West Hertfordshire Hospitals NHS
NHS Trust

West Hertfordshire Hospitals NHS Trust

Annual Plan 2010/11

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March 2010

Trust Details

Trust name
West Hertfordshire Hospitals NHS Trust
Key contact at trust (name, contact details)
Jason Seez, Head of Planning and Performance
Annual plan date
18th March 2010

1. Executive Summary

Our plan provides an overview of our expected performance for the coming financial year, April 2010 to March 2011.

Vision

Our vision is:

- We will embody in our hospitals all the principles, values and the sense of service that created the NHS by providing consistently good, safe care in a friendly, listening and informative way, as and when people need and want it and always with dignity and respect.

Strategic objectives

Our strategic objectives are listed below:

1) Provide safe patient care;
2) Improve outcomes and quality of care;
3) Improve the patient experience;
4) Sustain and improve performance;
5) Be financially sound;
6) Work in active partnership; and
7) Attract, retain and motivate an appropriately trained workforce.

Our Plan details how we will be implementing our strategic objectives in 2010/11.

Quality

As ever, patient safety will be our number one priority. We will build on our excellent progress, as demonstrated by us being banded 4, in the 2009 Dr Foster rating*, with the development and implementation of our updated Quality Improvement Strategy and Quality Account in continuously driving forward quality improvement.

Key deliverables and Quality, Innovation, Productivity and Prevention (QIPP)

Over the last two years we have profoundly changed - successfully managing a significant improvement in our delivery of the NHS agenda while fundamentally changing the way we provide services.
In 2010/11 we need to continue to evolve - ensuring we are 'lean' in our approach in order to ensure that our cost base is appropriately geared to the activity we deliver.
Integral to our approach will be our Quality Innovation Productivity and Prevention (QIPP) programme - driving up quality whilst improving productivity.

Service developments

Our key 2010/11 service developments are:

- Working towards achieving NHS Hertfordshire's activity assumptions;
- Implementation of our Cost Improvement Programme (CIP) 'the Big Ask';
- Implementation of our Institute for Innovation and Improvement Productivity Programme;
- Development of our acute model of care, focusing on improvements across the acute care pathway;
- Development of our planned model of care, focusing on developing new ways of working at St Albans Hospital; and
- Development of our maternity and new born model of care, focusing on achieving the recommended midwife to birthing ratio.

Underpinned by:

- Implementation of our quality, workforce, estate, and IM&T strategies.

*Dr Foster grouped hospitals into five bands where 1 is the poorest and 5 is the best

1. Executive Summary

Finance

Our key 2010/11 financial headlines are:

- To deliver a surplus of £8.6m;
- Our cost improvement programme, 'the Big Ask', to deliver £19.8m savings. As part of this process we will also be building robust plans for 2011/12 and 2012/13. Core to our approach is ensuring our plans are practical, deliverable and have no impact or a positive impact on quality;
- £8.6m capital programme, the big ticket items being the replacement of our pathology computer system and addressing the high risk elements of our backlog maintenance;
- Fully operational service line reporting system; and
- Achieve a financial risk rating of no less than 3.

Workforce, infrastructure and financial implications

Our staff are our greatest asset, and what we are planning to achieve will be down to them.
In 2010/11 we will continue to develop our workforce, and ensure that our workforce profile is in line with our activity and income.

Significant risks and mitigation

In 2010/11 in achieving a green governance rating we will continue to improve performance against those targets, which we performed below plan in 2009/10:

- A&E 4 hour wait;
- MRSA screening; and
- Cancer waiting times.

In achieving the two specified national goals in the 2010/11 CQUIN priorities we will improve our:

- Venous Thromboembolism (VTE) risk assessment processes and procedures; and
- Responsiveness to the personal needs of patients.

In 2010/11 in delivering the 18 weeks waiting time for admitted and non admitted patients on an aggregate and specialty basis waiting list management will continue as a priority for specialty leads supported by our dedicated 18weeks team.

In 2010/11 in achieving a financial risk rating of no less than 3 we will:

- Urgently seek resolution with NHS Hertfordshire and NHS East of England on finalising a mutually beneficial service level agreement;
- Reduce our costs, gearing our capacity to the activity we are commissioned to undertake; and
- Ensure we are appropriately rewarded for delivering quality services as measured by our CQUIN targets.

Sustainability

We have developed comprehensive plans to ensure that we meet our 2010/11 carbon reduction commitments.
We will continue to develop our green travel plans, reduce our use of energy and utilities, and improve the efficiency and effectiveness of our waste management systems.

Board statements

Sign off of the two services provided statements are dependent on NHS Hertfordshire and us reaching agreement on the 2010/11 Service Level Agreement (SLA).

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2. Annual plan commentary

2.1 Trust profile

We provide acute healthcare services to the local population of west Hertfordshire and the surrounding area.
We are one of eighteen acute and specialist trusts in the EoE.
We operate from three main hospital sites. Referenced to the EoE *whole service, whole life vision* our core business is illustrated below.
Table 1 provides an overview of our key statistics.

Watford Hospital

Main focus delivery of secondary care for

Acute care | Planned care | Maternity & new born | Children's health | Staying healthy – sexual health

St Albans Hospital

Main focus delivery of secondary care for

Planned care

and community care for

Acute care | Maternity & new born | Children's health | Staying healthy – sexual health

Hemel Hempstead Hospital

Main focus delivery of community care for

Acute care | Planned care | Maternity & new born | Children's health

Table 1: Key statistics

Key statistics	
Turnover	- £255.5m (forecast turnover 2009/10)
Reference cost	- 100 (2008/09)
Assets	- £94.3m (Forecast assets at 31/03/2010)
Number of staff	- 3,896 employees (January 2010)
Population served	Approximately 500,000 (Hertfordshire Joint Strategic Needs Assessment. Core Dataset April 2008)
Number of patients treated	- Approximately 200,000 patients treated a year - Over 500,000 patient contacts a year
Market position	- NHS Hertfordshire accounts for over 90% of our clinical activity
Dr Foster Quality ranking	- Score of 73.97 (out of 100, 100 being best) - Patient Safety Banding 4 (out of 5, 5 being best) (published November 2009)

2.2 Past year performance

2.2.1 Chief executive's summary of the year

With reference to the NHS EoE performance management regime, our 2009/10 performance, April 2009 to January 2010, is illustrated below. Performance is risk rated using a red, amber, green scale. A "red" rating marks the highest risk, and a "green" the lowest.
Our performance by target is detailed in **table 2**.

Our key performance risks in 2009/10 were:
- A&E 4hr target;
- Urgent GP cancer referral; maximum 2 week wait;
- MRSA; screening all elective inpatients; and
- National core standards compliance.

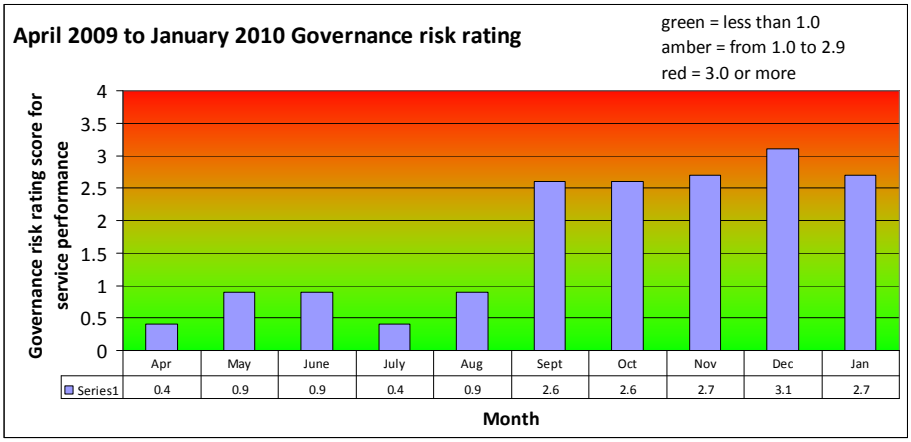


Table 2: 2009/10 significant divergences in performance*

Targets and national core standards	Number of months breached in year*
Clostridium Difficile - levels agreed with PCT**	0
MRSA target - levels agreed with PCT***	0
Cancer – 31 days subsequent treatment	0
Cancer – 62 days from referral to start of treatment	0
18 weeks – admitted patients	0
18 weeks – non admitted patients	0
A&E 4hr target	5
Urgent GP cancer referral – maximum 2 week wait	4
Cancer – 31 days from diagnosis to treatment	1
MRSA – screening all elective inpatients	6
National core standards compliance	6

* As at month 10 January 2010, year to date performance April 2009 to January 2010.
** In 2009/10 our performance target was less than 165 hospital acquired infections.
*** In 2009/10 our performance target was less than 18 bacteraemias.

2.2.2 Summary of financial performance

In 2009/10, we planned for a surplus of £4.6m. Achievement of this target means that we will meet our statutory breakeven target as per the timetable agreed with NHS EoE. As at 16th March 2010, we predict a year end surplus of £5.2m, which will exceed plan by £0.6m.

The revaluation of assets as part of the move to IFRS accounting standards contributed to us exceeding our planned surplus.

2009/10 has seen continued activity over performance above the levels agreed in our service level agreement with NHS Hertfordshire.

This resulted in us overspending on both pay and non pay in order to ensure we delivered the increased levels of activity.

Table 3 summarises our 2008/09 financial performance.

Table 3: Summary of 2009/10 financial performance

Summary of financial performance: high-level comparison between historical plan performance and actual performance			
£m	**2009/10 plan**	**2009/10 forecast***	**Variance**
Income			
Clinical income	222.7	226.1	3.4
Non-clinical income	21.8	23.6	1.8
Other income	6.4	5.9	(0.5)
Total income	**250.9**	**255.5**	**4.6**
Expenses			
Pay costs	(154.3)	(156.9)	(2.6)
Non-pay costs	(71.2)	(77.9)	(6.7)
Total costs	**(225.5)**	**(234.8)**	**(9.3)**
EBITDA**	**25.4**	**20.8**	**(4.6)**
Depreciation	(11.5)	(8.6)	2.8
Interest Payable	(1.8)	(1.8)	0.0
Interest Receivable	0.2	0.0	(0.2)
PDC*** Dividend	(7.8)	(5.2)	2.6
Net surplus/(deficit)	**4.6**	**5.2**	**0.6**

*Based on month 11 actual plus 1 month forecast
**Earnings Before Interest, Taxes, Depreciation and Amortization
***Public Dividend Capital

2.3 Other major performance issues

In addition to the main issues highlighted in **sections 2.2.1** and **2.2.2**, in 2009/10 NHS Hertfordshire also issued three performance notices:

- Two for A&E performance; and
- One for Choose and Book slots and us not achieving the phased target of no more than 8% slot failures by September 2009, with a final end of year target of 5%.

3.1 Strategic overview

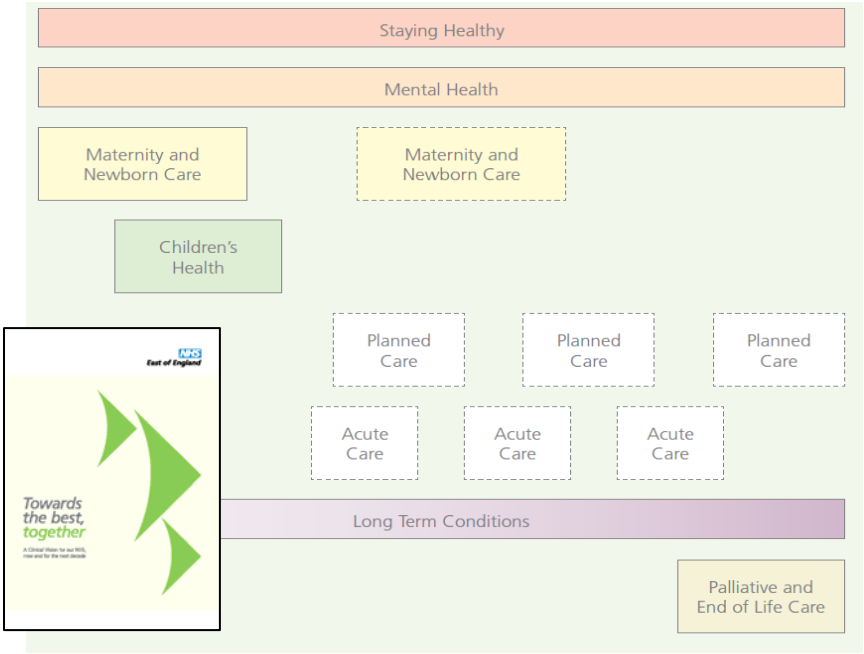
The EoE vision for healthcare for the next decade is set out in *Towards the Best Together – a clinical vision for our NHS, now and for the next decade'*. The EoE vision is 'to provide the best health service in England'.

Our vision is 'We will embody in our hospitals all the principles, values and the sense of service that created the NHS by providing consistently good, safe care in a friendly, listening and informative way, as and when people need and want it and always with dignity and respect.'

The EoE strategy focuses on a *whole service whole life vision*, which is illustrated below. The vision outlines healthcare in terms of seven care pathways:

- Staying Healthy;
- Mental Health;
- Maternity and newborn care;
- Children's Health;
- Planned Care;
- Acute Care; and
- Long term conditions.

Our service model is detailed in table 4.



Our core business is providing -

Working in partnership with primary and community care services in the delivery of -

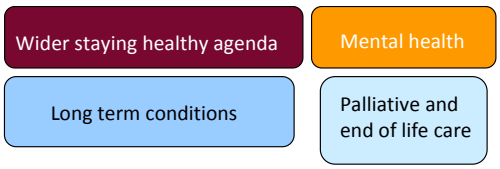
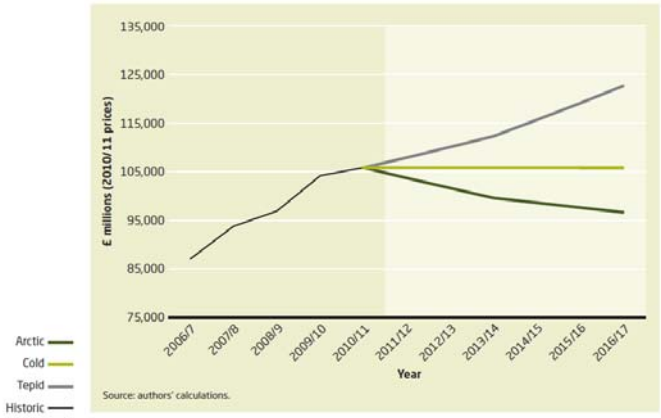


Table 4: Our service model

		Watford	St Albans	Hemel Hempstead
Maternity & new born		Consultant led delivery unit Midwife birthing unit Antenatal, intrapartum and post natal clinics and specialist antenatal services Community midwifery	Antenatal clinics Community midwifery	Antenatal clinics Community midwifery
Children's health		Inpatient unit Day surgery Medical day care Emergency department Outpatients	Outpatients	Outpatients
Acute care		Accident and Emergency Acute Admissions Unit Acute wards Critical care Emergency surgery	Minor Injuries Unit (MIU)	Step down beds UCC
Planned care	Surgery	Complex cases Limited day surgery Outpatients	Elective and Day surgery centre Outpatients	Outpatients
	Medicine	Endoscopy Cardiology Chemotherapy Outpatients	Outpatients	Endoscopy Outpatients
Sexual health		Hub of clinical service Family planning HIV, GUM	Family planning GUM	
Clinical support		X Ray Computerised Tomography Scanning (CT) Magnetic Resonance Imaging Scanning (MRI) Ultrasound Nuclear Medicine Cardiac Catheter Laboratories Cardiac and lung function 'Hot' and 'Cold' Pathology	X Ray Ultrasound Mammography Cardiac and lung function Blood/specimen collection	X Ray CT MRI Ultrasound Nuclear Medicine Cardiac and lung function 'Cold' Pathology

Our 2010/11 planning, and how we plan to deliver our service model and portfolio has been significantly influenced by the impact of the economic downturn.

National Financial Position
In July 2009 the Kings Fund published *How cold it will be: prospects for NHS funding: 2011-17.* The paper analysed the consequences for the NHS of the current national state of public finances. After significant real growth in National Health Service (NHS) funding this century (averaging nearly 7 per cent per year in England up to 2010/11), future prospects were reviewed in terms of three possible scenarios for the English NHS from 2011/12 to 2016/17: 'tepid', 'cold' and 'arctic'.
These scenarios are illustrated opposite.



- 'tepid' (annual real increases of 2 per cent for the first three years, increasing to 3 per cent for the final three years)
- 'cold' (zero real change, which is the lowest level of funding compatible with a pledge made by the Conservative Party)
- 'arctic' (annual real reductions of 2 per cent for the first three years, falling to 1 per cent for the final three years).

The Kings Fund reviewed these scenarios, informed by the 2002 Wanless report *Securing Our Future Health: Taking a long-term view, to project the productivity improvements that the NHS would need to deliver.*
On average for the three-year period 2011/12–2013/14 (based on an optimistic Wanless scenario) the average annual productivity gains that would need to be delivered are:

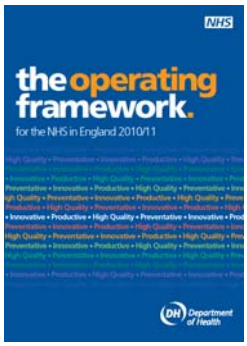
- 8.0 per cent for the worst case funding scenario (arctic);
- 6.0 per cent for the cold scenario; and
- 4.0 per cent for the tepid scenario.

The Framework highlighted the need for a relentless focus on three things:

- Improving quality whilst improving productivity;

For the subsequent spending review period up to 2016/17, productivity improvements would need to average 6.8 per cent, 5.8 per cent and 2.8 per cent, respectively.

The *2010/11 Operating Framework* was published by the Department of Health in December 2009, and detailed that the NHS would need to identify £15 to £20 billion of efficiency savings by the end of 2013/14.



- Local clinicians and managers working together across boundaries to spot the opportunities and manage the change; and
- To act now and for the long term.

3. Strategic overview

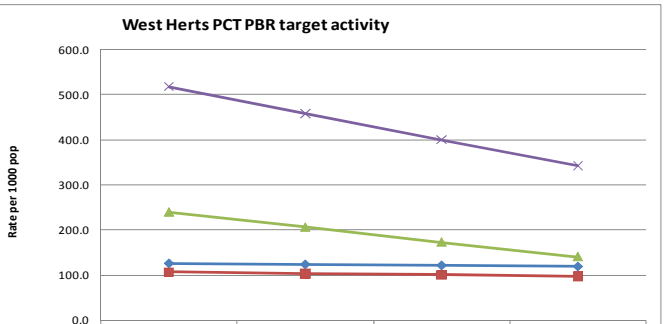
Sector Financial Position
The national picture has been reviewed in detail by NHS Hertfordshire.

Consequently their 2009/10 – 2013/14 Strategic Plan was refreshed in January 2010, informed by the national financial position and that a consistent trend for the last three years up to 2009/10 has been an increase in acute activity.

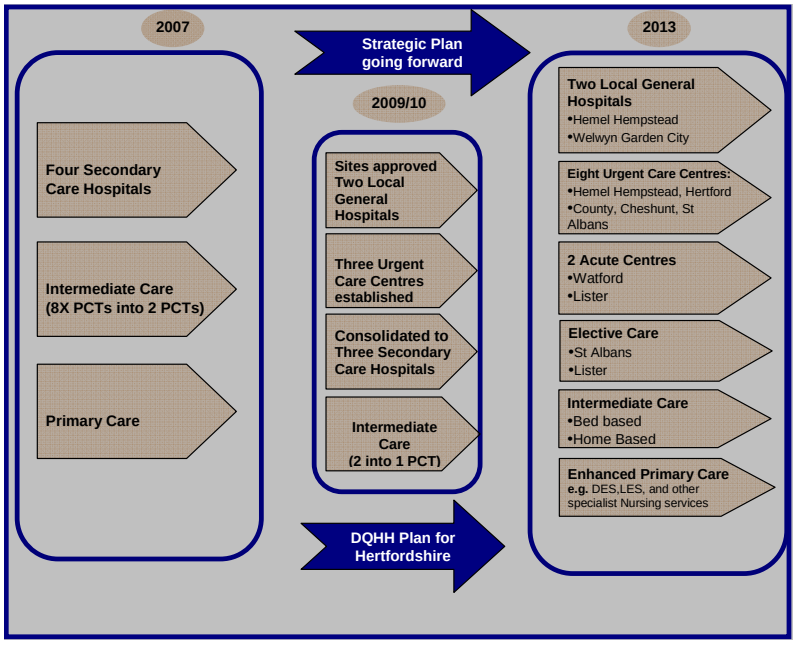
The graph opposite shows NHS Hertfordshire's activity projections that underpin their refreshed strategic plan, with upper decile performance planned to be delivered by 2012/13.

NHS Hertfordshire's ambitious projections for reducing acute activity will continue to be taken forward as part of the joint *Delivering Quality Healthcare in Hertfordshire* (DQHH) programme.

A key element of DQHH is reorganising service configuration, which is highlighted in the diagram opposite.



	Activity per 1000 pop 2009/10	20010/11	20011/12	20012/13
DayCase & Inpatients-D	126.6	124.3	122.0	119.8
Non-Elective Admissions-D	106.8	103.8	100.7	97.6
First Outpatient Attendance-D	239.8	206.2	173.2	140.6
Follow Up Outpatient Attendance-D	517.8	458.3	400.0	342.5

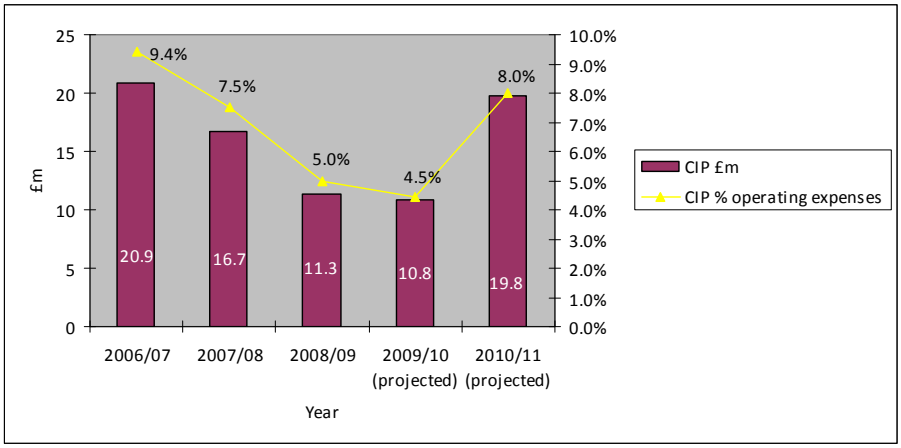


3. Strategic overview

Our position

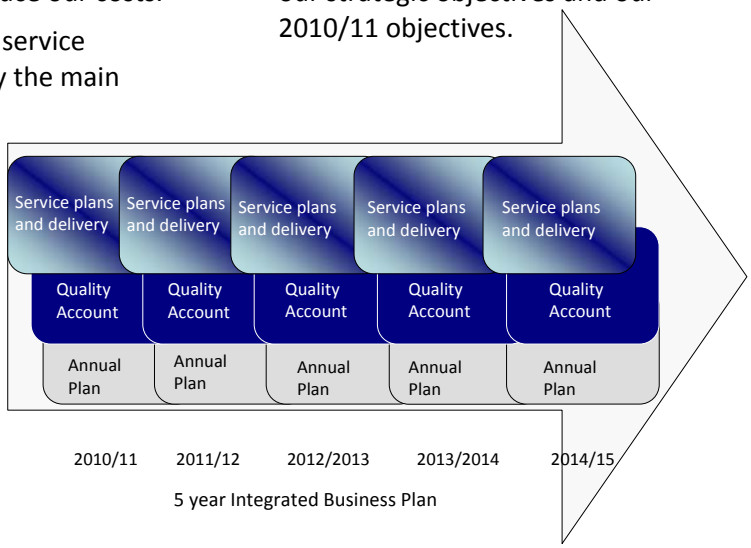
In February 2010, informed by the national and sector position we launched our 2010/11 savings programme - 'The Big Ask'.
The programme is tasked with delivering a projected £19.8m savings target; 8% of our operating expenses. Core to our approach is ensuring our plans are practical, deliverable and have no impact or a positive impact on quality.

Our projected and historical savings delivery is illustrated below.



In short, to continue to be a viable organisation capable of providing high quality care to our patients our key priority in 2010/11 is that we must significantly reduce our costs.

In taking forward our service portfolio, informed by the main national and sector drivers, our Integrated Business Plan (IBP) outlines our five year journey up to 2014/15. The next section details our strategic objectives and our 2010/11 objectives.



Strategic objectives and 2010/11 objectives

Our Integrated Business Plan (IBP) details six strategic objectives. These are:

1. Provide safe patient care;
2. Improve outcomes and quality of care;
3. Improve the patient experience;
4. Sustain and improve performance;
5. Be financially sound;
6. Work in active partnership;

In addition as part of our annual planning cycle we have added a seventh objective:

7. Attract, retain and motivate an appropriately trained workforce

Table 5 below details our key 2010/11 "must do's" in delivering our strategic objectives

Table 5: 2010/11 objectives

Strategic objective	2010/11 objectives
Provide safe patient care	- Develop and implement our Quality Improvement Strategy - Ensure integrated learning from Serious Untoward Incidents, all reported incidents, complaints and litigation claims - Continue to improve the safety of our services – maintaining our low levels of C-difficile and MRSA - Maintain compliance with the hygiene code - Ensure MRSA screening of all appropriate elective and emergency admissions - Ensure Venous Thrombo-embolism (VTE) risk assessment for all appropriate inpatient and day cases - Achieve NHSLA Level 2 for acute services
Improve outcomes and quality of care	- Develop and implement our Quality Improvement Strategy - Develop our Quality Account to drive forward continuous quality improvement o Ensuring that the achievement of quality improvements is a continuous process, subject to continuous review o Enhancing the patient experience - Getting it 'right first time' for all our patients o Promoting clinical effectiveness o Advancing patient safety - participate in Wave VI of the Leading Improvements in Patient Safety programme - Deliver the CQUIN targets agreed with NHS Hertfordshire - Further develop our capability to produce real time data on clinical effectiveness across all aspects of care - Further refine our clinical governance processes to ensure embedding from Ward to Board - Implement the High Impact Actions for Nursing and Midwifery
Improve the patient experience	- Deliver the NHS Constitution - Year on year improvement in national and our local patient satisfaction survey's - Reduce the number of complaints - Ensure Delivering Same Sex Accommodation (DSSA) compliance

Strategic objective	2010/11 objectives
Improve the patient experience (continued)	- Ongoing delivery of our ten Heart of Herts pledges o Treat patients with respect, courtesy and compassion o Welcome patients and make sure they know what to expect o Ensure our hospital is clean, safe, uncluttered and quiet o Follow the dress code, display our identity badges, and introduce ourselves to patients o Provide clear signs, directions and assistance so patients and visitors get to their destination o Answer all telephone calls and call buttons promptly; o Give patients our full attention and answer their questions fully o Make it our duty to prevent delays and explain the reasons if delays occur o Meet patients' needs for privacy, dignity and confidentiality o Challenge and change practice that falls below these standards
Sustain and improve performance	- Deliver the Operating Framework priorities and consistently achieve a 'Green' rating for compliance - Achieve NHS foundation trust status - Continued implementation of our service improvement programme, resulting in: o Reduced bed base (595 beds by March 2011) o Reduced emergency lengths of stay (LOS) (4.47 days by Q4 2011) o Reduced elective LOS (1.51 days by Q4 2011) o Reduce elective LOS excluding day cases (2.92 days by Q4 2011) o Improved theatre utilisation (rate of 73% by Q4 2011) o Improved day case rate (Achieve day case/spells ratio of 35% by Q4 2011) o Establish service line management o Reduce our carbon footprint o Implementation of Choose and Book
Be financially sound	- Achieve a liquidity ratio of at least 2 with a financial risk rating of at least 3 - Deliver our significant cost improvement programme of approximately £19.8m (projected CIP 16th March 2010) - Implement our business objectives (detailed in section 3.3 service development plans) - Embed service line reporting in the divisions - Deliver the level and standards of service commissioned - Implement our 2010/11 capital programme - Ensure the highest standards of financial governance

Strategic objective	2010/11 objectives
Work in active partnership	- Develop plans for long term viable and sustainable service provision - Jointly develop with NHS Hertfordshire robust plans for achieving the shifts in activity from secondary to primary care - Continue to work with specialty networks in developing our clinical portfolio
Attract, retain and motivate an appropriately trained workforce	By Q4 achieve – - 80% of all staff to have appraisals and attend mandatory training - Year on year improvement in the annual national staff satisfaction survey - Continue to develop new ways of working o With a particular focus on the development of assistant practitioners and review the overall workforce profile in theatres, emergency care and maternity care - Deliver an improvement in staff productivity with a particular focus on medical staffing costs - Reduce agency spend to 3% of paybill - Reduce overall temporary staffing spend to 6% of paybill - Reduce long term sickness absence to 2.1% - Reduce short term sickness absence to 1.9% - Continue to ensure European Working Time Directive (EWTD), New Deal compliance, and realise the benefits of Hospital at Night - To agree and launch a Staff Health and Well Being plan - To design a talent management process for medical leaders and Bands 8 and above by Q2

Update of how the Board conducts continuous market analysis of threats and opportunities for the Trust

Our application to become an NHS foundation trust has incorporated a detailed market analysis of the threats and opportunities for the Trust.

In July 2009, as part of the development of our IBP, the Trust Board approved our Marketing Strategy.

From January 2010, a market and service development update report has been developed, and in 2010/11 this will be regularly reported to our main governance forums.

Marketing Strategy

Market and service development update report

Author: Jason Seez, Head of Planning and Performance
Date – January 2010
Configuration Item Record – v1.1
Distribution
- Divisional Boards, C-Strat, Trust Board

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Figures 8 to 11: West Hertfordshire Hospitals NHS Trust's top 10 specialties by percentage for outpatient first attendances, emergency spells, elective spells, and combined spells (April to September 2009)	5

3.2 Achievement of NHS foundation trust status

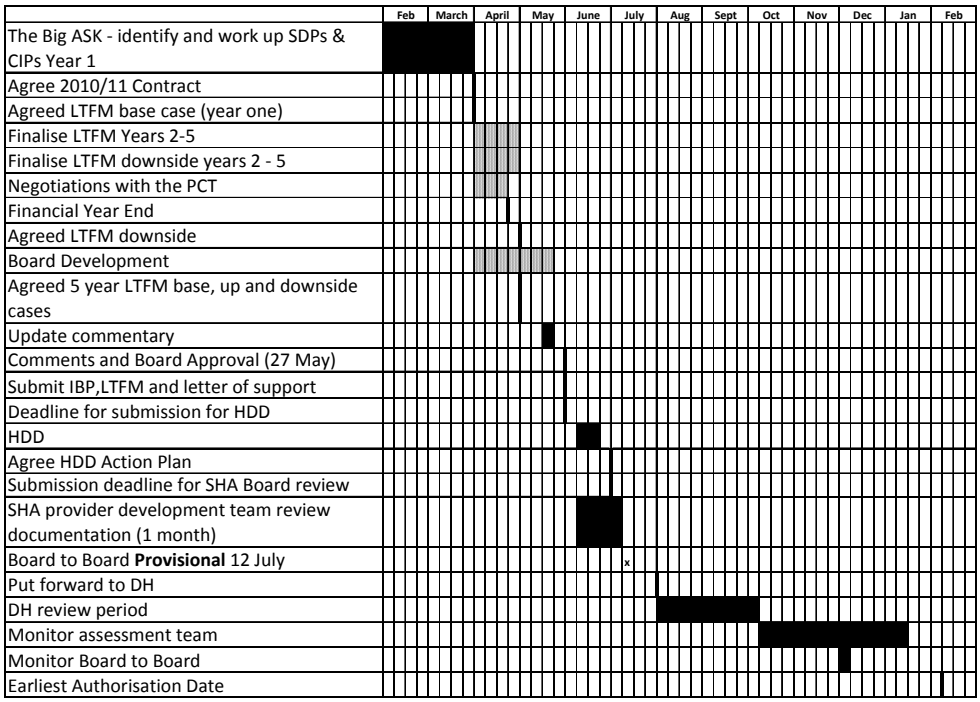
We will be submitting our updated Integrated Business Plan (IBP) and Long Term Financial Model (LTFM) to NHS EoE in May 2010.

In Quarter 1 2010/11 detailed scenario planning will be completed, which will be informed by NHS Hertfordshire's refreshed strategy. It is planned for NHS Hertfordshire's commissioning intentions to be modelled in the downside, with a prudent position based on current but reduced, activity in the base case. As part of this process we will be detailing an updated two year cost improvement programme.

We have a good relationship with NHS Hertfordshire with ongoing dialogue concerning our application to become an NHS foundation trust.

We have previously undertaken a Historic Due Diligence (HDD) assessment and a subsequent refresh. A further HDD assessment will be required, following the submission of our updated IBP and LTFM to NHS EoE.

Our timetable for achieving NHS foundation trust status is summarised on the next page. Currently the earliest date for authorisation is projected as Quarter 4.



3.3 Service development plans 2010/11

In addition to detailing our strategic objectives our IBP also details business objectives. We have five business objectives.

Two objectives to deliver the base case detailed in our IBP:

1) Sustain market share; and
2) Reshape and rationalise services to ensure financial viability.

Three objectives to deliver the upside case in our IBP:

3) Increase market share at the periphery;
4) Increase the range of specialist care provided locally; and
5) Deliver more care in community settings.

Our key 2010/11 service development plans are summarised in **tables 6 and 7.**

All proposed service developments will be subject to a business case being developed and presented for approval at the appropriate Trust governance forum.

Table 6: 2010/11 key clinical service developments

Clinical pathway	Cross pathway developments	Pathway specific proposed 2010/11 service developments
Maternity & new born	- Work towards delivering the planning assumptions detailed in DQHH, with particular focus on the development of robust referral management processes in gynaecology, ophthalmology, and orthopaedics - Implementation of our 2010/11 cost improvement programme 'the big ask' - Implementation of our Institute for Innovation and Improvement productivity programme	- In achieving the recommended midwife to birthing ratio continue to reprofile our workforce and appoint additional midwives, subject to funding support from NHS Hertfordshire - Reconfiguration of community midwifery services - Business case for consultant gynaecologist with an interest in minimal access surgery.
Children's health		- Business case for short stay paediatric assessment unit - Business case for general paediatrics consultant.
Planned care		- Business case for expanded theatre and day case facilities at St Albans Hospital to support the continued development of the surgical portfolio undertaken - Continued development of one stop shop services - Establishment of enhanced recovery programme in colorectal, MSK, gynaecology and urology - Development of our ENT service - Development of our pain service - Business case for joint orthopaedic fellowship with Royal National Orthopaedic Hospital - Business case for replacement consultant general surgeon - Business case for replacement consultant gastroenterologist - Continue to repatriate cardiac for which we now have the skills and facilities to undertake at Watford Hospital, and with the cardiac network in ensuring our skills and facilities are optimally utilised - As part of the Cancer Network ongoing development of Watford Hospital as a gynaecological, and upper GI cancer centre, Lister Hospital as a urology cancer centre and Luton Hospital as a head and neck cancer centre
Acute care		- Focus on improvements across the acute care pathway - Achieve hyper acute stroke status by Q1 2010/11 - Business case for additional consultant acute physician
Staying healthy – sexual health		- No major service developments proposed

Table 7: 2010/11 key support service developments

Clinical support - Strategic outline case for the replacement of the Magnetic Resonance Imaging (MRI) scanner at Hemel Hempstead Hospital - Implementation of a replacement pathology information system - Picture Archiving and Communication System (PACS) upgrade - Business case for additional consultant radiologist - Business case for additional histopathologist
Supporting strategy's - Implementation of our Information Technology programme detailed in **section 5.2**. - Implementation of our £8.6m 2010/11 capital programme detailed in **Section 4.3** - Ongoing implementation of our workforce strategy detailed in **Section 9**.

3.4 Summary of links to main commissioners strategies

Our 2010/11 annual planning has referenced NHS EoE's *Commissioning Framework 2010/11* and NHS Hertfordshire's *Strategic Plan Refresh 2009/10 – 2013/14*. **Section 5** details our response to the QIPP challenge referenced to the NHS EoE's *Annual Plan Guidance for Acute Providers*.

The three main divisions – Surgery, Medicine, and Women's and Children's completed their 2010/11 capacity planning in December 2009. Planning assumptions were based on analysis of waiting list trends in combination with clinical leads specialist expert knowledge of delivering acute secondary care. These plans were used to inform our 2010/11 negotiations with NHS Hertfordshire.

In terms of the contract standards and the contractual requirements our 2010/11 capacity planning is being updated in March 2010 to incorporate the proposed:

- Outpatient follow up cap;
- Conversion rate threshold of emergency admissions via A&E;
- Short stay (less than 48 hours) admissions to A&E attendances thresholds;
- Policy for non payment of planned procedures not carried out;
- Clinical review of readmissions thresholds;
- Prior authorisation arrangements;
- Locally agreed standards for excess bed days; and
- Locally agreed standards for consultant to consultant referrals.

We note NHS Hertfordshire's recognition that what is being proposed in their *Strategic Plan Refresh* for 2010/11 will entail the delivery of ambitious targets concerning the reduction in acute activity, and that activity will not all 'just disappear'.

In ensuring that we adhere to the DoH's Leading Local Change five pledges:

1) Change will always be to the benefit of patients;
2) Change will be clinically driven;
3) All change will be locally-led;
4) The local NHS will involve patients, carers, the public and other key partners; and
5) Existing services will not be withdrawn until new and better services are available to patients so they can see the difference.

We advocate that realistic timeframes for service change are agreed jointly to ensure robust project planning and implementation in the delivery of evolved models of service provision to the benefit of the patients we serve.

3.5 Delivery of Towards the Best Together (TTBT)

Our 2010/11 actions in our ongoing response to '*The case for change*' is summarised in **table 8.**

Table 8: Planned action in response to *'The case for change'*

Case for change	2010/11 actions
Standardised mortality ratios	- Dr Foster - less than 100 - CHKS – less than 100 (rebased data)
Heart attack	- We offer primary angioplasty as first/main treatment Monday to Friday 8.00am to 5.00pm.Out of hours patients go to Harefield - As part of the AAU development we opened two new cardiac catheter laboratories
Maternity	- Women's and Children's plans set out how will achieve the recommended ratios of midwife to births
Children's services	- We have assessed our position, and subsequently developed action plans, using the annual child health mapping exercise
Long term conditions	- As part of DQHH, we will continue to work in partnership with commissioners in the development of evolved models of care
End of Life care	- We will continue to work in partnership with primary and community agencies in continuing to develop our model of care
Health care acquired infections	- We will strive to maintain our national leading low levels of hospital acquired infection. Our 2010/11 targets are less than fifty six Clostridium Difficile hospital acquired infections and five cases of MRSA
Patient expectations	- Following the findings of the 2007 patient survey, we launched our Heart of Herts programme which has delivered significant improvements in patient satisfaction - Following the findings of the 2008 patient survey, we launched our review of outpatient services

Case for change	2010/11 actions
Choice	- We will continue to work with primary care partners in the implementation of Choose and Book and achieving EoE and performance expectations
Shift from secondary to primary care	- We will continue to review with commissioners the proposed shifts from secondary to primary care provision as part of DQHH
Surgery – centralise where necessary	- As part of the development of the Surgery Division's service development planning we are reviewing at specialty level critical volume and case mix, and resource required for sustainable delivery
Diagnostics	- We will be developing a strategic outline case for the replacement of our MRI scanner based at Hemel Hempstead Hospital
Stroke	- we are planning to achieve hyper acute status by Q1 2010/11
Neonates	- We will continue to reference the BAPM standards in the ongoing development of our neonatal services

3.6 Delivery of Improving Lives Saving Lives and the Pledges

Our 2010/11 actions in our ongoing response to '*Improving Lives, Saving Lives* summarised in **table 9.**

Table 9: 2010/11 actions in our ongoing response to '*Improving Lives, Saving Lives*

Pledge	2010/11 actions
We will deliver year on year improvements in patient experience	We will deliver year on year improvements in patient experience **Pledge 1.1: Net promoter** - We review on a quarterly basis the IPSOS Mori net promoter results - We have developed our own 'near real time' data collections to monitor patient experience. This information will continue to be reported monthly to divisional leads to address areas of concern. **Pledge 1.2: Delivering Same Sex Accommodation (DSSA)** - We are aiming to have completed our Phase 2 programme by 31st March 2010, which will ensure our Day Surgery Unit at SACH, Watford Radiology and the A&E Department at Watford are compliant - Phase 3, April 2010 onwards will focus on sustainability, compliance monitoring and promoting a culture, which promotes dignified care **Pledge 1.4: One to one care in established labour** - We achieved one to one care in established labour in 2009/10 and will continue to do so in 2010/11. We plan to continue to strengthen our model with ongoing recruitment to our midwifery establishment **Pledge 1.7: Advance Palliative and End of Life Planning** - In line with NHS EoE guidance we are working towards implementing the Preferred Priorities of Care documentation, and the target of documenting that the opportunity was offered > 75% by September 2010 **Pledge 1.8**: **Palliative and End of Life Care in the Last Days of Life** - We have plans in place to implement the Liverpool Care Pathway for the Dying for >75% by September 2010 - We will complete an annual audit of end of life care using the National Care of the Dying (Hospitals) Audit - We will complete a biannual survey of bereaved carers using the VOICES Questionnaire

Pledge	2010/11 actions
We will extend access guarantees to more of our services	**Pledge 2.3**: **Access Guarantees** - We have plans in place to deliver a maximum 18 week wait for all associated patients accessing non-consultant led services from the beginning of April 2010
We will ensure fewer people suffer from, or die prematurely from heart disease, stroke and cancer.	**Pledge 5.2 Cancer** - Sustained delivery of the cancer waiting time standards, with a particular focus on a maximum two week wait for urgent GP Cancer referrals will be a priority - As part of the Mount Vernon Cancer Network we will continue to work with partner agencies in delivering the recommendations for chemotherapy (NCAG) and the Improving Outcomes Guidance standards **Pledge 5.3: Stroke** By Q4 2010/11 we will achieve the National Vital Sign targets of: - >80% people treated on a stroke unit >90% of their stay - >60% people who have a transient ischaemic attack (TIA) and are high risk will be scanned and treated within 24 hours of contact but not admitted - >12% of non haemorrhagic strokes will receive thrombolysis within three hours of onset - >65% of patients with low risk TIA will have access to MRI or carotid scan within seven days **Pledge 5.4: Primary Percutaneous Coronary Intervention** (PPCI) - We currently exceed 75% of people having access to PPCI within a maximum call to balloon time of 150 minutes, with 100% having access within 165 minutes

Pledge	2010/11 actions
We will make our health service the safest in England	**Pledge 6.1: Trauma** - We will submit regular data on all relevant patients to TARN (Trauma Audit Research Network) and the National Hip Fracture Database **Pledge 6.2: Hospital Standardised Mortality Ratio (HSMR)** - HSMR data is reviewed monthly at a specialty level **Pledge 6.3: Venous Thrombo-embolism (VTE)** - In line with national priority setting, we have identified as a priority for all inpatient and day case patients to receive evidenced based VTE risk assessment on admission and if their clinical status changes, and for the appropriate thromboprophylaxis to be administered **Pledge 6.4: Abdominal Aortic Aneurysms** - Our vascular surgeons will continue to submit 100% of their outcome data to the National Vascular Database **Pledge 6.5: Healthcare Associated Infections** - We will continue implementing our robust infection control programme in ensuring less than fifty six Clostridium Difficile hospital acquired infections and five cases of MRSA
We will ensure that healthcare is as available to marginalised groups and looked after children as it is to the rest of us	**Pledge 9.1: Safeguarding and Child Protection** - We have an action plan to address the issues identified through the CQC and NHS EoE review of Safeguarding and Child Protection. The main actions to be implemented are: o For all staff ensure the appropriate training and development according to their level of involvement with children o Review the level of resources allocated to safeguarding children to reflect changes in service provision o Continue to develop joint working between maternity services and social care o Ensure safe staffing arrangements to promote the safeguarding of children accessing our services **Pledge 9.2: Learning Disability** - Adult Care Services provide a learning disability liaison nurse team to support our services
We will halt the rise in obesity in children and then seek to reduce it	**Pledge 11.1: Breastfeeding rates at initiation and 6-8 weeks** - We will implement the *EoE Breastfeeding Framework for Action* - We will continue working with NHS Hertfordshire's Public Health department in continuing to ensure that women are supported to initiate and maintain breast feeding

4.1 Operating resources

We project a 2009/10 year end surplus of £5.2m.
For 2010/11 our target is a surplus of £8.6m.

4.1.1 Operating income

Our 2010/11 income from commissioners will be affected by changes in the national tariff and NHS Hertfordshire's commissioning intentions.
We have reviewed the revisions to the PbR tariff, and our analysis is that the total impact of these tariff changes in cash terms, and based on current activity levels, would be a modest loss of £0.4m.

We have raised with NHS Hertfordshire the issue of the emergency marginal rate which seems inappropriate in view of the implementation of the jointly agreed new model of emergency care last year.

Concerning NHS Hertfordshire's commissioning intentions detailed in **Section 3 Strategy**, it is unlikely that there would be a full year financial affect, as at this stage plans to deliver change are embryonic and are unlikely to be in place by the 1st April 2010.
Further to the development of project initiation documents outlining the development of proposals, we will review the activity and associated financial implications.

Table 10, details our planned and forecast clinical income.

Table 10: Clinical income

Comparison between historic achievement and current plan					
Clinical Income*					
£m	**Plan**	**Forecast**	**Current plan**		
	2009/10	**2009/10**	**2010/11**	**2011/12**	**2012/13**
Elective	44.6	47.6	48.5	50.6	49.9
Non-Elective	78.8	80.8	78.1	78.9	77.8
Outpatient	47.3	50.7	49.0	48.1	44.4
A&E	8.7	7.9	9.0	10.7	10.6
Other	43.3	39.1	37.9	37.3	37.5
Total	**222.7**	**226.1**	**222.5**	**225.5**	**220.2**
					Based on Month 11, plus 1 month forecast

4.1.2 Operating resources required to deliver strategy

Our planned and forecast operating expenses are detailed in **table 11,** and mirror our 1-5 year business plan forecast position.

4.1.3 Turnaround and reconfiguration plans

Our Cost Improvement Programme (CIP) target for 2010/11 is projected as £19.8m.

As previously detailed in **Section 3 Strategy**, we are managing our delivery via a programme entitled 'The Big Ask', with the establishment of a programme office.

Our programme entails projects encompassing reductions in back office and management costs, reviewing our service model and use of our estate, in evolving our capacity in line with NHS Hertfordshire's strategy.

Our programme is being developed using a two staged approach;

- Stage 1, identification of c£19.8m of savings; and
- Stage 2, 2011/12 and 2012/13 identified CIPs as part of our application to become an NHS foundation trust.

Our framework for delivery will continue to be the 'gateway' process, which is summarised on the next page.

Table 11: Operating expenses

Comparison between historic achievement and current plan

Operating expenses — Based on Month 11, plus 1 month forecast

£m	Plan	Forecast	Current plan		
	2009/10	2009/10	2010/11	2011/12	2012/13
Pay costs	(154.3)	(156.9)	(157.4)	(157.5)	(153.7)
Drug costs	(11.7)	(12.7)	(12.8)	(13.8)	(14.7)
Clinical Supplies	(20.4)	(21.9)	(24.7)	(21.4)	(20.4)
Non-clinical Supplies	(39.1)	(43.2)	(31.4)	(42.3)	(41.1)
Depreciation & amortisation	(11.5)	(8.6)	(8.8)	(8.8)	(8.8)
Total	**(237.0)**	**(243.3)**	**(235.1)**	**(243.8)**	**(238.6)**

GATEWAY PROCESS

The idea generation process is designed to provide a generic set of principles and stages ('Gates') that will enable varying levels of management to generate and select ideas and track those ideas through the relevant stages until implementation and measurement.

Each idea will be subject to the formalised selection process ('Gate 1') and validation process ('Gate 2') before being worked into a detailed implementation plan that will explain what actually needs to happen.

Only ideas that have reached and passed 'Gate 3' will be monitored and included as part of your operational and financial plans.

Records of all ideas should be maintained by the relevant divisions and directorates detailing the stage each idea has reached (even if parked at a gateway).

Each gateway has required inputs with only six requirements across all gateway's. All inputs are referenced B1 to B6 and have a proforma for completion that is an adaptation of the 'Form B' and Gantt chart analysis currently in place. Completion of the proformas will be required before gateway progression.

IDEAS GENERATION

GATE 1

Gate 1	Key Questions & Decisions	Inputs	Outputs
	A1 Does the idea contribute to meeting our strategic and financial objectives?	B1 Summary narrative (max 1 page).	C1 Approved project definition.
	A2 Should we apply resources to develop it further (80/20)?	B2 Outline cost / benefit (max 1 page).	C2 Project leader is identified.
	A3 Is this scheme included in another work stream?	B3 Support of the key stakeholders	C3 Stakeholder matrix.

IDEAS VALIDATION

GATE 2

Gate 2	Key Questions & Decisions	Inputs	Outputs
	A4 Is the idea robust, risk assessed and achievable?	B4 Detailed cost/benefit case. To include (where applicable) rosters, costed time line, overheads, impact on other services, revenue generation and full risk assessment.	C4 Approval to proceed to implementation planning.
	A5 Does the idea still contribute to our strategic and financial objectives?		
	A6 Do we have, or can we get, the resources to deliver it?		

IMPLEMENTATION PLANNING

GATE 3

Gate 3	Key Questions & Decisions	Inputs	Outputs
	A7 Who does what by when and what will be delivered by when?	B5 Implementation plans (including relevant Gantt charts).	C5 Implementation starts.
	A8 Is there a clear critical path?		C6 Capture in financial plans.
	A9 Have stakeholders been identified and consultations planned?	B6 Appropriate approval papers.	C7 Measurement of plan success.
	A10 Can the project be implemented early or run longer to maximise saving.		C8 Potential extensions identified.

4.2 Service line reporting (SLR) and Patient Level Costing (PLCS)

SLR is a key element of our proposed financial strategy for the future. The system will be in full use by April 2010 for reporting on Quarter 1 in July 2010. Benefits of the system include:

- Empowering clinical and managerial leads to make the right business decisions on resource allocation based on the income levels and contribution generated by each service line;
- Supporting the continuing process; of engaging clinical staff in financial management and financial control.
- Supporting the Board in their strategic decision making process; and
- Supporting our Executive team in performance managing the organisation.

Our Trust Board has already agreed the principles which will provide the framework for the development of strategic business units to develop earned autonomy in the future. We plan for the majority of patient facing services to be part of a Strategic Business Unit within two years.

Our Trust Board recognises that the move to a SLM culture involves significant change at all levels of the organisation, and implementation will be on a staged basis.

Up to March 2010, the system is being rolled out with user testing and the development of modelling assumptions.

Our implementation has been worked through on a bottom up basis using Patient Level Costing techniques to ensure we can attribute all costs and income to individual patients.

Supporting the introduction of SLR is a small dedicated team within the Finance Department, accountable to the Director of Partnerships who is the executive lead. Our finance managers have been trained on the system and will be working with the SLR Project team in embedding this significant system change in 2010/11.

4.3 Investment and disposal strategy

During 2009/10 we completed the relocation of acute and planned inpatient facilities from Hemel Hempstead General Hospital to Watford General Hospital. This involved an investment of £6.8m in the facilities at Hemel Hempstead.

In 2010/11 we will be developing business cases to rationalise our estate across our three main sites.

We plan for our 2010/11 capital programme to be contained within the depreciation charge, currently estimated at £8.6m.

Current proposals for 2010/11 include:

- The replacement of our pathology computer system at a cost of £2.7m;
- Backlog maintenance of £3.7m; and
- Other schemes totalling £2.2m.

Our planned and forecast investment and disposal strategy is detailed in **table 12**.

Table 12: Investment and disposal strategy

Investment and disposal strategy					
£m	Plan	Forecast	Current plan		
	2009/10	2009/10	2010/11	2011/12	2012/13
Investment in fixed assets (non-maintenance)	2.6	1.4	3.7	3.8	2.5
Investment in fixed assets (maintenance)	5.9	5.2	3.3	4.4	5.2
Investment in other assets	9.9	9.0	1.6	0.5	0.9
Asset disposals	18.4	14.5	8.6	8.6	8.6

4.4 Summary of key assumptions

Our key 2010/11 financial assumptions are summarised below:

- Delivery of an £8.6m surplus;
- Delivery of £19.8m of savings;
- Liquidity maintained at a minimum level of 2 to enable a minimum FRR of 3;
- Capital expenditure maintained at or below the depreciation budget of £8.6m;
- Achievement of the CQUIN targets
- The impact of the tariff changes for 2010/11 is fairly neutral;
- Capacity is maintained at the level to meet demand; and
- Pay and non pay budgets are contained.

4.5 Efficiency Strategy and Cost Improvement Plans (CIPs)

Summary assessment on the delivery of our 2009/10 CIP including level of recurrent and non recurrent delivery

We forecast that we will deliver our 2009/10 £10.8m CIP target. Of this:

- £9.5m is forecast to be delivered recurrently; and
- £1.3m is forecast to be delivered non-recurrently.

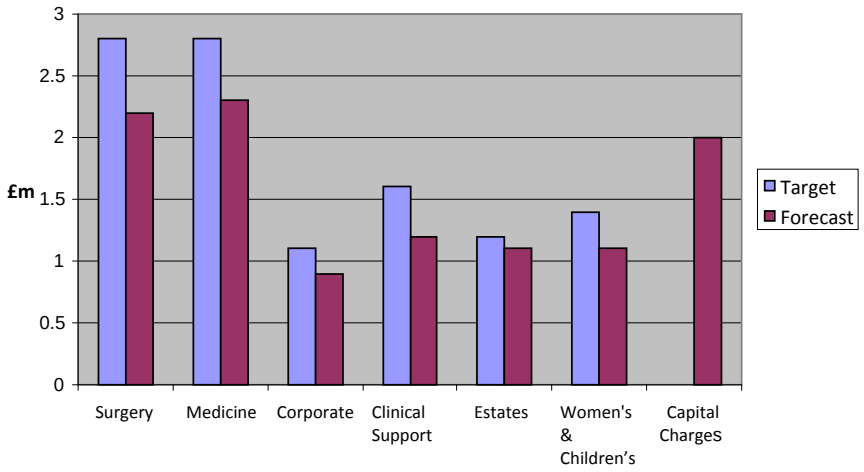
There was an element of slippage against the delivery of savings targeted at the start of the year. However, this has been offset by savings delivered through the reduction in dividends payable following the revaluation of our estate.

Table 13 summarises by category our 2009/10 savings programme, and the graph below summarises savings by division.

Table 13: 2009/10 savings programme

Type	Savings (£m)	Saving %
Procurement	0.3	3
Back Office	0.8	7
Pay	1.9	18
Clinical Supplies & Services	0.6	6
Utilities	0.3	3
Other	6.9	64
Total	**10.8**	**100**

Delivery of Savings Target by Division



Efficiency strategy for the next 2 years

Our planning for the development of our two year efficiency strategy is summarised in **Section 4.1.3**.

Our planned and forecasted cost improvement plan is summarised in **table 14**.
The impact of our projected CIPs on the workforce is estimated in **table 15**.

Table14: Cost improvement plans

Cost improvement plans (please reference section 5 QIPP below)					
£m	Plan	Forecast	Future plans		
	2009/10	2009/10	2010/11	2011/12	2012/13
Procurement	0.3	0.3	4.0	1.8	1.8
Back office efficiency	0.8	0.8	3.0	2.2	2.0
Pay	1.9	1.9	3.4	3.3	3.3
Drugs	0.0	0.0	0.8	0.7	0.9
Clinical supplies and services	0.6	0.6	1.7	1.2	1.4
Utilities	0.3	0.3	0.6	0.7	0.6
Other	6.9	6.9	6.3	4.9	3.8
Total	**10.8**	**10.8**	**19.8**	**14.8**	**13.8**

Table 15: Impact of CIPs (and QIPP plans) on the workforce

Impact of CIPs (and QIPP Plans) on the workforce – see section 5 below					
wte	**Plan**	**Forecast**	**Future plans**		
	2009/10	**2009/10**	**2010/11**	**2011/12**	**2012/13**
Clinicians	22.2	22.2	32	18	25
Nurses			34	41	43
Other Staff	15.2	15.2	24	48	27

5. Quality, Innovation, Productivity and Prevention (QIPP)

5.1 Link to main commissioner's strategy

Delivering Quality Healthcare in Hertfordshire (DQHH) remains at the heart of NHS Hertfordshire's refreshed strategy, with a key objective being to continue to move appropriate aspects of healthcare provision closer to home – away from acute hospitals to delivery in people's houses or in more local facilities.

It is recognised that the DQHH programme to date has not led to the desired shift of activity from acute to community provision, and this will be a priority in 2010/2011.

NHS Hertfordshire's intention is to reach DQHH target levels by 2012/13. The targets are referenced to top ten percent performance in England.

Our approach is to work in partnership with NHS Hertfordshire in taking forward the aspirations of DQHH, and delivering good quality clinical care in tandem with value for money. In achieving the proposed targets we fully subscribe to the principles of local change as detailed in the DoH's *Next Stage Review*.

5.2 Detailed plans

Our plans to support commissioners in the management of demand and decrease unnecessary interventions for patients

In January 2010, NHS Hertfordshire hosted a local health economy event to review and begin to develop our joint programme of work.

In 2010/11 we will be jointly working on a number of key initiatives to refine the patient pathway, with a particular focus on developing robust demand management processes for

- Dermatology;
- MSK;
- Gynaecology; and
- Cardiology.

Our plans to improve patient safety

We have been accepted as part of the sixth wave of the Institute for Innovation and Improvement Leading Improvement in Patient Safety (LIPS) programme.
The programme supports trusts in building capacity and capability within hospital teams to improve patient safety and embed patient safety in local service improvement.

Our plans to standardise the use and/or price of consumables including devices, drugs and non-medical consumables

As part of the Hertfordshire NHS Supply Management Confederation standardisation of products is reviewed by the West Hertfordshire Product Selection Group. In 2010/11 a number of products are scheduled to be reviewed, with a particular focus on theatres.

Our plans to integrate – vertically and horizontally

Vertical integration - If Hertfordshire Community Health Services do not achieve community foundation trust status, we would anticipate that in line with national guidance we would submit a bid to take over the appropriate elements of service provision.

Our plans to decrease our capital/estate costs

In 2010/11 we will be developing business cases to rationalise our estate across our three main sites.

Our planned changes to workforce spend in 2010/11

Currently we project that our overall workforce costs will reduce by approximately seven percent Our workforce plans are detailed in **Section 9**.

The NHS Institute's "Productive Series" we are implementing and the benefits we will realise in 2010/11

Throughout 2010/11 we will be rolling out the *Releasing Time to Care - Productive Ward project* across all our twenty four wards. We will measure our success in terms of delivering the following benefits:

- Improved patient observations, recognising the deteriorating patient;
- Increased time spent on direct patient care;
- Increased patient satisfaction;
- Reduction in slips trips and falls;
- Reduction in health care acquired infection;
- Reduction in acquired pressure ulcers;
- Reduction in length of stay;
- Reduction in unplanned absence rate;
- Increased staff retention rate and staff satisfaction; and
- Evidence of sustained service improvement.

In 2010/11 we will be establishing our *Productive Operating Theatre* project at St Albans hospitals. Test sites have demonstrated that improved quality and significant productivity gains are simultaneously deliverable with the implementation of the project. We will measure our success in terms of delivering the following benefits:

- Increased safety and reliability of care;
- Improved team performance and staff wellbeing;
- Added value and improved efficiency; and
- Evidence of sustained service improvement

We are one of the national innovation sites for the *Enhanced Recovery Programme* leading a joint approach across the local health economy. We are implementing the programme for the four main pilot elective care pathways –

- Colorectal;
- Gynaecology;
- Musculoskeletal; and
- Urology.

We will measure our success in terms of delivering the following benefits:

- Improved patient experience;
- Improved clinical outcomes;
- Reduced lengths of stay; and
- Improved cost efficiency.

Our plans for implementing the High Impact Actions for Nursing and Midwifery

For each of the eight high impact actions:

- Your Skin Matters;
- Staying Safe – Preventing Falls;
- Keeping Nourished – Getting Better;
- Promoting Normal Birth;
- Important Choices – Where to Die When the Time Comes;
- Fit and Well to Care;
- Ready to Go – No Delays;
- Protection from Infection;

Lead nurses have been identified for each of the actions and have reviewed our current position and detailed our planned future actions.

Our plans for improving management information including comparative performance management information

In 2010/11 we will continue to work with:

- CHKS in continually benchmarking our service delivery;

In 2010/11 we are planning to establish management information systems for:

- Upgraded Theatreman;
- Service Line Reporting; and
- Bed management.

We are also in discussion with:

- The DoH's Health Informatics Benchmarking Club on becoming a member;
- Establishing us as a pilot site for Map of Medicine initially for the enhanced recovery programme, and then to review the establishment of a joint care pathway programme with primary care;
- Neighbouring providers in the development of our 2010/11 Quality Account and reviewing the establishment of a peer review process in 2010/11.

These projects are part of the ongoing implementation of our five-year IM&T Strategy. Other wider key IM&T initiatives planned to be taken forward in 2010/11 are:

- Improvements to the technical infrastructure incorporating:
  - o Implementing a new network for St Albans Hospital;
  - o Deployment of virtualisation technology;
  - o Consolidating our IT infrastructure on fewer physical locations; and
  - o Upgrade of all desktop computers to Windows XP and Office 2007.

- Developing existing clinical and business systems to support improved quality and productivity:
  - o Single sign on;
  - o Patient context management;
  - o Image sharing;
  - o Electronic discharges and email transfer to GP'S;
  - o Order communications and results reporting;
  - o PACS version 2;
  - o Chemotherapy e-prescribing; and
  - o Pathology system replacement.

Our overall aim is to continue the delivery of the *Next Stage Review* vision of the information technology 'Clinical 5', which encompasses the key elements of essential functionality, required to support a clinician's 'day to day' business. These are:

- A patient administration system with integration to other systems and sophisticated reporting;
- Order communications and diagnostic reporting;
- Letters with coding;
- Scheduling for beds, tests, and theatres; and
- E-prescribing 'To Take Out' (TTO) medicines.

Our plans for improving performance in services or outcomes for which we are an outlier

The latest NHS indicators scorecard is for Quarter 2 2009/10, which is summarised below.

Your opportunity to increase productivity:	National position (out of 167)	Indicator score	Change from last period	Productivity opportunity
2 Clinical productivity: 2.1 Reducing length of stay — Potential bed days saved	12	11.7%	▲ -0.4%	£6,008,700
2.2 Increasing day case surgery rates — Day case rates for 25 procedures	128	71.3%	▲ +0.8%	£154,893
2.3a Reducing pre-operative Non Elective bed days	59	2.0	▼ +0.1%	£5,058,476
2.3b Reducing pre-operative Elective bed days	50	0.1	0.0%	£216,933
2.4 Reducing DNA — Reducing DNA	80	8.5%	▼ +0.4%	£967,211
2.5 New to Follow Up — New to follow up	86	2.2	0.0%	£1,626,974

The main areas where our relative ranking has highlighted that there continues to be the opportunity for us to further improve our clinical productivity are:

- Increasing day case surgery rates;
- Reducing pre-operative non elective bed days;
- Reducing pre-operative elective bed days;
- Reducing Do Not Attends (DNA's); and
- Reducing new to follow up's.

Although we are comparatively one of the best performing trusts in England for length of stay, the financial productivity opportunity for continuing to increase our performance is still significant, and therefore continuing to reduce our lengths of stay will remain a performance priority.

Our 2010/11 plans to improve productivity are summarised below.

- We have an established task group leading on reducing LOS. In addition to implementing our programme of Institute productivity projects we are planning to appoint a joint capacity planning manager with HCHS to improve our discharge management processes;
- We will continue to increase our day case surgery rates by implementing the British Association of Day Surgery (BADS) best practice guidance through peer review and learning from other acute providers who are delivering leading day case surgery performance. As part of this process we will continue to implement new surgical procedures and ways of working, with associated investment in new equipment;

- We will continue to reduce our pre-operative non elective bed days by increasing theatre efficiency, with an increased number of timetabled non elective sessions and embedded consultant led non elective reviews;
- In response to the findings of the national outpatient survey we have established an outpatients task group with one of the key workstreams being the reduction in outpatient DNA's. For inpatient DNA's, we have a nationally leading preoperative assessment process and our admissions office will continue to establish checking systems prior to admission; and
- As part of our 2010/11 service level agreement with NHS Hertfordshire, targets will be set for new to follow up's. We will continue to modernise the way we work with Trust wide improvement programmes such as the continued establishment of one stop shops, complimented by specialty specific performance management processes.

Our plans to collaborate with other organisations/partners in delivering productivity improvements

- Ongoing implementation of DQHH in partnership with other Hertfordshire healthcare agencies;
- Ongoing implementation of the Enhanced Recovery Programme. Our application was a joint local health economy application with NHS EoE and West Hertfordshire NHS;
- Ongoing implementation of our Medihome initiative in delivering reduced hospital lengths of stay; and
- As part of the Cancer Network ongoing development of Watford Hospital as a gynaecological, and upper GI cancer centre, Lister Hospital as a urology cancer centre and Luton Hospital as a head and neck cancer centre;
- We will continue to work with the cardiac network in ensuring our skills and facilities are optimally utilised;
- We will continue to work with neighbouring trusts on a networked specialty basis in order to improve productivity and ensure safe, sustainable secondary care delivery. On a tertiary basis we will continue to work with UCL Partners and Imperial Academic Health Science Centres and ophthalmic, cardiac, orthopaedic tertiary specialist centres in continuing to deliver productivity improvements for the tertiary patient pathway.

5.3 Governance and assurance arrangements

Our governance arrangements for ensuring delivery of QIPP

- The executive lead responsible for delivering our QIPP programme is Russell Harrison, Director of Delivery;
- The process for validating and ratifying innovative ideas is our Gateway process;
- Our 2010/11 divisional plans will detail the NHS Operating Framework and Commissioning.

Integral to the development of our QIPP programme in 2010/11 we will:

- Nominating a non executive lead; and
- Charging one of our Board sub committees with overseeing the delivery of our QIPP programme.

5. Quality, Innovation, Productivity and Prevention (QIPP)

5.4 Best practice

At the launch of the NHS EoE QIPP programme in September 2009, NHS Hertfordshire highlighted ten ideas, three accredited to our Trust, which are detailed below.

NHS Hertfordshire: Idea 1

Headline/Title: Biomass boiler scheme proposal

Short description: On our main site at Watford Hospital we are planning to replace our current two boilers which run on heavy fuel with two biomass boilers. This will ensure we meet our energy reduction targets and also reduce our costs.

QIPP elements*	
Estimated quality impact**	Reduction in carbon footprint. Good corporate citizenship. Reduced pollution.
Estimated productivity impact	Reduction in CO2 emissions of 6,865 tonnes. Improved energy efficiency by 10%.
Is it linked to the prevention agenda (if at all)?	Carbon reduction strategy.
What innovation is required (if any)?	Technology already provided by the private sector - the innovation
Are there additional effects on the system?	Outsourcing.

Making it happen	
What are the main barriers for implementation?	Procurement process for this size of investment within timescales.
What needs to be in place in order to implement?	Joint working between Estates and Procurement teams to develop and deliver a robust project timetable.
What clinical engagement will be required?	N/A.

* QIPP = Quality, innovation, productivity, and prev
** Initiatives should be quality-neutral or have a po

NHS Hertfordshire: Idea 3

Headline/Title: The development of an Acute Admissions Unit (AAU) at Watford Hospital.

Short description: In November 2003, we put in place a detailed plan and process to effect the move of services between our three Hospital sites - Watford, Hemel Hempstead, and St Albans. This programme culminated in the opening in March 2009 of an AAU at Watford.

QIPP elements*	
Estimated quality impact**	Reduced LOS. Reduced readmission rates. Reduced SMR. Reduction in complaints.
Estimated productivity impact	Reduced number of beds. Improved working on our 'hot site'. Staff turnover reduced. Increased emergency activity.
Is it linked to the prevention agenda (if at all)?	New model of emergency care. Consultant led service. Better access to diagnostics.
What innovation is required (if any)?	Improved quality of care resulting in better quality outcomes. Improved productivity resulting in better utilisation of our 'hot' site.
Are there additional effects on the system?	

Making it happen	
What are the main barriers for implementation?	Resistance to new ways of working. Ensuring appropriate time and time out of frontline staff to robustly implement.
What needs to be in place in order to implement?	Clinical leadership. Robust project governance. Appropriately resourced project team.
What clinical engagement will be required?	Each stage of the service change programme required clinical ownership and leadership.
Is anyone doing it already?	Clinical model is operated on a smaller scale by a number of other acute providers - however our 120 bedded AAU is the largest in the country.

* QIPP = Quality, innovation, productivity, and prevention
** Initiatives should be quality-neutral or have a positive impact on quality

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NHS Hertfordshire: Idea 10

Headline/Title: Colorectal Enhanced Recovery Programme.

Short description: In January 2009, we established a pilot project referencing the principles of the enhanced recovery programme in order to develop and embed a new patient pathway. In August 2009, we formally applied to join the national Enhanced Recovery Programme.

QIPP elements*	
Estimated quality impact**	Optimum condition for treatment. Reduced stay in hospital. Reduced risk of HCAI.
Estimated productivity impact	Reduced LOS from over 12 days to 6 days. Admission on day of surgery from 11% to 90%.
Is it linked to the prevention agenda (if at all)?	
What innovation is required (if any)?	Remodelled patient pathway. Improved model of care. Development of robust information systems and processes.
Are there additional effects on the system?	Improved quality of care resulting in better quality outcomes. Improved productivity resulting in better utilisation of our 'hot' site.

Making it happen	
What are the main barriers for implementation?	Ensuring appropriate time, project support, and sign up to ensure successful project establishment, initial and ongoing delivery.
What needs to be in place in order to implement?	Dedicated project support. Clinical and corporate sign up.
What clinical engagement will be required?	Sign up by clinical team - doctors, nurses, physio's and dieticians for change. Ongoing ownership by the clinical team in embedding new ways of working.
Is anyone doing it already?	Other pilot sites. St Marks - who we use as a reference site.

* QIPP = Quality, innovation, productivity, and prevention
** Initiatives should be quality-neutral or have a positive impact on quality

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Our key risks have been referenced to our Assurance Framework (January 2010).

As part of the development of our Assurance Framework, we will be undertaking a risk management workshop in Q1 2010/11 to review our strategic and key operational risks, and update our scoring.

6.1 Financial risk rating

Financial Risk Ratings - Monitor

Criteria	Metric	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Underlying performance	EBITDA margin %	3	4	3	3	3	3
Achievement of plan	EBITDA achieved %	3	3	5	5	5	5
Financial efficiency	Return on assets %	5	5	5	5	5	5
	I&E surplus margin %	4	5	4	3	3	5
Liquidity	Liquid ratio days	1	2	2	2	2	2
Overall rating	Overall rating	2	3	3	3	3	3

Our 2010/11 planned financial position is to achieve a Monitor financial risk rating (FRR) score of no less than 3. Our projected risk rating up to 2014/15 is highlighted above.

The forecast 2009/10 rating of "2" is due to our prior year liquidity position. Our forecast plan for 2010/11 to 2014/15 is that liquidity will improve going forward based on:

- a £7m working capital loan to improve short-term liquidity; and
- Strengthening the Balance Sheet through generating financial surpluses.

For the financial year 2010/11 we are planning to achieve an EBITDA margin of 9%, and an income and expenditure margin in excess of 2.5%. This will give us an overall rating of "3" from 2010/11 onwards, which improves to "4" from 2013/14.

The sale of part of the Hemel site could significantly strengthen our liquidity position, although this has not currently been included within our long term planning.

In achieving our forecast position our key 2010/11 financial risks are:

Risk 1 – As at 5th March 2010, we have not agreed our SLA with our host commissioner.
We are actively working with NHS Hertfordshire commissioning leads to reach agreement on the outstanding issues. However, if agreement is not reached, one of the options for mitigation which we are prepared for is pendulum arbitration hosted by NHS EoE.

Risk 2 – Challenging demands on the management of finance means we may not achieve the £8.6m planned surplus.
Plans to ensure we achieve, backed by rigorous monthly performance management are in place to ensure achievement and early notification of variances.

Risk 3 – We do not deliver the required cost improvement programmes (CIP)
The financial impact is we need to deliver an approximate £19.8m CIP (projection as at 16h March 2010). This is a very significant undertaking, accounting for 8% per cent of our operating expenses.
In implementing our 2010/11 CIP programme, 'the Big Ask', we have established a programme management office which oversees a robust performance monitoring framework, with clear accountability for delivery of CIPs and escalation plans for slippage.

Risk 4 – We do not deliver the agreed CQUIN targets and we are financially penalised as a result.
Initial review of the proposed CQUIN schedule to be incorporated in the contract, has highlighted significant financial risks. The 2010/11 potential financial impact is a financial penalty of up to 1.5% of contracted income (subject to the contract being agreed).
We currently review on a monthly basis with commissioners delivery of the current schedule of CQUIN targets, and this arrangement will continue in 2010/11. Internal monitoring of the targets will be incorporated into our performance management systems and our 2010/11 Quality Account.

Risk 5 – Implementation of the DQHH activity projections results in a shift of appropriate activity from a secondary care to a community care setting. In the proposed timeframes the risk is that our fixed capacity does not flex accordingly, resulting in us having a relatively high cost base referenced to the activity we undertake.
For 2010/11 we have undertaken capacity planning workshops with clinical leads and managers for our three main clinical divisions, and we will continue to update our capacity modelling informed by the resolution of the 2010/11 service level agreement.

Risk 6 – Failure to deliver an adequate Monitor risk rating level relating to liquidity.
We requested an additional £7m working capital loan in 2009/10 in order to ensure that we end 2009/10 with a minimum liquidity rating of 2, and that this is the minimum level going forward. The financial plans for 2010/11 and onward included within the LTFM and IBP show a gradual improvement in liquidity over the coming years.

Monitor has recently consulted on its 2010/11 Compliance Framework with one of the proposals to add an additional set of indicators, which, whilst not forming part of the calculation of a trust's FRR, will provide a good indication for 'earlier' meetings between a foundation trust and Monitor. **Table 16,** on the next page list Monitor's proposed set of new indicators.

Of the proposed indicators our 2010/11 liquidity position would be the area of most concern. Our Trust Board already reviews our position on a monthly basis.

Table 16: Monitor's proposed set of new indicators

Proposed indicator	Potential financial weakness
Unplanned decrease in EBITDA margin in two consecutive quarters	Deteriorating trend in operating performance and cashflow generation
Quarterly self-certification by trust that FRR may be less than 3 in the next 12 months	Identified risk of potential financial breach within the next year
FRR 2 for any one quarter	In year deterioration in financial performance
Working capital facility (WCF) agreement includes default clause. This will require all trusts to review their WCF agreements.	Risk that WCF, whilst included in calculation of liquidity days for the purpose of FRR, may not be available if and when required (eg: FRR 1 or 2).
Debtors more than 90 days past due account for more than 5% of total debtor balances	Potential for payment / debtor collection concerns
Creditors more than 90 days past due account for more than 5% of total creditor balances	Potential for build up in creditors, resulting in future liquidity concerns
Capital expenditure is less than 75% of plan for the year to date	Capital expenditure plans are delayed to conserve cash
Quarter end cash balance less than 10 days of operating expenses **or** less than £4 million.	Potential liquidity concerns and ability to meet liabilities as they fall due
Interim Finance Director in place over more than one quarter end	Absence of permanent / substantive appointment to key position
Two or more changes in Finance Director in a twelve month period	Multiple changes in a short period of lead financial officer

6.2 Governance risk rating

Risk 1: Non compliance with 2010/11 operational and financial requirements issued by the Department of Health and NHS East of England. Referenced to the key governance risk metrics our main performance risk areas are Accident and Emergency (A&E), 18 weeks by specialty, MRSA screening, and cancer targets.

Sustained delivery of the four hour A&E waiting target

In 2009/10 (as at January 2010) our performance adversely deviated from plan for five months.

In 2010/2011 we will work with the Emergency Care Intensive Support Team on reviewing and improving the whole of the emergency care

pathway, from admission to discharge.

In addition to improving our emergency model of care we continue to improve our model of planned care with the ongoing development of St Albans Hospital as our elective centre. This will result in planned operations that are currently undertaken at Watford Hospital being undertaken at St Albans Hospital, releasing bed capacity at Watford Hospital.

We expect through the implementation of these two programmes, and the associated implementation of our Institute for Innovation and Productivity projects we will sustain above 98% performance in 2010/11.

Sustained delivery of the 18 weeks waiting time for admitted and non admitted patients across the portfolio of our specialties

In 2010/11 performance monitoring will be based on both aggregate and by specialty for admitted and non admitted patients.

As at January 2010, our 2009/10 performance has exceeded the national performance thresholds on an aggregate basis. However, in certain specialties our performance needs to achieve consistent levels of performance to ensure we exceed the national performance thresholds on a specialty basis.

Each specialty's performance will continue to be managed on a weekly basis, with specialty leads supported by a dedicated central 18 weeks support team.

Achieving the MRSA screening

Further to clarification of the target by NHS EoE in September 2009, and taking into account the exceptions, we have consistently not achieved the MRSA elective screening target for the remainder of 2009/10, and we will need to improve our performance in 2010/11.

Clinical governance leads are reviewing our processes with divisional leads in order to improve our performance and achieve 100% compliance. As part of this process we will be developing our systems and processes in preparation for implementing MRSA emergency screening by Q4 2010/11.

Sustained delivery of the cancer targets - in 2009/10 (as at January 2010) for urgent GP Cancer referrals maximum two week wait we deviated from plan for four months. In 2010/11 our cancer team will continue to work with the Booking Office and the Outpatients Project Steering Group in ensuring referrals are booked within fourteen days.

Risk 2: Delivering the CQUIN targets to be detailed in our 2010/11 Service Level Agreement. The majority of CQUIN targets are subject to local agreement, with DoH guidance stipulating for only two indicators to be included Venous Thrombo-embolism (VTE) risk assessments and year on year improvements in the patient survey

Venous Thrombo-embolism (VTE) risk assessment - Review of our current VTE risk assessment processes has highlighted further scope for improvement.

We have identified as a priority for all inpatient and day case patients to receive evidenced based VTE risk assessment on admission and if their clinical status changes for the appropriate thromboprophylaxis to be administered.

Year on year improvements in the patient survey

Review of our 2009 outpatient survey findings has highlighted a number of areas of concern where we need to improve our performance. We have established a dedicated project group led by our Medical Director to lead on improving the outpatients experience.

Risk 3: Compliance with the Hygiene Code

We are fully compliant with the Hygiene Code with the exception of duty 4. In 2010/11 we will continue to address endoscope decontamination compliance at Watford Hospital, and are aiming for compliance by the end of Q2 2010/11.

In relation to TSSU/CSSD services, as part of the North West London Collaboration for decontamination services we aim to become decontamination compliant by the end of Q3 2010/11.

Risk 4: We have significant residual estates issues which may adversely affect service delivery.

Currently our backlog maintenance is in excess of £66m, which if not addressed could significantly impact our service delivery. Our 2010/11 mitigation is a planned investment programme of £3.7m to address the high risk items identified on our backlog maintenance register.

Risk 5: Implementation of national policy and guidance on planning for an incident; and maintaining an up to date business continuity plan

On an annual basis we undertake a planned review of our business continuity plans, with reference to the latest national guidance. This process is monitored by our Emergency Planning Group. This process will result in an updated business continuity plan, which will be presented to our Trust Board for approval in Q1 2010/11.

Our plans are complimented by the experience of our senior management team, who have first hand experience of competently managing a number of significant incidents.

6.3 Risk to services provided

As detailed in **Section 6.1**, as at 5th March 2010, we have not agreed our SLA with NHS Hertfordshire. We are actively working with commissioning leads to reach agreement on the outstanding issues.
However, if agreement is not reached, one of the options for mitigation which we are prepared for is pendulum arbitration by NHS EoE.

For our March 2010 version of the 2010/11 Annual Plan, we have not signed off the Board statements concerning:

- Contracts will be signed off with commissioners with reference to the latest 2009/10 sector timetable; and
- The activity assumptions underpinning the annual plan are consistent with the Trust's contracts.

6.4 Quality and safety risk

Risk 1: A poor patient experience
The results of the 2009 national outpatient survey are detailed in **Section 7.4**. In mitigation we have established a dedicated outpatients improvement project, with a multidisciplinary project group chaired by the Medical Director. The project group will oversee the implementation of a detailed action plan, which will ensure we maintain what we currently do well, and address those areas that have been identified as requiring improvement.

Risk 2: Approach to reducing healthcare acquired infections to levels not exceeding the monthly trajectory agreed with commissioners
In 2010/11 we will continue our successful approach of our infection control team coordinating a comprehensive programme supported by each of the four clinical divisions supporting infection control projects. Details of our programme are provided on the internet at: http://www.westhertshospitals.nhs.uk/infection_control/

Risk 3: Compliance with best practice for corporate and clinical governance, including appropriate board roles, structure and composition
Key areas of mitigation to be implemented in 2010/11 include:

- We will continue to improve our structures, with particular focus on the development of our Integrated Risk and Governance Committee and service line management incorporating quality metrics in our main performance processes.
- In February 2010, we achieved Clinical Negligence Scheme for Trusts (CNST) level 2 for maternity services and level 1 for acute services. We plan to be assessed for level 2 acute services accreditation in Q2 2010/11.

- We will continue to ensure all staff have an appropriate understanding of clinical governance through induction and ongoing training.
- Over the last two years we have expanded our service portfolio with the development of community based urgent care services, in partnership with Hertfordshire Urgent Care. In ensuring robust corporate and clinical governance, in 2010/11 we will be formalising service level agreements for the joint provision of services.

Risk 4: **Care Quality Commission (CQC) registration and compliance**

In January 2010, we submitted our registration application to the CQC, and stated non compliance with the related standards for complaints and medicines management. Both these standards were declared non compliant in our in interim declaration on core standards submitted in December 2009. We stated in our interim declaration we will be compliant by the 31st March 2010. As at the 5th March 2010, we have no indication whether there will be conditions imposed on our registration.

As requested by NHS EoE we can confirm:

- We have well established relationships and cooperate on an ongoing basis with bodies which have a remit in relation to healthcare provision;
- Our Clinical Governance Committee is responsible for overseeing that the recommendations of any reports or investigations into lapses in care quality or safety would be actioned.

6.5 Other risks

We are in the process of reviewing the development options for the proposed redevelopment of the Watford Hospital site to ensure the provision of a long term viable and sustainable service provision. One of the main risks is the "affordability" of the scheme.

As part of this process we will be reviewing and formalising our long term activity and financial projections referenced to NHS Hertfordshire's commissioning strategy, sector and national strategies.

We have established robust project governance arrangements and are working in close consultation with stakeholders in formalising the most appropriate way to proceed.

7.1 CQC registration

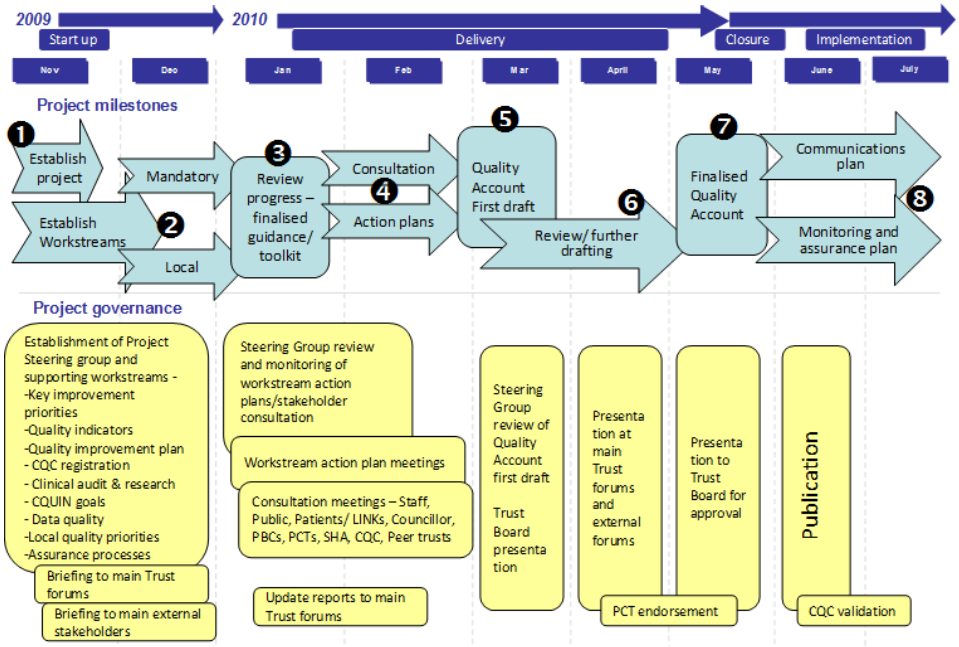
In January 2010, we submitted our registration application to the CQC. As at the 5th March 2010, we have no indication whether there will be conditions imposed on our registration.

7.2 Our quality account

Our 2009/10 Quality Account was approved by our Trust Board in July 2009, and highlighted three priorities:

- **Priority 1:** To reduce further the numbers of patients who contract a MRSA bacteraemia or CDiff in line with the aspirational targets set by NHS EoE;
- **Priority 2:** To continue to deliver services with a lower mortality level than would be expected for the patients we see and conditions we treat (a standardised mortality rate below 100 for all clinical divisions).
- **Priority 3:** increase the percentage of people who, through the national in-patient survey and other in house surveys, indicate that they have had a positive experience in respect of communication and privacy and dignity aspects of their care.

In November 2009 we established a Quality Accounts Steering Group constituted of the key directors to lead the development of our 2010/11 Quality Account.
Our project milestones are highlighted below.



As at March 2010, we have drafted our 2010/11 Quality Account headlines, building on our 2009/10 report and updated in line with the DoH guidance *Quality Accounts toolkit,* published in February 2010. We are currently consulting with internal and external stakeholders. Integral to our 2010/2011 Quality Account will be the development of a quality strategy and quality improvement plan which will detail our approach to embedding in everything we do the three key aspects of quality outlined in the DoH's *High Quality Care for All* , namely patient safety, patient experience and effectiveness of care.

As requested by NHS EoE we can confirm that inline with the DoH guidance *Quality Accounts toolkit,* continually improving our data quality is an integral workstream in the development of our Quality Account.

The Audit Commission in their 2009 Payment by Results Data Assurance Audit reported that our performance was above average.

The net impact of the audit was that we had undercharged commissioners by £176, on an audit sample of £342,000.

The Audit Commission reported that we had well structured and legible case notes and that coding was undertaken using the full patient case note, which supports accurate coding by allowing access to all relevant information.

In 2010/11 our clinical coding department will continue to improve our systems and processes.

7.3 Hospital Standardised Mortality Rates (HSMR)

Our HSMR data for 2008/09 and 2009/10 quarters one to three is provided in **table 17** (Quarter 4 data not available as at February 2010)

In instances where a specialty had mortality index higher than 100 divisional leads with service leads reviewed the individual circumstances. In all instances the conclusions were reviewed by the Medical Director, and that there were no underlying issues.

It is proposed HSMR will continue to be a key priority for our 2010/11 Quality Account.

Table 17: Hospital Standardised Mortality Ratios 2008/09 to 2009/10

2008/09				2009/10			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
83	85	71	75	68	56	58	n/a

Information on specialties with a score over 100

- 2008/09 Quarter 4 : no specialties over 100
- 2009/10 Quarter 1: haematology index 137
- 2009/10 Quarter 2: rheumatology index 141, vascular surgery index 115
- 2009/10 Quarter 3: haematology index 125, rheumatology index 163

7.4 Patient experience

The 2009 national survey focused on outpatients. **Table 18** summarises our relative scores compared against the national average.

As a result we have set up a dedicated outpatients improvement project. The project has identified a number of actions to be implemented in 2010/11 in addressing the key issues highlighted by the survey:

- Before the Appointment: waiting times, choice, patient information, standards of service;
- Arrival at our hospitals: parking, signage, standards of service;
- Waiting to be seen: waiting times, and communication, waiting facilities and amenities;
- Appointment: clear and consistent communication, privacy, ensuring we have the time to listen and care;
- After the appointment: clear understanding of medicine and usage, communication of what happens next; and
- Support systems: note availability.

As requested by NHS EoE we can confirm that we use the net promoter question in our patient surveys. Further details are available on the NHS Choices website: http://www.nhs.uk/ServiceDirectories/pages/Trust.aspx?id=RWG

Table 18: 2009 outpatient survey results

Domain	Score	How we compare against other trusts
Questions about getting an appointment	7.1	'About the same'
Questions about waiting in the outpatients department	4	**'Worse'**
Questions about outpatient environment and facilities	7.6	**'Worse'**
Questions about seeing a doctor during the appointment	8.4	**'Worse'**
Questions about seeing professionals other than a doctor	8.3	**'About the same'**
Questions about what happened during patients appointments at the OPD	8.3	**'About the same'**
Questions about tests and treatments for patients who received tests and treatments during their appointment	8	**'About the same'**
Questions about medications prescribed during the appointment	6.9	**'Worse'**
Questions about information given by staff	4.1	**'Worse'**
Questions about overall views and experiences	8	**'About the same'**

Survey results are split into domains and results given out of 10

8. Research and innovation

8.1 Clinical research

Our researchers currently participate in forty portfolio and three commercial research studies as well as a number of studies outside these two categories – for example, student research and pilot studies.
Patient recruitment into the United Kingdom Clinical Research Network (UKCRN) portfolio studies has risen dramatically over recent years as summarised below.

- 2007/08: 299 patients
- 2008/09: 371 patients
- 2009/10: projected target 445

The national ambition is to double the number of patients taking part in clinical trials and other well-designed research studies within five years and we are well on target to achieve this. For 2010/11 onwards, the support funding we receive for research will be directly related to the patient recruitment figures.

In 2010/11 we will update our Research Strategy, which will:

- Identify our research strengths, potential areas for growth and make proposals on where future investment should be targeted;
- State which type of research organisation (user, collaborator or lead) we aspire to be;
- Outline how we aim to increase income through major increases in patient recruitment into trials; and
- Outline how we will ensure that the results of research are systematically fed into local practice in continually improving quality

8.2. CQUIN framework

Our forecast position is that £1m of our 2009/10 income is conditional upon achieving quality improvement and innovation goals.
Our estimated 2010/11 position is that £1.5m will be received, conditional upon achieving quality improvement and innovation goals.
Our 2010/11 goals are:

- Reducing avoidable death, disability and chronic ill health from venous-thromboembolism (VTE);
- Improving our responsiveness to the personal needs of patients;
- Improving our discharge processes;
- Improving our rates of day surgery;
- Improving our maternity services;
- Improving our stroke service;
- Improving end of life care;
- Continuing to maintain and improve our low mortality rates;
- Improving our smoking cessation processes;
- Usage of the dementia toolkit; and
- Ongoing development of the chlamydia screening programme

For each goal there will be agreed thresholds of performance with our commissioners which will be monitored monthly as part of the service level agreement review process. The goals and associated targets are also by statute to be included in our 2010/11 Quality Account.

9. Workforce development

9.1 Valuing people

As detailed in **Section 3**, our workforce objectives for 2010/11 are to achieve by March 2011:

- 80% of all staff to have appraisals and attend mandatory training;
- Year on year improvement in the annual national staff satisfaction survey;
- Continue to develop new ways of working with a particular focus on the development of assistant practitioners and review the overall workforce profile in theatres, and emergency and maternity care;
- Deliver an improvement in staff productivity with a particular focus on medical staffing costs;
- Reduce agency spend to 3% of paybill;
- Reduce overall temporary staffing spend to 6% of paybill;
- Reduce long term sickness absence to 2.1%;
- Reduce short term sickness absence to 1.9%;
- Continue to ensure European Working Time Directive (EWTD), New Deal compliance, and realise the benefits of Hospital at Night;
- To agree and launch a Staff Health and Well Being plan; and
- To design a talent management process for medical leaders and Bands 8 and above by the end of September 2010.

9.1.1 Equality and diversity

Our philosophy is that we value all people and provide equality and opportunity for all employees and prospective employees. We recognise that only by using the skills of the whole workforce, developing the skills of all staff and recruiting from all parts of the community, thereby ensuring our workforce reflects the community we serve, will we meet our objectives.

As request by NHS EoE, **tables 19, 20, 21, and 22** breakdown our staff and proposed membership in terms of gender, ethnicity and age, as at February 2010.

Table 19: Equality and diversity breakdown of staff

Equality and diversity				
	Staff 2008/09	%	Staff 2009/10	%
Age				
0-16	0	0%	0	0%
17-21	42.1	1.3%	62.6	1.9%
22+	3136.8	98.7%	3305.8	98.1%
Ethnicity				
White	1985.7	67.6%	2131.7	68.1%
Mixed	49.4	1.7%	54.7	1.75%
Asian or Asian British	521.0	17.5%	548.9	17.5%
Black or Black British	231.7	7.9%	246.6	7.8%
Other	147.5	5%	149.7	4.8%
Gender				
Male	718.1	22.6%	757.2	22.5%
Female	2460.7	77.4%	2611.3	77.5%
Recorded disability	10	0.3%	17	0.5%

Table 20: Gender breakdown of proposed foundation trust membership

	Eligible Population	% Eligible Population	Voting Public Members	% Voting Public Members	Staff	% Staff	Total	% Total
Male	929490	48.13	1742	32.23	747	20.61	2489	26.43
Female	1001790	51.87	3597	66.55	2878	79.39	6475	68.77
Not specified	-	-	66	1.22			452	4.80
Total	**1931280**	**100.00**	**5405**	**100.00**	**3625**	**100**	**9416**	**100.00**

Table 21: Age breakdown of proposed foundation trust membership

	Out of Catchment	Public	Staff	Total
Total Up to 14	0	0	0	0
Total 15-24	160	766	2	928
Total 25+	108	3596	3	3707
Total All	**268**	**4362**	**5**	**4635**

Table 22: Ethnicity breakdown of proposed foundation trust membership

	Out of Catch ment	Public	% Public	Staff	% Staff	Total	% Total
Asian or Asian British	47	326	6.03	549	14.73	922	9.79
Black or Black British	37	200	3.70	245	6.58	482	5.12
Chinese or Other Ethnic Group	3	37	0.68	161	4.32	201	2.13
Mixed	13	109	2.02	47	1.26	169	1.79
Not specified	21	1036	19.17	275	7.38	1332	14.15
White: British/ Irish/ Other	164	3697	68.40	2449	65.73	6310	67.01
			100		100		100
Membership Total	285	5405		3726		9416	

9.1.2 Staff survey

The national staff survey results will be published towards the end of March 2010, and we will update our 2010/11 Annual Plan to incorporate the key results.
The national results will compliment our established in house staff engagement programme. We use the outcomes from both staff and patient surveys to inform our priority setting and to continually learn as an organisation. For example, further to the results of the 2008/09 national survey we worked with the black and minority ethnic (BME) network and St Albans staff group to address specific issues respectively.

This approach of inclusiveness will continue in 2010/11, highlighted by 'The Big Ask', integral to which is a comprehensive stakeholder engagement process. Staff engagement so far has resulted in over two hundred proposed projects.

9.2 Staff sickness

In 2010/11 we aim to achieve a reduction in long term sickness and short tem sickness absence to 2.1% and 2.9% respectively.

We will achieve this through an approach of workforce corporate leads working as key members of each of our clinical divisional teams, with robust information systems and processes to support addressing the key risk areas – musculoskeletal disorders (MSD) and stress.

9.3 Workforce development strategy

The focus of our strategy in 2010/11 will be to consolidate the service moves we successfully achieved in March 2009, and ensure that our staff are well supported and developed.
Implementation will be overseen by the establishment of a Workforce Strategy and Development Forum.

Key areas will be:
- Midwifery;
- AAU and the wider emergency care pathway;
- Theatres; and
- Job planning

Midwifery
In 2010/11 we will build on the excellent progress made in 2009/10 in improving our recruitment and retention, and to consequently reduce our reliance on agency staff. As part of our programme we will review the further development of assistant and advance practitioners in midwifery.

AAU and the acute care pathway
In 2010/11 in embedding our model of acute care we will review the staffing profile and ensure we recruit the right staff, both from a skills and a behaviours point of view, and in turn that we support and enable them to provide an excellent service. Again the review of the use of assistant practitioners and advance practitioners will be part of this programme.
A redefinition of the recruitment pathway for HCAs is planned for 2010/11.

Theatres
In 2010/11 we will address the current recruitment and retention issues in establishing a theatres workforce with the appropriate skills mix. Consequently we will reduce our reliance on agency staff. As part of this programme we are implementing an organisational development project for us to develop our own theatre practitioners and to develop a clear career path for all staff, both professionally and non professionally qualified. We will also link this project with the development of our intensive care staff.

Job planning
In 2010/11 we will ensure that our job planning delivers the benefits of the 2009 service changes.

Integral to this process will be the review of our European Working Time Directive (EWTD) compliance and ensuring compliance with 48 hour working for junior doctors.

9.4 Summary of workforce

In 2010/11 we will ensure that our workforce profile is in line with our activity and income.

Informed by NHS Hertfordshire's refreshed strategy and their emerging operational plans we will re-profile our workforce.
Currently we project that our overall workforce costs will reduce by approximately seven percent.

Also contributing to this reduction will be our priority of a significant reduction in agency spend.

Similarly, the development of assistant practitioners, with support from multi-professional education and training (MPET) investment via the Hertfordshire County Workforce Group, will be a key 2010/11 development.

9.5 Talent and leadership

As requested by NHS EoE we can confirm that our Trust Board approved our Talent and Leadership Plan as part of our Workforce Strategy in September 2008.

In line with our Plan the focus in 2010/11 will be the continued development of our Leadership Academy, particularly on:

- The development of medical leadership and their role as champions in the implementation of our QIPP programme;
- The development of cross boundary leadership between GPs and consultants in the implementation of our QIPP programme;
- The continuing development of our divisional managers, business and ward managers in the implementation of our QIPP programme; and
- The development of Passport to Practice and a talent management framework.

Key to harnessing our talent and developing our leadership will be the development of an effective appraisal system. In 2010/11 the appraisal system will use our strategic and annual objectives as the framework, which will enable all our workforce to understand their roles and how they fit into the bigger picture.
In 2010/11 our aim is for 80% of all staff to have appraisals.

We achieved our apprenticeship target for 2009/10 and though no new target has yet been received for 2010/11 we expect there will be an increased demand for apprenticeships from the DoH, which we will deliver.

We will be launching our Passport to Practice in May 2010 - drawing together of a number of strands of staff development into a single access point. This will provide both an online resource directory and a hard copy portfolio that will help both managers and staff to navigate through the development journey from the moment they start work with the Trust to when they are career planning their next job move.

Also, we have already begun preparatory work in relation to medical revalidation and this will be lead by the Medical Director and the Associate Medical Director (workforce).

9.6 Leadership programme

As requested by NHS EoE we can confirm:
In 2009/10 number of staff put forward for NHS EoE Leadership programmes:
- Aspiring directors 4; and
- High potential leaders 1

Nominations put forward for 2010/11
Aspiring directors 2; and
High potential leaders 0

9.7 Communicating your strategy

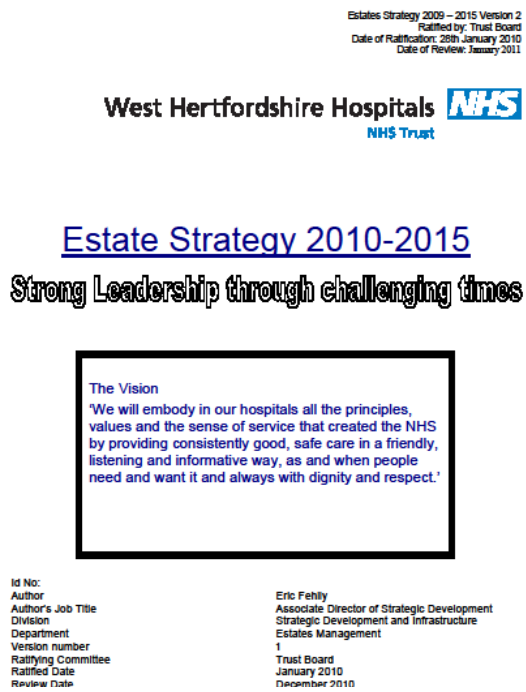
Our Annual Plan has been developed in close consultation with divisional clinical and managerial leads, and external stakeholders. Further to Trust Board approval of our plan we will produce a summary pamphlet to be communicated across all levels of the organisation and with patients and the wider community, outlining what we are setting out to achieve, when we plan to achieve it, and who is leading and how to get involved.

Our Annual Plan and details of lead contacts is also available on the intranet and internet.

10.1 Plans to reduce estate running costs and carbon emissions

Our updated Estate Strategy was approved in January 2010.

- Section 13 of the Strategy identifies where the Trust "want to be" in relation to environment and energy measures.
- Appendix 6 of the Strategy details our Energy Strategy, and our plans to minimise energy consumption and monitor progress.
- Key Performance Indicators (KPI's) are highlighted in Section 14 and our energy strategy is incorporated as Appendix 6 of the strategy.



Estates Strategy 2009 – 2015 Version 2
Ratified by: Trust Board
Date of Ratification: 28th January 2010
Date of Review: January 2011

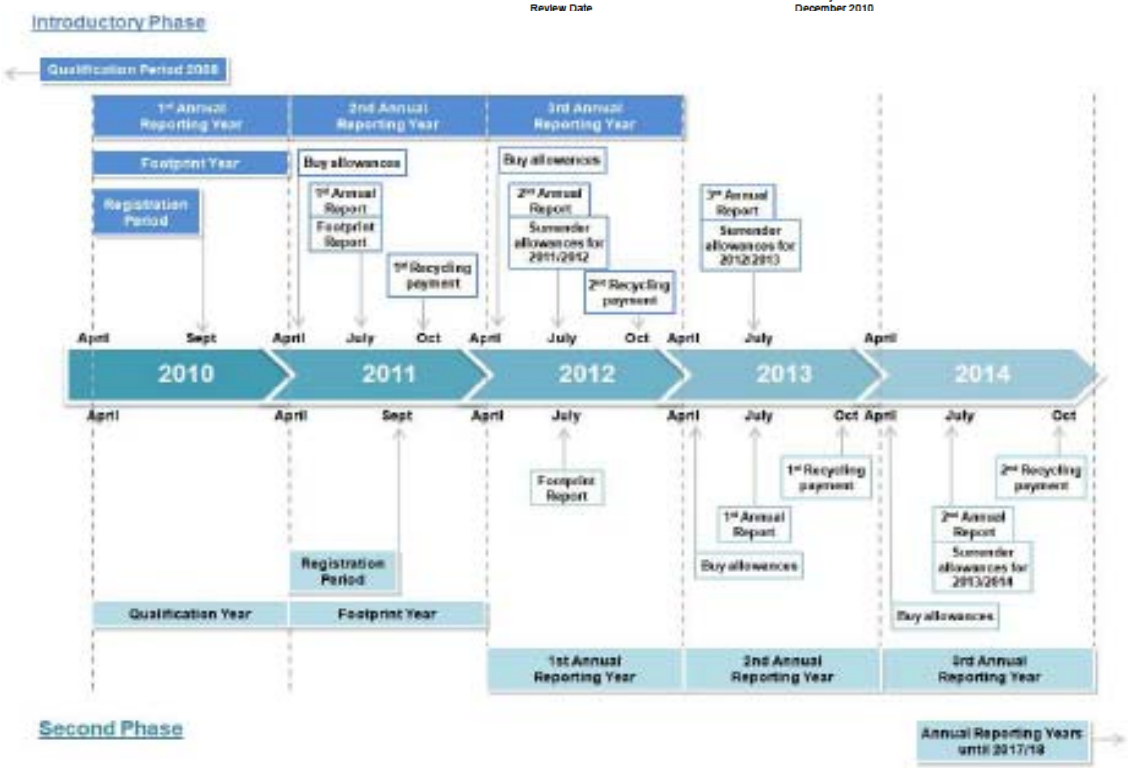
West Hertfordshire Hospitals NHS
NHS Trust

Estate Strategy 2010-2015

Strong Leadership through challenging times

The Vision
'We will embody in our hospitals all the principles, values and the sense of service that created the NHS by providing consistently good, safe care in a friendly, listening and informative way, as and when people need and want it and always with dignity and respect.'

Id No:	
Author	Eric Fehily
Author's Job Title	Associate Director of Strategic Development
Division	Strategic Development and Infrastructure
Department	Estates Management
Version number	1
Ratifying Committee	Trust Board
Ratified Date	January 2010
Review Date	December 2010



Concerning the carbon reduction commitment, which is a mandatory emissions trading scheme effective from 1st April 2010 we have undertaken a comprehensive review of our position.

Following this review we have developed an action plan, implementation of which will ensure that we meet the challenges of CRC, avoid financial penalties and strive to establish ourselves as a leader within the NHS.

Illustrated above is how we intend to measure and monitor progress.

In addition we have taken a proactive approach towards carbon reduction which includes the formation of an Energy Group within the Estates Department that meets monthly to discuss energy reduction measures that are planned and in progress

One of our most bold proposals is to reduce our CO^2 emissions with the replacement of our existing main boilers with Bio Mass alternatives.

This proposal was showcased as part of the NHS EoE QIPP programme highlighted in **section 5.4**.

In December 2009, the Trust Board approved the project to proceed to a preferred bidder stage, and subsequently four companies have been invited to present proposals. On completion of this project we would reduce our Watford Hospital CO^2 emission by 6,376 tonnes.

10.2 Our overall approach to sustainability

In implementing our Environmental Strategy in 2010/11 we will be establishing an Environment Task Group, which will prepare, develop and implement our environmental policy.
Our policy will incorporate:

- Continuing to develop and implement the green travel plan for Watford Hospital, and develop plans for St Albans and Hemel Hempstead hospitals
- Reducing the use of energy and utilities through awareness training
- Improving the efficiency and effectiveness of our waste management systems.

We will be appointing a Trust Board non executive director to champion this Group.

As requested we can confirm that Estates Returns Information Collection (ERIC) data is reported to the Trust Board. Our Board papers are available on the internet at: **http://www.westhertshospitals.nhs.uk/about/board_meetings/default.asp**

In 2010/11 we will develop an Estates and Facilities scorecard in order for estates and facilities information to be presented in a simple to understand format. As part of the reporting we will review progress on using the Good Corporate Citizenship Assessment Test and the new NHS Premises Assurance Model, further to its launch in April 2010.

11. NHS Constitution

The *NHS Constitution, January 2009*, brings together the principles, values, rights and responsibilities that underpin the NHS. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

The Constitution is broken down into sections for patients and staff, detailing the rights and responsibilities for each group. The patients' rights focus on:

- Access to health services;
- Quality of care and environment;
- Nationally approved treatments, drugs and programmes;
- Respect, consent and confidentiality;
- Informed choice;
- Involvement in your healthcare and in the NHS; and
- Complaint and redress.

Access to health services
In March 2010 the DoH updated the NHS Constitution to include new waiting time rights. From April 2010, patients will have the legal right to start treatment by a consultant within 18 weeks of GP referral and to be seen by a specialist within 2 weeks of an urgent GP referral for suspected cancer. If this does not happen we will be legally obliged to take all reasonable steps to offer patients a range of alternative providers. In 2010/11 delivery of these rights will continue to be a priority for us.

Quality of care and environment
Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. In ensuring compliance with same sex accommodation we are striving to deliver the DoH's requirements by the end of March 2010. In 2010/11 our drive will focus on embedding sustainability.

Nationally approved treatments, drugs and programmes
We have well established governance arrangements for the review of drugs that are used in only hospitals, and in hospital and by GPs. Our Drugs and Therapeutics Committee oversees the implementation of associated policies and procedures and works closely with the West Hertfordshire Joint Prescribing Group and Hertfordshire Medicines Management Committee in managing the entry of new drugs across the health economy.

NICE drugs introduction is managed across Hertfordshire by the Hertfordshire Medicines Management Committee to ensure consistent use of drugs and treatments that have been recommended by NICE for use in the NHS, if the patient's doctor feels it is appropriate.
Concerning the implementation of vaccinations, we are guided by the recommendations of the Joint Committee on Vaccination and Immunisation.
Our Information Governance Steering Group oversees the implementation of our policies and procedures and that action is taken where non-compliance is identified. Any incident involving personal information is dealt with and investigated in accordance with the Trust's Incident Reporting & Serious Untoward Incident (SUI) Policy. Our Caldicott Guardian is the Medical Director, Dr Colin Johnston.

All staff must attend mandatory information security and confidentiality awareness training.

We have updated our Consent Policy in accordance with the second edition of the DoH's Consent to Treatment guidance.

These arrangements will continue in 2010/11.

Respect, consent and confidentiality
We monitor compliance with relevant confidentiality related laws such as the *Data Protection Act* by completing the Confidentiality and Data protection Assurance component of the Information Governance Toolkit, and through the use of compliance checks and external audits.
We provide delegation of consent training to all appropriate staff. In 2010/11 we will be undertaking consent audits with the remit of assessing whether or not patients have been informed of the benefits and risks of the procedure and that an appropriate clinician has taken the consent.
These arrangements will continue in 2010/11.

Complaint and redress
Implementation of our 'Making Your Voice Heard', Complaints Policy, and Claims and Litigation Policy adhere to the NHS Constitution, and we will continue with this approach in 2010/11.

Table 23 details our position for the five statements requested by NHS EoE for us to provide confirmation on our business continuity plans for all inpatient areas.

Table 23: Confirmation on NHS EoE five statements for all inpatient areas

For all inpatient areas	
1. Clinical and business continuity risk assessment is current and the level of electrical supply resilience and contingency is related to risk. This has involved a review and is based on knowledge of equipment connected to UPS and battery systems.	Yes
2. Business continuity plans have been reviewed to ensure test procedures are in place to cater for extended loss of supply of power, fuel and water.	Yes
3. The business continuity plans does not assume that unexpected loss of power and running on generators is business as normal, even if the expectation is that the fault will be rectified quickly. Internal incident rooms would be activated and communication established with all stakeholders immediately.	Yes
4. The areas covered and not covered by generator back up have been reviewed. This is accepted and understood by senior clinicians	Yes
5 Maintenance and testing of standby generators are carried out in according with manufacturers recommendations and Health Technical Memorandum 06.	Yes

Accuracy of Board forecasting

Table 24 summarises the accuracy of our Board forecasting.

Table 24: Accuracy of Board forecasting

Forecast Quality of Service ratings for 2008 - 09 in last year's Annual Plan	Good
Actual Quality of Service rating for 2008 – 09	Fair
Forecast Use of Resources rating for 2008 – 09 in last years Annual Plan	Good
Actual Use of Resources rating for 2008 – 09	Good

Board statements

For our 2009/10 Annual Plan the Trust Board signed off twenty one of the twenty three statements. Our 2010/11 Annual Plan position is summarised in **table 25.** Our position is that the Trust Board have signed off twenty two of the twenty three statements.

- A full listing of the Board statements is provided in **Appendix A**.

Our proposed 2010/11 risk scoring position is summarised in **table 26**.

Table 25: 2010/2011 Board statements

Statements	Declaration
Governance statements: Risk and performance Management	10 out of 10
Board roles, structures and capacity	7 out of 7
Services provided	0 of 2
Quality and safety	2 of 2
Overall compliance	2 of 2
Overall declaration	**21 out of 23**

Table 26: Risk scoring

Risk scoring	
2010/11 Annual Plan Risk Ratings (unless otherwise stated)	**Score / RAG / rating**
Governance Risk Rating (RAG as per East of England Provider Management Regime guidance)	Tbc*
Financial Risk Rating (Assign number as per East of England PMR guidance)	4
Contractual Position (RAG as per East of England PMR guidance)	**
Care Quality Commission - Quality Rating 09/10 (Forecast out turn)	
Care Quality Commission - Use of resources Rating 09/10 (Forecast out turn)	

* Our 2010/11 governance risk rating projection is dependent on confirmation of the scoring and methodology to be used by the EoE Provider Management Regime.
** As at 5th March 2010 contractual agreement has not been reached with NHS Hertfordshire.

Annual Plan reviewed by the Board on: *25th March 2010*

Annual Plan signed off on the behalf of the Board by:

Name: _____

Position: **Chair**

Signature: _____

Date: _____

Annual Plan signed off on the behalf of the Board by:

Name: _____

Position: **Chief Executive**

Signature: _____

Date: _____

Appendix A – Board statements

Governance statements Risk and performance management	Tick
Issues and concerns raised by external audit assessment groups (including the RPST and CNST reports for NHS Litigation Authority assessments and Healthcare Commission investigations and reports) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in timely manner.	√
All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned.	√
All proposed and actual capital investments are compliant with the most relevant recent guidance, including the Capital Regime for NHS Trusts and the NHS Trust Manual for Accounts.	√
The necessary planning, performance management and risk management processes are in place to deliver the annual plan.	√
A statement of internal control ("SIC") is in place and the trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the latest guidance from HM Treasury.	√
All key risks to the trust's ability to operate within the parameters set by the Agency have been identified and addressed, especially including external risks such as PCT viability.	√
The trust has implemented national policy and guidance on planning for an incident.	√
The trust has an appropriate business continuity plan in place	√
The trust has an appropriate workforce strategy in place	√
The trust has an appropriate IM&T strategy in place.	√

Board roles, structures and capacity	Tick
The board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the board.	√
The board is satisfied that all directors are appropriately qualified to discharge their functions effectively including setting strategy, monitoring and managing performance and ensuring management capacity and capability.	√
The selection process and training programs in place ensure that the Non Executive Directors (NEDs) have appropriate experience, knowledge and skills and reflect the population being served.	√
The management team has the capability and experience, supported by timely interventions for required development, necessary to deliver the annual plan and lead the Trust to FT status.	√

The management structure in place is adequate to deliver the annual plan objectives for the next three years, including any preparations for achievement of NHS Foundation Trust status	√
The decisions taken by the board comply with its legal duties	√
The trust operates its systems on corporate and clinical governance in accordance with recognised good practice for NHS organisations.	√

Services Provided Statements	Tick
Contracts have been signed with commissioners	X
The activity assumptions underpinning the annual plan are consistent with the trust's contracts.	X

Quality and Safety Statements	Tick
The board is satisfied that the best of its knowledge and using its own processes, (supported by Healthcare Commission metrics and including any further metrics it chooses to adopt), the trust has and will keep in place effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to it's patients	√
The board is satisfied that plans are in place to ensure that all relevant national core standards and targets can be met going forwards, including all national core standards and targets due to come onto force within the following 12months.	√

Overall Compliance Statements	Tick
The board will ensure that the trust remains at all times complaint with its statutory duties and operates within the parameters, the level of severity and likelihood of a failure occurring and the plans for mitigation of these risks.	√
The Board has considered appropriate evidence to review these risks and has put in place action plans to address them where required to ensure continued compliance.	√

Version	Date	Circulation and Review:
V0.1 – 0.9	1st February to 15th March 2010	Drafting in consultation with executive, clinical and managerial leads
V0.9	16th March 2010	Draft circulated for presentation to Divisional Boards
V0.91	18th March 2010	Finance section updated.
V0.92	18th March 2010	Submitted for inclusion in March 2010 Trust Board papers.
		Finalised version