West Hertfordshire Hospitals NHS Trust

Quality Report

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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	Inadequate
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Requires improvement
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

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

West Hertfordshire NHS Trust provides services from 3 sites Watford Hospital, St Albans Hospital and Hemel Hempstead Hospital

We carried out this inspection as part of our comprehensive inspection programme. We undertook an announced inspection of Watford Hospital, St Albans Hospital and Hemel Hempstead Hospital between 14 and 17 April 2015.

We also undertook an unannounced inspection on 1 and 17 May at Watford General Hospital.

Overall, we rated West Hertfordshire Hospitals NHS Trust as inadequate with two of the five key questions which we always rate as being inadequate (safe and well led).

The main concerns were particularly at the Watford site where five of the 8 core services we inspected were rated as inadequate. Only one service was rated as good – the children's and young people's service. However, the concerns were not confined to the Watford site with a total of six of the 13 services inspected across the trust rated as inadequate.

Overall we have judged the services at the trust as requiring improvement for caring. In most areas patients were treated with dignity and respect and were provided with appropriate emotional support. We found caring in children's and young people's services to be outstanding. However caring required improvement in two areas - maternity and outpatient services where patients were not always treated with dignity and respect.

Improvements were needed to ensure that services were safe, effective, responsive to people's needs and well-led.

Our key findings were as follows:

- Most staff we spoke to were friendly and welcoming.
- The majority of staff were caring, compassionate and kind.
- Some senior staff told us they did not feel empowered to make decisions.
- Safety was not a sufficient priority, staff did not always report incidents and there was lack of a safety culture.
- The trust lacked a systematic approach to the reporting and analysis of incidents. When concerns, incidents and patient complaints were raised, or things went wrong, the approach to reviewing, investigating and learning was slow and in some cases absent. There was little evidence of trust wide learning and limited actions to improve patients' safety across the trust.
- There had been lack of response to external reports where actions had been recommended and not acted upon. During our inspection the trust took the decision to close one operating theatre due to issues relating to ventilation and the risk that that presented. It was acknowledged by the executive team that this had not been escalated appropriately or managed previously and that their governance processes had not been effective.
- There were inadequate plans in place to manage risks identified to prevent future incidents and opportunities to prevent or minimize harm were missed and feedback was not always provided on incidents reported.
- Staffing was a challenge. Recommended standards were not always complied with and there was an over reliance of agency and locum staff. In addition the trust's system for ensuring all temporary staff had had a comprehensive induction was not effective.
- The staffing situation was impacting on how staff felt, Many of the staff we spoke with expressed low levels of satisfaction, high levels of stress and work overload. Some staff told us they did not always feel respected, valued, supported and appreciated.
- The quality and accuracy of some of the data provided by the trust was poor.
- Facilities overall were in a poor state of repair and in some cases caused a potential risk to staff and visitors.

Summary of findings

- In most areas staff adhered to good infection control practices and cleaning standards were generally good however. The condition of the estate in some areas made effective cleaning of some areas a challenge.
- Equipment was not always maintained and the appropriate safety checks were not always completed. The Emergency department was consistently not meeting the national 4 hour waiting time target.
- The trust was failing to meet the national waiting time targets and had been for a considerable time. The Trust's new executive leadership team had now implemented an intensive programme of work to improve performance against referral to treatment targets.
- The Trust board were not a stable team and was relatively inexperienced with a number of the executive directors in their first executive post.
- Over the past year the Board had gone through a significant period of change. At the time of the inspection both the chief executive and the director of governance were interim appointments with the CEO having been in post just 3 months since January 2015. In addition the current Chairman of the Trust will be leaving the Trust at the end of his current term of office (October 2015).

The incoming interim Chief Executive demonstrated a good understanding of the challenges the trust faced, along with the commitment to address them. She took decisive action in some areas immediately following the inspection.

To address the areas of poor practice the trust needs to make significant improvements.

Importantly, the trust **MUST:**

• Ensure action is taken to ensure difficult airway management equipment is adequate and checked to ensure it is fit for purpose.

• Take action to ensure medical staff are suitably trained to manage the safe transfer of patients from critical care to other hospitals and services.

• Review the environment within the Emergency Department to meet patient demand effectively.

• Ensure that staffing levels within adult Emergency Department meet patient demand.

• Ensure there are prompt and effective triage systems in place within the Emergency Department undertaken by appropriate and competent staff.

• Ensure that all patient records are accurate and demonstrate a full chronology of the care provided.

• Ensure that medicines are always stored in accordance with trust policy.

• Ensure there is an effective clinical audit plan in place for all services.

• Ensure that major incidents arrangements are suitable to ensure patients, staff and the public are adequately protected and that patients are cared for appropriately should there be a major incident.

• Ensure there are effective arrangements in place for the management of risk at all levels within the organisation.

• Ensure that there is a robust incident and accident reporting system in place and that lessons learnt from investigations of reports are shared with staff to improve patient safety and experience.

• Ensure all incidents are investigated in a timely manner and necessary actions taken.

• Ensure that governance and risk management systems reflect current risks and that all staff are aware of these systems and risks.

• Ensure that all facilities are in safe state of repair.

• Ensure that staff delivering information to bereaved people receive training in communication and bereavement.

• Review the cancellation of outpatient appointments and take the necessary steps to ensure that issues identified are addressed and cancellations are kept to a minimum.

• Review waiting times in outpatients' clinics and take the necessary steps to ensure that issues identified are addressed.

• Ensure that patients' records including confidential computerised patient records are stored appropriately in accordance with legislation at all times.

• Ensure that all equipment has safety and service checks in accordance with policy and manufacturer' instructions and that the identified frequency is adhered to in respect of emergency equipment requiring daily checks.

Summary of findings

• Ensure all areas are fit for purpose and present no safety risks to patients or staff.

• Review the elective surgery cancellation rates and review the elective surgery service demand.

• Review the provision of the continuous piped oxygen.

• Ensure that service risk registers are current and fully reflective of all risks and that all staff are aware of the trust process for managing risks.

• Take action to review any risk to patients who have had surgery in Theatre 4 at St Albans Hospital.

• Ensure that all patients' records are kept up to date and appropriately maintained to ensure that patients receive appropriate and timely treatment.

• Ensure that all records are accurate and reflective of patients' assessed needs.

• Ensure staff are able to attend and carry out mandatory training, to care for and treat patients effectively, particularly regarding annual resuscitation training.

• Ensure that at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff to ensure people who use the service are safe and their health and welfare needs are met.

• Ensure that 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 appropriate premises are secure.

• Ensure security systems within the maternity unit are maintained at all times to ensure the safety of babies.

• Ensure that all staff are effectively supported with formal supervision and appraisals systems.

• Ensure that all facilities are in safe state of repair.

We saw several areas of outstanding practice including:

- The trust has delivered a significant reduction in mortality over the past two years, with Hospital Standardised Mortality Ratio (HSMR) dropping from 111.62 (significantly higher than expected) in March 2013 to 88.0 in March 2015 (significantly lower than expected). Equally, the Summary Hospital-level Mortality Indicator (SHMI) reduced from 107.4 (as expected) to 90.20 (lower than expected) and crude mortality reduced from 1.8% to 1.54% over the same period. Fracture neck of femur mortality rates have reduced from 12% to 7% over this period.
- Starfish ward staff had supported a parent whose child was frequently admitted to the ward to obtain funding to set up a carers' support team. The team was subject to the same governance and recruitment checks as the ward's staff. The carers' support team offered sitting services, information and signposting, and befriending for parents whose children were in-patients on Starfish ward.
- The care delivered within the Children's Emergency Department
- The trust had introduced a pilot pre-operative reminder telephone call service. The patient was called three days prior to their surgery for reminders and checks. Staff said if the service proved successful then it would become permanent.
- For world sepsis day, the sepsis team launched a 'sing-along' video called 'Stamp Out Sepsis' (SOS), sung in time to a well-known song. This was an innovative method that aimed to raise awareness of sepsis and encouraged staff to remember six actions that could improve patient outcome.
- The dementia care team had implemented a delirium recovery programme which aimed to reduce length of stay, readmissions, antipsychotic prescribing and promoted cognitive and physical functioning by cognitive enablement and health and wellbeing for patients. This allowed patients the opportunity to return home with up to three weeks of 24 hour live in care. The outcomes clearly demonstrated that the majority of patients with delirium went home with the programme in place when usual care would have predicted placement from hospital directly. Most patients recovered to a sufficient level to stay at home.

On the basis of this inspection, I have recommended that the trust be placed into special measures.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to West Hertfordshire Hospitals NHS Trust

The trust provides services from 3 sites: Watford Hospital, St Albans Hospital and Hemel Hempstead Hospital

The 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

The trust has undertaken a significant programme of service and estate reconfiguration in the last few years. This included the development of St Albans City Hospital into a dedicated centre for elective surgery, the move of A&E and in-patient services from Hemel Hempstead to Watford and the development of a new Acute Admissions Unit at Watford to provide an model of care and to accommodate an almost doubling of Emergency activity.

The Trust's vision is to embody in its hospitals all the principles, values and the sense of service that created the NHS by providing consistently good, safe care in a friendly, listening and informative way, as and when people need and want it and always with dignity and respect.

Inspection History

Hemel Hempstead General Hospital, 5th April 2013 – Compliant

St Albans City Hospital, 4th of April 2013 – Compliant

Watford General Hospital, 17th of Jan 2014- Non-compliant in outcome 4, 8, 13, 16 and 21 areas of non-compliance remained on a follow up inspection undertaken in December 2014.

Our inspection team

Our inspection team was led by:

Chair: Tony Berendt, Medical Director, Oxford University Hospitals NHS Trust

Head of Hospital Inspections: Helen Richardson

The team included 12 CQC inspectors and a variety of specialists including junior doctors, medical consultants, senior managers, child and adult safeguarding leads, trauma and orthopaedic nurses, paediatric nurses, an obstetrician, midwives, surgeons, an end of life care specialist and experts by experience who had experience of using services.

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 to people's needs?
- Is it well led?

Before visiting, we reviewed a range of information we held about West Hertfordshire NHS Trust and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning groups, the trust development authority, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

Summary of findings

We held a listening event in the week leading up to the inspection where people shared their views and experiences of services provided by West Hertfordshire NHS Trust. Some people also shared their experiences by email or telephone.

We carried out this inspection as part of our comprehensive inspection programme. We undertook an announced inspection between 14 and 17 April 2015 and an unannounced inspection of Watford Hospital on 2 occasions on the 1st and the 17th May.

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, health visitors, trainee doctors, consultants, midwives, healthcare assistants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

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

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at West Hertfordshire NHS Trust.

What people who use the trust's services say

The Friends and Family Test recommended rate overall for this trust dropped to below the England average in June 2014, although it returned to just under the average in November 2014.

The trust had very mixed results in the Cancer Patient Experience Survey. Out of 34 questions the trust scored in the top 20% of trusts for seven questions and in the bottom 20% of trusts for seven questions

The trust came out as about the same as other trusts in the CQC Inpatient Survey.

The PLACE score for Privacy, Dignity and Wellbeing is flagged as a 'Risk' in Intelligent Monitoring.

Facts and data about this trust

The trust has a total of Beds: 898

– 812 General and acute

– 67 Maternity

– 19 Critical care

The trust employs 4274 staff

– 571 Medical

– 1,357 Nursing

– 2,346 Other

The trust's Revenue is £290,763,000.

The trust has a deficit of Deficit: £13,370,000 (4.6% of revenue).

Overall the population served by the trust is relatively affluent, but there are some areas of deprivation. In Dacorum, which includes Hemel Hempstead, about 14% (4,000) of children live in poverty.

In Watford, life expectancy for women is lower than the England average.

Across the area, Hertsmere is ranked as the most deprived Local Authority at 223, Three Rivers 230,Watford 231, Dacorum 277 and St Albans is ranked least deprived at 282. These rankings are out of the 326 Local Authority districts across England.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall we rated safety of the services in the trust as 'inadequate.	Inadequate

The trust lacked a systematic approach to the reporting and analysis of incidents. There were inadequate plans in place to manage risks identified to prevent future incidents and opportunities to prevent or minimize harm were missed and feedback was not always provided on incidents reported.

There were staff shortages in some areas and an over reliance of agency and locum staff. In addition we found that the trust's system for ensuring all temporary staff had had a comprehensive induction was not effective.

The trust was not always meeting the requirements of the duty of candour regulation and there was a lack of ownership of some senior leaders within clinical teams.

Medicines were not stored safely and securely to prevent theft, damage and misuse in all services.

In the Emergency Department at Watford General Hospital patients arriving in the department were not always seen by a clinician in a timely way with untrained receptionists being used to assess patients and escalate any concerns about a patient's condition to the clinical staff. We rose this urgently with the trust.

At Watford General hospital, major incidents arrangements were not suitable to ensure patients, staff and the public were adequately protected or that patients were cared for appropriately in the event that a major incident occurred.

Facilities in some areas were in a poor state of repair and caused a potential risk to staff and visitors.

Not all Do Not Attempt Cardiopulmonary resuscitation forms were completed in accordance with trust procedures.

Duty of Candour

- There were processes in place to support the requirements of the duty of candour and there was in the main good knowledge amongst staff.
- The trust had a being open policy in place that outlined the expectations. However we found that there was not consistent application of this policy in the investigation and management of serious incidents and the communication that was had with

those involved or affected. As such the trust was not always meeting the requirements of the duty of candour regulation and there was a lack of ownership of with some senior leaders within clinical teams.

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 being updated to reflect changes in national guidance.
- Staff were able to tell us how they would report concerns through the trust's procedures and they knew who they should contact.
- The maternity service was not meeting the trust target for compliance with level 3 safeguarding children trained staff.

Incidents

- There were 5435 incidents reported in the previous 12 months. The number of incidents reported was lower to that of other similar trusts. 95% of all incidents reported were classified as no or low harm.
- There were 175 serious incidents reported and these included:
  - Skin damage (32% of all incidents)
  - Failure to act upon test results (16% of all incidents)
  - Slips, trips and falls (12% of all incidents)
- The trust reported four never events in the previous 12 months (Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) Of the four reported Never Events, three were retained swabs following surgery.
- Throughout the inspection we found that most staff knew how to report incidents using the trust wide electronic system. However, staff did not always report incidents, and feedback was not always provided on incidents reported.
- In the Maternity service, safety was not a sufficient priority. There was limited measurement and monitoring of safety performance. There was a backlog of incident investigations and staff were unable to learn lessons from incidents and improve safety in a timely way.
- In the past year, one 'never event' occurred in the maternity service. The never event occurred in November 2014 and involved a swab being retained following an operation. The investigation of this never event had not been completed at the time of our inspection.

Staffing

Summary of findings

- The trust used the nationally recognised Safer Nursing Care Tool along with NICE guidance to assess required nursing staff levels.
- There had been an increase in establishments of 160 nurses in an approach to promoting the supervisory sister role allowing senior sisters to spend more time supervising nurses and staff on our wards. However, we found that this was not happening, there were significant vacancies in most areas and staffing levels at the time of the inspection were not adequate in all areas. There was significant use of agency and locum staff and staff were frequently moved to other wards to cover for the shortfall in nursing teams which was having a negative impact on staff morale.
- We found that the trust's system for ensuring all temporary staff had had a comprehensive induction was not effective. We raised this with the trust.
- All staff we spoke with, from the management team to healthcare assistants, recognised nursing recruitment as a major safety risk to the service.
- Overall vacancy rates were at 12% at the time of inspection - higher than the average for the region which was at 9%. This was higher for nursing staff where vacancies were at 19%.
- This trust had a higher share of Bank and Agency staff with 13.9% compared with the England average of 6.1% We found that in some ward there was 100% bank and agency use on some shifts. This was brought to the trust's attention at the time of inspection.
- A rolling recruitment programme was ongoing with advertising websites, local media and university pitches. Plans were also in place to widen the recruitment drive internationally. Staff were aware of these initiatives and supportive of them.
- Nursing staff numbers were acknowledged as a major risk for the trust. The Royal College of Nursing told us problems with recruitment and staff turnover were a long standing issue for the trust.
- In the maternity service substantial and frequent staff shortages and poor management of agency or locum staff increased risks to patients. Vacancy levels for permanent midwives, nurses and health care assistants were at 25% and had been at high levels for a significant period of nearly a year. We found that this was affecting the permanent staff and many were under pressure to fill gaps, support less experienced staff and those unfamiliar with the working environment.

Summary of findings

- The mix of patients and staffing levels on Elizabeth Ward in gynaecology was of concern. The staff on this ward were unable to provide the care required by the dependency levels of patients on the ward and, although highly professional, were struggling to cope with the workload.
- Medical staffing for end of life care was below that recommended in the National Institute of Clinical Excellence (NICE) guidelines. We were also concerned about the availability of consultants to review patients in the critical care unit.

Environment and Equipment

- Facilities in some areas were in a poor state of repair and caused a potential risk to staff and visitors.
- The environment did not always meet the needs of patients; within the Emergency Department the environment was not adequate to meet patient demand.
- We found the environment the operating theatres was not suitably maintained. During our inspection the trust took the decision to close one operating theatre due to issues with ventilation and the risk that that presented. It was acknowledge by the executive that this had not been escalated or managed previously and that their governance processes had not been optimal.
- The air-change system in the mortuaries did not meet recommendations from the Human Tissue Authority (HTA) and the trust added this to the risk register but it had not been reviewed. The air-change system in the mortuary was being monitored to ensure there were no risks to staff.
- In the maternity service at Watford, there were security risks regarding access to Katherine ward found during the inspection, which were immediately raised as a concern and the trust took action to address this.
- We saw a broken door in the mortuary which created a security risk and also an injury risk to staff and visitors to the hospital. Although this was repaired on the day of our inspection, this had been broken for a number of weeks.
- We found that equipment had not always been maintained in line with manufacturers' recommendations. Daily checks on equipment such as defibrillators were not always completed and the checking of this equipment had not been monitored effectively.
- We found out of date clinical equipment, such as sterile needles and sterile sodium chloride solution in use in some areas.

Summary of findings

- We found significant health and safety concerns with building materials, tools, oxygen cylinders, containers of chemicals hazardous to health in full public access areas.
- We found numerous oxygen cylinders that were not securely stored in accordance with trust policy.
- The trust subsequently confirmed that the area had been made safe. However, the trust was not able to provide a copy of the fire risk assessment, including safe storage of chemical hazardous to health and storage of oxygen cylinders, that had been competed prior to the commencement of building works to provide a link corridor between A&E and Tudor and Castle Wards.
- On the unannounced inspection on 17 May 2015 we found clinical storerooms left unlocked, allowing access to clinical supplies and cleaning materials. We found door wedges being used on fire doors and staff told us they had reported the fire doors as defective and had not been repaired.

Medicines

- We found that medicines were not always stored in accordance with requirements.
- We found intravenous fluids and medication stored on an emergency trolley which were openly accessible and could therefore be tampered with. This meant that medicines were not stored safely and securely to prevent theft, damage and misuse.
- Medication storage fridges did not always have daily temperature checks recorded which was not in accordance with trust policy.

Cleanliness, Infection Control and Hygiene

- We observed that staff did not always follow infection prevention and control guidelines and good hand hygiene was not always practiced.
- We saw examples of where results from infection prevention and control audits had been responded to appropriately to ensure patient safety.
- In most areas we saw that the environment was clean, cleanliness was well maintained and staff took action when there were concerns about cleanliness.
- The processes for decontamination and sterilisation of instruments complied with Department of Health (DH) guidance.
- At the time of the inspection no cases of MRSA had been reported since May 2014.

Summary of findings

- C.difficile rates were higher than the England average at four times during the time period.

Mandatory Training

- Staff within the trust had not all received the required level of mandatory training.
- Within acute medicine, adult basic life support training compliance was 53% for medical staff and 65% for nursing staff.

Records

- Patient care records were not always completed in accordance with trust policy and records lacked sufficient detail to ensure a full chronology of their care had been recorded.
- Patient's records were not always stored securely. This meant there was a risk of people's records and personal details being seen or removed by unauthorised people in the department.

Major Incident Awareness and Training

- Major incidents arrangements were not suitable to ensure patients, staff and the public were adequately protected or that patients were cared for appropriately in the event that a major incident occurred.

Are services at this trust effective?

Requires improvement

Overall we rated the effectiveness of the services in the trust as requires improvement.

The trust was rated as requiring improvement because clinical staff were not always able to access the information they required. Where agency staff were used, they were not always able to access information about patients they were supporting.

Nursing staff in some areas had limited knowledge of their responsibilities under the Mental Capacity Act (MCA) and were unclear about the procedures to follow when reaching decisions in persons' best interest.

We found more work was needed to ensure all staff understood the mental capacity act and its implications on the delivery of care, especially in the maternity service and medical care service.

We saw evidence based care and treatment within the trust although most services were unable to provide a local audit plan and details of local audits undertaken in the previous six months. Outcomes of patient care and treatment were variable.

In the main we saw good multidisciplinary working. However, there was a lack of urgency for some services to move to seven day working.

Summary of findings

There was not an effective system in place for clinical and operational formal supervision. Staff said opportunities for development were limited due to rota pressures and the need to focus on operational demands.

There was not effective seven day working across all specialities.

Evidence based care and treatment

- Patient's needs were assessed and care and treatment was delivered in line with legislation, standards and evidence based guidance.
- Pathways were not consistently followed and there was evidence that not all patients at risk of developing a pressure sore were receiving appropriate care.However we noted that the Trust had implemented the Best Shot initiative,led by the Chief Nursing Officer to improve

pressure care across its hospitals.

- Services used national evidence based guidelines to establish and deliver the care and treatment they provided but there was not an effective system to ensure polices and guidelines were reviewed to reflect current national guidance. Where staff participated in national and local audits outcomes from audits had not consistently been used to make improvements in care.
- The trust had developed a care planning tool to replace the Liverpool Care Pathway (LCP) which had been withdrawn. However, this had not yet been implemented in nearly two years since the LCP ceased. Staff were not aware of the new plans.

Patient outcomes

- The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than expected. There had been a focus on understanding and reducing the trust mortality. According to the Board's Performance Report for March 2015, the HSMR was 83.6, which was much better than the national target of 100. The HSMR had reduced from 85.8 to 83.6 over the previous three months.
- The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the

patients treated there. According to the Board's Performance Report for March 2015, the SHMI was 90.3, which was better than the national target of 100. The SHMI had reduced from 97.6 over the previous three months

- The trust had undertaken significant work with the aim of improving mortality. The trust told us that there had been a number of factors influencing this included monthly mortality meetings chaired by the medical director or associate. Increasing the number of Care of the Elderly consultants and consultant delivered operative care for patients with a fractured neck of femur. It was acknowledged that an element of the reduction was also due to better reporting and data management.'
- An audit of compliance against service specifications for adult critical care, and core standards for intensive care and rehabilitation standards, had been completed. Six of the 49 standards were reported in July 2014 as not being met and 12 were only partially being met. Although there was evidence most recommendations had subsequently been met, one classed as urgent had not been addressed. This related to providing training for medical staff to manage the transfer of critically ill patients to another service.
- The trust took part in the National Care of the Dying Adult (NCADH) in 2013 and achieved three out of seven of the key performance indicators. The trust had an action plan in place to improve some aspects of end of life care, but this did not cover all of the items failed in the audit.

Multidisciplinary working

- We saw some good examples of multidisciplinary working across the trust.
- Generally ward teams had access to the full range of allied health professionals and team members described them as good, collaborative working practices.
- There was evidence of multidisciplinary working in the outpatients and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together.
- In maternity handovers involved a range of professionals to focus on a multi-disciplinary approach to care and treatment. This included community midwives and general practitioners when arranging for discharges.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

Summary of findings

- We found children's rights were protected and consent to care and treatment was obtained in line with the Children's' Acts 1989 and 2004.
- Most staff understood the concept of Deprivation of Liberty Safeguards (DoLS). However, we found one example where a patient had been restrained without a mental capacity assessment and DoLS in place.
- Mental capacity was not always assessed for patients who may lack capacity. Knowledge of staff was variable about the assessment and recording of mental capacity assessments.
- Deprivation of Liberty Safeguards were not always understood or recorded appropriately in patient's records.

Are services at this trust caring?

Requires improvement 

Overall we rated caring at the trust as requires improvement.

We found that in most areas of the trust whilst staff were busy they did show patients compassion, dignity and respect. However we found in both maternity and outpatients services caring required improvement.

The trust did not provide a formal bereavement service to support relatives.

We found caring in the children's and young people's services to be outstanding.

Compassionate care

- In most areas staff cared for patients in a compassionate manner ensuring dignity and respect. Both patients and their relatives were very satisfied with the care provided.
- Children and young people were supported and treated with dignity and respect and were involved as partners in their care. We observed many examples of compassion and kindness shown by staff across all the wards and department areas with staff going the extra mile to provide care for their patients.
- Children and their parents and their carer's were consistently positive in their feedback about the care they received.
- In the maternity unit we observed most staff interacting with women and their partners in a respectful compassionate way. However, we observed two interactions where patients were not treated with respect and dignity. In addition, we received feedback from patients and their partners who were unhappy with the behaviour of staff in how they had provided care and communicated with them.

Summary of findings

- In the outpatients department patients were not always treated with dignity and respect and staff were often task rather than patient focused.

Understanding and involvement of patients and those close to them

- Most patients spoke positively about the care and treatment they received.
- The trust used the NHS Friends and Family Test (FFT) to obtain feedback from patients. This was a single question survey which asked patients whether they would recommend the NHS service they had received to friends and family who needed similar care or treatment. The FFT recommended rate overall for this trust dropped to below the England average in June 2014, although it returned to just under the average in November 2014.
- The trust had very mixed results in the Cancer Patient Experience Survey. Out of 34 questions the trust scored in the top 20% of trusts for seven questions and in the bottom 20% of trusts for seven questions.
- The trust came out as about the same as other trusts in the CQC Inpatient Survey.
- The PLACE score for Privacy, Dignity and Wellbeing is flagged as a 'Risk' in Intelligent Monitoring with the score for Privacy, Dignity and Wellbeing in 2014 was 75%, much lower than the England average of 87%.
- In most areas patients told us that they were well informed and felt involved in decisions about their care or treatment.

Emotional support

- Patients told us that staff were approachable and they were able to talk to them if they needed to.
- There was a trust wide spiritual care and chaplaincy team available to patients' families.
- Staff were sensitive to children's and families emotional needs.
- The trust does not provide effective bereavement services and staff delivering information to bereaved people do not receive training in communication or bereavement.
- There was not a bereavement midwife in post to support parents in cases of stillbirth or neonatal death. Staff said they would provide that support as and when required.
- Some medical staff told us they thought the overall bereavement service was poor and could be improved.

Summary of findings

Are services at this trust responsive?

Requires improvement

Overall we rated responsiveness at the trust as requires improvement.

There were high levels of bed occupancy due to pressures on patient flow within the trust.

Significant issues with flow and capacity within the organisation meant that patients spent longer in the emergency department than appropriate and the trust had consistently fallen below the required performance for patients being discharged from the emergency department in 4 hours.

The trust was a significant statistical outlier for all referral time to treatment indicators in relation to other trusts in England at February 2015. There had been very poor performance for a considerable period of time in spite of reduced activity against plan. The Trust's new executive leadership team had implemented an intensive programme of work to improve performance against referral to treatment targets.

There were significant numbers of patients awaiting care in their own homes who could not be discharged by the hospital until this was available and funded. We saw some evidence of the trust working with the local health economy to promote patient flow.

The trust did not have a policy for the rapid discharge of dying patients to their preferred place of death.

Clinics were often cancelled and patients experienced delays when waiting for appointments.

The layout and size of some departments was insufficient to provide an adequate environment for patients.

Service planning and delivery to meet the needs of local people

- The trust was working with key stakeholders to ensure that health and social services met the changing needs of the local area.
- The trust did not have rapid discharge policy for patients to their preferred place of death. The trust was not able to tell us how many patients died in their preferred place of death.
- A whole system strategic review was underway during the time of the inspection. The trust has also commissioned external support to look at the response to the review and assist in their five year plan. The trust has also commissioned external support to look at the response to the review and assist in their five year plan.

Summary of findings

Meeting people's individual needs

- Clinics were often cancelled and patients experienced delays when waiting for appointments.
- We received consistently negative feedback from patients and staff about patient waiting times and parking.
- The layout and size of some departments was insufficient to provide an adequate environment for patients.
- The premises were appropriate for children with Starfish and Safari wards having been redecorated in child friendly décor.
- In End of Life care there were no specific care pathways in place for people living with dementia, learning difficulties, or other diagnosis that may inhibit their understanding of their condition. The trust had launched the 'Rose Project' in late 2014 which was to establish a more compassionate and respectful environment when a person was dying on a ward.
- We saw examples where there was support for people with a learning disability and reasonable adjustments were made. For example, patients were given longer surgical time to take account of any anxiety.
- Staff were aware of the learning disabilities liaison nurse and the safeguarding nurse, who both provided advice and support for people in vulnerable circumstances. Staff were able to refer any issues or concerns to the learning disability lead.
- Gynaecology: We spoke with the nurse and interim director with responsibility for Elizabeth ward. This was a 28 bedded ward that had originally been for gynaecology and gynaecology oncology patients. However, the ward was also being used to treat medical patients and those requiring elderly care. The interim head of quality and risk acknowledged that this was a concern. Staff said this issue had been raised at 'onion' meetings (which were daily meetings were ward leaders discussed ward performance and escalation issues, including staffing levels) over a period of time but had not been actioned.
- We saw some information leaflets were available in easy-to-read formats. An interpreting service was available and used.

Dementia

- The trust had a policy and procedure in place to make sure patients living with dementia were identified and supported and there was trust wide action to improve the management and care of this group of patients.
- We saw that the "This is Me" assessment document produced by the Alzheimer's Society was widely used to notify staff about the social history of people living with dementia and to alert staff to care preferences, and any special considerations relevant to their care.

Summary of findings

- Watford General hospital has a specific ward to cater for people living with dementia. The environment was dementia friendly and increased staffing levels enabled staff to provide meaningful stimulation for patients.

Access and flow

- There were significant issues with flow and capacity within the organisation meaning that patients spent longer in the emergency department than appropriate and the trust had consistently fallen below the required performance for patients being discharged from the emergency department in 4 hours.
- There had been very poor performance for a considerable period of time in spite of reduced activity against plan.
- The trust was a significant statistical outlier for all RTT indicators in relation to other trusts in England, in February 2015, with a number of patients waiting over a year for treatment; these peaked at 15 in November 2014 and were at 3 in December 2014. The Trust's new executive leadership team had implemented an intensive programme of work to improve performance against referral to treatment.
- In many areas there were challenges in discharging patients to an appropriate place.
- Delayed transfers of care have been rising from 2.3% in April to 3.8% in December 2014.
- At the time of the inspection there were 105 patients within the trust who could have been discharged. This was greater than 10% of the trust's available beds. This meant that patients were being cared for in areas that may not have been appropriate to meet their needs or by staff that had the right level of skill to provide their care.There had been meetings with local partners to try and address the issue.
- There were a number of patients who required the care of the medical specialities being cared for in other areas.

Learning from complaints and concerns

- Complaints and compliments information was displayed in most ward areas.
- Overall there was limited evidence of learning from complaints.
- Complaints to children and young people's services were monitored and responded to in a timely way. We saw examples of where improvements were made to children's care and treatment as a result of complaints or concerns.
- We saw written information about the complaints procedure and the Patient Advice and Liaison Service (PALS), but some of the patients we asked had not been given any information about complaints or knew how to make a complaint.

Summary of findings

Are services at this trust well-led?

Inadequate

Overall we rated the trust as inadequate for being well-led.

The Trust Board was not a stable team, having gone through a significant period of change over the past year. Furthermore it was relatively inexperienced with a number of the executive directors in their first executive post.

At the time of the inspection both the chief executive and the director of governance were interim appointments with the interim CEO having been in post just 3 months since January 2015. In addition the current Chairman of the Trust will be leaving the Trust at the end of his current term of office (October 2015). Another Executive we spoke to had recently obtained a post elsewhere.

Most members of the board were visible and well known to staff.

Although there was a trust vision this was not underpinned by detailed, realistic objectives and plans that staff understood and were able to describe. Understanding of the trusts vision was variable amongst the staff we spoke with.

There were not effective systems in place to report and learn from risk with no effective system for identifying, capturing and managing issues and risks at team, directorate and organisation level.

There was no effective process in place to review key items such as the strategy, values, objectives, plans or the governance framework.

Significant issues that threatened the delivery of safe and effective care were not always identified, and where risks were identified, adequate management of the risks, including assessment, mitigating action, and review, was not always demonstrated.

There was a lack of clarity about authority to make decisions and how individuals are held to account.

There was not a clear understanding between the risks and issues within the services and those that were on the trust board risk register.

The trust risk register needed both more effective management and better quality recording.

Investigations of serious incidents were not always completed in an effective or timely manner.

Action plans following serious incidents were not always adequately completed or monitored effectively.

Externally commissioned reports identifying areas of risk or areas requiring improvement were not always acted upon.

Summary of findings

Some staff expressed low levels of satisfaction, high levels of stress and work overload.

Some staff did not always feel respected, valued, supported and appreciated.

Effective fit and proper person checks were not in place.

There was an understanding of the duty of Candour amongst most staff, the trust had a being open policy. However, there were not effective systems in place to deliver the requirements consistently.

There had been significant work undertaken to review and improve the trusts approach to medical revalidation in partnership with the GMC.

There had been significant actions taken to develop the process in place to review and address mortality rates.

The incoming interim Chief Executive demonstrated a good understanding and of the challenges the trust had along with the commitment to address them and had already taken decisive action in some areas.

Actions were taken by the trust leadership team immediately following the inspection to address areas that were identified as a significant risk and those needing improving. A comprehensive improvement plan has been developed by the board to include a full review of trust wide governance and its processes from ward to board.

Vision and strategy

- Although there was a trust vision this was not underpinned by detailed, realistic objectives and plans that staff understood and were able to describe. Understanding of the trusts vision was variable amongst the staff we spoke with.
- Some of the information given to us by senior managers was not found to be what was happening at local level.

Governance, risk management and quality measurement

- We were not assured that the Corporate Risk Register provided an accurate reflection of the trust's key risks.
- We reviewed the trust risk register and found examples of risks within the register that need both more effective management and better quality recording.
- We reviewed the Risk Register Review paper submitted to the Quality & Safety Group on 10 April 2015 and the Corporate Risk Register.

Summary of findings

- The Risk Register Review paper did not adequately escalate the extent and seriousness of the risks at the trust and simply sets out those that have not been reviewed by their review date. The paper did not provide evidence of detailed discussion and appropriate recommendations.
- In the Corporate Risk Register we found a document that contained more than 112 risks and was extremely difficult to navigate.
- We were told by members of the board that the non-executives found it a difficult document with which to work and that the non-executives were frustrated by the lack of action by the executive. However there was no evidence that action had been taken by the board to address this.
- There were a significant number of risks on the risk register that were graded at 20 or 25. There were 19 in one division alone. This means that the Risk Review Group, Quality & Safety Committee, the Executives and Board felt that they had a high number of risks likely or almost certain to happen with major or catastrophic consequences (such as severe harm and / or death).
- On reviewing this risk and in discussion with members of the trust board it was acknowledged that the risk register was not effective that many risks had not been effectively managed or evaluated and many were over scored.
- This meant that the trust senior leaders at divisional level and trust board did not have oversight of the actual key risks and so could not prioritise and take the key actions that may have been required to reduce the risk of harm to patients and or staff.
- A number of risks had been on the risk register for a significant time, some for a number of years with limited or no review.
- The mitigating actions lacked detail and in some cases the review date had passed.
- We did not find effective action plans in place or a clear understanding of the severity of some of the risks or effective decision making to mitigate those risks.
- As an example there were two risks relating to the Operating Theatre ventilation and maintenance that had been on the Corporate Risk Register for 2 years with a grading of 25. During our inspection the trust took the decision to close one operating theatre due to issues with ventilation and the risk that that presented. It was acknowledge by the executive that this had not been escalated or managed previously and that their governance processes had not been optimal.

Summary of findings

- Whilst some staff told us that the Risk Register and the trust's approach to risk and governance had improved we found a Corporate Risk Register that was disconnected from the Board Assurance Framework and almost no shared understanding of the trust's key risks amongst directors and senior staff.
- It was acknowledged by the board that progress with the Corporate Risk Register was slow. The trust had neither a well-developed Board Assurance Framework nor an effective Corporate Risk Register as tools for explaining and escalating the trust's key risks.
- The Board Assurance Framework was niether effective or well written. It did not have version control and the sections on risk appetite are left blank.
- Externally commissioned reports identifying areas of risk or areas requiring improvement were not always acted upon in a timely manner. There had been a number of reports relating to the functioning of the maternity unit. The most recent had been undertaken by Royal College of Obstetricians & Gynaecologist and it identified recommended areas of improvement that were still required despite the same recommendations having been made in a previous report. There was no evidence that effective action had been taken against these recommendations at the time of the inspection.
- During the inspection we attended a meeting of the trust board. On reviewing the papers for the meeting we found an assessment paper providing assurance to the board that the current governance structures that were in place were adequate but in need of development. We brought this to the attention of the CEO and the papers were withdrawn and a further review of the governance processes was to be undertaken.
- We were not assured that risk was being effectively being managed by the Executive or the divisional senior teams. We were not assured that the Board held the Executive to account in an effective manner.
- 175 Serious Incidents were reported from February 2014 to January 2015, the most common type being Pressure Ulcers (56) at grade 3. There were also 12 incidents of 'failure to act on test results'
- The trust reports fewer incidents per 100 admissions than the England average.
- There had been four Never events (largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) reported from February 2014 to January 2015

Summary of findings

- Of the four reported Never Events, three were retained swabs following surgery.
- Although the trust were monitoring their compliance with the world health organisation surgical saftey check list there was no individual data available for the obstetric theatres, meaning there was lack of monitoring on the safety mechanisms that should be in place to reduce the risk of these Never Events occurring in the obstetric theatres and no oversight of this by the senior leaders in the division or the board.
- The trust had a daily Serious Incident Panel in place to review incidents that occur and to allow rapid Executive level decision making on reporting.
- We reviewed all of the Serious Incident Reports from 2014-2015 and felt that that majority had been correctly graded.
- We found that not all serious incidents were investigated in a timely way. We found 15 incidents that took between 6 months and a year to investigate. The trust policy stipulated a draft report was to be completed with 4 weeks.
- Given these timeframes we were not assured that the trust was sufficiently effective at initially evaluating incidents and putting urgent initial measures in place to prevent a recurrence whilst a thorough investigation takes place and recommendations are agreed.
- We found there was lack of ownership within the senior leaders of some divisions for investigating and learning when things went wrong and that the divisions were not being held to account by the executive.
- We also found concise RCA' processes were completed for some serious incidents and yet other incidents with less significant consequences were put through the full RCA process.
- We found that staff had not always been caring in there communications relating to investigations. We observed an RCA report had been sent to relatives of a patient without an apology or a review by a Director or a letter from the Chief Executive. We were informed that this was not the trust usual process and that communication with patients after RCA's is always managed as for complaints with communication coming from the Chief Executive. We were not assured that this is the case or that this situation was managed in a caring manner.
- There was no evidence that themes and trends from incidents were identified and acted upon. At the time of the inspection we found that a number of action plans relating to serious incidents had not been completed or actions taken place.

- We met with the Complaints Manager and reviewed a number of complaints. We found that progress had been made in this area and the team were appropriately resourced. However from reviewing papers from board and committee meetings we were not assured that complaints data was effectively evaluated by the Board or reviewed in the context of other data, such as serious incident and patient satisfaction data.
- The trust currently flag as a risk for provider complaints in CQC Intelligent Monitoring framework. This is because they did not submit complaints data to the Health and Social Care Information Centre, despite being reminded of the requirement.
- We were informed of forthcoming structural changes and merger of PALS with the complaints team given the recommendations in key reports about the importance of keeping these functions separate we were not assured this would be in the best interest of patients.
- We were not provided with evidence of an effective policy management and control system and we found that some policies were out of date.

Leadership of the trust

- A number of the executive directors in either first director posts, new to the acute sector or have minimal NHS experience.
- We were not assured that there were effective coaching or shadowing arrangements in place to support the individuals both professionally and personally with the challenges they face as a team and as individuals.
- At the time of the inspection both the Chief Executive Officer and the Director of Governance were interim appointments with the interim CEO having been in post just 3 months since January 2015. In addition the current Chairman of the Trust will be leaving the Trust at the end of his current term of office (October 2015). Another Executive we spoke to had recently obtained a post elsewhere.
- In addition we found that the trust had employed a substantial numbers of interim and temporary senior staff. Staff told us they felt this was unsettling and expressed concern relating to the potential financial impact of this to the organisation
- At the time of the visit with the number of interims had fallen from 81 to 32.
- The incoming interim Chief Executive demonstrated a good understanding of the challenges and opportunities the trust faced along with the commitment to address them. She had already taken decisive action in some areas.

- We were informed that the trust had recently implemented a new divisional leadership structure. One of the aims was to provide clearer focus for Emergency Care. This re-structure was described as a 'proof of concept' initiative but it was too early to assess its effectiveness at the time of the inspection.
- Most members of the board were visible and well known to staff.

Culture within the trust

- Most staff we spoke to were friendly and welcoming.
- Some senior staff told us they did not feel empowered to make decisions.
- We were informed of an initiative the trust had implemented called 'Onion', which is a daily meeting, designed to escalate key issues to the Directors in order to achieve a speedy resolution. We were told the concept was a daily meeting which focuses on peeling back the layers by listening to clinical and non-clinical staff and looking at immediate changes that could be made to ensure patients are treated quickly, efficiently and correctly, first time.
- Onion was a well-regarded initiative externally to promote a culture of safety and had been short listed in 2014-15 in the 'Best Safety Initiatives' Awards at the HSJ Awards. However, feedback from staff was mixed. Some staff were positive about this initiative but many felt that it disempowered line managers and delayed local decision making and resulted in lack of clarity about authority to make decisions.
- Most staff we spoke with felt that the system had been useful but now needed to be reviewed. This had been recognised by the executive team and we were informed that this was being developed to be a daily directorate focused meeting rather than trust wide.
- Many of the staff we spoke with expressed low levels of satisfaction, high levels of stress and work overload some staff told us they did not always feel respected, valued, supported and appreciated.

Fit and Proper Persons

- We were not provided with assurance that there were effective mechanisms in place for the Fit and Proper person test for executives and board members, not all the necessary checks were found to be in in place.
- We reviewed the Director's files to assess compliance against Fit and Proper Person legislation. Overall, we are not assured that this has been managed effectively or that even basic HR processes and procedures were all in place.

- This was brought to the attention of the relevant director at the time of the inspection.
- This 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.

Public engagement

- The trust participated in the national friends and family test and were worse than the England average for Percentage of patients recommending the organisation.
- The FFT recommended rate overall for this trust dropped to below the England average in June 2014, although it returned to just under the average in November 2014.
- The trust had very mixed results in the Cancer Patient Experience Survey. Out of 34 questions the trust scored in the top 20% of trusts for seven questions and in the bottom 20% of trusts for seven questions.
- The trust was rated "about the same" as other trusts in the CQC Inpatient Survey.
- The PLACE score for Privacy, Dignity and Wellbeing is flagged as a 'Risk' in Intelligent Monitoring with the score for Privacy, Dignity and Wellbeing in 2014 was 75%, much lower than the England average of 87%.

Staff engagement

- The trust took part in the national staff survey with their response rate being just below the England average.
- The trust returned 6 negative findings and no positive findings in the 2014 staff survey, following results of 8 negative findings and no positive in 2013.
- The areas where the trust results were worse than the England average in 2014 related to:

- Staff having had a well-structured appraisal in the last 12 months.
- Staff feeling secure about raising concerns or reporting incidents.
- Staff experiencing physical violence from staff.
- Job satisfaction.
- Staff experiencing discrimination.

- The results of the General Medical Council National Training Scheme survey was within expectations.
- Trust appraisal rates were variable and not in line with the trust required level in all areas.

Summary of findings

- Overall staff appraisal rates at the time of inspection were 70% an improvement from 35% in February 2015.

Innovation, improvement and sustainability

- There were significant issues with flow and capacity within the organisation meaning that patients spent longer in the emergency department than appropriate and the trust had consistently fallen below the required performance for patients being discharged from the emergency department in 4 hours.
- There had been very poor performance for a considerable period of time in spite of reduced activity against plan.
- The trust was a significant statistical outlier for all RTT indicators in relation to other trusts in England at February 2015, with a number of patients waiting over a year for treatment; these peaked at 15 in November 2014 and were at 3 in December 2014.
- A number of actions had been taken since January to address this.
- The trust did not meet its 18 week referral to treatment (RTT) standard of 95% from September 2013 onwards. The trust was consistently worse than the England average for that entire period. The trust told us that since January 2015 they had taken significant improvement actions regarding RTT and at the time of the inspection they were on trajectory to meet the standard.
- A whole system strategic review was underway during the time of the inspection. The trust has also commissioned external support to look at the response to the review and assist in their five year plan.
- Information technology access was considered by many staff to be generally poor with old, slow computers and lack of equipment in some areas. There was a plan in place to address this over a five year period with Hospital wide Wi-Fi being introduced.
- We found that information and data quality systems required improvement. The trust was aware of this and had plans in place to take action.
- We found significant maintenance issues with the trust's estate.
- The facilities that were provided for patients were not always adequate to meet their needs, avoid risks to patient safety or to improve the patient and staff experience.
- There had been a focus on understanding and reducing the trust mortality.
- Processes for reviewing mortality within the divisions had been developed although we found this was not embedded in all areas.

- Over a two year period the reported data showed a reduction of 21.4% in HSMR and a 28% reduction in crude mortality data including for hip fractures.
- The trust told us that there had been a number of factors influencing this included monthly mortality meetings chaired by the medical director or associate. Increasing the number of Care of the Elderly consultants and consultant delivered operative care for patients with a fractured neck of femur. It was acknowledged that an element of the reduction was also due to better reporting and data management.'

Recruitment and vacancies

- The trust had experienced challenges with recruitment and high turnover of staff. In December 2014, an external company were commissioned to undertake research to determine the root cause of the issue, and to support the Trust in developing plans to address it. The research highlighted many factors contributing to the Trust's recruitment and retention challenges, with a vast majority of these within the control of the Trust. These included:

- Issues with the working environment
- Lack of team working due to high ratios of temporary staff
- Variable experiences of leadership
- Insufficient opportunities for development
- Excessive work pressure with insufficient support for health and wellbeing

- A number of actions had been developed to address these issues including improving communication and development opportunities for staff. Implementation of a Listening into Action programme. This is a nationally recognized best practice programme in helping to engage staff.
- There had been significant work undertaken to review and improve the trust's approach to medical revalidation in partnership with the GMC, this was being led by the Medical Director and his associates following concerns relating to the effectiveness of a previous system.

Overview of ratings

Our ratings for Watford General Hospital

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

Our ratings for Hemel Hempstead Hospital

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

Overview of ratings

Our ratings for St Albans City Hospital

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

Our ratings for West Hertfordshire Hospitals NHS Trust

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients, Urgent Care Centres and Minor Injury Units.

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- The trust has delivered a significant reduction in mortality over the past two years, with Hospital Standardised Mortality Ratio (HSMR) dropping from 111.62 (significantly higher than expected) in March 2013 to 88.0 in March 2015 (significantly lower than expected). Equally, the Summary Hospital-level Mortality Indicator (SHMI) reduced from 107.4 (as expected) to 90.20 (lower than expected) and crude mortality reduced from 1.8% to 1.54% over the same period. Fracture neck of femur mortality rates have reduced from 12% to 7% over this period.
- Starfish ward staff had supported a parent whose child was frequently admitted to the ward to obtain funding to set up a carers support team. The team was subject to the same governance and recruitment checks as the ward's staff. The carers support team offered sitting services, information and signposting, and befriending for parents whose children were in-patients on Starfish ward.
- The care delivered within the Children's Emergency Department was outstanding.
- The trust had introduced a pilot pre-operative reminder telephone call service. The patient was called three days prior to their surgery for reminders and checks. Staff said if the service proved successful then it would become permanent.
- For world sepsis day, the sepsis team launched a 'sing-along' video called 'Stamp Out Sepsis' (SOS), sung in time to a well-known song. This was an innovative method that aimed to raise awareness of sepsis and encouraged staff to remember six actions that could improve patient outcome.
- The dementia care team had implemented a delirium recovery programme which aimed to reduce length of stay, readmissions, antipsychotic prescribing and promoted cognitive and physical functioning by cognitive enablement and health and wellbeing for patients. This allowed patients the opportunity to return home with up to three weeks of 24 hour live in care. The outcomes clearly demonstrated that the majority of patients with delirium went home with the programme in place when usual care would have predicted placement from hospital directly. Most patients recovered to a sufficient level to stay at home.

Areas for improvement

Action the trust MUST take to improve

- Ensure action is taken to ensure difficult airway management equipment is adequate and checked to ensure it is fit for purpose.
- Take action to ensure medical staff are suitably trained to manage the safe transfer of patients from critical care to other hospitals and services.
- Review the environment within the Emergency Department to meet patient demand effectively.
- Ensure that staffing levels within adult Emergency Department meet patient demand.
- Ensure there are prompt and effective triage systems in place within the Emergency Department undertaken by appropriate and competent staff.
- Ensure that all patient records are accurate and demonstrate a full chronology of the care provided.
- Ensure that medicines are always stored in accordance with trust policy.
- Ensure there is an effective clinical audit plan in place for all services.
- Ensure that major incidents arrangements are suitable to ensure patients, staff and the public are adequately protected and that patients are cared for appropriately should there be a major incident.
- Ensure there are effective arrangements in place for the management of risk at all levels within the organisation.
- Ensure that there is a robust incident and accident reporting system in place and that lessons learnt from investigations of reports are shared with staff to improve patient safety and experience.
- Ensure all incidents are investigated in a timely manner and necessary actions taken.

Outstanding practice and areas for improvement

- Ensure that governance and risk management systems reflect current risks and that all staff are aware of these systems and risks.
- Ensure that all facilities are in safe state of repair.
- Ensure that staff delivering information to bereaved people receive training in communication and bereavement.
- Review the cancellation of outpatient appointments and take the necessary steps to ensure that issues identified are addressed and cancellations are kept to a minimum.
- Review waiting times in outpatients' clinics and take the necessary steps to ensure that issues identified are addressed.
- Ensure that patients' records including confidential computerised patient records are stored appropriately in accordance with legislation at all times.
- Ensure that all equipment has safety and service checks in accordance with policy and manufacturer' instructions and that the identified frequency is adhered to in respect of emergency equipment requiring daily checks.
- Ensure all areas are fit for purpose and present no safety risks to patients or staff.
- Review the elective surgery cancellation rates and review the elective surgery service demand.
- Review the provision of the continuous piped oxygen.
- Ensure that service risk registers are current and fully reflective of all risks and that all staff are aware of the trust process for managing risks.
- Take action to review any risk to patients who have had surgery in Theatre 4 at St Albans Hospital.
- Ensure that all patients' records are kept up to date and appropriately maintained to ensure that patients receive appropriate and timely treatment.
- Ensure that all records are accurate and reflective of patients' assessed needs.
- Ensure staff are able to attend and carry out mandatory training, to care for and treat patients effectively, particularly regarding annual resuscitation training.
- Ensure that at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff to ensure people who use the service are safe and their health and welfare needs are met.
- Ensure that 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 security systems within the maternity unit are maintained at all times to ensure the safety of babies. Ensure that all appropriate premises are secure.
- The trust must ensure that all staff are effectively supported with formal supervision and appraisals systems.
- Ensure that all facilities are in safe state of repair.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 (1)(b),(c),(e) HSCA 2008 (Regulated Activities) Regulations 2014 **Premises and equipment** All premises and equipment used by the service provider must be suitable for the purpose for which they are being used. Concerns were found regarding the suitability of the premises in medicine, surgery, maternity, outpatients and end of life care both in terms of suitability, safety and security. Difficult airway management equipment on the Difficult Airway trolley provided in the critical care unit did not contain an appropriate emergency tracheostomy kit and therefore did not conform to professional standards. This meant staff could not effectively respond in an emergency situation.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1)(a),(c),(f),(g) HSCA 2008 (Regulated Activities) Regulations 2014 **Safe care and treatment** Care and treatment must be provided in a safe way for service users ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.

This section is primarily information for the provider

Requirement notices

There were concerns regarding assessing the risks to the health and safety of service users of receiving the care or treatment in ED, and staff had not received training to manage the safe transfer of critically ill patients. Medicines were not stored safely. Patients in radiology were being routinely being given medication without a prescription or a patient group directive in place.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a),(b),(c) HSCA 2008 (Regulated Activities) Regulations 2014 **Good Governance** Systems or processes must be established and operated effectively to ensure compliance with assessing, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity, maintaining and keeping secure appropriate records and evaluating and improve their practice in respect of the processing of the information The regulation was not being met because governance arrangements for auditing and monitoring clinical services were ineffective and unclear. Although there was some evidence of nursing audit and learning, information and analysis were not used proactively to identify opportunities to drive improvements in care. Risks identified were not always responded to in a timely manner. Records were not always completed or stored in accordance with trust procedures.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18,(1), (2),(a) ,(b) HSCA 2008 (Regulated Activities) Regulations 2014

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Requirement notices

Treatment of disease, disorder or injury	**Staffing** Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed and receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Staffing levels did not always meet patients' needs in ED, medicine, maternity, EoLC and outpatients. There was not a robust system in place for staff supervision and appraisal across all services. Not all staff had had mandatory training as required by the trust's policies.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Regulation 16, (1), (2) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: **Receiving and acting on complaints** The service should operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. There were not robust systems in place for monitoring and responding to complaints, and implementing actions required as a result of investigation, across all services.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 **Dignity and respect** Service users must be treated with dignity and respect.

This section is primarily information for the provider

Requirement notices

Not all patients in maternity and outpatients were treated with dignity and respect.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19(1),(2),(3) HSCA 2008 (Regulated Activities) Regulations 2014 **Fit and Proper Persons** Persons employed for the purposes of carrying on a regulated activity must be of good character and have the qualifications, competence, skills and experience which are necessary for the work to be performed by them. We found that robust procedures for carrying out the necessary fit and proper persons checks on board and executive team members had not been carried out.