were taken as a result of the never event:

- NG feeding on patients who require x-ray confirmation of tube position was not to commence until the x-ray had been reviewed by a consultant radiologist.
- Processes to be in place within radiology to ensure that reporting of NG tubes takes place in a timely manner.

Managers shared learning about never events with their staff and across the trust. Lessons learned were disseminated through corporate and divisional forums. These included safety huddles, newsletters, quarterly learning events, cross divisional attendance at clinical governance meetings, divisional clinical governance meetings, divisional quality summits, and bespoke training on wards.

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with trust policy. Staff we spoke with could clearly explain the procedures they would follow to report serious incidents.

**Watford General Hospital**
In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in medicine division at Watford General Hospital which met the reporting criteria set by NHS England from January to December 2019. This included the never event described above.

A breakdown of incidents by incident type are below.

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>4</td>
<td>66.7%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>1</td>
<td>16.7%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>1</td>
<td>16.7%</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

The trust carried out a root cause analysis (RCA) in relation to serious incidents and identified preventative actions. We reviewed a sample of the incident investigation reports for the reported serious incidents and found comprehensive investigations. The investigation reports included recommendations and actions taken to minimise the risk of recurrence. We saw evidence of patient involvement and application of duty of candour principles.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff were aware of and understood the duty of candour regulation and described how they applied the principles by being open and honest with patients always and admitted any mistakes. Staff could give us examples of where they had used this in practice or instances where they would use it.

Staff received feedback from investigation of incidents, both internal and external to the service. The service had several methods to ensure lessons were learned and shared with staff through daily safety huddles, board rounds, staff meetings, noticeboards, newsletters, learning events, and emails. Staff told us there was good communication about incidents through the daily handover time and discussion at meetings.

The quality governance department had introduced a newsletter which featured a section on ‘Learning from Incidents’. The section featured learning from serious incidents using the ‘Situation, Background, Assessment and Recommendations’ framework. The newsletter was distributed to all staff by email and hard copies were delivered to clinical and non-clinical areas.

Staff met to discuss the feedback and look at improvements to patient care. Feedback from incidents and improvements to patient care were discussed at clinical governance meetings. The staff teams held regular team meetings and discussed incidents. Individual staff members involved in incidents had the opportunity to get feedback and to have active involvement in any improvements they could make to their day to day practice.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers reviewed incidents daily, Monday to Friday, and where necessary investigations were initiated to identify any themes and actions needed to minimise recurrence. Any potential serious incidents (classed as moderate or above) were escalated appropriately. We reviewed a sample of serious incident root cause analysis reports and saw that they were investigated thoroughly with clear root causes identified. We also saw duty of candour was met and there were local arrangements in place for ensuring that patients were kept informed of incidents and any investigations and their outcomes.
Managers debriefed and supported staff after any serious incident. Staff who had been involved in incidents told us they were supported by the leadership team and their peers. Staff were encouraged to use reflective practice and discuss incidents openly, in order to minimise future events. Staff could also access the chaplaincy team for additional support, if they felt they needed to talk to someone about their experiences.

Safety thermometer

**The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.**

Safety thermometer data was displayed on wards for staff and patients to see. The service displayed the number of falls, infection incidents and pressure ulcers.

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.

Staff used the safety thermometer data to further improve services. Nursing staff collected information for the NHS safety thermometer and completed monthly nursing dashboards. Wards displayed information in a way that was meaningful to patients and visitors. Performance on the safety thermometer was discussed as part of the clinical governance process, and at handover meetings.

Data from the patient safety thermometer showed that the trust reported 49 new pressure ulcers, 16 falls with harm and five new urinary tract infections in patients with a catheter from November 2018 to November 2019 for medical services. This information is captured as a point in time and therefore unable to be compared to other organisations. There is no England average.

Data provided by the trust stated the increase in pressure ulcer reporting was partly attributable to the implementation of the nationally ‘Revised Definition and Measurement Framework (2018)’ introduced by NHS Improvement which required reporting of pressure ulcers which were present on admission. The framework ensured a more consistent approach, to defining, measuring and reporting pressure ulcers. Another identified theme was inconsistent skin assessment in the categorisation of pressure damage by nursing staff. In order to address this, the trust was part of the national pressure ulcer collaborative ‘Stop the Pressure’ in facilitating ongoing improvement.

As part of the collaborative project, the focus was on initial and daily skin assessment ‘Say What You See’. Included within this work was a plan incorporating digital photography for all ‘present on admission’ pressure damage to improve skin assessments and categorisation.

Lessons learnt from pressure ulcer incidents were shared widely. Incidents were discussed and monitored at the monthly pressure ulcer review group (PURG) and the quality improvement forum (QIF) meetings, which were chaired by the deputy chief nurse and attended by the heads of nursing, matrons, ward managers, clinical nurse specialists and allied health professionals. Themes and actions were discussed enabling lessons learnt to be fed back to clinical areas.

Pressure ulcers also formed part of the integrated performance review (IPR) that discussed and
provided assurance at the quality committee and trust board meetings. Pressure ulcers were also monitored monthly through ‘Test Your Care’ and ward score cards.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at West Hertfordshire Hospitals NHS Trust**

1. Total pressure ulcers (49)
2. Total falls (16)
3. Total CUTIs (5)

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 - Safety Thermometer)

**Major incident awareness**

The service planned for emergencies and staff understood their roles if one should happen.

The trust had a policy and plans in place for emergencies and other unexpected or expected events, such as adverse weather, flu outbreak or a disruption to business continuity.

There were regular tests of generators in case there was a failure of the electricity supply to the hospital. Staff were aware of the procedures for managing major incidents, winter pressures and fire safety incidents. Fire safety awareness training was part of mandatory training and staff attended the training annually.

There was an effective understanding amongst staff about their roles and responsibilities during a major incident.

**Is the service effective?**

**Evidence-based care and treatment**
The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service used nationally recognised guidance and standards relating to patient safe care and treatment. Policies and procedures were in date, and easily accessible to staff from the trust’s intranet. Patients received care in line with national guidance, such as ‘National Institute for Health and Care Excellence’ (NICE) guidance.

The trust had a process in place to identify new guidance published on the NICE website monthly. 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.

The service had a series of care pathways in place based on national guidelines. This included guidance for the assessment and treatment for conditions such as falls, sepsis and non-invasive ventilation (NIV).

Nursing staff used the sepsis (blood infection) six screening tool, which was best practice for the early identification of sepsis. The care pathway for suspected sepsis would usually be commenced in the emergency department. Wards had access to sepsis boxes to facilitate immediate treatment.

The service had a structured audit programme to ensure practise was reviewed and audits were completed to ensure staff followed local and national guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Nursing and medical staff had a good understanding of the Mental Health Act 1983 (MHA) and code of practice. Staff were able to explain how patients detained under the MHA were being treated for their mental health concern and if they required treatment for a physical illness, consent would have to be sought in line with current legislation.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff comprehensively discussed patient emotional and psychological needs during handovers. This ensured that appropriate referrals to specialist staff for example speech and language, occupational therapy, physiotherapy or the mental health team were actively managed.

**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 needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients chose meals from a menu, supported by catering staff to make choices where required. The service made dietary adjustments for patients for religious, cultural, personal choice or medical reasons when required. For example, a ‘cultural and vegan diet’ menu was available, as well as a ‘modified texture menu’ and ‘finger food menu’. Patients on specialist diets had this highlighted on the board above their bed and care plans reflected individual patient’s
dietary needs. The trust used a ‘red tray’ system to identify patients who needed additional support to eat their meals.

Patients had jugs of water within easy reach on their bedside tables. They told us that these were topped up regularly and that the choice and quality of the food was good.

Patients who had endoscopy procedures were provided with food and drinks following procedures that required fasting. The endoscopy service screened patients with diabetes to ensure they were at the beginning of a list and provided with food following the procedure.

Protected mealtimes were in place across the hospital wards. Protected mealtimes encouraged the hospital to stop all non-urgent clinical activity on wards during mealtimes. During this time, patients could eat their meals without interruptions and nursing staff were able to offer help to those who needed it. We observed healthcare workers providing support to patients with eating and drinking on the stroke and elderly care wards.

Hot drinks and sandwiches were provided for patients in the discharge lounge.

The trust completed monthly audits of nutrition as part of the “Test your Care” ward performance dashboard.

Staff fully and accurately completed patient’s fluid and nutrition charts where needed. We saw completed fluid balance charts to monitor fluid input and output for patients receiving intravenous fluids.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The trust used the malnutrition universal screening tool (MUST) as the validated screening tool. As well as identifying adults at risk of malnutrition, it also identified those patients who required dietetic input due to a medical condition or because of surgery. It was used to assess, and record patients’ nutrition and hydration needs, and we saw that nurses had completed this in the records we reviewed. Nursing staff re-evaluated the nutritional assessment throughout the patient’s stay, this ensured staff were aware and took appropriate action when there were any concerns, for example, making a referral to the dieticians if they were concerned about the amount the patient was eating, or their weight. There was clear guidance for staff to follow, to promote patient wellbeing in relation to nutrition and hydration.

Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it. The multidisciplinary team (MDT) worked together to identify patients who needed any additional support and to provide best practice guidance, for example, the use of additional food supplements, meal sizes or to increase fluid levels.

**Pain relief**

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

Staff assessed patient’s pain using a recognised tool and gave pain relief in line with individual needs and best practice. Nursing staff assessed patients’ pain regularly, as part of their routine observations, using the ‘National Early Warning Score 2’ (NEWS2). Staff said they would observe patients’ facial expressions, body language and any change in behaviour, if they were unable to communicate with them. Patients told us that every time staff checked on them, they were asked if they were in any pain. We observed staff routinely checked patients pain levels and gave pain relief as required.
Patients received pain relief soon after requesting it. Patients we spoke with during our inspection told us they received pain relief quickly and that staff responded positively to additional requests for pain relief. We observed staff carrying out medication rounds and asking patients for their level of pain, if their pain relief was effective and if they wanted to discuss their pain relief with medical staff.

Staff prescribed, administered and recorded pain relief accurately. From the 19 patient records we reviewed we noted pain relief was prescribed, administered and recorded appropriately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvement. The service had been accredited under relevant clinical accreditation schemes. However, performance in national outcome audits were variable.

Information about the outcomes of patients care and treatment was routinely collected and monitored.

The service maintained a dashboard which reported on items such as waiting times, length of stay, and emergency re-admission. The dashboard tracked monthly performance against locally agreed thresholds and national targets, where available.

Relative risk of readmission

Watford General Hospital

From August 2018 to July 2019, patients at Watford General Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

- Patients in gastroenterology, clinical haematology and cardiology had a lower than expected risk of readmission for elective admissions.

The service had a lower than expected risk of readmission for elective care than the England average.

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 represents the opposite. Top three specialties for specific site based on count of activity.

From August 2018 to July 2019, patients at Watford General Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
• Patients in general medicine and endocrinology had a lower than expected risk of readmission for non-elective admissions.

• Patients in geriatric medicine had a similar to expected risk of readmission for non-elective admissions.

The service had a lower than expected risk of readmission for non-elective care than the England average.

Non-Elective Admissions - *Watford General Hospital*

![Graph showing non-elective admissions by specialty.](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 represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

The service participated in relevant national clinical audits. Examples included, but were not limited to, the national lung cancer audit, the national stroke audit, national audit of dementia, and national inpatient falls audit.

Performance in national outcome audits were variable. There was variable performance in national audits relating to patient safety and treatment. However, appropriate action was taken to monitor and review the quality of the service and to effectively plan for the implementation of changes and improvements required. Staff ensured they had ownership of things that had gone well and that needed to be improved. We saw the specialties discussed audit results as part of their local governance and where necessary had action plans to address any developments.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The division showed evidence of a planned approach to clinical audit. A forward programme of audits for the current year was in place and progress against the plan was monitored.

Sentinel Stroke National Audit Programme (SSNAP)

Watford General Hospital

Watford General Hospital takes part in the Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade A in the latest audit, covering the period from April to June 2019. Over the last five audits the trust consistently achieved Grade A.

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
<th>Oct 18 - Dec 18</th>
<th>Jan 19 - Mar 19</th>
<th>Apr 19 - Jun 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

For patient centred performance, the ratings improved for one domain in the most recent time
period and deteriorated in one. The overall patient centred key indicator level remained the same as the last audit, at grade A.

For team centred performance, the ratings improved for two domains in the most recent time period and deteriorated in one. The overall team centred key indicator level remained the same as the last audit, at grade A.

(Source: Royal College of Physicians London, SSNAP audit)

The service had an action plan to address any areas of poor compliance.

### Lung Cancer Audit

#### Trust wide

The table below summarises West Hertfordshire Hospitals NHS Trust’s performance in the 2018 National Lung Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude proportion of patients seen by a cancer nurse specialist (Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)</td>
<td>78.4%</td>
<td>Does not meet the audit aspirational standard</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>
Case-mix adjusted one-year survival rate (Adjusted scores take into account the differences in the case-mix of patients treated) 34.0% Within expected range No current standard

Case-mix adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery (Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients treated) 22.7% Within expected range Met

Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment (For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen) 40.6% Worse than expected Did not meet

Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy (SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen) 52.5% Within expected range Did not meet

(Source: National Lung Cancer Audit)

The service had an action plan in place to improve performance. This included the recruitment of a lung multi-disciplinary team co-ordinator and to streamline the lung cancer pathway.

National Audit of Inpatient Falls

Watford General Hospital

The table below summarises Watford General Hospital's performance in the 2017 National Audit of Inpatient Falls. The audit reports on the extent to which key indicators were met and grades performance as red (less than 50% of patients received the assessment/intervention), amber (between 50% and 79% of patients received the assessment/intervention) and green (more than 80% of patients received the assessment/intervention).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit's rating</th>
<th>Met national aspirational standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the trust have a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?</td>
<td>Yes</td>
<td>n/a</td>
<td>Met</td>
</tr>
<tr>
<td>Crude proportion of patients who had a vision assessment (if applicable) (Having a vision assessment is indicative of good practice in falls prevention)</td>
<td>0.0%</td>
<td>Red</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) (Having a lying and standing blood pressure assessment)</td>
<td>0.0%</td>
<td>Red</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>
assessment is indicative of good practice in falls prevention)

| Crude proportion of patients assessed for the presence or absence of delirium (if applicable) (Having an assessment for delirium is indicative of good practice in falls prevention) | 6.7% | Red | Did not meet |
| Crude proportion of patients with a call bell in reach (if applicable) (Having a call bell in reach is an important environmental factor that may impact on the risk of falls) | 89.3% | Green | Did not meet |

(Source: National Audit of Inpatient Falls)

The service had an action plan in place to improve compliance with performance targets, including an educational programme for junior doctors and raising staff awareness.

**Chronic Obstructive Pulmonary Disease Audit**

**Watford General Hospital**

The table below summarises Watford General Hospital's performance in the October 2018 to April 2019 Chronic Obstructive Pulmonary Disease Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit's Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients seen by a member of the respiratory team within 24 hrs of admission? (Specialist input improves processes and outcomes for COPD patients)</td>
<td>39.2%</td>
<td>Worse than national aggregate</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%) (Inappropriate administration of oxygen is associated with an increased risk of respiratory acidosis, the requirement for assisted ventilation, and death)</td>
<td>100.0%</td>
<td>Better than national aggregate</td>
<td>Met</td>
</tr>
<tr>
<td>Percentage of patients receiving non-invasive ventilation (NIV) within the first 24 hours of arrival who do so within 3 hours of arrival (NIV is an evidence-based intervention that halves the mortality if applied early in the admission)</td>
<td>Not available</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy (Smoking cessation is one of the few interventions that can alter the trajectory of COPD)</td>
<td>38.7%</td>
<td>Worse than national aggregate</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission (Completion of a discharge bundle improves readmission rates and integration of care)</td>
<td>74.4%</td>
<td>Worse than national aggregate</td>
<td>Met</td>
</tr>
</tbody>
</table>
Percentage of patients with spirometry confirming FEV1/FVC ratio <0.7 recorded in case file

(A diagnosis of COPD cannot be made without confirmatory spirometry and the whole pathway is in doubt)

<table>
<thead>
<tr>
<th></th>
<th>0.0%</th>
<th>Worse than national aggregate</th>
<th>Did not meet</th>
</tr>
</thead>
</table>

(Source: Chronic Obstructive Pulmonary Disease Audit)

The service had an action plan in place to address any areas of poor compliance.

National Audit of Dementia

Watford General Hospital

The table below summarises Watford General Hospital's performance in the 2017 National Audit of Dementia.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good (A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital)</td>
<td>72.1%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>Percentage of staff responding “always” or “most of the time” to the question “Is your ward/ service able to respond to the needs of people with dementia as they arise?” (This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)</td>
<td>81.8%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium (Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary)</td>
<td>83.6%</td>
<td>Better</td>
<td>No current standard</td>
</tr>
<tr>
<td>Multi-disciplinary team involvement in discussion of discharge (Timely coordination and adequate discharge planning is essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission)</td>
<td>82.4%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Audit of Dementia)

Managers and staff used audit results to improve patient outcomes. For example, rheumatology recently completed an audit on the management of giant cell arteritis (GCA). The audit highlighted
the need for prompt initiation of corticosteroid therapy in all cases of suspected GCA. Actions implemented included introduction of a standardised pathway for patients suspected to have GCA to initiate steroid therapy.

Managers shared and made sure staff understood information from the audits. Audit results were discussed at team meetings and clinical governance meetings. Staff we spoke with during our inspection supported this.

Improvement was checked and monitored. The trust was proactive in conducting audits, gathering evidence to show improvement or decline in services. Where improvements were identified these were celebrated and further work done to improve performance. Any gaps in service or areas for improvement were shared with the staff team and the trust completed a gap analysis and developed action plans in order to drive change.

The endoscopy department was accredited by The Joint Advisory Group (JAG) for gastrointestinal endoscopy. JAG is an accreditation scheme that is awarded to endoscopy services following a peer review of standards. JAG awarded a trust with accreditation upon the achievement of a framework of requirements supporting the assessment of endoscopy services and achievement of person-centred care.

**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 development.

The service had processes in place to identify training needs and compliance, which ensured staff were confident and competent to undertake their roles.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. A competency framework was in place for both health care workers and trained nursing staff. A practice development nurse was in post to support staff to undertake training and oversee completion of training. 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, sepsis or nutrition and worked alongside staff to develop their competencies.

Managers gave all new staff a full induction tailored to their role before they started work, which included mandatory and role-specific training. Staff told us they received a comprehensive induction when they commenced work at the trust. This included a trust wide and local induction. The local induction included orientation to the area and support to complete local competencies.

The service provided development opportunities for staff at various grades, such as supporting nursing staff to move to the next level of seniority and the development of specialist roles. Nurses told us they were encouraged and supported to develop areas of interest and act as a source of advice for the team. Staff were also given the opportunity to undertake additional training courses that was relative to their role and specialty. For example, nurses working on the stroke ward had their neuro-specific competencies assessed, such as, the ability to complete swallow assessments, and staff on the respiratory wards had completed training in tracheostomy care and non-invasive ventilation. All junior sisters and sisters 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 in cancer services received competency-based training to enable them to carry out their roles effectively.

Other nurses had received training on how to care for patients with a central line (a long thin tube inserted into a vein in the chest), the insertion of a cannula (the insertion of a plastic tube into a vein to allow direct administration of fluids and medicines) and the monitoring of blood glucose levels which included knowledge of hyperglycaemia (high blood sugar level) and hypoglycaemia (low blood sugar level).

Nursing and medical staff received the correct level of life support training, depending on which area they worked in.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff completed an annual appraisal as part of their personal development review. Staff said they had completed an appraisal within the previous year and found it useful. Staff were encouraged to identify learning needs they had, and any training they wanted to undertake. Staff were supported to reflect, improve and develop their practice.

**Appraisal rates**

**Watford General Hospital**

As of October 2019, 92.3% of staff within the medicine department at Watford General Hospital received an appraisal compared to a trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>As of October, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>3</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>85</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>18</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>266</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>368</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>70</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>134</td>
</tr>
<tr>
<td>Total</td>
<td>944</td>
</tr>
</tbody>
</table>

Registered nursing staff in medicine at Watford General Hospital met the 90% target.

The trust was unable to provide site level appraisal data for medical staff. However, 96.3% of medical staff trust-wide had completed an appraisal.

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

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. Staff we spoke with valued the opportunity to discuss their performance and development during supervision.

The clinical educators supported the learning and development needs of staff. Junior doctors were supported to develop through regular, constructive clinical supervision of their work. Junior medical
staff said they were able to access their weekly teaching sessions and were allocated an educational supervisor and clinical supervisor.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Regular team meetings were held, and topics covered included feedback from complaints, audit results, patient safety, infection control and anything new that was happening in the hospital.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Training needs were identified through a variety of sources. These included any incidents staff had been involved in, appraisals and through staff requesting additional training. Staff told us their training and development needs were discussed at their appraisal.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with said they valued their appraisals and opportunities to discuss their training. Staff told us their line managers were supportive in developing their skills and that they felt confident in requesting additional training.

Managers made sure staff received any specialist training for their role. Staff who required specialist training for their role, for example, specialist stroke or oncology competencies, received these in order to carry out their roles. We saw completed competency booklets to evidence this.

Managers identified poor staff performance promptly and supported staff to improve. Discussion would be held with the staff member to see what support they needed to improve.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers went through a strict induction process and covered key areas of training required for their safety and in order to understand the needs of patients, for example safeguarding and dementia care.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Observation of practice, review of records and discussion with staff confirmed that all necessary clinicians were involved in assessing, planning and delivering patient care and treatment. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff in all areas of the service told us they worked closely together to make sure patients received person-centred and effective care. This included working with healthcare professionals outside the trust, and patient records we reviewed corroborated this. Staff reported good relations and communications with other professionals and/or agencies. They described effective multidisciplinary working between mental health teams, GPs and social services.

There was evidence of multidisciplinary working, for example, nurses working alongside specialist nurses, medical staff, healthcare assistants, pharmacy, and allied healthcare professionals. Notes we reviewed supported this.

Pharmacists were present on the acute medical wards daily and out of hours there was an on-call service for advice and support.
Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Board rounds were completed daily and were attended by consultants, junior doctors, the ward manager, nurses and allied health professionals. Discussions included patient milestones, discharge journey, plan for patient, whether Mental Capacity Act (MCA) Deprivation of Liberty Safeguards (DOLS) were in place, whether the patients required a speciality review or escalation.

Meeting minutes confirmed regular multidisciplinary meetings were held and were well attended. These included morbidity and mortality meetings and joint multi-disciplinary speciality meetings.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff we spoke with gave positive examples of cross sector working with district nurses, social care and the clinical commissioning groups (CCGs) in order to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff we spoke with during our inspection were aware of the mental health liaison teams and provided examples of cases where they referred patients to the service.

Patients had their care pathways reviewed by the relevant consultants. Care pathways were multidisciplinary, and staff of all disciplines developed and supported each other in the planning and delivering of patient care. Each professional group recorded their assessments in patient’s medical notes, and it was therefore easy to access information about the outcome of the valuation and the ongoing care of the patients from each professional’s perspective. It was clear which clinician had the overall responsibility of care.

Throughout our inspection, we observed good interactions between medical, nursing and support staff on all areas we visited. Staff we spoke with confirmed there was good multidisciplinary team working within the service and with external organisations.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

Consultants reviewed patients daily depending on the care pathway. 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. Consultants on the acute assessment unit were available seven days a week and all new patients were seen on a daily basis. Cardiology and respiratory consultant wards rounds were undertaken seven days per week in addition to a 24-hour, non-invasive ventilation advice service.

Access to medical support was available seven days a week throughout the service. Consultant cover was provided seven days per week, with on-call arrangements out-of-hours. Palliative care and haematology (blood specialist) consultant advice was available out-of-hours, including weekends and bank holidays. Endoscopy and radiology services were available out of hours.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. There was access to therapy services seven days a week with on call arrangements out of hours. Some wards had therapy or pharmacy staff based on the wards, otherwise the services were available through a referral system.

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.
Pharmacy services were available Monday to Friday 9am to 5pm, with out of hours on-call pharmacists available during evenings and weekends. Diagnostic tests, for example, MRI and x-rays were available 24 hours a day, seven days a week.

Chaplaincy support was available 24-hours a day, seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the wards. These included locally produced leaflets and leaflets provided by national organisations and charities. Information was available on a range of subjects, which included, but was not limited to, understanding radiotherapy, physical activity and cancer, and understanding chemotherapy, falls prevention, liver cirrhosis.

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.

Display boards across medical wards provided awareness and information about pressure care, reducing the risk of falls, dementia awareness and local service information.

The trust used the ‘End PJ paralysis’ initiative which pointed to evidence that if patients stayed in bed in their pyjamas for longer than they need to, they would have a higher risk of infection, loss of mobility and ultimately stay in hospital for longer. Staff had displayed posters throughout the wards encouraging patients to get up and get dressed.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients had a medical history taken on admission to the ward. Medical history could include information such as smoking and recreational drug use.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient’s consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients’ liberty appropriately. However, medical staff compliance with mandatory training was not in line with trust targets.

The trust had up-to-date policies regarding consent and the Mental Capacity Act 2005. Staff could access these via the trust intranet. 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 as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make decisions, any made on their behalf must be in their best interests and be as least restrictive as possible.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff understood the relevant consent and decision-making requirements of legislation and guidance and had received training on mental capacity and deprivation of liberty safeguards. Staff were familiar with the assessment which identified whether patients had mental capacity to make decisions about their activities of day to day living, care and treatment. Staff were
able to explain factors that could affect capacity, whether capacity was fluctuating or affected by delirium. Staff handovers had a keen focus on patients who lacked capacity and the decisions that had been made in the patient’s best interest. They knew who to contact for advice. Mental capacity assessments had been undertaken for patients who required this.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. For example, taking clinical observations or giving medication. Patients we spoke with during our inspection and records we reviewed showed that consent was gained prior to any patient treatment.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. Staff were familiar with best interest decision making and how to ensure care plans were as least restrictive as possible. Capacity was routinely discussed at handover meetings and care plans routinely updated where patient capacity fluctuated or if patients displayed distress or confusion.

Staff made sure patients consented to treatment based on all the information available. Medical staff informed patients about the risks and benefits of procedures, such as endoscopic procedures. We observed this during our inspection. Endoscopy medical notes included a written consent, and we saw that these were completed by the doctor, outlining possible side effects and risks of procedures.

Staff clearly recorded consent in the patients’ records. Out of the 19 patient records we reviewed, staff had recorded patient consent where required.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust set a target of 90% for the completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

**Watford General Hospital**

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Medical staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards, however, not all had completed it. Compliance for MCA/DoLS (essential) training from April to October 2019 for qualified nursing and medical and dental staff in medicine at Watford General Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>462</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>131</td>
</tr>
</tbody>
</table>

In medicine at Watford General Hospital, the target of 90% for MCA/DoLS (essential) training was met by qualified nursing staff while the completion rate for medical and dental staff was below the target.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff were familiar with the legislation regarding consent and the differences between legislation. Staff told us they would contact the safeguarding lead if they had any concerns or needed specialist advice.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Ward managers knew all patients who were subject to a DoLS and ensured that applications were completed on time and reviewed where necessary.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us they contacted the safeguarding lead if they had any concerns or needed any advice in relation to MCA or DoLS. MCA and DoLS were discussed at team handovers we observed, and staff had ample opportunity to advocate for patients to ensure their needs were being met.

Staff implemented DoL safeguards in line with approved documentation. We reviewed MCA and DoLS assessments within patient records and found these were completed appropriately and used least restrictive care practices.

**Is the service caring?**

**Compassionate care**

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observed patients being treated with respect and compassion throughout our inspection. We spoke with 21 patients and relatives. Most patients we spoke with were highly complementary of the care they had received, and feedback was generally positive throughout the inspection.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed throughout our inspection that staff took time to interact with patients and those close to them. Staff were respectful, considerate and treated them with kindness. Staff in the endoscopy unit ensured that patients were treated with respect and consideration.

Most patients said staff treated them well and with kindness. Feedback from people who used the service, those close to them and stakeholders was mostly positive. We saw feedback on ward notice boards from patients, saying how positive their experience had been. One patient we spoke with in ambulatory care told us he was very happy with the service he had received, and that staff were amazing, especially with all the challenges they faced.

Staff followed policy to keep patient care and treatment confidential. We observed all staff respecting the privacy and dignity of patients 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 positive interactions by staff that were kind and caring to both patients and their families.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff could identify when they had treated patients with mental health issues and highlighted how
they had sought to care for them in a non-judgemental way. We saw staff caring with compassion and kindness for a patient living with dementia on Bluebell ward. Staff sought to provide reassurance to the patient.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff understood and appreciated the varying social and religious needs of their patients. They provided examples of accessing the chaplaincy service for patients who wanted spiritual assistance.

We observed positive interactions between staff, patients and their relatives. All staff we spoke with were passionate about their roles and were committed to making sure patients received the best patient-centred care.

We saw cards displayed throughout the wards from patients thanking staff for caring for them.

**Emotional support**

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient’s personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the impact that a patient’s care, treatment or condition had on their wellbeing and on their relatives, both emotionally and socially. Staff explained how they helped patients understand their condition and signposted them to organisations to help them manage their condition. For example, dementia support groups.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff were aware of the importance of maintaining patients’ dignity and privacy, especially if they were distressed or confused. Throughout our inspection, we saw that distressed patients were spoken to kindly. Patients, who were confused, were given clear details of the time and place, and offered reassurance of safety.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. At staff handovers staff demonstrated great empathy and understanding for the patients and families, discussing plans in a sensitive and professional manner.

Chaplaincy support was available. Patients’ spiritual needs were considered irrespective of any religious affiliation or belief. The chaplaincy service supported spiritual care across the services and ensured the delivery of spiritual, pastoral and religious care was adequate and appropriate.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Emotional support and information was provided to patients and their relatives. Clinical nurse specialists (CNSs) were available for additional advice and support. 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 other medical specialties and provided ongoing emotional support to patients. Examples included, respiratory clinical nurse specialists and lung cancer nurse specialists.

Every patient who received a cancer diagnosis had a specialist nurse present to answer questions and provide emotional support.

Medical and nursing staff referred patients for mental health assessments if they were concerned about mental health conditions. Interactions were not rushed, and patients were given sufficient time to speak to staff about any concerns.
Understanding and involvement of patients and those close to them

Staff mostly supported patients, families and carers to understand their condition and make 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.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with told us that staff communicated with them in a way, which they could understand, explaining their care, treatment and condition. Most patients we spoke with told us that staff fully involved them in their care. However, we spoke with three patients and relatives 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. One patient we spoke with told us that whilst staff were friendly and caring, there was a lack of clear communications and involvement about treatment, particularly amongst medical staff.

We observed staff communicated with patients in a way that was appropriate and respectful.

We observed staff asking patients what they would like to be called and introduced themselves and their role. We observed staff involving patients and their relatives during assessments and when taking observations on the ward. If the patient’s relative had any questions, staff were able to discuss these at the time.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff had access to pictorial symbols to encourage communication with patients who were unable to speak. We observed staff used language that patients understood and gave patients time to ask questions if they were unsure about anything. Staff interacting with confused patients showed genuine empathy, gave patients extra time and reassurance. Staff showed insight into the patient perspective and how it would feel to have a sensory or physical impairment themselves.

Staff recognised when patients and their relatives needed additional support to help them understand and be involved in their care and treatment and enable them to access this. We saw, and staff told us how they could access language interpreters, sign language interpreters, specialist advice and advocates. There were special arrangements made for people living with dementia on medical wards.

Staff used the ‘Forget Me Not’, ‘This is Me’ and ‘Purple Folder’, which outlined the communication needs of patients living with dementia or a learning disability. Communication aids such as symbols and pictures were available to ensure patients could understand and be involved in their care and treatment.

We saw speech and language therapists were available on all wards and provided advice, support and equipment for people with problems with communication such as aphasia (or dysphasia), a condition which affects an individual’s ability to use and understand language effectively. We observed therapists supported and involved patients appropriately with their therapy assessments on all wards.
The chaplaincy service was available and provided spiritual and pastoral care when asked by the patient/families, and medical and nursing staff. The team offered support, prayers or a listening service to people who found it helpful to talk about their anxieties. The pastoral care team facilitated a network of local volunteer counsellors and professional faith-based representatives which assisted and supported patients, families and staff. They provided practical resources, training and a ward based pastoral support system that worked as an integral part of the wards multi-disciplinary team.

Patient information leaflets were widely available across the hospital, usually relating to specific conditions or illnesses. Staff encouraged patients to read leaflets to inform them of conditions and support groups.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and their relatives provided feedback by completing the friends and family test (FFT), patient surveys, and through the complaints and compliments procedure. We also saw thank you cards displayed on some wards.

Staff supported patients to make advanced decisions about their care. Staff we spoke with told us they spoke with patients and families about the importance of making advanced decisions so that they could make decisions about what happened to them. We observed in patient records that advanced decisions were made, for example, resuscitation status and care planning for the future.

Staff supported patients to make informed decisions about their care. Staff spoke openly with patients about the risks and benefits of procedures and treatment plans, so they could make informed decisions about their care. We noted where patients lacked capacity, family members had been involved in decision making and staff had a good understanding of the need to involve families and those close to the patient in their care.

Is the service responsive?

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The service understood the different requirements of the local people it served by ensuring that it actioned the needs of local people through the planning, design and delivery of services. Services were planned in a way which ensured flexibility and choice.

The service worked collaboratively with external agencies to improve services provided by the trust. This included working with the clinical commissioners, general practices and neighbouring NHS trusts to identify the needs for the local community and planning of clinical pathways to meet demands.

Since our last inspection, the trust had developed a system whereby specialist consultants were integrated in front door management (managing patients presenting at urgent and emergency services), to review patients quickly and identify alternative pathways to admission. The medical division supported the frailty unit in ambulatory care and had been working in partnership with the emergency care improvement programme (ECIP) on back door flow and enhanced working with the discharge planning team and social care services.
The frailty service aimed to identify patients with frailty as soon as possible, to improve outcomes, including reducing avoidable hospital admissions and supporting patients to be cared for in the community.

The hospital was committed to working very closely with its NHS and social care partner organisations, to prevent unnecessary admissions to hospital, to make best use of its beds, and to discharge patient’s home in a timely way.

The trust’s hospital discharge team worked closely with many different professionals, including doctors and nurses, therapists and the community teams such as the rehabilitation team and the stroke team to improve discharge arrangements.

The service worked closely with local social services to facilitate timely and appropriate discharges for those patients requiring complex social care packages in the community.

Planning the delivery of the service was coordinated at daily bed management meetings.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff were familiar with the importance of same sex accommodation. Data provided showed there were no mixed sex breaches within the medical care division from October 2018 to September 2019.

Facilities and premises were appropriate for the services being delivered. The facilities and premises provided adequate accommodation for the services being provided. However, we noted some areas of the hospital were aged, some wards lacked storage space for equipment and there was a lack of meeting or side rooms for patient activities.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia. The service worked well with local teams embedding a pathway to care and manage patients living with a mental health condition or a learning disability. A consultant lead for dementia was in post to provide support to patients, carers and staff.

The service had systems to help care for patients in need of additional support or specialist intervention. Specialist nurses were available and assisted staff with the management of patients admitted to the hospital with various medical conditions. The non-invasive ventilation (NIV) facility was available to patients that required high flow oxygen therapy.

The service relieved pressure on other departments when they could treat patients in a day. The service had an ambulatory care unit which was open from 8am till 8pm during weekdays, and 7.30am till 8pm at weekends. Ambulatory care units aimed to provide same day care to patients. Patients were assessed, diagnosed, treated and able to go home the same day, without being admitted into hospital overnight. This helped the flow within the hospital and reduced admissions.

Information was provided to patients in accessible formats before appointments. Appointment letters contained information required by the patient such as contact details, a map, directions and information about any procedures, including any preparation, such as fasting if required.

Visiting times on medical wards were usually in the afternoon and evening, with protected times scheduled during patients’ meals. However, relatives of patients who were receiving end of life care or living with dementia or a learning disability could visit at any time.

Patients felt the service met their needs. Relatives told us the service was flexible and offered choices.

**Meeting people’s individual needs**
The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

People’s individual needs and preferences were central to the delivery of tailored services. Services were made accessible and coordinated to take account of the needs of different people, including those with complex needs and in vulnerable circumstances.

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. We saw that 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.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service had systems in place which were able to identify patients living with dementia, learning disabilities or mental health problems.

Patients were screened for dementia on admission to hospital using prompts on the admission assessment proforma. If a cognitive impairment was identified, staff completed a further assessment. The trust identified patients with a diagnosis of dementia, with a blue clasp on the patient’s wrist band and a “forget me not” magnet alongside the patient’s name on the ward whiteboard. Activity boxes contained puzzles, books and ‘twiddlemuffs’ (a hand muff designed to provide sensory stimulation) and were available for patients living with dementia to assist calming them when agitated or confused.

Any patients living with dementia or a learning disability were highlighted during the daily safety briefings so that the appropriate teams could be involved.

The service were actively engaged with patients with learning disabilities and complex health needs and their carers to collate a service user evaluation report. The information was collected by evaluating a questionnaire. Feedback was shared to identify areas for improvement via a range of groups for example, the safeguarding panel (executive oversight), the adults at risk champion days, public engagement meetings and the learning disability committee. In addition, the findings were shared with matrons to feedback into their clinical areas. An annual ‘Carer Forum’ was held external to the organisation to facilitate access and attendance by service users and carers.

Wards were designed to meet the needs of patients living with dementia. Bluebell ward was a dedicated ward that supported patients living with dementia. There had been an investment made to make the ward dementia friendly, including a secure garden. 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. There was a dedicated activities coordinator in post and a higher ratio of staff to patients in place to support patients.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ and ‘Forget Me Not’ documents and patient passports. Staff told us that they used the ‘This is me’ and ‘Forget Me Not’ booklet for all patients living with dementia or who had complex communication
needs. The booklet included space to detail a person’s needs and preferences which meant that care was specifically tailored to the person’s needs.

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 for 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.

Carers were supported to be involved in a patient’s care if they wished to, so not to interrupt their important caring role by a hospital admission.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff we spoke with knew how to meet the communication needs of patients with a disability and where to go for more assistance if necessary. Staff told us they would speak to specialist staff if they were unsure how to communicate with patients.

Patients with particular needs were flagged on the white board above the patient’s bed so that care could be tailored to individual needs. For example, patients living with dementia, patients at high risk of falls, patients with diabetes, and patients with vulnerable skins were easily identified for staff to provide additional support if required.

The service had information leaflets available in languages spoken by the patients and local community. All leaflets on display in the hospital were printed in English. Staff told us that the trust could print them in other languages if required.

Managers made sure staff, patients and their loved ones and carers could get help from interpreters or signers when needed. Staff could access a translation service for patients whose first language was not English. All staff we spoke with knew how to access this service.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients chose meals from a set menu, supported by catering staff to make choices where required. The trust used a ‘red tray’ system to identify patients who needed additional support to eat their meals. The service made dietary adjustments for patients for religious, cultural, personal choice or medical reasons when required.

Staff had access to communication aids to help patients become partners in their care and treatment. Communication aids were in place to help communicate with patients who were non-verbal. These were booklets with pictures and words, to help patients share their views and preferences, even if they were unable to talk.

The trust sought feedback on how well they were meeting the needs of local people, for example through the patient advice and liaison team and informal contact through friends and family feedback, thank you cards, complaints, incidents, patient surveys or local concerns.

**Access and flow**

**People could access the service when they needed it and received the right care promptly.** Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were generally in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Waiting times from referral
to treatment and arrangements to admit, treat and discharge patients were generally in line with national standards.

The service had systems in place to improve access to timely treatment. Patients were generally admitted to the medical wards from the emergency department (ED), the medical assessment unit or from the acute admissions unit (AAU).

Staff had access to diagnostic services, such as computerised tomography (CT) scans and magnetic resonance imaging (MRI), seven days a week.

The endoscopy unit accommodated inpatients and outpatients. Out of hours arrangements were in place for procedures to be carried out by the on-call consultant.

The service had a super stranded length of stay meeting weekly. They looked at patients who had been an inpatient for longer than seven-10 days, depending on the clinical area. A stranded patient is anybody who has been in hospital for more than seven days, and they become super stranded once their stay in hospital exceeds 21 days.

Average length of stay

Watford General Hospital

Managers and staff worked to make sure patients did not stay longer than they needed to. The service worked with external services to ensure that patient were able to return to their homes as soon as possible. The integrated discharge team had partnered with the medicine division and worked closely with the flow manager to reduce length of stay.

From September 2018 to August 2019 the average length of stay for medical elective patients at Watford General Hospital was 5.6 days, which was lower than the England average of 5.8 days.

- Average lengths of stay for elective patients in gynaecological oncology and general medicine were higher than the England averages.
- Average length of stay for elective patients in cardiology was lower than the England average.

Elective Average Length of Stay - Watford General Hospital

Note: Top three specialties for specific site based on count of activity.

From September 2018 to August 2019 the average length of stay for medical non-elective patients at Watford General Hospital was 5.9 days, which was similar to the England average of 6.0 days.

- Average length of stay for non-elective patients in general medicine was similar to the England average.
- Average length of stay for non-elective patients in geriatric medicine was lower than the England average.
- Average length of stay for non-elective patients in endocrinology was higher than the England average.
average.

Non-Elective Average Length of Stay - Watford General Hospital

![Graph showing average length of stay for different specialties at Watford General Hospital and England average.]

*Note: Top three specialties for specific site based on count of activity.*

(Source: Hospital Episode Statistics)

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From November 2018 to October 2019 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was consistently better than the England average.

In the most recent month, October 2019, 94.2% of patients at the trust were treated within 18 weeks compared to the England average of 87.0%.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

From November 2018 to October 2019, three 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>Geriatric medicine</td>
<td>100.0%</td>
<td>96.5%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>97.8%</td>
<td>92.1%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>97.3%</td>
<td>93.8%</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>78.1%</td>
<td>80.2%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>73.0%</td>
<td>80.2%</td>
</tr>
</tbody>
</table>

(Source: NHS England)
Patient moving wards per admission

Watford General Hospital

From October 2018 to September 2019, within the top two medical wards at the hospital, 46.5% of individuals did not move wards during their admission for non-clinical reasons, and 53.5% moved once or more for non-clinical reasons.

A breakdown of the percentages of patients who moved once or more for non-clinical reasons by ward is shown below:

- Sarratt Ward: 51.8%
- Red Suite Ward: 55.4%

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Information provided by the trust reported the trust pathway was to admit patients from the emergency department to the acute admissions unit (AAU) which was an assessment area. Once patients had been identified as needing to stay longer than 48 hours, they were moved to a speciality ward. At the end of their stay, if patients were awaiting a package of care or a nursing or residential ward, they would be moved to a less acute ward to allow the more ill patients to be cared for on the acute ward.

Patient moving wards at night

Watford General Hospital

Staff did move patients between wards at night. From October 2018 to September 2019, there were 558 patients moving wards at night within medicine at Watford General Hospital, with 153 of these (27.4%) occurring in the medical assessment unit.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Moves occurred overnight only when patients were deemed suitable to step-down or outlay when demand for specialty capacity heightened.

Managers monitored that patient moves between wards/services were kept to a minimum. Managers were aware of patient moves. Staff informed us that care was taken to only move patients for non-medical reasons when unavoidable and in mitigation of potential clinical risk to another patient.

The service moved patients only when there was a clear medical reason or in their best interest. The trust reported that patients were only moved if clinically safe. They were assessed, and a risk assessment completed. The objective was to create specialty beds in other areas based on patient demand from the emergency department, critical care, elective cancer patients and trauma patients.

Managers and staff worked to make sure that they started discharge planning as early as possible. Throughout our inspection we found that staff had a strong focus on the patient discharge process. The trust used the SAFER patient flow bundle (practical tool to reduce delays for patients in adult inpatient wards), developed by the NHS Improvement team to track patient’s progress from...
admission, through the wards to discharge. The service used the Red2Green methodology to manage patient flow and expedite discharges. Red2Green bed days was a visual management system to assist in the identification of wasted time in a patient’s pathway of care. A red day was when a patient received little or no value-adding acute care, and a green day was when a patient received value-adding acute care that progressed them closer to discharge. Staff worked towards reducing red days and increasing green days, thereby reducing length of stay and improving patient flow and safety.

Staff discussed patients’ discharge dates at daily board rounds and multi-disciplinary team (MDT) meetings in the presence of social services, the discharge facilitator, and therapists. The team discussed all patients’ social history and started their discharge process. They liaised with the occupational and physiotherapists and the patient’s family, this was all identified and put into process at an early stage to ensure prompt discharges home, with no delays.

Patients were planned to be discharged from hospital as early as possible during the day to release a bed, which meant that new patients could be transferred into the vacant bed during normal working hours. Staff told us, that this was not always possible due to patients waiting for medicines to take home or transport. Patients that were ready for discharge across the medical service, would go to the discharge lounge, where they waited for their medications or transport.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. Staff ensured that patients were discharged to a safe location and care packages were in place, if required. Discharge co-ordinators supported nursing staff with discharging patients and followed up social care requirements needed for their discharge.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. Discharge assessment review teams were in place for patients with a length of stay over 21 days, whereby they were reviewed on the ward by a clinical team. Weekly length of stay meetings took place to monitor patients with delayed discharges.

Staff told us discharge was affected by a number of factors including lack of social care locally, family decisions, treatment plans changing and patients deteriorating or needing longer in hospital to prevent an unsafe discharge.

The senior leadership team told us of work they had been undertaking to reduce length of stay. There was a strong focus to improve patient discharge and reduce delays.

Staff supported patients when they were referred or transferred between services. Staff explained to patients why they were being moved between services and accompanied them to their new ward if needed. Ward administrators worked alongside the teams to ensure patient records and details went with the patients to minimise any delays in communication of the patients’ needs.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Consultants reviewed each medical patient on non-medical wards, known as outliers, on a daily basis and ensured care and treatment plans were in place to manage their condition. Outliers are patients who are placed on a different speciality ward, for example, a patient under the care of a medical consultant being placed on a surgical ward.

Managers worked to minimise the number of medical patients on non-medical wards. The trust monitored medical outlier numbers on a regular basis and staff told us medical outliers were seen in a timely manner. This usually occurred in response to a lack of the speciality beds for example, due to a shortage of medical beds in comparison to the number of medical patients admitted to hospital.
Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. However, complaint response times were sometimes longer than guidance within the trust policy.

Summary of complaints

The hospital had a clear process in place to ensure complaints were dealt with effectively. Patients, relatives and carers knew how to complain or raise concerns. Patients and families, we spoke with, confirmed that they knew who to contact if they had a complaint or wanted to raise any concerns. One patient told us they had been unhappy with their care and lack of involvement in their treatment plan and had made a complaint to the staff.

The service clearly displayed information about how to raise a concern in patient areas. Leaflets informing patients how to make a complaint or how to contact the patient advice and liaison service (PALS) were available in all medical areas. PALS provided advice and support to patients who wished to raise a concern or complaint.

Staff understood the policy on complaints and knew how to handle them and tried to resolve any patient concerns immediately to prevent the concerns escalating to a formal written complaint. Staff understood the principles of duty of candour and could describe them.

Watford General Hospital

Managers investigated complaints and identified themes. From November 2018 to October 2019, the trust received 93 complaints in relation to the medicine division at Watford General Hospital (29.8% of the total complaints received by the hospital).

For the 84 complaints that had been closed at the time of data submission, the trust took an average of 33.6 days to investigate and close complaints. The trust policy states that complaints should be closed with 30 days, with a 40 day or mutually agreed timeframe for more complex complaints.

The nine complaints, that had not yet been closed, had been open for an average of 23.3 working days at the time of data submission. This was in line with the trust's policy.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical care and treatment</td>
<td>58</td>
<td>62.4%</td>
</tr>
<tr>
<td>Staff attitude</td>
<td>11</td>
<td>11.8%</td>
</tr>
<tr>
<td>Admissions, discharge and transfers</td>
<td>10</td>
<td>10.8%</td>
</tr>
<tr>
<td>Communications</td>
<td>9</td>
<td>9.7%</td>
</tr>
<tr>
<td>End of life care</td>
<td>2</td>
<td>2.2%</td>
</tr>
<tr>
<td>Administration</td>
<td>2</td>
<td>2.2%</td>
</tr>
<tr>
<td>Privacy and dignity</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>Total</td>
<td>93</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff told us they initially verbally acknowledged complaints and tried to resolve them at ward level. If the complaint was more serious staff knew how to escalate the concerns to their manager and understood the role of the complaints team in investigating complaints.

Managers shared feedback from complaints with staff and learning was used to improve the service. Changes were made to the service as a result of feedback and complaints. Staff told us that complaints were discussed at team meetings, and we observed minutes of team meetings which showed complaints was part of the agenda.

Complaints were also discussed at governance meetings, team meetings and handovers to ensure staff understood shared learning from complaints to improve performance.

**Number of compliments made to the trust**

**Watford General Hospital**

From January to November 2019, there were 57 compliments received about medicine at Watford General Hospital (34.5% of the total compliments received by the hospital). Forty-eight of these (84.2%) related to Sarratt ward (acute elderly care).

The trust reported that the themes for compliments over the last 12 months had identified that staff were helpful, dedicated to providing good care and committed to being effective in delivering that care to patients. This had been the case for teams as well as for individuals.

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

**Is the service well-led?**

**Leadership**

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Medical care services were managed by a divisional director, divisional manager, and a head of nursing. They were responsible for the medical inpatient specialties, elderly and stroke services. The acute admissions unit, ambulatory care, and medical assessment unit were managed within the division of emergency medicine. During the inspection, we observed staff within the two divisions, working seamlessly together, to manage patient flow and achieve the best outcomes for patients. The leadership team were supported by clinical leads, matrons and governance facilitators.

We met with the senior leadership team who spoke with pride about the work and care their staff delivered on a daily basis. The team demonstrated an awareness of the service’s performance and the challenges they faced.

The leadership team were committed to nurturing and developing a more coordinated approach to enable quality improvement to be embedded across the service. Senior leaders were involved on a day to day basis, to support a safe and effective approach to clinical staffing and patient flow.
They worked collaboratively to make improvements in the effectiveness and responsiveness of care. They supported staff to take ownership of the issues, reflect and consider their practice and be open to new ways of working. For example, recent collaborative working with the urgent and emergency division had resulted in a reduction in admission rates and demand for beds, improved patient flow and a reduction in re-attendance rates.

Senior leaders had a thorough understanding of the improvements that were needed to strengthen the quality of their service. They understood the challenges to quality and sustainability the medical care service faced and had pro-active ongoing action plans in place to address them.

At local level matrons oversaw multiple wards and assisted ward managers. We observed matrons were visible on the wards. Ward managers said they were supported by the matrons and senior leads. Staff knew how to contact the medical and nursing lead for their area. Staff told us that ward managers and matrons were approachable and supportive and offered advice and training.

We met with the ward managers during the inspection and found they were organised and demonstrated strong and supportive leadership. They were knowledgeable about the ward’s performance against the trust priorities and the areas for improvement.

Managers arranged ward or departmental unit meetings regularly to ensure staff were kept up-to-date with information about their department and the service. There were various methods of communication across the teams, for example, meetings, notice boards and e-mail. Areas covered included: patient safety, staffing and ward performance.

The trust provided development programmes for staff, which supported them to progress with leadership and management skills. Courses were available for first line managers, middle managers and senior managers. Both internal and external programmes were available.

All staff we spoke with were aware of the whistleblowing policy and many staff told us they would escalate concerns or challenge colleagues if patient safety was compromised.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust vision was, “To deliver the best care for every patient, every day.” They had identified four key strategic aims:

- **Best care** - the very best care for every patient every day
- **Great team** - great people and a great place to work and learn
- **Best value** - deliver efficient care to make the best use of every NHS pound
- **Great place** - modern, fit for purpose estate and digital technology

The strategy acknowledged the importance of partnership working and collaboration across organisational boundaries to ‘join up care’ for local people and ensure that the whole health and care system was working together to improve the health of the population, improve care delivery and deliver a sustainable financial future. The strategy was aligned to national and local strategies such as the NHS long term plan and was underpinned by a suite of trust strategies and plans.
The trust’s vision and strategic aims were underpinned by the trust’s core values which were: ‘Commitment, Care 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 medical service had an outline strategy for the next two years. Members 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 an overview of the strategy for medical services from 2019 to 2021. This identified four areas of focus:

- The interface with the emergency department and acute admissions unit (AAU)
- Inpatient care and patient flow
- Integrated care and outpatient services
- Future planning

All wards displayed their improvement journeys on notice boards. These demonstrated achievements towards achieving the trust’s vision and improvements.

Throughout our inspection we noted that staff displayed behaviours which met the trust’s vision and ward philosophies.

**Culture**

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

All staff we met were welcoming, friendly and helpful. It was evident that staff were passionate about the services they provided. Staff were committed to providing the best possible care for patients.

We observed good working relationships across the service, and it was evident that staff morale was good in areas we visited. Staff spoke with pride about their role and most told us they felt respected and valued by their managers and senior management team. The exception to this positive feedback from staff was a nursing staff member who said she was constantly firefighting and trying to meet trust targets. She felt there was pressure from senior leaders to meet targets and not enough time to complete day-today task, such as staff appraisals.

Staff at all levels told us there was good team working throughout the service. Staff worked together to provide the best possible care for patients. During our inspection, we observed positive and respectful interactions, which were focused on meeting patients’ needs and providing safe care and treatment.

The service had mechanisms in place for providing all staff at every level with the development they required, including high-quality appraisal and career development conversations. We saw 92.3% of staff within the medicine department received an appraisal, compared to a trust target of 90%. Staff told us they found appraisals useful.

Staff were encouraged to report incidents and felt confident in doing so. The culture encouraged openness and honesty. Processes and procedures were in place to meet the duty of candour. Where incidents had caused harm, the duty of candour was applied in accordance with the regulation.
Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The governance framework in medical services 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 with regard to providing a safe service to patients and their families.

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 held in November 2019 and December 2019 and found there was good attendance from clinical leads, governance leads, and the senior management and leadership team for the division. The agenda included; discussion of incidents, audits and NICE guidance and other issues affecting the quality and safety of care.

Clinical governance meetings held at specialty level showed evidence of discussions of incidents, risks, audits and ongoing operational challenges to the quality of the services. Each specialty had a nominated audit or governance lead.

The service held joint audit half day meetings four times a year with the emergency medicine division. At these meetings departments shared audit findings and learning from incidents and complaints.

There was an effective governance structure and risk management framework to support the delivery of high-quality care. All incidents reported through the incident reporting system were reviewed daily. This was to ensure the service was safe and identify any immediate actions required to address safety concerns. Potential serious incidents were reviewed in more depth and were escalated when necessary.

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.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were assurance systems in place, and performance issues were escalated appropriately through clear structures and processes. There were processes to manage current and future performance, which were regularly reviewed at directorate meetings. There was a systematic programme of clinical and internal audit to monitor quality, and systems were in place to identify where action should be taken.
The service had robust arrangements in place for identifying, recording and managing risks. The medical division had a risk register which included a description of each risk, an assessment of the likelihood of the risk materialising, its possible impact and the lead person responsible for review and monitoring. We observed the risk register was monitored within the governance framework and regularly reviewed.

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.

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 three and grade four pressure ulcers and harmful falls. Nursing staff told us they completed an investigation and an action plan. The falls specialist nurse or the tissue viability nurse were involved, and a root cause analysis was undertaken.

The division had a planned approach to clinical audit in that each specialty had an audit plan for 2019 to 2020 and monitored progress against it.

The service had investigated the six serious incidents from January to December 2019, in line with national and trust requirements. We reviewed a sample of the root cause analysis reports which demonstrated clear actions and changes to practice.

There were regular staff meetings to share learning from incidents and complaints. Where specific actions were required, they were fed back at daily handovers and safety briefings.

Staff were aware of the duty of candour requirements which identified the importance of sharing information with patients and families when an incident had occurred which involved them. Duty of candour principles had been applied to particular incidents we reviewed.

The trust had a policy and plans in place for emergencies and other unexpected or expected events, such as adverse weather, flu outbreak or a disruption to business continuity.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. However, the trust information technology systems were slow.

The service had clear performance measures, which were reported and monitored. These included the dashboard, patient safety and experience indicators, and friends and family test results. Performance results were reported at ward to board level and were used to challenge and drive forward improvements in care, where indicated. 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.

Audit data was reviewed at clinical speciality and directorate level meetings. This meant that there was a service awareness of performance. The clinical and divisional directors had oversight of all
specialties within their division and escalated to the trust board appropriately. This enabled decision makers to have the relevant, up to date information to inform decisions being made about the service.

Information technology systems were used to monitor and improve patient care. There were arrangements in place which ensured data such as serious incidents and never events were submitted to external providers as required.

There were arrangements in place to ensure the confidentiality of patient information. Patients data and records were kept secure to prevent unauthorised access, however, authorised staff demonstrated they could be easily accessed when required.

There were sufficient computers available to enable staff to access the system when they needed to. Computers were available in all the areas we visited. All staff had secure, personal login details and had access to email and all hospital information technology systems. However, staff told us there were major problems with the information technology as the computer systems were very slow. Staff told us the time wasted waiting for delayed computers could be better spent looking after patients. This was an issue raised at our last inspection.

The service was aware of the requirements of managing a patient’s personal information in accordance with relevant legislation and regulations. General data protection regulations had been reviewed to ensure the service was operating within the regulations. Staff viewed breaches of patient personal information as a serious incident and would therefore manage a breach as a serious incident and escalate to the appropriate bodies.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service collaborated with partner organisations to help improve services for patients. There were positive and collaborative relationships with external partners and stakeholders to build a shared understanding of challenges and the needs of the local population, and delivery of services to meet those needs. The service worked collaboratively with service users, neighbouring NHS trusts, and commissioners.

The medicine division worked in partnership with general practice and clinical commissioning group colleagues through integrated care transformation pathways and other partners. A series of integrated services were in place within respiratory, diabetes and rheumatology.

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. For example, an annual patient satisfaction survey in endoscopy focused on how well the new bowel preparation instructions were working. Following initial feedback, a simplified patient information had been developed with the dietary instructions presented into a table form. A further example was a twice-yearly audit of patient comfort and practice changes which had resulted in a change to the dietary and preparation instructions for colonoscopy.

Staff working within bowel cancer screening services had made improvements to written patient information, change of scheduled appointment times and reducing the time patients spend waiting in a hospital gown and getting anxious by encouraging them to stay in their own clothes for longer.
Patients who used medical services were encouraged to give feedback on the quality of service they received. For example, the service contributed to the care quality commission’s (CQC) national inpatient survey as well as the national friends and family test (FFT). Adult patients being discharged from the trust received a follow up call from the ward leaders, which provided an opportunity for concerns with medications, follow up appointments and discharge letters to be resolved immediately.

The trust has a robust programme to review all patient surveys through the trust management committee and quality subcommittee of the board. The patient experience group monitored, and scrutinised actions taken across the trust divisions and included patient representatives. The patient experience group also undertook visits and reviews of work underway to gain further evidence for assurance to the quality committee.

The trust was actively working with partners to develop proposals for an integrated care partnership (ICP) and had recruited a director of integrated care partnership development to focus on internal organisational development work that was required to support new ways of working. The proposed approach was for a ‘shadow year’ from 2020 to 2021, with a particular focus on frail older people, urgent and emergency care and children and young people with mental health needs. The partnership was expected to be taken forward from 2021.

Information about the complaint’s procedure and patient advice and liaison service was available in clinical areas. Feedback was also gathered through social media forums.

Regular emails, team meetings, notices in staff areas, and safety briefings ensured staff were informed about important updates.

The minutes of meetings we reviewed showed good staff engagement at all levels.

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**

*All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.*

Staff of all disciplines were committed to improving service provision and the patient experience. Staff were encouraged to provide examples of improvements and changes made to processes based on patient feedback, incidents and staff suggestion. Staff were alert to new initiatives and ways of working.

Lessons learned from incidents were disseminated through corporate and divisional forums. These included safety huddles, newsletters, quarterly learning events, cross divisional attendance at clinical governance meetings, divisional clinical governance meetings, divisional quality summits, and bespoke training on wards.

The service was committed to training and staff development. All staff told us they were encouraged and supported to complete additional training. A variety of leadership programmes were available, including ‘Evolve’ (for first line leaders and managers), ‘Transform’ (for senior clinical leaders), ‘Rise’ (for middle level leaders and managers), and ‘Mary Seacole’ (six-month leadership development programme designed to develop knowledge and skills in leadership and management). Development programmes for nurses included the advanced nurse practitioner...
course and the nursing associate programme. Further to this, nurse and allied health professional development programmes at bands six and seven (senior roles) were also available.

Senior leaders told us they were beginning to embed quality improvement (QI) in the culture of the service and a number of QI projects were underway. The service participated in QI collaboratives with NHS England & Improvement. Five corporate QI projects currently underway included:

1. Improving patient communication
2. Get up, get dressed, get moving
3. Swarming strategy post falls
4. NHS Improvement pressure ulcer collaborative
5. Improving patient hydration

The therapies team were leading ‘get up, get dressed, get moving’ with the wider multi-disciplinary team. This had involved staff training and engagement to understand the challenges day-to-day, action planning with matrons and educating patients using discussion, posters and leaflets.

In October 2019, medical services in collaboration with emergency services, introduced a pilot named the ‘new medical take model’, which represented a radical overhaul of the medical take process (the process of which patients were reviewed when presenting at hospital). A team was introduced which involved senior respiratory, cardiology, acute medicine and care of the elderly clinicians who provided rapid expert review in emergency care. The new model was designed to optimise the use of non-admitted patient pathways, but more importantly to raise the overall standard of care for all medical emergency patients. With the new intervention, cardiology and respiratory consultants joined the on-call general medicine consultant in the emergency department and alongside junior doctors and senior nurses. The pilot was a needs-based patient focussed programme with no age limits. Preliminary findings had shown a significant positive impact on admission rates, reducing demand for beds and improving patient flow and a reduction in re-attendance rates. The overall length of stay had dropped, indicating a positive impact on patients seeing a consultant or specialist within one to two hours of arriving in hospital. Following the successful pilot, the new model of delivering care had recently been extended from five days to seven days.

The service had implemented a range of improvements to their frailty pathways as part of the sustainability and transformation programme. This included the ‘My Care Record’ patient held notes, all patients over 65 years presenting as an emergency screened for frailty, and implementation of a consultant GP telephone advice line.

The service had developed a joint upper gastrointestinal cancer centre with a neighbouring healthcare provider. A range of clinical outcome benefits had been identified through the development of a world class joint centre with increased volumes and a strong research base.

A new pathway had been established with a neighbouring trust to provide a specialist thrombectomy service for stroke patients. Thrombectomy is a procedure carried out in stroke patients whereby, instead of seeking to break the clot down using drugs (thrombolysis), thrombectomy aimed to physically remove it. Evidence had shown that thrombectomy, as compared to thrombolysis, significantly reduced the risk of long-term brain injury, disability and loss of independence in stroke patients.

Patients with pulmonary nodules were managed from a completely virtual pathway. This reduced hospital visits for patients whilst improving their experience. The service ensured patients were managed according to national guidelines and enabled the early detection of lung cancer. Also,
within respiratory medicine, an electronic referrals platform pilot had been so successful that work was underway to commission the platform permanently. The platform created a workflow which booked patients to the right clinic to ensure that they had diagnostic tests undertaken in advance, thus requiring fewer hospital visits and improving patient experience.

Within gastroenterology, a new service had been established for all patients referred on a colorectal two week wait pathway. Nurse led telephone assessments were completed in place of a face to face colorectal outpatient clinic with a surgeon. This had made the service more accessible and timely for patients who could then be referred for the most appropriate investigation.

The implementation of ‘my care record’ in the endoscopy service meant that patients could attend screening without medical records at short notice. This had enabled the best use appointments, improved capacity and provided better access for patients.

In cardiology, a small number of nurses had been trained to independently implant loop recorder devices (used to help the diagnosis of heart rhythm issues). This was now a nurse led service using no antibiotics. An audit of 104 nurse led patient against 142 conventional implants showed the procedure to be safe, with a projected annual cost saving of more than £20,000 per annum.

The cardiology service had completed a full audit loop of their outpatient cardioversion service. Cardioversion is a medical procedure by which an abnormally fast heart rate or other cardiac arrhythmia is converted to a normal rhythm using electricity or drugs. The service was previously doctor led and without a proper electronic system to monitor patients’ outcomes. This service was now almost fully run by specialist nurses with medical supervision, using an electronic database to monitor outcomes, such that there was a 30% reduction in waiting times and 0% (from 6%) loss to follow up rate.

Cardiology had also recently set up a nurse led angiography service. Angiography is an imaging technique used to visualise the inside of blood vessels and organs of the body, with particular interest in the arteries, veins, and the heart chambers. The service aimed to decrease waiting times for patients, whilst increasing the capacity in catheter laboratories. A nurse trained in angiography, would undertake with the supervision of a consultant cardiologist, the coronary angiogram under local anaesthetic.

In July 2019, the service received the ‘Gurney innovation award’ which was a certificate awarded to doctors for the creation of a teaching programme for junior doctors called 'morning report'. A teaching session delivered by the junior doctors, led by consultants looked at the dilemmas and difficulties in day to day clinics practice.

The department received a medical excellence award for its work on the undergraduate training programme.

The service delivered two “so you want to be a doctor?” study days for local school aged students. These two informative days were fully booked and had led to an increased number of work experience placements provided by the trust. This had helped with the links into the community and local schools.

Through improved recruitment and retention, the service were able to reduce their nursing vacancies in adult areas to zero. This had improved staffing consistency for patients and carers to deliver a better experience.

An improvement in staffing levels led to continuity of teams and increased supervisory time of the ward leaders. The service had introduced a follow up call to patients who were discharged to support a smooth transition and staff discussed their stay to support improvements to services.
In May 2019, the service introduced a new learning disability pathway. Patients with very complex needs were moved straight from the emergency department to a dedicated ward, Oxhey ward. An enhanced care worker was allocated to help care for the patients on this pathway and a carers chair was provided for patients’ relatives to use if they wished to stay overnight.

The trust held two ‘living well with cancer events’ each year. All cancer patients were invited to attend with their partners & carers. There was a market stall area with representatives from local partner organisations, for example, the cancer voluntary service, council benefits service, support centres, and cancer charities. At each event, senior colleagues talked to the group about cancer care and cancer nurse specialists were available to provide advice and support, patients were signposted to other appropriate services as needed. Between 75 – 100 people attend each event. Feedback from these events helped the service plan further improvements.

The trust recently won the nursing times magazine ‘best UK employer of the year award’ which reflected the work taken forward over recent years in improving recruitment, retention and staff engagement. The judging panel chose the trust for its sustained progress over recent years in improving the working life of staff. Judges gave praise for the wide range of measures implemented, which included the following:

- a successful nurse recruitment campaign
- a series of career development opportunities
- reduced use of agency staff
- the introduction of programmes to support newly registered nurses and midwives and those looking to progress their careers within the organisation
- a focus on staff wellbeing with staff being offered free health checks, mindfulness sessions, keep fit classes, stress management and mental health. The national staff survey put the trust in the top 20% of trusts for staff engagement and showed increased levels of motivation.

There was active participation in research throughout the medicine division, examples included:

- **HALO**: Registry radiofrequency ablation of Barrett’s columnar lined oesophagus and squamous dysplasia
- **ROCeTS**: Refining ovarian cancer test accuracy scores
- **MaPLe**: Molecular profiling for lymphoma
- **LuCID**: Lung cancer indicator detection
- **POSNOC**: Positive Sentinel Node
- **BADBIR**: British Association of Dermatologists’ Biological Interventions Register
- **BSTOP**: Bio-markers of Systemic Treatment Outcomes in Psoriasis
- **ORION-4**: The effects of inclisiran on clinical outcomes among people with atherosclerotic cardiovascular disease.
Surgery

Facts and data about this service

Watford General Hospital has eight operating theatres, including three for women’s and children’s services. Five main operating theatres cover general surgery, trauma, and orthopaedics. Theatre one was dedicated for orthopaedic trauma operations. Theatre five was dedicated for 24 hour emergency surgery in line with national recommendations. The theatre suite comprises of five theatres and the post operation recovery area. The hospital has six surgical inpatient wards (Cleves, Flaunden, Langley, Letchmore, Ridge and Elizabeth) with a total of 132 beds (please note, this figure was supplied after our inspection, data submitted prior to inspection demonstrated 120 beds in surgery), a preassessment 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 specialties they provide are:

- Trauma and orthopaedics
- Ophthalmology
- Ear, nose and throat (ENT)
- Oral surgery and orthodontics
- Urology
- General surgery including breast, vascular, upper gastrointestinal and colorectal surgery
- Pain

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.

St Albans Hospital provides the majority of planned surgery in West Hertfordshire. There are six theatres, 40 elective surgery beds and 24-day case trolleys. We did not visit St Albans hospital for this inspection.

(Source: Acute Routine Provider Information Request (RPIR) – Acute context tab)

The trust had 27,173 surgical admissions from September 2018 to August 2019. Emergency admissions accounted for 7,053 (26.0%), 15,864 (58.4%) were day case, and the remaining 4,256 (15.7%) were elective.

(Source: Hospital Episode Statistics)

During our unannounced inspection on 11 to 13 February 2020, we visited all areas providing surgery services at the hospital, spoke with eight patients or their relatives, observed patient care and treatment and looked at 12 patient care records. We spoke with 50 members of staff including nurses, doctors, surgeons, therapists, healthcare assistants, theatre staff, ward managers, ward
clerks, matrons, and senior managers. We also considered the environment and reviewed the trust’s surgery performance data. Surgery was previously inspected in October and November 2018 and was rated good for safe, effective, caring and well-led, and required improvement for responsive. The overall rating was good.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates

Nursing staff received mandatory training. The trust set a target of 90% for the completion of mandatory training. Trust wide compliance rates showed that nursing staff did not meet the 90% target for four out of 15 topics, including basic life support and fire safety.

Please note that the trust informed us that a small number of their surgery nursing staff at St Albans City Hospital have merged workloads with the gynaecology teams and a small number of medical staff in surgery at Watford General Hospital have merged workloads with critical care. Therefore, the analysis of mandatory training data below includes some staff working across surgery and critical care or gynaecology.

Trust level

A breakdown of compliance for mandatory training courses from April to October 2019 for qualified nursing staff in surgery (and gynaecology) at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual handling (non-patient)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic health, safety and risk</td>
<td>269</td>
<td>272</td>
<td>98.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control (clinical)</td>
<td>268</td>
<td>272</td>
<td>98.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism prevention (essential)</td>
<td>263</td>
<td>267</td>
<td>98.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>266</td>
<td>272</td>
<td>97.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>265</td>
<td>271</td>
<td>97.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>264</td>
<td>272</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disability (TEACH) (essential)</td>
<td>263</td>
<td>272</td>
<td>96.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood handling (essential)</td>
<td>232</td>
<td>242</td>
<td>95.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling (patient contact - level 2)</td>
<td>258</td>
<td>271</td>
<td>95.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>254</td>
<td>272</td>
<td>93.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In surgery (and gynaecology) at trust level, the 90% target was met for 11 of the 15 mandatory training modules for which qualified nursing staff were eligible.

Medical staff received their mandatory training. However, data shows that trust wide compliance was below target for nine out of 15 topics including fire safety, information governance and adult basic life support.

A breakdown of compliance for mandatory training courses from April to October 2019 for medical staff in surgery (and critical care) at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Manual handling (patient contact - level 2)</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Basic health, safety and risk</td>
<td>204</td>
<td>213</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>198</td>
<td>213</td>
</tr>
<tr>
<td>Fire safety and evacuation (clinical)</td>
<td>24</td>
<td>26</td>
</tr>
<tr>
<td>Infection control (clinical)</td>
<td>196</td>
<td>213</td>
</tr>
<tr>
<td>Manual handling (non-patient)</td>
<td>171</td>
<td>187</td>
</tr>
<tr>
<td>Fire safety (non-clinical)</td>
<td>167</td>
<td>187</td>
</tr>
<tr>
<td>Information governance</td>
<td>189</td>
<td>213</td>
</tr>
<tr>
<td>End of life care (essential)</td>
<td>103</td>
<td>121</td>
</tr>
<tr>
<td>Venous thromboembolism prevention (essential)</td>
<td>166</td>
<td>199</td>
</tr>
<tr>
<td>Blood handling (essential)</td>
<td>171</td>
<td>205</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>175</td>
<td>211</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>174</td>
<td>213</td>
</tr>
<tr>
<td>Learning disability (TEACH) (essential)</td>
<td>171</td>
<td>213</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>15</td>
<td>26</td>
</tr>
</tbody>
</table>

In surgery (and critical care) at trust level, the 90% target was met for six of the 15 mandatory training modules for which medical staff were eligible.

Please note that the trust did not provide any data for medical staff in surgery (and critical care) based at St Albans City Hospital. Therefore, the medical staff training data in the table above relates to staff located at Watford General Hospital.

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

Watford General Hospital

The mandatory training was comprehensive and met the needs of patients and staff. We saw the overall mandatory training divisional rate was 93% and 91% for essential training in January 2020. Staff we asked had all completed their mandatory training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Nursing staff received mandatory training. In surgery at Watford General Hospital, the
90% target was met for 11 of the 15 mandatory training modules for which qualified nursing staff were eligible. Only one member of nursing staff was eligible for non-clinical fire safety and had not completed it. The essential end of life care (EOLC) module completion rate should be viewed in context with lower numbers of eligible nursing staff. The only module that was still some way from meeting trust target was the clinical fire safety and evacuation.

This was an improvement since our last inspection. We found training compliance from July 2017 to June 2018 only met the 90% target for one of the 11 mandatory training modules for which qualified nursing and medical staff were eligible.

A breakdown of compliance for mandatory training courses from April to October 2019 for qualified nursing staff in surgery at Watford General Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Manual handling (non-patient)</td>
<td>1</td>
</tr>
<tr>
<td>Basic health, safety and risk</td>
<td>209</td>
</tr>
<tr>
<td>Infection control (clinical)</td>
<td>208</td>
</tr>
<tr>
<td>Venous thromboembolism prevention (essential)</td>
<td>205</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>205</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>205</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>204</td>
</tr>
<tr>
<td>Learning disability (TEACH) (essential)</td>
<td>202</td>
</tr>
<tr>
<td>Blood handling (essential)</td>
<td>180</td>
</tr>
<tr>
<td>Manual handling (patient contact - level 2)</td>
<td>198</td>
</tr>
<tr>
<td>Information governance</td>
<td>194</td>
</tr>
<tr>
<td>End of life care (essential)</td>
<td>106</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>180</td>
</tr>
<tr>
<td>Fire safety and evacuation (clinical)</td>
<td>154</td>
</tr>
<tr>
<td>Fire safety (non-clinical)</td>
<td>0</td>
</tr>
</tbody>
</table>

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

Medical staff received mandatory training. In surgery (and critical care) at Watford General Hospital, the 90% target was met for six of the 15 mandatory training modules for which medical staff were eligible. Although over half of medical staff’s eligible modules still missed trust target, this was a gradual improvement since our last inspection. We had previously issued the trust a requirement notice about medical staff’s lack of mandatory training completion.

A breakdown of compliance for mandatory training courses from April to October 2019 for medical staff in surgery (and critical care) at Watford General Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Manual handling (patient contact - level 2)</td>
<td>26</td>
</tr>
<tr>
<td>Basic health, safety and risk</td>
<td>204</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>198</td>
</tr>
<tr>
<td>Fire safety and evacuation (clinical)</td>
<td>24</td>
</tr>
</tbody>
</table>
Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Nursing and medical staff identified patients who had a cognitive impairment by completing a dementia commissioning for quality and innovation (CQUIN) form. The CQUIN is an NHS payment framework that links part of English healthcare providers’ income to quality improvement. The dementia CQUIN goals are designed to encourage the recognition of dementia in hospital. Staff uploaded these forms onto their integrated clinical system which was accessed daily and downloaded by the dementia CQUIN administrator. This informed the trust’s dementia team of patients who had a potential dementia diagnosis. The trust had a dementia steering group led by the lead consultant. At the time of our inspection the service had plans in place for quarterly dementia tier two training.

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.**

**Safeguarding training completion rates**

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

The tables below include Prevent training as a safeguarding course. Prevent works to help staff identify people at risk of getting involved in or supporting terrorism or extremist activity.

Please note the trust informed us that a small number of their surgery nursing staff at St Albans City Hospital have merged workloads with the gynaecology teams and a small number of medical staff in surgery at Watford General Hospital have merged workloads with critical care. Therefore, the analysis of mandatory training data below includes some staff working across surgery and critical care or gynaecology.

**Trust level**

Nursing staff received training specific for their role on how to recognise and report abuse. In surgery (and gynaecology) at trust level, the 90% target was met for all three safeguarding training modules for which qualified nursing staff were eligible. A breakdown of compliance for safeguarding training courses from April to October 2019 for qualified nursing staff in surgery (and gynaecology) at trust level is shown below:
Medical staff received training specific for their role on how to recognise and report abuse. However, compliance was below target for two out of four topics. A breakdown of compliance for safeguarding training courses from April to October 2019 for medical staff in surgery (and critical care) at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>266</td>
<td>272</td>
<td>97.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>265</td>
<td>272</td>
<td>97.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT WRAP</td>
<td>244</td>
<td>261</td>
<td>93.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In surgery (and critical care) at trust level, the 90% target was met for two of the four safeguarding training modules for which medical staff were eligible. Please note that the trust did not provide any data for medical staff in surgery (and critical care) based at St Albans City Hospital. Therefore, the medical staff training data in the table above relates to staff located at Watford General Hospital.

Watford General Hospital

Nursing staff received training specific for their role on how to recognise and report abuse. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. In surgery at Watford General Hospital, the 90% target was met for all three safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April to October 2019 for qualified nursing staff in surgery at Watford General Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>206</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>204</td>
</tr>
<tr>
<td>PREVENT WRAP</td>
<td>183</td>
</tr>
</tbody>
</table>

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

Medical staff did not always receive training specific for their role on how to recognise and report abuse. A breakdown of compliance for safeguarding training courses from April to October 2019 for medical staff in surgery (and critical care) at Watford General Hospital is shown below:
In surgery (and critical care) at Watford General Hospital, the 90% target was met for two of the four safeguarding training modules for which medical staff were eligible.

Staff knew their roles and responsibilities for escalating concerns internally and externally. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we asked demonstrated good awareness of safeguarding and gave examples of how they would protect vulnerable patients. For example, when patients were admitted, and staff found some unexplained injuries. Staff told us they routinely reported pressure ulcers of grade two or above as a safeguarding concern. The trust’s safeguarding team were highly regarded by ward staff who told us they were dynamic and responsive.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had safeguarding champions on most wards staff could ask if they were unsure. Champions helped them raise and report safeguarding incidents. We saw the safeguarding team’s contact details was clearly visible on ward whiteboards.

Service leads told us the trust’s safeguarding team had started advertising dates for level three training as per the latest intercollegiate document guidance. The service gave themselves a six-month trajectory to train all band 7 staff. This included safeguarding training on managing 16- and 17-year olds who were transitioning through services. This was one of the service’s main areas of focus and leads had developed guidelines for wards. At the time of our inspection the division had completed a full review of safeguarding level three training. Additional areas had been targeted which saw children frequently including all nursing staff in adult outpatients, all consultants who saw children, for example in ear, nose and throat (ENT) and dermatology, and all staff working in maxillofacial surgery/orthodontics.

The service included a safeguarding section on discharge summaries for all patients under 18. When this was completed by the discharging clinician, a copy was automatically sent to the safeguarding team. This allowed the team to review all discharges of young people where there were safeguarding concerns to ensure appropriate procedures were followed with appropriate referrals and follow up. The trust has had an integrated safeguarding team since May 2018 with adult and children safeguarding nurses working together to embed the ‘think family’ approach trust wide. This enabled much closer working, particularly for complex cases involving 16 and 17-year olds. This improved transition of safeguarding issues for this age group.

Nursing staff we asked were aware of female genital mutilation (FGM) guidance and would refer any patients at risk to the safeguarding team. Staff were aware of the mandatory reporting of FGM for under 18’s. All cases of FGM were recorded via the enhanced data collection process. Cases were shared with the trust’s informatics department and reported to NHS England. The trust considered safeguarding for all cases of FGM. Staff were encouraged to discuss all cases with the safeguarding team who considered a referral to children’s services. The trust worked within Hertfordshire’s multi agency FGM strategy using risk assessments tools within the strategy. FGM was covered in all levels of safeguarding training. Additional training around FGM was delivered following the introduction of mandatory reporting. However, staff told us they had not encountered FGM at the time of the inspection.

Staff followed safe procedures for children visiting the ward. We saw staff followed the service’s policy for managing 16 to 18-year-old patients. Staff told us they had no specific training to support children and young people (CYP). However, they felt well supported by the CYP service and safeguarding team.
Gynaecological ambulatory care unit (GACU) and Elizabeth ward staff told us they occasionally admitted 16-18-year-old patients. They were aware of the new policy and felt comfortable and capable of keeping younger people safe.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, effective hand hygiene was not always completed.

All ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Wards varied in size, but had designated single sex bays and bathroom facilities.

Cleaning was provided by an external provider and we saw cleaning schedules were in place. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw cleaning schedules for theatres, anaesthetic rooms and recovery. Records showed that cleaning was completed according to risks with high risk areas being cleaned more frequently that lower risk areas. However, staff in the emergency surgical assessment unit (ESAU) told us there was no deep cleaning provision for patients who attended with communicable infections. This meant the ESAU manager and their team had to carry out deep cleaning which could delay their next patient if no other beds were free. After our inspection, the trust provided us with evidence that demonstrated that there was a schedule in place for deep cleaning at agreed intervals.

Staff followed infection control principles including the use of personal protective equipment (PPE). Patients we asked felt the hospital was clean, and said they saw staff washing hands. However, we saw a lack of hand hygiene on several occasions when staff did not wash their hands. For example, one theatre staff member did not wash their hands after removing a surgical drain from a patient’s abdomen. This staff member was wearing gloves so disposed of the drain and waste with the gloves but did not wash their hands after removing them.

There was no isolation room within theatres and staff therefore managed patients with communicable infections through the day surgery unit (DSU) if possible. The DSU had six bays which enabled patients to be nursed in a separate area. Those patients who were unable to be operated on in the DSU due to the complexity of their procedure were added onto the end of the theatre list to reduce the risks of cross contamination. Staff told us ward nursing staff worked well with the infection control and prevention team who could always give them advice.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. For example, we saw green and dated 'I am clean’ stickers on all cleaned equipment. We also saw trolleys outer surfaces were damp dusted daily with disinfectant.

Staff worked effectively to prevent, identify and treat surgical site infections (SSIs). Elective surgical patients were screened for infections at pre admission assessment, when swabs were taken for MRSA. Those identified as having MRSA were given treatment to complete prior to being admitted for their procedure. The service had had a high rate of SSIs in elective arthroplasty patients. This risk was scored, monitored and reviewed on their risk register. The service held monthly SSI meetings to review and discuss infection rates. After our inspection, the trust provided evidence that demonstrated that they were no longer an outlier for the rates of SSI in elective arthroplasty.

The service had processes in place to ensure patient safety when medical patients from other providers or trust sites required admission for a procedure. For example, the service had
introduced a process to ensure patients were screened for communicable infections on transfer from another organisation.

**Environment and equipment**

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had suitable facilities to meet the needs of patient’s families. The hospital has six surgical inpatient wards (Cleves, Flaunden, Langley, Letchmore, Ridge and Elizabeth) with a total of 163 beds. The service had eight operating theatres, including three for women’s and children’s services. Five main operating theatres covered general surgery, trauma, and orthopaedics. The theatre suite comprised five theatres and the post operation recovery area. The surgical wards were located on the floor below the theatres.

All wards were easily accessible from the main entrances to the hospital. There was clear signage, although we saw that some signage which was shabby and out of date. For example, the Princess Michael of Kent (PMOK) lifts sign referred to the pre-operative assessment clinic on level three and surgical appliances on level one when both had moved to another trust site. Patients and relatives could access all areas using stairs or lifts. We were told that lifts were problematic and frequently broke down resulting on additional journey times between patients. For example, we were told that when lifts broke porters had to use alternative lifts across the hospital which added time onto transfers and the risks associated with nursing staff transferring post-operative patients and being off their clinical ward.

Not all clinical areas were wholly suitable for the use. For example, we saw that the emergency surgical assessment unit (ESAU) was not sufficiently large enough which meant that some patients were excluded from using the service. Some ward bays were also small which meant patient manoeuvres (such as using a slide board to transfer between beds) was difficult, and some areas were not suitable for obese patients. ESAU also had no call bells, piped oxygen or suction which meant that if there was a clinical emergency staff needed to access equipment from elsewhere. However, all bays on wards we visited were single sex.

The service had numerous environment issues due to their aging estate. For example, the floor of Flaunden B ward was cracked, in poor condition and needed repair. The theatres recovery layout was poor as we saw no nurse screening between their paediatric and adult patients and the orthodontics and maxillofacial services were based in a pre-fabricated portacabin which suffered extreme temperatures.

We found theatre environments were generally clean and tidy, despite a lack of storage. Some theatres contained excess equipment which limited staff movement and needed extra cleaning, for example a microscope in theatre three. Areas of theatre needed repair, for example a broken door with a split cover between theatre two’s dirty utility room and back corridor. The theatre manager told us the service had a maintenance programme for 2020 to repair these areas. They confirmed the day surgery unit (DSU) had been refurbished. At the time of our inspection theatre five was very small. The service had plans to downgrade this to a procedure room until the new planned theatre was built.

The current recovery environment was not in line with guidance as there was no dedicated area for children and young people. This posed a safeguarding risk. We saw that children and adults were recovered in the same area and separated by curtains. We heard plans were in progress to
revise the theatre department and increase the recovery room to 12 bays. This would include designated paediatric and adult areas and enable better patient flow in and out and improve compliance. The service had raised the lack of a dedicated paediatric recovery unit as a risk on their divisional risk register in August 2013.

The service had well advanced plans to refurbish their main operating theatres and there was a trust wide plan to rebuild large parts of the hospital. A theatre development plan was in progress. For details of the refurbishment of the theatres please see our ‘responsive’ section (service delivery to meet the needs of local people).

The service had enough suitable equipment to help them to safely care for patients. Staff told us they were able to access equipment readily from a private contractor helpdesk, the trust’s equipment library or hire and borrow items from other wards and departments. However, the service was using obsolete, unsupported stock such as colonoscopes and gastrosopes. This risk of dated equipment was added to their divisional risk register in May 2019 with a score of six and reviewed accordingly.

We checked portable appliance testing (PAT) and service tests on ten pieces of equipment. A microscope in theatre three was the only item which did not have a sticker with the date on. This meant we could not be sure it was tested or in date. We raised this with a member of theatre staff who removed it from use until it was tested.

Staff carried out daily safety checks of specialist equipment. We reviewed daily equipment checks on resuscitation trolleys, a paediatric resuscitation trolley and a difficult airway trolley in theatres. All equipment was checked daily or weekly according to trust wide guidance. Equipment was in date and restocked after use. At the time of our inspection the resuscitation training department had updated the service’s main operating theatres resuscitation trolleys with a new area specific checklist. Trolleys outside theatres were checked daily and those inside the theatres weekly. All were labelled outside or inside accordingly. The service had access to all the necessary paediatric equipment to care for children and young people such as an airway trolley.

Staff disposed of clinical waste safely. All sharps containers we saw on wards and in dirty utility and sluice rooms were not overly filled. All containers were correctly labelled, dated and signed at the start and end of use. The service’s clinical waste store kept sharps containers for incineration separate from offensive hygienic waste and domestic waste.

**Assessing and responding to patient risk**

*Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.*

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessment tools included falls risk assessments, nutritional assessments and manual handling needs. The trust used the National Early Warning Score (NEWS2) tool which is a point prevalent system which helps staff to identify changes in a patient’s clinical condition. We found this was well embedded and scores were reviewed at daily safety huddles. 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.

The service undertook initiatives on recognition of the deteriorating patient to expand staff awareness and knowledge of sepsis and national early warning scores (NEWS2). NEWS2 observation charts detailed escalation procedures that gave staff clear instructions on what to do
when a patient showed signs of deterioration. 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).

Patients were assessed as soon as possible by a doctor. Patients admitted through the emergency department or the emergency surgery assessment unit were reviewed by a surgical specialist and a consultant within 12 hours of admission as per NICE guidance. On call doctors completed ward rounds regularly.

Staff knew about and dealt with any specific risk issues. Theatre staff assessed patient’s American society of Anaesthesiologists (ASA) grades on admission. The ASA system’s purpose is to assess and communicate a patient’s pre-anaesthesia medical co-morbidities. This can be helpful in predicting perioperative risks. For example, the service audited patient satisfaction on optimal analgesia for all types of shoulder surgery. The audit recruited 125 patients; 64 males and 61 female patients with an ASA grading of one or two. The ASA physical status classification system’s purpose is to assess and communicate a patient’s pre-anaesthesia medical co-morbidities. The classification system alone does not predict the perioperative risks but used with other factors such as type of surgery, frailty and level of deconditioning, it can be helpful in predicting perioperative risks. The service also had extra standard operating procedures (SOPs) for specialist procedures.

We observed theatre staff following the world health organisation’s (WHO) five steps to safer surgery checklist. They carried out briefings at 8:30 before sending for their first patient of the day. The sign in was completed by anaesthetist practitioner with input from all the anaesthetic team. We observed the timeout stage of the WHO checklist which was surgeon-led, in-depth and included introductions and contributions from the whole team. However, the two-theatre team debriefs we observed post-procedure lacked detail as only one question was asked. Staff noted it was difficult to complete the debrief for every procedure and were looking at how to improve compliance. The hospital theatre manager made attempts to highlight the need for debriefs with medical and theatre staff. They had laminated an example in each theatre and recently revised the checklist.

Flaunden B ward held safety huddles three times daily to pick up all issues and share information. These huddles went ahead in the morning, lunchtime and another for the nightshift. They were recorded in the communications book and covered issues such as patients with do not attempt cardio-pulmonary resuscitation (DNACPR) orders, mental capacity assessments (MCAs) and deprivation of liberty safeguards (DoLS) authorisation in place, patients at risk of deterioration and those with mental health conditions.

Staff shared key information to keep patients safe when handing over their care to others. For example, NEWS2 scores were reviewed at daily safety huddles which helped staff to identify deterioration or other changes in a patient’s clinical condition. Ward safety huddles discussed safe care staffing support which was monitored by the senior team with mitigation added. Safety huddles also shared divisional lessons learned from any recent incidents.

Staffing levels were adjusted to meet the needs of patients, for example, the Ridge hip fracture ward allocated more night staff to their bay two post-operative patients with high acuity. This meant they had better oversight. Staff were aware of who to contact in an emergency and how to escalate concerns regarding a patient’s condition.

The service had intra-operative cell salvage (ICS) leads which were the senior anaesthetic nurse and the senior operating department practitioner. Provision of ICS depended on there being enough trained staff on duty when it was needed. For elective cases, the registrar or consultant surgeon or anaesthetist requested ICS availability by email. The service was available weekdays from 9am to 5pm. At the time of our inspection two weeks’ notice was required for surgery with ICS. ICS had set criteria. We reviewed ICS usage and saw the service’s vascular specialty had a
total of five patients in 2019.

We saw that patients could reach call bells and staff responded quickly when called. The service’s only ward without call bells was the emergency surgical assessment unit (ESAU). This was recorded on the services risk register and there were plans to install a system as part of the refurbishment programme. We were told that to ensure patient safety in the interim, staffing numbers were reviewed and patients were not permitted to stay in the department overnight. Patients were always assessed by medical staff within an hour and nursing staff within 30 minutes.

Staff on the children’s ward helped with the care of children in theatre recovery if a paediatric nurse was not on duty to monitor child patients.

The trust’s antimicrobial stewardship (AMS) team were focused on the delivery of the national CQUIN 2019; “reducing the impact of serious infections”. This included timely identification and treatment of sepsis, antibiotic review and reduction in total consumption, which they successfully achieved. The AMS team was now focussed on implementing and improving diagnostics.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Please note that the trust informed us that a small number of their surgery nursing staff at St Albans City Hospital have merged workloads with the gynaecology teams and a small number of medical staff in surgery at Watford General Hospital have merged workloads with critical care. Therefore, the analysis of staff data below includes some staff working across surgery and critical care or gynaecology.

Trust level

The table below shows a summary of the nursing staffing metrics in surgery (and gynaecology) at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual agency hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>10%</td>
<td>13%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>921</td>
<td>12%</td>
<td>10%</td>
<td>3.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>283</td>
<td>6%</td>
<td>9%</td>
<td>2.7%</td>
<td>65,121</td>
<td>13,092</td>
<td>5,395</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)
Nurse staffing rates within surgery (and gynaecology) at trust level were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover and sickness.

Please note that the trust was unable to provide total hours including those covered by substantive staff to allow us to calculate bank and agency usage or unfilled hours for nursing staff as a percentage of the total hours available.

![Bank hours - registered nurses](image)

Monthly bank use over the last 12 months for registered nurses showed a downward shift from May 2019 to October 2019.

![Agency hours - registered nurses](image)

Monthly agency use over the last 12 months for registered nurses was not stable and may be subject to ongoing change.

*Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab*

**Watford General Hospital**

The service had enough nursing and support staff to keep patients safe. All the service’s inpatient wards used the allocate system ‘safecare’. Senior staff input staffing level information twice daily which incorporated reviewing the staffing numbers, staffing skills and patient acuity on the ward. Matrons had oversight and managed any safety issues that arose. A safer care staffing report was sent out after the morning operational meeting and all updates were also sent by email.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. Managers reviewed staffing numbers using the ‘sun
burst wheel’ within the operations meeting. This meeting had executive and senior team oversight where mitigation was managed if needed. Matrons identified ward red flags in line with national quality board (NQB) guidance. They then discussed what level of support was required with the ward sister. This support was discussed within the ward safety huddle and monitored by the senior team with mitigation added to ‘safecare’.

The table below shows a summary of the nursing staffing metrics in surgery at Watford General Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>November 2018 to October 2019</th>
<th>September 2018 to August 2019</th>
<th>November 2018 to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average establishment</td>
<td>Annual vacancy rate</td>
<td>Annual turnover rate</td>
</tr>
<tr>
<td>Target</td>
<td>10%</td>
<td>13%</td>
<td>3.5%</td>
</tr>
<tr>
<td>All staff</td>
<td>789</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>216</td>
<td>0%</td>
<td>8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

The ward manager could adjust staffing levels daily according to the needs of patients. The number of nurses and healthcare assistants matched the planned numbers. Ward managers were able to request additional staff if there was a clinical need. Requests were approved by matrons following a review of risk assessments.

Nurse staffing rates within surgery at Watford General Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and sickness.

Please note that the trust was unable to provide total hours including those covered by substantive staff to allow us to calculate bank and agency usage or unfilled hours for nursing staff as a percentage of the total hours available.

**Vacancy rates**

The service had reducing vacancy rates for nursing staff. At the time of our inspection we heard the Flauden B ward had a 6.4 whole time equivalent (WTE) vacancy rate but had recruited three of those staff. There was also a reported shortage of theatre nurses. The trust had completed recruitment programmes nationally and internationally, with some success. The service used the Association for Perioperative Practice (AfPP) staffing guidance. At the time of our inspection we heard they had 15 WTE vacancies for trained and untrained staff.
Monthly vacancy rates over the last 12 months for registered nurses showed a downward trend from November 2018 to March 2019, although this did not continue. The vacancy rate had risen back to the national average in the last three months of this data. This was equivalent to 131.3 WTE vacancies in the division.

Please note that the negative vacancy rates in the chart above indicate that there were more staff in post than planned.

**Turnover rates**

The service had low turnover rates for nursing staff. The division’s total headline turnover rate for January 2020 was 12%. The turnover rate for voluntary only was 10.2%. This gave the division a stability rate of 87%.

The Ridge ward nurse in charge told us they had a high turnover of registered nurses. At the time of our inspection the ward had an uplift of two new hip fracture (HF) nurses to meet national requirements as their orthopaedic team grew.

**Sickness rates**

The service had low sickness rates for nursing staff. The division’s total sickness rate for January 2020 was 3.6% which was 0.1% higher than trust target.

**Bank and agency staff usage**

Bank staff covered 99% of their shifts so very little agency staff were used.

The service had low rates of bank and agency nurses. Theatre staff told us they were less reliant on agency staff as bank shifts could cover most gaps.
Monthly bank use over the last 12 months for registered nurses showed a downward shift from May 2019 to October 2019. This rate had fluctuated since April 2019 but was below the national average. Bank use amounted to 9.3% of the division’s total paybill in January 2020.

Monthly agency use over the last 12 months for registered nurses showed a downward shift from May 2019 to October 2019. This rate had fluctuated since April 2019 but was below the national average. Agency use amounted to 5.2% of the division’s total paybill in January 2020. This was slightly above trust target of 5%.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The trust worked with the Crown Commercial Service (CCS) framework to provide their temporary agency staff. They also worked with NHS Performance to provide their bank staff.

Managers made sure all bank and agency staff had a full induction and understood the service.

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

Medical staffing

The service’s medical staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. However, extra activity was putting pressure on anaesthetists. This was caused by increased demand to cover activity which needed anaesthetic support year on year. However, the service’s lack of anaesthetic staff numbers at all grades was not impacting on patient care.
Please note that the trust informed us that a small number of their surgery nursing staff at St Albans City Hospital have merged workloads with the gynaecology teams and a small number of medical staff in surgery at Watford General Hospital have merged workloads with critical care. Therefore, the analysis of staffing data below includes some staff working across surgery and critical care or gynaecology.

**Trust level**

The table below shows a summary of the medical staffing metrics in surgery (and critical care) at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>November 2018 to October 2019</th>
<th>September 2018 to August 2019</th>
<th>November 2018 to October 2019</th>
<th>October 2018 to September 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average establishment</td>
<td>Annual vacancy rate 10%</td>
<td>Annual turnover rate 13%</td>
<td>Annual sickness rate 3.5%</td>
</tr>
<tr>
<td><strong>Target</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>All staff</strong></td>
<td>921</td>
<td>12%</td>
<td>10%</td>
<td>3.3%</td>
</tr>
<tr>
<td><strong>Medical staff</strong></td>
<td>240</td>
<td>8%</td>
<td>5%</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

Medical staffing rates within surgery (and critical care) were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy.

Please note that the trust was unable to provide total hours including those covered by substantive staff to allow us to calculate bank and locum usage or unfilled hours for nursing staff as a percentage of the total hours available. In addition, the trust did not provide any data for medical staff in surgery (and critical care) based at St Albans City Hospital. Therefore, the medical staffing data in the table above relates to staff located at Watford General Hospital.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

**Vacancy rates**

The service had low vacancy rates for medical staff.

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

**Turnover rates**

The service had low turnover rates for medical staff.
Monthly turnover rates over the last 12 months for medical staff showed a downward shift from March 2019 to August 2019.

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

**Sickness rates**

The service had low and reducing sickness rates for medical staff.

Monthly sickness rates over the last 12 months for medical staff showed a downward shift from May 2019 to October 2019.

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

**Bank and locum staff usage**

The service had low rates of bank and locum staff.
Monthly bank use over the last 12 months for medical staff showed a downward trend from February 2019 to August 2019, although this did not continue in September 2019.

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

Watford General Hospital

The service had enough medical staff to keep patients safe. The medical staffing matched the planned number.

The table below shows a summary of the medical staffing metrics in surgery (and critical care) at Watford General Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual agency hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>10%</td>
<td>13%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>789</td>
<td>11%</td>
<td>10%</td>
<td>3.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Medical staffing rates within surgery (and critical care) at Watford General Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy.

Please note that the trust was unable to provide total hours including those covered by substantive staff to allow us to calculate bank and locum usage or unfilled hours for nursing staff as a percentage of the total hours available.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

**Vacancy rates**

The service had low vacancy rates for medical staff. This was 8% which was 2% lower than trust target.

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

**Turnover rates**

The service had low turnover rates for medical staff.

![Turnover rate - medical staff](image)

Monthly turnover rates over the last 12 months for medical staff showed a downward shift from March 2019 to August 2019.

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

**Sickness rates**

The service had low and reducing sickness rates for medical staff.
Monthly sickness rates over the last 12 months for medical staff showed a downward shift from May 2019 to October 2019.

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

**Bank and locum staff usage**

The service had low rates of bank and locum staff.

Monthly bank use over the last 12 months for medical staff showed a downward trend from February 2019 to August 2019, although this did not continue in September 2019.

**Locum hours - medical staff**
Monthly locum use over the last 12 months for medical staff showed a downward shift from April 2019 to September 2019.

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

The service had invested time to recruit medical staff and as a result, required reducing numbers of locum staff. Consultants were positive about this change. Managers could access locums when they needed additional medical staff. The anaesthetic team had increased the number of locum anaesthetists used in response to increased activity. Staff told us that there were some concerns with the abilities of the locum staff, and this had increased pressure on existing staff. Staff also said that the anaesthetist department was reliant the goodwill and flexibility of its existing staff in meeting increased demand year on year. This was highlighted on the divisional risk register.

Managers made sure locums had a full induction to the service before they started work.

**Staffing skill mix**

The service had a good skill mix of medical staff on each shift and reviewed this regularly. In September 2019, 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 slightly higher.

**Staffing skill mix for the 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>44%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>18%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>24%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>14%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least three years at Senior House Officer (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)

Consultants were responsible for designated wards according to their speciality. Consultants completed an on call rota where they would be responsible for the patients admitted into surgery either through the emergency department or through the emergency surgical assessment unit. The consultant and their team would be responsible for each patient admitted until they were either transferred to another speciality or discharged. The service ensured that a consultant was on call out of hours and at weekends. We heard the on-call rota for surgeons, registrars and anaesthetists was well organised and satisfactory.

**Records**
Staff kept records of patients’ care and treatment. Records were clear, up-to-date, and stored securely. However, DNACPR and treatment escalation plan (TEP) records were not always detailed and some speciality notes were not easily available.

The trust used largely paper records. Some specialities used electronic records to record speciality specific patient information.

Patient notes were not always comprehensive or easily accessible by all staff. We checked 12 sets of patient notes. All records we checked had risk assessments completed by nurses, with updates where applicable. For example, around infection prevention control, falls, pressure ulcers (PUs), nutrition and intravenous (IV) access. Some patient had additional care plans based on their clinical condition, for example, catheter care plans, and specific site infections (SSIs). We saw nurses reviewed, signed and dated these daily. We saw that venous thromboembolism (VTE) assessments and national early warning scores (NEWS) were complete and escalated appropriately.

However, records we checked were not always complete and information was not always easy to locate or in order. For example, one ‘do not attempt cardio-pulmonary resuscitation’ (DNACPR) form we checked had no review, endorsement name or position printed. We also found one blank and one incomplete treatment escalation plan (TEP). TEPs are used to identify an agreed ceiling of treatment for patients with long term or life limiting illnesses. We flagged this with the nurse in charge who told us the doctor meant to complete another as that TEP no longer applied.

We heard nursing staff recorded any missing records as an incident on the trust’s incident reporting system. However, the DNACPR forms and TEPs we found meant we could not ensure all incomplete paperwork was flagged.

The trust had several quality improvement (QI) projects in progress regarding medical and nursing notes. We were told that the storage of notes was under review and that there was another group focusing on do not attempt cardio pulmonary resuscitation forms (DNACPR) and the completion of TEP forms. Trust wide audits showed 90% compliance for documentation completion and an increase in the consideration of DNACPR decisions and increased compliance with treatment escalation plan (TEP) completion.

Inpatient doctors and nursing staff records of care were recorded in paper notes either as care plans or daily reviews. However, we saw that some speciality notes were recorded electronically. We reviewed an oncology patient’s multidisciplinary team (MDT) referral report which was brief and illegible. We raised this with a ward sister who told us specialist gynaecological cancer nurses did not record their notes in patient records but used their own electronic system. This meant oncology patient’s records were not accessible to all staff as they were not all stored in one place.

When patients transferred to a new team, there were no delays in staff accessing their records. Nursing staff completed transfer checklists and handed over patients to the new clinical area. If patients were referred to another speciality, the doctor would send a referral to the relevant clinician and the patient reviewed by the speciality before accepting to take over their care.

The trust had an electronic flagging system in place to identify people with learning disabilities (LD). All patients with LD were recorded on a designated electronic system which contained the trust’s electronic special register. The register was updated by the safeguarding administrator on a quarterly basis with information provided by the strategic nurse for the acute health liaison team (AHLT). When a patient presented, they were electronically registered, so the system flags they are on the special register. This alerted staff that the patient may require reasonable adjustments to be made.

Records were stored securely. We saw patient records trolleys were kept locked and tidy when
not in use. Notes trolleys were usually let at the nurses station or in designated areas by the ward bays.

The service’s theatres and wards we visited had no confidential personal information visible on display as whiteboards used a privacy screen to cover patient names. Patients surnames were displayed above their beds.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We looked at six medicine charts. We saw that staff recorded the weight and any allergies of patients on drug charts we checked. This enabled correct dosing of medicines. A pharmacist visited wards daily and completed medicine reviews to ensure medicines were prescribed correctly. We found medicines reconciliation was generally completed. Medicines reconciliation is the process of checking patients’ medicines to ensure that those prescribe in hospital match what the patient was taking on admission. The pharmacist completed this process.

Medicines were stored in locked cupboards within treatment rooms. Staff requested items from pharmacy to maintain a stock of frequently used medicines. Keys to medicines were held by qualified nurses. Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. Nurses administered medicines according to the prescriptions. However, staff did not always ensure patients had taken their medicine. One registered blind patient told us nursing staff did not always tell them when they placed a pot of medicines on their table which meant that there was a risk that medicines were missed.

Controlled medicines, those that require additional secure methods due to the risk of misuse under the Misuse of Drugs Act 1971, were stored in line with guidance. We saw that pharmacy completed regular audits of stock levels and administrations. Two nurses completed daily checks.

Staff told us that there were sometimes delays in obtaining tablets to take home (TTOs), although pharmacists stated that they were not always the cause of delays. Nurses used a tracker system so they could check and ask porters to collect TTOs or go themselves. Pharmacy had a tracking system for tablets to take home (TTOs) and had a two hour wait flagging system for TTOs which turned red if this time was breached. Possible reasons for delay included doctors writing prescriptions later or nurses not checking the tracking system and waiting for porters to collect the TTOs.

Staff followed current national practice to check patients had the correct medicines. Where appropriate two nurses checked medicines and all medicine charts were signed when medicines were administered. For example, we saw two signatures for the administration of an antibiotic and reconstitution advice from the pharmacy. The pharmacy team also noted observations for certain medicines and provided advice. For example, paracetamol was prescribed orally as the first line of pain control, advice was given that if the patient became nil by mouth (NBM) then they could have intravenous (IV) paracetamol.

Antibiotic review dates and indications were stated. We observed one of the charts which contained input from the microbiology team and pharmacy. The service introduced the antibiotic review tool (ART) on drug charts in November 2019 to improve prescribing practice. The antimicrobial stewardship (AMS) team also presented several quality improvement (QI) projects at national and international conferences.
Within theatres, we saw that staff stored medicines in anaesthetic rooms and within recovery. Cupboards were locked and qualified staff held keys. We checked medical gases in theatres such as CO2 and oxygen. All were stored correctly and were clearly labelled.

Controlled medicines within theatres were stored and checked in line with policy. For example, in theatre four we found the controlled drugs (CD) book in good condition. Within theatres, the CD stock checks were completed twice or three times daily. We found only CDs stored in the CD cupboard as per correct practice. However, we checked theatre three’s CD register and all CDs were supplied, administered and discarded with the relevant sections completed correctly. However, on days the theatre was not in use staff had not written ‘closed’. This meant it was not always clear whether daily checks had been missed. We also found that there were items which should not be stored in the CD cupboard within theatre three. We found laser keys kept in the CD cupboard. We highlighted this to the nurse in charge who ensured they would be removed and stored somewhere else. The last pharmacy CD audit was on 13 January 2020 and stock was checked and correct. We observed a nurse and doctor signing out medicines with two signatures as per the correct practice. All medicine stock and expiry dates were checked and correct.

Staff across the service, stored and managed all medicines and prescribing documents in line with the provider’s policy. We saw daily completed checklists of room and fridge temperatures in theatres and wards. Most areas ensured that fridges were checked daily. However, there were a few exceptions. The theatre pharmacy fridge, freezer and specimen fridge were not checked daily with checks completed on the 4, 6 and 10 February 2020 only, all other checks were missing.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. In level one theatres we saw learning from incidents was shared by the pharmacy team with the theatre manager and lead anaesthetist. This information was disseminated to the OPD who shared it with rest the of the theatre team. The last incident shared was a stock shortage of diamorphine. In response the pharmacy team supplied alternative strength vials and shared reconstitution instructions with theatre staff.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew their roles and responsibilities for the reporting of incidents internally and externally. All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust/provider policy using an electronic reporting system.

Managers investigated incidents and staff received feedback from investigation of incidents, both internal and external to the service. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations if appropriate. Where relevant proposed actions and next steps were completed. The service had two incidents of cross contamination when transferring medical patients onsite to the clean elective unit at another trust site. The service had since reviewed this risk and put robust controls and assurances in place. This risk was kept on the division’s risk register for review in summer 2020 to monitor compliance.

**Never Events**
The service reported never events in line with national guidance. Never events (NEs) 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 January to December 2019, the trust reported two never events for surgery at trust level.

(Source: Strategic Executive Information System (STEIS))

The hospital’s most recent NE was a nerve block administered to the wrong side. The previous NE was a wrong implant/prosthesis, suggesting a lack of undertaking sufficient checks. A prosthesis or prosthetic implant is an artificial device that replaces a missing body part, which may be lost through trauma, disease, or a condition present at birth.

Neither NE resulted in patient harm and the trust took immediate actions in response to the incidents. This included the reinforcement of the ‘stop before you block (SBYB)’ requirements and a strengthening of their current team debriefing practice. We saw SBYB signs in anaesthetic rooms. Other key immediate actions included adding SBYB to the world health organisation (WHO) checklist form. The revised form now included a section on what should be done to rectify the situation if a debrief was not performed. Staff awareness had improved as information was shared at staff meetings and on the governance noticeboard. The service was also undertaking human factors training for clinicians and theatre staff and using and implementing the ‘just culture’ tool. Whilst implementation was being carried out in response to NEs, the service stressed patient safety remained their main priority. They planned to develop an action plan and implement this in response to key learning points from the route cause analysis (RCA) investigations.

Managers debriefed and supported staff after any never event or serious incident. We reviewed minutes of the never event (NE) debrief meeting held in January 2020. This NE occurred at another trust site but was minutes included all proposed mitigating actions and controls the theatre team could put in place.

Managers shared learning about never events with their staff and across the trust. The service distributed monthly newsletters with any latest incidents and learning from them. We saw a trust NEs briefing on wards. Leads requested all divisions raise these two NEs through their governance and communication channels to maximise awareness and learning. We saw that the service adhered to the duty of candour guidance to be open and transparent.

Breakdown of serious incidents reported to STEIS

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from January to December 2019. Two of these occurred at Watford General Hospital and two were trust-wide issues.

A breakdown of incidents by incident type are below.

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>3</td>
<td>75.0%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
Watford General Hospital

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in surgery at Watford General Hospital which met the reporting criteria set by NHS England from January to December 2019. One of these serious incidents was categorised as sub-optimal care of the deteriorating patient and the other as a treatment delay.

We followed up these SIs on inspection. The treatment delay had resulted from referral forms being lost for a period of time, resulting in a lack of follow up. We read the 72-hour report for the treatment delay dated 12 November 2019. The trust reviewed the 34 pink waiting list cards which were missed and found that three patients had potentially come to moderate harm due to the delay in undergoing surgery/treatment.

Staff reported serious incidents clearly and in line with trust policy. The trust took prompt action to manage the incident and ensure patient safety. Immediately after the trust reported the incident, the chief medical officer set up and led meetings to establish the extent of the incident. The referral cards were validated and found to date back to June 2019. The trust carried out a clinical review of the 34 patients. Patients were then seen in clinic to discuss the results and further treatment.

The process for reviewing referral cards was changed by the speciality and a one stop process was introduced to prevent the risk of reoccurrence. This meant the patient was given their next appointment before they left.

Staff met to discuss the feedback and look at improvements to patient care. The deteriorating patient’s incident had also been reviewed by the team and learning implemented. We saw that staff had completed additional training in National Early Warning Scores and completed reflective accounts.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff we asked were familiar with the duty of candour and gave us examples of when it was appropriate to apologise and contact patients. For example, we were given an example where a patient had a post-operative allergic reaction to latex. The consultant met with the patient and family and gave them a full explanation and apology.

We saw comprehensive and proactive wider shared learning from ward incidents. The divisional matron was well aware of past SIs and their subsequent detailed actions such as robust staff refresher training and improved governance safety measures. Divisional lessons learned from incidents were disseminated through their forums. These included safety huddles, newsletters, quarterly learning events, cross divisional attendance at clinical governance meetings and the meetings themselves, quality summits, bespoke and ad-hoc training on wards and quality and safety group (QSG). However, we saw that not all staff were aware of serious incidents and there learning. For example, staff on Cleves ward were not aware of an SI relating to delayed treatment or any changes to practice made in response to findings. Staff were however, able to describe how they had changed practice in response to a local incident.

Staff received a copy of the trust’s quality governance department newsletter which featured a section on learning from incidents and serious incidents (SIs) using the situation, background, assessment and recommendations (SBAR) framework. The newsletter was distributed to all staff by email and hard copies were delivered to clinical and non-clinical areas.
Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The safety thermometer was 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 took place one day each month – a suggested date for data collection was given but wards could change this. Data was submitted within ten days of the suggested data collection date. Patient harm was measured for pressure ulcer prevalence, urinary tract infections and patient falls.

Data from the Patient Safety Thermometer showed the trust reported eight new pressure ulcers, four falls with harm and two new catheter urinary tract infections from November 2018 to November 2019 for surgery.

### Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at West Hertfordshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>Number of Patients per 100 Surveyed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total pressure ulcers (8)</td>
<td></td>
</tr>
<tr>
<td>2. Total falls (4)</td>
<td></td>
</tr>
<tr>
<td>3. Total CUTIs (2)</td>
<td></td>
</tr>
</tbody>
</table>

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)

Safety thermometer data was displayed on wards for staff and patients to see. We saw governance whiteboards with safety thermometer data which was updated monthly. For example, on Cleves ward we saw data from January 2020. This included trends from the
previous month, such as pressure ulcers and patient falls with any lessons learnt. Examples of lessons learnt were staff ensuring patients had pressure relieving mattresses, best shot and wound care plans all in place and shared with the team for continuous monitoring.

Information boards also included the number of safety incidents reported and the degree of harm; moderate, low or no harm. The number of safety incidents investigated and closed with any trends and lessons learnt, and the number currently in progress were also displayed.

Ward staff we spoke to were proud of their previous pressure ulcer (PU) prevention rates. For example, Flaunden B ward staff had gone 600 days without a hospital acquired pressure ulcer.

Staff used the safety thermometer data to further improve services. For example, on Cleves ward we saw January 2020 data which showed trends from the previous month. Lessons learnt from patient falls were to ensure staff reoriented patients to their environment and encouraged them to use call bells if they needed help.

Is the service effective?

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.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and procedures were based on national guidance such as the National Institute for Health and Care Excellence (NICE). Policies were easily located on the trust wide intranet and staff knew how to access them. Polices we reviewed were in date and reviewed regularly.

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.

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 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.

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 handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. At their pre-operative assessment, patients saw all members of the multidisciplinary team including nurse, anaesthetist, and pharmacist.

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 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.

The service participated in local audit reporting. For example, 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 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 surgery service contributed to most 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), the National Vascular Registry 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.

**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 needs.**

**Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.**

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff used a nationally recognised malnutrition universal screening tool (MUST) to monitor patients at risk of malnutrition on admission and at intervals throughout their admission. Staff fully and accurately completed patient’s fluid and nutrition charts where needed. We reviewed eight MUST scores which had mostly been fully completed, signed and updated by...
staff. However, we saw one record where an assessment had been missed.

Patients who were identified as being at risk of malnutrition could be referred to the dietitian. For example, we saw surgical patients on Letchmore ward could be seen by a dietitian daily between 9.00 and 11.00am. Underweight patients or those with a low body mass index (BMI) score were given a supplementary diet. Patients were weighed twice weekly.

Patients who needed specialist diets at their initial screening were tracked using an electronic system. Staff updated patient’s dietary care plans and risk assessments every Saturday and Wednesday or as clinically indicated.

Wards we visited had protected mealtimes in place for an hour and they encouraged families to only visit during meal times if they were helping the patient to feed. Protected mealtimes is an intervention developed to address the problem of malnutrition, particularly for hospital patients. The intervention aims to provide interruption-free time to eat during a hospital admission, thus supporting increased nutritional intake.

Oral diets were managed according to the patient’s condition, for example, we were told that some patients were unable to eat for prolonged periods of time and therefore alternative nutrition was provided, wither via a feeding tube or through artificial feeding into a vein. These patients were monitored closely to ensure that they did not become malnourished and oral diets were started as soon as possible.

Patients at risk of choking, were assessed by speech and language therapists to determine what food type they could eat. Those patients with soft or liquid diets only were clearly identified to prevent them being given the wrong food type.

Staff carried out and documented 24 hours rounding at least every two to four hours. A housekeeper on the Letchmore ward told us they did a ward round to help with patient’s dietary needs.

Patients waiting to have surgery were not left nil by mouth for long periods. We reviewed the trust policy for nil by mouth patients. Patients were allowed food six hours before and clear fluids up to 4 hours before their surgery. For morning list patients, this would take effect from midnight on the day of their pre-operative assessment. For afternoon patients this would be from 6am. Staff told us doctors on ward rounds gave instructions for sips of water if there were delays to surgery. Patients were encouraged to eat as soon as possible after surgery.

**Pain relief**

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

Staff prescribed, administered and recorded pain relief accurately. Staff assessed patient’s pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain management was clearly recorded on the national early warning score (NEWS) charts in patient notes we checked. For example, we saw three pain management care plans completed and updated daily. Staff recorded in patient's notes whenever they had given medicines to control their pain. The service could assess and manage pain for people with communication difficulties. Staff said they would observe patients’ facial expressions, body language, and a change in behaviour if they were unable to communicate with them.

Patients received pain relief soon after requesting it. A patient we asked reported their pain control was adequate as they were not in any discomfort. Another patient told us the timing of their drugs administration was changed at their request.
Pain control was prescribed as regular or ad hoc medicines. We saw that the service used nurse prescribers within the emergency surgical assessment unit (ESAU). Where advanced nurse practitioners (ANPs) could prescribe pain control when they triaged patients attending the unit for assessment.

The service’s emergency surgical assessment unit (ESAU) could fast track early blood observations to be sent asap for accident and emergency (A&E) or acute assessment unit (AAU) patients with complex regional pain syndrome (CRPS). CRPS is a condition where a person experiences persistent severe and debilitating pain.

At the time of our inspection, the theatre improvement group (TIG) had actioned the information analyst to send pain utilisation data to the assistant divisional manager of the point of access (POA), admissions and pain to review this against their bookings data. The January 2020 TIG minutes also reported a meeting took place which identified the division’s need to ensure staff were recording pain data appropriately.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers and staff used audit results to improve patient outcomes.

The service encouraged health professionals, patients and the public to get involved in health and social care research. This was based on the outcome of a national institute for health research (NIHR) survey called ‘I am research’ which gave ten compelling reasons.

We reviewed divisional audit improvements. These included changes in the reporting of national audits and more focus on the benchmarking data published by the hospital quality improvement plan (HQIP). The division had improved compliance with NICE guidelines. At the time of our inspection only 3% of NICE baselines required a review compared to 10% in March 2018. Divisional resources were reallocated to improve note pulling to support audits after clinical engagement. The division had also raised awareness and communication through roadshows, newsletters, ‘audit hero’ nominations and an audit intranet page updated with learning outcomes.

We saw a general surgery audit from April 2019 which assessed the insertion and removal of drains to improve compliance with drain management. Results successfully showed the introduction of drain charts and fluid balance chart changes improved the service. Key concerns were that documentation was difficult to interpret whether readings were of output since the previous reading or cumulative. After the audit the service took action to start the drain chart in recovery and modify the fluid balance chart.

We saw an audit to evaluate the quality and completion of operation sheet as per the royal college of surgeons (RCS) England guideline in May 2019. Results showed according to the RCS guideline, every operative sheet should include 18 different criteria (fewer categories if applicable). The trust achieved above 90% in eight categories. Key concerns were there still prevailed five categories with a relatively poor score of less than 15%. There were few handwritten operative notes which was difficult to understand. The audit highlighted the service’s need to improve surgical note taking, the possible use of electronic templates, decrease confusion in understanding operative documentations, make the audit better and easier and reduce the risk of medicolegal dispute.
We saw an audit of patient satisfaction on the optimal analgesia for all types of shoulder surgery following a single shot of interscalene brachial plexus block (SSIB). The audit aimed to show if SSIB was superior analgesia to either single shot intra-articular local anaesthetic or supra-scapular nerve block. This was in response to a significant growth in the amount of shoulder surgery performed in the last decade, and a greater number of frail patient operations in a day case setting.

The SSIB were performed by the same consultant anaesthetist experience in performing the blocks. Patient were given a questionnaire at discharge to complete and return by post. The patient’s experience in the anaesthetic room, staff friendliness and pain during SSIB were rated with post-operative questions. The audit showed the use of an enhanced educational care bundle for shoulder surgery patients resulted in high patient satisfaction and experience. This high level of satisfaction was across all surgeries, from the least invasive arthroscopies to the often complex redo total shoulder replacements. Excellent pain relief was achieved throughout the patient care pathway, with average shoulder block duration of 20.1 hours. Only one block of the 125 was repeated in recovery. Results also showed low recovery pain scores, short times to discharge averaging 2.06 hours for outpatients and a minimal post-operative nausea and vomiting (PONV). However, the area of low patient satisfaction scores were for pain whilst performing the SSIB. The audit considered the liberal use of pre-operative sedation and extra use of local anaesthetic in future. Overall, they felt the analgesic benefits outweighed this concern.

The service carried out an audit to streamline the pathway process for neck of femur (NoF) cancellations. Systematic reviews of NoF surgery showed operative delays over 48 hours resulted in increased morbidity and mortality. Delays in the operative management of a NoF fracture increased mortality significantly. Many NoFs were cancelled from the trust’s trauma list weekly. The audit aimed to identify the reasons behind cancellation and ultimately reduce the incidence of avoidable or unnecessary cancellations as per the NICE guidelines.

We heard about examples of improved patient outcomes in colorectal surgery. This specialty cancer service was well above the national average for outcomes, as reflected in the national bowel cancer audit published (NBOCAP) data. The service carried out more than 90% of cancer resections laparoscopically in the trust. The national average was 66%. At the time of our inspection they were also achieving complete clearance of rectal cancer with surgery in 88% of cases when the national average was 77%. This was despite their lower use of pre-operative radiotherapy; 10% compared to 36% nationally. The service hoped this reduced the proportion of patients who got recurrent disease, and significantly improved their long-term quality of life by reducing symptoms after treatment.

The service conducted several educational sessions to improve management of urinary tract infections (UTIs) in elderly patients. The team successfully reduced the number of UTIs in older people as well as increased compliance to antibiotic prophylaxis.

Relative risk of readmission

Trust level

From August 2018 to July 2019, all patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
- General surgery and trauma and orthopaedics patients at the trust had higher than expected risks of readmission for elective admissions when compared to the England average.

The service had a lower than expected risk of readmission for elective care than the England
Elective Admissions – Trust Level

![Graph](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 represents the opposite. Top three specialties for specific trust based on count of activity.*

All patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery and urology patients at the trust had lower than expected risks of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

The service had a lower than expected risk of readmission for non-elective care than the England average.

Non-Elective Admissions – Trust Level

![Graph](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 represents the opposite. Top three specialties for specific trust based on count of activity.*

From August 2018 to July 2019, all patients at Watford General Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

- General surgery and urology patients at Watford General Hospital had higher than expected risks of readmission for elective admissions when compared to the England average.
- Oral surgery patients at Watford General Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

The service did not have a lower than expected risk of readmission for elective care than the England average.
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 represents the opposite. Top three specialties for specific site based on count of activity.

From August 2018 to July 2019, all patients at Watford General Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery and urology patients at Watford General Hospital had lower than expected risks of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at Watford General Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

The service had a lower than expected risk of readmission for non-elective care than the England average.

**Non-Elective Admissions - Watford General Hospital**

The table below summarises Watford General Hospital’s performance in the 2018 National Hip Fracture Database. For five measures, the audit reports performance in quartiles. In this context, ‘similar’ means that the trust’s performance fell within the middle 50% of results nationally.

<table>
<thead>
<tr>
<th>Metrics (Audit indicators)</th>
<th>Hospital performance</th>
<th>Comparison to other trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment</td>
<td>101.1%</td>
<td>Similar</td>
<td>Met</td>
</tr>
<tr>
<td>(Proportion of eligible cases included in the audit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metrics (Audit measures)</td>
<td>Trust performance</td>
<td>Comparison to other trusts</td>
<td>Met national standard?</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>----------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Crude proportion of patients having surgery on the day or day after admission</strong></td>
<td>80.8%</td>
<td>Better</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crude peri-operative medical assessment rate</strong></td>
<td>99.3%</td>
<td>Better</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(NICE guidance specifically recommends the involvement and assessment by a Care of the Elderly doctor around the time of the operation to ensure the best outcome)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crude proportion of patients documented as not developing a pressure ulcer</strong></td>
<td>97.4%</td>
<td>Similar</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(Careful assessment, documentation and preventative measures should be taken to reduce the risk of hospital-acquired pressure damage (grade 2 or above) during a patient’s admission); this measures an organisation’s ability to report ‘documented as no pressure ulcer’ for a patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crude overall hospital length of stay</strong></td>
<td>21.0 days</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>(A longer overall length of stay may indicate that patients are not discharged or transferred sufficiently quickly; a too short length of stay may be indicative of a premature discharge and a risk of readmission)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk-adjusted 30-day mortality rate</strong></td>
<td>7.0%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Hip Fracture Database)

Managers shared and made sure staff understood information from the audits. For example, we heard about recovery hip fracture improvements on the Ridge ward with an improved mortality rate of 5.4% (national 10%).

**Bowel Cancer Audit**

The table below summarises West Hertfordshire Hospitals NHS Trust’s performance in the 2018 National Bowel Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case ascertainment</strong> (Proportion of eligible cases included in the audit)</td>
<td>113.3%</td>
<td>Good</td>
<td>Good is over 80%</td>
</tr>
<tr>
<td><strong>Risk-adjusted post-operative length of stay &gt;5 days after major resection</strong></td>
<td>57.4%</td>
<td>Better than national aggregate</td>
<td>No current standard</td>
</tr>
<tr>
<td>(A prolonged length of stay can pose risks to patients)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Risk-adjusted 90-day post-operative mortality rate
*(Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure)*

<table>
<thead>
<tr>
<th>Category</th>
<th>Performance</th>
<th>Comparison</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk-adjusted 90-day post-operative mortality rate</td>
<td>4.5%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

### Risk-adjusted 2-year post-operative mortality rate
*(Variation in two-year mortality may reflect, at least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy)*

<table>
<thead>
<tr>
<th>Category</th>
<th>Performance</th>
<th>Comparison</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk-adjusted 2-year post-operative mortality rate</td>
<td>18.6%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

### Risk-adjusted 30-day unplanned readmission rate
*(A potential risk for early/inappropriate discharge is the need for unplanned readmission)*

<table>
<thead>
<tr>
<th>Category</th>
<th>Performance</th>
<th>Comparison</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk-adjusted 30-day unplanned readmission rate</td>
<td>9.3%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

### Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection
*(After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases, it will not, and a temporary stoma would be created. For some procedures this can be reversed at a later date)*

<table>
<thead>
<tr>
<th>Category</th>
<th>Performance</th>
<th>Comparison</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection</td>
<td>42.0%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Bowel Cancer Audit)

### National Vascular Registry

The table below summarises West Hertfordshire Hospitals NHS Trust’s performance in the 2018 National Vascular Registry.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Aortic Aneurysm Surgery <em>(Surgical procedure performed on an enlarged major blood vessel in the abdomen)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment <em>(Proportion of eligible cases included in the audit)</em></td>
<td>118.0%</td>
<td>Not applicable</td>
<td>Met</td>
</tr>
<tr>
<td>Risk-adjusted post-operative in-hospital mortality rate <em>(Proportion of patients who die in hospital after having had an operation)</em></td>
<td>1.7%</td>
<td>Within the expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Carotid endarterectomy <em>(Surgical procedure performed to reduce the risk of stroke; by correcting a narrowing in the main artery in the neck that supplies blood to the brain)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment <em>(Proportion of eligible cases included in the audit)</em></td>
<td>85.0%</td>
<td>Not applicable</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Metrics (Audit measures)</td>
<td>Trust performance</td>
<td>Comparison to other Trusts</td>
<td>Met national standard?</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>-----------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Trust-level metrics</strong> (Measures of hospital performance in the treatment of oesophago-gastric (food pipe and stomach) cancer)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Case ascertainment</strong> (Proportion of eligible cases included in the audit)</td>
<td>71% to 80%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td><strong>Age and sex adjusted proportion of patients diagnosed after an emergency admission</strong></td>
<td>2.3%</td>
<td>Better</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends that overall rates over 15% could warrant investigation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk adjusted 90-day post-operative mortality rate</strong> (Proportion of patients who die within 90 days of their operation)</td>
<td>5.9%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td><strong>Cancer Alliance level metrics</strong> (Measures of performance of the wider group of organisations involved in the delivery of care for patients with oesophago-gastric (food pipe and stomach) cancer; can be a marker of the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results. Contextual measure only.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crude proportion of patients treated with curative intent in the Cancer Alliance</strong> (Proportion of patients receiving treatment intended to cure their cancer)</td>
<td>37.7%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Oesophago-Gastric Cancer Audit)

**National Oesophago-gastric Cancer Audit**

(Audit of the overall quality of care provided for patients with cancer of the oesophagus [the food pipe] and stomach)


**Crude median time from symptom to surgery**
(Average amount of time patients wait to have surgery after the onset of their symptoms)

- **10 days**
- **Not applicable**
- **Met**

**Risk adjusted 30-day mortality and stroke rate**
(Proportion of patients who die or have a stroke within 30 days of their operation)

- **2.7%**
- **Within the expected range**
- **No current standard**

(Source: National Vascular Registry)
Watford General Hospital

The table below summarises Watford General Hospital’s performance in the 2018 National Emergency Laparotomy Audit. The audit reports on the extent to which key performance measures were met and grades performance as red (less than 50% of patients achieving the standard), amber (between 50% and 80% of patients achieving the standard) and green (more than 80% of patients achieved the standard).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>100%</td>
<td>Green</td>
<td>Met</td>
</tr>
<tr>
<td>Crude proportion of cases with pre-operative documentation of risk of death</td>
<td>71%</td>
<td>Amber</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(Proportion of patients having their risk of death assessed and recorded in their notes before undergoing an operation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of cases with access to theatres within clinically appropriate time frames (Proportion of patients who were operated on within recommended times)</td>
<td>74%</td>
<td>Amber</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre (Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation)</td>
<td>89%</td>
<td>Green</td>
<td>Met</td>
</tr>
<tr>
<td>Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to surgery post-operatively (Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation)</td>
<td>79%</td>
<td>Amber</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Risk-adjusted 30-day mortality rate (Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider)</td>
<td>15%</td>
<td>Worse than expected</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Emergency Laparotomy Audit)

We saw an audit on the rate and causes of mortality amongst patients undergoing emergency laparotomy. The audit’s success was the development of laparotomy guidance/pathway. However, the trust needed to improve its contribution to the dataset as there was a high degree of inaccuracy. Data gaps were giving the impression of a high mortality rate that was three standard deviations away from the national average.

National Ophthalmology Database Audit

(Audit of patients undergoing cataract surgery)

West Hertfordshire Hospitals NHS Trust did not participate in the 2018 National Ophthalmology Database Audit.

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National Joint Registry

(Audit of hip, knee, ankle, elbow and shoulder joint replacements)

Watford General Hospital

The table below summarises Watford General Hospital’s performance in the 2018 National Joint Registry.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment (hips, knees, ankles and elbows) (Proportion of eligible cases within the trust that were submitted to the audit)</td>
<td>90.3%</td>
<td>Similar</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Proportion of patients consented to have personal details included (hips, knees, ankles and elbows) (Patient details help ‘track and trace’ prosthetics that are implanted. It is regarded as best practice to gain consent from a patient to facilitate entering their patient details on to the register)</td>
<td>71.1%</td>
<td>Worse</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Risk-adjusted 5 year revision ratio (for hips excluding tumours and neck of femur fracture) (Proportion of patients who need their hip replacement ‘re-doing’)</td>
<td>2.2</td>
<td>Worse than expected</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Risk adjusted 90-day post-operative mortality ratio (for hips excluding tumours and neck of femur fracture) (Proportion of patients who die within 90 days of their operation)</td>
<td>1.5</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Risk-adjusted 5 year revision ratio (for knees excluding tumours) (Proportion of patients who need their knee replacement ‘re-doing’)</td>
<td>1.0</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
<tr>
<td>Risk adjusted 90-day post-operative mortality ratio (for knees excluding tumours) (Proportion of patients who die within 90 days of their operation)</td>
<td>1.0</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
</tbody>
</table>

National Prostate Cancer Audit

We saw a recent action from January 2020 on the divisional theatre activity group (TAG) action log. This involved the review of session times for joint cases across all specialties.
National Prostate Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men with complete information to determine disease status</td>
<td>94.9%</td>
<td>n/a</td>
<td>Did not meet</td>
</tr>
<tr>
<td><em>(This is a classification that describes how advanced the cancer is and includes the size of the tumour, the involvement of lymph nodes and whether the cancer has spread to different part of the body)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy</td>
<td>No data available</td>
<td>n/a</td>
<td>No current standard</td>
</tr>
<tr>
<td><em>(A radical prostatectomy involves the surgical removal of the whole prostate and the cancer cells within it; emergency readmission may reflect that patients experienced a complication related to the surgery after discharge from hospital)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy</td>
<td>No data available</td>
<td>n/a</td>
<td>No current standard</td>
</tr>
<tr>
<td><em>(Complications following surgery may reflect the quality of surgical care)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy</td>
<td>No data available</td>
<td>n/a</td>
<td>No current standard</td>
</tr>
<tr>
<td><em>(External beam radiotherapy uses high-energy beams to destroy cancer cells)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Prostate Cancer Audit)

Adult cardiac surgery

The trust did not participate in the 2018 National Cardiac Audit.

(Source: National Cardiac Audit Programme)

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. These changes are measured in a number of different ways, descriptions of some of
the indicators presented are below.

Visual analogue scale (EQ VAS) asks patients to mark their health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to "the worst health you can imagine", and the highest rate (100) corresponds to "the best health you can imagine".

The EQ-5D-5L questionnaire has two parts. Five domain questions ask about specific issues, namely mobility, self-care, usual activities, pain or discomfort, anxiety, or depression. The EQ-5D-5L uses five levels of responsiveness to measure problems. The range is: no problem to disabling/extreme.

The Oxford Hip Score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living. A simple scoring and summing system provides an overall scale for assessing outcome of hip interventions.

In 2016/17 performance for groin hernias and hip replacements was about the same as the England averages.

Performance for knee replacements was better than the England average for EQ VAS and about the same for the EQ-5D index and the Oxford knee score.

For varicose veins, performance on the EQ VAS and EQ-5D index was worse than the England averages and about the same for the Aberdeen Varicose Vein Questionnaire.

(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 development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. For example, recovery staff we asked were trained in paediatric recovery skills. The trust had devised a quality checklist on the top ten things to check when preparing for a CQC inspection. The checklist was in the form of questions to prompt staff ahead of our visit.
We saw people on the margins of palliative care training arranged by the local hospice in March 2020. This promoted trust staff’s increased understanding of the needs of seldom heard communities within palliative care.

Managers gave all new staff a full induction tailored to their role before they started work. Staff had competencies for speciality skills used across the service. When commencing in post, staffs competence was assessed and ensured before staff were able to complete skills independently. For example, nurses in theatres had various skills as they had various backgrounds.

Junior doctors told us they had all received a full induction, including duty of candour training. Theatre staff told us they completed role specific training in unused bays when not operating on patients.

Staff felt supported in their roles and encouraged to develop. We spoke with two ward clerk receptionists who started working at the trust in January 2020. They told us they felt well supported by their line manager and all staff were helpful. A ward clerk with 18 years’ experience had helped train them and their induction would be refreshed in April 2020.

External organisations providing the service’s agency and bank staff followed strict pre-employment and identity checks as well as the right to work. The service needed disclosure barring service (DBS) for all staff, occupational health, employment history and relevant reference checks. Agencies had to send relevant checks and workers could not accept shifts until they confirmed the agency had approved all documents.

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work. The division’s latest appraisal rate for January 2020 was 90.8%.

Please note that the trust informed us that a small number of their surgery nursing staff at St Albans City Hospital have merged workloads with the gynaecology teams and a small number of medical staff in surgery at Watford General Hospital have merged workloads with critical care. Therefore, the analysis of appraisal data below includes some staff working across surgery and critical care or gynaecology.

**Trust level**

As of October 2019, 87.0% of staff within surgery (and critical care or gynaecology) at the trust received an appraisal compared to a trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>As of October, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>3</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>159</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>218</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>35</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>97</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>88</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>4</td>
</tr>
</tbody>
</table>
Medical and dental staff in surgery (and critical care or gynaecology) at trust level met the 90% target.

Please note that the trust did not provide any data for medical staff in surgery (and critical care) based at St Albans City Hospital. Therefore, the medical staff appraisal data in the table above relates to staff located at Watford General Hospital.

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

Watford General Hospital

As of October 2019, 87.4% of staff within surgery (and critical care) at Watford General Hospital received an appraisal compared to a trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>As of October, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>3</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>159</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>159</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>25</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>74</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>84</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>3</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>511</strong></td>
</tr>
</tbody>
</table>

Medical and dental staff in surgery (and critical care) at Watford General Hospital met the 90% target.

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

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The trust carried out ten deep dives getting it right first time (GIRFT) visits since November 2018. GIRFT is a national NHS improvement programme which helps improve care in the NHS by addressing variations in service. We heard visits were always well attended by the clinical team, with divisional and executive support. A new GIRFT steering group had been established to strengthen the governance process and oversee divisional and specialty accountability and compliance with GIRFT recommendations.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Appraisals were effective and encouraged staff to develop. Staff told us that career progression was well supported. One staff member told us that they started working the trust as a healthcare assistant and was supported to train as a nurse and develop into senior nursing roles.
Managers made sure staff received any specialist training for their role. Staff were supported with managers meetings and senior nurse training sessions. The clinical educators supported the learning and development needs of staff. Staff we spoke to were very ambitious and enthusiastic about their clinical training and learning and development (L&D), particularly in the emergency surgical assessment unit (ESAU).

Junior doctors could access a trust doctor’s toolbox which was a one stop website and smartphone app to help them orientate themselves to the trust. This toolbox was written by junior doctors and welcomed input from all staff grades and multidisciplinary teams (MDTs). The toolbox included information on how to complete day to day tasks such as requesting investigations, bleep numbers as well as “survival guides”.

Managers identified poor staff performance promptly and supported staff to improve. At the time of our inspection we reviewed divisional data which showed in the last 12 months two surgical staff were suspended and one was on supervised practice. One of these was for a lapsed registration. Hearings had been booked after investigation for the other two.

Managers recruited, trained and supported volunteers to support patients in the service. The trust had begun a new partnership with an external provider, which had resulted in a growth in volunteer numbers. The external provider worked in partnership with NHS trusts to develop innovative as well as safe, reliable and effective volunteer roles.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary (MDT) meetings to discuss patients and plan their care. We saw MDT input where relevant in patients notes, for example by physiotherapists where they had treated and advised patients. However, outcomes of meetings were not always clearly recorded in notes. We saw that one record showed that MDT discussion outcome was handwritten and hard to read. We saw the lack of standard practice for recording and validating data from MDT outcomes was a scored, targeted and reviewed risk on the divisional risk register from February 2016. This risk was as a result of variation in whom, where and when MDT outcomes were recorded. MDT outcomes were not always stored in patients notes, recorded by non-clinical staff or available in the trust’s cancer information system. Information was cut and pasted from other documents. This risk impacted upon patient safety and data quality. The service’s head of cancer and palliative care took action to present this risk at the cancer committee in October 2019. They highlighted the need to validate all patient outcomes discussed and requested assurance from each lead clinician about their process.

MDT meetings were inclusive of all professions. For example, the service’s Ridge hip fracture ward had an MDT meeting every Tuesday. This included an orthogeriatric consultant, a hip fracture nurse, an occupational therapist, a physiotherapist and a discharge coordinator.

The service used video conferencing for some MDT meetings, however, this was sometimes problematic. We saw the service had failed to have clinical information available at two MDTs due to problems with video conferencing (VC) equipment. This was highlighted on their risk register in September 2019. Service leads acted to decommission the VC equipment. The service was awaiting the IT team’s verdict on whether the replacements were on a procurement framework. They were required to purchase three sets of VC equipment and an interim solution was being trialled during this time.

Ward staff told us they worked very closely with allied health professionals (AHPs) such as physiotherapists, occupational therapists and dietitians. They knew how to easily and quickly
access these. Surgical physiotherapists based on the Letchmore ward would see post-operative patients as a priority twice daily. Ridge ward staff had seven-day access to AHPs for patients with prolonged rehabilitation.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service submitted and reported national cancer standards monthly. We asked divisional leads about diagnoses to multidisciplinary team (MDT) surgery cancer pathways. They told us the challenge in the past was finding suitably trained MDT coordinators which they now had. Any cancer diagnosis had an MDT review, so any specialist had timely access. They assured us the MDT report never delayed surgery or the surgeon making a decision. Cancer pathways were audited frequently by the trust’s cancer team.

We heard orthodontics and maxillofacial struggled to access highly specialised speech and language therapists (SALTs) for some patients. For example, post-operative patients with half a tongue. The orthodontic consultant saw this as a network issue.

Wards reported close working and communications with primary care. They could complete district nurse online referrals and book GP appointments. The discharge coordinators could arrange packages of care for patients with social services. They told us there were some delays, but these were not excessive or stretch into weeks.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Mental health assessors were co-located within the trust and saw patients in a timely manner.

Seven-day services

**Key services were available seven days a week to support timely patient care.**

The surgery directorate provided most services seven days a week. Ward rounds and emergency operating was available seven days per week. There was a registrar on duty 24 hours seven days a week. Consultants were available Monday to Friday from 8am until 6pm, with out of hours on call cover. At weekends, consultants shared an on-call rota with responsibility for admissions through the emergency department. Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway, at weekends the on-call consultant would review any new or deteriorating patients. Nursing staff told us the on-call consultant covered the rota well. The service was making changes from April 2020 to improve continuous monitoring.

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.
The service’s day surgery unit was open 9-5 weekdays and closed on weekends when the emergency surgical assessment unit (ESAU) worked with them to manage and cover patient flow. The service had two new hip fracture nurses who were split to cover all seven days.

Theatres were open 12 hours daily from 8:30 until 20:30. 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 pharmacy provided a seven-day service and had recently extended their opening hours. They were open Monday to Friday from 8.45 until 5.15 with a late team and on-call pharmacist available out of hours (OOH). They were open Saturday and Sunday from 10am to 3pm with an on-call pharmacist available before and after working hours. This enabled staff to access any newly prescribed medicines and tablets for patients to take home on discharge.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Staff could access a 24-hour specialist palliative care advice line in conjunction with two local hospices for patients with a life-limiting illness, registered with a GP in the county, their families and the health and care professionals supporting them. The advice line provided specialist support and advice quickly and efficiently with calls managed by an experienced nursing team who liaised with on-call doctors and consultants if needed.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the wards/units. Patients with life changing illnesses or long-term conditions received support from specialist nurses or clinicians. They were able to provide patients and their families with advice or information about the condition. Or signpost them to support organisations.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients were given advice on how to access support for weight management or smoking cessation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients’ liberty.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion

Nursing and clinical staff received and kept up to date with training in the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS). Staff we spoke to had completed their MCA and DoLS training. The trust set a target of 90% for the completion of MCA and DoLS training.

Please note that the trust informed us that a small number of their surgery nursing staff at St Albans City Hospital have merged workloads with the gynaecology teams and a small number of
medical staff in surgery at Watford General Hospital have merged workloads with critical care. Therefore, the analysis of MCA/DoLS data below includes some staff working across surgery and critical care or gynaecology.

**Trust level**

Compliance for MCA/DoLS (essential) training from April to October 2019 for qualified nursing and medical and dental staff in surgery (and critical care or gynaecology) at trust level is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>266</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>158</td>
</tr>
</tbody>
</table>

In surgery (and critical care or gynaecology), the target of 90% for MCA/DoLS (essential) training was met by qualified nursing staff while the completion rate for medical and dental staff did not meet the target.

Please note that the trust did not provide any data for medical staff in surgery (and critical care or gynaecology) based at St Albans City Hospital. Therefore, the medical staff training data in the table above relates to staff located at Watford General Hospital.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

**Watford General Hospital**

Compliance for MCA/DoLS (essential) training from April to October 2019 for qualified nursing and medical and dental staff in surgery (and critical care) at Watford General Hospital is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>205</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>158</td>
</tr>
</tbody>
</table>

In surgery (and critical care) at Watford General Hospital, the target of 90% for MCA/DoLS (essential) training was met by qualified nursing staff, while the completion rate for medical and dental staff did not meet the target.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

Staff understood their roles and responsibilities for gaining consent. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients’ records. We saw comprehensive consent forms signed with patient copies in all medical records we checked. However, no copies were given to patients.

Staff made sure patients consented to treatment based on all the information available. Staff told us that when patients were planned to attend for procedures, time was taken to explain what was planned and the potential impact of the procedures. This enabled them to make an informed decision about their care.
Staff did not routinely care for patients under 18 years of age and therefore did not know about Gillick competency. However, they told us doctors assessed competency and would therefore assess all patients under 18 years.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff on Flaunden B ward understood the basics of mental capacity and how it may affect surgical patients and gave examples of when they escalated concerns.

Staff would escalate concerns regarding anyone’s ability to consent to doctors and staff could access specialists to support patients who required additional support, such as those with a learning disabilities (LD).

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. Staff demonstrated the ‘confused patient – behaviour observation and management care plan’ and ‘this is me’ leaflet. They completed a mental capacity assessment where the patient was found to lack capacity. The doctor and nurse in charge completed a deprivation of liberty safeguards (DoLS) authorisation and provided one to one nursing support to the patient.

Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005. However, they knew who to contact for advice. Mental capacity assessment forms we checked were incomplete for four patients that lacked capacity. The ‘best interests decision (BID) factors’ side of the form was only completed on one of four we checked. We raised this with the nurse in charge (NiC) who acknowledged the oversight and ensured us the doctors would fill this in.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act (MCA) and DoLS. The trust’s MCA and DoLS policies and information were accessible to staff on their intranet. A staff nurse told us they would contact the safeguarding team to assess patients if they were unsure.

Managers monitored how well the service followed the MCA and made changes to practice when necessary.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. A patient we asked said they were happy with the care provided by both nurses and medical staff. Staff we observed interacting with patients were friendly, approachable and talkative.

Patients said staff treated them well and with kindness. Patients we spoke to told us nursing staff went above and beyond to care and support them with an attentive bedside manner.

Staff followed policy to keep patient care and treatment confidential. Where possible private conversations were completed away from other patients, notes were not left in accessible areas and personal identifiable information was not displayed.
Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We spoke to a blind patient on the Flaunden B ward who took care to ensure that they were smart, clean and well groomed. They told us nursing staff laid out their food as a clock face, so they knew the order in which to eat. However, not all nurses knew how to treat registered blind patients. The patient also told us some staff were too passive in their care. For example, they just left his pills on the table without telling him they were there.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We saw staff using memory boards on wards to comfort patients with dementia.

**Emotional support**

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient’s personal, cultural and religious needs.**

Staff gave patients and those close to them help, emotional support and advice when they needed it. A patient on Flaunden A ward told us there was some noise at night but they expected this. Letchmore ward staff ensured all phones including their own, patient’s and visitors were turned down at night. They offered patients earplugs to aid sleeping.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Where possible offices or meeting rooms were used for personal discussions, or curtains were drawn. We saw staff managing a nervous patient on Flaunden B ward by reassuring them in a sensitive and calm manner.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. We witnessed an Elizabeth ward sister interacting with an anxious and cross patient in a reassuring, caring way. They were unhappy with the care given by a doctor as they felt it had made things worse. The patient was ready to be discharged so the sister calmed them down, apologised for their distress and made arrangements to discharge as soon as possible. For example, they scheduled a GP appointment and a sick note which asked the patient’s GP to call the ward if they had any problems.

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

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Explanations were given and patients were signposted to support staff/external providers where necessary. However, one patient we spoke with awaiting MRI scan results told us there was poor communication and a lack of daily updates from consultants. They felt consultants should give more realistic timescales for following up as they were never seen the next day.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff allowed up to two visitors per patient onto the wards during visiting hours.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and their relatives were encouraged to complete questionnaires about their care and were able to speak to staff if they had any concerns.
Patients could not always access medical staff for support making decisions. One Letchmore ward patient referred for an ankle infection three days before was yet to meet their assigned trauma consultant. They felt communication was poor as they were also awaiting advice about their heart murmur. We followed this up with the nurse in charge who we saw update the patient and apologise for the delays.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test (FFT) survey. The service had FFT surveys available in most clinical areas. They collected and collated patient feedback on a weekly basis and survey information was anonymised so patients could not be identified. The service also had a patient experience group who underwent a bi-monthly audit on care aspects with patient feedback elements of the audit. Audit results were shared at the group with escalation to the executive group where required.

Patients gave positive feedback about the service. Staff could give examples of how they used patient feedback to improve the quality of care they provided. We heard examples of an onsite signage review after poor patient feedback. This resulted in a commitment to make improvements that would benefit patient orientation.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The service provided emergency surgery in line with national best practice standards. To improve flow and performance the emergency surgical assessment unit (ESAU) had been expanded and the assessment process had reviewed. The team had introduced an enhanced recovery model ensuring patients were optimised for their procedures. Service leads had also continually expanded their endoscopy and bowel cancer screening services to meet demands.

Facilities and premises were not always appropriate for the services being delivered. However, divisional leads had a well-established project to mitigate and deal with theatre issues. The trust’s chief executive officer (CEO) had asked the divisional leads to re-evaluate their program which caused delays. However, all funding was now approved which meant they were tendering enabling work. The cytology department was outsourced so their building was being left for development in March 2020. The main buildings level 5 administrative and clerical staff could then move into cytology allowing level 6 theatre refurbishment project to make use of this space. Theatre sections would be shut down. One new theatre will be in the old decontamination space and recovery. The hospital’s theatre manager shared updates with staff and discussed the divisional strategy at meetings. The clinical director told us a separate group were looking at the long-term rebuilding of theatres program.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Ward staff told us they would move patients to accommodate their needs in the event of a breach of mixed sex bays.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Mental health support was provided by the local mental health trust.
Since our last inspection of the service, therapies team had started leading 'get up, get dressed, get moving' with the wider multi-disciplinary team. This involved staff training and engagement to understand the challenges day-to-day, action planning with matrons and educating patients using discussion, posters and leaflets.

Managers monitored and acted to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted. The theatre improvement group (TIG) reviewed the division’s number of on the day (OTD) or same day cancellations in December 2019. These were increasing due to a rise in patient self-cancellations, did not attends (DNAs) and patients being unwell.

We were told theatre lists regularly overrun. The main causes and reasons for theatre overruns were reported as equipment issues, the anaesthetic consultant being unavailable, morning list overrun and previous complex cases. We saw delayed theatre start times due to switching patients between theatres. Theatre start times were also occasionally delayed. We observed theatre two during inspection where the first patients were not brought into theatres until 10:30. Theatres should start at 9:00.

The service endeavoured to reduce pressure on inpatient areas and planned day cases where possible.

Divisional leads were working collaboratively with other providers to develop an integrated care system (ICS). They had made a successful decision to merge clinical service provision for new upper gastrointestinal (GI) and GI cancer specific pathways with another provider. They were also looking at other specialities where partnership working would improve patient’s pathway and experience.

**Meeting people’s individual needs**

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Patients accessed the service in several formats, for example, as an emergency case through the emergency department, through the emergency surgical assessment unit (as a GP referral) or as a planned admission following a consultation as an outpatient. The service arranged multidisciplinary teams (MDTs) if the team became aware of a patient that may need to have an elective procedure undertaken to establish the patient’s needs and devise a plan to ensure their visit was uneventful and any distress could be avoided.

If a patient was admitted for a procedure, the booking team would identify the most convenient date for surgery and the patients was able to change this if it was inconvenient. Prior to admission, patients attended the hospital for a pre-operative assessment. Patients individual need would be assessed at this appointment along with a review of their clinical condition and review of risks with any underlying conditions.

Service staff were expected to make reasonable adjustments for patients with additional needs. For example, staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. This may include ensuring patients were first on a theatre list, visits to clinical areas to de-sensitise, moved to a quiet area / environment, arranging for sedation to ensure a variety of investigations are able to be undertaken.

Wards were designed to meet the needs of patients living with dementia. Staff we spoke to showed good awareness of the needs of patients living with dementia or delirium. They gave us
examples of reasonable adjustments they would make and environmental considerations for these patients. Staff supported patients living with dementia and learning disabilities by using ‘this is me’ documents and patient passports. The service assessed any dementia patients on the medical proforma. If a cognitive impairment was noted, then an abbreviated mental test (AMTS) was carried out. The service took other measures to improve the experience of patients with cognitive impairment. For example, a report on standardising all bathroom and toilet door colours had been submitted for funding approval.

The admission and assessment process was supported by the "this is me" document. Staff we asked demonstrated their knowledge and use of the leaflet for people who had delirium or communication difficulties. This was completed by nursing staff and passed on to the relevant department. Although this is me was not a medical document it was included in the patient’s notes.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to communication aids to help patients become partners in their care and treatment. The service had access to an interpreter service, and we saw phone numbers on display boards. One matron told us these could be booked through PALS. They gave the example of a time-critical Eritrean patient admitted at 4am for whom PALS helped access an interpreter by 9am.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Patients were assessed on admission. The trust adopted the hospital communication book which provided specific questions to assess individual care. All adjustments were managed on an individual basis within the ward settings. At the time of our inspection the service carried out trials of hearing loops using a co-production approach in day surgery and on one of the surgical wards. However not all staff were aware of the hearing loop on Cleves ward when we asked her about this.

The service could acquire equipment to meet individual patient needs. For example, Ridge hip fracture ward’s nursing staff could prepare equipment in advance if patients were identified as being at high risk of tissue damage.

The service’s day surgery unit (DSU) waiting area did not have enough space for wheelchair patients. However, they could still access the service. Patients waited in the reception room until being seen when staff escorted them onto the main corridor.

When the service identified a patient as requiring a British sign language (BSL) interpreter, following assessment on admission, a booking could be made at any time. During office hours the booking was made via the patient advice and liaison service (PALS) and out of hours (OOH) using a standard telephone number.

The trust had established a ‘let me hear you, see you’ working party led by an occupational therapist (OT). This had representation from patients, volunteers and staff to promote the needs of people with a hearing/visual loss and improve their experience. The group had successfully implemented hearing devices on the trauma and orthopaedic (T&O) ward for patients with hearing loss. They worked in collaboration with the consultant lead and trauma nurse. They also contributed to the operational audit on signage completed as part of the patient experience group.

The service had information leaflets available in languages spoken by the patients and local community. We saw information and advice for patients, friends and relatives. For example, guides with pictures on falls prevention and discharge.

The service planned and supported patient discharges. We reviewed the integrated discharge team’s (IDT) examples of advanced care and discharge planning. The service could offer patients
community-based multi systemic therapy (MST). MST teams worked with patients at risk of admission to look at opportunities to prevent admission and identify plans should patients be discharged. IDT staff worked in assessment areas trust wide. These staff included clinical navigators, discharge coordinators, social workers and community care officers. They all worked to prevent admission and discharge quickly with support from admission areas. The IDT had trusted and impartial assessment activity in place. Trust wide therapy teams could access social care or community health rehabilitation and enablement care pathways. The IDT hosted an acute facilitator who could assess on behalf of social care to access enablement care pathway where needs were simple and low level.

At the time of our inspection the IDT had deployed two staff in assessment areas to collate referral information at the point of admission. This improved their opportunities in identifying patient complexity to support their early discharge and reduce length of stay. This project was in its infancy, but service leads felt it had the potential to reduce the length of time for assessment notifications issued by the ward.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

**Access and flow**

**People could not always access the service when they needed it. Some surgical specialties had long waits for treatment. We saw delayed theatre start times due to last minute theatre changes for an emergency case and a patient with multiple cancellations. Theatre utilisation measures for touch time missed trust targets by at least 10%. All theatre utilisation targets were missed in December 2019.**

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service was working to improve performance and reduce long waits for elective procedures. This included workstreams looking at theatre efficiency, scheduling, point of access (POA) pathways and processes to reduce cancellations and outsourcing. The division had oversight of progress with workstreams and reported progress weekly to the director of performance.

Service leads were aware of capacity issues in theatres to treat colorectal patients which impacted upon their performance. They acted in response. Additional capacity had been agreed as part of the refurbishment of the theatres. We reviewed the trust’s theatre utilisation rates across all specialties and sites for elective surgery sessions only from November 2019 to January 2020 (the last three months). The trust’s touch time target was 85% for both overall utilisation which was the touch time minutes for on the day planned sessions and utilisation of on the day hours planned, including early starts and overruns. Both these measures of utilisation improved slightly during this period, but still missed trust target by at least 10%.

The division’s theatre improvement group (TIG) reviewed theatre utilisation data in December 2019 and identified many areas were in a worse position than in December 2018. The group noted a few differences from last year. These included reviewed job plans and a higher number of anaesthetic vacancies.

Trust wide theatre utilisation rates were worst in December 2019 when all their targets were missed. For example, the trust target for the number of hours stood down as a percentage of original session hours was 4%. In December 2019 this was 22.9%. This meant nearly a quarter of the total theatre session hours were stood down for emergency cases. The percentage of planned session time lost due to early finishes in December 2019 was 17.5%. This was over three times higher than the trust target of 5%. The percentage of session time lost due to late starts in December 2019 was 11.2%. This was more than double the trust’s target of 5%. The percentage
of overrun time per session in December 2019 was 3.7% when the trust target is 0%. However, all these percentages had improved in January 2020.

The divisional theatre activity group (TAG) action log reviewed underutilised theatre lists across all specialties. These were escalated to the relevant consultant for timely feedback within two weeks to investigate underlying causes. At the time of our inspection the specialties with the most underutilised theatre times were general surgery and urology. In February 2020 one general surgery theatre shift was underutilised by over three hours with only four joint case patients.

At the time of our inspection the division had actions in progress to improve theatre utilisation for each speciality. For example, task and finish groups had been arranged in ear, nose and throat (ENT) to identify how best to do this. The theatre improvement group (TIG) had also actioned improvement work around late starts in theatres.

The ESAU manager told us about several improvements they had made to policies and procedures around patient flow. For example, they created a triage bay alongside the doctor’s assessment space with swabs and microbiology forms. The ESAU manager was also attending the next monthly patient flow meeting.

### Average length of stay

#### Trust Level

From September 2018 to August 2019, the average length of stay for patients having elective surgery at the trust was 3.2 days. The average for England was 3.8 days.

- The average length of stay for patients having elective trauma and orthopaedics surgery at the trust was 3.5 days. The average for England was 3.7 days.
- The average length of stay for patients having elective general surgery at the trust was 3.6 days. The average for England was 3.9 days.
- The average length of stay for patients having elective urology surgery at the trust was 2.0 days. The average for England was 2.4 days.

#### Elective Average Length of Stay – Trust Level

![Average length of stay chart](chart.png)

*Note: Top three specialties for specific trust based on count of activity.*

From September 2018 to August 2019, the average length of stay for patients having non-elective surgery at the trust was 4.4 days. The average for England was 4.6 days.

- The average length of stay for patients having non-elective general surgery at the trust was 2.9 days. The average for England was 3.5 days.
- The average length of stay for patients having non-elective trauma and orthopaedics surgery at the trust was 8.0 days. The average for England was 8.4 days.
- The average length of stay for patients having non-elective urology surgery at the trust was 2.3 days. The average for England was 2.6 days.
Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics)

Watford General Hospital

Managers and staff worked to make sure patients did not stay longer than they needed to. Ward estimated and updated patient’s discharge dates on their board and relayed this to them and their families at least daily. The service had a patient call back service in place where calls were made to patients discharged within 24 hours to ensure they were safe and had the correct care package.

From September 2018 to August 2019, the average length of stay for patients having elective surgery at Watford General Hospital was 3.8 days. The average for England was also 3.8 days.

- The average length of stay for patients having elective general surgery at Watford General Hospital was 4.4 days. The average for England was 3.9 days.
- The average length of stay for patients having elective urology surgery at Watford General Hospital was 2.1 days. The average for England was 2.4 days.
- The average length of stay for patients having elective trauma and orthopaedics surgery at Watford General Hospital was 4.5 days. The average for England was 3.7 days.

Elective Average Length of Stay - Watford General Hospital

Note: Top three specialties for specific site based on count of activity.

From September 2018 to August 2019, the average length of stay for patients having non-elective surgery at Watford General Hospital was 4.4 days. The average for England was 4.6 days.

- The average length of stay for patients having non-elective general surgery at Watford General Hospital was 2.9 days. The average for England was 3.5 days.
- The average length of stay for patients having non-elective trauma and orthopaedics surgery at Watford General Hospital was 8.0 days. The average for England was 8.4 days.
- The average length of stay for patients having non-elective urology surgery at Watford General Hospital was 2.3 days. The average for England was 2.6 days.

Non-Elective Average Length of Stay - Watford General Hospital
Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. Staff told us bed managers and matrons would move non-surgical patients accordingly. The emergency surgical assessment unit (ESAU) manager would attend bed management meetings when required to help patient flow.

Managers worked to minimise the number of surgical patients on non-surgical wards.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From November 2018 to October 2019 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was consistently lower than the England average.

In the most recent month, October 2019, 57.8% of this group of patients at the trust were seen within 18 weeks, compared to the England average of 62.5%.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

From November 2018 to October 2019, 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>74.2%</td>
<td>53.5%</td>
</tr>
</tbody>
</table>

Five specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.
<table>
<thead>
<tr>
<th>Speciality</th>
<th>% Waiting &gt; 52 weeks in Oct 2018</th>
<th>% Waiting &gt; 52 weeks in Sept 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>60.4%</td>
<td>74.0%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>56.8%</td>
<td>57.7%</td>
</tr>
<tr>
<td>General surgery</td>
<td>54.5%</td>
<td>71.8%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>40.6%</td>
<td>59.6%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>23.1%</td>
<td>60.6%</td>
</tr>
</tbody>
</table>

The number of patients waiting over 52 weeks for surgery had improved from 87 patients in October 2018 to 3 patients in September 2019. Unpublished data for October 2019 demonstrated further improvement with no patients reported as waiting over 52 weeks at the time of writing.

In October 2018 performance against the 62-day cancer waiting times standard was 79%. Since July, this had improved incrementally and compliance with the standard was achieved in September 2019 at 85.7%. Since our last inspection the service had reviewed and strengthened their harm review processes for patients waiting longer than 48 weeks for surgery and breaches of the 62-day cancer standard. Regular updates were provided to committee to provide assurance of the process and on actions taken to address any harms identified.

**Cancelled operations**

Managers worked to keep the number of cancelled appointments to a minimum. The trust struggled to meet their targets for the number of cancelled appointments. We reviewed the trust’s total number of cancellations across all specialties and sites for elective surgery sessions from November 2019 to January 2020. Their total same day number of cancellations was worst in December 2019 with 110 cancellations. Although this had reduced in January 2020 to 100, the trust still lost the same total number of working hours for both months which was 146. Cancellations as a percentage of planned session cancelled within 14 days or two weeks missed the trust’s target of 10% in December 2019 with 11.3%. However, this reduced to 9.2% and met trust target in January 2020.

Divisional leads were aware of the main causes of cancellations and ensured the delayed treatment was risk assessed and/or harm reviewed. For example, the service leads reviewed orthopaedic cancellations recording the reason for cancellation. This was reported to the theatre improvement group (TIG) and the board.

When patients had their appointments/treatments/operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

From October 2017 to March 2019 (2017/18 quarter 3 to 2018/19 quarter 4), the percentage of cancelled operations where the patient was not treated within 28 days at the trust was consistently higher than the England average. However, in the most recent two quarters, 2019/20 quarters 1 and 2 (April to September 2019), the proportions at the trust decreased to below the England averages.

In the most recent quarter, 2019/20 quarter 2 (July to September 2019), this trust cancelled 158 surgeries, of which 5% were not treated within 28 days.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - West Hertfordshire Hospitals NHS Trust**
Over the two years, October 2017 to September 2019, the percentage of cancelled operations at the trust was higher than the England average in all quarters with the exception of 2018/19 quarter 3 (October to December 2018) when it was similar.

Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

**Cancelled Operations as a percentage of elective admissions - West Hertfordshire Hospitals NHS Trust**

(Source: NHS England)

**Patient moving wards per admission**

Managers monitored that patient moves between wards/services were kept to a minimum. The service moved patients only when there was a clear medical reason or in their best interest, for example, between specialities. Staff did occasionally move patients between wards at night. Letchmore ward’s staff told us post-operative surgical patients were sometimes moved at night due to their day consultant prioritising acutely unwell patients.

Managers monitored patient transfers and followed national standards. Staff supported patients when they were referred or transferred between services. Ward staff told us they could access patient notes and records in a timely way. Staff told us surgical patients would be moved to other wards such as Elizabeth or the Heronsgate suite if they were awaiting community care packages. Ward staff tried to avoid moving any patients with dementia or delirium if possible until they were stabilised. The nurse in charge raised an incident on the reporting system and followed up with the bed manager if patients were moved more than twice.

**Watford General Hospital**

From October 2018 to September 2019, within the top three surgical wards at the trust, 61.9% of individuals did not move wards during their admission for non-clinical reasons, and 38.1% moved once or more. All of the ward moves occurred from wards at Watford General Hospital.

A breakdown of the percentages of patients who moved once or more for non-clinical reasons by
ward is shown below:

- Letchmore Ward: 55.2%
- Ridge Ward: 33.7%
- Langley Ward: 28.8%

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

Trust level

From October 2018 to September 2019, there were 250 patients moving wards at night within surgery at trust level. A breakdown of the ward moves at night by ward at the trust is shown below:

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Number of ward moves at night</th>
<th>Percentage of ward moves at night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letchmore Ward</td>
<td>113</td>
<td>45.2%</td>
</tr>
<tr>
<td>Ridge Ward</td>
<td>45</td>
<td>18.0%</td>
</tr>
<tr>
<td>Flaunden Ward</td>
<td>42</td>
<td>16.8%</td>
</tr>
<tr>
<td>Langley Ward</td>
<td>38</td>
<td>15.2%</td>
</tr>
<tr>
<td>Cleves Ward</td>
<td>7</td>
<td>2.8%</td>
</tr>
<tr>
<td>De La Mare</td>
<td>5</td>
<td>2.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>250</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Watford General Hospital

From October 2018 to September 2019, there were 245 patients moving wards at night within surgery at Watford General Hospital. A breakdown of the ward moves at night by ward at the hospital is shown below:

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Number of ward moves at night</th>
<th>Percentage of ward moves at night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letchmore Ward</td>
<td>113</td>
<td>46.1%</td>
</tr>
<tr>
<td>Ridge Ward</td>
<td>45</td>
<td>18.4%</td>
</tr>
<tr>
<td>Flaunden Ward</td>
<td>42</td>
<td>17.1%</td>
</tr>
<tr>
<td>Langley Ward</td>
<td>38</td>
<td>15.5%</td>
</tr>
<tr>
<td>Cleves Ward</td>
<td>7</td>
<td>2.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>245</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Managers and staff worked to make sure that they started discharge planning as early as possible. Throughout our inspection we found that staff had a strong focus on the patient discharge process. The service used the Red2Green methodology to manage patient flow and expedite discharges. Red2Green bed days was a visual management system to assist in the identification of wasted time in a patient’s pathway of care. A red day was when a patient received little or no value-adding acute care, and a green day was when a patient received value-adding acute care that progressed them closer to discharge. Staff worked towards reducing red days and increasing green days, thereby reducing length of stay and improving patient flow and safety.
Staff discussed patients’ discharge dates at daily board rounds and multi-disciplinary team (MDT) meetings in the presence of social services, the discharge facilitator, and therapists. The team discussed all patient’s social history and started their discharge process. They liaised with the occupational and physio-therapists and the patient’s family. This was all identified and put into process at an early stage to ensure prompt discharges home, with no delays.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. The service reviewed any patients with learning disabilities (LD) or complex needs awaiting elective surgery in pre-operative assessment. The team highlighted any special care requirements on the relevant documentation which was shared with the relevant ward/day surgery unit. This included surgical emergency patients with complex needs, learning disabilities, or dementia.

Patients were planned to be discharged from hospital as early as possible during the day to release a bed, which meant that new patients could be transferred into the vacant bed during normal working hours. Staff told us, that this was not always possible due to patients waiting for medicines to take home or transport. Patients ready for discharge would go to the discharge lounge, where they would wait for medicines or transport. Patients still on the suite 45 minutes before they closed were transferred back onto inpatient wards overnight.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. However, complaint response times were sometimes longer than guidance within the trust policy.

Patients, relatives and carers knew how to complain or raise concerns. Wards encouraged patients to feedback about the care they received and informed patients of how to make formal complaints. The hospital Patient Advice and Liaison Service (PALS) was accessible to all and positioned at the main entrance which enabled patients and/or relatives to drop in.

The service clearly displayed information about how to raise a concern in patient areas. Posters were displayed on ward notice boards detailing who to contact if there were any concerns regarding care.

Staff understood the policy on complaints and knew how to handle them. Staff were familiar with complaint management. Where possible, staff tried to resolve any issues as they occurred as this reduced escalation of concerns. However, if a relative complained to the team, staff would usually escalate to the nurse in charge. The nurse lead felt as wards were better established staff intervened earlier to resolve issues and stop complaints escalating. They explained fewer temporary staff meant wards felt a greater sense of collective responsibility.

Managers investigated complaints and identified themes. The most appropriate person managed complaints. For example, if a complaint was about medical care, the consultant was asked to investigate. If the complaint was about nursing care, the nursing team would investigate. The service had support from the complaints team in identifying themes and were supported in formulating responses to complex or cross division concerns.

Summary of complaints
Trust level

From November 2018 to October 2019, the trust received 73 complaints in relation to surgery at the trust (20.5% of the total complaints received by the trust).

For the 61 complaints that had been closed at the time of data submission, the trust took an average of 41.1 working days to investigate and close the complaints. This was not in line with their complaints policy, which states that complaints should be closed with 30 days, with a 40 day or mutually agreed timeframe for more complex complaints.

The 12 complaints, that had not yet been closed, had been open for an average of 40.1 working days at the time of data submission.

A breakdown of complaints by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watford General Hospital</td>
<td>53</td>
<td>72.6%</td>
</tr>
<tr>
<td>St Albans City Hospital</td>
<td>19</td>
<td>26.0%</td>
</tr>
<tr>
<td>Hemel Hempstead Hospital</td>
<td>1</td>
<td>1.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>73</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

Watford General Hospital

From November 2018 to October 2019, the trust received 53 complaints in relation to surgery at Watford General Hospital (17.0% of the total complaints received by the hospital).

For the 41 complaints that had been closed at the time of data submission, the trust took an average of 40.5 working days to investigate and close the complaints. This was not in line with their complaints policy, which states that complaints should be closed with 30 days.

The 12 complaints, that had not yet been closed, had been open for an average of 40.1 working days at the time of data submission. This was also not in line with the trust's policy.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical care and treatment</td>
<td>37</td>
<td>69.8%</td>
</tr>
<tr>
<td>Admissions, discharge and transfers</td>
<td>8</td>
<td>15.1%</td>
</tr>
<tr>
<td>Staff attitude</td>
<td>3</td>
<td>5.7%</td>
</tr>
<tr>
<td>Communications</td>
<td>2</td>
<td>3.8%</td>
</tr>
<tr>
<td>Appointments, assessment and waiting times</td>
<td>2</td>
<td>3.8%</td>
</tr>
<tr>
<td>Privacy and dignity</td>
<td>1</td>
<td>1.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>53</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

There was a robust process for managing complaints. This included an initial feedback letter and then a formal response. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Where possible and appropriate complainants were involved with complaint processes or outcome meetings.
Managers shared feedback from complaints with staff and learning was used to improve the service. With help from the head of complaints, some complaints were re-opened to improve their response or for wider learning.

Complaints within the service were closed on average 10.1 working days later than the trust target. The clinical director (CD) told us they had redesigned the band six role around a divisional complaint coordinator. This post would help to write responses in conjunction with assistant divisional managers (ADMs). At the time of our inspection the CD said the division had reduced the backlog of delayed complaints to 18 complaints from 70.

**Number of compliments made to the trust**

**Trust level**

From January to November 2019, there were nine compliments received about surgery at the trust (5.5% of the total compliments received by the trust). All of the complaints related to care received at Watford General Hospital.

The trust reported that the themes for compliments over the last 12 months had identified that staff were helpful, dedicated to providing good care and committed to being effective in delivering that care to patients. This had been the case for teams as well as for individuals.

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

**Watford General Hospital**

From January to November 2019, there were nine compliments received about surgery at Watford General Hospital (5.5% of the total compliments received by the hospital). A breakdown of the compliments by department is shown in the table below:

<table>
<thead>
<tr>
<th>Department</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast care nurses</td>
<td>2</td>
<td>22.2%</td>
</tr>
<tr>
<td>Cleves Ward</td>
<td>1</td>
<td>11.1%</td>
</tr>
<tr>
<td>Ridge Ward</td>
<td>1</td>
<td>11.1%</td>
</tr>
<tr>
<td>Oral and maxillofacial</td>
<td>1</td>
<td>11.1%</td>
</tr>
<tr>
<td>Flaunden Ward</td>
<td>1</td>
<td>11.1%</td>
</tr>
<tr>
<td>Surgical admissions lounge</td>
<td>1</td>
<td>11.1%</td>
</tr>
<tr>
<td>Langley Ward</td>
<td>1</td>
<td>11.1%</td>
</tr>
<tr>
<td>Theatres</td>
<td>1</td>
<td>11.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

**Is the service well-led?**

**Leadership**

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
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. 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.

We spoke with the divisional triumvirate who felt surgery had a stable management team and structure in place. They explained assistant divisional managers (ADMs) were building resilience to respond to unexpected issues. However, they also had comprehensive oversight of the division’s challenges and had embedded improved governance framework.

We saw matrons were very visible in surgical areas, and their office was based on Ridge ward. Staff on all neighbouring wards spoke highly of matrons and told us they completed regular ward rounds. Staff were able to call or visit to discuss any issues and they were responsive. For example, if wards were short staffed. 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. The ward managers confirmed the matron had a detailed knowledge of the pressure on the wards and took prompt action to address any problems. For example, Ridge ward staff would call the matron if they needed to follow up patient’s pressure ulcer relief after discussion at their hip fracture meeting.

Consultants we spoke to felt well supported. However, two consultants in theatres told us some directors did not always listen to clinicians. Some staff also expressed concern about assistant divisional managers and the service management level of leadership. They felt a divisional level staff member was out of touch with clinicians and worked above their comfort zone.

We heard that the turnover of management level staff impacted on the ability for teams to have meetings and progress projects. For example, one service reported four general managers in two years which resulted in no regular meetings for several months.

Some staff felt that the managers focus had been on capacity and demand in the last 18 months. We heard discourteous emails were sent to all staff on basic issues that should have been resolved easily.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a vision which was reflected in the services. All staff were aware of the trust vision and reported that they had been included in its development.

The trust was in the process of developing the 2020-25 strategy. We saw a summary of the division’s strategic outline. This pulled together many of the elements of their strategy, described in more detail elsewhere and was aligned to the trusts strategy. This included business planning, the workforce strategy, project development and capital funding. The division’s vision was to provide the best experience for elective and emergency patients by organising their services to maximise the efficient use of current resources whilst planning to enhance future service delivery.

Some of the division’s 2019-20 financial year achievements were gold and silver ward accreditation, strong leadership team development, robust governance structure, a reduction in agency spend, vacancy rates reduced/recruitment and retention increased, improved patient areas in day surgery, emergency surgical assessment unit (ESAU), wards and a dedicated elective
orthopaedic area, a reduction in the number of complaints received and response times, getting it right first time (GIRFT) action plans in place for a number of specialities, improved communication and clinical engagement; sharing success, transparent learning and excellent response to the divisional “big 5” staff surveys.

Divisional leads told us about their strategy and highlighted their main plans over the next few years which had been fully reviewed and costed. The service planned to treat as many elective procedure patients graded up to three on the American Society of Anaesthesiologists (ASAs) classification system at the neighbouring trust site as possible. Leads were trying to enhance the complexity of patients so were working hard with surgical and anaesthetic colleagues to achieve this. They were developing an enhanced care package to cover dedicated ease of access spaces to work suitability.

Staff were aware of the trust wide vision and plans for the hospital developments.

**Culture**

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were proud to work for the trust and felt valued. We were given examples of how staff had been supported to develop and staff felt that they were able to contribute ideas to their services. Staff felt that patient safety was a priority, and that all staff focused on the same objectives. Staff felt that they could raise any concerns if they wished.

The service had a freedom to speak up guardian (FTSUG) and freedom to speak up champions that staff could access if they had issues or concerns at work including bullying and harassment. Staff could locate their nearest FTSU champion through the employee registrations intranet page or via the human resources (HR) lead. The trust’s appointed FTSUG was a non-executive director who acted independently.

The divisional nurse lead was a FTSU champion and they told us that junior doctors came to raise any issues directly with them. As a result, the division’s rates of overall exception reporting had reduced. We saw the number of exception reports per quarter from all trainees from August 2018 to January 2020. Rates were highest during this period between August and October. However, November 2019 to January 2020 rates matched the same quarter the previous year with 32 reports.

Patients told us they felt confident in raising any concerns with staff.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a robust governance process which included regular divisional and directorate meetings, which reported into trust board. This ensured that the board had oversight of all activity, enabling the identification of trends or themes.
Staff were clear about their roles and responsibilities. Staff reported that there were processes in place to enable them to review and discuss performance.

Surgeons were adhering to the ‘stop before you block’ part of the checklist. Divisional leads told us they carried out peer auditing from the neighbouring trust site. Their governance lead has been the anaesthetist for the past two years. At the time of our inspection they planned half day governance session dedicated to never events (NEs) to embed a different culture. Previously these sessions have been very well attended by over 100 doctors. The human factors training team were also coming to run a session. In response to serious incidents the service did not just put measures in place but supported the medical and nursing staff involved as they felt errors could be made by anybody.

The divisional lead sat on the trust board which enabled a clear process for escalating concerns directly between ward and board and visa versa. Divisional consultants told us governance processes were good. Consultants had oversight of performance through dashboards which were reviewed by directorates and divisions. Performance was reviewed formally at board and divisional meetings; however, weekly performance was monitored by speciality leads and the director of performance.

Ward Managers attended clinical leaders event half a day per month. They had new shared governance themed meetings each quarter to improve understanding. For example, the last two meeting’s themes were quality improvement (QI) and plan, do, study, act (PDSA) cycles with the aim of improving ward round times.

All meetings were minuted and any actions identified with a specific timeline for completion. We saw meetings were generally well attended. Staff who were unable to attend were sent copies of meeting minutes.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had a risk register which was reviewed regularly, updated and any mitigation clearly recorded. Divisional leads encouraged staff to report risks in their area with a suitable contact on the register. All proposed risks were submitted and presented at the divisional quality governance meeting for discussion and to agree scores. Once approved risks were uploaded by the divisional governance team onto the trust risk register for monthly review at the risk register review group.

We saw the division’s 28 current risks reported and monitored on their risk register for January 2020. 18 of these related to infrastructure and equipment. Four related to resource and three each related to compliance and IT. Divisional risks were reviewed according to their score, with those scored highest reviewed monthly.

The service’s risk with the highest score of 16 related to anaesthetist staffing levels and another risk scored 12 related to being unable to recruit to band five positions within theatres. The service had four high scoring infrastructure and equipment risks which all scored 12. These included the lack of perioperative digital Explorer (XR) templating, the risk of anaesthetic machine failure, surgical procedures being delayed and cancelled due to lack of availability of ultrasound machine, and the inability to identify known number of products and implants used on patients that may not have the appropriate product CE accreditation. The letters ‘CE’ appear on many products traded on the European economic area (EEA) single market.

The service had two IT risks which also scored 12. These related to their cancer information system (CIS) being inadequate which meant it was unable to produce effective cancer outcome service data (COSD), and their ophthalmology server which was a confidentiality risk.
The service’s IT risks were some of their oldest and were reviewed having been on the divisional risk register for over two years. The trust had ongoing difficulties with their cancer information system in producing accurate and timely reports on patient tracking, cancer waiting times, cancer outcomes and COSD, and tumour site audits. This affected the service’s reporting data as it was onerously delayed and required specific knowledge of their system and processes. Staff spent time correcting errors and completing data quality checks. The impact on the service was significant time spent by cancer service members and cancer information teams to ensure data was correct and complete. At the time of our inspection the trust was implementing a new CIS which was in place from December 2019.

We saw some risks fed up to the corporate level risk register. For example, those covering the post inpatient discharge appointment booking processes for surgery, anaesthetics and cancer. The division had acted in response to this escalated risk.

At the time of the review, the divisional risk register had 30 risks scoring 12 and below. Of these, three risks had been closed since and 12 risks were opened over two years ago. Compliance with risk reviews was 100%. 21 risks were commented upon and highlighted for further review. These were all reviewed and dealt with by the division ahead of September’s risk review group meeting.

The division had agreed for a business case to be submitted to their corporate financial performance group (CFPG) for £120,000 funding. Service leads had drafted a standard operating procedure (SOP) for action when equipment failed in October 2019. The service also acted to implement and fund a rolling replacement scheme and service contract in December 2019.

**Information management**

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. However, IT systems were often slow and unreliable.**

The trust had numerous IT and infrastructure issues as many of their systems were slow and outdated. A consultant and other theatres staff told us their log-in delays were a patient safety concern. However, we found no evidence this impacted upon patient harm. We observed a doctor who took ten minutes to log onto their PC. It took them another 15 minutes to load their scans software to view patient images and another five minutes for the scan to load. Their system to check blood results took 18 minutes until they could reach the relevant patient information. We heard part of the problem was that systems used different web browser applications. There was a trust wide improvement plan which looked at IT as part of the hospital’s development.

Trust wide we heard it took staff an average of 25 minutes to write reports onto their system. We heard one case where staff could not upload the necessary scans before surgery. As a result, the surgeon had to ask the radiology department staff to copy and burn a compact disc (CD) to view the images pre-operatively.

Poor IT also impacted on patient discharge letters. Staff told us that the time taken to prepare and print discharge letters was lengthy and this impacted on staff's ability to complete letters in a timely way.

Clinic staff told us they would be automatically logged out of their system after five minutes if they were idle which caused them problems. Consultants told us they would like to access digital scan and blood samples from home as this would make their job easier and quicker. The out of hours team reviewed scans and noted any discrepancies in hours.
Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust’s main hospital entrance displayed a flu leader board with monthly flu rates by service. The divisional rate for December 2019 was 72.7% and they hoped to achieve 80% by February 2020.

Theatre nursing staff told us they were happy and felt approachable and flexible in their roles. Many staff had worked for the trust for several years. Ward staff were generally happy and told us that the mood and culture of the hospital had improved over the last year to 18 months. However, this was not the case in all areas. In the orthodontics department we heard nursing staff morale was negatively affected as they felt ignored and neglected. An orthodontics consultant said their department’s service level agreement (SLA) with a neighbouring hospital had expired three years ago with which they shared four cross-site consultants. This had been revised but not formalised which affected staff robustness and management. We followed this up with the trust who confirmed the provision of oral surgery and orthodontic services was included within the clinical commissioning group (CCG) NHS standard contract. We reviewed the latest contract which started in April 2019 and included oral surgery and orthodontics within the schedule of essential surgical services.

The division held weekly theatre activity (TAG) and productivity (TPG) group meetings as well as monthly theatre improvement group (TIG) meetings. This helped the divisional triumvirate and senior management follow guidelines for turnaround times on the day for smoother patient flow.

We read about the gastrointestinal (GI) service’s development of a joint upper GI cancer centre with a college healthcare trust based in London. The service planned for approximately 50 patients a year to receive complex surgery at a major teaching hospital in West London. All these patient’s outpatient assessments and follow up care would be delivered locally. The service had identified a range of clinical outcome benefits through the development of a world class joint centre with increased volumes and a strong research base. A new pathway had also been established with another acute general teaching hospital to provide a specialist thrombectomy service for stroke patients.

The colorectal surgery service also had a new pathway for anterior resection to support patients in pro-active management and prevention of bowel dysfunction symptoms. The service saw all patients on the ward before discharge. Patients were given pathway information and self-care advice in preparation for reversal of their stoma. All patients were subsequently seen in nurse-led clinic.

Staff told us that there were some concerns with locum staff abilities which put increased pressure on existing staff. Staff also said the anaesthetist department was reliant on the goodwill and flexibility of its existing staff in meeting increased demand year on year. This was highlighted on the divisional risk register.

The local sustainability and transformation partnership (STP) aimed to streamline pathways providing an integrated service. Neighbouring trusts were looking at areas where consultants could work across clinical areas to improve patient pathways and experience.

Junior doctors told us they received good training which they had protected time to complete and felt well supported by the senior staff. They also praised the beverage and food ordering canteen facilities by phone available to them and other staff who were on call out of hours (OOH). However, junior doctors reported a lack of service clarity around rest periods. For example, they were unsure if they could switch off their bleeps or take a nap. We heard they had no designated
appropriate doctor’s mess within the main hospital building to rest, so they stayed in the
department office.

We saw a royal college of anaesthetists (RCoA) checklist adapted for clinicians to assess fatigue
and fitness to work which included prompts under categories such as wellness, medication,
stress, alcohol, fatigue and eating. This gave advice on working well at night under four periods;
before, during, between and recovery after. Examples of advice were a 15 to 20-minute nap can
significantly improve alertness and to be vigilant for the 4am dip which was the lowest
physiological point.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good
understanding of quality improvement methods and the skills to use them. Leaders
couraged innovation and participation in research.

We found the service had made improvements since our last inspection. The service had
improved compliance with the world health organisation’s five steps to safer surgery. The service
had continued with theatre and day surgery unit improvement plans to ensure each area would
become compliant with national standards. We found venous thromboembolism (VTE) risk
assessments were complete across the service. Compliance had increased since our last
inspection, so assessments were now recorded in line with national guidance. The service
ensured action plans were developed where national audits and clinical audits had shown a
weakness in order to drive forward improvement. The service ensured personal patient
identifiable information was no longer displayed as we found patient records were securely
stored. The service had also taken action in meetings to improve practice and ensure there was
learning from all incidents and patient deaths. However, the service’s medical staff were still not
meeting the 90% safeguarding trust target or completing a detailed debrief following surgery.

At the time of our inspection the service’s corporate team had appointed a quality improvement
(QI) lead nurse. The divisional nurse lead told us they had started coaching together and were
working their way through different areas. The service had also appointed two improvement leads
to their ‘quality hub’ to lead QI development trust wide. A baseline assessment was undertaken. A
local database to log all QI projects had been developed. The QI team were working with the
audit team to ensure all junior medical staff QI projects were registered and support was offered
as needed.

The division had appointed a project manager with quality improvement (QI) skills and a data
analyst to support their clinical pathway group (CPG) programme. All eight pathways had been
process mapped and measurement plans agreed. The data collection process was ongoing to
identify unwarranted variation in clinical and non-clinical processes. Some pathways were well
advanced in implementing identified improvements using the plan, do, study, act (PDSA)
methodology. The PDSA was a model improvement cycle encouraged by NHS improvement to
test ideas by trialling small scale changes and asses their impact, building upon the learning from
previous cycles in a structured way before wholesale implementation. For example, the early
pregnancy CPG pathway aim was “to streamline care for all women with pain or bleeding in early
pregnancy-leading to a timely and accurate diagnosis of pregnancy”.

The service developed a dosing strategy to identify and meet the different needs for organisation-
wide training. At the time of our inspection a number of staff were undertaking QI courses as the
first stage in implementing the dosing plan with plans to accelerate this from April 2020.

The service issued a monthly research and development newsletter. We read the December 2019
copy. This encouraged staff to become research active through the national institute for healthcare
research’s (NIHR) ‘your path in research’ campaign which offered new free online courses. The newsletter also promoted UK clinical research network (UKCRN) good clinical practice (GCP) sessions. The newsletter included any upcoming clinical studies, studies in focus and access to clinical trial protocols out of hours (OOH).
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.

Acute services

St Albans City Hospital
Waverley Road
St Albans
Hertfordshire
AL3 5PN
Tel: 01727 866122
www.westhertshospitals.nhs.uk

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

The Minor Injuries Unit (MIU) at St Albans City Hospital forms part of West Hertfordshire Hospitals NHS Trust emergency care division which also 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 senior management team.

The MIU is staffed by emergency nurse practitioners (ENPs) and administrative support staff. The service is managed by a lead emergency nurse practitioner who at the time of our inspection had been in post four months. The service runs from 9am to 8pm, seven days a week with radiology services available during these times. It provides treatment for adults and children with minor...
injuries such as sprains and strains, arm and leg injuries, cuts and grazes, burns and scalds, eye injuries, minor head injuries, insect and animal bites and allergic reactions.

Patients who attend the MIU should 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 had previously been inspected in November 2018 which resulted in conditions being imposed on the trust’s registration. This required the trust to ensure that all patients who presented to the MIU were assessed within fifteen minutes of arrival by a suitably trained member of staff. This was to ensure that in the event an extremely sick patient presented to the unit, they would be assessed and treated in a timely way.

We carried out an unannounced inspection on 18 and 19 February 2020. During our inspection, we spoke with five members of staff and five patients, and we reviewed fifteen sets of patient records which included adult and paediatric records. We also followed up on the enforcement actions we served following our previous inspection.

Details of emergency departments and other urgent and emergency care services

- Watford General Hospital: Emergency department, including the children’s emergency department
- St Albans City Hospital: Minor injuries unit
- Hemel Hempstead Hospital: Urgent care centre

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

The trust’s urgent and emergency care service is delivered across all three of their sites:

- The emergency department is located at Watford General Hospital. This has a nine bedded resus department which accepts both trauma and stroke patients; an eight bedded (plus chairs) clinical decision unit; a minors area run by dedicated emergency nurse practitioners (ENPs), including triage by a registered nurse; a five space senior team rapid assessment and treatment (STARR) area (plus chairs); a 22 bedded majors area; plus, a mental health room and chair area.
- The trust’s children’s emergency department is adjacent to their adult emergency department. This has a dedicated paediatric resuscitation area and paediatric assessment unit. The service benefits from both paediatric ENPs and emergency paediatricians.
- At Hemel Hempstead Hospital, the trust has an urgent treatment centre which is supported by both GPs and ENPs. It runs from 8am to 10pm seven days a week, offering radiology services during these times.
- At St Albans City Hospital, the trust has an ENP-led minor injuries unit which runs from 9am to 8pm seven days a week, offering radiology services during these times.

(Source: Acute Routine Provider Information Request (RPIR) – Acute context tab)

Activity and patient throughput

From January 2019 to December 2019 there were 15,695 attendances at the MIU. Attendances were increasing from 2019 to 2020; 1067 patients were treated in January 2019 and 1297 patients were seen in January 2020. Figures provided by the provider for October to December 2019 showed paediatric attendances formed one third of all attendances. From September 2018 to August 2019 there were 157,177 attendances at the trust’s urgent and emergency care services as indicated in the chart below.
Total number of urgent and emergency care attendances at West Hertfordshire Hospitals NHS Trust compared to all acute trusts in England, September 2018 to August 2019

(Source: Hospital Episode Statistics)

Urgent and emergency care attendances resulting in an admission

The percentage of accident and emergency (A&E) attendances at this trust that resulted in an admission remained similar in 2018/19, compared to the previous year, 2017/18. In both years, the proportions were higher than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from September 2018 to August 2019
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills including the intermediate level of life support training to all staff. However, mandatory training compliance was not in line with the trust target.

Mandatory training completion rates

Nursing staff received and mostly kept up-to-date with their mandatory training. A breakdown of compliance for mandatory training courses from April to October 2019 for qualified nursing staff in urgent and emergency care at St Albans City Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning disability (TEACH) (essential)</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control (clinical)</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic health, safety and risk</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In urgent and emergency care at St Albans City Hospital, the 90% target was met for eight of the 12 mandatory training modules for which qualified nursing staff were eligible. However, the completion rates should be interpreted with care as the analysis is based on low numbers of staff being eligible for each module.

After the inspection the trust provided up to date mandatory training compliance rates which showed completion rates had improved. All required staff had completed training in Venous Thromboembolism Prevention and End of Life Care and no staff were required to carry out blood handling training.

The mandatory training was comprehensive and met the needs of patients and staff. Nursing staff at the MIU were required to complete 17 core mandatory training courses plus seven essential training courses. The mandatory training was comprehensive and met the needs of patients and staff. Staff undertook additional training such as paediatric basic life support, paediatric intermediate life support, intermediate life support, caring for the sick child and x-ray training to better meet patient need.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers ensured mandatory training met compliance by keeping records of staff for which training was due. Managers we spoke with knew which staff were due to attend training and we saw records reflected this.

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.

Safeguarding training completion rates

Nursing staff received training specific for their role on how to recognise and report abuse. The trust set a target of 90% for the completion of safeguarding training. The majority of staff were up to date with their training.

The table below includes Prevent training as a safeguarding course. Prevent works to help staff recognise those at risk of getting involved in or supporting terrorism or extremist activity.
A breakdown of compliance for safeguarding training courses from April to October 2019 for qualified nursing staff in urgent and emergency care at St Albans City Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>8</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>7</td>
</tr>
<tr>
<td>PREVENT WRAP</td>
<td>6</td>
</tr>
</tbody>
</table>

In the minor injuries unit at St Albans City Hospital, the 90% target was met for one of the three safeguarding training modules for which qualified nursing staff were eligible. However, the completion rates should be interpreted with care as the analysis is based on low numbers of staff being eligible for each module.

Following the inspection, the trust provided up to date training completion rates which showed 100% of relevant staff had completed Safeguarding Children Level 3.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The trust provided examples of incident reporting and safeguarding referrals which staff had made to keep patients safe from harm.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff completed safeguarding referrals using an electronic system which alerted the safeguarding lead who followed up the referral.

Staff were aware of female genital mutilation and sex trafficking, although had minimal or no experience. Staff were able to describe how they would escalate concerns.

**Cleanliness, infection control and hygiene**

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

All areas of the MIU including treatment rooms were clean and had suitable furnishings which were visibly clean and well-maintained. Furniture had appropriate coverings which were able to be wiped clean. Disposable curtains were visibly clean with installation dates to prompt when they should be replaced.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning schedules were used, and staff were able to request additional deep cleans should these be required.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff washed their hands before and after treating patients. Staff were observed to...
use best practice techniques including being bare below the elbow, using the five moments of hand cleaning and aseptic techniques for dressings and wound care. Staff working in the MIU demonstrated 100% hand hygiene compliance in the most recent trust audit. Records we looked at showed infection control audits were carried out regularly.

Staff completed cleaning and equipment checks at the beginning and end of their shift. Hand hygiene dispensers were readily available for staff and patients to use. There was an infection control notice board which contained additional information and advice for staff and patients about MRSA, Clostridium difficile and hand hygiene.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff we observed during consultations, carried out cleaning following all patient contacts.

**Environment and equipment**

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff carried out daily safety checks of specialist equipment and the service had enough suitable equipment to safely care for patients. Paediatric and adult resuscitation equipment was checked daily and all equipment was in date. Relevant equipment such as the glucose machine was safety tested in March 2019.

The service had suitable facilities to meet the needs of patient’s families. The waiting room contained enough seating for patients with a separate children’s play area, all visible by CCTV. The booking in area contained a glass screen behind which the reception staff were seated.

Staff disposed of clinical waste safely. All hazardous substances such as cleaning materials were stored safely in a locked room.

**Assessing and responding to patient risk**

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and acted upon patients at risk of deterioration.

Managers had introduced a new formalised system to clinically assess patients presenting to the MIU. This ensured patients were triaged by a registered nurse within fifteen minutes and assessed, admitted, transferred or discharged within four hours. At our previous inspection, we found a lack of oversight of patient risk as there was no formal process to clinically assess patients. At this inspection, we saw significant improvements had been made in this area and risk to patients had been minimised. Data from the trust showed initial assessment rates from October 2019 to January 2020 were above the 95% rate required and in December and January remained at 99%. The audit included information about how the unit were keeping safe those patients who waited 30 minutes or longer. Senior staff completed a harm review for these patients, the results of which were discussed at clinical governance meetings.
Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. We saw staff asked patients if they had travelled to any of the high-risk areas for prevalence of coronavirus. The trust had recently set up coronavirus pods where patients could be isolated and where they were asked to ring 111 for advice. Reception staff were able to monitor any patients in the pods using CCTV.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. We saw staff completed hourly checks of the waiting area to ensure patients were safe and were not becoming more unwell. Should a patient be waiting in the MIU for four hours or longer, staff completed a risk assessment. The National Early Warning Score 2 (NEWS2) was used to identify and respond to adult patients who may be at risk of deteriorating and staff were trained to recognise the signs of sepsis. Staff used the paediatric early warning score in the same way to assess the risk of children deteriorating.

Patients were triaged within 15 minutes of arrival by a qualified nurse, who delivered first line treatment such as pain relief. Staff managed patient safety at the initial assessment using the Manchester Triage System to apply best practice standards. Two additional qualified nurses undertook full assessments including a management plan and treatment.

Staff knew about and dealt with any specific risk issues. They shared key information to keep patients safe when handing over their care to others. Staff who became aware of patients needing urgent treatment, called 999. Staff were able to arrange for patients to be transferred to Watford General Hospital for additional assessments and treatment if necessary. Staff reported that this rarely happened.

Shift changes and handovers included all necessary key information to keep patients safe. Due to the type of service, staff worked one shift pattern which covered the opening hours of the MIU so there were no handovers.

Emergency Department Survey 2018 – Type 3 A&E departments (urgent care centres, urgent treatment centres and minor injury units)

In relation to type 3 A&E departments, the trust scored about the same as other trusts for the four Emergency Department Survey questions relevant to safety. Type 3 A&E departments are all services that are not designed to treat patients with an acute medical emergency. These include Minor Injuries Units. The trust’s other Type 3 A&E department was the Urgent Care Centre at Hemel Hempstead Hospital.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. How long did you wait before you first spoke to a health professional?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. Sometimes, people will first talk to a health professional and be examined later. From the time you arrived, how long did you wait before being examined?</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q30. In your opinion, how clean was the urgent care centre?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Q31. While you were in the urgent care centre, did you feel threatened by other patients or visitors? | 9.9 | About the same as other trusts

(Source: Emergency Department Survey 2018)

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The table below shows a summary of the nursing staffing metrics in urgent and emergency care at St Albans City Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Urgent and emergency care annual staffing metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>November 2018 to October 2019</strong></td>
</tr>
<tr>
<td><strong>Staff group</strong></td>
</tr>
<tr>
<td>Target All staff</td>
</tr>
<tr>
<td>Qualified nurses</td>
</tr>
</tbody>
</table>

The MIU ran on three emergency nurse practitioners (ENPs), Monday to Friday and two ENPs at the weekend. Rotas were completed 12 weeks in advance. When the unit required additional staff due to sickness or leave, extra bank staff were utilised from permanent staff who worked at the hospital or other trust sites. The lead emergency nurse practitioner also worked clinically, should this be required. The number of nurses on duty matched the planned numbers.

Nurse staffing rates within urgent and emergency care at St Albans City Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and sickness. The trust did not report any agency use.

Please note that the trust was unable to provide total hours including those covered by substantive staff to allow us to calculate bank usage or unfilled hours for nursing staff as a percentage of the total hours available.

Vacancy rates

The service had low vacancy rates for nursing staff. There were two full time vacancies with interviews planned for the week after our inspection.
Monthly vacancy rates over the last 12 months for registered nurses showed an upward shift from May 2019 to October 2019. Please note that the negative vacancy rate in April 2019 in the chart above indicates that there were more staff in post than planned in this month.

**Turnover rates**

The service had low turnover rates for nursing staff.

**Sickness rates**

The service had reducing sickness rates for nursing staff.

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

**Bank and agency staff usage**

The service utilised bank nurses from elsewhere in the trust and did not use agency staff.

Monthly bank use over the last 12 months for registered nurses showed an upward shift from May 2019 to October 2019. Managers limited their use of bank staff and requested staff familiar with the service. Managers made sure all bank staff had a full induction and understood the service.
Records

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

Patient notes were comprehensive, and staff could access them easily. Records were maintained electronically and in paper format. There was an electronic book in system which staff updated when they triaged, assessed and discharged patients.

On the day of the inspection, we reviewed 15 sets of patient records, which included four paediatric and 11 adult records. The majority of notes contained information including the time the patient was booked in, the time they were triaged and the time the assessment took place. The pain score was noted and reviewed in all of the records we looked at. We saw evidence staff asked relevant questions and notes included an assessment and plan. Four of the patient records did not contain a readable staff signature or their role. We escalated this to the unit manager who told us an audit of patient notes was planned for the following month.

In order for staff to more easily identify vulnerable patients such as those with learning disabilities and dementia, coloured stickers were used on patient records. These were placed in patients records for patients with a known condition. This enabled patients to be seen quickly and if necessary additional measures implemented to meet the patient needs. For example, carers to accompany patients.

When patients transferred to a new team, there was no delays in staff accessing their records. When a patient was handed over to another service a referral would be completed, and a verbal handover given.

Records were stored securely. Patient records were photocopied so there were no delays in staff accessing their records. Paper records were stored in a secure area not accessible to patients.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The medicines management policy was in date for review and had been approved by the multidisciplinary team. The policy contained information about controlled drugs (CDs) and referred staff to a separate controlled drugs policy. Controlled drugs are medicines which may cause serious problems like dependence and harm if they are not used properly. Some staff we spoke with did not know where to find the separate CD policy which meant they may not have had access to the information they needed. The CD policy was in date and reviewed by the pharmacy and medical team.

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy. Emergency medicines were stored securely with a tamper proof seal and controlled drugs (CDs) were doubled locked and alarmed to prevent unauthorised access.
We saw that FP10 prescriptions were managed in line with guidance. FP10 prescriptions are purchased by NHS organisations including hospital trusts and are distributed free of charge to medical and non-medical prescribers. FP10 prescriptions can be dispensed at any pharmacy and therefore there is a potential risk of misuse. We saw that FP10 prescriptions were stored in a locked cupboard and staff kept a log of the FP10 prescription numbers, staff member that used them and the medicines prescribed, enabling an audit process.

Oxygen cylinders were full and in date so patients could receive oxygen when required. The enhanced nurse practitioners (ENPs) checked the pharmacy stock weekly and sent a top up form to the pharmacy so any depleted medicines could be replenished. Fridge temperature logs were completed, and staff knew who to contact if the temperature was out of range.

Staff provided specific advice to patients and carers about their medicines. Staff followed agreed patient group directions when prescribing medication for specific conditions and types of patient. PGDs are documents that permit the supply of prescription-only medicines to groups of patients, without individual prescriptions. This demonstrated improvement from the previous inspection.

The patient group directions (PGDs) provided specific advice about all the medicines including doses used for paediatric patients. During the inspection, there were five ENPs, one of which was qualified to prescribe medicines. Those that were not prescribers administered medicines under PGDs. We reviewed five PGDs and these were in date, appropriately completed and authorised by a senior doctor, chief pharmacist and the Medicines Use and Safety Panel. Records showed staff had been trained and were competent to use.

Staff followed current national practice to check patients had the correct medicines. If staff needed additional support regarding medicines, they contacted the pharmacy for advice. The pharmacy team was available Monday to Friday 9am to 5pm. If out of hours advice was required, staff were able to contact the on-call consultant and an on-call pharmacist was available at Watford General Hospital.

Staff followed national guidance to check patients had the correct medicines. We saw staff asked patients about any allergies at the initial assessment consultation and this was documented on patient records.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff reported incidents using an electronic reporting system. Managers were alerted by the system and they reviewed the information contained in the alert.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff told us
they shared learning from incidents across the trust at team meetings and huddles, as well as via the intranet and trust newsletters.

**Never events**

The service had no never events.

**Breakdown of serious incidents reported to STEIS**

Staff understood how to report serious incidents and were familiar with trust policy and reporting. Should a serious incident be reported, the trust policy instructed managers to debrief and support staff following any such incidents.

In accordance with the Serious Incident Framework 2015, the trust did not report any serious incident (SIs) in urgent and emergency care at St Albans City Hospital which met the reporting criteria set by NHS England from January to December 2019.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Records we looked at showed staff followed the duty of candour guidance, apologised when things went wrong and provided a full explanation. Staff also gave details of how the trust would change following the incident and how the learning would be implemented.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. Security in the MIU had been improved following an incident elsewhere in the trust which had led to the installation of a glass screen in the reception area and other security improvements.

Records we looked at showed managers within the trust investigated incidents thoroughly and that patients and their families were involved in these investigations.

**Is the service effective?**

**Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. Staff at the MIU used an electronic and paper records system they could all update.**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We saw evidence-based resuscitation UK guidelines were visible in the resus area. Staff followed the Manchester Triage System so nurses assigned clinical priority to
patients. A standard operating procedure had been introduced which helped staff to prioritise appropriately. Sepsis screening and management was done effectively and in line with national guidance. Staff received sepsis training and used tools adapted from the UK Sepsis Trust’s ‘Sepsis Six’ bundle which was recognised by NHS England and the Royal College for Emergency Medicine.

The MIU met the Royal College of Emergency Medicine (RCEM) guidance for Unscheduled Care Facilities 2009 which set out the minimum requirements for the less seriously ill or injured.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff we spoke with told us patients who may be subject to the Mental Health Act did not present for treatment at the MIU. Should a patient with significant mental health concerns request treatment, the staff would ensure the patient was safely transferred to Watford General Hospital or call 999.

**Nutrition and hydration**

**Patients could access oral hydration and nutrition, but this was not routinely offered.**

Due to the nature of the service staff did not routinely provide patients with nutrition or oral hydration. Patients had access to water should this be required while they were waiting for treatment although they had to request this from staff. There was also a vending machine close to the unit for snacks.

At our last inspection we saw the water cooler was kept behind the reception desk which was not always staffed so there were periods when patients were not able to access water. When we spoke to managers about this, they explained the water cooler had been moved back to the waiting area for patients to use. However, as a result the waiting area had become untidy, more difficult to keep clean and cups of water had been spilt. The decision had been made to move the water cooler back to the staff only area. There was now a notice clearly displayed in reception which advised patients to ask staff should they require water. Improvements had been made to ensure reception staff cover reflected the MIU’s opening hours, so water was available at all times. The hospital had a café on site where patients and their relatives could purchase drinks, food and snacks, including healthy food and drink options.

**Emergency Department Survey 2018 – Type 3 A&E departments**

In the CQC Emergency Department Survey, the trust scored 6.4 for the question “Were you able to get suitable food or drinks when you were at the urgent care centre?”. This was about the same as other trusts.

*(Source: Emergency Department Survey 2018)*

**Pain relief**

Staff generally assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
Staff assessed patient's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain was assessed during triage.

Staff used a smiley face for children to indicate their level of pain and the Stanford Pain Scale for adults to score their pain on a scale of one to 10. We saw patients received pain relief after their initial assessment which was carried out within fifteen minutes of arrival. Staff prescribed, administered and recorded pain relief accurately.

**Emergency Department Survey 2018 – Type 3 A&E departments**

In the CQC Emergency Department Survey, the trust scored 6.6 for the question “Do you think the hospital staff did everything they could to help control your pain?”. This was about the same as other trusts.

(Source: Emergency Department Survey 2018)

**Patient outcomes**

**Staff did not always monitor the effectiveness of care and treatment.**

Managers and staff did not routinely use audit results to improve patient outcomes. There was a local audit programme in place which included an audit of initial assessments and an oversight audit. Staff were encouraged to complete additional audits into specific conditions, for example, a head injury audit had been completed in November 2019. However, the audit programme was not fully developed and there were plans to introduce further topics, for example a patient records audit.

The unit lead carried out an initial assessment audit in January 2020 showing a breakdown of the numbers of patients who received their initial assessment within 15 minutes from October to December 2019. We saw the audit will be re-run in April 2020 to check whether improvements have been sustained.

**Competent staff**

The service made sure staff were competent for their roles. Managers generally appraised staff’s work performance and held supervision meetings with them to provide support and development. However, not all staff had an annual appraisal.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Staff were qualified to work in an urgent and emergency care setting.

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work. As of October 2019, 80.0% of staff within urgent and emergency care department at St Albans City Hospital received an appraisal compared to a trust target of 90%. The breakdown by staff group can be seen in the table below:
Registered nursing staff did not meet the target. However, this was based on low numbers of staff being eligible for an appraisal which had impacted on the rates.

At the time of the inspection, appraisal rates had increased and 100% of staff had received an appraisal.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Minutes were shared electronically and in paper format. Staff were encouraged to raise topics for discussions at team meetings.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. All staff we spoke with told us they received supervision and felt supported in their clinical roles.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff were encouraged to develop and gain additional skills and qualifications.

Managers made sure staff received any specialist training for their role. Every three months staff worked one day within the emergency department and childrens’ assessment unit at Watford General Hospital to develop their skills for caring for sick children, deteriorating conditions and resuscitation.

Managers identified poor staff performance promptly and supported staff to improve.

**Multidisciplinary working**

*Nurses and support staff worked together as a team to benefit patients. They supported each other to provide good care.*

Staff worked across healthcare disciplines and with other agencies when required to care for patients. We saw staff worked closely with the x-ray department to improve patient treatment time and patient experience. Staff we spoke with told us improvements made since the last inspection resulted in the MIU staff working more closely together as a team. As a result, patients needing treatment outside of the MIU were advised more quickly and waiting times were minimised. Staff told us recent changes had empowered them to work more closely with other hospital staff and departments, ringing them for advice when required.
Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, seven days a week.

The MIU was open from 9am to 8pm seven days a week and x-ray services were accessible to patients during this time. Staff could call for support and advice from doctors and other disciplines should this be required.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support. Patients could access leaflets and promotional information encouraging healthy lifestyles. We saw leaflets and posters displayed on the mental health crisis service, patient advice liaison service (PALS), domestic abuse support, antibiotic use, ‘is A+E right for me’, female genital mutilation (FGM).

Staff assessed each patient’s health and provided support for any individual needs to live a healthier lifestyle. Advice and information leaflets on sepsis, smoking cessation and good sexual health were easily accessible to patients, relatives and carers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. Should it be required, they knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke had an awareness of the Mental Health Act and they provided examples of when they may have to assess whether a patient had capacity. Staff were able to seek advice from the mental health liaison team should this be required.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff we spoke with told us patients who were unable to give consent did not present for treatment at the MIU.

Staff made sure patients consented to treatment based on all the information available. We saw evidence that staff clearly asked for and recorded consent in the patients’ records.

Staff made sure patients consented to treatment based on the information available. Staff we spoke with were able to explain the importance of requesting and recording consent in the patient records. Staff clearly recorded consent in the patients’ records. Records we looked at had consent documented.
Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) training completion

Compliance for MCA/DoLS (essential) training from April to October 2019 for qualified nursing staff in the Minor Injuries Unit at St Albans City Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>MCA/DoLS (essential)</td>
<td>6</td>
</tr>
</tbody>
</table>

Nursing staff received and most kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

In the MIU at St Albans City Hospital, the target of 90% for MCA/DoLS (essential) training was not met by qualified nursing staff. However, after the inspection the trust provided data the 75% completion rate for MCA/DoLS training had improved to 88% of staff.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with told us patients subject to the MHA did not attend the MIU.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, mostly respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. However, we saw staff treating patients in rooms with open doors on one occasion, which did not promote respect. Once we brought this to the attention of the provider, we saw treatment doors were closed when staff were with patients providing treatment.

Patients said staff treated them well and with kindness. Patients we spoke with praised staff, their care and treatment and they felt staff respected their privacy and dignity.

Some patients booking into reception and providing personal information could be heard from the waiting area. We spoke with the provider about this and they were reviewing options for reception. A glass screen had been installed following an incident at another trust location in order to improve staff security. The provider was aware patient privacy had been compromised and they were considering how to retain a secure environment for staff while improving patient confidentiality.
Friends and Family test performance

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey.

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 88.6% and 95.7% from October 2017 to September 2019.

The data shows seven sudden change data points in May, June, July and September 2018, and June, July and August 2019. These sudden change data points indicate that two out of three consecutive data points sit between the upper or lower warning limits and the upper or lower control limits.

Friends and family test performance – West Hertfordshire Hospitals NHS Trust – October 2017 to September 2019

The graph below shows the response rates at the trust over the 24-month time period:

West Hertfordshire Hospitals NHS Trust – response rate – October 2017 to September 2019
Staff did not always follow policy to keep patient care and treatment confidential. We saw staff did not always close treatment room doors when assessing and treating patients. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We saw patient records were locked securely in cabinets in an area inaccessible to patients.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We observed caring and warm interactions between staff and patients. Staff were aware of patients’ individual needs and responded to these accordingly.

**Emotional support**

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. They supported patients who became distressed in an open environment and helped them maintain their privacy and dignity by taking them to a separate room.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. We saw staff showed kindness, treated patients with respect and provided emotional support when they were unwell. Patients in pain were assessed quickly and given pain relief to ease their condition.

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

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed four initial assessments and three consultations where treatment was provided. We saw
staff explained proposed treatments before undertaking any action and staff sought permission to continue with treatment after explaining the options.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff used interpreter services to support patients for whom English was a second language.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We spoke with five patients who all spoke positively about the service, their treatment and the staff who treated them. Reception staff encouraged patients to complete feedback forms which were used to improve the service. Staff supported patients to make informed decisions about their care.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff we spoke with told us due to the nature of the minor injuries service, patients were not usually distressed. However, should they become upset, they would be taken to a private room. All patients we spoke with told us they felt staff did respect their privacy and dignity.

Emergency Department Survey 2018 – Type 3 A&E departments

The feedback from the Emergency Department survey test was positive.

The trust scored about the same as other trusts with type 3 A&E departments for the 20 Emergency Department Survey questions relevant to the caring domain.

Please note: Four questions were excluded from analysis due to the low number of responses received nationally (While you were waiting, were you able to get help from a member of staff to ask a question?; Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?; Did a member of staff tell you about medication side effects to look out for?; Did hospital staff take your family or home situation into account when you were leaving the urgent care centre?).

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust score</th>
<th>RAG</th>
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</thead>
<tbody>
<tr>
<td>Q9. Were you informed how long you would have to wait to be examined?</td>
<td>4.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your condition with a health professional?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
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<tr>
<td>Q13. While you were in the urgent care centre, did a health professional explain your condition and treatment in a way you could understand?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the health professional listen to what you had to say?</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the health professional examining and treating you?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did health professionals talk to each other about you as if you weren't there?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. If a family member, friend or carer wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. While you were in the urgent care centre, how much information</td>
<td>8.9</td>
<td>About the same as other trusts</td>
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<td>Question</td>
<td>Trust score</td>
<td>RAG</td>
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<td>about your condition or treatment was given to you?</td>
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<td>as other trusts</td>
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<tr>
<td>Q22. Sometimes, a member of staff will say one thing, and another will</td>
<td>9.5</td>
<td>About the same as other</td>
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<tr>
<td>say something quite different. Did this happen to you?</td>
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<td>trusts</td>
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<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions</td>
<td>8.5</td>
<td>About the same as other</td>
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<tr>
<td>about your care and treatment?</td>
<td></td>
<td>trusts</td>
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<tr>
<td>Q42. Overall, did you feel you were treated with respect and dignity</td>
<td>9.3</td>
<td>About the same as other</td>
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<td>while you were in the urgent care centre?</td>
<td></td>
<td>trusts</td>
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<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment</td>
<td>8.2</td>
<td>About the same as other</td>
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<td>, did a health professional discuss them with you?</td>
<td></td>
<td>trusts</td>
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<tr>
<td>Q25. Did a member of staff explain why you needed these test(s) in a</td>
<td>9.3</td>
<td>About the same as other</td>
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<td>way you could understand?</td>
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<td>trusts</td>
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<tr>
<td>Q26. Before you left the urgent care centre, did you get the results of</td>
<td>8.7</td>
<td>About the same as other</td>
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<td>your tests?</td>
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<td>trusts</td>
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<tr>
<td>Q27. Did a member of staff explain the results of the tests in a way</td>
<td>8.7</td>
<td>About the same as other</td>
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<td>you could understand?</td>
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<td>trusts</td>
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<tr>
<td>Q37. Did a member of staff tell you when you could resume your usual</td>
<td>6.4</td>
<td>About the same as other</td>
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<tr>
<td>activities, such as when to go back to work or drive a car?</td>
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<td>trusts</td>
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<tr>
<td>Q39. Did a member of staff tell you about what symptoms to watch for</td>
<td>7.0</td>
<td>About the same as other</td>
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<tr>
<td>regarding your illness or treatment after you went home?</td>
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<td>trusts</td>
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<tr>
<td>Q40. Did hospital staff tell you who to contact if you were worried</td>
<td>7.7</td>
<td>About the same as other</td>
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<td>about your condition or treatment after you left the urgent care centre</td>
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<td>trusts</td>
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<tr>
<td>Q41. Did staff give you enough information to help you care for your</td>
<td>8.0</td>
<td>About the same as other</td>
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<tr>
<td>condition at home?</td>
<td></td>
<td>trusts</td>
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<tr>
<td>Q43. Overall</td>
<td>8.4</td>
<td>About the same as other</td>
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<tr>
<td>Q10. Did staff refer you to a specialist?</td>
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<tr>
<td>Q14. About your condition or treatment was explained to you?</td>
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<tr>
<td>Q12. On average, how quickly were you seen as you walked into the</td>
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<td>urgent care centre?</td>
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<td>Q13. About the time you were waiting compared to other trusts?</td>
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<tr>
<td>Q16. Did you have any anxieties or fears about your condition or</td>
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<tr>
<td>treatment?</td>
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<tr>
<td>Q17. Did you have any anxieties or fears about your treatment?</td>
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<tr>
<td>Q20. About the time you spent in the urgent care centre?</td>
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<td>Q21. About the amount of staff you saw during your visit?</td>
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<td>Q24. About the same as other trusts</td>
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<tr>
<td>Q36. Were the results of your tests explained to you?</td>
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<td>Q38. Did you have the chance to speak to someone who was trained to</td>
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<td>discuss your condition or treatment?</td>
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<tr>
<td>Q44. If your condition or treatment was explained to you?</td>
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<tr>
<td>Q45. In general, staff did their best to explain to you your</td>
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<td>condition or treatment?</td>
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<td>Q46. If you had any anxieties or fears about your condition or treatment</td>
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<td>, did a health professional discuss them with you?</td>
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<td>Q47. Did you feel you were involved in important decisions about your</td>
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<td>treatment or condition?</td>
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<td>Q48. Did you feel you were treated with respect and dignity in the</td>
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<td>urgent care centre?</td>
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<td>Q49. Did you receive a copy of your medical records?</td>
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<td>Q50. Did you receive a copy of the referral letter to your GP?</td>
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<td>Q51. Did you receive a copy of the referral letter to your consultant?</td>
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<td>Q52. Did you receive a copy of the referral letter to your specialist?</td>
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<td>Q53. Did you receive a copy of the referral letter to your pharmacist?</td>
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<td>Q54. Did you receive a copy of the referral letter to your dentist?</td>
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<td>Q55. Did you receive a copy of the referral letter to your optician?</td>
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<td>Q56. Did you receive a copy of the referral letter to your audiologist?</td>
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<td>Q57. Did you receive a copy of the referral letter to your psychologist</td>
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<td>Q58. Did you receive a copy of the referral letter to your physiothera</td>
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<td>Q59. Did you receive a copy of the referral letter to your dietician?</td>
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<td>Q60. Did you receive a copy of the referral letter to your chiropodist?</td>
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<td>Q61. Did you receive a copy of the referral letter to your social worker</td>
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<td>Q62. Did you receive a copy of the referral letter to your counsellor?</td>
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<td>Q63. Did you receive a copy of the referral letter to your social</td>
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<td>worker?</td>
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<td>Q64. Did you receive a copy of the referral letter to your solicitor?</td>
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<td>Q65. Did you receive a copy of the referral letter to your legal</td>
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<td>advisor?</td>
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<td>Q66. Did you receive a copy of the referral letter to your translator?</td>
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<td>Q67. Did you receive a copy of the referral letter to your translator?</td>
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<td>Q99. Did you receive a copy of the referral letter to your translator?</td>
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<td>Q100. Did you receive a copy of the referral letter to your translator?</td>
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<tr>
<td>(Source: Emergency Department Survey 2018)</td>
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</tbody>
</table>

**Is the service responsive?**

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

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services, so they mostly met the needs of the local population. There was adequate seating and space in the reception and waiting areas with a separate waiting area for children. The children’s’ waiting area was sited away from the main waiting area and there was audio visual separation. The main waiting area contained a television and there was also a small children’s play area. Staff we spoke with told us the local community presented with sporting injuries resulting from accidents and the MIU provided appropriate services to meet this local need. Reception staff used a microphone and speakers to enhance sound so patients could hear them.

Staff could access emergency mental health support seven days a week for patients with mental health problems, learning disabilities and dementia. Staff could access the on-call psychiatrist and the mental health liaison team should this be required.
The service did not have systems to help care for patients in need of additional support or specialist intervention. Due to the nature of the care and treatment provided by MIU nurses, patients in need of additional support or specialist intervention, were directed to the appropriate services. There were no direct admissions from the MIU; should a patient require admission they were transferred to the emergency department at Watford General Hospital.

The service relieved pressure on other departments when they could treat patients in a day. Patients assessed with conditions that could be treated in a day relieved pressure on the main emergency department at Watford General Hospital and local GP practices.

**Meeting people’s individual needs**

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Managers we spoke with told us patients with mental health needs rarely attended the MIU. In the event a patient required mental health support, the service used a standard operating procedure to respond to and support these patients who were referred to mental health services at Watford General Hospital.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment and a hearing loop was available should this be required for communication with patients.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff used a telephone translation service and patients sometimes asked them to use a translation app on the patients’ mobile phone.

**Emergency Department Survey 2018 – Type 3 A&E departments**

The trust scored 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>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the urgent care centre last?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. Were you given enough privacy when being examined or treated?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 2018)

**Access and flow**
People could access the service when they needed it and received the right care promptly. However, waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

**Median time from arrival to treatment (all patients)**

Managers monitored waiting times and made sure patients received treatment within agreed timeframes and national targets. We saw managers monitored waiting times and the electronic booking system enabled them to see a live view of patient progress and waiting times.

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 did not meet the standard in any of the 12 months from November 2018 to October 2019 and the median time was consistently higher than the England average.

In the most recent month, October 2019, the trust’s median time to treatment was 74 minutes compared to the England average of 65 minutes.

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

Managers and staff worked to make sure patients did not stay longer than they needed to.

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. We saw the MIU performance for 2019 was 99.9%.

Managers and staff worked to make sure that patients were assessed and treated as early as possible. We saw leaders had made improvements to the system and monitored this closely to ensure targets were being met. This had had a significant positive impact on triage and treatment times which were 99%. Managers had introduced fundamental changes to how the unit functioned. Changes included ensuring all staff worked full shifts which started before the MIU opened and ended at the time of closing. Other improvements included the introduction of the electronic booking system which gave immediate feedback on the initial assessment and treatment times. Huddles had been introduced to optimise team communication, ensure staff understood what was expected and to support staff wellbeing. Staff supported patients when they were referred or transferred between services.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with told us they knew how to complain or give feedback.
The service clearly displayed information about how to raise a concern in patient areas. We saw patients booking in at reception were given a form to fill in about their experience. Patient Advice and Liaison Services (PALS) leaflets were available for patients who wanted advice and support to make a complaint.

Staff understood the policy on complaints and knew how to handle them. The complaint we reviewed showed managers investigated complaints, considered how the service could have done things differently and shared learning.

**Summary of complaints**

**Trust level**
From November 2018 to October 2019, the trust received 62 complaints in relation to urgent and emergency care at the trust (17.41% of the total complaints received by the trust). Of these complaints, 33 were standard complaints, 26 were complex and three complaints resulted in a local resolution meeting. For the 58 complaints that had been closed at the time of the inspection, the trust had taken an average of 45 days to investigate and close the complaint. The trust endeavoured to respond to all complaints within 30 working days of receipt, or 40 working days for complex complaints. However, responses could take longer, and timelines were discussed with each complainant. The trust aimed to respond to 80% of complaints within the agreed timeframe.

The four complaints, that had not yet been closed, had been open for an average of 16 working days at the time of data submission. This was in line with the trust’s policy.

A breakdown of complaints by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watford General Hospital</td>
<td>51</td>
<td>82.5%</td>
</tr>
<tr>
<td>Hemel Hempstead General Hospital</td>
<td>10</td>
<td>16.13%</td>
</tr>
<tr>
<td>St Albans City Hospital</td>
<td>1</td>
<td>1.62%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>59</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

From November 2018 to October 2019, the trust received one complaint in relation to urgent and emergency care at St Albans City Hospital (1.7%) of the total complaints received by the hospital.

The service took 25 working days to investigate and close the complaint. This was in line with their complaints policy, which states that complaints should be closed with 30 days. The complaint related to clinical care and treatment.

We reviewed the complaint and saw the trust provided a comprehensive response which included details of the investigation carried out. The trust was open and transparent, apologised and provided information about how they could have done better.
Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. We saw the trust responded to negative patient feedback on social media by contacting the patient and discussing their experience further in order to learn and make improvements.

**Number of compliments made to the trust**

**St Albans City Hospital**

From January to November 2019, there were no compliments received about urgent and emergency care at St Albans City Hospital.

Staff we spoke with told us patients left feedback on social media platforms as well as NHS Choices. Feedback we looked at showed patients who had visited the MIU in the last six months praised staff, the service they received and the whole experience. Older feedback we looked at was more mixed and reflected both positive and negative experiences.

All of the patients we spoke with on the day of the inspection told us they would recommend the service and that their experience had been positive. We saw the unit displayed patient comments praising the staff and the care received.

**Is the service well-led?**

**Leadership**

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The urgent and emergency care senior leadership team worked as a divisional triumvirate and consisted of the lead nurse, divisional director and divisional manager. The divisional manager had been in post four months, as had the manager of the MIU. The divisional triumvirate worked across all three of the hospital sites at Watford General, Hemel Hempstead General Hospital and St Albans City Hospital.

The senior leadership team had oversight of and management of the MIU and its staffing. Members of the team regularly worked in and spent time in the MIU. The clinical lead visited the site weekly and conducted training and meetings. There was an assistant divisional manager who spent most of their time between the St Albans and Hemel Hempstead sites. Staff we spoke with told us leaders were very visible and accessible. They told us leaders were supportive of their work and the contribution they made to the running of the MIU and patient care and treatment.

An emergency nurse practitioner provided local leadership. This had changed since our last inspection, when local management was shared between the St Albans and Hemel Hempstead sites. Staff felt that this had improved the ability to concentrate on the service and plan
Managers had implemented an agenda for change which aligned staff working hours with the Urgent Care Centre at Hemel Hempstead Hospital. Staff working hours changed from 9am to 8:30pm to 8:30am to 9pm. The purpose was to increase resilience and move towards a more flexible workforce which more closely aligned and worked across both hospitals. These changes were implemented in February 2020.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had developed a strategy for emergency medicine which included the MIU which set out the trust’s priorities for performance, workforce, quality and environment. The strategy included delivering 95% four-hour performance, encouraging innovation and learning, identifying, investigating and learning from adverse incidents and providing a fit for purpose, clean and safe environment. The strategy identified four local priorities which were excellent high-quality care 24/7, streaming to the right pathway, rapid initial assessment and supporting and developing the workforce. The service’s vision was the same as the trust: “The very best care for every patient, every day”. Managers referred to a visual representation of the strategy displayed in the department which showed the progress made and future plans. The trust’s values were displayed in the MIU as Care, Quality, Commitment. The mission was “Right place, right care, first time, every time”.

Staff we spoke with described how the vision and values related to them, their role and how they cared for patients. Staff told us they had good relationships with the leadership team, and they were able to approach them should they need to. Staff were encouraged to develop and progress within the trust and they felt appreciated for carrying out their role.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with told us they enjoyed working on the MIU and there were opportunities to develop and progress. We saw improvements in morale since our last inspection and staff told us they enjoyed their work. Changes made by the management team were viewed favourably by nursing staff and they acknowledged improvements had been required. We were told that nurses working in other emergency departments at the trust now wanted to be seconded to the MIU or work there as part of bank cover.

Staff rotated through the minor injuries unit and the ED at Watford general Hospital, enabling them to maintain skills and competence and build professional relationships. Staff said this
helped them feel included.

Staff described the trust as having an open culture and any concerns could be escalated without fear or concern.

**Governance**

*Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, there was not a robust audit programme in place.*

The trust had reviewed and implemented new governance processes for the MIU service. Managers from the Urgent Care Centre at Hemel Hempstead and the MIU worked more closely together, including attending joint governance meetings. These were attended by the trust clinical lead, lead nurse and managers ensuring oversight of the whole trusts emergency services.

Information requiring escalation from the joint governance meetings was discussed at the divisional governance meetings and then escalated to board level. Information was also disseminated from the board to divisional and local leaders and teams. Staff we spoke with told us the channels of communication had been improved and information was flowing effectively from board to local levels.

Managers and lead staff attended the Quality and Safety Group and Emergency Medicine meetings to ensure all governance levels shared information and interacted effectively with each other.

Staff in the MIU attended daily huddles where information was discussed, and staff were involved and updated about relevant decisions. Staff acknowledged there had been improvements within the culture of the organisation and people now worked more closely together.

Although MIU staff had completed or participated in several audits, there was not a robust audit plan in place. Audits were limited to minimal topics such as initial assessments and oversight compliance. Staff were in the process of promoting other audit topics and had completed a head injury proforma audit in November 2019 and were planning to complete a patient records audit, however, this was not in place at the time of inspection. Managers we spoke with told us the initial assessment audit would be repeated three monthly and a quality of patient records audit was planned for April.

**Management of risk, issues and performance**

*Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.*

Leaders understood risks and had identified the top three risks to the unit. These were discussed at the Quality and Safety group and the Trust Board meetings. We looked at the risk register for the MIU which identified three main risks and the date the risks should be reviewed. We saw
leaders had responded to the risks with a range of measures put in place or mitigations. The first risk referred to security and that the MIU was unable to lockdown. In response, the trust had installed a glass screen in reception after an incident in which a receptionist had been assaulted. As a result, privacy for patients booking into the reception area was more difficult to achieve. Managers told us they were reviewing the current arrangements and considering making changes which would retain staff safety levels but improve patient confidentiality.

Other measures put in place to improve security included alarms and doors that closed and locked should the unit need to go into lockdown. Other risks identified were insufficient paediatric trained enhanced nurse practitioners (ENPs) and no clear pathway for mental health patients. Managers we spoke with told us the former risk was mitigated by staff completing additional training and working regularly in children's' emergency care, until paediatric trained ENPs could be recruited.

Staff we spoke with were aware of the risks identified in the risk register and they identified the same three risks. Risks were discussed at team meetings and daily huddles.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Managers used electronic systems to monitor and analyse data about performance. We saw managers and some staff were able to view real time data for patient waiting times, time to initial assessment, time to treatment and discharge. Data analysis which managers had completed showed initial assessments completed outside of fifteen minutes were taking place more frequently at weekends which related to lower staffing levels at this time. Managers used this data to plan service improvements and minimise risk.

Information about the MIU's performance was displayed in the reception area and in staff only areas. Staff provided data to external organisations and used the information to make improvements. Staff accessed policies and procedures electronically using the trust’s intranet.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff, and the public.**

Staff we spoke with told us leaders were accessible and they spent time on the unit interacting with staff. Since the lead nurse started in post, the unit had introduced huddles to ensure staff felt supported and included in trust activity. The team had started a social media group to help them stay in touch and improve communication.

Staff we spoke with told us they enjoyed working at the MIU and they felt their feedback contributed to the development of the service. Recent improvements made and a change in leadership had increased staff engagement and morale.
Patient comments about the MIU were actively sought with the Friends and Family test and acted upon whenever practicable. Staff photocopied patient feedback before it was collated centrally and displayed this in the waiting area.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The service has participated in improvement projects including a rescue pack for sepsis patients. Leaders were planning to upskill emergency nurse practitioners to care for patients with minor illnesses.

The lead emergency nurse practitioner had made numerous changes and improvements since joining the service and had implemented a new way of working which included shift changes. All staff were now required to work a continuous shift from 8:30am to 9pm to enable them to complete checks at the start and end of shift. Managers we spoke with told us staff were fully engaged with improvements made and there had been a shift to empower staff. Staff were communicating more with each other which was leading to patients receiving the treatment they required sooner which resulted in fewer breaches.

Staff were given dedicated time to focus on service improvements by spending a day in each of the following: resus, the emergency department and in children’s emergency care. There were systems to support and recognise staff achievements called a ‘Time to Shine’

We saw there was no formal audit programme although some audits had been carried out. An audit for waiting and assessment time showed the MIU achieved 99% performance for the four-hour target and 98% for triage within 15 minutes. Staff were encouraged to take on improvement work such as audits and one member of staff had completed a head injury audit. However, the service was not able to make improvements to patient outcomes as it had not adequately assessed the quality of the service it provided.
Evidence appendix
Hemel Hempstead General Hospital
Hillfield Road
Hemel Hempstead
Hp2 4AD
Tel: 01442 213141
www.westhertshospitals.nhs.uk

Date of inspection visit: 11 to 12 March 2020
Date of publication: 17 June 2020

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.

Acute services

Hemel Hempstead Hospital
Hillfield Road
Hemel Hempstead
HP2 4AD
Tel: 01442 213141
www.westhertshospitals.nhs.uk

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

Hemel Hempstead Urgent care centre is part of the emergency services provided by West Hertfordshire Hospitals NHS Trust. There are three emergency care providers which include:

• Watford General Hospital: Emergency department, including the children’s emergency department
• St Albans City Hospital: Minor injuries unit
• Hemel Hempstead Hospital: Urgent care centre

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

Urgent and emergency care service is delivered across all three of their sites:

• The emergency department is located at Watford General Hospital. This has a nine bedded resus department which accepts both trauma and stroke patients; an eight bedded (plus chairs) clinical decision unit; a minors area run by dedicated emergency nurse practitioners (ENPs), including triage by a registered nurse; a five space senior team rapid assessment and treatment (STARR) area (plus chairs); a 22 bedded majors area; plus, a mental health room and chair area.
• The trust’s children’s emergency department is adjacent to their adult emergency department. This has a dedicated paediatric resuscitation area and paediatric assessment unit. The
service benefits from both paediatric ENPs and emergency paediatricians.

- At Hemel Hempstead Hospital, the trust has an urgent treatment centre which is supported by both GPs and ENPs. It runs from 8am to 10pm seven days a week, offering radiology services during these times. The department has ten treatment/assessment rooms which are used to triage, assess and treat patients. There is one GP consultation room and additional services such as a plaster room, clinical treatment room and x-ray facilities.

- At St Albans City Hospital, the trust has an ENP-led minor injuries unit which runs from 9am to 8pm seven days a week, offering radiology services during these times.

(Source: Acute Routine Provider Information Request (RPIR) – Acute context tab)

Activity and patient throughput

From September 2018 to August 2019 there were 157,177 attendances at the trust's urgent and emergency care services as indicated in the chart below.

**Total number of urgent and emergency care attendances at West Hertfordshire Hospitals NHS Trust compared to all acute trusts in England, September 2018 to August 2019**

(Source: Hospital Episode Statistics)

**Urgent and emergency care attendances resulting in an admission**

The percentage of accident and emergency (A&E) attendances at this trust that resulted in an admission remained similar in 2018/19, compared to the previous year, 2017/18. In both years, the proportions were higher than the England averages.
Urgent and emergency care attendances by disposal method, from September 2018 to August 2019

Admitted to hospital 31,776
Discharged* 96,603
Referred^ 14,494
Transferred to other provider 3,604
Died in department 108
Left department# 7,130
Other 7,130
Not known 3,462

* 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)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

Mandatory training completion rates

Nursing staff received and kept up-to-date with their mandatory training. Service data showed that nursing staff were compliant in 14 out of 16 topics. The compliance for adult basic life support was just below the trust target at 87.4%, whilst fire safety training was 75.8%. The trust set a target of 90% for the completion of mandatory training.

Trust level

Some nursing staff worked across all sites, and therefore trust wide training information is included in the Hemel Hempstead report. Medical staff were not part of the trust and therefore there is no data for medical staff within this report.

A breakdown of compliance for mandatory training courses from April to October 2019 for qualified nursing staff in urgent and emergency care at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Manual handling (non-patient)</td>
<td>1</td>
</tr>
<tr>
<td>Infection control (non-clinical)</td>
<td>1</td>
</tr>
<tr>
<td>Basic health, safety and risk</td>
<td>154</td>
</tr>
<tr>
<td>Fire safety (non-clinical)</td>
<td>1</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>153</td>
</tr>
<tr>
<td>Learning disability (TEACH) (essential)</td>
<td>151</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>151</td>
</tr>
<tr>
<td>Infection control (clinical)</td>
<td>149</td>
</tr>
<tr>
<td>Blood handling (essential)</td>
<td>130</td>
</tr>
<tr>
<td>Venous thromboembolism prevention (essential)</td>
<td>145</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>147</td>
</tr>
<tr>
<td>Information governance</td>
<td>142</td>
</tr>
<tr>
<td>Manual handling (patient contact - level 2)</td>
<td>141</td>
</tr>
<tr>
<td>End of life care (essential)</td>
<td>110</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>132</td>
</tr>
<tr>
<td>Fire safety and evacuation (clinical)</td>
<td>116</td>
</tr>
</tbody>
</table>

In urgent and emergency care at trust level, the 90% target was met for 14 of the 16 mandatory training modules for which qualified nursing staff were eligible.

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

Hemel Hempstead Hospital
Nursing staff received and kept up-to-date with their mandatory training. Training compliance for nursing staff was like the trust wide picture with most topics over 90% compliant. Fire safety and adult basic life support training compliance was almost at the 90% target (87.5%).

A breakdown of compliance for mandatory training courses from April to October 2019 for qualified nursing staff in urgent and emergency care at Hemel Hempstead Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
<th></th>
<th>Completion</th>
<th>Trust</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual handling (patient contact - level 2)</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control (clinical)</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>End of life care (essential)</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic health, safety and risk</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disability (TEACH) (essential)</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood handling (essential)</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism prevention (essential)</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety and evacuation (clinical)</td>
<td>14</td>
<td>16</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>14</td>
<td>16</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care at Hemel Hempstead Hospital, the 90% target was met for 11 of the 13 mandatory training modules for which qualified nursing staff were eligible.

Please note that the urgent care centre at Hemel Hempstead is a nurse-led unit, with medical cover provided by local GPs. Therefore, no medical staff analysis has been provided.

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

The mandatory training was comprehensive and met the needs of patients and staff. Training was varied and provided staff with basic skills in all relevant areas. Staff told us that training was usually completed online or in person depending on the type of skill being taught. For example, basic life support and manual handling were completed in person, whereas conflict resolution was completed on line.

Managers monitored mandatory training and alerted staff when they needed to update their training. Any expiry dates were flagged and then training was planned into the individuals off duty.

Clinical staff did not receive training on recognising and responding to patients with mental health needs. Administration staff who worked at the reception received training on managing aggressive patients.

The service managed walk in patients which included children. Staff were trained in paediatric life support and emergency nurse practitioners were trained in advance paediatric life support, which was in line with the Standards for Children in Emergency Care settings.
There was a trust-wide sepsis pathway which was used for all patients who were suspected of having sepsis. There was a sticker to be inserted into the notes of patients who were identified as potentially having sepsis. Sepsis training was part of the mandatory training for all staff.

**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.

**Safeguarding training completion rate**

Nursing staff received training specific for their role on how to recognise and report abuse. Trust data showed that safeguarding training for nursing staff was largely compliant with the trust targets. Although Safeguarding children level 3 and Prevent training was slightly below target. The trust set a target of 90% for the completion of safeguarding training.

The tables below include Prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

**Trust level**

A breakdown of compliance for safeguarding training courses from April to October 2019 for qualified nursing staff in urgent and emergency care at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>1</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>1</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>47</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>148</td>
</tr>
<tr>
<td>PREVENT WRAP</td>
<td>135</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>85</td>
</tr>
</tbody>
</table>

In urgent and emergency care at trust level, the 90% target was met for four of the six safeguarding training modules for which qualified nursing staff were eligible.

Please note that the urgent care centre at Hemel Hempstead and the minor injury unit at St Albans City Hospital are both nurse-led units (with medical cover provided in the urgent care centre by local GPs).

**Hemel Hempstead Hospital**

Nursing staff received training specific for their role on how to recognise and report abuse. Staff completed training when they commenced in post and updated regularly as per hospital guidance.

A breakdown of compliance for safeguarding training courses from April to October 2019 for qualified nursing staff in urgent and emergency care at Hemel Hempstead Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Month Year to Month Year</th>
</tr>
</thead>
</table>

20190416 900885 Post-inspection Evidence appendix template v4
In urgent and emergency care at Hemel Hempstead Hospital, the 90% target was met for all four safeguarding training modules for which qualified nursing staff were eligible.

Staff were aware of their roles and responsibilities in the protection of children and adults at risk of abuse or neglect. Staff were aware of the trust policies and procedures and could access them on the hospital intranet if they required clarification.

There were processes and practices in place to protect patients from abuse. Staff were able to make referrals regarding safeguarding concerns using electronic referral forms. These were shared with the local authority and reviewed to identify any actions. Staff also escalated internally if there were any concerns about an individual’s safety, seeking support from specialists or the safeguarding team. Staff said that if they had any concerns, they would discuss them directly with the nurse in charge or ward manager.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We were given examples of when staff had escalated concerns to the safeguarding team.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were aware of different types of abuse and felt confident in making decisions about a patient’s risk. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could access the safeguarding team based at Watford General Hospital for advice or support if necessary.

Staff followed safe procedures for children visiting the ward. Children were not left unaccompanied. Children presenting with an injury were assessed using a screening tool to identify if there was a risk of physical abuse. There was a children’s waiting area with CCTV and all visitors with children were advised to wait in this area.

Staff were aware of female genital mutilation (FGM) and reported that FGM was covered in training modules.

All staff had data barring service checks completed prior to commencing in post. These were repeated every three years.

### Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

There were processes and practices in place to ensure that infection control and prevention practices were well maintained. Staff were aware of their responsibilities for ensuring cleanliness and for managing potential infections. Patients were seen in treatment rooms which were cleaned between uses. Any patient identified as having a communicable infection were seen in a separate treatment room which was deep cleaned after the patient had been discharged.
All clinical areas were clean and had suitable furnishings which were clean and well-maintained. There was a cleaning schedule in place for the environment and clinical rooms and nursing staff were responsible for cleaning any clinical waste or equipment.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning was provided by an external contractor and was completed a minimum of twice daily.

Staff followed infection control principles including the use of personal protective equipment (PPE). Gloves and aprons were easily accessible for staff to wear for all clinical contacts.

We also saw that the trust was prepared for the potential outbreak of communicable infections. A room had been designated to be accessed externally for people who were seeking advice for Covid-19 (corona virus). The clinical team managed this room although they did not provide direct care for any patients attending the service. Patients could access NHS 111 from the room, who then completed telephone screening and directed the patient to the best course of action. If a patient became unwell in the screening room, staff could gain access from an internal corridor and had access to biohazard clothing and masks for protection. The screening room was cleaned regularly and between patients. Staff were familiar with what actions to take in the event of a positive screening and knew how to prevent the risks of cross contamination. Patients who were unwell were signposted to a designated hospital or were collected by an ambulance arranged by NHS 111.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment was labelled with ‘I am clean’ stickers or recorded as being cleaned on the daily cleaning checklist.

Staff completed monthly hand hygiene and cleanliness audits. We saw that the results were displayed, and data showed that staff were 100% compliant with hand hygiene.

Patients did not routinely have internal devices inserted during their visit to the department, however, if a patient was unwell and required transferring to Watford General Hospital a device would be inserted and this would be recorded on a trust wide form, which gave details of the date and site of device, which enabled staff to monitor for signs of infection.

**Environment and equipment**

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

The department was situated in the main building of the hospital, however, we found that this was not clearly signposted. The entrance to the urgent care unit was shared with other services, and there was no clear signage showing that the reception desk was for the urgent care centre only. During the inspection, we saw multiple patients using the reception desk for general enquiries.

The service consisted of a waiting area and reception. There was a small children’s waiting area which had been recently refurbished. The children’s waiting room was adjacent to and adjoining the main waiting area with no secure door. The area had CCTV for security which was viewed at the reception desk. Behind a secure door was a series of treatment rooms and store rooms off a large quadrant. This ran parallel to a corridor with offices and the x-ray department, and another corridor where patients could attend other services or access the rest of the hospital. We were concerned that the department was not secure, and patients could access the department from other areas of the hospital. We were told that the doors were secured out of hours and therefore access was restricted. During working hours, staff felt that there were enough staff to prevent any unauthorised access to equipment or patient records.
There were two triage rooms, one GP clinic room, four consulting rooms and two treatment rooms. Staff told us that they were looking to introduce a third triage room, in the next few months. There was one resuscitation room which could be used for unwell patients who required monitoring. There was a plaster room which was used for managing plaster casts and infected wounds. This area was clean and well equipped. One room was identified as the isolation room which was used for patients who had suspected infectious conditions. There was a supply of personal protective equipment which could be placed outside the room when it was in use.

Each clinic room had a call bell, although patients were not routinely left in a room unaccompanied. Staff told us that staff responded quickly when called.

There was a room which was identified as being suitable for patients with mental health concerns or those at risk of self-harm. Patients attending who required supervision were always accompanied by a member of staff to ensure their safety.

The design of the environment followed national guidance. There was enough space for treatment, handwashing sinks were available, and rooms were suitably furnished.

Staff carried out daily safety checks of specialist equipment. We saw that resuscitation equipment was checked daily. Resuscitation equipment was available for children and adults. We saw that all single-use equipment was in date.

The service had suitable facilities to meet the needs of patient’s families. Waiting areas were sufficiently sized to accommodate families and treatment areas were large enough to accommodate at least one patient escort.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely. Waste was segregated according to type and clearly labelled and stored whilst waiting for removal.

The service had access to an x-ray department located adjacent to the department. This was open 8am to 10pm and could complete a full range of imaging.

**Assessing and responding to patient risk**

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and acted upon patients at risk of deterioration. However, it was not clear how site-specific triage times were recorded. National Early warning scores were not always recorded for every admission.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. On arrival to the department, patients registered at the reception desk and then waited to be called through for triage. Patients could be prioritised depending on their complaint. We saw that staff prioritised children and any patients who complained of potential life-threatening conditions.

Trust data for triage times was reported across all sites and not as individual sites. This meant that there was a risk that triage times at a specific site did not meet national targets. Service leads told us that they had oversight of performance at each site relating to meeting triage times. This enabled them to identify where additional support was required. Hemel Hempstead was reported as consistently performing above expectations. However, we saw that time to triage varied depending on levels of activity.
The service used a computer-based appointments system to slot patients in after staff triaged them. Staff could see on the system when a patient had arrived at the service, and what time they had been triaged. However, the system did not provide a reliable method for tracking the waiting times for patients after triage. Managers used a time-intensive method to review times to triage for patients, by cross-checking records. During our inspection, there was a period of about one hour when activity was high, and triage was delayed greater than the 15 minutes target. Time was recorded by staff as being 40 minutes. The following day, we observed activity and saw that triage time was less than 15 minutes.

We reviewed patient flow logs and triage harm reviews for the 18 February 2020 and found that for four hours the triage time was longer than 15 minutes, with a maximum wait time of 40 minutes recorded between 7pm and 7.59pm. The service had an escalation plan in place for managing patients. The trigger for escalation was when more than 15 patients were waiting over two hours for treatment, but staff could escalate any concerns to the clinical leads. Staff told us that triage was completed within 15 minutes for over 95% of patients attending the department, and they were very proud of the performance.

Staff told us that they could not record triage times and had to complete a patient record review to capture data. However, clinical leads told us that this was not the case, and that triage times could be isolated electronically. We asked the trust to confirm how triage was recorded and what the average triage time was. However, the process of calculating triage times was not shared with us. The trust did supply us with data that showed some triage times which is below.

(It should be noted that the analysis below is based on a small sample of data for between 39 and 40 adults, and 20 children, each month. This should therefore be treated with caution. This data is not directly comparable to the trust-wide time to initial assessment data above, which relates to patients arriving at the trust's main emergency department by emergency ambulance.)

Data supplied by the trust showed that for September 2019 to January 2020, between 45% and 68% of adult patients were triaged within 15 minutes of arrival in the urgent treatment centre (57% overall over these five months). Between 23% and 35% of patients were triaged within 15 to 30 minutes of arrival (28% overall). The remaining 15% of patients were triaged after 30 minutes of arrival.

Over the same five-month period, for children attending the centre, between 60% and 80% were triaged within 15 minutes of arrival (68% overall). Between 10% and 30% were triaged within 15 to 30 minutes of arrival (average 19%). The remaining 13% were triaged after 30 minutes of arrival.

(Source: data request DR135)

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Patients' clinical observations were recorded on arrival along with a brief description of the compliant. Once this had been completed, patients were asked to return to the waiting room until a nurse was available to complete their assessment and treatment. The National Early Warning Score (NEWS) was calculated for each patient as part of this initial assessment. However, we reviewed ten sets of notes and found that the NEWS was not recorded in three records. NEWS is a point system that can be used to identify deterioration or the severity of a clinical condition.

Staff knew about and dealt with any specific risk issues. Any patients at risk were escalated to the nurse in charge.

We saw that high-risk patients were triaged upon arrival and action taken to ensure their safety. For example, we saw that one patient was admitted after sustaining a head injury. The nurse
triaged the patient immediately and took the patient to the resuscitation room. Observations were completed and the GP asked to attend. The patient was transferred to Watford General Hospital by ambulance 30 minutes later.

Staff received training on sepsis as part of their mandatory training. Staff were able to describe the types of assessments and triggers that would be used. Although during inspection, we did not see any patients admitted with sepsis and therefore did not see any patient records.

X-rays were reviewed by the emergency nurse practitioners (ENPs), emergency care practitioner (ECPs) at the time of the image being taken. A radiologist reviewed all images retrospectively and if there were any differences in diagnosis, the patient was contacted to attend for further investigations or a review. Any differences were fed back to the ENP/ ECP for learning.

Staff did not have specific training on assessing patients presenting with a mental health issue. There was no specific risk assessment in place, however, staff were able to refer to the mental health liaison team based at Watford General Hospital. Staff did not complete psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. However, if the nurse was concerned about a patient’s mental health, they were transferred to or advised to attend Watford General Hospital to be assessed by the specialist mental health team. GPs were able to refer to mental health teams for assessments and support.

Staff shared key information to keep patients safe when handing over their care to others. The service worked collaboratively with the GP based in the department. If necessary, the team would liaise directly with the GP for advice or refer patients to Watford General Hospital (WGH). We were told that patients referred to the GP or WGH would wait in the department for transport, unless they agreed to transfer themselves. Staff would check that patients arrived at WGH and contacted them directly if they did not attend within an agreed time scale. Patients would also receive a letter from the service prompting them to see their own GP if the problems persisted.

Shift changes and handovers included all necessary key information to keep patients safe. Staff worked a variety of shifts to ensure that the service was covered from 8am to 10pm. Handover was completed when staff arrived on duty and as they left.

Staff reported that security were responsive to any calls for assistance with difficult or aggressive patients. Security staff also completed regular walkabouts to monitor safety in all areas.

Staff completed daily safety huddles which looked at the activity and staffing levels along with any information that may be required for the day. We saw that staff captured information discussed at the huddle on a template which was saved in a file. These showed that staff discussed new procedures, equipment, staffing concerns and the previous day’s activity and risks.

Emergency Department Survey 2018 – Type 3 A&E departments

In relation to Type 3 A&E departments, the trust scored worse than other trusts for one of the five Emergency Department Survey questions relevant to safety, question 33. The trust scored about the same as other trusts for the remaining four questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at A&amp;E, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.7</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>5.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Q33. In your opinion, how clean was the A&E department? 7.9 Worse than other trusts
Q34. While you were in A&E, did you feel threatened by other patients or visitors? 9.4 About the same as other trusts

(Source: Emergency Department Survey 2018)

Emergency Department Survey 2018 – Type 3 A&E departments (urgent care centres, urgent treatment centres and minor injury units)

In relation to type 3 A&E departments, the trust scored about the same as other trusts for the four Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. How long did you wait before you first spoke to a health professional?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. Sometimes, people will first talk to a health professional and be examined later. From the time you arrived, how long did you wait before being examined?</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q30. In your opinion, how clean was the urgent care centre?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q31. While you were in the urgent care centre, did you feel threatened by other patients or visitors?</td>
<td>9.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 2018)

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Although staff at Hemel Hempstead predominantly worked at the same site, managers told us that staff could and did work across other sites if needed.

Trust level

The table below shows a summary of the nursing staffing metrics in urgent and emergency care at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Urgent and emergency care annual staffing metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2018 to October 2019</td>
</tr>
<tr>
<td>Staff group</td>
</tr>
<tr>
<td>Target</td>
</tr>
<tr>
<td>All staff</td>
</tr>
<tr>
<td>Qualified</td>
</tr>
</tbody>
</table>
Nurse staffing rates within urgent and emergency care at trust level were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and sickness.

Please note that the trust was unable to provide total hours including those covered by substantive staff to allow us to calculate bank and agency usage or unfilled hours for nursing staff as a percentage of the total hours available.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Vacancy rates

Monthly vacancy rates over the last 12 months for registered nurses showed an upward shift from May 2019 to October 2019.

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

Bank and agency staff usage

Hemel Hempstead Hospital

The service had enough nursing and support staff to keep patients safe. Staffing consisted of a lead nurse, emergency care practitioners, emergency nurse practitioners, staff nurses and healthcare assistants.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients. Staffing numbers matched requirements and in the event of a shortfall in cover, all attempts were made to cover with the units’ own staff or bank/ agency. Throughout our inspection, the number of nurses and healthcare assistants matched the planned numbers.

The table below shows a summary of the nursing staffing metrics in urgent and emergency care at Hemel Hempstead Hospital compared to the trust’s targets, where applicable:
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual agency hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>10%</td>
<td>13%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>28</td>
<td>19%</td>
<td>8%</td>
<td>3.0%</td>
<td>490</td>
<td>0</td>
<td>148</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>12</td>
<td>-5%</td>
<td>8%</td>
<td>2.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within urgent and emergency care at Hemel Hempstead Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and bank use. No agency use was reported over this time period.

Please note that the trust was unable to provide total hours including those covered by substantive staff to allow us to calculate bank usage or unfilled hours for nursing staff as a percentage of the total hours available.

The negative vacancy rate in the table above indicates that there were more nursing staff in post than planned.

**Vacancy rates**

The service had low reducing* vacancy rates for nursing staff.

![Vacancy rate - registered nurses](image)

Monthly vacancy rates over the last 12 months for registered nurses were not stable and may be subject to ongoing change. The service reported that there had been several changes in staffing since our last inspection, however, recruitment had been successful, and staff were in post.

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

**Turnover rates**

The service had a reducing turnover rate for nursing staff. Staff told us that they had successfully recruited staff to the department.
Sickness rates

The service had a reducing sickness rates for nursing staff ("Delete as applicable).

Bank and agency staff usage

The service had low rates of bank and agency nurses. Where possible the service used their own staff to fill in gaps, however this was not always possible, and bank or agency staff were used. The service had a number of staff on maternity leave, which meant that there was regularly the need for staff coverage. Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service. Staff were given a tour of the department and supported by substantive staff to complete activities. This process ensured that agency staff knew how to escalate and concerns.

Medical staffing

The service had enough medical staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels.

The service had enough medical staff to keep patients safe. Doctors working at Hemel Hempstead urgent care centre were not employed by West Hertfordshire Hospitals NHS Trust. The service was co-managed by a community trust who provided GPs to cover the services. Managers said they worked in partnership with the community provider to ensure the service was fully operational and met the expected standards.

Medical staff from Watford General Hospital provided the clinical oversight and leadership of the service.

Medical staffing rates within urgent and emergency care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and locum usage.

The Urgent Care Centre at Hemel Hempstead and the Minor Injury Unit at St Albans City Hospital are both nurse-led units (with medical cover provided in the Urgent Care Centre by local GPs). Therefore, the medical staff training data in the table above relates to staff located at Watford General Hospital.

A community provider managed GP staffing. Nursing staff told us that there were occasionally gaps within the service, however, this did not happen frequently. The impact of this was that patients who were booked for GP appointments either waited longer to be seen by the next GP.
or were seen by the nursing team. The same GPs tended to work within the service which enabled continuity of care and facilitated good multidisciplinary working as staff knew each other, their roles and responsibilities. Nursing staff reported that GPs were helpful.

The service was covered by one GP from 8am to 10pm, although an additional GP was available from 11am to 6pm to assist with peak activity. GPs assisted with the management of patients with pre-planned appointments and those who walked in with minor illnesses.

**Records**

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

Patient notes were comprehensive, and all staff could access them easily. Notes were clearly written and detailed patients past medical history, reason for visiting and details of any advice or treatment provided. Patients records were predominantly held electronically.

Staff reported that they worked on a separate IT system to the other urgent and emergency departments in the trust. This meant that staff could not scan the patient’s assessment document onto the live system and therefore some information needed to be added manually. This meant that additional time was required to upload information into the system.

We saw that the IT system did not have a mandatory field for the recording of time of triage, and therefore it was free text. This meant that it was sometimes forgotten. This resulted in the treatment priority not being displayed on the screen, which meant that staff could not always prioritise the order in which patients were seen.

There were mandatory fields in other areas of the electronic patient record. For example, pain scores were required to be completed, and there were prompts for children under 16 years old, relating to safeguarding.

The electronic patient record also enabled special notes to be added, for example, any aggression to staff, a diagnosis of learning disability or dementia. This enabled staff to complete assessments safely, for example, triage could be completed by a nurse and a health care assistant if there were concerns about a patient’s behaviour.

Staff gained consent from patients to share their notes with the GP. This was an automatic process. When patients transferred to a new team, there were no delays in staff accessing their records. Details of any treatments or care were shared with the receiving practitioner ensuring that there was a clear account of what had been done to manage the patient. For example, if a patient required transfer to Watford General Hospital, staff ensured that they completed a transfer checklist detailing what medication and treatment had been given, this prevented medicines or treatments being repeated.

Records were stored securely. Any paper records were held securely and were not left unattended. Computers were locked when not in use to prevent unauthorised access and all computers were password protected.

**Medicines**

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and
Staff reviewed patients’ medicines and provided specific advice to patients and carers about their medicines. Patients were asked about any medicines they were taking as part of the nursing assessment. This enabled staff to identify what treatment could be given. For example, if a patient was in pain and reported that they had already taken paracetamol, a different analgesia could be administered.

Staff were able to prescribe several medicines and give the patient a supply of the tablets to take home. These were stored securely with a log of all medicines being given to patients.

GPs were able to print prescriptions for patients which meant that there was a record of the medicines prescribed and details of the prescriber recorded within the patient’s records. GPs also provided prescriptions for patients attending the deep vein thrombosis clinic (DVT) clinic who required ongoing treatment.

Controlled medicines, which are those medicines which are subject to additional checks to ensure they are not misused, were stored correctly. We saw that two nurses completed checks when these were prescribed and that regularly pharmacy audits were completed to monitor stock levels and adherence to policy.

Staff reported that they did not use patient group directives (PGDs) for the administration of medicines. PGDs are prescriptions for a predetermined group of patients, which enables nursing staff to administer medicines without a prescription. Triage staff reported that if a patient reported pain during the initial triage, they would contact the emergency nurse practitioner or GP and obtain a prescription. The team were working on completing a PGD for paracetamol.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. However, not all staff were familiar with the process. We were told that the lead nurse would receive communication from either the pharmacy department or from senior managers and this would be passed onto staff at ward meetings and handovers. However, when we asked staff about the process for keeping informed, not all staff were able to describe any updates.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff were aware of their roles and responsibilities for reporting incidents internally and externally. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Incident reporting was completed using an electronic system. This process flagged any incident to the lead nurse, and the managers, along with the governance team. This enabled all staff to have immediate oversight of incidents as they occurred.

Managers investigated incidents, and information gathered was fed back to staff during handovers or huddles. Huddle notes detailed information about incidents that had occurred, and any actions taken to prevent reoccurrence.
Staff received feedback from investigation of incidents. Information gathered in response to an incident was shared locally at the huddle and in team meetings. Huddle records showed that incidents from the previous day were discussed to promote awareness.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. Huddle and team meeting minutes showed that staff discussed how they could help reduce incidents, for example, by changes to shift patterns to increase the number of staff available when the service closed at night. Staff also discussed any changes to the trust wide service in response to either incidents, complaints or changes in guidance.

Where appropriate staff told us that they would include patients and their families in investigations. However, the service had not had a serious incident which required a full investigation. Managers reported that there was a process in place to support staff in the event of a serious incident.

Staff completed an incident form for any patient who was referred from the service to the emergency department at Watford General Hospital. This enabled the service to have oversight of the number of transfers.

**Never events**

The service reported no never events during the reporting period.

**Trust level**

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 January to December 2019, the trust reported no never events for urgent and emergency care at trust level.

*(Source: Strategic Executive Information System (STEIS))*

Managers shared learning with their staff about never events that happened elsewhere. This included newsletters and shared learning events.

**Hemel Hempstead Hospital**

In accordance with the Serious Incident Framework 2015, the trust did not report any serious incident (SIs) in urgent and emergency care at Hemel Hempstead Hospital which met the reporting criteria set by NHS England from January to December 2019.

*(Source: Strategic Executive Information System (STEIS))*

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. Nursing staff told us that although they had not had any serious events they would always apologise to patients if something went wrong.

**Safety thermometer**
The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff and visitors.

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.

The safety thermometer data showed the service achieved harm free care within the reporting period.

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 November 2018 to November 2019 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients’ subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We saw several standard operating procedures, which were all in date and had clear review dates. Policies were accessible on the trust intranet and those reviewed were found to be in date and reflected national and professional guidance.

There was no clear system in place to keep staff informed of updates in national guidance. Staff were not aware of guidance published in 2019 relating to the treatment of children with high temperatures (pyrexia) and the treatment of head injuries.

Some information leaflets were not in line with NICE guidance. For example, the adult head injury leaflet did not refer to patients who had sustained a head injury being observed by a responsible adult for 24 hours after discharge. Staff were also unaware of the intercollegiate guidelines for the assessment and management of children within the emergency setting.

The service had completed several audits over the last year and we saw that this included, pain management in children, correct completion of a head injury proforma, time to triage and treatment of burns. Some data was displayed on the walls and we were told that audit results were peer reviewed and discussed at the clinical governance meetings.

Additional audits included a review of unplanned attendances which showed that most patients were those who had been advised to return to a GP for dressings.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Patients presenting with mental health illnesses were referred
to Watford General Hospital for an assessment by the mental health team.

Staff ensured that patients were not discriminated on the grounds of their protected characteristics. Decisions for care and treatments were based on the patient’s presenting condition.

**Nutrition and hydration**

**Due to the type of service staff did not provide patients with nutrition or oral hydration.**

Staff made sure patients with specialist hydration needs received appropriate fluids. For example, intravenous fluids (IV) were commenced if necessary whilst waiting to transfer a patient to Watford General Hospital as an emergency.

Staff fully and accurately completed patients’ fluid charts where needed. When IV fluids were commenced, these were clearly recorded on charts.

Patients had access to water in the waiting room, and there were vending machines that offered snacks and drinks.

**Emergency Department Survey 2018 – Type 3 A&E departments**

In the CQC Emergency Department Survey, the trust scored 7.0 for the question “Were you able to get suitable food or drinks when you were in A&E?”. This was about the same as other trusts.

(Source: Emergency Department Survey 2018)

**Emergency Department Survey 2018 – Type 3 A&E departments**

In the CQC Emergency Department Survey, the trust scored 6.4 for the question “Were you able to get suitable food or drinks when you were at the urgent care centre?”. This was about the same as other trusts.

(Source: Emergency Department Survey 2018)

**Pain relief**

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

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain scores were usually recorded as part of the triage process, although we saw some exceptions to this. Of the ten records reviewed, four omitted a pain score, despite the presenting complaint including pain. Records clearly identified that pain relief was administered. Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately. Medicines for pain control were clearly recorded on the patient’s records.

**Emergency Department Survey 2018 – Type 3 A&E departments**

In the CQC Emergency Department Survey, the trust scored 7.0 for the question “Do you think
the hospital staff did everything they could to help control your pain?”. This was about the same as other trusts.

(Source: Emergency Department Survey 2018)

Emergency Department Survey 2018 – Type 3 A&E departments

In the CQC Emergency Department Survey, the trust scored 6.6 for the question “Do you think the hospital staff did everything they could to help control your pain?”. This was about the same as other trusts.

(Source: Emergency Department Survey 2018)

Pictorial charts were used for patients who could not communicate and children. These enabled staff to gauge the level of pain and the effects of any medicines given.

If a patient was asked to wait in the waiting area after being triaged, they were told to inform staff if pain worsened. Reception staff had oversight of the waiting area, and nursing staff attended the area regularly between patients, which meant that any patient who deteriorated could be identified.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant clinical audits. There were several trust wide audits which included infection control and prevention audits such as handwashing compliance, and service-led audits such as compliance with triage times.

Performance was monitored and tracked by clinical leads and reported to the executive team at directorate and divisional meetings. Urgent and emergency care performance was also reported nationally. The service did not complete any site-specific audits. Details of performance data can be found in the Watford General Hospital Emergency Department report.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Most patients were seen, treated and discharged within the expected timescale of four hours. Any exceptions were escalated to the management team and reported as an incident for local investigation. Staff told us that patients awaiting transfer to another location often remained on site longer than planned and these were always escalated as exceptions.

Managers and staff used audit results to improve patient outcomes. Data was reviewed by managers at all levels and information used to identify areas of poor and good performance. If poor performance was noted, staff took steps to address the concerns, however this was not always possible due to the nature of the department and having limited control over attendances.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. All hospital audits were completed as per trust audit calendar. These were reviewed as part of trust wide performance dashboards and compared to national data.

Unplanned re-attendance rate within seven days

Data for the all the trusts emergency departments was reported and combined if necessary, to give overall trust figures. The service had a lower than expected risk of re-attendance than the England average.
From November 2018 to October 2019, the trust’s unplanned re-attendance rate to A&E within seven days was consistently higher than the national standard of 5% and the England average.

In the most recent month, October 2019, the trust’s performance was 11.0% compared to an England average of 8.3%.

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

![Graph showing the comparison of this trust's unplanned re-attendance rate within seven days to England average and standard](image)

*(Source: NHS Digital – A&E quality indicators)*

**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 development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff working within the unit were trained in specialist skills to enable them to complete their roles. In addition to emergency nurse and care practitioners, there were healthcare assistants and nursing staff who gained additional skills to meet demands. For example, nurses also managed the deep vein thrombosis clinic held within the department. This role involved additional skills in assessing patient. Skills were largely competency based and these were signed off by competent practitioners.

Staff completed competencies in line with their roles. This included competencies in managing the sick child. We spoke with a children’s nurse who rotated through the children’s emergency department at Watford General Hospital and the urgent care centre to promote competency in a variety of skills. This process meant that there was always a children’s nurse available. Other staff said that they could work across sites if necessary, to gain experience in different types of emergency care.

Managers gave all new staff a full induction tailored to their role before they started work. There was a clear process for commencing in the service. Staff were expected to complete an orientation programme and worked closely with the lead nurse until they felt confident and were assessed as being competent.

Healthcare assistants reported that training was detailed, and staff supported them in their roles explaining aspects as necessary or when requested. Managers made sure staff received any specialist training for their role. Staff were largely positive about the opportunities they had to develop.

There was clear guidance for the skills and training required to be completed by GPs working within the department. GPs were expected to complete mandatory training in all topics including
safeguarding adults and children (levels 2 and 3), sepsis training, and basic life support. The agreement between providers also stated that GPs needed to have enough training to manage minor injuries and illnesses including fractures, pneumothorax (collapsed lung), head injuries, acute abdomens as well as emergency skills.

Emergency nurse practitioners, emergency care practitioners and children’s nurses were trained in appropriate paediatric or adults intermediate of advanced life support skills. This ensured that there was suitably trained staff available in the event of an emergency.

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The lead nurse completed all staff appraisals and encouraged them to identify areas for learning. Staff reported that appraisals were completed regularly and were effective. Staff said there had been a focus on team development and staff were getting involved with topics that interested them and shared their knowledge.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Where possible, training was completed in work time, however, staff reported that they could access training in their own time and claim back any hours spent.

**Trust level**

As of October 2019, 92.8% of staff within urgent and emergency care department at the trust received an appraisal compared to a trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>As of October, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>1</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>1</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>37</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>38</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>3</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>128</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>37</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>245</strong></td>
</tr>
</tbody>
</table>

Medical and dental and registered nursing staff in urgent and emergency care services both met the 90% target.

Please note that the Urgent Care Centre at Hemel Hempstead and the Minor Injury Unit at St Albans City Hospital are both nurse-led units (with medical cover provided in the Urgent Care Centre by local GPs). Therefore, the medical staff appraisal data in the table above relates to staff located at Watford General Hospital.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)
Hemel Hempstead Hospital

As of October 2019, 100% of staff within urgent and emergency care department at Hemel Hempstead received an appraisal compared to a trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>As of October, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received</td>
</tr>
<tr>
<td></td>
<td>Eligible staff</td>
</tr>
<tr>
<td></td>
<td>Completion rate</td>
</tr>
<tr>
<td></td>
<td>Trust target</td>
</tr>
<tr>
<td></td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Add prof scientific and technic</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

All staff groups in urgent and emergency care at Hemel Hempstead Hospital met the appraisal completion target.

Please note that the urgent care centre at Hemel Hempstead is a nurse-led unit, with medical cover provided by local GPs. Therefore, no medical staff analysis has been provided.

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

The division’s clinical lead supported the learning and development needs of staff. Regular training sessions were held with the clinical lead to support staff in their roles. All staff were able to access this training.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Minutes were shared in paper format and via email.

Managers identified poor staff performance promptly and supported staff to improve. When necessary staff worked alongside a buddy to support learning.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Due to the type of service provided, staff did not hold regular and effective multidisciplinary meetings to discuss patients and improve their care. However, they met to hand over and discuss patients’ treatments at the time of need.

Staff worked across health care disciplines and with other agencies when required to care for patients. The team worked collaboratively with the GPs who worked alongside the team in the unit. There was evidence of clear roles and responsibilities and staff engaged with each other openly. Teams were respectful of each other. Patients attending for pre-planned appointments were seen by nursing staff if there was a delay in appointments. This process ensured that patients were seen by a qualified practitioner and could be escalated in an emergency. Nursing staff would inform GP of any clinical assessments or treatments completed.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Any patient who was identified as requiring mental health support was escalated...
appropriately to Watford General Hospital or the patients GP for follow up care.

Some staff reported that some GPs “disliked” seeing certain types of patients which resulted in them waiting longer to be seen. An example of this, was a child who attended a pre-planned appointment arranged by NHS 111, who waited two hours to be seen. Staff reported that this had been escalated to the urgent care liaison officer, however there had been no improvement. Staff reported that this made them anxious and created additional stress and pressure.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

The service was open from 8am to 10pm daily. As staff were largely unable to determine the numbers of attendees at any one point, staff reported that they regularly closed later than 10pm to ensure that all patients were seen. Protocol stated that patients arriving in the department up to 10pm would be treated. Staff did not routinely record when they closed later than 10pm, so we are unable to determine the frequency.

Staff could call for support from doctors and other disciplines, including diagnostics, 24 hours a day, seven days a week. Diagnostic imaging mirrored the opening times of the urgent care centre which enabled patients to receive investigations in a timely manner.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support on the unit. Staff could refer patients to smoking cessation teams or dieticians if necessary, although staff reported that this rarely happened. Staff largely referred patients to their GPs for additional health promotion.

Staff did provide information regarding clinical conditions. Information leaflets were available for a wide range of common illnesses.

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

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff asking patients permission to complete clinical examinations and tests. Consent was also recorded in patients notes. When patients could not give consent, staff made decisions in their best interest, considering patients’ wishes, culture and traditions. For example, staff told us about a patient who had been unresponsive because of their injuries, and they treated the patient in their best interest.

Staff made sure patients consented to treatment based on all the information available. Patients were kept informed of what treatment was required and what it would involve. Staff gave patients information leaflets when possible to help them make informed decisions about their care and treatment. Staff clearly recorded consent in the patients’ records.
Staff understood Gillick Competence and supported children who wished to make decisions about their treatment. Staff told us that an adult usually accompanied children, but they were asked to confirm consent to treatments in an appropriate manner.

**Mental Capacity Act and Deprivation of Liberty training completion**

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

The trust set a target of 90% for the completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. All staff had completed mandatory safeguarding training.

**Hemel Hempstead Hospital**

Compliance for MCA/DoLS (essential) training from April to October 2019 for qualified nursing staff in urgent and emergency care at Hemel Hempstead Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>MCA/DoLS (essential)</td>
<td>3</td>
</tr>
</tbody>
</table>

In urgent and emergency care at Hemel Hempstead Hospital, the target of 90% for MCA/DoLS (essential) training was met by qualified nursing staff.

Please note that the urgent care centre at Hemel Hempstead is a nurse-led unit, with medical cover provided by local GPs. Therefore, no medical staff analysis has been provided.

*Source: Routine Provider Information Request (RPIR) – Training tab*

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Clinical leads were identified and easily contactable for support.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff told us that they knew how to refer patients if necessary and gave us examples of when this had been done.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Mental capacity leads were accessible.

Staff did not have need to implement Deprivation of Liberty Safeguards within their department, however knew how to escalate concerns and refer patients if necessary. Staff ensured that patients received treatment in their best interests and if there were any concerns with regards to a patient’s ability to consent or understand treatment assistance was sought from the GP.

**Is the service caring?**

**Compassionate care**

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients were called into triage and treatment rooms and doors were closed for consultations. Patients were spoken to respectfully, and with kindness. We saw staff being sympathetic to patients’ injuries and illnesses providing them with comfort as necessary. Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential. Doors were closed, care was taken not to speak about patients’ conditions within earshot of other patients and all records were kept secure.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We saw that all patients were treated in a friendly and open manner.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Care was taken to ensure that patients’ beliefs and cultures were respected.

Staff told us that they would challenge any poor behaviour or disrespectful comments by patients or other members of staff.

Patients who attended with more serious conditions were supported by staff whilst they waited for investigations or a transfer to another hospital. Staff told us that they would keep patients and their loved ones informed of any decisions affecting their care. We were given examples of patient who required resuscitation and how staff kept relatives informed of treatments and decisions.

**Friends and Family test performance**

The service had varied responses to the friends and family test. Staff reported that it was sometimes difficult to capture patients' views about the service because of the type of patient being treated. For example, patients attending with a minor injury would be seen, treated and discharged within a short period and may not complete a survey based on the limited time spent within the department.

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. We did not receive data specific to Hemel Hempstead. However, the trust scored between 88.6% and 95.7% from October 2017 to September 2019.

**Emotional support**

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.**

We saw that staff engaged positively with patients. They were observed chatting with patients as well as asking them questions about their health. Staff took care to make patients relax and feel calmer when they were distressed or complaining of pain. Reassurance and comfort was provided.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients were given advice on their clinical conditions and advised of services outside the hospital who could provide support if necessary.
Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We saw that one patient became agitated due to their injury, the patient was quickly taken into a treatment room and care provided. The patient returned to the waiting area after they had calmed down. Nursing staff continued to check that the patient was ok, between other duties.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff provided reassurance to patients who were clearly concerned about their condition.

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

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Patients told us that staff asked questions, listened to them and checked if they were taking any medication.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Children were spoken to with using age appropriate language.

Patients said that they were informed of expected waiting times when they arrived at the service which enabled them to decide as to whether they would stay for treatment or not.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patient feedback was promoted using simple feedback forms. There was a comments box within the reception area and posters asking for feedback displayed in public areas. Patients were able to choose whether relatives accompanied them into treatment rooms, and staff confirmed that patients were happy to be escorted. Chaperones were also available.

Patients gave positive feedback about the service. All patients we spoke with were positive about their experiences in the department.

**Emergency Department Survey 2018 – Type 3 A&E departments**

The trust scored about the same as other trusts with type 3 A&E departments for the 20 Emergency Department Survey questions relevant to the caring domain.

Please note: Four questions were excluded from analysis due to the low number of responses received nationally (While you were waiting, were you able to get help from a member of staff to ask a question?; Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?; Did a member of staff tell you about medication side effects to look out for?; Did hospital staff take your family or home situation into account when you were leaving the urgent care centre?).

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9. Were you informed how long you would have to wait to be examined?</td>
<td>4.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your condition with a health professional?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the urgent care centre, did a health professional explain your condition and treatment in a way you could</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust score</td>
<td>RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Q14. Did the health professional listen to what you had to say?</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the health professional</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>examining and treating you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q17. Did health professionals talk to each other about you as if you</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>weren’t there?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q19. If a family member, friend or carer wanted to talk to a doctor,</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>did they have enough opportunity to do so?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q20. While you were in the urgent care centre, how much information</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>about your condition or treatment was given to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q22. Sometimes, a member of staff will say one thing, and another will</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>say something quite different. Did this happen to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>your care and treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q42. Overall, did you feel you were treated with respect and dignity</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>while you were in the urgent care centre?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>treatment, did a health professional discuss them with you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q25. Did a member of staff explain why you needed these test(s) in a</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q26. Before you left the urgent care centre, did you get the results</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>of your tests?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q27. Did a member of staff explain the results of the tests in a way</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q37. Did a member of staff tell you when you could resume your usual</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>activities, such as when to go back to work or drive a car?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about what symptoms to watch for</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>regarding your illness or treatment after you went home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q40. Did hospital staff tell you who to contact if you were worried</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>about your condition or treatment after you left the urgent care centre?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q41. Did staff give you enough information to help you care for your</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>condition at home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q43. Overall</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 2018)

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. The service offered a variety of appointments which included GP and drop in for minor injuries. This meant that the local population could access health care support and advice when they needed it during operational hours. Patients were able to choose which hospital to access for treatment and the trust regularly updated their internet webpage with information about...
any pressures on each site.

Facilities and premises were appropriate for the services being delivered. The department was sufficiently sized to enable multiple clinic rooms to be used for treatments. There was a resuscitation room for clinical emergencies, a plaster room and a minor procedure room.

Managers monitored and acted to minimise missed appointments. Patients who had booked appointments through NHS 111 were contacted if they did not arrive for appointments. One NHS 111 appointment was scheduled for every hour, which limited access to the department and enabled walk-in patients to be seen in a timely manner.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Patients admitted overnight with a mental health care issue were referred to Watford General Hospital where there was 24-hour access to the mental health team.

Managers ensured that patients who did not attend appointments were contacted. The service followed up on patients who were referred, for example to their GP, to the accident and emergency department in Watford, or to the child and adolescent mental health services (CAMHS) team. If a patient did not attend within a certain timeframe this was flagged and staff tried to contact the patient, or a family member or carer. Where necessary, for example if there was a risk to the patient, a safeguarding was raised with the local authority or the police were contacted. Staff gave examples of when they had followed up on a patient’s non-attendance after being referred, and this had highlighted safeguarding concerns.

The service had systems to help care for patients in need of additional support or specialist intervention. Hearing loops were available at the reception desk. Patients with additional needs were usually escorted by a relative, friend or carer.

The service relieved pressure on other departments when they could treat patients in a day. Managers were aware that by providing the service 9am to 10pm daily prevented additional attendances at the emergency department at Watford General Hospital.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The service provided different types of treatment for patients. As an urgent treatment centre, the centre offered treatments for walk-in patients, and pre-planned GP appointments, and pre-planned NHS 111 GP appointments.

Staff made sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet all their needs. Staff knew who to contact for further advice on helping patients with mental health problems or learning disabilities and their families and carers.

Patients with learning disabilities or dementia were highlighted clearly on the triage and appointments system so that service staff could prioritise their care and treatment. Their records were highlighted yellow, which enabled flagging and prioritisation. We saw that patients with additional needs such as those with dementia and children were prioritised to reduce time spent within the department.

Staff were aware of the ‘This is me’ documents and patient passports which could be used when a patient living with dementia was planned to be admitted. If a passport was in place, when a
patient attended the hospital, it was used to inform the staff’s clinical assessment of patients. For example, using appropriate terminology.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment. Staff used a picture chart to allow children and patients with communication needs to score their pain more easily. Staff knew how to request information in Braille. Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff could access a translation service via the phone.

Staff could refer young patients to the child and adolescent mental health services (CAMHS) and gave examples of when they had given advice to children with mental health problems and their families.

The service had information leaflets available although all were seen to be in English only. Staff said that they could access information leaflets in languages spoken by the patients and local community if necessary. Staff had access to language line to assist with communicating with patients whose spoke little or no English.

The service had created a children’s area in a room in the waiting area, where children and their families could wait separately to other patients, while also remaining visible to the reception staff. There was also CCTV for this area.

The service provided all facilities on one level which meant that it was easily accessible for patients who required walking aids or those using wheelchairs. However, we did not see a wheelchair friendly toilet within the waiting area. There were disabled toilet facilities located across the site.

**Emergency Department Survey 2018 – Type 3 A&E departments**

The trust scored 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>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the urgent care centre last?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. Were you given enough privacy when being examined or treated?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 2018)

**Access and flow**

People could access the service when they needed it and received the right care. Waiting times from referral to treatment were below the national standards. However, the percentage of patients admitted, transferred or discharged within four hours was in line or above the England average.

As an urgent care centre, a variety of pathways were available. Patients could access treatment either as a walk in, a GP appointment or an NHS 111 referral. The appointment system allowed
one NHS 111 booking per hour, which ensured that there was enough time to manage the patients that walked in to the centre for treatment.

**Median time from arrival to treatment (all patients)**

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. Trust data showed that patients were triaged within 15 minutes of arrival in the department, although we saw variable triage times during inspection. However, after triage, patients were required to wait for treatment. 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 did not meet the standard in any of the 12 months from November 2018 to October 2019 and the median time was consistently higher than the England average.

In the most recent month, October 2019, the trust’s median time to treatment was 74 minutes compared to the England average of 65 minutes. It is important to note, that the information provided refers to all emergency care departments across the trust. Data provided by the trust following the inspection showed that the median time to treat at Hemel Hempstead UTC was 90 minutes.

**Median time from arrival to treatment from November 2018 to October 2019 at Hemel Hempstead**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Median time - arrival to treatment in (mins)</td>
<td>80</td>
<td>92</td>
<td>74</td>
<td>72</td>
<td>81</td>
<td>99</td>
<td>96</td>
<td>94</td>
<td>93</td>
<td>103</td>
<td>99</td>
<td>95</td>
</tr>
</tbody>
</table>

(Source: Factual Accuracy submission)

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

Managers and staff worked to make sure patients did not stay longer than they needed to. 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 December 2018 to November 2019, the trust met the standard and performed better or similar to than the England average.

**Four-hour target performance - Hemel Hempstead**
Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

The number of patients leaving the service before being seen for treatments was low. From November 2018 to February 2019, the trust did not report any patients who left the trust’s urgent and emergency care services before being seen for treatment. However, from March to October 2019, the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was consistently higher than the England average.

In the most recent month, October 2019, the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 3.0%, compared to the England average which was 2.0%. The trust was unable to determine specific data for each site relating to all key performance indicators. Therefore, the service leads could not determine specific actions on each site to ensure compliance or an improvement in performance.

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)

Median total time in A&E per patient (all patients)

From November 2018 to October 2019 the trust’s monthly median total time in A&E for all patients was similar to the England average. In the most recent month, October 2019, the trust’s monthly median total time in A&E for all patients was 152 minutes, compared to the England average of 165 minutes.

Median total time in A&E per patient - West Hertfordshire Hospitals NHS Trust
Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. Staff made the decision whether additional treatment or support was required and ensured that the necessary referrals were in place prior to discharging vulnerable patients.

Staff supported patients when they were referred or transferred between services. Staff ensured that all information relevant to their care was shared with the patient. This process ensured that patients were kept informed of treatment plans.

Managers monitored patient transfers and followed national standards. Patients attending the department who required a transfer to another provider were recorded and tracked. Incident forms were completed to highlight numbers. The service moved patients only when there was a clear medical reason or in their best interest.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. There were posters displayed in public areas suggesting that patients speak to the nurse in charge if they had any concerns. The service clearly displayed information about how to raise a concern in patient areas. There were also posters relating to the patient advice and liaison service (PALS) who could support patients with any concerns.

Staff understood the policy on complaints and knew how to handle them. If there were any issues flagged, staff would escalate to the nurse in charge or the manager on call depending on the issue. Staff reported that there was a positive relationship and when concerns were raised, they always received support and advice on how to manage it.

**Summary of complaints**

**Trust level**

From November 2018 to October 2019, the trust received 62 complaints in relation to urgent and emergency care at the trust (17.4% of the total complaints received by the trust). The majority of complaints were standards complaints (33), there were 26 complex complaints and three complaints that resulted in a local resolution meeting.

The trust aimed to respond to all complaints within 30 working days, or for more complex
complaints, within 40 days. The timelines could be adjusted according to the complaint complexity with agreement with the complainant. The trust aimed to respond to over 80% of complaints within the agreed timeframe. There were three complaints that had not been closed during the inspection, these had been open for an average of 16 working days.

A breakdown of complaints by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watford General Hospital</td>
<td>51</td>
<td>82.25%</td>
</tr>
<tr>
<td>Hemel Hempstead General Hospital</td>
<td>10</td>
<td>16.13%</td>
</tr>
<tr>
<td>St Albans City Hospital</td>
<td>1</td>
<td>1.62%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>62</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

**Hemel Hempstead Hospital**

From November 2018 to October 2019, the trust received 10 complaints in relation to urgent and emergency care at Hemel Hempstead Hospital (58.8% of the total complaints received for the hospital).

For the nine complaints that had been closed at the time of data submission, the trust took an average of 42.2 working days to investigate and close the complaints. This was not in line with their complaints policy, which states that complaints should be closed with 30 days.

The one complaint, that had not yet been closed, had been open for 50.0 working days at the time of data submission. This was not in line with the trust’s policy.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical care and treatment</td>
<td>5</td>
<td>50.0%</td>
</tr>
<tr>
<td>Communications</td>
<td>2</td>
<td>20.0%</td>
</tr>
<tr>
<td>Appointments, assessment and waiting times</td>
<td>1</td>
<td>10.0%</td>
</tr>
<tr>
<td>Discrimination</td>
<td>1</td>
<td>10.0%</td>
</tr>
<tr>
<td>Staff attitude</td>
<td>1</td>
<td>10.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. There was a standardised process for the management of complaints. Issues identified were investigated by the most appropriate person. Within this service, it was usually the lead nurse, or the general manager. If issues were raised with the service about the GPs, the complaint was referred to their provider. Managers told us that they would work with the other provider to formulate a joint response to concerns raised if necessary.

Staff were aware of their roles and responsibilities in ensuring duty of candour. Staff were aware of the duty of candour principles and could give examples when this would be used.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints or issues raised were discussed at daily huddles and staff meetings. We saw minutes for meetings where concerns or investigation outcomes had been discussed.
Staff also told us that they shared any positive feedback with the team, however this was not formally captured.

**Number of compliments made to the trust**

**Trust level**

From January to November 2019, there were four compliments received about urgent and emergency care at the trust (2.4% of the total compliments received by the trust). All the compliments related to care received at Watford General Hospital.

The trust reported that the themes for compliments over the last 12 months had identified that staff were helpful, dedicated to providing good care and committed to being effective in delivering that care to patients. This had been the case for teams as well as for individuals.

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

**Hemel Hempstead Hospital**

From January to November 2019, there were no compliments received about urgent and emergency care at Hemel Hempstead Hospital.

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

### Is the service well-led?

**Leadership**

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leadership of the urgent and emergency care services consisted of a divisional director, a divisional lead nurse and a divisional manager. The divisional manager had been in post for four months. These staff worked across all sites offering leadership and support. In addition to this leadership structure, there was a deputy manager who attended the site most days, working out of the department or St Albans minor injuries unit on a regular basis. Their role was to oversee the functioning of the department and support staff. Staff reported that this individual was visible, easily accessible and offered support with any concerns or areas for escalation.

There was a clinical lead, who visited the service a minimum of half a day, once a fortnight. The clinical lead attended the governance meetings which were shared with the St Albans minor injury unit staff monthly and supported staff with clinical skills training, incidents and clinical projects.

Nursing leadership had changed since our last inspection. The lead nurse was now full time on site, having previously worked across Hemel Hempstead and the St Albans Community Hospital minor injury unit. Staff felt that this was a positive step as it enabled the lead nurse to focus on developing the service.

The service was positive about the trust executive team. The chief executive officer (CEO) was well known and visible. Staff reported that they knew the CEO by sight.
For details of the senior leadership, please see the Watford General Hospital Urgent and Emergency Care report.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Staff were aware of the trust strategy and vision which included the development of emergency medicine. Staff were aware of the vision for emergency services although it was not clear what individuals’ roles were in the redevelopment of the Watford General Hospital site.

The service had identified its functioning and developed this alongside the external partners in conjunction with the commissioning group. The service worked collaboratively with partner organisations and commissioners to ensure that there was an effective joint service for the urgent treatment centre. Staff were aware of their roles and responsibilities to ensure effective and collaborative working with GP to ensure that patients received appropriate care.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were largely positive about working at the hospital and reported that the team were friendly and worked well together. The team were focused on providing a high-quality service and were engaged in identifying areas where improvements could be made. Staff had completed projects and shared learning from these with the rest of the team at meetings. Staff reported that the enthusiasm for the service was contagious and the whole of the staff had been invigorated by changes which had encouraged them to become involved with service developments.

Staff told us that they were supported to develop and gain additional qualifications or experience. This was consistent across all grades of staff. Healthcare assistants felt supported in gaining experience and nursing staff could complete additional training if they wished. Staff told us that development opportunities were discussed at appraisals and in ad hoc conversations with senior staff.

Staff were very open and encouraged feedback from patients. We saw that concerns were managed sensitively, and patients did not feel that their care would be impacted negatively by any concerns raised.

Staff reported that they had access to the trusts Freedom to Speak Up Guardian (FTSU) or a FTSU champion if they wished to raise any concerns. Nursing staff told that the trust was good at listening to people and maintained confidentiality. FTSU champions were based on the site which meant that staff could access someone locally if they wished.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the
Since our last inspection, the trust had reviewed the governance processes for the service. There was now a joint governance meeting for the service and the minor injuries unit in St Albans. This was attended by the trust wide clinical lead, lead nurse and managers as well as the local managers and governance representatives. The meetings alternated between the two sites and followed a set agenda. Any information from this meeting was escalated to the divisional governance meetings and to the board if necessary. These meetings were also used to share information from the board to local leaders and teams. Staff were confident that there was a robust system to share information across the service and trust with representation from all sites at all governance meetings.

Staff were aware of their roles and responsibilities for ensuring good governance across the organisation. Staff reported that there was good attendance at governance meetings and people read any minutes produced. Minutes were shared in paper and electronically to ensure that all staff had access.

Information from the governance meetings was shared at the urgent care meetings, where performance across all sites was reviewed and monitored for compliance against targets and themes/ trends. Divisional and directorate leads were able to identify pressures on each department and regularly completed actions to address them. For example, triage times had been reviewed and an additional triage nurse added to ensure that staff met the targets. Staff reported that there was good attendance at governance meetings and people read any minutes produced.

There was evidence to support effective partnership working with the external provider who facilitated GP attendance and receptionist staffing. The services met regularly to discuss performance and any incidents or issues. Managers told us that meetings were productive and enabled decisions to be made on how performance could be improved. This included discussions around appointment scheduling and the management of emergency cases.

The service provided regular updates and newsletters for staff detailing additional trust wide or service specific information. Staff told us that they felt kept up to date with projects and service plans.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

There were robust systems in place to monitor performance and escalate concerns. Staff used audits to monitor performance against local and national key performance indicators. There was a trust wide audit calendar. All audit results were reviewed by the local leaders and the wider emergency department leads and trust board. There was a focused approach to managing activity and managers at all levels were able to describe how they managed activity daily and flexed services to cope with demands.

Risks were identified locally and reviewed at regular intervals. Any risks higher than a score of 12 (medium/ high risk), were also reviewed as part of divisional meetings. There was a risk lead for each division, and they managed the risk register ensuring that mitigation was clearly recorded. Minutes showed that risks were discussed as part of monthly meetings.

Staff told us that staffing was their greatest concern, particularly as there were a number of staff members on maternity leave which meant that there were reduced numbers available.

Due to the type of service provided, staff were unable to identify peaks and troughs in activity in advance although had some understanding of busiest times and days based on previous
attendances. Patients attended because of a recent injury or illness, which meant that activity could not be planned. During inspection we saw that the numbers of attendees varied dramatically from hour to hour.

For more details on the management of risk and performance please see the emergency department report for Watford General Hospital.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff used an electronic system for patients. Staff told us that the system used at Hemel Hempstead was different to the systems used at the other two sites. This meant that there was the potential for information to be duplicated when patients were transferring to Watford General Hospital.

Managers used electronic systems to monitor and analyse performance data. Staff could see patient waiting times, appointments and patient outcomes. We spoke with the leadership who demonstrated how data supported an understanding of the wider performance and how it was used to inform decision making.

Staff participated in national clinical audits. This included audits by the Royal College of Emergency Medicine. Staff provided data to external bodies and organisations and used the information to help them manage performance.

Engagement

Leaders and staff actively and openly engaged with patients, staff and equality groups. They collaborated with partner organisations to help improve services for patients.

Staff reported that there had been an increase in the number of complaints since the service had changed to an urgent care centre. The reasons given were that patients who had an appointment scheduled by NHS 111, were usually seen quicker than patients who self-presented with an acute injury.

Staff felt that the lead nurse was responsive to any concerns or issues raised. For example, following discussions about the number of staff available in the evenings, staff had agreed to trial a shift change, which provided more staff at the end of the day.

Staff told us that there was a sense of ownership and that this helped to improve the service. For example, we were told that there had been a lot of work completed on triage structure as staff were not meeting the 15 minutes timescale. Staff took ownership of the issue and worked together to restructure the process, which showed an improvement in 15-minute triages. Staff reported that 90% of triages were completed within 15 minutes.

Staff reported that the team were very positive and were taking on additional responsibilities, assisting with personal development. The team said they felt more integrated and transferred to Watford site as necessary. However, some staff reported that they sometimes felt isolated. The service was quite isolated within the hospital as there were not many inpatient areas out of hours, which meant that staff were potentially lone working. There was a trust wide policy relating to lone working. This was not cited on the risk register as a risk.

The service worked collaboratively with another provider to provide the services required for the
urgent treatment centre. Another provider supplied the GPs and one receptionist daily.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had understanding of quality improvement methods and the skills to use them. Leaders encouraged participation in research.

Staff were proud of projects that they had completed, and we saw that these were displayed in public areas. Staff told us that information was shared as part of team meetings and each staff member who had a specific interest was encouraged to complete research on new guidance and processes and share this with the team. We saw that staff had reviewed activity in specific complaints such as children with head injuries and displayed their findings.

Managers told us that following our last inspection, staff had felt invested in and this had promoted an interest in the service and finding new ways of working. Nursing staff were encouraged to come up with solutions to any issues they raised.

Since our last inspection, the nursing team had introduced clinical training sessions and a robust governance framework. This meant that there were processes in place to improve the service and encourage continual learning.
Medical care (including older people’s care)

Facts and data about this service

Trust wide, the medicine division at West Hertfordshire Hospitals NHS Trust oversees the care of 320 medical inpatient beds (this excludes acute admission units), the cardiac catheter laboratory and endoscopy services. This section of the inspection report relates to medical care provided on Simpson Ward and the endoscopy service at Hemel Hempstead General Hospital only.

Simpson Ward is located on the Hemel Hempstead site; it was transferred to the trust on 1 October 2019. Nursing leadership is provided by a full-time band 8A (matron). Beds are allocated to patients who meet pathway 3 of the South Warwickshire Discharge to Assess (DTA) model of care or meet Flex Criteria (point of care) when there is capacity and no pathway 3 patient identified. The integrated discharge team had partnered with the medicine division and work closely with the flow manager to reduce length of stay.

The endoscopy service at Hemel Hempstead General Hospital performs approximately 7500 outpatient gastroscopies, therapeutic colonoscopies and flexible sigmoidoscopies per year. The unit is open Monday to Friday, 8am to 6pm and also offers additional sessions dependent on demand at weekends. We did not visibly inspect the endoscopy service at Hemel Hempstead General Hospital due to the situation with coronavirus/COVID 19 at the time of our planned inspection date. Due to this, we requested various information relating to the service which was accredited by The Joint Advisory Group on gastrointestinal (GI) endoscopy (JAG). Accreditation is awarded following peer-reviewed process supporting fit for purpose, safe endoscopy service delivery, by providing an independent evaluation of a service. The most recent review took place in February 2018.

(Source: Acute Routine Provider Information Request (RPIR) – Acute context tab)

Trust wide, there were 52,396 medical admissions from September 2018 to August 2019. Emergency admissions accounted for 26,563 (50.7%), 514 (1.0%) were elective, and the remaining 25,319 (48.3%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 21,557 admissions
- Gastroenterology: 15,511 admissions
- Clinical haematology: 4,012 admissions

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff however not all staff had completed it. There was a plan in place to ensure compliance across all staff.
Mandatory training completion rates

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

Hemel Hempstead General Hospital

Nursing staff received and kept up-to-date with their mandatory training. Training was a mixture of face to face and e-learning with staff given protected time to attend training where required.

A breakdown of compliance for mandatory training courses from April to October 2019 for qualified nursing staff in medicine at Hemel Hempstead General Hospital is shown below (please note this data pertains to all nursing staff at Hemel Hempstead General Hospital based within the endoscopy service):

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning disability (TEACH) (essential)</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>End of life care (essential)</td>
<td>30</td>
<td>30</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling (patient contact - level 2)</td>
<td>31</td>
<td>31</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic health, safety and risk</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood handling (essential)</td>
<td>22</td>
<td>22</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling (non-patient)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>31</td>
<td>31</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism prevention (essential)</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety (non-clinical)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>31</td>
<td>32</td>
<td>96.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control (clinical)</td>
<td>31</td>
<td>32</td>
<td>96.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>27</td>
<td>31</td>
<td>87.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety and evacuation (clinical)</td>
<td>26</td>
<td>31</td>
<td>83.9%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine at Hemel Hempstead General Hospital, the 90% target was met for 13 of the 15 mandatory training modules for which qualified nursing staff were eligible.

After our inspection we requested up to date training data. Overall as of 17 February 2020, mandatory training compliance for nursing staff can be seen in the table below (relating specifically to staff on Simpson Ward only):

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of 17 February 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Completion rate</td>
</tr>
<tr>
<td>Learning disability (TEACH) (essential)</td>
<td>57%</td>
</tr>
<tr>
<td>End of life care (essential)</td>
<td>0%</td>
</tr>
<tr>
<td>Training module name</td>
<td>April to October 2019</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Information governance</td>
<td>2 2</td>
</tr>
<tr>
<td>Infection control (clinical)</td>
<td>2 2</td>
</tr>
<tr>
<td>Manual handling (non-patient)</td>
<td>2 2</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>2 2</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>2 2</td>
</tr>
<tr>
<td>Basic health, safety and risk</td>
<td>1 2</td>
</tr>
</tbody>
</table>

Out of 18 mandatory training courses, staff were non-compliant with the 90% target in 13 subjects. The service and its staff had recently transferred from a local community provider to West Hertfordshire NHS Trust in October 2019. At the time of our inspection, leaders were reconciling training records from the previous provider and identifying where changes to mandatory training requirements and improvements were needed.

After our inspection we saw that staff had been pre-booked on training where compliance was noted to be poor, for example end of life care training. This was not previously offered to staff from prior to West Hertfordshire Hospital NHS Trust acquiring Simpson Ward in October 2019.

After our inspection we requested up to date training data for nursing staff working within the endoscopy service at Hemel Hempstead General Hospital. As of March 2020, 90-100% of nursing staff were up to date with mandatory training across all subjects which met the service's target of 90%.

A breakdown of compliance for mandatory training courses from April to October 2019 for medical staff in medicine at Hemel Hempstead General Hospital is shown below (please note this data pertains to all medical care staff at Hemel Hempstead General Hospital in the endoscopy service only):
In medicine at Hemel Hempstead General Hospital, the 90% target was met for five of the 12 mandatory training modules for which medical staff were eligible. However, please note that the completion rates should be interpreted with care as the analysis is based on low numbers of staff being eligible for each module.

After our inspection we requested up to date training data. Overall as of 17 February 2020, there was one member of medical staff at Hemel Hempstead General Hospital who worked on Simpson ward. The trust told us this member of staff was compliant with all mandatory training subjects as of 17 February 2020 (relating specifically to the one member of medical staff on Simpson ward).

The mandatory training was comprehensive and met the needs of patients and staff. Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Senior staff completed and oversaw monthly reports on mandatory training compliance in conjunction with West Hertfordshire Hospital NHS Trust. Managers monitored mandatory training and alerted staff when they needed to update their training. Leaders within the service oversaw compliance with mandatory training subjects and booked staff on to training when required. Training compliance was overseen by the ward manager and matron of Simpson ward.

(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 to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training completion rates

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

The tables below include Prevent training as a safeguarding course. Prevent works to help staff identify those at risk of getting involved in or supporting terrorism or extremist activity.

Hemel Hempstead General Hospital medicine department

Nursing staff received training specific for their role on how to recognise and report abuse.

<table>
<thead>
<tr>
<th>End of life care (essential)</th>
<th>1</th>
<th>2</th>
<th>50.0%</th>
<th>90%</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning disability (TEACH) (essential)</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety (non-clinical)</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Venous thromboembolism prevention (essential)</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Blood handling (essential)</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
A breakdown of compliance for safeguarding training courses from April to October 2019 for qualified nursing staff in medicine at Hemel Hempstead General Hospital is shown below (relating to the endoscopy service only):

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT WRAP</td>
<td>31</td>
<td>32</td>
<td>96.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In medicine at Hemel Hempstead General Hospital, the 90% target was met for all three safeguarding training modules for which qualified nursing staff were eligible.

After our inspection we requested up to date training compliance data for nursing staff which can be seen in the table below (relating specifically to staff on Simpson ward):

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of 17 February 2020</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PREVENT WRAP</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses from April to October 2019 for medical staff in medicine at Hemel Hempstead General Hospital is shown below (please note this data pertains to all medical care staff at Hemel Hempstead General Hospital):

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>PREVENT WRAP</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In medicine at Hemel Hempstead General Hospital, the 90% target was met for all three safeguarding training modules for which medical staff in medicine were eligible. However, please note that the completion rates should be interpreted with care as the analysis is based on low numbers of staff being eligible for each module.

After our inspection we requested up to date data outlining mandatory training compliance for medical staff working on Simpson ward. Please note, at the time of inspection this pertained to one member of staff (relating specifically to staff on Simpson ward). For all three safeguarding subjects, the staff member was compliant with required training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.
Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff described access to the local authority if required and safeguarding leads within West Hertfordshire Hospitals NHS Trust.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff we spoke with could describe safeguarding reporting processes. Information and guidance to report safeguarding concerns was displayed throughout the ward. In addition, a senior nurse was available for guidance if required. Staff had access to the West Hertfordshire hospital safeguarding team for advice and guidance if required.

After our inspection we requested safeguarding training compliance data for staff working in the endoscopy service at Hemel Hempstead General Hospital. Data showed that 100% of all nursing staff were up to date with both safeguarding adults and children level two training.

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

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Simpson ward was visibly clean and had suitable furnishings which were clean and well-maintained. All areas we inspected were visibility clean and free from dirt. Cleaning records were up-to-date and demonstrated that all areas were cleaned on a regular basis. Cleaning was outsourced to a third party company with levels of cleanliness being overseen by senior nursing staff through regular audits. During our inspection we saw cleaning taking place at regular intervals.

We saw that staff washed their hands regularly prior to and after providing episodes of patient care and used hand cleansing gel at regular intervals. Each bed and side room had access to individual hand cleansing gel dispensers, and these were also located at the entrance to the ward to encourage public and staff to use prior to and upon leaving the department. Staff followed infection control principles including the use of personal protective equipment (PPE). Staff had access to PPE including gloves, aprons and masks. We saw staff using appropriate PPE during our inspection.

Curtains separating cubicles were visibly clean and had been replaced on a regular basis.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw that equipment such as commodes and hoists were cleaned after use and marked with ‘I am clean’ stickers. All equipment we reviewed was visibly clean.

Regular audits monitored compliance with infection control and prevention (IPC) processes including hand hygiene on Simpson ward. Data showed 100% compliance for the months of October 2019, December 2019, January 2020 and February 2020. No audit was carried out in November 2019.

Patients on Simpson ward were transferred from Watford General Hospital where MRSA screens took place prior to transfer. The ward did not accept direct referrals from the community and therefore did not routinely offer MRSA screening. MRSA screening results were reviewed prior to patients accessing the ward.
Monthly audits took place within endoscopy services at Hemel Hempstead General Hospital to assess levels of cleanliness and effective infection prevention control (IPC) measures. We requested audit data after our inspection. Data showed that in January 2020, the endoscopy service achieved 86% compliance with IPC audits. We were not provided with details of actions taken in response to this audit.

**Environment and equipment**

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff managed clinical waste well however cleaning chemicals were not always stored in a safe manner.

Simpson ward consisted of three bays containing six beds, three single side rooms a large gym. An additional room was allocated for the storage of hoists and other equipment to ensure that corridors were free from obstructions to allow safe movement of people and building evacuation if required. This was an improvement since our previous inspection in 2016.

The trust had replaced all doors to ensure compliance with fire regulations. This was an improvement from our last inspection in 2016. We saw fire exits were free from obstruction.

The design of the environment on Simpson ward followed national guidance. The service had suitable facilities to meet the needs of patient’s families. The gym area could be used for sensitive discussions to take place with relatives and carers in a private environment.

Patients could reach call bells and staff responded quickly when called. During our inspection we saw that call bells were answered within a timely manner. Each bed had its own call bell. During periods where the gym was used for escalation purposes, further call bells were placed with each patient.

Staff carried out daily safety checks of specialist equipment on Simpson ward. We reviewed checklists for emergency resuscitation equipment from 1 November 2019 to 18 February 2020. We saw checks of emergency equipment had taken place on all days where indicated. Emergency equipment was well ordered, tidy and equipment had tamper proof tags on to indicate when storage areas had been opened. There was a range of equipment to provide care and treatment patients of various sizes.

The service had enough suitable equipment to help them to safely care for patients. We saw adequate supplies of equipment such as hoists, turntables and other mobility aids to safely care for patients. Storage areas were well organised with equipment stored above floor level to enable effective cleaning to take place.

Staff disposed of clinical waste safely. Clinical waste was appropriately segregated, placed in colour coded bags and labelled. Sharps containers were correctly assembled and within safe ‘fill limits’ to prevent needlestick injuries.

Substances subject to the Control of Substances Hazardous to Health Regulations 2002 (COSHH, 2002), were not stored in line with service policy. We found diluted disinfectant cleaning fluid in an unlocked store room. This posed a risk to patients who may be confused or children visiting the service. We raised our concerns with the matron for the service who immediately ensured this was stored in a locked cupboard. When we returned for a subsequent unannounced inspection, we saw that all chemicals were stored and locked in a secure manner.

The endoscopy service at Hemel Hempstead General Hospital was located in the outpatient department and consisted of two procedure rooms.
The endoscopy department at Hemel Hempstead General Hospital participated in the Joint Advisory Group (JAG) on gastrointestinal endoscopy and was an accredited service. Accreditation covered a number of aspects including the safety, comfort and quality of service provided, which included having systems in place to ensure the maintenance and quality of equipment and water testing.

Assessing and responding to patient risk

Staff did not always complete or update risk assessments for each patient or take actions to remove or minimise risks. However, staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. The service used the latest version of the National Early Warning Score (NEWS2). The scoring systems helps to standardise patient assessment and subsequent responses to acute illness. Medical records demonstrated timely and appropriate action had been taken to escalate patients with signs of deteriorating NEWS scores.

Staff completed risk assessments for each patient on admission however we found that risk assessments were not always updated when necessary. We reviewed nine sets of medical records, out of these, six records did not demonstrate that risk assessments were updated on a regular basis.

Staff knew about and dealt with any specific risk issues. Risk assessments were in place for a number of things including but not limited to; pressure ulcers, hydration, falls and venous thromboembolism (VTE). However, we saw that relevant risk assessments were not always comprehensively completed. Please see the medical records section of this report for more information.

Staff received training in sepsis recognition and management as part of infection prevention and control training. As of 17 February 2020, 72% of staff on Simpson ward had received this training. This fell below the trust’s target of 90%. At the time of our inspection, senior leaders were working to reconcile training records and identify where improvement were needed since the service came to West Hertfordshire Hospitals NHS Trust in October 2019.

Staff working within the endoscopy received sepsis recognition and management training, with 90% of nursing up to date with this subject, which met the service’s target of 90%.

There were clear escalation processes in place for patients with known or suspected sepsis. Staff could describe escalation processes in line with the ‘monitoring and recoding of physiological observations policy, which was due review in October 2022.

The service used an inclusion criterion to ensure only suitable patients were accepted to Simpson ward. Guidance for staff could be found in the 'referral to a Simpson discharge to assess bed' document which outlined the inclusion criteria and clear exclusions. Senior nursing staff reviewed all admission requests prior to acceptance top ensure only clinically suitable patients accessed care on Simpson ward. The inclusion criteria was as follows: following a multidisciplinary team (including social worker) that a permanent placement is required, patient is medically fit for discharge, no discharge destination arranged within 24-48 hours, transfer would not be too distressing to the patient and the family/patients consents to transfer. The exclusion criteria included: the patient does not require one to one care; the patient requires a side room for infection control and any patient with nasogastric feedings tube in place.

We reviewed all patients on Simpson ward on day one of our inspection and found that two patients fell outside of the referral criteria. Senior staff told us these patients were accepted prior
to the transfer of service to West Hertfordshire Hospitals NHS Trust in October 2019. These patients required additional support to maintain their safety and additional staffing was planned where possible to assist with this. Staff told us when Watford General Hospital were experiencing an increase in demand, Simpson ward felt pressured to accept patients outside of the inclusion and exclusion criteria to create capacity at the Watford General hospital site.

During times of high demand at Watford General Hospital, Simpson ward had capacity to open an additional three beds within the gymnasium area as an escalation area. From 1 October 2019 to 20 February 2020, this area had been used on 105 days. There was a clear inclusion/exclusion criterion for patients admitted to this area, with a focus on medically fit patients without the high risk of falls. We spoke with staff who described challenges in providing care for patient located with escalation areas when this extra space was open from staffing perspective. Senior staff told us in times of need, supernumerary staff returned to the ward to assist.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). This was provided through a local community provider. Staff described the mental health support team as accessible and responsive when contacted.

During normal working hours (Monday to Friday, 9am to 5pm), the ward manager was present on site. Outside of these hours, staff could contact the trust wide senior nurse on call or the site management team for West Hertfordshire Hospitals NHS Trust.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We reviewed one patient’s records who had mental health illness. We saw that escalation had taken place to the mental health team where required.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. We observed one handover and saw it was comprehensive, detailing each patient and their needs.

There were clear processes in place to escalate a deterioration in patient health. Simpson ward accepted patients who were medically fit, however in the event of unexpected deterioration, the onsite doctor attended in hours (Monday to Friday, 9am to 5pm). Outside of these times, staff contacted the NHS 111 service for a doctor’s visit or the local emergency ambulance service to take the patient to the nearest acute trust. All staff we spoke described escalation processes in accordance with trust policy. At the time of our inspection, all staff working on Simpson ward were up to date with basic life support training.

There were clear escalation processes in place for the clinical deterioration of a patient within the endoscopy service at Hemel Hempstead General Hospital.

Staff had access to an anaphylaxis treatment pack. Anaphylaxis a serious allergic reaction that is rapid in onset and may cause death. We checked equipment and saw emergency equipment and medicines were organised and in date.

The endoscopy service at Hemel Hempstead General Hospital screened patients for eligibility prior to offering appointments at site. This ensured that high risk patients were not seen; the assessment and management of high-risk patients took place at Watford General Hospital.

Nurse staffing
The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

On Simpson ward, the service had enough nursing and support staff of relevant grades to keep patients safe. The service had recently undergone a staffing review and subsequent uplift in the numbers of registered nurses and healthcare assistants. At the time of our inspection, there were no vacancies for nursing or healthcare assistant staff.

Each day shifts was staffed with three registered nurses and three healthcare assistants. Monday to Friday, the ward sister and matron were onsite and supernumerary in role. Night shift staffing consisted of three registered nurses and two healthcare assistants. Staffing levels were based on the ‘Safe Care’ model which brings information on the actual staff levels together with the numbers and needs of patients.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. In the event of unfilled shifts, senior staff contacted the site team at Watford General Hospital to arrange cover if required at short notice.

Hemel Hempstead General Hospital

Simpson Ward

The service had enough nursing and support staff to keep patients safe.

Whilst managers calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance, numbers of required staff varied when the escalation area was opened, allowing an additional three patients to the ward.

The Simpson ward manager adjusted staffing levels on a daily basis, according to the needs of patients. However, there were occasions when staffing numbers were not at required levels if any patient required one to one care, if the escalation area was open, or due to staff sickness.

We reviewed all incidents of a lack of staffing since October 2019 and found two submitted incident reports relating to staffing. Senior staff told us that staffing was reviewed on a regular basis at daily bed management meetings and an incident was reported when staffing was at ‘red levels’. Senior staff gave examples of where staff had been moved from Watford General Hospital to fill vacant shifts. In addition, the ward sister and matron were supernumerary to assist with patient care if required.

During our inspection of Simpson ward, the number of nurses and healthcare assistants matched the planned numbers with the exception of one healthcare assistant shift on the second inspection date.

Endoscopy

Nurse staffing rates within medicine at Hemel Hempstead General Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and agency use.

The endoscopy service at Hemel Hempstead General Hospital was staffed by eight nurse endoscopists, who worked between Hemel Hempstead and Watford General Hospital. Data
provided after our inspection demonstrated that from February 2019 to February 2020, there were no unfilled shifts within the service.

Overall, there were 17.38 whole time equivalent nurses at Hemel Hempstead General Hospital, from various bands (two, four, five, six and seven). The staff assisted with gastric endoscopy lists and also surgical outpatient cystoscopy clinics.

Please note that the trust was unable to provide total hours including those covered by substantive staff to allow us to calculate bank and agency usage or unfilled hours for nursing staff as a percentage of the total hours available.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Vacancy rates

The service low vacancy rates for nursing staff.

![Vacancy rate - registered nurses](image)

The negative vacancy rate for nursing staff in the table above indicates that there were more staff in post than planned.

Monthly vacancy rates over the last 12 months for registered nurses showed an upward trend from November 2018 to September 2019, although this did not continue into October 2019.

The negative vacancy rates for nursing staff from November 2018 to May 2019 and in October 2019 in the chart above indicate that there were more staff in post in these months than planned.

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

Simpson ward

After our inspection we requested staffing data for registered nurses. The service advised there were 15 registered nurses in post, with vacancy rate of 5.21 full time equivalent members of staff. The service was actively recruiting at the time of our inspection. This was due to an uplift in staffing, rather than staff leaving the service.

Turnover rates

The service had low turnover rates for nursing staff.
Data provided after our inspection showed there was a 0% turnover rate for nursing staff for staff on Simpson ward (under care of West Hertfordshire Hospitals NHS Trust since October 2019).

**Sickness rates**

The service had reducing sickness rates for nursing staff.

![Sickness rate - registered nurses](image)

Monthly sickness rates over the last 12 months for registered nurses showed an upward shift from May 2019 to October 2019.

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

**Bank and agency staff usage**

The service had increasing rates of bank and agency nurses please note this data pertains to endoscopy service at Hemel Hempstead General Hospital only.

![Bank hours - registered nurses](image)

Monthly bank use over the last 12 months for registered nurses showed an upward trend from January 2019 to June 2019, although this did not continue.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Staff told us that they used bank and agency staff who were familiar with the ward to ensure continuity in care and familiarity of the ward environment and processes.

Managers made sure all bank and agency staff had a full induction and understood the service.
Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers did not need to regularly review medical staffing levels and skill mix as there was one member of medical staff on the ward. Managers gave locum staff a full induction.

Hemel Hempstead General Hospital

The table below shows a summary of the medical staffing metrics in medicine at Hemel Hempstead General Hospital compared to the trust’s targets, where applicable (relating specifically to within the endoscopy service at Hemel Hempstead General Hospital as this time frame was before Simpson ward was under the care of West Hertfordshire Hospitals NHS Trust):

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual locum hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>68</td>
<td>11%</td>
<td>13%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>7</td>
<td>83%</td>
<td>0%</td>
<td>0.0%</td>
<td>6,464</td>
<td>741</td>
<td>4,644</td>
</tr>
<tr>
<td>Medical staff</td>
<td>7</td>
<td>83%</td>
<td>0%</td>
<td>0.0%</td>
<td>6,464</td>
<td>741</td>
<td>4,644</td>
</tr>
</tbody>
</table>

Medical staffing rates within medicine at Hemel Hempstead General Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover and sickness.

Please note that the trust was unable to provide total hours including those covered by substantive staff to allow us to calculate bank and locum usage or data on unfilled hours for medical staff.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

On Simpson ward, the service had enough medical staff to keep patients safe. The medical staff matched the planned number at all times during our inspection. At the time of our inspection, there was one member of medical staff working on Simpson ward between the hours of Monday to Friday, 9am to 5pm. If access to a doctor was required outside of these hours, staff called either NHS 111 or 999 for an emergency ambulance to arrange transportation to the nearest acute trust. All patients on Simpson ward were deemed ‘medically fit’ prior to acceptance/transfer.

In the event of medical cover being required to cover annual leave or study days, this was arranged in advance with cover being provided from Watford General Hospital. Locum doctor checklists were completed prior to the commencement of work.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)
Vacancy rates

The service had no vacancies at the time of our inspection for medical staff on Simpson ward.

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

Turnover rates

The service had no turnover for medical staff for medical staff on Simpson ward at Hemel Hempstead General Hospital.

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

Sickness rates

The service had low sickness rates for medical staff (please note this pertains to one member of medical staff).

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

Bank and locum staff usage

We had no data specifically pertaining to Simpson ward around the use of bank and locum staff. There was one member of medical staff working on Simpson ward at Hemel Hempstead Hospital.

Managers could access locums when they needed additional medical staff. Staff contacted Watford General Hospital to arrange medical cover in the event that the permanent member of medical staff was not available.

Managers made sure locums had a full induction to the service before they started work.

The service did not require an on-call consultant on call during evenings and weekends as Simpson ward accepted medically fit patients only. There were clear processes in place to escalate unexpected deteriorating health.

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

Records

Staff did not always keep detailed records of patients’ care and treatment. Records were not always clear or up-to-date however they were easily available to all staff providing care.

Simpson Ward

Patient records on Simpson ward were not always comprehensive however all staff could access them easily. Records were paper based within Simpson ward and consisted of a medical record and nursing file for each patient.
We reviewed nine sets of medical records on Simpson ward. We found medical records to be legible and signed by grade/designation of staff when making entries. However, falls risk assessments were not regularly completed and updated in all records that we reviewed. In two sets of nursing records we saw that the Malnutrition Universal Screening Tool (MUST) had been incorrectly calculated. MUST scores are used to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. We escalated our concerns to senior staff who commissioned a report, reviewed documentation and completed a referral to a dietitian where indicated.

Generally, we saw that medical records lacked up to date risks assessments, lying and standing blood pressures, up to date care plans and holistic care plans detailing a full range of problems and needs. We reviewed nine sets of medical records. In one set, the patient’s lying and standing blood pressure was not recorded, mouth care plans were not completed, and records lacked a referral to the dietitian. In five other records, we saw that risk assessments were not always up to date. In two out of nine records, nutritional risks assessments had not been thoroughly completed.

In one set of records we found a lose information sheet without patient identifiable and demographic information. We could not gain assurances that this was located in the correct patient record. We escalated our concerns to the matron who took action to address this concern.

When patients transferred to a new team, there were no delays in staff accessing their records. Paper based records travelled with the patient throughout their care at West Hertfordshire Hospitals NHS trust. When accepting patients from Watford General hospital, medical records accompanied the patient at the point of transfer.

Records were mostly stored securely. We saw that records were securely locked when not in use. Throughout our inspection we saw that records were attended at all times when in use. Patient information was protected on the ward’s information board with a panel to maintain confidentiality. However, we found a patient information booklet within the unlocked sluice room. The booklet contained confidential personal information, including patient name, date of birth and presenting condition. We immediately escalated this to the ward manager who was unsure how long, or why this documentation had been there and removed it from this area.

Senior staff carried out monthly medical record documentation audits. Compliance for the last four months showed a decline in performance: October 2019 (99.7%), November 2019 94.7%, December 2019 (98.9%) and January 2020 (90.5%). We spoke with senior staff around documentation completion. They had previously identified this area as non-compliance and put in place a number of measures to improve standards including but not limited to; monthly ‘test your care’ audits, additional training, discussion at monthly staff meetings and at daily safety huddle meetings.

Senior staff recognised that medical records completeness was a challenge for the service. In response to this they had encouraged the use of ‘check and challenge’ initiative at each handover (twice daily) where staff reviewed each other’s medical records and challenged where gaps were noted.

Endoscopy services

We were unable to physically review medical records for patients that used the endoscopy service at Hemel Hempstead General Hospital due to restrictions in place around coronavirus/COVID 19.
Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Simpson ward

Staff mostly followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were generally reconciled appropriately, with patients’ allergy status generally recorded. On one occasion we observed the patient’s weight not recorded when anticoagulants were prescribed. This was not in line with the trust policy and could have resulted in an inappropriate dose being prescribed.

Patients were given a red identification band to highlight an allergy to medicines. We reviewed nine records of patient care and saw one patient with an antibiotic allergy did not have a red wrist band in place. We immediately escalated our concerns to the matron who replaced the wrist band.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. Medicines were stored securely in a locked cupboard in a treatment room with keycode access. The medicines were stored appropriately with labels for different classes of medicines, for example; antibiotics, liquids and laxatives. This was good practice to help reduce medicines related errors.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. Patients own medicines were stored in labelled bags which helped reduce the risk of health care professionals selecting the wrong medicines. Staff followed current national practice to check patients had the correct medicines. We saw staff administering controlled drugs in line with best practice.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. However, staff we spoke with were not aware of any recent medicine related incidents. It is good practice to share medicine related incidents to prevent future incidents from occurring. We could not gain assurances that learning was shared as a result of medicines errors.

Controlled drugs (CDs) were stored securely in the CD cupboard which was double locked. Controlled drugs are subject legal controls and legislation determines various aspects around their prescription, storage, administration and destruction. The CD keys were kept separate to other keys which helped prevent unauthorised access.

The CD record book was in good condition and the last pharmacy CD audit was on 8th January 2020 where the stock checked was correct and in balance. We checked four CD’s and the balances were correct. Two members of staff daily completed stock checks of CDs.

The trust’s controlled drug policy was in date and staff knew how to access this if they had any queries regarding controlled drugs. Staff were aware to contact the pharmacy team if there were any concerns about CD discrepancies or if they required information that was not in the CD policy.

Antibiotics were prescribed with a review date and indication to reduce the risk of antimicrobial resistance.

Medicine fridges were locked, and fridge temperature records were completed appropriately and in range for the months of January and February 2020. If the fridge temperatures became out of
range, staff knew to contact the pharmacy team for advice. We identified one medicine which had expired, and the nurse appropriately actioned this.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored. However, we could not gain assurances that incidents were always reported appropriately.

All staff knew what incidents to report and how to report them. Staff could give examples of what constituted, and how to report and escalate incidents.

Staff raised concerns and reported incidents and near misses in line with trust policy. All staff could describe incident reporting processes in line with trust policy. However, we reviewed all incidents of a lack of staffing since October 2019, however, there were only two submitted incident reports relating to staffing.

We also identified one patient had experienced four falls within a three week period. As of 19 February 2020, a post inspection data request showed that one fall (with a minor injury) had not been reported on the service’s incident reporting system. We could not gain assurances that staffing was reported as an incident on each occasion concerns were identified.

From October 2019 to 19 February 2020 the service had 61 reported incidents relating to Simpson ward. All of these were either no harm (50) or low harm (11). There were no reported serious incidents during this time frame.

Staff could provide examples of learning from incidents, for example after a patient had acquired a pressure ulcer. We saw actions had been taken from reporting of various incidents. For example, Simpson ward did not have access to a service camera to record images of pressure ulcers. At the time of our inspection a standard operating procedure was in the process of being compiled, with support from the tissue viability nursing team in the interim, if required.

During our inspection we found cleaning chemicals were being stored in an unlocked sluice room on Simpson ward. We immediate escalated our concerns to the ward’s matron on 18 February 2020 who took immediate action to mitigate the risk.

We saw evidence that the deterioration of patients were escalated in line with service policy and documented through internal incident reporting systems.

Endoscopy service

From February 2019 to January 2020 there had been 23 incidents relating to endoscopy services at Hemel Hempstead General Hospital. All incidents were either no harm or low harm, there were no serious incidents during this time frame. The incident log clearly demonstrated actions taken after incidents and how learning was shared.

Never Events

The service had no never events at Hemel Hempstead General Hospital.
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.

Managers shared learning with their staff about never events that happened elsewhere. Incident learning from Watford General Hospital was shared across the healthcare group for learning.

**Breakdown of serious incidents reported to STEIS**

We were unable to see evidence that staff reported serious incidents (SIs) clearly and in line with trust policy as there had been no reported SI’s since the service was transferred to West Hertfordshire Hospitals NHS Trust in October 2019. However, senior staff described the processes for serious incident identification and investigation in line with trust policy.

Managers told us they investigated incidents thoroughly and that patients and their families were involved in these investigations where necessary. However, there were no serious incidents in the service from October 2019 to the date of our inspection. We were therefore unable to review any investigations or root cause analysis reports.

**Hemel Hempstead General Hospital**

In accordance with the Serious Incident Framework 2015, there were no serious incidents (SIs) in medicine at Hemel Hempstead General Hospital which met the reporting criteria set by NHS England from January to December 2019. *(Source: Strategic Executive Information System (STEIS))*

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We spoke with ward and managerial staff. All could describe the meaning of the duty of candour.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff could describe changes to practice as a result of incidents. Staff we spoke with gave examples of incident discussion and daily safety huddles, team meetings and monthly clinical governance meetings.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety thermometer data was displayed on wards for staff and patients to see. Information boards on Simpson ward at Hemel Hempstead General Hospital displayed pressure ulcer and falls information for visitors and patients to see. This data was also discussed at team meetings and daily safety huddles.

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 49 new pressure ulcers, 16 falls with harm and five new urinary tract infections in patients with a catheter from November 2018 to November 2019 for medical services. Please note, this data pertains to West Hertfordshire Hospitals NHS Trust as a whole.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at West Hertfordshire Hospitals NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>Total pressure ulcers (49)</th>
<th>Total falls (16)</th>
<th>Total CUTIs (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>November</td>
<td>1.80</td>
<td>0.55</td>
<td>0.22</td>
</tr>
<tr>
<td>December</td>
<td>1.65</td>
<td>0.45</td>
<td>0.20</td>
</tr>
<tr>
<td>January</td>
<td>1.40</td>
<td>0.35</td>
<td>0.20</td>
</tr>
<tr>
<td>February</td>
<td>1.25</td>
<td>0.25</td>
<td>0.18</td>
</tr>
<tr>
<td>March</td>
<td>1.10</td>
<td>0.20</td>
<td>0.15</td>
</tr>
<tr>
<td>April</td>
<td>0.95</td>
<td>0.15</td>
<td>0.12</td>
</tr>
<tr>
<td>May</td>
<td>0.80</td>
<td>0.10</td>
<td>0.10</td>
</tr>
<tr>
<td>June</td>
<td>0.65</td>
<td>0.05</td>
<td>0.08</td>
</tr>
<tr>
<td>July</td>
<td>0.55</td>
<td>0.03</td>
<td>0.05</td>
</tr>
<tr>
<td>August</td>
<td>0.45</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>September</td>
<td>0.35</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>October</td>
<td>0.25</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>November</td>
<td>0.15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 - Safety Thermometer)

After our inspection we requested safety thermometer information directly relating to Simpson ward and Hemel Hempstead General Hospital. The trust told us this data was not available at individual ward level throughout the trust.

Is the service effective?
Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed a number of policies and guidelines and saw they referenced national guidance and were up to date. For example, resuscitation guidance referenced the UK resuscitation council guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff could describe the protected rights and described how to access mental health teams, where required.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Daily handovers addressed both the psychological and emotional needs of patients. We saw good attendance from staff at handover meetings and that other healthcare professional were included in care, where required.

Nutrition and hydration

Staff mostly gave patients enough food and drink to meet their needs and improve their health.

Staff mostly made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. During our inspection we saw staff offering and providing support to patients with food and drink. Water jugs and glasses were left in reach and patients were given a choice of food and refreshments.

Staff did not always fully and accurately complete patient’s fluid and nutrition charts where needed. In our review of nine nursing records, two were not accurately or comprehensively completed. Senior staff had recognised this concern and were taking steps to improve documentation and nutrition assessment awareness at the time of our inspection with online training planned after our inspection.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff used the malnutritional universal screening tool (MUST). However, we saw that in some cases, MUST scores were incorrectly calculated. Staff were due to attend online training to improve compliance with this at the time of our inspection.

Specialist support from staff such as dietitians was available upon requested from Watford General Hospital. Simpson ward accommodated patients who were deemed ‘medically fit’ only.

Pain relief

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

Staff assessed patient’s pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain scoring was adapted for patients with additional needs such as dementia.
Patients received pain relief soon after requesting it. In medical records we reviewed, we saw that patients received pain relief in a timely manner. Staff checked with patients to see if pain relief had been effective.

Staff prescribed, administered and recorded pain relief accurately. During our inspection and medical records review, we saw that staff prescribed, administered and recorded pain relief in line with trust policy.

**Patient outcomes**

**Due to the nature of service provided on Simpson ward, monitoring of the effectiveness of care and treatment was not always possible.**

The service had a lower than expected risk of readmission for elective care than the England average (please note this data pertains to August 2018 to July 2019).

Locally at Hemel Hempstead General Hospital, the service did not measure the risk of readmission for non-elective care as this was not relevant to the service provided.

**Relative risk of readmission**

**Trust level**

**Hemel Hempstead General Hospital**

From August 2018 to July 2019, patients at Hemel Hempstead General Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average of 100. All of these patients were cared for under gastroenterology.

**Elective Admissions - Hemel Hempstead General Hospital**

![Graph](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 represents the opposite. Top specialty for specific site based on count of activity.*

There were no readmissions for non-elective admissions recorded at the hospital over this time period.

*(Source: Hospital Episode Statistics)*

The service did not participate in national clinical audits as Simpson ward was an area for medically fit patients only, awaiting packages of care in the community.

The endoscopy service at Hemel Hempstead General Hospital participated in the Joint Advisory Group (JAG) on gastrointestinal endoscopy and was an accredited service.
Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers carried out a number of audits, including but not limited to; documentation, hand hygiene, fire safety and infection prevention and control.

**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 development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Training had been tailored to meet the needs of staff to care for patients on Simpson ward after transfer to West Hertfordshire Hospitals NHS Trust in October 2019.

Managers gave all new staff a full induction tailored to their role before they started work. All permanent and agency staff had a full induction prior to the commencement of role.

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of our inspection, the service had recently transferred from another healthcare provider. Therefore, staff were in the process of receiving their first appraisal within their employment at West Hertfordshire Hospitals NHS Trust.

**Hemel Hempstead General Hospital**

As of October 2019, 93.0% of staff within the medicine department at Hemel Hempstead General Hospital received an appraisal compared to a trust target of 90%. The breakdown by staff group can be seen in the table below (Simpson ward only):

<table>
<thead>
<tr>
<th>Staff group</th>
<th>As of October 2019,</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>12</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>29</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>9</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>53</td>
</tr>
</tbody>
</table>

Registered nursing staff in medicine at Hemel Hempstead General Hospital met the 90% target.

The trust was unable to provide site level appraisal data for medical staff. However, after our inspection the service provided evidence for the one member of medical staff who worked full time at the service on Simpson ward. Please see the table below for more details.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)
After our inspection we requested up to date appraisal compliance data which can be seen in the table below (relating specifically to staff on Simpson ward):

<table>
<thead>
<tr>
<th>Grade of staff</th>
<th>Appraisal compliance as of February 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 2</td>
<td>66.7%</td>
</tr>
<tr>
<td>Band 3</td>
<td>50%</td>
</tr>
<tr>
<td>Band 4</td>
<td>100%</td>
</tr>
<tr>
<td>Band 5</td>
<td>100%</td>
</tr>
<tr>
<td>Band 6</td>
<td>66.7%</td>
</tr>
<tr>
<td>Band 7</td>
<td>100%</td>
</tr>
<tr>
<td>Band 8a</td>
<td>100%</td>
</tr>
<tr>
<td>Staff grade practitioner (medical staff – 1 member)</td>
<td>100%</td>
</tr>
<tr>
<td>Overall compliance</td>
<td>83.3%</td>
</tr>
</tbody>
</table>

Whilst the overall target of 90% compliance was not met, staff had recently transferred employment from another healthcare provider. We saw plans in place to provide a structured support system for all staff, with a named mentor and clinical supervisor to aid learning and development.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Each member of staff had a named clinical supervisor as part of support structures in place.

The clinical educators supported the learning and development needs of staff. The matron of Simpson ward was passionate about developing staff to achieve their best potential and had a strong focus from their background in nursing education.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw team meeting minutes were shared electronically and through paper versions to ensure staff remained up to date with service changes and other information. Staff were encouraged to attend monthly team meetings.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff could approach senior staff for advice on development and discuss requirements at appraisal meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We saw where staff had been encouraged to develop, for example, enrolment on the associate practitioner training scheme.

Managers made sure staff received any specialist training for their role. We saw that senior staff arranged various training to increase staff knowledge in various areas including but not limited to; nutrition and continence care.

Checklists were in place to ensure that temporary locum staff had the necessary skills to safely work within Simpson ward.

**Multidisciplinary working**
Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw regular discussion taking place with medical staff and other healthcare professionals such as occupational therapists and physiotherapists.

Patients had their care pathways reviewed by the relevant consultants. Weekly consultant reviews took place on Wednesday each week. Monday to Friday, a registrar was present on site to liaise with their consultant around patient care should the need arise. The registrar told us their consultant was supportive and accessible at all times.

Staff worked closely with colleagues from Watford General Hospital to ensure that only clinical suitable patients accessed the service at Simpson ward at Hemel Hempstead General Hospital.

Staff within the endoscopy service at Hemel Hempstead General Hospital worked at Watford General Hospital also. This meant staff could work across both sites to provide tailored care for patients.

Staff at Hemel Hempstead General Hospital worked closed with other health and ages services such as care homes and social services. The service had ‘progress chaser’ in post three days a week, whose role was to liaise with various services to arrange and facilitate timely discharge.

Staff worked across health care disciplines and with other agencies when required to care for patients. There was a strong focus on the process of discharge for patients on Simpson ward. We saw regular communication taking place with other agencies such as social services to ensure correct packages of care were in place prior to discharge.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff we spoke with could describe of escalation processes for patients requiring mental health team input. We saw an example where one patient had been referred to this service and assessed within a timely manner.

Seven-day services

Key services were available seven days a week to support timely patient care on Simpson Ward. The endoscopy service operated Monday to Friday with the provision of weekend opening dependent on demand.

Consultants led weekly ward rounds on Simpson ward on a Wednesday. All patients on Simpson ward were deemed ‘medically fit’ with a registrar doctor available Monday to Friday, 9am to 5pm.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Out of hours, medical advice was available through the NHS 111 system or through emergency ambulance transfers to the nearest emergency department.

The endoscopy service was open Monday to Friday, with weekend appointments offered dependent on demand.

Health promotion
Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the wards/units. Various information leaflets were provided including dementia advice and healthy lifestyles.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient’s consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients’ liberty appropriately.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw staff seeking verbal consent where required prior to treatment.

Staff clearly recorded consent in the patients’ records. In all records we reviewed, we found documented evidence of informed consent and evidence that mental capacity assessments had taken place.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff described how they assessed if a patient had capacity. Staff were clear on what actions to take if there were unsure including escalation to a senior member of staff.

When patients could not give consent, staff made decisions in their best interest, taking into account the patient’s wishes.

Staff made sure patients consented to treatment based on all the information available. We saw staff discussing various treatments and medication administration with patients so they could understand their care and give informed consent where possible.

Mental Capacity Act and Deprivation of Liberty training completion

Nursing and midwifery staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the trust’s target.

The trust set a target of 90% for the completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

Trust level

Hemel Hempstead General Hospital

Compliance for MCA/DoLS (essential) training from April to October 2019 for qualified nursing and medical and dental staff in medicine at Hemel Hempstead General Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>32</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>2</td>
</tr>
</tbody>
</table>
In medicine at Hemel Hempstead General Hospital, the target of 90% for MCA/DoLS (essential) training was met by both qualified nursing staff and medical and dental staff.

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 (MCA) and the Children Acts 1989 and 2004 and they knew who to contact for advice. All staff we spoke with could describe the process of obtaining consent and who to escalate concerns to if required.

Managers monitored the use of Deprivation of Liberty Safeguards (DoLS) and made sure staff knew how to complete them. We reviewed all DoLS for patients being cared for at the service. All had been completed correctly. Whilst we saw that not all DoLS had been approved within a timely manner due to a shortage of assessors, staff could explain when a DoLS order required review; for example, in circumstances where the condition of a patient may change.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff at Hemel Hempstead General Hospital had access to a trust wide mental capacity policy. The policy was in date and due for review in June 2021. The policy contained guidance for staff on the MCA and outlined staff’s responsibilities in relation to the act.

Data provided after our inspection demonstrated that 100% of nursing staff working in the endoscopy service at Hemel Hempstead General Hospital, had received and were up to date with MCA and DoLS training. This exceeded the service’s target of 90%.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients told us that staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential. We saw that sensitive conversations took place in private and with curtains drawn around the bedside. Staff knocked and waited prior to entering side rooms.

Staff introduced themselves by name and at all times during our inspection we saw staff treating patient with dignity and respect when interacting with patients, their relatives and when providing care.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We saw evidence of staff discussing a patient with mental health needs in a kind and compassionate manner, taking in to account the holistic needs of the patient.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We spoke with a number of staff who described additional
information around religious and cultural needs was gathered at the point of admission to Simpson ward. We saw this information was discussed and reviewed on a daily basis and that individual needs, such as dietary requirements, were catered for.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. (After our inspection we requested three months of friends and family test data (November 2019 – January 2020). The trust told us that they received 17 responses relating directly to Simpson ward at Hemel Hempstead General Hospital, all of which were likely or extremely likely to recommend the service to their friends or family.

Patients gave positive feedback about the service. All patients, relatives and carers we spoke with gave positive feedback about the service they loved one received. Comments included but were not limited to; ‘I am happy with the care provided and feel well informed about what is happening’.

Staff could give examples of how they used patient feedback to improve the quality of care they provided. For example, changes and improvements to communication as a result of patient feedback.

**Emotional support**

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient’s personal, cultural and religious needs.**

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff interacted with patients and family members/carers on a regular basis, ensuring they were supported to cope and understand the individual needs of patients.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. During our inspection, we saw that staff maintained patients’ privacy, dignity and provided support when patients became distressed. We saw that patients living with dementia were given one to one time and support when distressed.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Relative and carer feedback about the service and staff was positive.

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

**Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. We saw staff speaking with patients and their relatives over the course of our inspection. In addition, each patient had a named doctor and nurse, so this ensured consistency in care.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We saw that staff involved both patients and their family/carers in to discussions about their care, discharge plans and treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff encouraged patients and their families to feedback. Information
on Simpson ward encouraged feedback and we saw staff regular speaking with patients and their families during our inspection.

When speaking with patients and their relatives, they described feeling involved with their plan of care and discharge.

**Is the service responsive?**

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Simpson ward provided a service at Hemel Hempstead General Hospital to alleviate pressure on Watford General Hospital and specifically care for patients who were deemed medically fit and awaiting discharge. The service relieved pressure on other departments such as medical wards at Watford General Hospital by providing care for patients awaiting discharge packages (who were medically fit).

The endoscopy service at Hemel Hempstead General Hospital was planned and delivered in conjunction with the service at Watford General Hospital. This allowed patients to access the service both locally and in a timely manner. For more information, please see the access and flow section of this report.

Staff understood the standards for mixed sex accommodation and knew when to report a breach. There had been no mixed sex breaches since the service was acquired by West Hertfordshire Hospitals NHS Trust in October 2019. Each bay was gender specific with dedicated washing and toilet facilities.

Facilities and premises were appropriate for the services being delivered. The premises were accessible by both car and public transport with plenty of public car parking. There was a dedicated area for the storage of large equipment such as hoists and storage areas for other consumable items.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

**Meeting people’s individual needs**

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Simpson ward was designed to meet the needs of patients living with dementia. Wards were created as dementia friendly environments and had occupational therapy input with its design and flooring. Flooring was ‘matted’ to prevent reflection/glare and colour schemes were neutral to promote a relaxing environment.
Additional and complex needs were reviewed and assessed at point of admission to Simpson ward and reviewed with staff on a daily basis at huddles.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We evidence that regular multidisciplinary team meetings gathered together healthcare professionals to provide a rounded package of care to meet patient needs.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. Staff had received dementia awareness training. Simpson ward staff had access to a number of items such as colouring books, twiddle mitts and other tactile objects to help patients with dementia.

Daily activities took place to engage patients with additional needs. During our inspection we saw one member of staff organising and playing bingo with patients. Support and encouragement was provided to patients with additional needs such as dementia to encourage participation.

Managers made sure staff, patients and their loved ones and carers could get help from interpreters or signers when needed. Staff had access to translation services where required. Upon arrival at Simpson ward, patients and their relatives received a welcome letter explaining facts and information about the ward. This was available in a variety of languages. The service had information leaflets available in different languages spoken by the patients and local community. These were available on request from West Hertfordshire Hospitals NHS Trust.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff discussed individual patient requirements on a daily basis and liaised with onsite catering teams to meet the needs of patients.

**Access and flow**

**People could access the service when they needed it and received the right care promptly.**

All patient accessing care at Hemel Hempstead General Hospital were deemed medically fit prior to discharge from Watford General Hospital. Patients transferred to Hemel Hempstead General Hospital were awaiting packages of care or placement into residential care services.

Managers and staff worked to make sure patients did not stay longer than they needed to on Simpson ward. Staff worked closely with other healthcare professional and agencies such as social workers to discharge patients in a timely manner with appropriate packages of care.

Managers and staff worked to make sure that they started discharge planning as early as possible. Daily reviews of discharge planning took place for all patients within the ward. During our inspection we saw full discussion taking place with updates on packages of care.

Staff planned patient’s discharge carefully, particularly for those with complex mental health and social care needs. We saw evidence that staff took in to account various patient needs with often difficult and complex discharge requirements.

Managers monitored the number of delayed discharges. This was carried out my senior staff on Simpson ward in conjunction with West Hertfordshire Hospitals NHS Trust site team based at Watford General Hospital.
Patient accessed the endoscopy service at Hemel Hempstead General Hospital through GP referral and the NHS ‘choose and book’ system. Endoscopy booking staff were available on site at Hemel Hempstead General Hospital to facilities bookings and appointments.

All patients for endoscopy were seen as ‘day cases’. As we did not visit this service due to ongoing coronavirus/COVID 19 restrictions, we requested performance data for all endoscopy services. Data for February 2020 showed that between 99.4% and 100% of all patients were seen within a six week timeframe.

**Average length of stay**

**Hemel Hempstead General Hospital**

Managers and staff worked to make sure patients did not stay longer than they needed to.

From September 2018 to August 2019 the average length of stay for medical elective patients at Hemel Hempstead General Hospital was 1.7 days, which was lower than England average of 5.8 days.

- Average length of stay for elective patients in gastroenterology was lower than the England average.

There was no data for other elective specialities at Hemel Hempstead General Hospital over this time period. Simpson ward at Hemel Hempstead General Hospital provided care for medically fit patients only.

**Elective Average Length of Stay - Hemel Hempstead General Hospital**

![Average Length of Stay Chart](Image)

*Note: Top specialty for specific site based on count of activity.*

Data on average length of day for non-elective readmissions at Hemel Hempstead General Hospital has been suppressed due to low numbers to protect patient confidentiality.

*(Source: Hospital Episode Statistics)*

After our inspection we requested data showing the average length of stay for patients on Simpson ward. Data showed that for the months of November 2019, December 2019 and January 2020, length of stay ranged between 36.3 and 38.7 days.

**Patient moving wards per admission**

**Hemel Hempstead General Hospital**
From October 2018 to September 2019, the trust did not report any ward moves for non-clinical reasons at Hemel Hempstead General Hospital.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

**Patient moving wards at night**

**Hemel Hempstead General Hospital**

From October 2018 to September 2019, the trust did not report any ward moves at night at Hemel Hempstead General Hospital. There was only one ward at Hemel Hempstead General Hospital under the care of West Hertfordshire NHS Trust. Therefore, ward moves at night were not possible.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

**Learning from complaints and concerns**

*It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.*

Patients, relatives and carers knew how to complain or raise concerns. All patients, carers and relatives we spoke with could describe how to make a complaint or raise a concern if required.

The service clearly displayed information about how to raise a concern in patient areas. Complaints and feedback information was available on Simpson ward to signpost patients, relatives and carers to the complaints process.

Staff understood the policy on complaints and knew how to handle them. The ward sister and matron oversaw complaints handling.

**Summary of complaints**

**Hemel Hempstead General Hospital**

Staff could give examples of how they used patient feedback to improve daily practice. We saw evidence where a verbal complaint had been appropriately escalated, discussed and shared with staff, with mitigating actions taken to improve communication with the family of one patient.

Managers investigated complaints and identified themes. Senior staff described complaint investigation processes in line with trust policy.

**Hemel Hempstead General Hospital**

There were no complaints made relating to the endoscopy service at Hemel Hempstead General Hospital for the 12 months prior to our inspection.

Staff at Hemel Hempstead General Hospital had access to a trust wide complaints and concerns handling policy. The policy was in date and due for review in April 2022. The policy contained guidance for staff on complaints handling and referenced the duty of candour.

**Number of compliments made to the trust**
Hemel Hempstead General Hospital

From January to November 2019, there were no compliments received about medicine at Hemel Hempstead General Hospital. Please note, this data pertained to the endoscopy service at Hemel Hempstead General Hospital only.

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

Is the service well-led?

Leadership

Leaders had the right skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Trust wide, the medicine division at West Hertfordshire Hospitals NHS Trust was overseen by clinical director, divisional manager, and head of nursing.

The service had a clear leadership structure in place. Locally, the ward manager for Simpson ward reported to the matron, who in turn reported to the trust wide deputy head of nursing, and overall head of nursing based at Watford General Hospital. The leadership team was new as the service had come to West Hertfordshire Hospitals NHS Trust in October 2019.

All staff we spoke with described the matron and ward sister as visible and approachable on Simpson ward at Hemel Hempstead General Hospital. However, the matron’s role was a secondment and due to come to an end in March 2020. Whilst the post was out to advert, staff expressed concerns over the uncertainty of future leadership of the service.

Leaders were driven to develop existing staff to take on more senior roles such as associate practitioner from healthcare assistant.

The matron for the service described the trust wide executive team as approachable and supportive.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. However, the strategy was more focused on West Hertfordshire Hospitals NHS Trust rather than Simpson ward at Hemel Hempstead General Hospital. We could not see evidence that the vision and strategy were focused on sustainability of services on Simpson ward at Hemel Hempstead General Hospital.

The service had a medicine division strategy 2019-2021 in place. The service’s vision was ‘to provide the very best care for every patient, every day’. The mission was ‘to provide safe quality care for patients, carers and staff’. During our inspection we saw that all staff were aware of and demonstrated the service’s vision.
We reviewed the strategy and noted that there was no reference to Simpson ward, based at Hemel Hempstead General Hospital. The strategy focused more on Watford General Hospital. At the time of our inspection, there was uncertainty if Simpson ward would remain part of West Hertfordshire Hospitals NHS Trust or be transferred to another provider.

All staff we spoke with were passionate about providing a high quality and safe service and were proud to work at the service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff we spoke with told us they valued, respected and proud to work on Simpson ward at Hemel Hempstead General Hospital.

Staff described an open culture where concerns could be raised without the fear of reprisal and that senior staff were both visible and approachable.

Senior staff were passionate about empowering staff to take ownership of learning and develop their role.

During our inspection we saw that staff of all grades worked as a team to benefit patients.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear governance structure in place within the medical division at West Hertfordshire Hospitals NHS Trust. For more information, please see the medical care report relating to Watford General Hospital.

Locally, on Simpson ward staff at Hemel Hempstead General Hospital were clear about their roles, responsibilities and accountability within the service.

Monthly clinical governance meetings took place. After our inspection, we requested clinical governance meetings minutes from November and December 2019. Minutes showed that a range of subjects were discussed including but not limited to; risks, incidents, complaints and the service’s strategy.

Our review of meeting minutes showed that whilst Simpson ward was referenced in the December 2019 minutes, information around this service was limited and neither the matron or ward manager for the service had attended the November and December 2019 meetings.

There were effective processes in place to ensure that identified risks were escalated and reviewed in a timely manner and that risks were taken to the trust wide team.
Within the endoscopy service, clinical governance meetings took place on a three monthly basis. Monthly governance reports were reviewed on a monthly basis to monitor the quality of the service. We saw that incidents rates, risk registers and other information was monitored on a regular basis.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact.

Senior staff were clear in their roles and responsibilities to escalate potential risks. Any new risks were assessed, prior to presentation at governance meetings with input from the trust wide governance team.

During our inspection, senior staff told us that the risk register for Simpson ward was held at Watford General Hospital. Locally, senior staff verbally described the top risks the service faced on Simpson ward. This included but was not limited to; mandatory training and staffing. The medicine division overarching risk register included risks on Simpson ward at Hemel Hempstead General Hospital (held at Watford General Hospital).

We saw a risk register specific to Simpson ward which detailed two risks; education and training (documentation compliance) and information technology (network issues linking with Watford General Hospital). The risk around mandatory training compliance was not documented as a risk. Therefore, we could not gain assurances that all risks had been effectively identified, reviewed and that mitigation was in place where possible.

Although compliance with documentation had been identified as a risk, we found concerns with medical records completion throughout our inspection. We could not gain assurances that action had been taken in a timely manner to improve compliance and that processes were effective and embedded.

In addition, we identified concerns and risk around the Substances subject to the Control of Substances Hazardous to Health Regulations 2002 (COSHH, 2002). Substances were not stored in line with service policy. This had not been identified as a risk by service leaders.

Senior staff told us that risks were regularly discussed, reviewed and overseen at monthly governance meetings in conjunction with staff at West Hertfordshire Hospitals NHS Trust. This was demonstrated in our review of clinical governance meetings relating to the endoscopy service at Hemel Hempstead General Hospital.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The service on Simpson ward at Hemel Hempstead General Hospital regularly monitored the quality of care provided through the use of dashboards and audits.
Staff received training on information governance as part of mandatory training. During our inspection we saw that computer terminals, paper based medical records and other confidential information was securely stored.

Due to the nature of services provided, Simpson ward did not participate in national audit programmes. This was not required as the service provided care for patients who were deemed medically fit and awaiting discharge.

**Engagement**

*We saw evidence that leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.*

Leaders told us that Simpson ward staff engagement meetings took place on a monthly basis. After our inspection we requested meetings minutes from October 2019 to January 2020. We reviewed the November 2019, December 2019 meetings minutes and saw attendance from a wide range of staff including leaders from the service. Minutes demonstrated discussion around a number of areas including but not limited to; medical records documentation, infection prevention and control, mandatory training and staffing. Ward meeting minutes were held in a folder on site and also emailed to staff for information.

All staff we spoke with told us that they attended staff meetings on a regular basis and that senior staff maintained a visible presence for support where required. However, we spoke with a number of staff who outlined concerns around the future of Simpson ward, voicing concerns around the possibility of the service moving to another provider. Staff described uncertainty and a lack of information from trust wide senior staff around the future of the ward and service.

Staff within the endoscopy service at Hemel Hempstead General Hospital received electronic updates on a regular basis to inform them of news and another service related information.

The service collaborated with other organisations such as the previous provider of care on Simpson ward. In addition, they worked closely with social services to manage the flow of patients upon discharge to home, or other care services.

**Learning, continuous improvement and innovation**

*All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.*

At the time of our inspection, Simpson ward had been recently transferred to West Hertfordshire Hospitals NHS Trust in October 2019.

Locally, senior managers had made a number of improvements to the service since our last inspection in 2016.

Improvements included but were not limited to; staffing meeting the individual need of patients, appropriate Deprivation of Liberty Safeguards were in place, multidisciplinary team involvement and regular consultant led reviews, the provision of activities to meet the needs of individual patients, a formal admission criteria was now in place and discharge processes were monitored and reviewed on a regular basis.