Governance Declarations

2010/11

NHS East of England

Strategic leadership for your local NHS

Name of Organisation: West Herts Hospitals NHS Trust

Date: June 10

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance as per the 2009/10 Provider Management Regime, in addition to providing comment with regard to any contractual issues and performance against projected CQC targets:

Key Area for rating / comment by Provider	**Score / RAG rating**
Governance Risk Rating (RAG as per East of England Provider Management Regime guidance)	2.5
Financial Risk Rating (Assign number as per East of England PMR guidance)	3
Contractual Position (RAG as per East of England PMR guidance)	

Governance Declarations

EofE Organisations subject to the Provider Management Regime must ensure that plans in place are sufficient to ensure compliance in relation to all national targets including ongoing compliance with the *Code of Practice for the Prevention and Control of Healthcare Associated Infections* and declare any contractual issues and highlight any material changes to the 2010/11 CQC forecast. **Supporting detail is required where compliance cannot be confirmed.**

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, you are required to print your name.

Governance declaration 1

The board is satisfied that plans in place **are sufficient** to ensure continuing compliance with all existing targets (after the application of thresholds), 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 CQC rating.

(Signed by) _____

(Please Print Name) _____

on behalf of the Trust Board

Acting in capacity as _____

Date: _____

Governance declaration 2

For one or some of the following declarations 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 suggesting that at the current time there is **insufficient assurance available, or targets or standards are not met,** to ensure continuing compliance with all existing targets (after the application of thresholds), 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 CQC rating.

(Signed by)

(Please Print Name) Jan Filochowski – Chief Executive

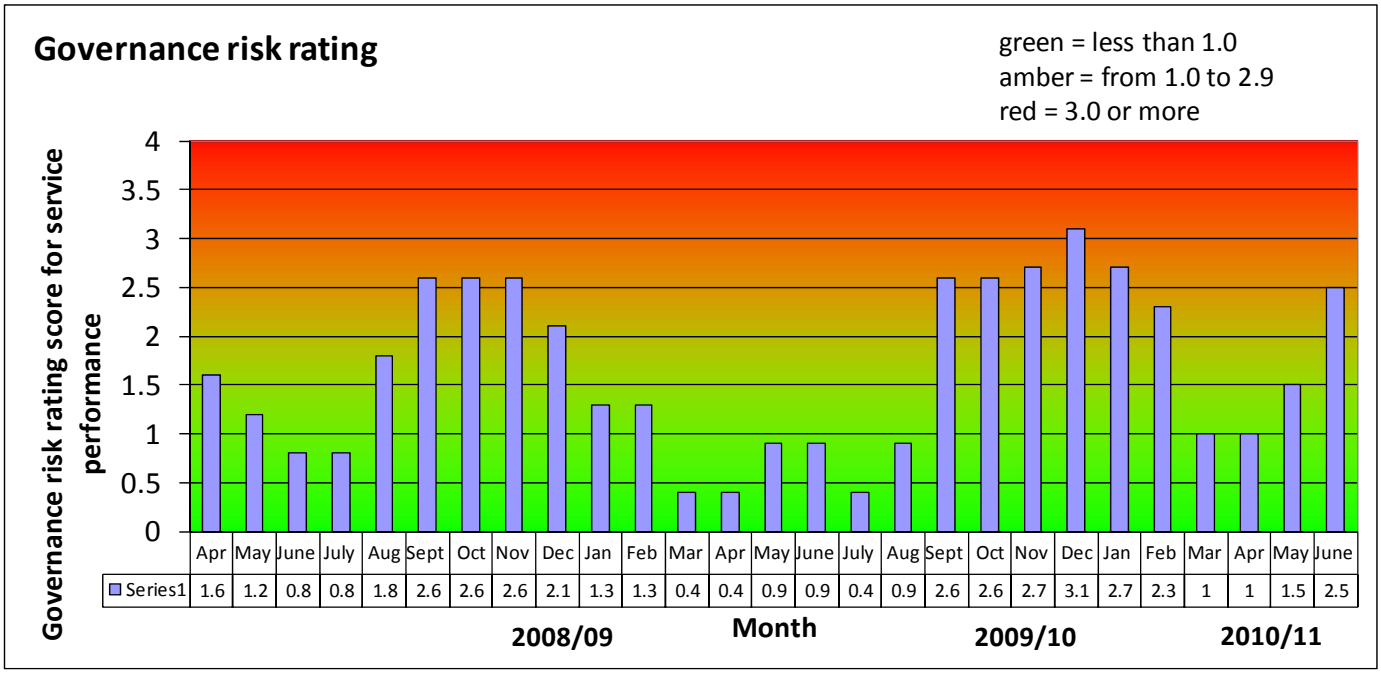
On behalf of the Board Directors

* 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 CQC rating forecast (including relevant national targets) Where the board is declaring insufficient assurance against targets*** 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.

1.0 Governance Declaration to Date



		2010/11 Financial Year Governance Scores											
Weight	**DoH Metrics**	**Apr**	**May**	**June**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
1.0	Clostridium Difficile												
	MRSA Target			x									
	Cancer - 31 days subsequent treatment			x									
	Cancer - 62 days wait RTT												
0.5	A&E - 4 hour	x	x										
	Thrombolysis - 60 minutes												
	Urgent GP cancer referral												
	Cancer - 31 days diagnosis to treatment		x										
	MRSA Screening	x	x	x									
1.0	CQC Registration: Compliance conditions on reg												
2.0	CQC Registration: Restrictive conditions												
1.0	Moderate CQC concerns: Safety of healthcare												
2.0	Major CQC concerns: Safety of healthcare												
4.0	Failure to rectify by the date set												
1.0	HSMR Rolling 12 month average												
	Total	**1.0**	**1.5**	**2.5**									

2.0 Non Compliance as at March 2010

The following sections provide commentary on West Hertfordshire Hospitals NHS Trust's areas of non compliance as at June 2010:

2.1 Code of Practice for the Prevention and Control of Healthcare Associated Infections (including the Hygiene Code);
2.2 Cancer – 31 days subsequent treatment
2.3 MRSA Bacteraemia
2.4 MRSA – screening all elective inpatients.

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 June 2010, 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 Q1 of 2010/11. Endoscopy Decontamination facilities at Watford will also remain non-compliant for the full 2009/10 year. Further evaluation of a new endoscope decontamination approach is being undertaken for Watford to identify a fast-track solution that will achieve compliance before end of Q3 2010/11.

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 Q3 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 end of Q3 2010/11.

2.2 Target / Core Standard: Cancer – 31 days subsequent treatment

The Issue
Two patients commenced subsequent treatment for cancer during the month of June. Of these two, one commenced treatment within 31 days of the Earliest Clinically Appropriate Date (ECAD) for treatment. The second commenced treatment outside the 31 day period. This second patient commenced his pathway in Barnet Hospital had chemotherapy in Mt Vernon and was operated on at WHHT on a date selected by the surgeon.

The monthly target is 96%. One patient breached this target leading to an achievement of only 50%.

The cause of the breach was in two parts. Firstly, the patient was insistent on surgery by a particular surgeon, Mr Livingstone. Secondly, Mr Livingstone's lists were fully booked for the 31 day period after the ECAD.

Proposed Actions
The proposed action is to work with multidisciplinary team coordinators to reiterate the importance of tracking patients on a daily basis and notifying the appropriate parties of the status of patients. This will allow extra capacity to be brought on stream in a timely manner.

Next Steps:
Complete the above and review. No additional support is required from the SHA.

Executive Lead: Nick Evans, Director of Partnerships
Management Lead: James McQuillan, Associate Director Service Improvement

2.3 Target / Core Standard: MRSA Bacteraemia

The Issue:
A patient was infected with hospital acquired MRSA bacteraemia during an emergency admission for abdominal pain during the month of June. The most likely cause of the infection was contamination from a femoral line.

The maximum allowable number of such infections over the year is five, and this is the second such infection this financial year.

Proposed Actions
The immediate care of the patient was carried out in accordance with current best practice.

A Root Cause Analysis was conducted shortly after the incident to identify the cause of the infection and to learn lessons to help prevent further infections in the future. This led to an immediate change in policy for the management of femoral lines plus a tightening up on the application of current elements of the policy.

The amended policy reminds staff of their obligation to observe and document, daily, the reasons for the line remaining in situ. In addition, the policy has been amended to ensure there should be no femoral lines in-situ for longer than 24 hours.

Next Steps:
The SHA has been advised via the *SHA Healthcare Associated Infection Feedback Form*. No further support is required.

Executive Lead: Colin Johnston, Medical Director
Management Lead: Frances Stratford, Infection Control

2.4 Target / Core Standard: MRSA Screening all elective in-patients

The Issue
During the month of June 2010 the elective in-patient screening achieved only 97.6% against a target of 100%.

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.

Proposed Actions
This target is monitored on a weekly basis at the highest level in the organisation. It is proposed to continue this monitoring identifying each and every area which falls below the 100% target and identify the cause of non-compliance. A plan of action specific to each area is prepared and implemented.

Next Steps:
No support is required from the SHA

Executive Lead: Colin Johnston, Medical Director
Management Lead: Frances Stratford, Infection Control