West Hertfordshire Hospitals NHS Trust - Governance Declaration December 2009

2009/10 In year Reporting

Name of Organisation: **West Hertfordshire Hospitals NHS Trust** (V1.0)

Organisational risk rating score

Each organisation is required to calculate their risk score and RAG rate their current performance as per the Provider Management Regime, in addition to providing comment with regard to any contractual issues and performance against projected CQC targets:

Risk scoring	
Annual Plan Risk Ratings	**Score / RAG rating**
Governance Risk Rating (RAG as per East of England Provider Management Regime guidance)	3.1
Financial Risk Rating (Assign number as per East of England PMR guidance) - Overall rating	Year to date 2
	Forecast full year outturn 3
Contractual Position (RAG as per East of England PMR guidance)	
Healthcare Commission Quality Rating 08/09 (Out turn)	Fair
Care Quality Commission Rating 09/10 (Forecast)	Projected good
Healthcare Commission Use of resources Rating 08/09 (Out turn)	Good
Care Quality Commission Use of resources Rating 09/10 (Forecast)	Projected good

Governance Declarations

EoE Organisations subject to the Provider Management Regime must ensure that plans in place are sufficient to ensure compliance in relation to all national targets and core standards including ongoing compliance with the *Code of Practice for the Prevention and Control of Healthcare Associated Infections*.

Please complete sign **one** of the two declarations below. If you sign declaration 2, provide supporting detail using the form below. Signature may be either hand written or electronic, however please be sure to print your name.

Governance declaration 1

The board is satisfied that plans in place **are sufficient** to ensure ongoing compliance with all existing targets (after the application of thresholds) and national core standards and with all known targets going forward. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the *Code of Practice for the Prevention and Control of Healthcare Associated Infections* (including the Hygiene Code). The board also confirms that there are no material contractual disputes and that it is on track to deliver the projected HCC rating.

Please see declaration 2.

Governance declaration 2

For Governance, Finance, Service Provision, Quality and Safety or the *Code of Practice for the Prevention and Control of Healthcare Associated Infections* the Board cannot make Declaration 1 and has provided relevant details below.

The board is satisfied that plans in place **are sufficient** to ensure ongoing compliance with all other existing targets (after the application of thresholds) and national core standards and with all known targets going forward. The board also confirms that there are no material contractual disputes and that it is on track to deliver the projected HCC rating.

(Signed by)

(Please Print Name) **Jan Filochowski**

on behalf of the Board of Directors

Acting in capacity as **Chief Executive**

* delete as appropriate

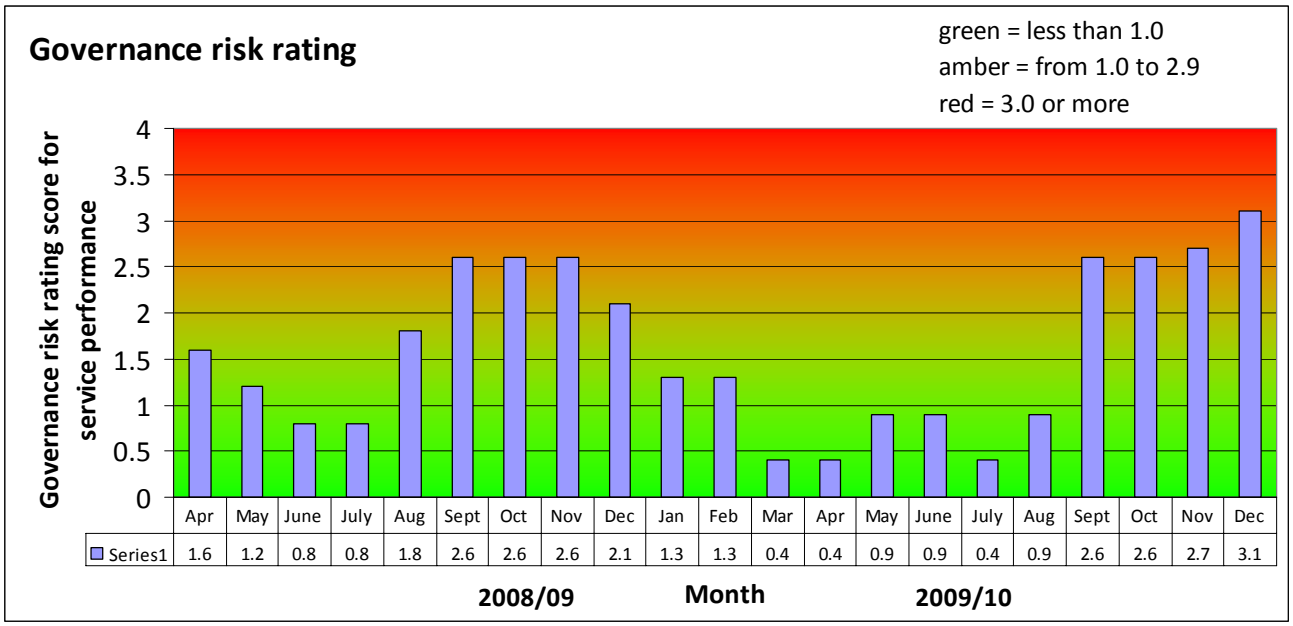
If Declaration 2 has been signed:

Please identify which targets have led to the Board being unable to sign declaration 1. For ***each area such as Governance, Finance, Service Provision or HCC rating forecast (including as relevant national targets or core standards)*** please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

West Hertfordshire Hospitals NHS Trust - Governance Declaration December 2009

2009/10 In year Reporting

1. Governance declarations to date



Score	DoH Metrics	2009/10 Financial Year Governance Scores											
		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
1	Clostridium difficile												
	MRSA												
	Cancer – 31 days subsequent treatment												
	Cancer – 62 days from referral to start of treatment												
	18 weeks admitted patients												
	18 weeks non admitted patients												
0.5	A&E 4hr target		x					x	x	x			
	Thrombolysis within 60 minutes	Not applicable											
	Urgent GP cancer referral – max. 2 week wait						x		x	x			
	Cancer – 31 days from diagnosis to treatment			x									
	MRSA – screening all elective inpatients					x	x	x	x	x			
0.4	National core standards compliance					x	xx xx	xx xx	xx x	xx xx			
	Total	**0.4**	**0.9**	**0.9**	**0.4**	**0.9**	**2.6**	**2.6**	**2.7**	**3.1**			

2. Non Compliance as at December 2009

The following sections provide commentary on West Hertfordshire Hospitals NHS Trust's areas of non compliance as at December 2009:

2.1 Code of Practice for the Prevention and Control of Healthcare Associated Infections (including the Hygiene Code);
2.2 Core standards compliance;
2.3 A&E – 4 hours target;
2.4 MRSA – screening all elective inpatients;
2.5 Urgent GP cancer referrals; - max. 2 week wait

2.1. Code of Practice for the Prevention and Control of Healthcare Associated Infections (including the Hygiene Code)

We are compliant with the Hygiene Code, with the exception of duty 4.

As at December 2009, we are fully compliant with the Hygiene Code, with the exception of duty 4f. We are not compliant with duty 4f; decontamination of instruments and equipment. Our service is acknowledged as clinically safe, but due to the requirements of building technical notes for the physical environments in which we operate, we cannot achieve full compliance.

To be compliant with decontamination the Trust has instigated a "Decontamination Compliance Programme" within which there are three key projects and two follow-on projects which need to be delivered:

- Key Projects
  - Trust wide TSSU/CSSD services
  - Endoscopy at Hemel Hempstead Hospital
  - Endoscopy at Watford Hospital
- Follow-On Projects
  - Refurbish TSSU at St Albans Hospital
  - Refurbish TSSU at Watford Hospital

In relation to endoscopy:

Works to deliver a compliant service at Hemel Hempstead are due to be completed during Q4 of 2009/10. It is expected that the facilities at Watford will remain non compliant for the full 2009/10 year. However further evaluation of a new endoscope decontamination approach is being undertaken to try and identify a solution that will achieve compliance within financial year.

In relation to TSSU/CSSD services:

The Trust was formerly part of the Hertfordshire and North London Decontamination Collaboration. The Trust withdrew from that Collaboration following an options appraisal conducted to evaluate the revised prices submitted by the single remaining private bidder after the withdrawal of the third (of 6) collaboration partner.

The Trust has concluded that an alternative solution would be more beneficial to the Trust in terms of cost, speed of achieving compliance and overall risk. The Trust Board decided in July 2009 to seek entry to the North West London Collaboration for decontamination services. In August 2009, the Board of the North West London Collaboration agreed to the Trust's entry.

A Project Team has begun working with the provider (IH Sterile Services Ltd) to achieve a transition into the new and fully compliant facilities during Q2 2010/11.

Decontamination facilities at St Albans and Watford will therefore remain non-compliant for the whole of 2009/10.

Despite the non compliance it should be noted that at the Hygiene Code inspection in October 2008 the then Healthcare Commission were satisfied that safe services were being delivered and that the level of non compliance related to the current environments for the services and some restrictions in relation to technical improvements that current equipment was not able to meet. The Trust continues to operate to the same quality standards as were seen in October 2008.

We aim to become decontamination compliant by Q2 2010/11.

2.2. Core standards compliance

The table below details our year to date core standards non compliance for the 2009/10 financial year.

Month	Core standards non compliance	Changes in compliance – Quarters 1 and 2
April 2009	**0**	-
May 2009	**0**	-
June 2009	**0**	-
July 2009	**0**	-
Aug 2009	**1 – C4e**	**Core standard C4e**; The prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.
Sept 2009	**4** C4e, C4d, C1b, C14c	**Continued non compliance with C4e, and declaration of non compliance on three additional core standards:** **Core standard C4d;** Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely. **Core standard C1b;** Healthcare organisations protect patients through systems that ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required time-scales. **Core standard C14c;** Healthcare organisations have systems in place to ensure that patients, their relatives and carers are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.

West Hertfordshire Hospitals NHS Trust - Governance Declaration December 2009

2009/10 In year Reporting

Month	Core standards non compliance	Changes in compliance – Quarter 3
Oct 2009	**4** C1b, C4d, C4e, C14c	**Continued non-compliance with C1b, C4d, C4e, C14c.**
Nov 2009	**3** C1b, C4d, C14c	**Compliance with Core standard C4e**: The prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment. This was in line with the actions detailed in our October 2009 declaration having been implemented; The waste policy has been updated and ratified and the waste segregation audits have re-commenced.
Dec 2009	**4** C1b, C4d, C14c, C4e	**Non compliance with C4e**: The prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment. Further consideration was given to compliance with standard C4e following the outcomes of the audits undertaken across all sites. It is clear that despite the ratification of the Policy on 31 October 2009, there remain a number of issues which compromise full compliance at this time. The Trust is unlikely to achieve full compliance with this standard until the year-end, 31 March 2010.

As at December 2009 we are non compliant on 4 core standards.

Our projected end of year position is that all standards declared non-compliant will be compliant by year end, 31 March 2010 if not before.

2.2.1. Core standard C1b; Healthcare organisations protect patients through systems that ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required time-scales.

On inspection by the Care Quality Commission (CQC) on 1st July 2009, this standard was qualified for the following reasons:

Assessment:

The assessors found that although the Trust had policies and procedures in place in respect of patient safety and communications to ensure that alerts are properly disseminated and appropriately risk assessed and managed, its litmus test of one alert, NPSA 24 (Wristbands), revealed that the policies were not being consistently followed. The litmus test of NPSA 24 identified that for this alert the Trust had not met the first deadline (July 2008) and on review of documentation concluded it was not going to meet the second deadline for the production of compliant wristbands issued at bedside. It found that the Trust had not kept the NHS East of England (EoE) informed of issues, which would prevent the Trust from meeting the deadlines and providing assurance that notwithstanding the delay, the risks were being appropriately managed.

Trust Action:

The Trust is reviewing its policies and processes governing the timely implementation of Patient Safety Alerts via the CAS system. The Trust will be represented at a national training event on 29 January 2010, which will inform the development of an updated policy and associated processes. The new process will ensure all new CAS alerts are appropriately reviewed to determine resource implications and any implications for operational implementation, including staff training. Where the alert cannot be implemented without investment, the Trust will adopt a business planning/project management approach to implementation, which will be monitored through the Business Integrated Executive Committee on behalf of the Clinical Quality Committee. The Trust will ensure that risks relating to implementation are appropriately assessed, recorded and monitored, and where there are risks to implementing to deadline, these are communicated to the SHA with an action plan. The Trust will also ensure that all alerts are incorporated into the Trust's Clinical Audit Programme and reported to the Business Integrated Executive Committee. These policy and process changes will be completed by 31st March 2010.

The Trust will be able to demonstrate compliance with this standard by 31st March 2010 (previously reported December 2009).

Executive Lead: Dr Colin Johnston, Medical Director

Managerial Lead: Patricia Duncan, Assistant Director of Clinical Governance and Risk.

2.2.2. Core standard C4d; Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely

On inspection by the Care Quality Commission (CQC) on 1st July 2009, this standard was qualified.

Assessment

The assessors found there were gaps in the assurance processes for monitoring and implementing the findings of pharmacy audit and the Trust did not submit information that demonstrates how it benchmarks medication usage to monitor clinical appropriateness or effectiveness of use. The Trust did not demonstrate how medication errors are followed up to minimise the risk of reoccurrence and did not demonstrate monitoring of medication reviews for the whole year

The standard was assessed through a litmus test of National Patient Safety Agency (NPSA) alert 18 which found that the Trust is aware that procedures for management of anticoagulants are not currently compliant as there are gaps in Trust monitoring processes for this medication and not all documented audit activities are undertaken in line with policy

The assessment found the Trust did not have a separate policy for medicines reconciliation on admission and could not evidence how the Board was assured of this line of enquiry.

Whilst the trust has medicines management policies and procedures in place and has identified an Accountable Officer for controlled drugs and shared this information with the CQC, the assessment found that information relating to controlled drug incidents was not submitted to the local intelligence network within the review period.

Trust Action

Pharmacy audits are in place and will continue to be taken to appropriate committee/ forums, however assurance processes for monitoring the implementation of audit findings by such committees will be reviewed.

Performance against National Better Care, Better Value indicators (statins and PPIs) in addition to ACEI will continue to be taken to the Drugs and Therapeutics Committee each month and the Trust will continue to review performance of Trust antibiotic usage both via the Drugs and Therapeutic Committee (D&T) and the Infection Control Committee – expressed as defined daily doses (other trusts in East of England setting up systems and Antibiotics Network to be formed by 31/3/10)

Quarterly drugs expenditure reporting to be reviewed by D&T- and benchmarked against other trusts in the East of England and nationally. There will be ongoing reporting and development of non-formulary usage reporting to D&T and reporting of medication expenditure at the Acute Medicine Divisional forum.

The Trust has established a Medicines Safety Committee which is a sub group of the Drugs and Therapeutic Committee and will meet quarterly, its inaugural meeting took place on 1 December 2009. The Trust has appointed a Medicines Safety Pharmacist. The Trust has improved its process for recording medication reviews informed by pharmacist intervention records. It reports trends/issues to Medicine & Surgery divisions.

As indicated, the Trust is reviewing and improving its procedures for managing the implementation of NPSA/CAS alerts. It will undertake repeat audits for 2009/2010 to ensure adherence to NPSA requirements relating to medication alerts and feedback will be taken to appropriate Committees/forums.

Whilst there were in place at inspection, standard operating procedures for reconciling patient medication on admission, these have been replaced by a Trust Medicines Reconciliation policy, which has now been ratified.

The Trust will review its arrangements for six monthly controlled drug audits and ensure action plans are implemented and monitored and that findings are fed back to Drugs and Therapeutic Committee and to the Nursing and Midwifery Strategy Group and Clinical Practice forum.

The Trust will continue to submit incidents to the local intelligence network for controlled drugs.

As indicated, the Trust has begun the work required to address the findings following assessment and is scheduled to be compliant with this standard by 31st March 2010 (previously reported January 2010).

Executive Lead: Dr Colin Johnston, Medical Director and Director of Patient Safety

Managerial Lead: Martin Keble, Chief Pharmacist.

2.2.3. Core standard C4e; The prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.

This standard was declared non compliant in the CQC mid year declaration following a review by the Trusts Clinical Governance and Risk Team, for the following reasons:

Assessment:

Further consideration was given to compliance with standard C4e following the outcomes of the audits undertaken across all sites. It is clear that despite the ratification of the Policy on 31 October 2009, there remain a number of issues which compromise full compliance at this time. These audits revealed breaches of policy in relation to segregation of waste with specific issues relating to hospital site and variance in practice. Further analysis revealed problems with waste disposal facilities and lack of awareness of requirements.

Trust Action:

An action plan has been developed to address the deficiencies, which have been identified, and is focusing on:

- Review of disposal of medicines
- Raising staff awareness of the Waste Management Policy and their responsibilities to ensure compliance
- Improve the reporting of waste segregation breaches to improve in year assurance processes
- Review of containers used to support efficient practice in waste segregation to achieve standardisation across Trust sites.
- Whilst the above are in train, it is recognised that further funding is required to maintain and sustain progress and a business case is being developed to secure the funding necessary to achieve the above.

The Trust will be able to demonstrate compliance with this standard by 28 February 2010.

Executive Lead: Sarah Wiles, Director of Strategy and Infrastructure

Managerial Lead: Paul Mosley, Associate Director of Hotel Services.

2.2.4. Core standard C14c; Healthcare organisations have systems in place to ensure that patients, their relatives and carers are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.

From September 2009 we have declared non-compliance with C14c.

We have developed and are currently implementing a detailed action plan. We have improved our performance management processes with the Chief Executive reviewing progress with Divisional Managers on a weekly basis.

Preliminary indicators are that we will have achieved 68% of complaints responses being completed within the required timescales. The target for January has been set at 80%.

We aim to be compliant on C14c by February 2010.
Executive Lead: David McNeil, Interim Director of Nursing
Managerial Lead: Mark Jarvis, Associate Director of Integrated Governance.

2.3. A&E – 4 hours target

Assessment
Our performance for December was 96.1%, a significant reduction in performance since November. An analysis of the data, has shown that the main cause for failure to meet the 4 hour emergency target was related to bed pressures. Extreme weather conditions and the containment of an outbreak of noravirus placed considerable strain on our services.

Trust Action
In conjunction with the PCT we have revised the the joint action plan and outlined a trajectory until the end of March 2010. We continue to have interagency emergency care meetings weekly and daily conference calls to manage the situation.

Executive Lead: Russell Harrison, Director of Delivery
Managerial Lead: Pat Reid, General Manager for Emergency Medicine

2.4. MRSA screening of all elective inpatients

NHS EoE clarified on 22nd September 2009 the approach to be followed when calculating compliance with the national target for the MRSA screening of elective inpatients, which is summarised below.

A number of Trusts have raised concerns on the threshold applied on the MRSA screening target. The Department of Health (DH) issued guidance in July 2008 on the introduction of the MRSA screening for all elective patients by the end of March 2009. The DH issued further guidance in December 2008 outlining the steps that organisations needed to take to ensure that they were ready.

Our expectation is therefore that all elective patients, with the exception of those outlined in Monitor's Compliance Framework, are screened for MRSA. The Provider Development Board has agreed that a threshold of 100% should be applied to the target.

Further to this, we expect performance to be reported at a patient level to ensure that every patient is being screened. A number of Trusts have been reporting the ratio between the number of patients seen and the number of screening tests done, our view is that this methodology does not accurately capture the requirements of the standard. Organisations should therefore ensure that they have the correct systems in place to be able to report this information at a patient level.

Assessment

Our December 2009 performance of 92.9% was below the 100% target (taking into account the exclusions detailed in Monitor's Compliance Framework).

Trust Action

Clinical governance leads are reviewing our processes with divisional leads in order to improve our performance and achieve 100% compliance.

Executive Lead: Dr Colin Johnston, Medical Director and Director of Patient Safety

Managerial Lead: Frances Stratford, Associate Director of Infection Control.

2.5. Urgent GP cancer referral – maximum 2 week wait

Assessment

Our December 2009 provisional performance of 92.1%, was below the 93% performance threshold.

Trust Action

This is the second month in a row we have not achieved this target. The Cancer Team continue to work with the Booking Office and the Outpatients Project Steering Group in ensuring referrals are booked within fourteen days.

Executive Lead: Mr Nick Evans, Director of Partnerships

Managerial Lead: James McQuillan, Associate Director Service Improvement