Agenda Paper No: 67/04

West Hertfordshire Hospitals NHS
NHS Trust

From: Howard Borkett-Jones, Medical Director

To: Trust Board, 1st July 2004

Subject: Report on progress against CHI Action Plan

Action: For noting

The attached document summarises the Trusts response to date to the CHI report produced after the CHI monitoring visit in 2002.

An extensive action plan was produced, which has been monitored through a series of widely based CHI Action days. The details indicate that the large majority of the actions identified as being necessary in the light of the CHI report, are now completed. The remaining actions relate to sustained programmes of work which continue.

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West Hertfordshire Hospitals NHS Trust was subject to CHI review during the summer of 2002. A draft review report was received at the end of August, followed by the full report in September.

The principle concerns identified were:

i. little or no progress in developing risk management systems at strategic or operational level, although a Trust-wide reporting system was introduced in 2001
ii. IM&T poorly developed with a number of different systems in place
iii. significant waits in A&E and slow access to some radiology services
iv. complaints not always dealt with effectively
v. some wards dirty and untidy

In response, the first WHHT CHI Action Plan was formulated in October 2002. The plan (50+ pages long) is available on the WHHT intranet. The actions were divided into twelve sections:

1. Building a Corporate Identity
2. Right Services at the Right Time
3. Wider listening, Closer working
4. Responding to Patients Complaints
5. Use of Information
6. Improving Clinical Practice
7. Improving the environment
8. Staff Appraisal
9. Raising Risk Awareness
10. Training & Education
11. Recruitment & Retention
12. Strategic Capacity

Within each section, a tabular format was used showing

- Key Action
- Action Plan
- Objective
- Timescale
- Constraints
- Lead Director
- Outcome Measures
- Monitoring

CHI Action Days, involving staff from a range of disciplines were held and a CHI Network Leaders Group was established, with a wide and flexible remit to suggest and undertake initiatives across the Trust to progress the action plan.

In summary, within the above sections and 35 key headings, progress against 135 action points has been assessed in two formal Progress Reports (both available if required).

The first, produced in August 2003, showed that 97 actions had been completed. By March 2004, when the second report was written, 110 actions had been completed, 1 was partially finished and 24 were on-going pieces of work. (It should be acknowledged that a number of the discreet actions have become continually 'on-going' as the Trust strives to improve the services offered.)
This performance demonstrates a huge amount of commitment and effort from WHHT staff at all levels throughout the organisation.

If the original three-year cycle is adhered to, a further review by the Healthcare Commission (successor to CHI/CHAI) is expected during 2005. No firm notification has yet been received, but planning for this will need to begin this autumn.

Howard Borkett-Jones
Medical Director
June 2004

West Hertfordshire Hospitals NHS
NHS Trust

CHI ACTION PLAN

PROGRESS REPORT

MARCH 2004

1. Building a Corporate Identity

Key Action	Action Plan	Timescale	Outcome Measure	Achieved Yes / No	Evidence
Corporate Identity ~ shared vision and clinical governance development	Mt Vernon's future to be clarified within the context of the Strategic Health Authority 'Investing in Health' process.	On-going	Clarification of Trust configuration.	Yes	IIYH documentation produced by SHA. Document available on Trust intranet. Regular 'walk-abouts' to all departments and wards by Board members.
	Introduction of cross-site events: Induction days rotate between sites; increased rotational working between sites and wards; introduction of staff 'buddying'.	Start Jan '03	Common induction for all staff.	Yes	Trust induction alternates between all 4 main Trust sites. Revised corporate induction programme commenced Jan '04, incorporating (from March '04) NHSU programme in communications and induction. Job shadowing introduced to encourage staff to work across sites/departments. Many inter-site workshops held.
	Development of cross-site functions.	On-going	Trust events organised.	Yes	Social activities, including football, cricket bowling matches organised.
				Yes	Nursing & Midwifery 'Celebration of Success' event planned for 2 August.
	Introduction of 'refresher' induction programmes, that focus on Trust-wide processes, care pathways and line management structures, for staff.	Start: Jan '03	Existing staff attend relevant induction courses.	Yes	New Trust Mandatory Training Plan introduced (from Jan '04) the requirement for the provision of an additional induction programme for all new and promoted managers and supervisors. Local induction on appointment, promotion or transfer will also address specific training needs appropriate to the specialty in which the member of staff works. All staff will receive an annual review of training requirements through the Trust appraisal process and the PDP will contain 'refresher' and updated training needs as appropriate.
	Senior clinicians and managers to have clear understanding of, and accountability for the delivery of Trust-wide clinical governance and shared Trust aims through the new Trust-wide divisional arrangements.	November '02	Clear evidence of progress through clinical governance monitoring reports.	Yes	Proceedings of Clinical Governance Committee (including clinical reports) are minuted. CG monitoring reports are produced monthly and quarterly. Discussed at Executive Team/Board meetings.
	New DoH, NICE directives to be introduced Trust wide.	On-going	Systematic introduction & evaluation	Ongoing	Establishment of Clinical Divisions complete.

1. Building a Corporate Identity (cont/d)

					DMG has regular presentations on Clinical Governance issues.
	Introduction of single communication system: Team Talk.	On-going	Evidence of information cascaded.	Yes	Relevant DoH directives pertaining to risk are discussed at Risk Management Committee. Systematic evaluation of WHHT compliance with NICE guidance underway.
				Yes	Team Talk occurs monthly. Cascaded (with paper backup) on Friday following each Board meeting. Posted on the intranet & available as hard copies.
Clear & consistent signage & documentation format in all departments	Each Hospital has Trust notice boards with Trust logo in key staff & patient areas.	April 2003	Standardised notice boards.	Yes	The Trust has corporate notice boards across the sites that provide information on corporate issues & events.
	All external & internal signs comply with Trust requirements.	March 2004	100% compliance.	In part	A Trust-wide replacement programme is progressing well. All 4 sites have been reviewed and a priority replacement list has been established.
	All departments/wards comply with corporate information standards & NHS Documentation standards.	January 2003	100% compliance.	Yes	Corporate guidelines based on NHS ID guidance are being systematically rolled out throughout the Trust.
Discharge Policy	Revise Trust discharge policy to incorporate best practice nationally.	April 2003	Policy complete.	Yes	Next policy review ~ June '04.
	Discharge planning to commence on admission.	December 2002	Discharge plans in place for all patients within 48 hours of admission.	Yes	Elective patients' discharge planning begins on admission. More work required for emergency patient discharge planning achieving this aim.
	Enhance discharge lounge facilities.	November 2002	Discharge lounges on both sites 80% occupancy.	Yes	Discharge lounges are located on HHGH and WGH sites.
	Focus discharge co-ordinators on all patients not just 'bed blockers'.	November 2002	Clear plans in place for all patients.	Ongoing	Policy review currently underway. Escalation policy developed. Collaborative working with other local organisations to demonstrate a co-ordinated approach taking place.

2. Right Services at the Right Time

Key Action	Action Plan	Timescale	Outcome Measure	Achieved Yes / No	Evidence
Access for emergency admissions (& diagnostic times ~ not covered explicitly)	Review the speed of the booking service in A&E.	Nov 2002	4 hour maximum (75% patients to spend less than 4 hours in A&E).	Yes	75% target met from March 2003.
		March '04	90% outcome required.	No	Currently around 85%.
	Raise public awareness of primary care & other local services to ensure patients presenting at A&E require emergency or urgent treatment.	Ongoing	All patients assessed by doctor within 1 hour.	Yes	'See and treat', has been introduced at both WGH and HHGH sites. This means that patients are seen in order of arrival time.
	Review the streamlining processes for heralded patients.	November 2002	As above.	Yes	12 hr trolley waits (12 exceptions in '03/'04). 4 hr trolley waits significantly reduced (now around 85%).
		By Dec.'04	98% requirement.	-	A major target for acute services: the Emergency Services Task Force has been convened, working with PCT CEOs to deliver a 'whole system' solution.
	Benchmark with Norfolk & Norwich Hospital in clinical streaming process & NHS Beacon sites & source from Modernisation Agency web-site; & trial scoring for patient volume.	As above	As above.	Yes	Work progressed via Emergency Services Collaborative.
	Link with NHS Direct as information source on appr. patient referral.	Now 04/05	As above.	No	Now subsumed into Emergency Services Task Force: key Trust objective for '04 in collaboration with wider health system.
	Work more collaboratively & improve communication between A&E & primary care.	Ongoing	4 hour maximum.	Yes	Involved in discussions with BHAPS.
			75% patients to spend less than 4 hours in A&E.	Yes	Met since March 2003.
			All patients assessed by doctor within 1 hour.	Yes	Patients are 'streamed' ~ not all see a doctor as a significant % see other practitioners.
Patient Access across sites	Improve communication with the public & general practitioners to inform:	Ongoing	As above.	Yes	Production of Hospital Portfolio.

	▪ Their expectations of key departments/facilities & their availability of services; ▪ Best times for access & that various investigations and specialisms are located on alternate sites; ▪ Joint agreement with PCTs about service location.				Ongoing reconfiguration discussions with PCTs & SHA. IIYH agreed objective to focus major A&E services at WGH.
Strengthen service planning to ensure effective utilisation of Trust facilities	Commence theatre utilisation project to ensure lists are used to maximum effect.	September 2002	Increase theatre throughput by 5%.	Yes	Theatre Policy reflects Utilisation issues.
	Review Outpatient services: ▪ Clinic templates ▪ DNA rates ▪ Clinic cancellations ▪ Booking systems	March 2003	Achieve 21-week maximum wait.	Yes	Target met. All specialities are reviewing their local templates. A full revision of outpatient services is being undertaken. All short notice cancellations & DNAs are coded, allowing better tracking & analysis. The partial booking system is being rolled out across the Trust.
	Ensure principles of booked admissions are implemented across the Trust.	December 2002	Booked admissions target met.	Yes	80% of day cases booked by April 2003. Progress being made to meet 2004 target.
	Improve bed management system (see also discharge section).	November 2002	Achieve 4-hour trolley wait.	Ongoing	Revision of the Discharge Policy due for completion in June '04: link to Bed Management Policy.
	Maximise use of day surgery facilities for day surgery.	April 2003	% day surgery achieved.	Yes	67% achieved: activity remains at this level.

3. Wider Listening, Closer Working

PPI Manager has produced a very detailed base line assessment of progress in 2003/04 by Directorate/Department. It is not possible to do justice to all this work within this report. The full assessment is available on request.

Key Action	Action Plan	Timescale	Outcome Measure	Achieved Yes / No	Evidence
Develop a comprehensive patient, user & public involvement strategy	Linking to external organisations: (PPI ~ set direction, definition & aims.	Ongoing	Publication of a list of Patient Forums and Panel dates.	Yes	Public community liaison work to support and help members of the public: dates published.
	Interlink all Patient Forums/Panels across the local health economy; ♦ Make use of communities i.e Beds & Herts database of 'expert' patients.	November 2002	Better understanding liaison and co-ordination.	Yes	Joint working with PCTs, HPT, Carers in Hertfordshire, Adult Care Services, Social services established.
	♦ Agree work programme to collaborate with external parties to maximise control with more remote or disparate users.	December 2002		Yes	Joint working with Cancer network, SHA, MVH, LJC, Macmillan Nurses, E&N Herts to formulate cancer user groups. External links made with PCT outside agencies and Dacorum Council aiming to establish an interpretation and translation service within the Trust. Working with CPPIH Editorial to help them promote their recruitment campaign for PPI. Joint working with SHA to improve women's services following independent review. Relationships established with African, Caribbean & Asian communities: regular liaison with Black Carers Forum. PPI Manager, Non-Executive Director, Coroner, Chaplains, Registry Office and undertakers currently working with the

3. Wider Listening, Closer Working (cont/d)

					Muslim community in respect of releasing deceased patients out of hours. Working with main leads at the Mosque to formulate a cancer pathway for patient information. A Patients' Panel continues to provide invaluable services within the Trust. Currently there are 40 patient representatives wanting to work within the Trust to improve our services. A Patient & Public Involvement Steering Group has been set up. An Organ Retention help-line is still active within the Trust providing information for affected families.
Develop a comprehensive patient, user & public involvement strategy	PALS to undertake 'customer care' role & roam to seek out concerns proactively. Listening to patients	January 2003		Yes	PALS officers walk the wards daily.
	▪ Introduction of comments scheme.	January 2003	PALS monthly monitoring showing increased patients and staff satisfaction.	Yes	Comments boxes have been put up across the Trust. Also 'Listening Boards' being introduced to show comments made and action taken.
	▪ Encourage anonymous (if desired by service user) feedback, raise awareness of issues faster than or supplementary to complaints process.	January 2003		Yes	Patient Panel members regularly conduct surveys in A&E & OPD.
	▪ Publicise early successes that promote confidence in system & celebrate constructive & collaborative working in PALS newsletter.	January 2003		Yes	This is achieved through the Listening Boards. These will show thank you cards & 'lessons' learnt from complaints.

3. Wider Listening, Closer Working (cont/d)

Key Action	Action Plan	Timescale	Outcome Measure	Achieved Yes / No	Evidence
Develop a comprehensive patient, user & public involvement strategy	▪ Nursing Patient stories programme to form part of the clinical governance reports.	March 2003	Board Reports / Annual Reports.	Yes	The RCN Clinical Leadership Programme, which is the origin of the Nursing Patients stories approach, is referenced in the CG Annual Report 2002/03. Observation of Care Strategy piloted in 10 clinical areas in January '04: to be launched Trust-wide in June '04. Essence of Care Food & Nutrition benchmark well underway: progress reports produced every 4 months.
	▪ Involve users in care pathway audits.	June 2003	Publication of quarterly schedule of open days & events.	Yes	Patient representatives have been involved in the Orthopaedic Care Pathway and are due to attend the ENT Care Pathway event. The Stoke Steering Group includes user members.
	▪ Training & Development All patient care staff to attend customer care courses. In the new training programmes implemented or planned, the concept of customer care has been broadened to include the range of communication competencies contained in the *NHS Knowledge and Skills Framework.* Therefore, 'customer care' is now incorporated into a range of development activities rather than being provided as a specific programme. All staff will have their development needs reviewed as part of the appraisal and personal development plan process.	Start June 2003 and ongoing	Fewer complaints about staff attitude.	Ongoing	Quality Manager inputs to training on Induction Programme, F grade development & Clinical Leaders days. New corporate induction programme incorporates the NHS programme for Communication skills (module 4:learning patient and staff communications) & PALS/Patient Complaints teams participate in Day 1. The Trust also plans to implement Suzy Lamplugh programme to support staff in managing difficult and challenging communications scenarios. A range of other training activities including the Buddy Programme/Skills Facilitation and the wider use of individual Learning Accounts.

4. Responding to Patient Complaints

Key Action	Action Plan	Timescale	Outcome Measure	Achieved Yes / No	Evidence
Learning from complaints	Quarterly complaints data produced by theme & frequency for Executive Team.	December 2002	Monthly & quarterly reports include 'common themes ' & change in practice reports from key departments.	Yes	Monthly data produced and circulated, to the DMG and Trust Board.
	Lessons from complaints shared with departments.	December 2002		Yes	Actions, themes & trends circulated monthly.
	Complaints about cleanliness to be monitored against actual specification.	December 2002		Yes	Ward staff regularly review. Awayday with Chief Executive, Modern Matrons & Medirest staff held on 20/01/03 & 24/03/03. Revised monitoring arrangements in place ~ August 2003.
	Complaints review & changes in practice discussed at clinical audit & effectiveness, and clinical governance meetings.	December 2002	Improved co-ordination of process.	Yes	Noted in Clinical Governance Committee Meetings.
	Establishment of Complaints Advisory Forum	Inaugural meeting April '04 then quarterly		-	Minutes to be circulated Trust wide.
PALS & Complaints department to provide comprehensive service to staff & patients	Develop structure & system that ensures all complaints acknowledged in 48 hours.	January 2003	Monthly & quarterly reports include 'common themes' & change in practice from key departments.	Yes	Watford QA Office re-opened January 2003. All complaints are now acknowledged within 48 hours of receipt. 'Making your Voice Heard' booklet to advise about complaints process produced.
	All staff to attend 'Responding to Complaints' course.	March 2003	Staff trained and confident in dealing	Ongoing	Key Personnel attended the ALARM and Handling Patient Complaint

4. Responding to Patients Complaints (cont/d)

			with queries and complaints.		Courses. Awaiting further advice from DoH, in light of new guidance, on forthcoming training courses to be available via NHSU.
	Publicise the different roles of PALS from the complaints process.	June 2003	Staff will be able to signpost patients/carers into the correct forum for complaint.	Yes	Complaints Policy to be revised and ratified by Trust Risk Management Committee in April 2004.
	PALS to resolve issues arising at ward or departmental level at staff or patient request ~ establish 'assistance line'.	December 2002	Themes and trends of PALS issues now produced.	Yes	Data included in monthly/quarterly Clinical Governance Reports.
Complaints department to provide efficient & user focussed service	All complaints responded on an individual basis:		Monthly & quarterly reports include		
	▪ The key issues of the complaint or concern should be checked with the patient.	December 2002	'common theme' & change in practice reports from key departments.	Yes	Included in letter of acknowledgement.
	▪ Avoidance of medical or professional jargon ~ development of 'user friendly language glossary' for staff who respond to complaints & supported by training workshops.	January 2003		Yes	Responses to letters of complaint are quality controlled by the Quality Manager.
	▪ Response letters should outline where Trust has learned from the complaint.	December 2002		Yes	The report format has been changed to include lessons learned.
	▪ Establish system for validating with complainants their satisfaction level with the response letter or action taken by the Trust.	January 2003		Yes	Patient Survey designed.
	▪ Regular review & sharing of comments & complaints performance & key issues in PALS newsletter.	January 2003		Yes	Information included in 'On The Pulse'.

5. Use of Information

Key Action	Action Plan	Timescale	Outcome Measure	Achieved Yes / No	Evidence
Secure funding to deliver comprehensive Trust wide information	IM&T should be included as a specific cost pressure in the SAFF round.	December 2002	Increased level of funding to deliver the IM &T development requirements.	Yes	Capital program 2003-2004 and ongoing part of business plan.
	IM & T draft constructive business case that includes explicit assessment of impact of 'make do & mend' scenario.	November 2002	Agreed preferred option.	Yes	Systems and requirements have been documented to support the national NPfIT programme. This is being consolidated into a business case for the SHA.
	Recognise constraints of competition for LIS funding.	Ongoing	Prioritised plan for health economy re IM&T investment.	Ongoing	Funding approved by the LIS programme board for 2003/4 to support ongoing work programmes.
	Ensure that all computer equipment requirements and purchasers are cleared through IM &T.	Ongoing	Ensuring compliance controls assurance.	Yes	No `new' equipment is purchased without IM & T `view' and authorisation, supplies ensure compliance.
	Ensure Divisional business plans reflect and are approved by IM & T procedures & requirements.	Ongoing	Corporate agreed work programme.	Ongoing	Work programmes reflect prime national targets plus key identified local requirements.
	Communication between Divisions and IM & T are regular and channelled through nominated individuals.	Ongoing	Improved planning & support of projects & corporate understanding.	Ongoing	New mechanisms have been put in place to improve communications across the Trust e.g. roadshows and newsletter.
	Highlight cost & inefficiency implications of incorrect or inconsistent data inputting: ▪ Increase personal responsibility for the accurate data provision; ▪ Promote understanding & dialogue between data providers & data users; ▪ Introduce system of senior manager's sign off data quality. ▪ Provide training for staff to ensure data inputting Consider a 'fast-tracking' assessment & training for new employees to access the e-mail system.	March 2003	Achievement of data accreditation certification.	Yes	The Trust has achieved Qualified Certification for Data Accreditation Stage 2. This has ensured improved awareness /understanding of roles and responsibilities.

5. Use of Information (cont/d)

Key Action	Action Plan	Timescale	Outcome Measure	Achieved Yes / No	Evidence
Secure funding to deliver a comprehensive trust wide information	Source good data collection practices from organisations within & outside the NHS.	March 2003	Audited improvement in practice.	Ongoing	The data accreditation process has been instrumental in this area. Data accreditation external assessment undertaken. Links are currently in place across the SHA to review data quality and benchmark across organisations, to enable learning and improvement.
	Rollout existing good departmental practice.	March 2003	Audited improvement in practice.	Ongoing	Information on improving practice is available within departments; regular formal audit now required.
	Comply in full with the Data Protection Act.	As Act requires	Audited compliance with DPA.	Ongoing	Developments are in hand to improve information governance reporting.
	Consider a pilot scheme for patient held records (e.g. Maternity cards).	Ongoing	-	Ongoing	Handheld records have now been rolled out across the Trust for maternity services.
	Consider the introduction of bar coding of patient notes to track better the movement of case notes.	Ongoing	-	Ongoing	Broader use of bar coding will be introduced.
Improve the trace ability & security of patient notes	Unify the medical record	Ongoing	Single unique record for WHHT.	Ongoing	Focussed resources have recently been put in place to merge current multiple cases notes to move towards a single unique case note. New standard Trust case notes introduced with a single Trust based number format for all new records.
	Ensure that the complete record always contains electronic data (pathology/haematology results) and hard copy information.	Ongoing	-	Ongoing	Data accreditation has re-enforced the need to ensure the cases notes are complete. Essence of Care Record Keeping benchmark work is well underway and a progress report has been produced (Oct. '03).
Efficient & effective IM&T	Consider the electronic integration of systems for procurement	Ongoing	Paper reduced procurement process with audit trails.	Ongoing	In train via the supplies consortium.
	Consider requests to Estates department integrated electronically that allows quicker feedback on current work status.	Ongoing	Improved processes for managing work orders.	Ongoing	

5. Use of Information (cont/d)

Key Action	Action Plan	Timescale	Outcome Measure	Achieved Yes / No	Evidence
Ensure passwords are individually held & used	▪ The responsibility for password secrecy is reflected in the Code of Conduct.	Already in place	Compliance with legislation.	Yes	Mandatory training has started and the induction process has been updated.
	▪ Importance of Data Protection, confidentiality, professional best practice and Password secrecy covered at induction and relevant training programmes.	November 2002 start rollout	Compliance with legislation.	Ongoing	
	▪ Ensure bank & agency staff provided with time limited personal passwords as requested.	Ongoing	Compliance with legislation.	Ongoing	

6. Improving Clinical Practice

Key Action	Action Plan	Timescale	Outcome Measure	Achieved Yes / No	Evidence
Develop clinical effectiveness & audit strategy (ies)	Produce strategy that: ▪ builds on existing internal & external best practice; ▪ sets systems to monitor & improve processes; ▪ promotes sharing of quality information on performance, outcome & ▪ patient experience; ▪ clarifies personal & collective responsibility in the clinical divisions for clinical audit & effectiveness.	February 2003	Strategies in place.	Yes	Separate strategies for clinical audit and clinical effectiveness have been produced and ratified.
Improve attendance at clinical effectiveness & audit meetings	Clinical Audit Co-ordinator & Associate Medical Director to meet regularly with specialist teams to: ▪ Develop a culture of clinical commitment and confidence in the delivery ▪ of quality of care; ▪ Encourage multi-disciplinary working in clinical and learning forums; ▪ Use meetings to share clinical practice guidelines, changes in practice and demonstrate evidence-based working; ▪ Strengthen & co-ordinate support for meetings.	Re-started Sept. '03	Agendas of clinical Effectiveness & Audit meetings & attendance lists.	Yes	New Clinical Audit Lead appointed and in post Sept. '03. New strategy/work plan produced.
Ensure clinical guidelines implemented & evidence based changes in clinical practice occur, by sharing throughout the Trust	▪ Identify existing processes of clinical guidelines implementation & evaluation. ▪ Divisions to produce individual clinical team plans to introduce local clinician led models that have managerial support. ▪ Include practice that covers clinical & non-clinical issues. ▪ Continue promotion of ethical reporting & link to complaints so that real events/outcomes affect clinical protocols & behaviours. ▪ Clinical staff training & CPD is adapted or introduced that reflects continued learning & experience. ▪ Monitor consultant practice through appraisal.	Start January 2003	Appropriate treatment within the resources available analysed by case note audit. Staff appraisal More effective use of consultant experience & skills.	Ongoing Yes	Addressed in the Clinical Governance Annual Report '02/'03. CG Development Plan for '04/'05 based on both corporate and divisional plans. Links to complaints echoed in both the above. New Policy Development Framework produced, approach agreed and implemented. '03/04 round completed.
Develop system to register & monitor audit activity, record, implement	▪ Map current audit work (departmental & corporate led).	March 2003 (re-started Sept. '03)	Completed register reflecting Trust priorities.	Yes	Audit survey across Trust undertaken.

& re-audit changes to clinical practice	▪ Establish register of activity & system to prioritise audit work. ▪ Initiate 'tracking' system to monitor completion, findings and any changes in practice.	March 2003 October 2003	Copy of Trust CA programme. Copy of audit registration form. Copy of audit project database. Copies of Divisional programmes and timetables.	Yes Yes Yes Yes	Trust audit programme agreed and currently being rolled out to Divisions, starting with Acute Medicine at HHGH. New audit registration form agreed and implemented. Existing audit registration database being revised. Work to further develop system for registration/ monitoring underway. Dates for presentation of findings/agreeing change set as part of WHHT audit programme: dates set for AMC at HHGH. Further date set for assessing whether loop has been closed. Clinical audit officer assigned to attend meetings to track activity and progress.
Develop strategy that gives clear vision for audit activity & links to primary care	Produce strategy that sets: ▪ Explicit & planned multi-disciplinary working within the Trust & local health economy partners; ▪ Develop joint key actions, progress milestones & monitoring criteria	January 2003	Joint work projects.	Yes	Some joint projects undertaken, but further joint-working development needed. Strategy agreed and circulated.
Develop a robust & systematic method of identifying, developing & implementing care pathways	Establish programme for the development & roll-out of care pathways that: ▪ Close loop between audit & risk; ▪ Identifies resources required; ▪ Prioritises implementation & support	Start January 2003	Consistent & approachable delivery of clinical care.	Yes	Fractured neck of Femur pathway has been implemented. Currently developing Stroke Care pathway and Care of the Dying pathway.

A Trust Nursing & Midwifery Strategy was produced in July 2003. Progress reports are produced every 6 months and considered by the Nursing & Midwifery Strategy Group & Executive Team. Further details can be obtained by contacting the Director of Nursing, Midwifery, Quality & Risk.

7. Improving the Environment

Key Action	Action Plan	Timescale	Outcome Measure	Achieved Yes / No	Evidence
Safeguard Patient Privacy & Dignity	▪ Encourage individual responsibility of all staff to identify and ensure patient dignity, comfort and privacy.	November 2002	Monthly PALS report & complaints analysis.	Yes	Staff awareness forms part of the Privacy & Dignity Benchmark work. Ward teams currently identifying elements of good practice & areas for improvement, using a tool developed in-house.
	▪ Wards to check door signage, locks, curtains, and locker facilities. ▪ Review visiting times to allow more access & visiting for carers & relatives.	November 2002	PEAT Reports.	Yes & ongoing	The PEAT team visits were re-launched in June 2003. This has led to the regular production of PEAT Team & Departmental reports.
	▪ National Inpatient Survey recommendations reviewed against current Trust facilities & required improvements made.	November 2002	Audit of compliance with survey recommendations.	Yes	An external body & NHS Estates reviews Trust progress and the PEAT Team provides additional 'view' of the compliance as part of the routine PEAT inspections.
	Ensure that access to PALS & the complaints department is advertised clearly to all patients.	December 2002	Patients/Carers have better access to complaints process.	Yes	Posters are displayed throughout the four sites.
	Each ward to have comments box that is opened & its contents read daily.	January 2003		Yes	Comments boxes and cards are now available in all areas across the four sites and are emptied weekly.
	Posters in all key areas that encourage patients & visitors to report anything untoward or unsatisfactory.	January 2003		Yes	Via PALS Poster.
	Encourage staff to report and address any compromise to dignity & privacy immediately.	January 2003		Yes	Essence of Care Privacy & Dignity Benchmark work (e.g. standardisation of curtains) commenced in September 2003. Communications benchmark work has started and will follow a similar process.
	Ensure staff know the contract specifications & how to report any divergence.	February 2003	Audit of compliance with survey recommendations.	Yes	Performance Mgt Review group set up (March '03). It monitors performance against the contract standards.

7. Improving the environment (cont/d)

	Reporting system must be clear, fast & responsive.	February 2003	Flowchart & reporting template & standards for reporting produced.	Yes	Incident and complaints reporting systems now implemented.
Safeguard Patient Privacy & Dignity	All reports of poor cleanliness & time taken to be addressed must be monitored.	February 2003	As above.	Yes	A monthly summary of complaints and issues is sent to the Facilities Mgt Group. The introduction of the Comment Card Scheme provides a Trust wide means for patients & visitors to comment on the fabric and condition of the Trust.
	Produce a set of values & expectations for the patient environment with Trust & contract staff.	February 2003	As above.	Yes	Wards have producing 'ward pledges' that set a standard for the cleanliness and safety of each ward.
	Establish regular mystery shopper patrol of areas that includes patients & stakeholders.	February 2003	As above.	Yes	Members of the patient's panel undertake spot checks and PALS staff walk the sites regularly.
Condition of Estate	Consider detailed review of current satisfaction with quality of contractor' services.	February 2003	Joint contractor & Trust survey.	Yes	The Estates & Capital Group is undertaking a comprehensive survey that looks at suitability and condition of equipment.
	Establish Trust ranking of standards' compliance – i.e. hygiene & cleanliness cannot be compromised in theatre or in the wards.	February 2003	Development of Trust accepted standards.	Yes	The Performance Mgt Review Group is looking at Domestic & Housekeeper roles to ensure that the training and performance standards are adequate to fulfil the tasks required.
	Trust wide review of 'fitness for purpose' of its facilities ~ e.g. are doors automatic, are benches placed in longer corridors, are chairs soft or supportive?	March 2003	Trust Survey.	Yes	This is covered in the work being undertaken by the Estates & Capital Planning Group. Recent proposal to place lift-up seats in Tudor/Verulam bridge corridor.

7. Improving the Environment (cont/d)

Condition of Estate (cont/d)	Introduce sponsorship of ward/garden/ corridor scheme.	April 2003	Areas sponsored.	Yes	A range of sponsors including Church Groups, Cadbury Schweppes and MacDonald's are interested in participating in this scheme.
Maintain staff & Trust appearance & safety standards	Improvements register produced following the review & development of minimum standards.	March 2003	Register produced.	Yes	This is being achieved in 2 ways: 1) Ward Pledges set out what the patient can expect as a minimum standard. 2) PEAT visits are providing additional baseline data.
	Consideration given to 'no smoking' policy throughout the Trust.	January 2003	Elimination of safety hazards.	Yes	Smoking Policy introduced Summer 2003.
	Staff should be identifiable, wear name badges and be appropriately dressed.	2003		Yes	Any breaches are reported by the PEAT Inspection Team, and appropriate managers are notified.

8. Raising Risk Awareness

Risk targets progressed within the Trust are detailed within the Trust's Risk Action Plan, which can be obtained by contacting either the Trust's Risk Manager or the Director of Nursing, Midwifery, Quality & Risk.

Key Action	Action Plan	Timescale	Outcome Measure	Achieved Yes / No	Evidence
Risk built into daily routine & responsibility of all	▪ Run training programme(s) that helps staff proactively define, identify & assess risk.	December 2002	Scheduled risk workshops & attendance lists.	Yes	The new Mandatory Training Plan approved by the Risk Management Committee in November '03 addresses the risk training requirements for CNST, RPST and H&S standards. Risk Scoring Workshops were run in March, April and June 2003. These are being repeated in September and December 2003. Again, further training sessions will be addressed within the Risk Management Training Strategy. A ½ day risk away day was held in 2003 to promote good practice. Implementation of Datix with training.
	▪ Include risk in Trust induction day & junior doctors' induction.	December 2002		Ongoing	Doctors' Training is being taken forward as part of working towards compliance for CNST 2. Risk forms a key component of the corporate induction programme. A risk process has been instigated to ensure the medical staff induction programmes fully meet the requirements of the Mandatory Training. RPST Level 1 attained and CNST Level 1 retained in February 04.
Develop & implement robust risk management procedures	Introduce single incident reporting form.	January 2003	Introduction of new form & amended policy.	Yes	Single Incident Reporting Form to be implemented Trust wide in April '04
	Amend incident reporting policy.			Yes	Incident Reporting Policy has been reviewed and ratified. Staff awareness sessions have been re-launched as part of the major risk programme.
	Schedule staff awareness training linked to above.			Yes	Child protection local action plan developed to address targets highlighted in Climbie Report. Hospital Child Protection Steering Group established ~ Feb

8. Raising Risk Awareness (cont/d)

					04. Quarterly Clinical Indicator Reports produced and circulated at Executive level. New Risk policies/procedures ratified by Trust Board: - Incident Policy - Consent to Treatment - Risk Management Strategy - Datix Policy
	Actions resulting from identified risk, risk/incident reports or activity are communicated regularly to staff (closing the feedback loop). Identify, share & develop existing good practice.	January 2003	Local change in practice or actions taken communicated.	Yes	Divisional Risk Leads are in the process of tightening up arrangements for feedback of incidents to staff. They will be required to produce evidence of this for CNST Level II. Staff will also request direct feedback on any incident they report by ticking a box on the new Single Incident Reporting form. Quarterly Divisional Risk Lead meetings (chaired by the DoN) have been established. Establishment of Trust Risk Committee and Risk sub-committees. In 2004 the Divisional Risk Leads will be receiving 4 full day training sessions with external facilitator.
Development of Risk Register	Develop central risk register that:		Risk register produced.		
	▪ Indicates level of risk;	January 2003		Yes	The Trust has a Trust Risk Register (Datix).
	▪ Develops standardised scoring system;	January 2003		Yes	The Trust's organisational structure has been reviewed to ensure clinical/non-clinical Risk convergence with strong links to Clinical Governance.
	▪ Appointment of local champions to lead & review development & ensure that clinical & non-clinical risk is linked to clinical governance;	December 2002		Yes	The Clinical Governance Template for Reporting has been revised to comply with aims of the Risk Management Department.
	▪ Benchmark with Trusts that CHI scored well in Risk.	December 2002	Available benchmarks.	Yes	Lessons learnt across Trust will in future feed into CG Committee to further facilitate Trust Wide Sharing. Benchmark review ~ Wirral & Chesterfield CHI. Reviews.
Address cleanliness, security & waste management	Ensuring staff deal with poor environment & risk factors with direct involvement of patients' views: ▪ Distribution of posters that invite patient's comments.	January 2003	Visible & easy way for patients & family to report concerns.	Yes	Posters have been put up across the Trust.

8. Raising Risk Awareness (cont/d)

	▪ Introduction of comment cards.	January 2003		Yes	Comment Card Boxes have been placed around Trust (e.g. WGH: A&E waiting room, Maternity Reception, Main Reception). The comments cards are collected & analysed by PALS. Attention to detail project involving patients held week commencing 11 August 2003.
West Hertfordshire Hospitals NHS Trust badges worn by staff	Staff to be identified by single Trust badge or identification that is easy to read & states name, title & department.	February 2003	All staff will wear Trust named badges.	Yes	The uniform policy requires proper identification to be worn. Policed regularly by Director of Nursing & Midwifery, Heads of Nursing/Midwifery & Modern Matrons.
	Locum, agency & bank staff to have badges that are time limited & available as required.	February 2003		Yes	As above. Checked by senior staff regularly. Agreement reached to provide Medirest staff with security badges.

9. Training & Education

Key Action	Action Plan	Timescale	Outcome Measure	Achieved Yes / No	Evidence
Develop a written education & training plan	Draft a written training strategy that is transparent and builds on existing good practice and policy.	January 2003	Organisation meets performance targets Quality of services improves Effective recruitment, retention & development.	Yes	Education & Training Strategy formally approved by Trust Board February 2003.
	Ring fence the training & education budget.	November 2002	Resources effectively targeted within agreed cost profile.	Yes	Trust resources targeted at priority areas in line with Training strategy. Review completed of the funding streams and allocation from WDC and Trust and the budget reconfigured to ensure WDC revenue monies are targeted. Work is in progress to develop local workforce development plan as part of the Division's Business Planning process.
	Improve access to training days and events by: ▪ Reviewing study leave policy; ▪ Identifying alternative means of learning.	February 2003 & ongoing	Wide range of learning opportunities and PDPs.	Yes	Draft Study Leave Policy being amended to reflect new corporate policies including Mandatory Training Plan and the NHS KSF. Alternative means of training being promoted e.g. CD ROMs, videos etc. NHSU programme will pilot CD ROM-based learning fro all staff groups. Funding has been received from the NHSU in line with Trust's new status as a 'first wave' affiliate: this will support development of a dedicated staff learning resource centre.

9. Training & Education (cont/d)

	In partnership with the workforce development confederation establish innovative training programmes to fill skills gaps caused by shortages of qualified staff.	September 2002 & ongoing	Flexible workforce to meet changing service needs.	Yes	The WDC has confirmed the funding allocation for 03-04. A new funding policy will be produced in 2004.
	Link training need & competence: ▪ Standardise competence levels; ▪ Share expectations between staff, trainers and managers; ▪ Clarify role boundaries.	April 2003 & ongoing	Flexible workforce to meet changing service needs.	Yes Ongoing	Work progressing to link to competencies identified in knowledge and skills framework of Agenda for Change (to be implemented October 2004).
	Integrate training on 'softer skills' within induction & other training programmes as appropriate.	February 2003	Reduction in number of complaints & through other feedback measures.	Yes Ongoing	Revised training plan being developed by the Trust Quality Manager.
	Training programmes to reflect improvements or changes in practice identified through complaints process.	February 2003	As above.	Yes	As above.

10. Staff Appraisal

Key Action	Action Plan	Timescale	Outcome Measure	Achieved Yes / No	Evidence
Ensure staff appraisal system is universal & applied consistently	Establish steering group to identify the Trust's and staff requirements of the appraisal system, and promote a 'client service' approach to appraisal.	December 2002 to December 2003	PDPs & training plans Retention. Succession Planning & Improved Communications.	Yes	Training and Education Steering Group Established. Review of appraisal processes commissioned.
	Give appraisal greater profile throughout the Trust & include in objectives of all managers.	December 2002 to December 2003	PDPs & training plans Retention. Succession Planning & Improved Communications.	Ongoing	
	Establish joint objectives & appraisals with contracted staff.	December 2002 to December 2003	PDPs & training plans Retention. Succession Planning & Improved Communications.	Ongoing	To be implemented as contracts are reviewed.
	Ensure appraisal informs training strategy & delivery.	December 2002 to December 2003	PDPs & training plans Retention. Succession Planning & Improved Communications.	Yes	Responsibility of managers for the identification of training needs clearly identified in Education & Training strategy.
	Establish system to prioritise departmental and/or individual training needs.	December 2002 to December 2003	PDPs & training plans Retention. Succession Planning & Improved Communications.	Yes	Detailed in Education & Training strategy.
	Extend in-house training.	December 2002 to December 2003	PDPs & training plans Retention Succession Planning & Improved Communications.	Yes	External training contacts reviewed to replace where possible with in house provision.
	Promote alternative opportunities for training & development e.g. shadowing to encourage knowledge of other departments and personnel.	December 2002 to December 2003	PDPs & training plans Retention Succession Planning & Improved Communications.	Yes	A number of staff have shadowed Trust colleagues. Flyers advertising training opportunities circulated via e-mail.

11. Recruitment & Retention

The Trust's Nursing & Midwifery R&R Plan can be obtained from either the Trust's Nursing & Midwifery R&R Manager or the Director of Nursing, Midwifery, Quality & Risk.

Key Action	Action Plan	Timescale	Outcome Measure	Achieved Yes / No	Evidence
Develop a Trust wide recruitment and retention strategy for all staff groups	Standardise & make consistent the: ▪ Approach to retention & to recruitment issues; ▪ Information to staff and candidates; ▪ Monitoring criteria; ▪ Evaluation process.	January 2003	Defined plan to cover all staff groups; Reduction in number & reduction of vacancies.	Yes & ongoing	Fall in vacancies and turnover. N&M R&R Plan updated quarterly and presented to Exec.
	Identify all staff groups' recruitment and retention & concerns in professional and personal context (i.e. ranging from working schedules to crèche facilities) and reduce variance in employment conditions.	February 2003	Increased retention; more candidates & staff knowing about the benefits we offer.	Yes & ongoing	On going work to harmonise conditions of employment between sites.
	Establish 'promotional' benchmarks: ▪ Opportunities for in-house promotion (skills escalator), employee of the month, training & personal development events; ▪ Show role of individual and teams in wider context of supporting patient care; ▪ Encourage multi-disciplinary working.	February 2003	Increased staff satisfaction. Improved recruitment & retention.	Yes & ongoing	Increased development opportunities for unqualified staff. Employee of month awards established. HCA cohort example of good practice.
	Broaden & make formal the induction process: ▪ Encourage 100% attendance in 8 weeks of appointment; ▪ Develop 'cooks tour'/patient tracking for staff (linked to individual training needs); ▪ Strengthen appraisal system.	April 2003	Attendance & Retention.	Ongoing	Training Records: all new starters from Feb '04 will commence with a full corporate induction. A detailed N&M recruitment & retention plan is reviewed & updated quarterly.
	Ensure that the results of the exit interviews are collated to inform recruitment & retention strategy	December 2003	Reduced labour turn over.	Yes	Exit interviews are analysed quarterly.

12. Strategic Capacity

Key Action	Action Plan	Timescale	Outcome Measure	Achieved Yes / No	Evidence
Address cultural differences between the sites	Radiology pilot to develop a common culture & working practice & standards on 4 sites: ▪ Common documentation & performance standards agreed; ▪ Complete integration & adoption of seamless cross trust working.	March 2003	Completion of departmental documentation & performance standards Full integration of departmental working & vision.	Yes	Across site RINE audit meetings set up to agree common practice. Across site regular superintendent meetings New consultant radiologist to work at both Hemel & Watford. New joint ultrasound manager to be appointed who will bring together policies & procedures.
Financial constraints do not undermine patient experience or staff training needs	Trust to continue through Team Talk & staff information leaflets; To brief staff on financial issues & financial management actions; To inform staff about the Acute Service; Review progress & implications.	Ongoing	Staff aware of financial issues.	Yes	Included in Team Talk each month and In Touch. Also, where appropriate we conduct parallel briefings across the Trust sites.
Consolidate work with public partners	Expand partnership working to develop comprehensive communication & services review.	Ongoing	Local partners engaged with Trust to support patient experience.	Yes & ongoing	Pride in the Workplace initiative held on 17th May 2003. Further event being planned during 2004. Community involvement from a number of different organisations which is ongoing. Undertaking a fundraising feasibility study to embrace partnership working more broadly.

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