Title of the Paper: Standards for Better Health Review - Domain 3 Declaration Year 08/09 Quarter 1

Agenda item: (112/08)

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Trust Objective: Achieve compliance against the Standards for Better Health

Key issues
Standard C8b – The Training and Development Department have not received an adequate number of staff appraisal returns

Purpose
This report focuses on each of the Standards within Domain 3 providing an update on the Trusts progress towards compliance.

Risk Implications for the Trust:

| The Standards for Better Health Core Standards contribute towards the Trusts overall quality of services rating for the Annual Health Check. | Action plans are in place for those standards that are not compliant |

Recommended Levels of Assurance
Level of Assurance recommended to the Trust Board from the report:

Recommend Status: Sufficient
Standard C7a & c Apply the principles of sound clinical and corporate governance and undertake systematic risk assessment and management.
Standard C7b Actively support employees to promote openness, honesty and effective use of resources.
Standard C7e Challenge discrimination and promote equality
Standard C8a Support staff through permitting them to raise concerns
Standard C8b Healthcare organisations support staff through personal development
Standard C9 Systematic and planned approach to the management of records
Standard C10a Undertake appropriate employment checks
Standard C10b Require all professionals to abide by codes of practice
Standard C11a Ensure staff are appropriately recruited, trained and qualified
Standard C11b Staff participate in mandatory training programmes
Standard C11c Staff participate in further development
Standard C12 Research governance frameworks in place

Recommendation to the Trust Board:
The Trust Board members are asked to:
- Note the contents of this report
- Monitor at Board level progress towards compliance of standards not being met ensuring compliance by declaration year end
Standard C7a&c

Healthcare organisations: a) apply the principles of sound clinical and corporate governance

The Trust had a ‘Scheme of Governance’ approved by the Trust Board on 20th March 2008, it sets out the governance arrangements for the Trust matching the good practice outlined in the Department of Health’s Integrated Governance Handbook, it states that the Trust should be doing its ‘reasonable best’ to manage itself in order to meet the objectives of the organisation, and to protect patients, staff, the public and other stakeholders against foreseeable risks. The Trust Board responsibilities include providing leadership, strategic direction, monitoring performance, exercising financial supervision and ensuring the Trust meets external requirements in respect of high standards of quality in healthcare provision, safety, governance and corporate behaviour.

The Trust Board and Audit Committee regularly review the Trusts Assurance Framework. The Assurance Framework provides the Board and Audit Committee with a simple but comprehensive method for the effective and focused management of the principal risks to meeting the Trusts objectives. The Trust Board identified within the Assurance Framework an improved rating with the Annual Health Check as one of its 4 strategic objectives. In order to achieve this the Trust Board has established the Audit Committee as a sub committee:

Audit Committee
In line with the requirements of the NHS Audit Committee Handbook and NHS Codes of Conduct and Accountability the Audit Committee has been established to provide the Board with an independent and objective review of its financial systems, financial information, organisational governance and compliance with laws and guidance governing the NHS. The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trusts activities that supports the achievements of the Trusts objectives. The Audit Committee meets on a quarterly basis

Clinical Quality and Governance Committee
The Trust has established a new Clinical Quality and Governance Committee (CQuaC), which has a direct reporting line to the Chief Executive and Trust Board but does not have status as a formal sub committee of the Board. CQuaC will assure the Trust is delivering safe and competent delivery of clinical care optimizing patient safety and clinical outcomes and will report to the Director of Patient Safety. The 1st meeting of CQuaC was held on Tuesday 3rd June 2008.

Clinical Standards Executive
The Trust has organised and developed clinical governance arrangements through the Divisional Clinical Standards Executive (CSE) Committee’s, which occur six times a year per division. The CSE will seek assurance of the implementation of robust systems and processes that support the objectives of clinical, corporate and research governance.

The Trust has ongoing Clinical Governance Half Days
c) undertake systematic risk assessment and risk management

The Trust has well organised risk management arrangements with an annually approved Risk Management Strategy, last approved in March 2008, which is supplemented with a Women’s and Children’s Services Risk Management Strategy, which is due to be ratified by the Board in June 2008.

The Trust has a very active risk management department and is currently looking to recruit a new Risk Manager following the departure of the previous manager in April.

The Risk Manager will be supported by divisional risk leads who are responsible for coordinating operational risk management in their specific areas, although at present only Surgery and Anesthetics and Women’s and Children’s Services have a risk lead.

Each division has its own risk register of which the top risks are reviewed at the Divisional Clinical Standards Executive Committees.

In March 2008 the Trust achieved Level 1 of the NHSLA Risk Management Standards.

All risk assessments are recorded on the DATIX Risk Management System.

Recommended Status: Compliant

Standard: C7b

Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources

The Trust has a Counter Fraud and Corruption Policy in place, which was ratified by the Audit Committee in March 08. The Policy states that the Trust is committed to maintaining an honest, open and well-intentioned atmosphere, so as to best fulfil the objectives of the Trust and of the NHS. It is, therefore, also committed to the elimination of fraud within the Trust and to the rigorous investigation of any such allegations and to taking appropriate action against wrong doers, including possible criminal prosecution, as well as undertaking steps to recover any assets lost as a result of fraud.

The Trust employ’s a local counter fraud specialist. This officer’s role is to ensure that all cases of actual or suspected fraud are notified to the Trust’s Director of Finance and reported to the NHS Counter Fraud and Security Management Service (CFSMS).

The Director of Finance is also responsible for informing the Audit Committee of significant cases of Fraud.

The annual Auditors Local Assessment (ALE) has a Key Line of Enquiry entitled Value for Money. The Trust scored a Level 2, fair, score for 2007/08.

Gifts and Hospitality Register is reviewed regularly at Audit Committee

All Board members on appointment agree to abide by a Code of Conduct.

The Scheme of Governance for WHHT states that as the Trust is a publicly funded body it must ensure accountability, openness and probity.

Recommended Status: Compliant
Standard: C7e

Healthcare organizations challenge discrimination, promote equality and respect human rights

Equality & Diversity Group is established. Terms of Reference have been developed and the Director of Nursing is Chair of the meeting.

A Scrutiny Group to monitor Impact Assessments has been established. An Impact Assessment tool has been developed. It is designed to bring together patient and staff equality agendas. Managers are required to assess equality impact when writing a policy/protocol. Impact Assessments are published on the Intranet.

Through the scope of the Equal Opportunities Policy the Trust aims to maintain and extend a fair working environment for all employees through the implementation and development of policies and procedures aimed at promoting equal opportunity in employment.

The Equality Framework is available on the intranet and sets out how the Trust is progressing with its Equality and Diversity Agenda. It has been subject to Internal Audit in May 2008 and is described as very comprehensive and fit for purpose. However there is a need for updating and that will be taken forward through the Equality & Diversity Group.

Diversity Training has been sourced and the Trust will roll out a ‘Train the Trainers’ course in 2008. Half day sessions on aspects of Equality & Diversity for AfC Bands 1 – 4 are one of the suggestions under consideration.

A role outline has been agreed and is to be advertised to recruit support for staff with a disability. This links with the 2 Ticks symbol commitment that the Trust makes –

- to interview all applicants with a disability who meet the minimum criteria for a job vacancy and consider them on their abilities;
- to ensure there is a mechanism in place to discuss at any time, but at least once a year, with disabled employees what can be done to make sure they can develop and use their abilities.

Ethnicity data on Staff in Post and Applicants for posts in WHHT is published on the Trust’s website. Trends will be monitored by the Equality & Diversity Group.

Recommended Status: Compliant

Standard: C8a

Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services.

The Trust has had a “Raising Concerns Policy” since 2001 which includes the requirements of “The Public Disclosures Act 1998” and “Whistle Blowing in the NHS (HSC) 199/198. The policy is widely available on the intranet and details how staff should raise concerns. This policy is currently being updated to include a confidential e-mail address for reporting concerns.

Recommended Status: Compliant
Standard: C8b

Healthcare organisations support their staff through organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under representation or minority groups.

The Trusts Lifelong Learning Policy forms the core of applying the NHS KSF in practice within the Trust including appraisal reviews and personal development plans.

Summary of Appraisal Returns April 07 – March 08
Acute Medical Division – 104
Clinical Support – 271
Surgery and Anaesthetics – 80
Women’s & Children’s Services – 30
A total of 511 appraisals were returned to Training and Development (including those from other areas not mentioned in the summary)

In April 08 the Training and Development Department updated the action plan for embedding the appraisal process into the Trust and put together a paper on the design and delivery of an appraisal skills programme, this programme will be available for both managers and staff and is expected to be delivered over a 9-month period commencing June 08. The reason for the programme is that the National Staff Survey 2007 found that only 47% of staff said that they had received an appraisal, performance development review or KSF development review in the last 12 months. Only 38% of staff said they had agreed a personal development plan.

The action plan includes developing a clear map of the appraisal process, redefining the KSF administrator role, updating the Life Long Learning Policy, delivering appraisal training sessions and monitoring appraisal completion rates. The plan’s target is for 65% of staff to have undergone an appraisal by 2009.

The Trusts Equal Opportunity Policy aims to ensure that no employee is unfairly discriminated against including the areas of training/staff development.

The new Learning Management System (LMS) will be able to provide information on ethnicity.

Recommended Status: Compliant

In order to further enhance the compliance on this standard evidence will need to be presented at year end on the level of appraisals undertaken and that this level is satisfactory. Specific actions are being implemented to reinforce the need across the Trust that completion of staff appraisals is a requirement and that these need to be reported to the training department.
Standard: C9

Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organization maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

The Trust has a number of policies in relation to the management of records. The Trust’s Records Management Policy defines retention periods for all records types used within the Trust and includes staff roles and responsibilities and record keeping standards. In addition to this the Trust has a Health Records Policy, Information Governance Policy, Data Protection Policy, Information Security Trust Code of Conduct, Information Security Policy and Waste Management Policy to ensure information is disposed of correctly and securely. With regards to the process for managing and reporting breaches of confidentiality, the recent guidance from the DoH has resulted in addendums to the Incident Reporting and Investigation policy that are to be ratified imminently.

In terms of governance structures, the Trust has a newly reformed executive steering group in the form of the Information and Implementation Governance Group (IIGG). With clinical and non-clinical membership the remit is to monitor and approve the plans and systems for reducing risk and compliance with IG standards. IIGG reports to the board via the Delivery Group and maintains effective liaison by means of its chair and membership with the Clinical Quality and Governance Committee.

The management of records is covered in the Information Security & Confidentiality awareness training and record keeping standards are written into staff contracts and junior doctors handbooks. Staff also have the opportunity to connect to an eLearning Tool available on the intranet that covers various Information Governance modules. One of these explains the need for the application and good practice of a ‘Records Management’ system and the correct procedures that accompany the management of health records within the NHS.

Performance and monitoring
The Trust continues to assess compliance with legislative and national guidance on records management as part of the framework of the Information Governance Toolkit. Information Governance scores for 2007/2008 were submitted to NHS Connecting for Health (CFH) on 31st March 2008. Our overall score improved from 46% last year to 60% however improvements within the Corporate Information Assurance Initiative have been identified and documented in the 2008/2009 IG Action Plan.

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<tbody>
<tr>
<td>Clinical Information Assurance</td>
<td>62%</td>
<td>62%</td>
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<tr>
<td>Confidentiality &amp; Data Protection Assurance</td>
<td>63%</td>
<td>76%</td>
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<tr>
<td>Corporate Information Assurance</td>
<td>0%</td>
<td>8%</td>
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<tr>
<td>Information Governance Management</td>
<td>28%</td>
<td>56%</td>
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<tr>
<td>Information Security Assurance</td>
<td>53%</td>
<td>57%</td>
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<tr>
<td>Secondary Use Assurance</td>
<td>51%</td>
<td>72%</td>
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The Information Governance Management initiative within the toolkit includes the requirement to satisfy the NHS CFH Statement of Compliance (SoC). The SoC assures the security of environments where records are accessed and stored. In order to connect to and use NHS CFH provided infrastructure and national services it is compulsory for health organisation to meet and sustain compliance at level 2. The Trust attained level 2 for 2007/08.

In addition to the IG toolkit and subsequent remedial IG action plans, the performance of records management is monitored and audited by the Audit Commission reviews of data quality issues and the NHS Litigation Authority assessment of risk. Ongoing internal audit
processes to assess record availability and data security, further review the provision of records within the Trust.

**Recommended Status: Compliant**

**Standard: C10a**

**Healthcare organizations undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies**

The Trust’s Recruitment & Selection Policy incorporates all of the requirements of “Safer recruitment – A guide for NHS employers” and “CRB disclosure in the NHS”.

Recruitment staff follow the policy and use a checklist for each new member of staff to ensure that all of the appropriate checks are undertaken before an unconditional offer letter is issued. This checklist is double-checked by another member of the team and an audit is carried out on a quarterly basis of all employment checks to ensure full compliance with the policy and the standard.

Under Standards for Better Health (Core Standard C10a) the Trust Board should be assured of the Trust’s compliance with this standard that states that all Healthcare organisations undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies.

All new staff in the Trust undergo pre-employment checks as defined in the Trust’s Recruitment & Selection policy & procedure, in line with the ‘Safer Recruitment – A guide for NHS employers’ and CRB disclosure guidance. A database of all of these pre-employment checks is kept and quarterly audits undertaken by the Workforce Team Manager.

**Audit Data**

**April – June 2007**

41 new starters commenced work in the Trust. All 41 were audited as having undergone the appropriate pre-employment checks.

**July – September 2007**

52 new starters commenced work in the Trust. All 52 were audited as having undergone the appropriate pre-employment checks.

**October – December 2007**

147 new starters commenced work in the Trust. All 147 were audited as having undergone the appropriate pre-employment checks.

**Recommended Status: Compliant**
### Standard: C10b

Healthcare organizations require that all employed professionals abide by relevant published codes of professional practice.

In the past 12 months no referral has been made to the ‘Fit to Practice’ Committee of the General Medical Council (GMC)

**Recommended Status: Compliant**

### Standard: C11a

Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare are appropriately recruited, trained and qualified for the work they undertake.

NHS Employment Check Standards have been implemented. This is evidenced by:

- Verification of identity checks – These checks have been incorporated into the Personnel file checklist. Results are recorded on the audit database for reporting quarterly.
- Right to Work checks – The categories have been included in the Personnel file checklist.
- All others checks are made within current Recruitment and Selection procedures, as outlined in the Recruitment & Selection policy.

The Recruitment and Selection Policy was last reviewed in February 2008 and aims to ensure that the appropriate staff are recruited for the work they undertake.

At interview the panel is required, for each candidate interviewed, to complete an interview assessment form. This assesses the competencies of candidates in relation to the person and job specification.

**Recommended Status: Complaint**
**Standard: C11b**

**Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in mandatory training programmes**

The Trust has an Induction and Mandatory Training Policy, which details the requirements for Corporate and Local inductions both for permanent and temporary staff. The policy identified all the mandatory training required as defined by the NHSLA Risk Management Standards.

The Training and Development Department provides Mandatory Training Summary: April 07 – March 08

**All Staff Updates**
- Number of delegates booked – 10155
- Number of delegates attending – 7339 (72%)
- Number of DNA’s – 2816 (28%)

**Clinical Updates**
- Number of delegates booked – 5353
- Number of delegates attending – 3786 (70%)
- Number of DNA’s – 1567 (30%)

**Corporate Induction**
- Number of delegates booked – 4933
- Number of delegates attending – 3510 (71%)
- Number of DNA’s – 1413 (29%)

The Training and Development Department is currently reviewing the functionality of two mandatory training matrix databases with the aim of the implementation of a learning management system (LMS) by September 2008. The review of the functionality of these two systems provided by At Learning and Oracle will be completed on Monday 26th May, which will enable the Trust to make a decision on which application to purchase.

The new system should provide the following training information on each mandatory session:
- Total staff in the department
- Total staff who need to attend the training
- Total number that have attended (actual/percentage)
- Total number of staff who were booked but did not attend
- Total number of staff who have not attended and not booked on future schedule
- Total number of staff who have been booked on future schedule

**Recommended Status: Compliant**

The figures represented only take into account those that booked on the Mandatory Staff Updates. Only the new system will be able to inform the Trust how many should have booked.
**Standard: C11c**

Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in further professional and occupational development commensurate with their work throughout their working lives.

The Trust has an allocated funding and sanctioning process for Continuing Professional Development (CPD).

In previous years the Multi-professional Education and Training Levy (MPET) funding has been split between Nursing and Midwifery and Allied Health Professionals staff. A new process is being introduced this year to ensure an equitable approach and sound decision-making. This will be based on the principles of fair distribution across the Trust for all multi-professional staff groups but with training supporting key Trust service priorities.

This year's allocation is £354,880 (April 08 – March 09) and will be proportioned between the six divisional areas based on contracted Band 5 – 9 staff. The process has been aligned to the University of Hertfordshire semester dates, through which the majority of the CPD will be provided.

All applications need to form part of the staff members Personnel Development Plan, summary reports will be presented to the Training and Development Forum on a monthly basis with all applications being reviewed at the Workforce Board for final sanctioning.

**Recommended Status: Compliant**

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**Standard: C12**

Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.

West Hertfordshire Hospitals NHS Trust is part of the Hertfordshire Hospitals Research and Development Consortium, which also incorporates East and North Hertfordshire NHS Trust.

The Trust has an appointed R&D lead and R&D Manager.

All research in the Trust has to be approved by an Independent Local Ethics Committee and by the Research and Development Department before a study can commence, all applications are subject to a standardised approval process which details the essential documentation required for all applications.

The R&D Department maintains a database of all projects.

The Hertfordshire Hospitals R&D Consortium has a Research Governance Policy and standard operating procedures covering systems and processes for research.

No studies can commence until:

- a sponsor has confirmed responsibility for the project
- the study has received a favourable ethical opinion
- a person, authorised to do so, has given written permission on behalf of the Trust
- the allocation of responsibilities is agreed and documented
- agreements are in place between organisations for complex studies, those involving more than one site and those with associated funding arrangements.

**Recommended Status: Compliant**