Name of Organisation: West Hertfordshire Hospitals NHS Trust

Date: January 11

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)	4
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,* CQC Essential standards and declare any contractual issues.
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) and CQC Essential standards. The board also confirms that there are no material contractual disputes.

(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)

Jan Filochowski – Chief Executive

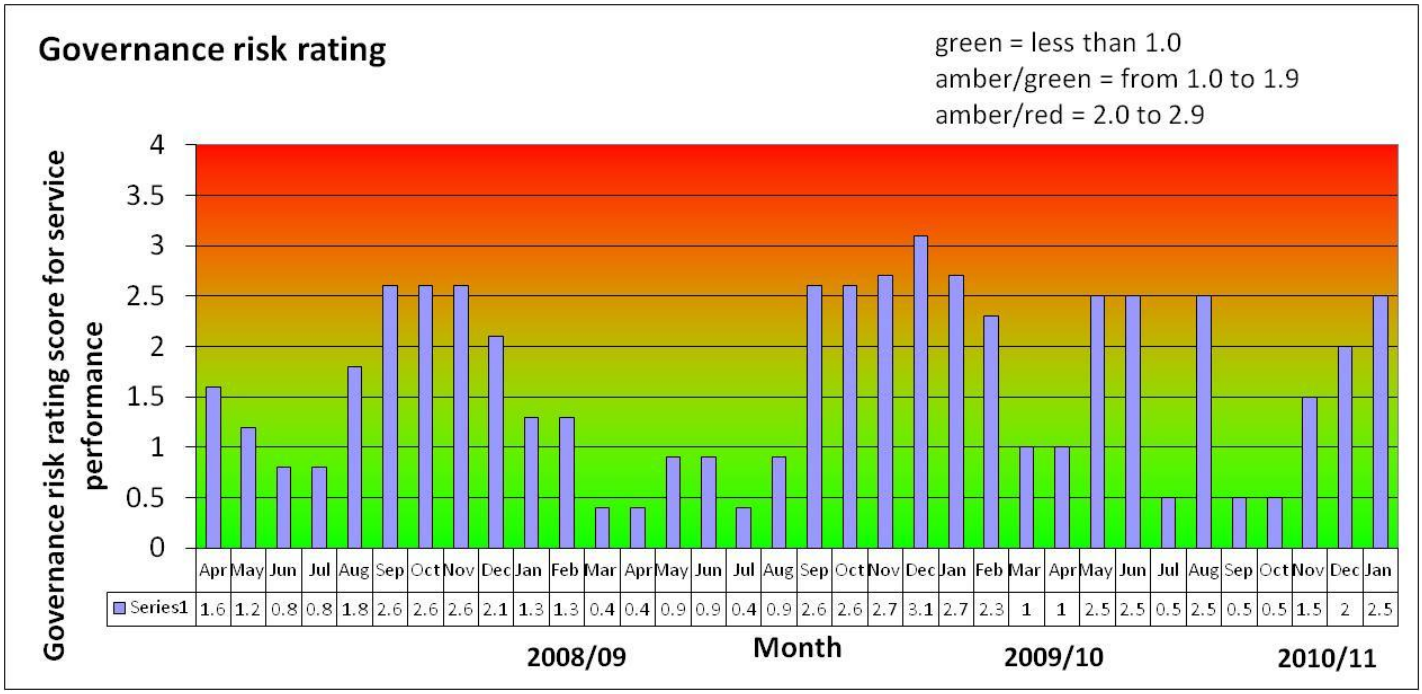
On behalf of the Board of Directors

* 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								x	x	x		
	MRSA Target		x	x		x							
	Cancer - 31 days subsequent treatment			x		x							
	Cancer - 62 days wait RTT												
0.5	A&E - 4 hour	x	x							x	x		
	Thrombolysis - 60 minutes												
	Urgent GP cancer referral												
	Cancer - 31 days diagnosis to treatment		x								x		
	MRSA Screening	x	x	x	x	x	x	x	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**	**2.5**	**2.5**	**0.5**	**2.5**	**0.5**	**0.5**	**1.5**	**2.0**	**2.5**		

2.0 Non-Compliance as at January 2011

The following sections provide commentary on West Hertfordshire Hospitals NHS Trust's areas of non-compliance as at January 2011:

2.1 Code of Practice for the Prevention and Control of Healthcare Associated Infections (including the Hygiene Code);
2.2 Clostridium Difficile – 56 or fewer cases during the year
2.3 A&E – 4 hour target
2.4 Cancer – 31 days from diagnosis to treatment
2.5 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 January 2011, 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:

The Trust has re-evaluated its strategy for achieving compliance in its Hemel Hempstead endoscopy decontamination unit and decided that it will spend a significantly larger sum in order to secure the service for the long-term. This involves the purchase and installation of the same decontamination system as will be installed at Watford. Endoscopy Decontamination facilities at both Watford and Hemel Hempstead will therefore remain non-compliant for the full 2010/11 year. Steps are being taken to ensure that works start on site to achieve compliance as early in the new financial year as is possible.

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 is working with the provider (IHSS Ltd) to achieve a transition into the new and fully compliant facilities at the earliest possible time. For various commercial reasons relating to their current contract with the North West

London Collaboration (their master agreement), neither the Trust nor IHSS is, at this time, able to complete the contract, allowing the transition to the compliant facilities. The NW London Collaboration expects that the contractual issues between them and IHSS will be resolved by end March 2011. Only then will WHHT be able to sign contracts with IHSS. It is to be noted that these issues are outside the Trust's control and do not reflect the degree of commitment to achieving compliance that has been made by the Trust.

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 anticipate becoming decontamination compliant by end of Q2 2011/12.

2.2 Clostridium Difficile Standard: 56 or fewer cases during the year

The Issue
A higher number of Clostridium Difficile cases occurred than was anticipated within the month – eight cases compared to a planned monthly trajectory of four. Overall, however, the Trust remains well below its annual trajectory. RCAs on all eight cases have revealed no areas of poor practice or issues of cross-infection. None of the cases were thought to be preventable

Overall the Trust continues to have rates well below trajectory

Proposed Actions
Continued vigilance but no specific further action required

Next Steps
No support is required from the SHA

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

2.3 Target: 4 hour A&E target

The Issue
The Trust's performance in January 2011 was 89.4%. An analysis of the data has shown that capacity issues were the main reason for failing to meet the 4-hour emergency target. There has been an increase in emergency admissions compared to 2009/10: A 7% increase in emergency admissions in December 2010 compared with December 2009; and a 10.6% increase in January 2011 compared with January 2010. This is part of a general pattern, which has seen an increase for every month this financial year (2010/11) compared with the same month in 2009/10

The Trust has had a number of multi-agency groups looking at Emergency Care performance and has been implementing a joint action plan with the PCT. In the light of the recent significant pressures, the Trust has set up an Emergency Care Delivery Group at director level. This group will oversee the drawing up of a definitive Action Plan drawing on all existing past action plans.

Proposed Action
The following immediate actions have already been taken to help alleviate the situation:

- Changes to nursing / medical roles in A&E to improve throughput
- Changes to the layout of A&E to improve patient flow

- Additional locum doctors in A&E at periods of highest demand
- Additional beds opened at Watford and Hemel hospitals
- NIV (Level 2 dependency) beds increased on Respiratory ward
- Critical care increase from 15 to 19 permanent beds
- Hours of Physician of the Day (on-call consultant) changed to improve continuity of care
- Hours of junior doctor on-call shifts changed to improve assessment process
- Junior doctors resources on the 'take' increased by eight hours per day
- Specialist telephone consultations offered as an alternative to admissions (commenced on 7th February 2011).
- Spot purchasing of nursing home beds by the PCT.

The Action Plan is being developed to further improve the position as part of the recovery plan. The plan will include analysis of the causes of the recent problems, actions to assist recovery, and actions to prevent future occurrence, and will include:

- Providing a governance framework for managing current pressures
- Building work (already started) to convert non-clinical space in the main body of the hospital into clinical space thus augmenting bed capacity
- Setting up separate ambulatory pathways. Pathway work is in progress. Two pathways to be 'piloted' in March (once a day iv antibiotics for cellulitis/and osteomyelitis)
- Implementing changes to manage future bank holidays and anticipated capacity pressures
- Revised capacity plan to ensure optimum use of all available bed stock across all three sites

Next Steps

The Action Plan will be prioritised and once complete and approved by the Emergency Care Delivery Group, it will be forwarded to the PCT. All relevant parties have been informed and involved in the issues associated with the 4- hour target. This includes the PCT and EofE.

Executive Lead: Chris Pocklington, Director of Delivery
Managerial Lead: Pat Reid, General Manager for Emergency Medicine

2.4 Target: Cancer 31 days from diagnosis to treatment

The Issue

The Trust's performance in January 2011 against the cancer 31day diagnosis-to-treatment target was 90.9%. An analysis of the data has shown that six patients breached the target. Of these, four patients were treated outside the target period as a result of a temporary capacity issue. This temporary issue arose as a result of a general increase in admissions (compared to the same period last year) exacerbated by an influx of patients with flu symptoms. This increase in admissions crowded out some elective work. The remaining two patients who breached were medical suspensions: One requiring further anaesthetic review (high risk); and the other needing cardiac assessment prior to surgery.

Proposed Action

The actions to address the capacity issues are highlighted in the four hour A&E target section.

Next Steps

No further action is required from the SHA

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

2.5 Target / Core Standard: MRSA - screening all elective in-patients

The Issue
During the month of January 2011 the elective in-patient screening achieved only 98.4% 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. We have significantly improved but on methodology outlined above a genuine 100% is always going to be challenging. 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