West Hertfordshire Hospitals NHS Trust

Quality Report

Trust Headquarters
Vicarage Road
Watford
Hertfordshire
WD18 0HB
Tel: 01923 436228
Website: www.westhertshospitals.nhs.uk

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

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

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

This was the second comprehensive inspection of the trust the first taking place in April and May 2015. It was rated as inadequate overall and went into special measures in September 2015.

Part of the inspection was announced taking place between 6 and 9 September 2016 during which time Watford Hospital, St Albans Hospital and Hemel Hempstead Hospital were all inspected. Unannounced inspections were undertaken of Watford Hospital and Hemel Hempstead on the 19 September 2016.

Overall, we rated West Hertfordshire Hospitals NHS Trust as requires improvement. The key questions for safe, effective, responsive and well led were all rated as requires improvement and caring was rated as good.

Our key findings were as follows:

- Whilst most staff were kind and caring we found concerns relating to staff attitude towards patients on the medical ward at Hemel Hempstead Hospital. In addition there were some examples in the outpatients department where patients' privacy and dignity was compromised.
- There were systems and process in place for the assessment and response to risk however these were not consistently adhered to.
- Patients attending the emergency department were not consistently receiving treatment in a timely manner.
- There was no clear streaming process at the urgent care centre at Hemel Hempstead Hospital or the minor injury unit at St Albans City Hospital. This had not improved since the last inspection. It was raised with the trust who took actions to address this risk to patient safety. Also in these areas there was not a robust process to monitor arrival to initial clinical assessment or ensure all children were seen by a clinician within 15 minutes.
- There was no process in place for the safe storage of patients own controlled drugs. Also some room temperatures were higher than deemed appropriate for the safe storage of medicines and appropriate action had not been taken to address this.
- Not all relevant staff that required level three safeguarding children training had been identified as requiring this. There were areas in the trust that cared for patients aged 16 to18 years in which staff had not been trained to level three.
- Pain relief was not routinely checked or provided to patients in the emergency department.
- Regular fluids were not provided to patients in the emergency department, despite the high temperatures during the inspection.
- Records were not completed consistently in a timely manner.
- Whilst most staff were aware of their roles and responsibilities in the management and reporting of incidents, concerns and near misses, this was not consistent in all areas of the trust. Evidence of learning was inconsistent throughout the trust.
- Although there was a comprehensive duty of candour policy in place, staff knowledge was variable and processes were not robust, not all incidents that met the threshold were identified or managed appropriately.
- Patients did not have their mental capacity assessed in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and associated code of practice.
- Results from audits varied with a lack of clear action planning to address areas of weakness.

Summary of findings

- There was not an effective process in place to monitor and review patient outcomes on the urgent care centre, minor injury unit or the medical ward at Hemel Hempstead.
- The access to the service and flow of patients through the trust was not effective. Medical patients were transferred numerous times often out of hours.
- The trust had a higher proportion of delayed transfers of care at 26.7%; this was nearly 10% higher than the proportion for all trusts in England.
- The emergency department was failing to meet a number of targets and breaches had become acceptable.
- The trust was not meeting the target of two weeks wait for suspected cancers, including possible breast cancer.
- Patients did not always have timely access to initial assessment or treatment with referral to treatment times below the England average.
- Complaints were not responded to in a timely way.
- Risks to the service had not all been identified by the trust, in particular on Simpson ward.
- Whilst the trust had a governance framework in place there were some areas of weakness. Both this and the divisional structure were relatively new so the processes were not yet fully embedded and it was too early to assess the impact.
- Most staff felt respected and valued however there were some areas where there was friction between staff disciplines and staff who felt uncomfortable speaking out.
- The trust had a relatively stable board since the last inspection so had been able to develop their skills and experience, although the chair and chief executive had both commenced in the intervening period.
- Staffing levels and skill mix was planned and reviewed using bank and agency staff when required to maintain safe care and treatment. The trust reported that they would have no consultant vacancies by October 2016.
- Care was mostly delivered in line with legislation, standards and evidence-based guidelines.
- The Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) was lower (better) than expected. The trust was one of 17 trusts nationally with a lower than expected HSMR.
- The percentage of patients waiting less than six weeks for a diagnostic appointment was consistently better than the national average.
- The trust was working with stakeholders to ensure service were planned to take account of different people.
- The numbers of MRSA, MSSA), and **Clostridium difficile,** reported between June 2015 and May 2016 were lower than the England average. Between June 2015 and June 2016 there were low numbers and prevalence rates of pressure ulcers, falls with harm and catheter acquired urinary tract infections reported.
- The children's emergency department was outstanding in terms of environment. Children and young people had a dedicated resuscitation area away from the adult department, which was set up with equipment and medicines for children. The medicines storage and management of medicines in the children's emergency department was exemplary.
- The urgent care centre and minor injury unit consistently met the target to admit, transfer or discharge 95% of patients within four hours of arrival at the unit.

We saw several areas of outstanding practice including:

- The children's emergency department was outstanding in terms of environment. Children and young people had a dedicated resuscitation area away from the adult department, which was set up with equipment and medicines for children and young people up to the age of 16 years.
- The trust reduced the mortality rate for hip fractures, from February 2013 to February 2016 from 12% to 4%, with a continuing downward trajectory, by reviewing their hip fracture care pathway. This

Summary of findings

pathway supported good communication between the emergency department and the orthopaedic service and there were dedicated "ring fenced" beds to support fast treatment.

- The trust has Hospital Standardised Mortality Ratio (HSMR) rates lower than expected, sustained for 18 months.

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

Importantly, the trust must:

- Ensure that care for patients with mental health issues in the emergency department is safe by ensuring that they are cared for in a safe environment, that their safety is risk assessed, and that staff are suitably trained to meet their needs, as well as keep staff safe from harm.
- Ensure governance quality systems, including the reporting of incidents, duty of candour, completion of local audits, learning from incidents and complaints and ensuring the risk register is up to date.
- Ensure that observations of patients who could be acutely unwell are undertaken in a timely way and escalated as required.
- Ensure the timely completion of patient records.
- Ensure that patients who have been in the emergency department for more than six hours are reviewed by a senior clinician and are risk assessed.
- Ensure that there is a provision for the offering of regular drinks to patients during their time in the emergency department.
- Ensure that there are appropriate systems in place to track the patients and the expiry of those being treated under a deprivation of liberty safeguards.
- Ensure that staff completing 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms where a person lacks capacity to make an informed decision or give consent act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- Ensure that all staff caring for patients less than 18 years of age have completed safeguarding level 3 training.
- Ensure the safe management of medicines at the hospital complies with Home Office 2016 guidelines on the security of controlled medicines. This includes patients' own medication.
- Ensure that there are procedures in place for the safe management of temperatures within treatment rooms and areas where temperature sensitive medications are stored.
- Prescriptions for syringe pumps must comply with the trust's prescribing standards.
- Ensure that mandatory training compliance meets trust targets of 90%, including
- Devise an action plan to address the shortfall between appraisal rates and the trust target and make sure that the trust target is reached.
- To ensure that there are effective streaming systems in place in the urgent care centre and minor injury unit and all staff have had appropriate training to carry out this process.
- Ensure there are processes in place to monitor arrival time to initial clinical assessment for all patients in the urgent care centre and minor injury unit.
- To establish a process so that all children are seen by a clinician within 15 minutes of arrival in the urgent care centre and minor injury unit.
- To ensure that there are effective processes in place in the urgent care centre and minor injury unit to provide clinical oversight for patients waiting to be seen.
- To ensure non-clinical staff in the urgent care centre and minor injury unit receive sufficient support or training to provide oversight to recognise a deteriorating patient.
- To ensure the urgent care centre and minor injury unit have direct access to a registered children's nurse at all items and that paediatric competencies for emergency nurse practitioners are recorded as a part of their continuous professional development (CPD) in line with national recommendations.

Summary of findings

- To ensure that effective governance frameworks, standard operating procedures and policies are in place to support service delivery urgent care centre and minor injury unit.
- To ensure that systems and processes are in place to monitor and review all key aspects of performance to identify areas for improvement and all potential risks in the minor injury unit and surgery at St Albans and the urgent care centre and Simpson ward at Hemel Hempstead.
- To ensure that staff are given training and support to understand the duty of candour statutory requirements.

- Plans must be put into place to ensure referral to treatment (RTT) times to continue to improve so that they are similar to or better than the England average.
  - To ensure that the Simpson ward can meet the needs of patients with vulnerabilities, including those living with a dementia and those displaying difficult behaviours and to ensure the provision of activities to engage patients in meaningful stimulation.
  - To review the admission and exclusion criteria for Simpson ward to ensure all referred patients have their needs met.
  - To improve the percentage of patients to be seen within 18 weeks of referral from a GP for an outpatient appointment.
  - To improve the percentage of patients waiting to see a consultant with a suspected cancer to meet the national target of 93%.
- To ensure all resident medical officers (RMOs) receive a trust induction.
  - Actions on fire risk assessments in surgery at St Albans City Hospital must be completed and areas regularly monitored for future compliance
- To ensure staff levels and competency of staff meets patient need at all times on Simpson ward.

On the basis of this inspection, I have recommended that the trust remains in special measures.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to West Hertfordshire Hospitals NHS Trust

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

There are 681 inpatient beds throughout the trust and over 4000 staff are employed. The majority of acute services are delivered at Watford Hospital, which provides a full range of district general hospital services, with over 600 inpatient beds, of which 48 are maternity and 19 are critical care. Hemel Hempstead Hospital provides an urgent care centre, one medical ward of 22 beds, 12 of which are dedicated stoke beds and the others for intermediate care. Outpatients and diagnostic services are also provided. St Albans City Hospital is the trusts elective care centre. It provides inpatient low risk surgery and day-case surgery as well as outpatient and diagnostic services. It has 40 beds and a minor injuries unit.

In 2015/16 the trust had revenue of £299.8m and a deficit of £41.2m.

We carried out an announced comprehensive inspection of the trust from 6 to 9 September 2016. We undertook unannounced inspections on 19 September 2016.

This was the second comprehensive inspection of the trust, the first taking place in April and May 2015. It was subsequently rated as inadequate overall and went into special measures in September 2015.

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

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

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children's and young people
- End of life care
- Outpatients and diagnostic imaging

The following four core services at Hemel Hempstead Hospital:

- Urgent and emergency services
- Medical care (including older people's care)
- End of life care*
- Outpatients and diagnostic imaging

* included safety issues in the mortuary only

The following three core services at St Albans City Hospital:

- Minor injuries unit
- Surgery
- Outpatients and diagnostic imaging

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Specialist advisor

Head of Hospital Inspections: Bernadette Hanney, Care Quality Commission

The team included 15 CQC inspectors, two CQC pharmacy inspectors and a variety of specialists: safeguarding lead, consultants and nurses from accident and emergency departments, medicine and surgical services, senior managers, an anaesthetist, senior paediatric nurses and a neonatal consultant, a consultant obstetrician, midwife, allied health professionals and a palliative care consultant.

Summary of findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive of people's needs?
- Is it well-led?

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

We set up a display near the restaurant at Watford Hospital and at St Albans Hospital to encourage and ask people to share their views and experiences of services provided by West Hertfordshire NHS Trust. Some people also shared their experience by email, telephone or completing comment cards.

We carried out this inspection as part of our comprehensive programme of re-visiting trusts which are in special measures. We undertook an announced inspection from 6 to 9 September 2016 2016 and unannounced inspection on 19 September 2016.

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

What people who use the trust's services say

In the CQC inpatient survey 2015 the results were similar to other trusts except for one question relating to the length of delay which scored within the worst performing trusts.

The trusts overall score in the friends and family test (June 2015 to May 2016) was consistently similar to the national average.

In the National Cancer Patient Experience Survey 2015, the trust scored:

- 43 questions within expectations
- five questions higher than expected, which included staff giving patients information on financial help, that they could get free prescriptions and patients being given a plan of care
- two questions lower than expected, which included staff talking in front of patients as if there were not there and discussing with the patient taking part in cancer research.

In the patient-led assessment of the care environment (PLACE) survey 2015, the trust scored lower than the England average in all four areas. There was an improvement in the trust's score for privacy, dignity and wellbeing compared to their 2014 result.

Facts and data about this trust

Overall, West Hertfordshire Hospitals NHS Trust has 681 beds, over 4,500 staff and provides acute healthcare services to a core catchment population of approximately half a million people living in west Hertfordshire and the surrounding area. The trust also provides a range of more specialist services to a wider population, serving residents of North London, Bedfordshire, Buckinghamshire and East Hertfordshire.

In 2015/16 the trust had 94,530 inpatient admissions, 454.558 outpatient attendances, 88,673 attendances at the accident and emergency department at Watford Hospital, 14,683 attendances at the minor injury unit at St Albans Hospital and 34,524 attendances at the urgent care centre at Hemel Hempstead General Hospital.

In 2015/16 the trust had revenue of £299.8m and a deficit of £41.2m.

Summary of findings

Bed occupancy was around the England average of 90% which is above the level, 85%, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.

Overall the population served by the trust is relatively affluent, but there are some areas of deprivation. Statutory homelessness is worse than the English average in the areas of: Dacorum, Three Rivers, Hertsmere and Watford. Decorum is worse than the English average for physically active adults, Hertsmere for road injuries and death and Watford for acute sexually transmitted diseases and excess winter deaths.

As an employer of over 4,500 staff the trust is one of the biggest employers in the area.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We rated safety in the trust as requires improvement. Eight services were rated as requires improvement, two as inadequate and four as good. We did not rate safety in end of life care at Hemel Hempstead Hospital. We have made a decision on proportionality that the inadequate rating for safety at Hemel Hempstead Hospital, as it relates to just one ward, will not impact on the overall rating for safety at trust level. • Whilst there was a comprehensive duty of candour policy in place, staff knowledge was variable and processes were not robust, not all incidents that met the threshold were identified or managed appropriately. • Not all relevant staff who required safeguarding children level three training had been identified. There were areas within the trust that saw patients aged 16-18 years that did not have training to level three. This was not compliant with the Royal College of Paediatrics and Child Health (2014) Intercollegiate document. Therefore we could not be sure staff had the sufficient knowledge and skills to safeguard children. • Most staff were aware of their roles and responsibilities in the management and reporting of incidents, concerns and near misses, however this was not consistent in all areas of the trust. Evidence of learning was inconsistent throughout the trust. • There were systems and process in place for the assessment and response to risk however these were not consistently adhered to. • There was no clear streaming or triage process in place at the urgent care centre (UCC) or minor injuries unit (MIU) although the trust took action when we raised this with them. • In the emergency department at Watford the median time to treatment had been higher than the England average between September 2015 and March 2016. • The majority of ward and clinical areas were visibly clean. Overall infection rates were low. • There was no process in place for the safe storage of patients own controlled drugs. • Staffing levels and skill mix was planned and reviewed using bank and agency staff when required so that patients received safe care and treatment. • Records were stored securely.	**Requires improvement** 

Summary of findings

Duty of Candour

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- The trust had a comprehensive duty of candour policy dated November 2015, for review November 2017 which detailed the background, responsibilities, reporting arrangements, key performance indicators and template for letters and a communication log.
- The chief nurse was the nominated executive lead for championing and implementing the principles of being open and duty of candour. The safety and quality team had overall responsibility for the being open and duty of candour process. Duty of Candour compliance was reported on in the quality and safety integrated performance report which was presented to the safety and quality committee at its meeting which took place every two months. The focus of the report was on the timeliness of duty of candour rather than including a review on whether cases had been appropriately considered against the requirements of the regulation.
- We reviewed seven incidents, four of which were recorded as moderate harm and three as serious harm. In three of the records there was no evidence of any consideration of duty of candour. We were therefore not assured that all incidents that met the threshold were identified or that the trust policy was consistently followed.
- The trust recognised that the processes for duty of candour were not robust and were in the process of taking action which included introducing a mandatory field in the electronic incident reporting system to log and record compliance.
- Staff knowledge of the duty of candour was variable across the trust. Staff were aware of their responsibility to be open and honest when things went wrong but were not all aware that there was a specific process and regulation, or of the trust's duty of candour or 'being open' policy.

Safeguarding

- Overall, staff told us they felt confident reporting safeguarding concerns and were given support with this. Policies and procedures for safeguarding were in place and were updated to reflect changes in national guidance and legislation.

Summary of findings

- Staff were able to tell us how they would report concerns through the trust procedures and knew who they should contact.
- We saw evidence of the use of an electronic child protection alert system in the emergency department (ED) which was linked to community and primary care.
- We were told by trust staff of the strong links with the adult and children safeguarding boards and this was reflected in the trust safeguarding annual report.
- The trust's safeguarding children handbook (3rd edition) had been fully updated with new information relating to the mandatory duty to report female genital mutilation (FGM), child sexual exploitation (CSE) and Prevent. The handbook provided information and support for staff to use in the assessment and decision making process when they had safeguarding concerns about a child.
- The trust sexual health pro-forma was a document used to assist in assessing young people attending with concerns about risky sexual behaviour and to assist in identifying potential CSE.
- The trust produced a bi-annual safeguarding newsletter which was distributed to all staff. This provided information on the safeguarding team, contact numbers and key safeguarding issues.
- Overall, compliance with safeguarding training met the trust internal threshold of 90%. As of September 2016, 90% of medical and dental staff and nursing and midwifery staff had achieved level one safeguarding adult training and 92% had received training to level two. For safeguarding children, 91% of medical and dental staff and 94% of nursing and midwifery staff had achieved level one, 94% of medical and dental staff and 96% of nursing and midwifery staff had achieved level two and 98% of medical and dental staff and 96% of nursing and midwifery staff had achieved level three. However not all relevant staff who required level three training had been identified. There were areas within the trust that saw patients aged 16-18 years that did not have training to level three. This was not compliant with best practice outlined by the Royal College of Paediatrics and Child Health (2014) Intercollegiate document, which states that level three is the required level of training for those staff assessing, planning or intervening with children, young people and/or their parents or carers where there are safeguarding concerns.
- We saw evidence of an appropriate safeguarding supervision programme in maternity and paediatrics.

Incidents

- Most staff were aware of their roles and responsibilities in the management and reporting of incidents, concerns and near misses, however this was not consistent in all areas of the trust. Evidence of learning from them was inconsistent throughout the trust.
- There was an in date incident policy on the intranet at the time of inspection which had been ratified in November 2015. It was a comprehensive policy clearly detailing the roles and responsibilities of the board, senior staff and relevant committees with regard to incident management.
- There had been one Never Event reported between July 2015 and June 2016. This had occurred in the maternity service. A root cause analysis had been undertaken and there was evidence of learning from this event and actions taken to mitigate future risk. Never
- Thirty nine serious incidents were reported between July 2015 and June 2016. There were 6,801 incidents reported to NRLS between May 2015 and April 2016; 96% of these incidents were classed as no or low harm. The trust had a lower incident rate per 100 admissions (6.7) compared to the England average (8.7). This could be an indicator that not all incidents were being reported. In addition, feedback from incidents was not always provided.
- Review of serious incidents had improved since the last inspection with a panel meeting three times a week; however there remained some weaknesses in the process. We reviewed seven serious incidents, four recorded as moderate harm and three as serious harm. Root cause analysis of these had been undertaken but they tended to contain description of the event rather than detailed analysis. Actions were noted but lessons learnt were frequently a narrative of events rather than what was learnt and would change as a result.
- There was limited oversight and monitoring of actions following root cause analysis, for example the action tracker had an outstanding action dating back to May 2015.

Cleanliness

- The majority of ward and clinical areas were visibly clean with cleaning schedules in place. The exception to this was the dermatology clinic, where we found the air conditioning was not working and blinds were dirty and broken. This was rectified by the unannounced inspection.
- Equipment appeared clean and “I am clean” stickers were in place.
- Staff had access to, and were seen using personal protective equipment such as gloves and aprons.

- Staff were “arms bare below the elbows” and were seen to clean their hands appropriately although compliance with this was not consistent in outpatients at Watford Hospital.
- Low numbers of MRSA and MSSA were reported between June 2015 and May 2016. With the exception of MRSA in October 2015, both have a lower number of cases per 10,000 bed days when compared the to the England average.
- The number of cases of C.Diff were also below the England average with the exception of November 2015 and May 2016.

Environment and equipment

- At the previous inspection we found significant maintenance issues with the trust’s estate and facilities that were not always adequate to meet patients’ needs or to avoid risks to patient safety. Since then, considerable work had been undertaken to ensure the environment was in a fit state to prevent patients from avoidable harm. However, the age of the estate and equipment such as boilers meant maintaining this positon was a challenge. The trust had developed an interim estates strategy.

Assessing and responding to risk

- The trust had systems and processes to assess and respond to patient risk however these were not consistently adhered to.
- The trust wide rate for venous thrombolytic embolism (VTE) assessment was around 91% against a target of 95%. Whilst an assessment was frequently completed on admission, these were but not consistently repeated and recorded after 24 hours. The proforma for VTE risk assessments was being updated to emphasise the requirement for an additional VTE assessment to be completed within 24 hours of admission.
- The majority of National Early Warning Scores (NEWS) were completed in line with clinical condition or specified timescales, with evidence of patients’ risks or clinical deterioration being escalated as necessary. The exceptions to this were in the emergency department where the frequency of observation was not consistently undertaken in line with the scoring.
- In the emergency department at Watford the median time to treatment had been higher than the England average between September 2015 and March 2016. The 60 minute standard was not met for 10 months in a 12 month period. Time to see a doctor was also outside recommended guidelines consistently

during the inspection. Treatment was not consistently started in a timely manner and patients who were at risk of changes to their clinical condition were not always managed appropriately or safely.

- There was no process in place in the UCC or MIU at Hemel Hempstead General Hospital and St Albans City Hospital to monitor and review arrival time to initial assessment. There was not an effective process in place to ensure that all children under the age of 16 received an initial assessment within 15 minutes in line with The Intercollegiate document 'Standards for Children and Young People in Emergency Care Settings, 2012'.
- During the last inspection, we found that there was no clear streaming or triage process in place at the UCC or MIU. This had not improved at this inspection. At this inspection, the trust was in the process of developing their triage and streaming process based on Royal College of Emergency Medicine (RCEM) guidelines. We escalated this as an urgent concern to the trust, who took a range of actions to address this risk to patient safety.

Staffing

- Whilst the overall vacancy rate was reported in the integrated performance report to the board in September 2016 as 14.4%, against a target of 9%, adequate staffing levels were maintained through the use of bank and agency staff.
- The trust's medical staffing mix showed a higher percentage of junior grade staff compared to the England average. Registrar grade was lower than average and middle grade and consultant grade staff were in-line with the average. The trust reported that they expected to have no consultant vacancies by October 2016.
- Over 400 new nurses and midwives had been appointed since the last inspection in September 2015.

Medicines

- Arrangements were in place for managing medicines. This included obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal.
- Temperatures for the storage of medicine were recorded but when these went out of acceptable range appropriate action was not always taken.
- There was no process in place for the safe storage of patients own controlled drugs. On some wards these were checked and recorded when used and daily; however, on others patients' own controlled drugs were sealed in envelopes and stored in

the locked controlled drug cupboard. The envelope was checked daily, however was not opened to check the number of tablets contained. This meant that there was risk that not all controlled drugs were being accurately recorded and were at risk of misuse. The medicines management policy 2016 states that patients own controlled drugs should be sealed in envelopes, which are labelled with the patients' addressograph and double signed across the seal by two nurses. These were to be returned to patients on discharge. Action had been taken to address this by the time of the unannounced inspection.

Records

- The quality of record keeping had overall improved and nursing staff in particular welcomed the new documentation. However there were issues in the emergency department where records were not always completed thoroughly or in a timely manner.

At the last inspection we found that records were not always stored securely. This time we found they were store in locked cabinets.

Are services at this trust effective?

Requires improvement

We rated effectiveness in the trust as requires improvement. Five services were rated as requiring improvement and six as good. We do not rate effectiveness for outpatients and diagnostic imaging.

- Patients did not have their mental capacity assessed in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and associated code of practice. There was a lack of oversight of the authorisation and expiry of these; therefore patients were potentially being deprived of their liberty without appropriate authorisation made.
- Provision for patients who had a mental health problem was poor in the emergency department.
- Results from audits varied with a lack of clear action planning to address areas of weakness.
- Whilst there were good examples of multidisciplinary working, this was not evident in all areas of the trust.
- Care was mostly delivered in line with legislation, standards and evidence-based guidelines.
- The Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) was lower (better) than expected. The trust was one of 17 trusts nationally with a lower than expected HSMR.

Evidence-based care and treatment

- Care was mostly delivered in line with legislation, standards and evidence-based guidelines from the National Institute for

Health and Care Excellence (NICE), Intensive Care Society and Faculty of Intensive Care Medicine Guidelines and specialist guidance from royal colleges. Local policies were written in line with these guidelines. Some polices had passed their review date.

- Pathways had been developed for particular conditions; of note was the fracture neck of femur pathway. This pathway supported good communication between the emergency department and the orthopaedic service and there were dedicated "ring fenced" beds to support fast treatment.
- The trust had a replacement for the Liverpool care pathway called individualised care plans for the dying person (ICPDP). The ICPDP was embedded on all wards across the trust.

Patient outcomes

- The trust took part in the majority of applicable national audits; however it was not currently participating in the National Diabetes Audit due to issue with the database and the ability to access the system.
- Results from audits varied for example:
- March 2016 national stroke audit (Sentinel Stroke National Audit Programme, SSNAP) the trust was rated as band C (A being the best and E the worst).
- The most recent published **Myocardial Ischaemia National Audit Project (MINAP)** audit for 2013/14 reported that the trust performed in line with England average.
- In the Heart Failure Audit 2013/14, Watford General scored better than the England average for in-hospital care in one indicator (input from specialist). The remaining three indicators scored worse. All seven discharge indicators scored better than the England average. The service had no action in place to address the audit results.
- National Diabetes Inpatient Audit (NaDIA) 2014/15 data showed that the trust was better than the England average for six out of 17 applicable domains including insulin errors, meal choice and timing and assessment of feet. However, scored worse than England average for the remaining domains, which included staff knowledge, visit by specialist diabetes team and overall satisfaction.
- In the National Lung Cancer Audit 2015, the trust achieved a better than peer average in the completion of multidisciplinary meeting (99%) and number of patients seen by a nurse specialist (99%). The trust performance for pathological diagnosis (73%) was lower than peer average (84%). There was no action plan associated with this audit at the time of inspection.

Summary of findings

- Patient Reported Outcome Measures (PROM) for groin hernia were slightly better than the England average, with less patients reporting worsening in their condition after the procedure and more patients reporting improvement. The outcomes for hip replacement and varicose veins were mixed, but similar to the England average.
- The National Emergency Laparotomy Audit considered the structure, process and risk adjusted outcome measures for the quality of care received by patients undergoing emergency laparotomy. The hospital had two greens for when computerised tomography (CT) was reported before surgery and consultant anaesthetist presence in theatre. However the remaining nine measures were rated red or amber.
- The data from the National Bowel Cancer Audit (2015) showed that 74% of patients stayed in hospital more than five days, which was worse than the England average of 69%. The remaining results were within the expected ranges.
- The National Hip Fracture Database (NHFD) is part of the national falls and fragility fracture audit programme. A review of the 2015 report indicated that overall hospital length of stay was 13.8 days, which was lower than the England average of 20.3 days. The hospital was within the expected ranges for the remaining three measures. The trust reduced the mortality rate for hip fractures, from February 2013 to February 2016 from 12% to 4%, with a continuing downward trajectory, by reviewing their hip fracture care pathway. Other indicators, for example, the time taken to being admitted to an orthopaedic ward, time from admission to theatre and inpatients stay, were all better than the national average. In November 2015, the trust was awarded the Health Service Journal award for patient safety for their work in improving mortality rates for patients who had sustained a hip fracture.
- The Intensive Care National Audit and Research Centre (ICNARC) ICNARC annual report from 2015/16 showed that the unit was performing as expected (compared to other similar services) in all indicators apart from one which showed the unit had a higher than national average for delayed discharges of 14% compared to the national average of 5%. The trust was in the worst 5% of units for this element.
- The trust has gone from being in the bottom decile (2013) to being in the top performing quartile within the Hospital Standardised Mortality Ratio (HSMR). For the most recent 12 month period (March 2015 to February 2016), the HSMR of 85.25

was lower than expected. Whilst it was noted that there was a significant difference between the weekday and weekend HSMR for emergency admissions, neither was higher than expected.
- The Summary Hospital Mortality Indicator (SHMI) was as expected.
- The trust holds monthly divisional mortality review meetings and a trust wide mortality review bi-monthly, chaired by the medical director.

Competent staff

- There were concerns at the last inspection that the appraisal rate for non-medical staff was not meeting the target. This had considerably improved and was 93.5% against a target of 95%; however within this there was variances with some areas at nearly 100% and others quite low. In addition we were not confident that the reported figures were accurate as what staff told us and the recorded rates differed.

Access to information

- Overall, staff had access to the information required to deliver patient care. The area of concern and frustration was the IT system which staff said was slow and at times unreliable. The trust was aware of the issues and the information management and technology strategy was in the process of being updated.

Multidisciplinary working

- There were some good examples of multidisciplinary working of particular note were the improvements since the last inspection in the maternity service. However there were also some examples of where multidisciplinary working was not as effective as it could be, for example in the emergency department, neonatal unit and outpatients.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Patients did not have their mental capacity assessed in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and associated code of practice. There was no trust database relating to the total number of patients, the expiry of initial authorisation or the date of external assessment. This meant that patients were potentially being deprived of their liberty without appropriate authorisation made. Locally, some wards had understanding of those patients who were being

cared for under a deprivation of liberty safeguard (DoLS). In addition, the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form did not prompt staff to complete a capacity assessment as part of the decision making process.
- Provision for patients who had a mental health problem was poor in the emergency department.

Are services at this trust caring?

Good

We rated caring in the trust as good. Two services were rated as requiring improvement, 11 as good and one outstanding.

We have made a decision on proportionality that the requires improvement rating for caring at Hemel Hempstead Hospital, as it relates to just one ward, will not impact on the overall rating for caring at trust level.

- Patients were generally treated with kindness, compassion, courtesy, dignity and respect throughout the trust.
- There was one incident where a patient was not discussed in respectful manner and other examples of where care was provide in an area that did not promote confidentiality or privacy and dignity.

Compassionate care

- Feedback from the majority of patients and their relatives was positive, with the friends and family test scores consistently good and in line with the England average.
- Maternity services were rated as requiring improvement following the last inspection. Although the maternity NHS Friends and Family Test results between June 2015 and May 2016 were worse than then England average for antenatal, postnatal and birthing care, all the women we spoke to during the inspection were positive about the care and treatment.
- There was a strong person centred culture in the services for children and young people in which patients were recognised as individuals and their preferences and needs clearly respected. In addition, patients and their families were empowered to have a voice and their views were reflected in how care was delivered.
- In the PLACE survey 2015, the trust scored lower than the England average in all four areas. However, there was an improvement in the trust's score for privacy, dignity and wellbeing compared to their 2014 result.
- There were a minority of examples of care that were not considered compassionate or maintained privacy and dignity, such as in the medical ward at Hemel Hempstead where a patient was not discussed in a respectful manner. In

Summary of findings

outpatients, patients were not always treated with privacy and dignity. Ophthalmology tests and consultation took place in areas where confidentiality could not be maintained and in the dermatology clinic we saw a patient being treated in an area which acted as a reception area and a corridor.

Understanding and involvement of patients and those close to them

- Most patients and their relatives spoke positively about their care and treatment and felt involved in their care.
- Patients told us staff spoke to them and their relatives clearly and in a manner they could understand, offering to provide further information if required and encouraging them to ask questions
- Doctors and nurses worked with play specialists to minimise distress to children.

Emotional support

- Staff supported patients and those close to them to with their care, treatment or condition.
- The chaplaincy team offered spiritual support to patients of all faiths and general support to those with no faith.

Are services at this trust responsive?

Requires improvement

We rated responsiveness in the trust as requires improvement. Eight services were rated as requiring improvement, two as inadequate and three as good.

We have made a decision on proportionality that the inadequate rating at Hemel Hempstead Hospital, as it relates to just one ward, will not impact on the overall rating for responsiveness at trust level.

- The emergency department consistently failed to meet standards in terms of the amount of time patients spent in the department and waited for treatment.
- There was a rise in the number of black breaches, where it has taken over an hour from the time of an ambulance arriving at the hospital to handing over to staff.
- The trust was not meeting the target of two weeks wait for suspected cancers, including possible breast cancer.
- Patients did not always have timely access to initial assessment or treatment with referral to treatment (RTT) times below the England average.
- Medical patients were transferred numerous times often out of hours.
- Complaints were not responded to in a timely way.

- The percentage of patients waiting less than six weeks for a diagnostic appointment was consistently better than the national average.
- The trust was working with stakeholders to ensure service were planned to take account of different people.

Service planning and delivery to meet the needs of local people

- Services were planned to take account of the needs of different people however the trust was restricted by the age and condition of its buildings and infrastructure. They were working with stakeholders with the aim of a fundamental system wide redesign of care pathways and service models to improve outcome and integrate care.
- In end of life care the majority of patients were seen by the specialist palliative care team within 24 hours of referral and all were seen within 48 hours. A rapid discharge process and policy was now in place, which was an improvement since the last inspection. Whilst 82% of patients had died in their preferred place of death, the trust was not collecting effective information on the percentage of patients that were discharged to their preferred place within 24 hours.

Meeting people's individual needs

- The trust had a named lead nurse to support patients and offer advice to staff with regards to learning disabilities. The adult safeguarding lead had a trust wide remit for learning disabilities. There were also 2.6 whole time equivalent learning disability nurses who had honorary contracts with the trust.
- We saw the “this is me” document in use across all areas for patients admitted to hospital with a learning disability. “This is me” is a standardised template, which is completed by carers or family members and details the patient’s social and medical history, their likes and dislikes. The nursing documentation included a section on the “this is me” document, which gave guidance on completion of recording of key information.
- The trust did not have a system to capture information on the number of inpatients with a learning disability, so were unable to comment on how many patients were with learning disabilities were inpatients at any one time in.
- Two ward areas have commenced working towards the purple star award. Purple star awards were given to services that work really hard to give the best help to patients with learning disabilities. The wards were waiting to be assessed by Hertfordshire Learning Disabilities team.

- A range of leaflets were available to patients and their relatives most were only available in English although staff could access them in other languages, easy read format and Braille as required.
- Staff had access to translation services via a telephone service, when there was a need to communicate with a patient whose first language was not English.

Dementia

- There was a dementia care lead nurse who offered advice and support to staff who cared for patients living with dementia. There were also dementia champions in the ward areas.
- "This is me" was used to support the care of patients living with dementia by understanding their preferences and life story. Patients were identified by a blue plastic disk that fitted discreetly to their identification bracelet.
- Bluebell ward was the hospital's designated dementia care ward and organised activities for patients to participate in, such as gardening or bingo. However, we found a lack of activities for patients on other wards.
- Wards offered extended visiting for relatives of patients with confusion or agitation, or patients with a learning disability or mental health diagnosis. We observed this on Bluebell ward, when visitors attended the ward out of normal visiting times prior to treatment. This enabled patients to see familiar people which assisted with administration of treatment, promoted wellbeing and recovery.
- Patients living with dementia or delirium being discharged through the trust's delirium recovery programme were offered bespoke care packages as part of their discharge plans. Families were involved with devising activity plans, which were as near to the patients' preadmission activity as possible.

Access and flow

- Bed occupancy at around 90% was similar to the England average. When the level rises above 85% it was generally accepted this could start to affect the quality of care provided to patients and the orderly running to the trust.
- The trust had a higher proportion of delayed transfers of care at 26.7%; this was nearly 10% higher than the proportion for all trusts in England. The trust stated this averaged 50 patients per day. The most common reason for delayed transfers of care was 'awaiting package of care in own home'. In addition to this the trust had a significant number of stranded patients with an average of over 100 per day. Stranded patients can be identified as those with a length of stay of seven days or more. A

proportion of these will have an illness that requires them to be in hospital that long. However, a significant proportion will have spent seven or more days in hospital because of unnecessary waits in the system. The trust was working both internally with clinical teams and externally with stakeholders to reduce these unnecessary waits.

- In the emergency department there was a culture of acceptance of waiting time breaches, with opportunities for improvements missed. There was a lack of challenge of the number and level of breaches over four hours. However at the unannounced inspection the number of breaches had reduced.
- The urgent care centre (UCC) and minor injuries unit (MIU) were consistently meeting or exceeding the target to admit, transfer or discharge 95% of patients within four hours of arrival.
- Black breaches are when it has taken over one hour from the time of the ambulance arriving at the hospital to handing over to staff. The trust saw a rise in such breaches between November 2015 and August 2016 with a figure of 2107.
- The percentage of patients leaving the emergency department without being seen was higher at 6.5% than the England average of 3%, at the UCC it was 5%.
- Patients did not always have timely access to initial assessment, diagnosis and treatment. Between June 2015 and May 2016, the trust's referral to treatment (RTT) indicators were below the England average at 66% compared to 79% for admitted and 87% compared to 92% for non-admitted. The trust had a number of actions in place to address this such as waiting list initiatives, streamlining referral processes, the introduction of demand management and seeking capacity from other providers.
- The number of patients waiting less than six weeks for a diagnostic appointment was consistently better than the national average.
- The national cancer waiting standard requires at least 93% of patients urgently referred by their GP with a suspicion of cancer should wait no longer than two weeks to be seen. The trust met this target for the period from April 2015 to April 2016. However, the position had deteriorated, falling to 81.3% in July 2016, leading to a year to date average of 89.4% and a downward trajectory.
- The trust missed the national cancer wait target for patients with breast lumps; 93% of these patients were required to be seen within two weeks. However, the trust's performance was consistently lower than this and had fallen to 46% in July 2016 with a year to date percentage of 76.

- The trust performed worse than the national average for the number of patients not offered another appointment within 28 days of a cancelled operation.
- Medical patients were transferred multiple times within the acute admissions unit and between wards, often out of hours. The medical ward at Hemel Hempstead had originally been established as a stroke rehabilitation ward however at the time of the inspection 14 patients were there, not for stroke rehabilitation, but who were medically fit for discharge awaiting appropriate discharge packages.

Learning from complaints and concerns

- There was a complaints policy in place dated 2015 approved by the quality and safety committee. It set out a comprehensive process stating who the policy applied to, who could complain and how the complaint could be made. The policy had been developed in accordance with appropriate guidance including the NHS Complaints Regulations (2009), NHS Constitution (2013) and the Parliamentary Health Service Ombudsman PHSO Principles of good complaint handling (2012).
- All complaints were acknowledged within three days of receipt. They were triaged by the complaints manager and rated as red, amber or green. A red rating was attributed when there was direct or potential serious impact on care. If a complaint was scored red the chief nurse and medical director were informed and advice on how it should be investigated was obtained. The complaint was then forwarded to the division involved for investigation. Amber rated complaints were those said to have had a direct impact on patient care, a formal investigation and response were required.A green rating was given when it was thought to have had no direct impact on care but still required a formal investigation and response.
- The corporate risk register included an entry on complaints, which was added on the 26 July 2016. The risk was described as being at risk of not meeting regulatory requirements when responding to concerns raised. The cause was detailed as being due to an increase in the number of complaints received and an increase in the number not being responded to within the timeframe as a result of capacity and capability within divisions, as well as within the complaints team. It was also recorded that the quality of the complaint responses were inconsistent and did not always address the root cause. In July 2016 a 90 day complaints improvement plan was taken to the board, aiming to address this risk.

Summary of findings

- Just prior to the inspection, a pilot had commenced with the input of a complaints facilitator who offered support to the investigator of the complaint. It was hoped this would improve the quality of the investigations and the letters being written.
- Complaints were not responded to in a timely way with a year to date figure of 26.5% of complaints responded to within one month or the agreed timescales with complainant.
- The annual complaint report for 2015/2016 was presented to the board in September 2016.This provided an analysis of formal complaints, there were 19 referred to the Parliamentary Health Service Ombudsman.Complaints performance, themes and trends were monitored by the patient experience group which was chaired by the chief nurse. In addition complaints were also discussed at the quality and safety committee. The board minutes did not reflect any challenge with regard to complaints management.
- The trust had seen an increase in the number of complaints received between 2012/13 and 2015/16, rising from 530 to 821.

Are services at this trust well-led?

Requires improvement

We rated well led at the trust as requires improvement. Four services were inadequate, four were requires improvement and six were good.

Although both St Albans City Hospital and Hemel Hempstead Hospital are each rated as inadequate overall for well-led, we have made a decision on proportionality and to reflect the trust wide leadership that the overall rating for the trust should be requires improvement.

- Whilst the trust had a governance framework in place there were some areas of weakness. In addition due to the changes made in both the framework and the divisional structures, this was not yet embedded.
- Most staff felt respected and valued however there were some areas where there was friction between staff disciplines and staff who felt uncomfortable speaking out.
- The trust had a relatively stable board since the last inspection so had been able to develop their skills and experience, although the chair and chief executive had both commenced in the intervening period.
- The divisional and support structure had been updated.
- The trust board was becoming more strategically focused, previously having to concentrate on managing the operational challenges.

Leadership of the trust

Summary of findings

- At the previous inspection many of the executive directors were both new to the trust and to an executive role. The team now had more stability, although there had been two changes in the last year; the interim chief operating officer had been in post since April 2016 and the chief executive started about eight weeks before the inspection.
- A new chair started in November 2015 otherwise there had been stability with the non-executive directors with the other most recent appointment in June 2015.
- Staff and stakeholders spoke positively about the new chief executive.
- The trust had updated its board, division and support structure in June 2016. There were five clinical divisions, each with a divisional director, a divisional manager and a head of nursing. There were associate divisional managers and assistant service managers for each speciality within the division as well as a deputy head of nursing and matrons who supported the speciality and divisional team. A management programme had been developed to support the divisional directors in these new roles.
- The trust had also identified the need for a leadership programme for nursing staff at band six and seven. Staff who had taken part in this spoke highly of its value.
- The trust had received the support from an improvement director from NHS Improvement for 18 months.

Vision and strategy

- The trust vision was to "provide the very best care to every patient every day". There were four aims which underpinned this and a set of objectives for each. These were discussed at the board meeting in April 2016 and were reflected in the minutes.
- The trust had a shared strategy, entitled "Your Care, Your Future" developed with partner organisations. This considered what changes were needed to ensure the people of west Hertfordshire have access to the best possible health and social care services and to ensure these were sustainable.
- The trust values had been recently developed. Whilst staff could quote them, they were not yet driving behaviours.
- It had been challenging for the trust to be strategic-looking due to the operational challenges it has faced, however this is now changing.
- The trust had developed a clinical strategy which was approved at the board meeting in September 2016. This set out the trust vision and priorities and was aligned to the 'Your Care, Your Future' system wide strategy. Some specialties such as

maternity, children and young people and end of life care now had well developed local strategies in place. For maternity and end of life care these had been developed since the last inspection. Staff told us they had been involved in the development of the strategies and they valued the clear vision to develop high quality services they provided.

Governance, risk management and quality measurement

- The governance framework had been recently reviewed together with the supporting committee structure and divisional structures. These now had the ability to support the delivery of the strategy and good quality care. Each division within the trust held governance meetings that fed into the trust's quality safety group. In turn, these fed into the trust board. However the framework was relatively new and not yet embedded, so together with weaknesses in quality assurance and an overlapping of roles, this was not yet providing robust assurance to the board or information back to the ward and departments.
- There was a comprehensive risk management policy and strategy in place which was approved in August 2016. It clearly articulated the governance structure for the identification, management and mitigation of risk. Operational risk was managed through corporate and divisional risk registers, with strategic risks managed through the board assurance framework. The named divisional quality governance leads were accountable for ensuring their risk registers were up to date.
- The trust had a safety and quality committee which was a committee of the trust board that met every two months. Its duties and responsibilities included strategy and governance, safety, effectiveness and patient experience and was chaired by the trust chair. The terms of reference had been reviewed by the board in June 2016.
- We reviewed the corporate risk register and board assurance framework. At the last inspection the corporate risk register contained over 100 risks and was difficult to navigate. The current corporate risk register identified 19 risks and was more focused. However for some risks, the details in the controls and assurances were the same and the controls included actions that had not yet been completed, therefore it was difficult to see how these were being used as controls.
- The board assurance framework was not complete. On some issues the board was taking reassurance on issues rather than

robust assurance. However it was noted the assurance framework had developed over the last year and there was a willingness to link with the quality objectives as well as ensuring it linked with the corporate risk register.
- There was limited oversight and monitoring of actions following root cause analysis, for example the action tracker had an outstanding action dating back to May 2015.
- The trust had a comprehensive quality improvement plan. This was divided into 20 projects such as vision, values, engagement and staff retention, people development, harm free care, medicines management, environment, estates and facilities. Each project was looked at progress to date and planned activity, as well as the key milestones. This was presented to the monthly oversight meeting chaired by NHS Improvement.

Culture within the trust

- Staff expressed how disappointed and upset they had been by the ratings following the previous inspection and going into special measures. However, many also expressed the view that it had been a good thing to have happened as it had been a catalyst for improvement. They had a renewed pride in their work.
- Most staff felt respected and valued however there were areas where this was not the case, such as in the emergency department and the children and young people's service. In the latter, some junior doctors reported that they felt uncomfortable speaking out and reporting incidents for fear of blame or punishment.
- Overall sickness absence was consistently less than the national average.

Equalities and Diversity – including Workforce Race Equality Standard

- In July 2014 the Equality and Diversity Council agreed new work to ensure employees from black, minority and ethnic (BME) backgrounds had equal access to career opportunities and received fair treatment in the workforce. There were two measures in place the equality and diversity system 2 (EDS2) and the workforce race equality standard (WRES) to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010.
- The trust had an equality and human rights policy which was reviewed and updated in August 2015. This policy referred to bullying and harassment/raising concerns (whistle blowing), interpretation and translation policies. The policy set out an

organisational commitment to provide equal opportunities in both employment and receipt of healthcare to avoid discrimination. The policy referred to the nine key characteristics, clearly defined roles and responsibilities and definitions.

- The trust employed 32.9% of staff from BME groups; however 8.3% of the voting members of the board were BME. In addition:
- 7% of non-clinical staff in Band 8a, 9 and very senior managers were from BME backgrounds, compared to 11.24% of white non-clinical staff.
- 3.8% of clinical staff in Band 8a, 9 and very senior managers were from BME backgrounds compared to 6.4% of white staff.
- Non-clinical BME staff in Bands 1 to 3 and 6 were over represented.
- Clinical BME staff were over represented in Band 5 and under represented in Band 6.
- White candidates that were shortlisted to vacant roles were 1.64 times more likely to be appointed than BME candidates.
- BME staff were 2.3 times more likely to be subject to formal disciplinary proceedings compared to white staff.
- 68.4% of BME staff believed that the trust acted fairly with regard to promotion and career progressions compared to 87% of white staff. This was significantly below the national average for such trusts.
- 14.3% of BME staff experienced discrimination from a manager, team leader or other colleagues during 2016, compared to 6.2% of white staff
- An equality and diversity manager was in post at 0.5 whole time equivalent. Their role was to develop the equality and diversity agenda within the organisation. This was supported by harassment advisors to support staff.
- The organisation had an equality and diversity plan which was developed from the completion of the 2015/16 Workforce, Race, Equality Standard (WRES) submission based on EDS2. From the WRES a workforce equality forum was developed to look at priority areas and develop work streams such as those detailed above. It was currently at an early stage of development. The forum consisted of a mix of staff from across the organisation. The plan for this forum was to develop focused workshops to identify objectives and external engagement in order to improve equality and diversity across the organisation and increase engagement. One work stream within the forum was to explore why there was a lower conversion of BME groups from interview to recruitment.

- A copy of the WRES and an accompanying action plan was available on the trust website. The action plan focused on each element of the WRES, it was appropriate to the issues identified and demonstrated a good focus on equality and diversity.

Fit and Proper Persons

- The Fit and Proper Person Test is covered by Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014, which ensures that directors of NHS providers are fit and proper to carry out this important role. The trust had a fit and proper persons policy dated June 2016 which covered the requirement of the regulation.
- We looked at the files of the chair and five non-executive directors as well as the chief executive and 14 executive directors and senior staff. These demonstrated that the fit and proper person test was part of the recruitment process and involved a combination of self-declaration and checks. The checks made included a disclosure and barring check, financial checks and references.

Public engagement

- The trust was in the process of developing a patient experience and carer strategy for 2016-2019. It was involving with patients, carers, volunteers and staff. Success measures were also being developed to assess the impact of the strategy
- Patients were given the opportunity to provide feedback regarding their care and treatment through the family and friends test.
- There were volunteers throughout the hospital who undertook a range of tasks including meeting and greeting patients, helping people with directions and as well as working on specific wards. For example on Starfish ward there was a 'Carer Support Team' made up of volunteers who worked from Monday to Friday supporting relatives. Volunteers spent time talking with families on the ward and offered assistance, such as making coffee and playing with children so parents could rest. At the beginning of each volunteer's shift, nurses highlighted families that they thought were in particular need of emotional support.
- Wards displayed their 'I want great care' scores which were generally high, for example 4.5 out of five.

Staff engagement

- In the 2015 NHS staff survey there were no positive indicators, eight negative indicators and the remaining 25 were similar to expected.

- In the General Medical Council National Training Scheme Survey 2015, the trust scored worse than expected for induction, access to educational resources and feedback and the same as expected for the remaining areas.
- The trust took part in a medical engagement survey in 2016 (July IRGC papers), the results showed that consultant medical staff were disengaged. However consultants in a position of managerial responsibility were significantly more engaged than their colleagues without a position of managerial responsibility. The trust recognised that successful engagement with the clinical workforce was essential to change the culture of the organisation and in delivering high quality patient care. An action plan had been developed to address the issues identified.
- With the development of the new divisions the trust had taken the opportunity to review the job descriptions of the divisional directors and all the posts had been advertised. This provided an opportunity for the trust to demonstrate transparency, as well as ensuring leaders had the right skills and experience for the role. There was also a leadership programme developed for clinicians new to management roles.

Innovation, improvement and sustainability

- Significant improvements were seen in some services since the last inspection. Of particular note were maternity and critical care, which, having previously been rated as inadequate overall are now rated as good; medical services at Watford have improved from inadequate to good and outpatient services at St Albans City Hospital and Hemel Hempstead Hospital are now rated as good. However some services such as those for children and young people at Watford Hospital had deteriorated. In addition, other than outpatient services at Hemel Hempstead Hospital and St Albans City Hospital, the services had not made as much progress as expected. Some of the requirement notices issued following the last inspection, such as the timeliness for assessing patients receiving care or treatment in the urgent care centre at Hemel Hempstead Hospital were not yet addressed.
- The trust recognised that financial and clinical sustainability were intrinsically linked. Due to the fabric of the estate they had significant challenges in maintaining a harm free environment and providing care that maintained patients' privacy and dignity.
- In the emergency department the children's resuscitation area was separate; this was innovative and unique within the region.

Summary of findings

- The surgical assessment team had developed an outreach service that enabled elderly and frail patients to be pre-assessed in their own home.
- Since our previous inspection in April 2015, the maternity service had established a designated team of midwives (known as the Lavender team) who provided care, support and treatment for vulnerable women, such as those who had misused substances, perinatal mental health concerns, teenagers and asylum seekers. A member of the Lavender team was on call from Monday to Friday, 8am to 6pm to provide advice and support to vulnerable women, as required. The team had established a secure database of all women with safeguarding concerns under their care. The information on the database was reviewed regularly and updated as required. Each woman was graded as low, medium or high risk. The database provided midwifery and medical staff with up-to-date details of the care plan for each woman, so that if they were admitted and/or discharged from the hospital, appropriate actions were taken by staff to protect these women and/or their babies. The database also included a record of all known women with female genital mutilation (FGM). At the time of inspection, the team were in the process of setting up a de-infibulation clinic for women who had undergone FGM.
- That the Trust has sustained HSMR rates 'lower than expected' sustained for 18 months.
- The trust reduced the mortality rate for hip fractures, from February 2013 to February 2016 from 12% to 4%, with a continuing downward trajectory, by reviewing their hip fracture care pathway. Other indicators, for example, the time taken to being admitted to an orthopaedic ward, time from admission to theatre and inpatients stay, were all better than the national average. In November 2015, the trust was awarded the Health Service Journal award for patient safety for their work in improving mortality rates for patients who had sustained a hip fracture.
- In May 2016, the paediatric team won a 'certificate of excellence' for 'best video' at the national SAFE (situation awareness for everyone) celebration event. The video showcased the work of the team to improve safety awareness, ensuring the very best care for every child, every day.

Overview of ratings

Our ratings for St Albans Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Minor injuries unit	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Inadequate	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Hemel Hempstead Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Medical care	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate	Inadequate
End of life care	Not rated	N/A	N/A	N/A	N/A	N/A
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate	Inadequate

Overview of ratings

Our ratings for Watford Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	☆ Outstanding	Good	Requires improvement	Requires improvement
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for West Hertfordshire Hospitals NHS Trust

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

Notes

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

2. The overall ratings for safe, caring, and responsive have been moderated to requires improvement, good and requires improvement respectively in order to be proportionate to the smaller services at Hemel Hempstead Hospital and St Albans City Hospital. The trust wide rating for well-led has also been moderated to requires improvement in order to be proportionate and reflect the trust wide leadership.

Outstanding practice and areas for improvement

Outstanding practice

- The children's emergency department was outstanding in terms of environment. Children and young people had a dedicated resuscitation area away from the adult department, which was set up with equipment and medicines for children and young people up to the age of 16 years.
- The trust reduced the mortality rate for hip fractures, from February 2013 to February 2016 from 12% to 4%, with a continuing downward trajectory, by reviewing their hip fracture care pathway. This pathway supported good communication between the emergency department and the orthopaedic service and there were dedicated "ring fenced" beds to support fast treatment.
- That the trust has Hospital Standardised Mortality Ratio (HSMR) rates lower than expected, sustained for 18 months.

Areas for improvement

Action the trust MUST take to improve

- Ensure that care for patients with mental health issues in the emergency department by ensuring that they are cared for in a safe environment, that their safety is risk assessed, and that staff are suitably trained to meet their needs, as well as keep staff safe from harm.
- Ensure governance quality systems, including the reporting of incidents, duty of candour, completion of local audits, learning from incidents and complaints and ensuring the risk register is up to date.
- Ensure that observations of patients who could be acutely unwell are undertaken in a timely way and escalated as required.
- Ensure the timely completion of patient records.
- Ensure that patients who have been in the emergency department for more than six hours are reviewed by a senior clinician and are risk assessed.
- Ensure that there is a provision for the offering of regular drinks to patients during their time in the emergency department.
- Ensure that there are appropriate systems in place to track the patients and the expiry of those being treated under a deprivation of liberty safeguards.
- Ensure that staff completing 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms where a person lacks capacity to make an informed decision or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- Ensure that all staff caring for patients less than 18 years of age have completed safeguarding level 3 training.
- Ensure the safe management of medicines at the hospital complies with Home Office 2016 guidelines on the security of controlled medicines. This includes patients' own medication.
- Ensure that there are procedures in place for the safe management of temperatures within treatment rooms and areas where temperature sensitive medications are stored.
- Prescriptions for syringe pumps must comply with the trust's prescribing standards.
- Ensure that mandatory training compliance meets trust targets of 90%, including
- Devise an action plan to address the shortfall between appraisal rates and the trust target and make sure that the trust target is reached.
- Ensure there are effective streaming systems in place in the urgent care centre and minor injury unit and all staff have had appropriate training to carry out this process.
- Ensure there are processes in place to monitor arrival time to initial clinical assessment for all patients in the urgent care centre and minor injury unit.
- Establish a process so that all children are seen by a clinician within 15 minutes of arrival in the urgent care centre and minor injury unit.
- Ensure there are effective processes in place in the urgent care centre and minor injury unit to provide clinical oversight for patients waiting to be seen.

Outstanding practice and areas for improvement

- Ensure non-clinical staff in the urgent care centre and minor injury unit receive sufficient support or training to provide oversight to recognise a deteriorating patient.
- Ensure the urgent care centre and minor injury unit have direct access to a registered children's nurse at all items and that paediatric competencies for emergency nurse practitioners are recorded as a part of their continuous professional development (CPD) in line with national recommendations.
- Ensure that effective governance frameworks, standard operating procedures and policies are in place to support service delivery urgent care centre and minor injury unit.
- Ensure that systems and processes are in place to monitor and review all key aspects of performance to identify areas for improvement and all potential risks in the minor injury unit and surgery at St Albans and the urgent care centre and Simpson ward at Hemel Hempstead.
- Ensure that staff are given training and support to understand the duty of candour statutory requirements.
- Plans must be put into place to ensure referral to treatment (RTT) times to continue to improve so that they are similar to or better than the England average.
- Ensure that the Simpson ward can meet the needs of patients with vulnerabilities, including those living with a dementia and those displaying difficult behaviours and to ensure the provision of activities to engage patients in meaningful stimulation.
- Review the admission and exclusion criteria for Simpson ward to ensure all referred patients have their needs met.
- Improve the percentage of patients to be seen within 18 weeks of referral from a GP for an outpatient appointment.
- Improve the percentage of patients waiting to see a consultant with a suspected cancer to meet the national target of 93%.
- Ensure all resident medical officers (RMOs) receive a trust induction.
- Actions on fire risk assessments in surgery at St Albans City Hospital must be completed and areas regularly monitored for future compliance.
- Ensure staff levels and competency of staff meets patient need at all times on Simpson ward.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: • Staff completing 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms did not comply with the Mental Capacity Act 2005 and the Code of Practice. Systems were not in place to assess, monitor and mitigate the risks relating to non-compliance with the Mental Capacity Act 2005. Seven out of the 36 DNACPR forms we reviewed stated that the patients did not have mental capacity. However, there was no evidence of mental capacity assessments being completed.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: **Hemel Hempstead Hospital and St Albans City Hospital** • There were not effective streaming systems in place in the urgent care centre or the minor injury unit and not all staff had appropriate training to carry out this process. • There were not robust processes in place to monitor arrival time to initial clinical assessment for all patients in the urgent care centre or the minor injury unit. • There was not a process so that all children were seen by a clinician within 15 minutes of arrival in the urgent care centre or the minor injury unit.

This section is primarily information for the provider

Requirement notices

- The urgent care centre and the minor injury unit did not have sufficient systems in place to ensure that patients who were waiting to see a clinician were safe to do so.
- Non-clinical staff in the in the urgent care centre and the minor injury unit had not received sufficient support or training to provide oversight to recognise a deteriorating patient.
- The urgent care centre was not able to evidence that staff treating children had appropriate competencies in line with national guidance.
- In surgery at St Albans City Hospital processes already in place to protect patients from harm were not always followed. This included infection control guidelines, reusable medical devices guidelines, water safety policy and fire safety.
- In Simpson Ward at Hemel Hempstead Hospital patient identification was not confirmed prior to the administration of medicines. Staff did not follow safe administration procedures and did not maintain security of medicines during medicine rounds.

Watford General Hospital

- Pain relief was not being routinely checked or provided to patients.
- Patients who were clinically deteriorating were not being observed consistently.
- Records were not being completed consistently.
- Staff in outpatients were not complying with good practice or with the trust's hand hygiene policies.
- Treatment rooms where invasive procedures take place were not clean.

Trust wide

- Theatre teams were not consistently using the five steps to safer surgery checklist.

This section is primarily information for the provider

Requirement notices

- The percentage of patients to be seen within 18 weeks of referral from a GP for an outpatient appointment was below the national indicator.
- The percentage of patients waiting to see a consultant with a suspected cancer did meet the national target of 93%.
- There was not proper and safe management of medicines in place and the hospital and hospital management had not taken reasonably practicable actions to mitigate any such risks.
- There was no standardised approach to the management of patients own controlled medication, with wards using different systems to store medicines brought into hospital. Patients own controlled drugs were not reconciled adequately.
- Controlled drugs were not disposed of in line with current guidance.
- Prescriptions for syringe pumps did not comply with the trusts prescribing standards.
- Medications were stored in treatment rooms where temperatures exceeded recommended levels. During inspection, there was limited evidence that this had been reviewed or escalated appropriately.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: • Patients were appropriately referred to the deprivation of liberty safeguards team for assessment, which enabled an initial period authorisation whilst awaiting external assessment. However, the DoLS applications were not tracked to identify expiry dates and not reapplied for when the initial assessment period expired. • Medical and nursing staff did not have safeguarding children level 3 training, in all wards and departments, for example in outpatients and all areas

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Requirement notices

caring for 16- 18 year olds. All staff caring for 16-18 year olds should receive level 3 training in line with the Royal College of Paediatrics and Child Health Intercollegiate document 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: • Regular fluids were not provided or offered to patients in the emergency department despite the department temperature regularly being above 28°C during the course of our inspection.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met **Trust wide** • There were not effective governance systems and polices in place across the whole trust to monitor, review and improve safety and quality performance. • The trust did not have oversight of incidents as not all were being reported, opportunities for learning taken or feedback to staff consistently provided. In addition, in some areas the culture did not allow an open style where this could be done. • Not all services had a robust audit plan. **Simpson Ward Hemel Hempstead** • On Simpson ward, action plans were not in place to address non-compliance with infection control standards.

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Requirement notices

- On Simpson ward, intentional rounding charts provided evidence that these interactions had been completed, however this was as a "tick" and signature record. This meant that there was not always a complete record of all nursing interventions provided for all patients.
- Simpson ward did not have a local risk register. There were no risks associated with Simpson ward on trust risk registers meaning that risk present were not being identified or responded to.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1) and (2)(a) (b) which states:** Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. How the regulation was not being met: • Not all staff who were responsible for assessing, planning, intervening and evaluating children were trained in safeguarding to level 3. This did not meet the Royal College of Paediatrics and Child Health (RCPCH) guidelines or those contained in the Intercollegiate Document (March 2104) which stated safeguarding level 3 training should be provided for clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/ child protection concerns'. • Appraisal rates varied across the trust with not all staff having received an appraisal in the last 12 months. • Compliance in mandatory training across the service was not in line with trust targets which may place patients at risk. • Staff in the urgent care centre at Hemel Hempstead Hospital and the minor injury unit at St Albans did not

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Requirement notices

have direct access to a registered children's nurse at all items and that paediatric competencies for emergency nurse practitioners were not recorded as a part of their continuous professional development (CPD) in line with national recommendations.

- Medical staff cover was not always provided when required at the urgent care centre at Hemel Hempstead Hospital.
- Whilst there were sufficient staff to provide general nursing care for the allocated number of patients on Simpson ward, staffing levels did not allow for one to one care, rehabilitation or assistance with therapies and activities.
- Not all resident medical officers (RMOs) staff in surgery received a trust induction

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour • Staff knowledge was variable and processes were not robust. Not all incidents that met the threshold were identified or managed appropriately.