East of England

NHS East of England

Annual Plan 2011/12 DRAFT V9

Organisation details:

Organisation name:
West Hertfordshire Hospitals NHS Trust
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Annual plan date:
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1. EXECUTIVE SUMMARY OF ANNUAL PLAN

Executive Summary – (max ½ page). Summarise the key elements of the Annual Plan including:

- Key priorities for 2011/12
- Key challenges to overcome
- Key risks
- Impact on workforce

This plan provides an overview of the Trust's expected performance for the coming financial year, April 2011 to March 2012. It is based on the Trust's Integrated Business Plan (IBP).

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.'

Strategic Objectives

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

Key Priorities

- Continue to deliver safe patient care
- Continue to improve outcomes and quality of care
- Improve the patient experience significantly
- Deliver the savings needed to achieve the planned financial surplus
- Address emergency inpatient flows to allow a more orderly response to winter pressures
- Achieve foundation trust status

Key Challenges

- Managing the downward trend in activity and the transfer of services to the community
- Delivering the QIPP/CIP programme
- Managing the maintenance backlog for the estate

Key Risks

- The Trust will not achieve the originally planned surplus at year-end 2010/11 and therefore achieve a financial risk rating of 3 if it fails to achieve saving targets agreed
- The Trust will fail to achieve an adequate Monitor risk rating based on Trust liquidity levels if expenditure levels cannot be reduced
- Increased capacity resources required to respond to spikes in activity and additional (ITU) requirements associated with seasonal issues will adversely impact on the Trust's ability to deliver services within budget
- Inability to discharge patients when acute medical care is no longer required will affect the Trust's ability to deliver its elective workload and its ability to achieve A&E targets
- The residual estate issues that have to be managed in advance of the development of a new hospital will affect smooth delivery of services.

Impact on Workforce

- As a consequence of the changes necessary to achieve the Trust's objectives, the workforce is likely to reduce from the 2010/11 level of 3,562 wte to 3,347 wte in 2013/14

2. ANNUAL PLAN COMMENTARY

2.1 HIGH LEVEL ORGANISATIONAL PROFILE

2.1.1 Organisational Profile

Short bulleted profile of the organisation: To include:

- Size (FOT 2010/11 income & expenditure)
- Population served
- Number & wte of staff, turnover and sickness rates
- Range of services – see also table below
- Number of sites operated from
- Demographic growth and change in demand
- Reference cost for 2009/10 and 2010/11
- Changes to market or competitive position

The following table provides a summary of key information[1] on the Trust for 2010/11:

Finances[1]	
Turnover	£258.3m
Operating Expenses	£239.0m
EBITDA	£19.3m
Non Operating Expenses	£11.7m
Net Surplus (forecast)	£7.5m
Net Surplus after Impairments	£1.7m
Reference Cost – 2009/10	101
Reference Cost – 2010/11	Not available yet
Demographics	
Population served	Approx 500,000
Demographic Growth	0.67%
Workforce[1]	
Number of wte	3,758
Staff turnover	9.5%
Staff sickness rates	4.0%
Activity[1]	
Emergency Admissions	37,900
Elective Cases	38,300
Outpatient Attendances	405,600
Births	5,900
Other	
Number of sites operated from	3

High Level Description of Range of Services

The Trust provides a full range of acute hospital services for the local population of West Hertfordshire and some neighbouring communities.

The Trust's core business is to:

- Deliver a full range of emergency secondary care services, including intensive and high dependency care
- Provide a comprehensive range of planned in- and outpatient services, in an environment of patient choice and contestability
- Ensure that a broad span of diagnostic services is available locally.

The three main hospitals have complementary but differing roles:

- Acute emergency care and complex elective care is provided at Watford

[1] Note: Certain figures are estimates as at the end of January 2011

- Hemel Hempstead Hospital offers a range of locally based services including an Urgent Care Centre not requiring the full backup of a major hospital with intensive care
- St Albans has the dedicated elective centre for West Hertfordshire focussing on daycase and less complex care and also offers a wide range of other services including the Minor Injuries Unit.

The Trust also delivers services from a range of community based settings.

Demographic Growth and Change in Demand

Population growth has been built into the plan across all specialties at a rate of 0.67%. This will increase demand but is more than counter balanced by the demand management plans of NHS Hertfordshire. The drive to control referral activity in 2010/11 did not significantly dampen demand during the year. The Trust believes, however, that the demand management measures will be more effective in 2011/12 and demand is expected to fall by 10% in certain specialties. This has been built into plans.

Changes to Market or Competitive Position

Market factors are considered below:

- ***The health economy is under significant pressure to reduce expenditure on acute care***
  The jointly agreed Hertfordshire QIPP Plan sets out the local health economy's response to growing financial pressures. A clear imperative is to further constrain and reduce expenditure, particularly where it may be adding little value. One of the ways of achieving this is by demand management of elective and emergency care. The Trust believes the QIPP initiatives will become increasingly effective and has based the activity projections on this belief.

- ***There is relatively limited competition for the Trust's core emergency workload***
  There is limited potential for new providers of emergency care except at the least specialist end of the market. There is a small threat in areas such as Urgent Care Centres, which do not require the full range of support of a specialist acute hospital. This is mitigated by the Trust providing the Hemel Hempstead Urgent Care Centre services itself.

- ***The elective market is more competitive***
  ….however the Trust has a number of strengths which mitigate this threat. The elective centre at St Albans is separate from emergency services, (which are mainly at Watford) and therefore is insulated from the emergency pressures for elective capacity which other hospitals without this separation experience. This also results in an extremely low infection risk. The competitive risk is also mitigated by the fact that the Trust offers outpatient clinics and services at more than three different locations. Notwithstanding these strengths, the Trust is subject to competitor activity. Hillingdon Hospitals NHS Trust, for example, has increased the activity at their elective care centre on the Mount Vernon Site. This has already attracted a small number of patients from the Trust's elective catchment to the south west of Watford and the practice based commissioning group there has committed to sending more.

  A Surgicentre is opening at the Lister Hospital in Stevenage. This is due to open in late April 2011 and will take elective surgery hitherto carried out at the Queen Elizabeth II Hospital in Welwyn Garden City. It is not clear whether the attraction of a brand new centre will outweigh the disadvantage of greater distances.

- ***The Trust has scope to provide additional services for patients from neighbouring localities***
  This partly relates to effective marketing to GPs in "border" practices, but also to service rationalisations outside the current catchment area. The Trust's sites will become attractive to patients who may have increased travel times to their traditional providers. This is also well received by the NHS Hertfordshire as an opportunity to minimise expenditure on Market Forces Factor (MFF), a supplement to the tariff to cover geographic and location costs. Trusts to the south of existing catchment areas receive a higher percentage MFF, and therefore work can be repatriated at less cost to the local health economy.

- ***There is scope to repatriate specialist work currently carried out by tertiary providers***
  As demand reduces and this is reflected in capacity changes, there is an opportunity to

expand current areas of expertise and provide a wider range of services to local people. Again, driven by the opportunity to reduce the impact of the MFF associated with London's tertiary centres, NHS Hertfordshire and the Trust are working closely to identify areas for repatriation, for example, cardiology cath lab work.

2.1.2 Range of Services

Range of services (including relative size) by activity and value				
Service by Point of Delivery 20010/11	**Activity**		**Value**	**% of Total**
	Unit	No.	£m	%
Elective	Spells	35,995	£47.5	20.7%
Emergency	Spells	44,479	£78.9	34.4%
Outpatient	Attendances	408,091	£52.8	23.0%
A&E – including Minor Injuries Unit + Urgent Care Centre	Attendances	94,613	£11.5	5.0%
Other Non PBR			£38.7	16.9%
TOTAL			**£229.4**	**100%**

Range of services (including relative size) by activity and value				
Service by Division 2010/11	**Activity**		**Value**	**% of Total**
	Unit	No.	£m	%
Surgery	activities	184,737	£81.5	35.6%
Medicine	activities	227,709	£77.6	33.8%
Women & Children	activities	144,851	£47.5	20.7%
Clinical Support			£11.8	5.1%
Other	activities	25,881	£11.0	4.8%
TOTAL	activities		**£229.4**	**100%**

2.1.3 Growth and Changes in Demand

Outline areas of significant service growth including reasons:
– List the services experiencing significant increases in growth / demand. Outline the % growth (including trend over 2010/11) and the reason for the growth e.g. demographic or otherwise and your plans to address it.

The following factors impact on demand:

- **Demographic Change:** The age structure of the population of the whole catchment will alter as the population's average age increases. These changes have been factored into activity assumptions on the basis of a 0.67% increase every year. This growth is shown across all specialities equally.
- **Prior Approval:** The Trust has reflected the expected reduction in elective activity as a result of NHS Hertfordshire implementing a 'prior approval' process for low priority procedures in 2010/11. The Trust expects this process to continue into 2011/12 as set out in the QIPP Plan.
- **Outpatient Demand Management:** The planning assumptions reflect the Trust's aim of working in partnership to deliver care closer to home wherever possible, and assumes a shift of 36% of the activity across most specialties to primary care by 2013/14 (10% per annum from 2010/11).
- **Urgent Care Centres:** The Trust is assuming that it will continue to provide the Urgent Care

Centre at Hemel Hempstead. No change is expected at St Albans.

Service Growth

In general, the majority of specialties are expected to see a decline in activity in 2011/12 in line with the QIPP Plan. This largely relates to outpatient activity.

Looking back over 2010/11, overall activity levels remained substantially the same as in previous years. The anticipated reduction in GP referrals did not begin to materialise until late in the year thus total levels of OP activity and OP procedures are significantly above commissioned levels for the year. This has caused some operational challenges for the Trust in maintaining access standards.

Significant increases in orthopaedic referrals during the early part of the year, particularly for spinal problems, reflect the limited access to these services in surrounding areas. This growth fell off during the second half of the year and activity in 2010/11 is not expected to be significantly different from that in 2009/10. The Trust is forecasting a 10% decline in activity in 2011/12.

Increases in cardiology procedures reflect planned repatriation of more specialised treatments from non-local providers to the service at WGH.

During the course of the year specialist cancer services for gynaecology and upper GI surgery have become fully established at WGH, with patients from across Hertfordshire and south Bedfordshire coming to the hospital for specialist care. The Trust's specialist urology surgeon has moved operating sessions to the Lister Hospital as the specialist cancer service there has become established.

During the winter months the Trust experienced severe pressure upon its acute services, with high levels of ventilated and acutely ill patients. This resulted in some performance challenges in respect of emergency services, and associated disruption of elective care.

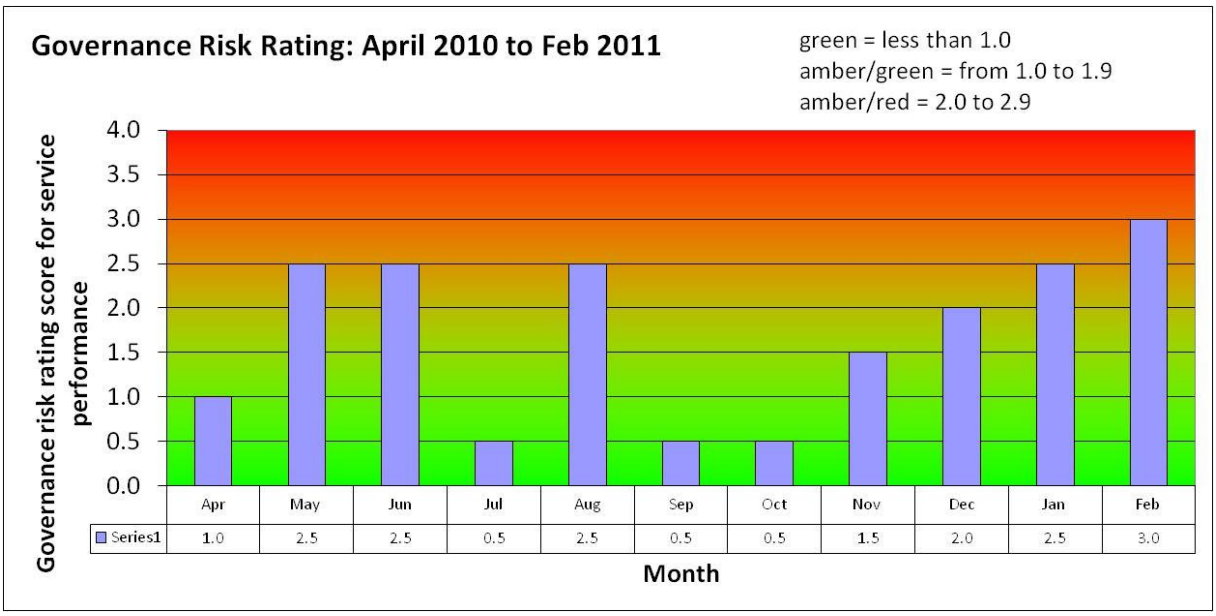
2.2 PAST YEAR PERFORMANCE

2.2.1 CEO's / COO's Summary of 2010/11 Performance

CEO's / COO's Overview of Performance in 2010/11

- Performance in delivering 2010/11 objectives with explanations for significant variances
- Delivery of national / regional performance targets
- FT progress (detailed more in Section 3)
- Turnarounds / reconfigurations
- Significant service developments and major investments
- Significant issues overcome

With reference to the NHS EoE performance management regime, the Trust's 2010/11 performance 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. The Trust's performance against specific targets is detailed in the table below.



Trust Governance Performance Against Specific Targets

Target and National Core Standard	Number of months breached in year[2]
Clostridium Difficile – 56 or fewer over year	4
MRSA target – 5 or fewer over year	3
Cancer – 31 days subsequent treatment	3
Cancer – 62 days from referral to start of treatment	0
A&E – 4 hour target	5
Thrombolysis within 60 minutes	0
Urgent GP cancer referral – maximum 2 week wait	0
Cancer – 31 days from diagnosis to treatment	2
MRSA – screening all elective inpatients	11
HSMR	0

[2] Figures are for the months April 2010 to February 2011 inclusive. Figures for the final month not available at the time of preparing this plan

2.2.2 Summary of Financial Performance

High-level comparison between plan financial performance and actual performance				
£000s	**2010/11 plan**	**2010/11 FOT***	**Variance**	
Income	£000s	£000s	£000s	% of plan
Clinical income	222,500	229,445	6,945	3.1
Non-clinical income	2,236	2,520	284	12.7
Other income	24,764	26,289	1,525	6.2
TOTAL INCOME	**249,500**	**258,254**	**8,754**	**3.5**
Expenses				
Pay costs	(165,758)	(160,222)	5,536	3.3
Non-pay costs	(60,542)	(78,775)	(18,233)	30.1
Other costs				
TOTAL EXPENDITURE	**(226,200)**	**(238,997)**	**(12,697)**	**5.6**
EBITDA	23,200	19,257	(3,943)	17.0
Interest receivable	(2,200)	(1,400)	800	36.4
PDC dividend	(3,600)	(3,240)	360	10.0
Depreciation	(8,800)	(7,066)	1,734	19.7
Net surplus/(deficit)	8,600	7,551	(1,049)	12.2
* Based on month 10 actuals plus 2 months forecast.				

Financial performance commentary on the above table including::

- Large variances
- Significant In year issues
- Value of CIPs delivered and as a % of income
- Split of recurrent to non-recurrent
- Proportion of CIPs delivered in last 6 months
- Impact on future years
- Performance against Public Sector Payment Policy

SLA income is forecast to substantially exceed plan, chiefly due to activity levels in respect of outpatient referrals and prescribing of high cost drugs.

At the time of the submission of the 2010/11 plan, plans for the delivery of 2010/11 cost improvements were yet to be fully worked up and it was not possible to split the cost improvement target between pay and non-pay. The cost improvement target was therefore allocated entirely against non-pay. This explains the significant variance on this line.

Pay is forecast to be lower than the opening planned amount due to the delivery of £7.5m pay savings. This is offset by forecast budgetary pressures due to the cost of filling vacancies with agency staff.

Non-pay is forecast to be higher than the opening planned amount due to the identification of savings against pay, depreciation and financing, and income budget lines rather than non-pay. Additionally, following the finalisation of SLA levels for 2010/11, non-pay budgets and spend increased due to higher activity.

2010/11 other expenditure is forecast to be lower than plan due to a reduction in depreciation and dividend charges following a revaluation of the Trust's estate in 2010.

The Trust is forecasting delivery of £18.3m CIPs (7.3% of total income). This is a substantial achievement however £6.1m of this amount will be delivered non-recurrently. The savings process acquired momentum over 2010/11, with 70% of savings forecast to be delivered in the last six months of the year.

The Trust will build on the progress it has made in 2010/11 to develop its 2011/12 savings programme. Schemes to progress work begun in 2010/11 have already made substantial progress and work is continuing to deliver additional new savings as well as the conversion of non-recurrent into recurrent savings.

Performance against the Public Sector Payment Policy has been in excess of 80% in 2010/11. This represents an improvement compared to previous years.

2.2.3 Other Major Performance Issues

Summary of Other Major Issues in 2010/11:

- Non- delivery of KPI(s)
- Failure to meet national/regional performance targets
- Third party investigations
- Serious Incidents / Never Events
- Contract disputes / non delivery of CQUIN
- Major changes to senior leadership, auditors etc.

Extended contract negotiations with the host commissioner resulted in the Trust's main contract for services being signed in June 2010. The Trust has not received any contractual Performance Notices during the year.

Acute activity levels during the winter months resulted in the Trust failing to achieve the operating standards for the A&E 4 hour wait during November 2010, December 2010 and January 2011, and for the admitted care 18 week target during November 2010, January 2011 and February 2011.

There were several changes of Board membership during the year:

Post	Left the Board	Joined the Board
Director of Nursing	Gary Etheridge	Natalie Forrest
Director of Delivery	Russell Harrison	Chris Pocklington
Director of Workforce	Sarah Childerstone	Mark Vaughan
Non Executive Director	Colin Gordon	Chris Green

3. STRATEGY

3.1 STRATEGIC OVERVIEW

3.1.1 Mission and/or Vision Statement(s) and Organisational Values

Mission and/or Vision Statement(s)

The Trust aims to maintain and improve its position as the local provider of choice for secondary care services in west Hertfordshire, consistently delivering high quality, safe services while ensuring financial robustness in an environment of financial retrenchment and uncertainty.

The Trust's vision is encapsulated in the statement below:

'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.'

Organisational Values

The values of the Trust are encapsulated in the Pledge, a published set of standards governing the way the Trust and its staff interacts with patients and their relatives.

"We will…

- Treat you with respect, courtesy and compassion
- Welcome you and make sure you know what to expect
- Ensure our hospital is clean, safe, uncluttered and quiet
- Follow the Trust dress-code, display our identity badge and introduce ourselves to you
- Provide clear signs, directions and assistance so you get to your destination
- Answer all telephone calls and call buttons promptly
- Give you our full attention and answer your questions fully
- Make it our duty to prevent delays and explain the reasons if delays occur
- Meet your needs for privacy, dignity and confidentiality
- Challenge and change practice that falls below these standards"

3.1.2 Longer Term and Annual Strategic Objectives

List your Longer term (3-5 year) Strategic Objectives

The Trust's strategic objectives are as follows:

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

The Trust will ensure these objectives are delivered through a number of key change initiatives as follows:

1. Embedding change in emergency care
2. Reshaping planned care
3. Delivering an appropriate range of services
4. Reshaping the Estate
5. Reshaping the Workforce
6. Developing information systems
7. Corporate efficiency and effectiveness

List your "2011/12" Objectives (if different from above)
The change initiatives above are supported by the following objectives. This is not an exhaustive list but represents those objectives most closely linked with the initiatives above: 1. Reduce length of stay for emergency patients and develop admission avoidance strategies in partnership with NHS Hertfordshire 2. Reduce unnecessary use of tests 3. Achieve other pay savings 4. Increase day case rates 5. Reduce length of stay for elective inpatients 6. Shift more elective care to St Albans City Hospital 7. Improve theatre utilisation 8. Improve outpatient services a. Reduce follow up rates b. Develop options to move services into community settings c. Increase throughput per unit resource d. Improve quality as defined by patient experience 9. Develop range of services a. Cardiology and Restorative Dentistry b. Outpatients in the Community c. Tablet Packing Unit 10. Improve the job planning process for consultants 11. Rationalise the Trust's estate portfolio These objectives are incorporated into the Trust's Big Ask programme. In addition to the above, the Trust has a series of ongoing operational objectives and targets which will continue to be subject to rigorous performance management during the course of the year. It is the Trust's firm intention to achieve foundation status during 2011/12.

3.1.3 Key Measureable Deliverables for 2011/12

Bullet KEY measureable (SMART) deliverables for 2011/12 with deadlines and Executive responsible		
SMART Deliverables	**When by?**	**Who?**
The Big Ask – CIP/QIPP: Deliver savings of approx £15.5m by March 2012	March 2012	Director of Strategy and Infrastructure
Ongoing operational objectives: Deliver performance against local and national targets	Weekly/ monthly	Executives
Achievement of Foundation status	Late 2011	CEO

3.1.4 SWOT Analysis

SWOT Analysis Please provide your high level organisational SWOT analysis agreed with your Board.	
Strengths	**Weaknesses**
• Good vision and leadership • Sustained significant performance improvement • Strong current performance • Big natural compact catchment population • Successful service rationalisation • Good reputation, locally, regionally and internally • Low SMR and Perinatal mortality rates • Very low infection rates	• Investment required in infrastructure, including backlog maintenance and IT • Size of borrowing • Low liquidity • Insufficient capacity at Watford particularly because of high level of emergency services meaning marginal costs exceed average costs
Opportunities	**Threats**
• Realise the benefits of the recent successful service reconfiguration • Build further on current strong performance • Further developments of services at SACH • Strong and further developing relationships between primary and secondary care • Surplus estate to be disposed • Buoyant demand • Reduce activity at Watford so that marginal costs become much less than average	• Economic climate • Reduction in commissioned activity • Continuing unfunded demand in activity • Difficulty in maintaining services on all sites • Political climate • New commissioning regime

Commentary regarding the above table.
In particular how you are to address your weaknesses and mitigate your threats

The SWOT has been constructed following detailed discussions with divisional and specialty teams in facilitated seminars and workshops held across the Trust's operational sites and services.

Addressing Weaknesses
The Trust will address the issue of investment in infrastructure through a tightly focused five year capital expenditure programme. This programme balances the requirements for investment, particularly in backlog maintenance and IT, with the need to ensure the Trust works within its financial constraints. In 2011/12 the Trust will invest some £9.3m in capital programmes. Of this, £3.3m, or over one-third will be invested in estate maintenance. This is an increase of 10% over the investment made in 2010/11 and will address critical backlog maintenance. The investment in the following year, when the Trust's financial position is expected to be stronger, will increase to £4.5m. Investment in IT follows a similar pattern: £1.3m in 2011/12 and £1.7m in 2012/13.

The Trust has three loans as follows:

- Working capital loan 1 for £11.2m drawn down in March 2007 with a five year repayment period
- Working capital load 2 for £7.0m drawn down in March 2010 with a five year repayment period

- Capital loan for £27m drawn down in September 2007/March 2008 with a ten year repayment period

The Trust has applied to the DH, with the support of the East of England Strategic Health Authority, to restructure its three loans. The Trust has proposed that the three loans will be consolidated into a single loan over a longer period and with a more favourable interest rate. This will reduce the monthly charges, improving cash flow and contributing towards achieving a cash balance of 10 days of operating expenses.

The constraints of the Watford site will be addressed via a number of initiatives:

- A drive to increase the day case rate and to shift more care from Watford to St Albans City Hospital – as set out as an objective in section 3.1.2
- Closer working with community colleagues to ensure that patients are efficiently discharged and do not wait for intermediate care facilities, care homes, etc
- A drive to reduce the length of stay for both emergency and elective patients
- Utilising surplus buildings to improve estate utilisation

Mitigating Threats

A difficult economic and political climate is an occupational hazard for staff within the NHS. The Trust has already mitigated this threat by leveraging on several of its strengths: good vision and leadership, sustaining significant performance improvements and successful service rationalisation. This will continue through 2011/12.

The likely reduction in commissioned activity has been analysed and associated cost reduction initiatives are planned. This is in accordance with the QIPP Plan. Should commissioned activity reduce significantly further or fall significantly faster than current expectations additional actions will be taken.

The new commissioning regime is both a threat and an opportunity. The Trust will mitigate the threat element (and exploit the opportunity) by continuing to deliver good patient care and continuously improving this care. At the same time, the Trust will continue to deliver a good service to GPs and continuously improving this service. These improvements are inherent in the objectives the Trust has set.

3.1.5 PESTLE Analysis

PESTLE Analysis Please provide your high level organisational SWOT analysis agreed with your Board.	
Political	**Economic**
• Reduction in Government spending reflecting the recession and the political response to it • Recent change of government and political leadership • Tougher Care Quality Commission (CQC) standards and national targets • New Operating Framework • Some hostility locally to the Trust largely in response to the move of acute services to Watford • Build on the improved relationship with PCT • Local PBCs increasingly active and less predictable than PCT commissioning • Work on the care pathways from secondary to primary is variable and	• The need to maintain financial performance • Recession and economic climate • Weak balance sheet • Funding of the new hospital • Pace of change in the Local Authority is much faster, may impact on Health as their budgets reduce (delayed discharge) • The impact of choice: patients are empowered, the Trust's strategy needs to respond – elective waiting times remain key • Independent sector will be hit by recession and therefore may look to take more NHS patients as a result • Public sector may benefit from recession in employment terms (better applicants, people valuing current jobs, graduates choose public sector)

reliant on strong clinical leadership • There is a political imperative with respect to the work to reduce demand • Plurality of providers increasingly on commissioner agenda • Possible demise of PFI as vehicle to deliver large capital schemes • HCHS becoming a Foundation Trust and future change in the governance of the PCT provider services • Future of PbR	• Value of Hemel site is variable/uncertain • Better prices from contracted-out services • Other Trusts keen to spread into Hertfordshire catchment.

Social & Demographic	Technological
• Growing population – need to be aware of demographic changes • Ageing and more dependent population • Increasing patient expectations • Focus on patient experience and increased patient satisfaction (individualisation and personalised services) • Assertive consumers and government being assertive on their behalf • Increased expectations of public services and patient choice • Reputation management and the need to market" NHS services better • Recession and society changes, possible changing health demand • Informed customers using IT to inform themselves and also use of IT in booking services • New access – road and tube and improved transport infrastructure via the Watford Health Campus irrespective of NHS decisions • Green agenda and carbon trading • Patients expecting more services closer to their home • Changing working patterns and the resulting work life balance and expectations.	• Need for IT development • Electronic booking of elective care means new relationship with patient • National Institute for Health and Clinical Effectiveness (NICE) new approvals and deferrals impact on cost control and clinical technology developments, drugs and services, impact on cost control • Increasing sub-specialisation within clinical specialties, viability and sustainability • Service modernisation and development of integrated care pathways • Improved access and use of diagnostics • Increases in Telemedicine - cost and benefits • Green agenda and carbon trading • Better shared common data • Need for critical mass to sustain efficient service and training needs

Legal	Environmental
• Health and Social Care Bill 2011 ○ strengthening commissioning of NHS services ○ increasing democratic accountability and public voice	• Sustainability agenda • Clean hospitals and Hospital Acquired Infection Rates • Backlog maintenance • Car parking

○ liberating provision of NHS services ○ strengthening public health services ○ reforming health and care arm's-length bodies • Liberating the NHS 2010 • Health Act 2009 ○ Framework for NHS Constitution ○ Quality Accounts • New commissioning framework • Bribery Act • European Working Time Directive	• Carbon footprint pressures • Energy efficiency • Energy costs and variability in costs • Transport links

Comment on the above table.
The PESTLE analysis above has been used in the formulation of business plans and the IBP.

3.1.6 Major Service Development Plans for 2011/12

Detail your major service developments required to delivery your strategy	
– Confirm these have been agreed with your commissioners	– Explain growth – new / expanding existing services, demographics – Detail the margin of each service which is growing

The Trust has the following service developments at various stages in the planning process:

- Decontamination – moving the service off site to a commercial operator
- Repatriation of minor oral surgery – being discussed with PCT
- Establishment of a restorative dental service – being discussed with the PCT
- Moving the Urology Department from Watford to St Albans – no impact on PCT but decongests the Watford site
- Extending the Enhanced Recovery Project to:
  - Breast Surgery
  - MSK Surgery
- Establishing a Non Invasive Ventilation Service – being discussed with PCT
- Establishing a radio frequency ablation service - being discussed with PCT
- Establishing a private patient unit at Watford – no impact on the PCT

3.1.7 Strategic Context - Local Health Economy

Summarise the context within which your organisation operates. To include:
– The situation within the local health economy (LHE)
– Forecast of the likely impact of the economic downturn and QIPP
– Relationships with healthcare stakeholders (e.g. PCTs, GP's, other providers)

The Trust is situated in west Hertfordshire and is largely covered by a single PCT, NHS Hertfordshire. NHS Hertfordshire accounts for approximately 91% of the Trust's clinical activity.

As detailed in the latest population census data, the total population for West Hertfordshire is just over 500, 000 people.

Key population characteristics are:

- The population density locally is over three times the average in England with 45% of the population living in the main towns of Watford, Hemel Hempstead and St Albans

- Compared with the rest of the country, health in west Hertfordshire is good

- The average birth rate is 12.7/1000 population compared with the England average of 11.7/1000. Watford has the highest rate at 14.6/1000

- West Hertfordshire has a slightly higher proportion of under 5 year olds (6.1%) compared with England (5.7%). In contrast, there are comparatively fewer people of pensionable age (17.6%) compared with England (18.5%)

- In the 2001 Census, 7% of the population was classified as coming from a black and ethnic minority group. The largest concentration of people classifying themselves as Asian or Asian British was in Watford (8.2% of population). Watford also had the largest proportion of people classifying themselves as Black or Black British (2.66%)

- Most, but not all, deprived areas lie within the urban wards of Watford, Hemel Hempstead and Borehamwood

- Life expectancy has been increasing in line with national trends. Death from cancer, heart disease and other circulatory diseases has been falling in the under 75s group

- Smoking is a leading cause of preventable death in west Hertfordshire. Smoking prevalence is highest in Northwick ward (Three Rivers), Central ward (Watford) and Cowley Hill ward (Hertsmere)

- Obesity is a major public health issue, linked to heart disease, diabetes and some cancers. There is wide variation in the prevalence of obesity in west Hertfordshire, with 1-in-10 people being obese in Moor Park and Eastbury ward (Three Rivers) compared with 1-in-5 adults in Highfield and St Paul's ward (Dacorum)

In addition to the west Hertfordshire catchment, services are also provided to parts of the London boroughs of Hillingdon (particularly the wards of Harefield and Northwood), and Harrow, for which Watford General Hospital is the most accessible local acute hospital. This covers a polulation of approximately 30,000. The Greater London Authority has projected that population growth has been higher in these boroughs than in the Trust's main catchment and will continue to be so. The core catchment population is predicted to grow steadily over the next five years.

NHS Hertfordshire is the Trust's dominant commissioner by a very large margin. The next commissioner in terms of the size of income derived from the commissioner is responsible for only 2.27% of the Trust's income. The detailed breakdown of income by commissioner is shown in the table below:

2010/11 Income by Commissioner

Commissioner	**2010/11 (£m's)**	**Percentage**
Hertfordshire	202.5	90.8%
Barnet	1.1	0.5%
Bedfordshire	1.1	0.5%
Brent	0.4	0.2%
Buckinghamshire	0.9	0.4%
Harrow	3.5	1.6%
Hillingdon	5.2	2.3%
Luton	1.5	0.7%
EoE Specialist Services Commissioning Group (SSCG)	4.1	1.8%
Non Contract Activity (NCA) etc	2.7	1.2%
Total	**223.0**	**100%**

The principles of the NHS Hertfordshire commissioning strategy to 2014 are rooted in the *Investing in Your Health* strategy 2003, as further developed in *Delivering Quality Healthcare for Hertfordshire*. These strategies laid the basis for the overall service model now in place in the Trust; that of centralising acute care at Watford and the development of a new elective care centre. NHS

Hertfordshire has issued a strategy covering the period 2009/10 to 2014/15.

The key issues of relevance for this Trust stemming from these strategies are as follows:

- Potential development of services which will reduce emergency admissions to the acute hospital
- An ambition to meet a greater range of patients' elective needs in community and primary care settings, particularly for outpatient attendances and minor surgical procedures
- Investment in community midwifery and community paediatrics
- Support for the further development of Stroke Services at Watford General Hospital

These issues have been addressed and incorporated into the jointly developed QIPP Plan 2011/12 to 2014/15, and outpatient activity – the gateway into the Trust – is expected to decline by 10% for many specialties during 2011/12. This assumption has been built into the planning process.

The market environment will change for the Trust as plans for new GP Consortia proposed by the government it its white paper "*Liberating the NHS*" are developed. Currently there are two pathfinder groups emerging – Red House (Radlett) and Herts Vale (Dacorum, Watford, Hertsmere and possibly Harpenden and St Albans). The Trust is ensuring that it responds to the clinical agenda of the current PBC groups (and will include the emerging pathfinder groups as and when their leadership is established) through the West Hertfordshire Clinical Conclave. This group of senior clinicians, with representatives of the four west Hertfordshire PBC groups, the PCT and Trust, meet monthly to develop and drive a challenging clinical agenda to shape and redesign services, to improve patient experience and to reduce cost to the local health economy. This group builds on the good relationships the Trust has with GPs and has demonstrated its success by agreeing initiatives for joint work including:

- Diabetes care pathway
- Chronic Obstructive Pulmonary Disease (COPD) care pathway
- Chronic heart failure care pathway
- Development of the model for Urgent Care Centre
- Demand management of Outpatient referrals
- Development of the model for Intermediate Care.

3.1.8 Overview of your 2011/12 Strategy

Provide commentary / an overview of your strategy for 2011/12 incorporating:	
– Key elements from the above boxes – How your Strategy links to your main commissioner(s) strategy (including delivering QIPP) – The market within which you operate – Confirm your Annual Plan has been discussed AND agreed with your main commissioner	– Overview of major impacts re: ○ Workforce ○ Quality ○ Finance ○ Activity ○ IM&T ○ Capital / major investments (to be detailed more in section 4)

The Trust aims to maintain and improve its position as the local provider of choice for secondary care services in west Hertfordshire, consistently delivering high quality, safe services while ensuring financial robustness in an environment of financial retrenchment and uncertainty.

Taking the Trust's seven strategic objectives as the headings, the overall approach is as follows:

1. **Provide safe patient care**
    a. This is a key *raison d'être* for the Trust and the organisational structure, reporting lines, governance structures, incident reporting systems, performance management systems, complaints handling, personal responsibility, etc, are largely geared towards the delivery of this objective. Through a series of committees and reports the provision of safe patient care is monitored and reported to the board, and actions identified to address any concerns.

2. **Improve outcomes & quality of care**
    a. In addition to providing safe patient care, improving outcomes and the quality of care is a key *raison d'être* for the Trust and the organisational structure, reporting lines, governance structures, incident reporting systems, performance management systems, complaints handling, etc, are largely geared towards the delivery of this objective.

3. **Improve the patient experience**
    a. The Trust's approach to improving the patient experience is largely overseen by the Patient Experience Working Group chaired by the Director of Nursing and Quality. The approach is based on the PDSA model of Plan, Do, Study, Act where the study element is informed by both local and national patient surveys.

    b. A significant factor in the patient experience relates to the state of the built environment. Over the course of 2010/11, several 'estate improvements' were implemented including: a refurbished outpatient department in Hemel; a newly painted suite of outpatient rooms at Watford; and improved and extended patient parking at Watford. This 'low cost, high value' approach will continue in 2011/12.

    c. Several individual projects have a patient experience improvement element in their remit. These include the outpatients project and the productive ward project.

4. **Sustain and improve performance**
    a. The Trust's general approach to sustaining and improving performance is to monitor performance heavily, review performance at one of several weekly (and at times daily) review meetings, identify issues, risks and opportunities, and to allocate personal responsibility for actions – with a follow up to ensure actions are undertaken and are effective.

    b. In addition, the Trust frequently uses its internal auditors to give an independent assessment of areas of concern. The auditors identify risk areas and make recommendations. There is a process to ensure that recommendations are acted upon.

5. **Be financially sound**
    a. The Trust has an ongoing Big Ask Programme which has developed a body of expertise in the identification and delivery of quality improving (or neutral) cost savings. This is the Trust's CIP/QIPP. This programme, led by the Director of Strategy and Infrastructure, will continue into 2011/12 and will deliver the estimated £15.5m savings required.

6. **Work in active partnership**
    a. The coalition Government's health white paper "Liberating the HHS" makes a number of proposals to reform the NHS. It proposes changes to where power sits in the system, replaces much of the existing hierarchy and moves from quasi-markets to market mechanisms and it involves a large structural reorganisation of the NHS.

    The white paper published on 12 July 2010, sets out a new vision for the health service in England. It has at its heart three key principles:

        i. patients at the centre of the NHS
        ii. changing the emphasis of measurement to clinical outcomes
        iii. empowering health professionals, in particular GPs.

    The Trust is aware that these reforms will touch every part of the NHS and have an impact on almost every organisation that delivers NHS care. Developing GP commissioning is the centrepiece of the reforms and success will depend on how effectively GPs control finances and address difficult decisions. The Trust is working with local GP groups, through its monthly clinical conclave (senior clinicians in the Trust and local GPs) and with the NHS Hertfordshire to assist in managing this change.

    The focus of development is still continuing to change from acute services to locally based community services. The Trust is working closely within the health economy to redesign service pathways to deliver high quality services closer to home, coupled with

a whole system cost reduction.

b. Of particular importance is the partnership working with NHS Hertfordshire and the joint development of the joint QIPP Plan for delivery of quality, innovation, productivity and performance over the period 2011/12 to 2014/15.

c. The Trust will continue to engage with Luton & Dunstable NHS Foundation Trust, East & North Hertfordshire NHS Trust and others for the delivery of cancer services.

7. Attract, retain and motivate an appropriately trained workforce

a. The Trust's approach to attracting, retaining and motivating an appropriately trained workforce is multifaceted. It includes careful listening to staff, not only through the route of sound management but also via extensive staff surveys, director walkabouts and CEO question & answer sessions.

b. The Leadership Academy is another notable facet. This academy has a programme of staff development courses scheduled for 2011/12 aimed at giving staff the tools they need to excel.

This Annual Plan is based on the QIPP and the IBP both of which have been extensively discussed with, and agreed by, NHS Hertfordshire.

3.1.9 Capacity and Capability

Highlight any gaps in the capacity or capability of the Board, including details of any interim appointments, and what action the organisation is taking to address these gaps. **Highlight also gaps in clinical and operational capacity and capability and actions to address**
The board has no gaps in its capacity or capability. In operational terms the Trust is faced with difficulty in recruiting midwives, A&E staff and some grades of junior doctors. These difficulties are being managed by means of carefully targeted recruitment campaigns and devising alternative approaches to filling skill shortages.

3.2 ACHIEVEMENT OF FT STATUS OR OTHER ORGANISATIONAL FORM

Progress to date
• SHA board-to-board – complete • Submission by SHA to DH – complete • DH Technical Committee review – commenced in September 2010
Actions identified to achieve FT status or alternative organisational form
• DH/SHA to agree proposals on loan restructuring • Improve performance in key areas
Outline the key milestones including timeline for completion
• DH/SHA to agree proposals on loan restructuring – end of March 2011 • If new Historic Due Diligence required – Beginning of April 2011 • Resubmission to Technical Committee – End of April 2011 • DH Application Committee considers application and forwards to Monitor – May 2011 • Monitor assessment process commences (and continues for four months) – June 2011 • Board-to-board meeting with Monitor – End September 2011 • Earliest authorisation as an FT – October 2011

Risks – Outline key risks and mitigating actions

• Lack of resolution on loan restructuring
  ○ No mitigating actions as the case is with DH. If the loan package is rejected, the Trust will negotiate an alternative loan arrangement
• Monitor assessment is during a period of historically high financial pressure on the NHS
  ○ Sharp focus on performance management of normal business
  ○ Strong project structure and team for CIP/QIPP

3.3 DELIVERY OF IMPROVING LIVES SAVING LIVES (ILSL) AND THE PLEDGES

Demonstrate how your strategy will support the delivery of the "*Improving Lives Saving Lives*" Pledges Include specific actions / developments
Deliver year on year improvements in the patient experience a. The Trust's approach to improving the patient experience is largely overseen by the Patient Experience Working Group chaired by the Director of Nursing and Quality. The approach is based on the PDSA model of Plan, Do, Study, Act where the study element is informed by both local and national patient surveys. b. A significant factor in the patient experience relates to the state of the built environment. Over the course of 2010/11, several 'estate improvements' were implemented including: a refurbished outpatient department in Hemel; a newly painted suite of outpatient rooms at Watford; and improved and extended patient parking at Watford. This 'low cost, high value' approach will continue in 2011/12. c. Several individual projects have a patient experience improvement element in their remit. These include the outpatients project and the productive ward project. **Ensure fewer people suffer from, or die prematurely from, heart disease, stroke and cancer** a. The Trust's organisational structure, reporting lines, governance structures, incident reporting systems, performance management systems, complaints handling, etc are geared toward improving outcomes and quality of care. b. As new NICE guidance becomes available the Trust delivers improvements to its services in order to comply with the guidelines. **Ensure patient safety** a. The Trust's organisational structure, reporting lines, governance structures, incident reporting systems, performance management systems, complaints handling, personal responsibility, etc, are largely geared towards the delivery of safe patient care. Through a series of committees and reports the provision of safe patient care is monitored and reported to the board, and actions identified to address any concerns.

4. FINANCE

4.1 FINANCIAL OBJECTIVES FOR 2011/12

4.1.1 Financial Objectives / Deliverables for 2011/12

Bullet your high level SMART financial objectives for 2011/12. To include:	
– Operating surplus/deficit	– Capital
– Cash flow position	– Target Public Sector Payment Policy Performance

Financial Objectives

Finance Objectives for 2011/12 are as follows:

- Maximise Operational Efficiency
- Generate sufficient cash to service debt and hold cash at 10 days of operating expenses
- Reshape and maintain the Trust's Estate to support the delivery of changing patient services

Cash Flow Position

Target surplus for 2011/12 is £4.4m and is based on cash flow within year. The planning assumption is that the Trust's preferred loan refinancing option is approved by Treasury and that the Trust has 10 days of cash, £6.5m, at year end.

Capital

The capital programme for 2011/12 is £9.3m and is based on the lower level of depreciation estimated for the year of £7.2m resulting from the revaluation of assets plus expected net proceeds of land sales of £1.3m . The biggest schemes next year are endoscopy compliance and decontamination with £3m, planned for essential backlog maintenance and smaller allocations for equipment replacement and IT.

Target Public Sector Payment Policy Performance

In order to achieve a cash holding of 10 days of operating expenditure creditor days will increase in 2011/12 to just under 30 days. This will however be improved in later years returning to 2010/11 levels (c24.2 days) as liquidity improves.

4.1.2 Contract Agreement and 2011/12 Budget sign off by the Board

Confirm the contract with your main commissioner for 2011/12 has been agreed AND signed	
– What date was it agreed AND signed?	– If not been agreed and signed when will this be achieved?
Expected by 31/3/11	

Other contract(s) 2011/12 Agreed AND Signed	
– Confirm other contracts for 2011/12 have been agreed AND signed?	– If not, which ones, why have they not been agreed / signed and when will this be achieved?
Not signed as at mid-March 2011 although the process is well controlled.	

Confirm the Board has signed off the 2011/12 Budget by 31st March 2011
If the Board has not approved the budget, when will it be approved?
Expected by 31/3/11

4.2 FINANCIAL ASSUMPTIONS UNDERPINNING THE PLAN

4.2.1 Assumptions

Bullet the significant assumptions underpinning the 2011/12 financial plan. In particular:

- Activity
- Pay & prices
- Income
- Demand and growth (including demographic)
- CIPs
- Working capital
- Estate and capital

The assumptions for the period are:

Activity/ Income

- A 10% reduction in outpatient referrals across most specialties, this is the Trust's assessment of the impact of PCT demand management initiative to reduce inappropriate referrals to hospital consultants. NHS Hertfordshire has put in place a local enhanced scheme (LES) to incentivise GPs to do this. The plan assumes this level of reduction annually until 2014/15
- Plans also include the expected impact of protocols to obtain prior approval for interventions of limited clinical value, these will reduce elective admissions
- NHS Hertfordshire's plans do not explicitly forecast reductions in emergency activity so, whilst the Trust will work with the PCT on this area, no specific reductions are included in the plan
- Population growth in Hertfordshire of 0.6% per annum
- A reduction of 1.5% overall, prices outside the tariff regime are also expected to reduce by 1.5%. With provider inflation assumed at 2.5%, this results in the 4% efficiency requirement
- Hospitals will be not be paid for elective patients who are readmitted within 30 days, and the target is to reduce these by 25%. An estimate of £500k has been made of the impact of the new rules.
- Payments for quality through CQUIN remain at 1.5%.
- The 30% marginal tariff for emergency admissions remains, with a 2008/09 baseline
- MFF is reduced by 0.7% in 2011/12
- No significant changes are expected to case mix

For Hertfordshire, the income assumption is broadly in line with QIPP plan and discussions about how this translates into a contract for next year have commenced.

Other assumptions include:

CQUIN

CQUIN targets were introduced in 2009/10, when commissioners were required to link payments to quality improvements. For the acute sector, payment of 1.5% on top of the 2011/12 contract value for clinical services is linked to the specific achievement of quality and innovation goals. These targets are a mixture of national, Strategic Health Authority and local PCT objectives. For 2011/12 the Trust has assumed that there are no changes to the 1.5% rate.

Pay & Prices

Inflation assumptions have been made in line with 2010/11 SHA and Monitor guidance, updated to include the impact of the pay freeze for all staff who earn in excess of £21,000 per annum and any known cost pressures:

- Inflation funding of £4.6m
- Cost pressures of £2.5m primarily relating to paying an Agenda for Change uplift to Medirest staff and increased revenue costs of decontamination, decontamination in endoscopy and specific divisional pressures
- Adding back £4.4m for non recurring savings in 2010/11
- Savings of £15.5m or 6.1% of expenses

Working Capital

The following table shows the number of days it will take, on average, to pay the Trust's creditors each year and how long its debtors take to pay to 2015/16. The increase in 2011/12 relates to the retention of 10 days cash balance. As liquidity is strengthened it is possible to return to 2010/11 levels while continuing to hold a cash balance of 10 days operating expenses.

	2010/11 Days	2011/12 Days
Creditor Days	25	29
Debtor Days	16	16
Cash Days	2.6	10

Capital

Capital investment plans for 2011/12 is summarised below:

	2011/12
	£m
Estate Maintenance	3.3
IM&T	1.3
Medical Equipment	0.5
Service Development	4.3
Total Investment	9.3

Service development in 2011/12 relates mainly to compliance with decontamination standards and £3.3m is planned to address high priority estate backlog maintenance. Due to the reduction in funds available, and the high levels of essential backlog maintenance and commitments from 2010/11, there is minimal scope for any discretionary spending or to reduce the size of the programme further.

4.2.2 Financial Phasing

Comment upon the financial phasing of your plans	
– Income and Expenditure	– Investments and Financing
Phasing of income and expenditure is based on the average of the previous two years for activity, spending profile and savings delivery. Phasing of investments and financing is based on the assumption that the Trust's preferred loan refinancing option is approved by Treasury in the early part of 2011/12.	

4.3 RISK AND FINANCIAL RISK RATING (FRR)

4.3.1 Financial Risks

Top Financial risks (add more rows as required)

	There is a "Risk" that…	Likeli-hood	Im-pact	Score	High Level Mitigating Actions Agreed / Planned
1	Planned savings and capacity reductions are not fully achieved	4	4	16	• Strong programme management and support for the divisions • Executive team leadership and support • Analysis of activity to support capacity reductions for divisions to implement • Ongoing work to identify and bring forward new savings

Top Financial risks (add more rows as required)					
	There is a "Risk" that…	**Likeli-hood**	**Im-pact**	**Score**	**High Level Mitigating Actions Agreed / Planned**
2	Loans are not refinanced or refinanced on less advantageous terms	4	3	12	• Continuing dialogue with SHA • Possible bid for one-off funding – Transformational Fund • Faster rationalisation across sites
3	A shortfall against the plan leads to cash flow problems and 10 days cash is not achieved at the end of the year	4	4	16	• Accelerate the implementation of savings • Further dialogue with PCT about contract payment profile • Other cash management measures
4	The contract with the NHS Hertfordshire leaves the Trust with a high level of risk	3	4	12	• Continue to negotiate to agree more acceptable terms and value • Manage capacity and pace of elective work • Ensure recording and coding is robust
5	There are further capital investment requirements which cannot be met within the funding available	3	3	9	• Careful prioritisation for the use of funds • Review in year to respond to urgent issues as they arise

4.3.2 Financial Risk Rating (FRR)

Please insert your predicted 2011/12 FRR table

Criteria	Metric	2011/12
Underlying performance	EBITDA margin %	3
Achievement of plan	EBITDA achieved %	3
Financial Efficiency	Return on assets %	5
	I&E surplus margin %	3
Liquidity	Liquidity ratio days	3
Overall rating	Overall rating	3

Comment upon your predicted 2011/12 FRR

The Trust plans to maintain its financial risk rating by generating surpluses from improved efficiency/productivity. In turn this will improve liquidity/cash holding.

The Trust will maintain an EBITDA margin of 5% to 6% and an I&E margin of 1%. This gives the Trust an overall rating of '3' throughout the model period.

4.4 RESOURCES REQUIRED TO DELIVER YOUR STRATEGY

4.4.1 Income (from all sources)

Income from main commissioners (health, social care and other) - add additional rows as required				
Income Source / Commissioner Name	**2010/11**		**2011/12**	
	£000s	**%**	**£000s**	**%**
Hertfordshire	206,896	90.2%	200,600	89.8%
Barnet	1,008	0.4%	1,016	0.4%
Bedfordshire	1,239	0.5%	1,306	0.6%
Brent	351	0.2%	370	0.2%
Buckinghamshire	889	0.4%	790	0.4%
Harrow	3,437	1.5%	3,437	1.5%
Hillingdon	5,593	2.4%	5,508	2.5%
Luton	1,462	0.6%	1,574	0.7%
EoE Specialist Services Commissioning Group (SSCG)	4,048	1.8%	4,138	2.1%
Non Contract Activity (NCA) etc	4,524	2.0%	4,662	1.8%
TOTAL INCOME	**229,446**	**100%**	**223,400**	**100%**

Breakdown of Other Income is as follows (£000's):

	Plan	**Forecast**	**Current plan**		
	2010/11	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Private Patient revenue	1,205	1,205	2,005	2,005	2,005
Other Non NHS clinical revenue	1,065	1,315	1,325	2,245	4,145
Research & Development Income	564	579	570	562	553
Education & Training Income	7,722	8,143	8,020	7,610	7,496
Other Operating Income	17,630	17,489	18,857	20,948	17,948
TOTAL OPERATING INCOME	28,186	28,731	30,777	33,369	32,147

Comment on above table, in particular:

- The breakdown between health and social care income and between years
- The predominant reliance on one commissioner
- "Other" income streams – What are these and how confident are you of these in future years.

The Trust is forecasting receipt of £0.3m income from social care in respect of delayed discharges in 2010/11. This is forecast to continue in 2011/12.

NHS Hertfordshire is the Trust's most significant customer and accounts for 90% of its SLA income. Whilst reliance on one commissioner increases the impact that NHS Hertfordshire's changes in commissioning has on the Trust, the Trust seeks to mitigate this through regular discussions and a close working relationship with its main commissioner.

4.4.2 Operating Income by Service / Point of Delivery (POD)

Comparison between historic achievement and current plan (add additional rows as required)					
Clinical Income (£000s)					
Service / POD*	**Plan**	**Forecast**	**Current plan**		
	2010/11	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Elective	£48,744	£48,029	£46,232	£46,459	£46,056
Emergency	£79,162	£78,917	£77,502	£76,829	£76,172
Outpatients	£50,989	£52,773	£51,303	£48,058	£45,148
A&E	£8,769	£9,132	£8,918	£8,819	£8,723
Other NHS Clinical Income	£34,836	£40,594	£39,445	£41,507	£42,172
Other Operating Income	£27,000	£28,731	£30,777	£33,369	£32,147
TOTAL OPERATING INCOME	**£249,500**	**£258,176**	**£254,177**	**£255,041**	**£250,418**

Comment on above table if necessary
2010/11 elective activity is forecast to be lower than plan due to changes in case mix in some specialties, including general surgery and urology, and to lower levels of activity than planned in some specialties, including paediatrics. NHS Hertfordshire's 'prior approval' process has also put downward pressure on demand. Outpatient income is higher than planned as a direct result of greater than planned referrals. This was particularly the case in general surgery, ophthalmology, midwifery, orthopaedics and GUM. A&E activity is higher than forecast due to income from NHS Hertfordshire in respect of the Urgent Care Centre. Other NHS Income is forecast to be higher than planned due to higher income from high cost drugs, direct access activity, CQUIN and critical care. Other income is forecast to be higher than planned for a variety of reasons including: the identification of additional estates and recharge income as part of the Trust's delivery of savings; and over performance against a number of income lines. Income for 2011/12 and subsequent years has been forecast in line with discussions with NHS Hertfordshire.

4.4.3 Expenditure

Financial performance : Delivery against plan and future						
Operating expenses (*£000s*)						
Spend Area	**Plan**	**FOT**	**Var**	**Future Plan**		
	2010/11	**2010/11**	**%**	**2011/12**	**2012/13**	**2013/14**
Pay expenditure	£165,758	£160,222	-3.3%	£162,016	£159,836	£155,757
Non-Pay expenditure	£60,542	£78,118	29.0%	£76,916	£81,382	£80,944
Total Operating Expenditure	**£226,300**	**£238,340**	5.3%	**£238,932**	**£241,218**	**£236,701**

Any Other expenditure	£14,600	£11,726	-19.5%	£10,800	£11,113	£11,048
Total Expenditure	**£240,900**	**£250,066**	3.8%	**£249,732**	**£252,331**	**£247,749**

Commentary on above table, in particular:

– Explain significant variances from plan

– Explain future trends / changes

At the time of the submission of the 2010/11 plan, plans for the delivery of 2010/11 cost improvements were yet to be fully worked up and it was not possible to split the cost improvement target between pay and non-pay. The cost improvement target was allocated against non-pay, which affects expenditure variances.

Pay is forecast to be lower than the opening planned amount due to the delivery of a forecast £7.5m pay savings. This is offset by forecast budgetary pressures due to the cost of filling vacancies with agency staff.

Non-pay is forecast to be higher than the opening planned amount due to the identification of savings against pay, depreciation and financing, and income budget lines. Additionally, following the finalisation of SLA levels for 2010/11, non-pay budgets and spend increased due to higher activity.

2010/11 other expenditure is forecast to be lower than plan due to a reduction in depreciation and dividend charges following a revaluation of the Trust's estate in 2010.

Overall, expenditure has been above plan in 2010/11. This has been linked to activity levels and is forecast to be partially offset by higher income.

Future expenditure plans are based on the Trust's Long Term Financial Model. This reflects the forecast impact of commissioning changes agreed as part of the QIPP process, inflationary changes, and the planned delivery of efficiencies.

4.4.4 Reference Costs

Detail your Reference Costs for the last two years	2008/09	2009/10
	100	**101**

Comment on above table, in particular:

– Explain the scores and direction of travel

– Future target

– Particular areas / specialties with high scores

The Trust's relative efficiency has marginally worsened in 2009/10 when compared to 2008/09. The main reason for this appears to be a reduction in the Trust's Market Forces Factor (MFF). The MFF is an additional percentage added onto the Payment by Results tariff to cover the cost of providing services, including land / building costs and wages, in a particular geographical area of the country. Using the MFF from 2008-09 would give an index score of 100.4 for 09/10. The MFF has reduced from 1.177532 to 1.170761. Additionally the opening of the AAU has added to the cost base.

The Trust is looking at gaining further efficiencies from the re-organisation of services, including better use of the St Albans site and from reducing the operational inefficiency caused by providing the same services on 3 sites. These service redesign projects are embedded with the CIP and will obviously reduce the index if achieved.

The specialties with high scores are as follows:

A&E

The index for A&E is driven by the A&E department at Watford, the Minor Injuries Unit (MIU) at St Albans and the Urgent Care Centre (UCC) at Hemel Hempstead. However, it should be noted that the UCC is an expensive service model having 24/7 GP support.

Care of the Elderly (Geriatric Medicine)

The RCI is calculated with reference to the national average cost for the Healthcare Resource Group

(HRG) in question regardless of clinical specialty and age of the patient. The length of stay of elderly patients (and thus cost) is considerably higher than the average for all ages of patients. There may also be issues around how a patient's stay is recorded on PAS. At present there is no distinction between the acute phase of their stay and the rehab phase.

Ophthalmology and ENT
Both specialties have RCI scores of well in excess of 100 for their Day Case and Elective Inpatient work.

The utilisation of the Theatre suites has been reported as poor by NHS standards. Elective surgery has the advantage of a "cold" elective site at St Albans and should be returning a RCI well below 100.

Clinical Support
Both Pathology and Radiology are significantly more expensive than the national average. The Trust is reviewing data input processes to ensure costs are appropriately allocated to Pathology and Radiology.

4.4.5 Other Considerations

Outline other issues for consideration, for example, the impact of changes / developments upon:	
– Operating forecasts (e.g. impact on headcount or Agency/non-Agency mix); – Changes in resources needed to ensure compliance with national targets or core standards	– Confirmation that resource plans are consistent with projected service levels and funding

Unexpectedly high activity levels during 2010/11 put pressure on the Trust's resources, particularly beds. The Trust has managed this, in part, by the reallocation of space to create additional beds.

Decontamination has remained a difficult issue for the Trust. Plans are underway to provide a private sector solution to theatre sterilisation.

4.5 CAPITAL & ESTATE

4.5.1 Current Estate

Please provide a high level summary of your estate:	
– Number of sites operating from – Net Book Value – % identified as not fit for purpose	– Estate revenue implications (including capital charges but excluding Facilities Mgt) – proportion of leased/owned estate

Watford General Hospital, Hemel Hempstead Hospital, St Albans City Hospital
The Trust provides services from three main sites – Watford General Hospital, St Albans City Hospital, and Hemel Hempstead Hospital.

Watford Hospital occupies a 7.4 hectares freehold site to the west of Watford town centre in a low value residential area. The buildings on the site provide c62,274m2 of accommodation. The Cardiff Road industrial estate, Watford Football & Rugby Stadium, Vicarage Road and private residential accommodation bound the site.

Hemel Hempstead Hospital occupies a 5.3 hectares freehold site on the fringes of Hemel Hempstead town centre. The buildings on the site provide c22,760m2 of accommodation. The site is bounded by private residential accommodation at Maynard Road and Hillfield Road, by the English Partnerships owned "Maynard Road Car Park" to the South and by the English Partnerships owned "Paradise Fields" to the East.

St Albans City Hospital occupies a 6.1hectares freehold site on the fringes of St Albans town centre. The buildings provide in excess of c19,711 m2 of accommodation The land is bounded on all sides by residential accommodation and open parkland.

The Trust also operates from a small site of 0.15 hectares in St Albans separate from the main hospitals. This site is used to provide a pharmaceutical packing and assembly service. The building on the site provides in excess of c380m2 accommodation. Whilst isolated from the main hospital

sites the services generates income for the Trust which makes its continued use worthwhile.

The Trust owns the freehold to all the sites it manages. The PCT lease the Runcie Wing at St Albans and the Urgent Care Centre and GP Health Centre at Hemel.

Net book value is given in the table below:

	Watford Site	Hemel Site	St Albans Main Site	St Albans Minor Site
Land (hectares)	7.4	5.3	6.1	0.15
Gross Internal Area (m sq)	62,274	22,760	19,711	382
Land Value	£8.92m	£4.51m	£14.52m	£0.1m
Building Value	£41.53m	£30.47m	£15.80m	£0.20m

4.5.2 Backlog Maintenance

Backlog Maintenance					
	Plan	Forecast	Current plan		
	2009/10	2009/10	2011/12	2012/13	2013/14
Total Backlog Maintenance	£66.36m	£64.31m	£61.30m	£58.0m	£55.0m
Risk Adjusted Backlog Maintenance	£	£18.7m	£17.5m	£16.0m	£15.0m

Commentary on the above table re backlog maintenance

The Details on the Trust's backlog maintenance have been extracted from the ERIC return data 2009/10.

The Trust has planned and identified a minimum c£3.5m year on year to address this backlog maintenance, together with a site rationalisation project to reduce the Trust's backlog maintenance burden and utilise the estate in a more productive way. A comprehensive Strategic Estates Rationalisation Plan is currently being developed to ensure clinical services are delivered from the most appropriate locations within the Trust's sites and that high cost or high backlog space is vacated. This strategy was deployed at Hemel Hempstead in 2009/10 and realised a backlog saving of c£12m.

4.5.3 KPIs to demonstrate Estate Utilisation

Detail the KPIs reported to demonstrate increasing Estate Utilisation?
Include figures from last two reports

The Trust's ERIC Return Data Table for 2009/10 is shown below. This table shows the Trust's performance against key estate utilisation performance indicators and compares this to the performance of all acute trusts in England. The 'all trusts' performance is divided into ternaries which are shaded to indicate better (white), worse (dark grey) and medium (light grey) performance.

		Grouping PI		
PI Summary	**Trust PI**	**33%**	**34%**	**33%**
Space Efficiency				
Income £10/msq	242	242	243 and 284	285
Activity/100msq	92	99	100 and 110	111
Asset Value £10/msq	117	120	121 and 155	156
Occupancy Cost £/msq	207	174	175 and 206	207

Asset Productivity				
Asset Value £10/msq	117	120	121 and 155	156
Capital Charges £/msq	122	120	121 and 143	144
Total Backlog £/msq	612	90	91 and 197	198
Rent and Rates £/10msq	184	0	1 and 144	145
Asset Deployment				
Land £/msq	280	251	252 and 279	280
Building £10/msq	75	82	83 and 108	109
Equipment £/msq	146	166	167 and 199	200
Capital Charges £/msq	122	120	121 and 143	144
Estates Quality				
Asset Value £10/msq	117	120	121 and 155	156
Depreciation £/msq	71	80	81 and 92	93
Critical Backlog £/msq	133	20	21 and 47	48
Risk Adjusted Backlog £/msq	178	24	25 and 55	56
Cost of Occupancy				
Rent and Rates £/10msq	184	0	1 and 144	145
Energy/Utility £/10msq	306	210	211 and 239	240
Maintenance Costs £/10msq	356	214	215 and 299	300
Capital Charges £/msq	122	120	121 and 143	144

The Trust's ERIC Return Data Table for 2008/09 is shown below:

		Grouping PI		
PI Summary	**Trust PI**	**33%**	**34%**	**33%**
Space Efficiency				
Income £10/msq	209	215	216 and 266	267
Activity/100msq	76	93	94 and 121	122
Asset Value £10/msq	198	129	130 and 176	177
Occupancy Cost £/msq	246	89	90 and 196	197
Asset Productivity				
Asset Value £10/msq	198	129	130 and 176	177
Capital Charges £/msq	167	4	5 and 136	137
Total Backlog £/msq	506	87	88 and 197	198
Rent and Rates £/10msq	122	29	30 and 139	140
Asset Deployment				
Land £/msq	569	239	240 and 346	347
Building £10/msq	126	87	88 and 105	106
Equipment £/msq	142	159	160 and 188	189
Capital Charges £/msq	167	4	5 and 136	137
Estates Quality				
Asset Value £10/msq	198	129	130 and 176	177
Depreciation £/msq	91	4	81 and 92	93
Critical Backlog £/msq	125	13	14 and 48	49
Risk Adjusted Backlog £/msq	166	31	32 and 61	62
Cost of Occupancy				
Rent and Rates £/10msq	122	29	30 and 139	140
Energy/Utility £/10msq	338	238	239 and 302	303
Maintenance Costs £/10msq	327	205	206 and 228	229
Capital Charges £/msq	167	4	5 and 136	137

The PIs suggest an estate which is at the end of its design life, and possibly in need of rationalisation to achieve a more modern and functionally suitable infrastructure (depreciation £/m2 is low). There are also strong indications that the quality of this estate is generally below acceptable standards (total backlog £/m2 is high).

In order to address these concerns the Trust is embarking on a number of schemes to reduce risks and burden. These include a site rationalisation project to ensure the Trust delivers its clinical services in the right place for patients, energy projects to address its carbon footprint liability over the coming years and a c £10m backlog maintenance programme to bring it more in line with other NHS Acute Trusts.

4.5.4 Estates Strategy – including investment and disposals

Please bullet the key elements of your estates strategy which demonstrate how you will:	
– Improve estate efficiency and utilisation detailing from what, to? – Ensure functional suitability (fitness for purpose)	– Meet your planned service developments (including activity assumptions underpinning your plan) through your investment and asset disposal plans

Estates management plans 2011 -13 are being generated to

- Plan capital works for next three years to reduce backlog maintenance burden
- Improve the Trust's compliance and resilience of infrastructure to meet fitness for purpose
- Reduce poor ERIC return data

Site rationalisation plans to

- Improve estate operational efficiency through services delivered in "Right Place" model
- Reduce backlog maintenance burden
- Reduce energy costs
- Improve sustainability issues
- Dispose of surplus estate i.e. Pill Packing
- Improve space utilisation
- Improve patient experience and clinical adjacencies

4.5.5 Investment and disposal plans

Plan for material investment and disposals
The Trust is currently developing a disposal plan as part of the work associated with the Strategic Estate Rationalisation Plan.

Total Capital Spend – Actual spend against plan and future plans					
£000s	Plan	Actual	Current plan		
	2010/11	2010/11	2011/12	2012/13	2013/14
Estate	£3,600	£3,200	£3,300	£4,500	£4,100
Medical Equipment	£500	£600	£500	£1,000	£1,000
Decontamination Compliance	£1,300	£100	£2,900	£0	£0
Pathology Computer System	£2,300	£2,100	£500	£0	£0
Other Information Technology	£900	£1,100	£750	£1,700	£1,300
Site Reconfiguration	£0	£0	£1,350	£1,500	£2,100
TOTAL	**£8,600**	**£7,100**	**£9,300**	**£8,700**	**£8,500**

4.5.6 Source of Funding for Investments

Funding mechanisms for planned asset investment 2011/12 (£000s)							
Scheme Description	Scheme value £000s	Funding Source (*£000s*)					
		Depreciation	Surpluses from operating activities	Proceeds from assets sales	Charitable funds	Public capital via the DH	Private Funding
Estate	£3,300	£3,300	£	£	£	£	£
Medical Equipment	£500	£500	£	£	£	£	£
Decontamination Compliance	£2,900	£2,350	£	£550	£	£	£
Pathology Computer System	£500	£0	£500				
Other Information Technology	£750	£750	£0				
Site Reconfiguration	£1,350	£300	£0	£1,050			
TOTAL	**£9,300**	**£7,200**	**£500**	**£1,600**	**£0**	**£0**	**£0**

Brief commentary on the above table
Forecast depreciation in 2011/12 is £7.2m. Work in progress as at the end of 2010/11is £500k, as a significant proportion of this relates to the pathology computer system it is shown under this heading in the table above. Gross planned sale proceeds total £1.6m some of which will be used to relocate displaced services.

4.6 COST IMPROVEMENT PLANS (CIPS)

4.6.1 Past Year Performance and Future CIPs

Cost Improvement Plans (CIPs) - £000s						
	Plan	Forecast		Future plans		
	2010/11	2010/11	Var	2011/12	2012/13	2013/14
CIPs - Please include:						
– Pay	£3,400	£6,736	£3,336	£5,479	£5,136	£6,001
– Drugs	£800	£598	-£202	£543	£387	£569
– Estate		£881	£881	£2,572	£783	

– IM&T		£100	£100			
– Back office	£3,000	£310	-£2,690	£1,300		
– Procurement	£4,000	£306	-£3,694	£1,100	£500	£500
– Clinical supplies	£1,700	£176	-£1,524	£80	£66	
– Clinical services		£110	£110	£600	£120	£1,927
– Utilities	£600	£101	-£499	£10		
– Management		£903	£903	£400	£600	
– Other (Additional Income through working in active partnership/ repatriation/ negotiation of additional SLA income/ development of facilities)	£6,300	£8,114	£1,814	£1,416	£4,208	£2,933
Capacity Saving				£2,000		
Total	**£19,800**	**£18,335**	**-£1,465**	**£15,500**	**£11,800**	**£11,930**

Comment on 2010/11 CIP Delivery Against Plan including:	
Split between recurrent and non-recurrent CIPs in 2010/11	Recurrent - £13.7m Non-recurrent - £5.1m
Proportion of CIPs delivered in second half of the 2010/11	70.2%

Comment on the above tables including significant variances:

The Trust is forecasting delivery of £18.8m CIPs (7.3% of total income).This is a substantial achievement. However, at the time of annual plan submission, schemes were not yet fully worked up. This is reflected in the variances between forecast and planned delivery.

The savings process acquired momentum over 2010/11, with 70% of savings forecast to be delivered in the last six months of the year.

The Trust will build on the progress it has made in 2010/11 to develop its 2011/12 savings programme. Schemes to progress work begun in 2010/11 have already made substantial progress and work is continuing to deliver additional new savings.

Future CIP including:

- Split between recurrent and non-recurrent
- Proportion delivered in first half of year
- How CIPs are profiled to take account of seasonal variation?

Confirm you have detailed, risk assessed, implementation plans for 100% of your CIPs in 2011/12 and 2012/13. IF not 100% provide the %	2011/12 = 30%
	2012/13 = % TBA
Split between recurrent and non-recurrent CIPs in 2010/11	Recurrent - £13.7m Non-recurrent - £5.1m
Proportion of CIPs delivered in second half of the 2010/11	70.2%
Are CIPs profiled e.g. to take account of seasonal variation OR straight line	To take account of seasonal variation
Level of contingency (to take account of CIPs not delivered to plan or on time) as a value and percentage of CIPs	All departments will be tasked with delivering an amount in excess of their target to provide a contingency against delay in identifying savings.

Comment on Future CIP Delivery:

The Trust will build on the progress it has made in 2010/11 to develop its 2011/12 savings programme. Schemes to progress work begun in 2010/11 have already made substantial progress and work is continuing to deliver additional new savings.

4.6.2 Impact of CIPS on workforce

Impact of CIPs (and QIPP Plans) on the workforce (wte) (show total staff wtes for the organisation)

wte	**Plan**	**Forecast**	**Var**	**Future plans**		
	2010/11	**2010/11**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Clinicians	32	44	12	44	25	40
Nurses	34	71	37	70	70	64
Other Staff	24	44	20	50	55	39

4.7 IMPLEMENTATION OF SLR / PLICS

Detail your progress in implementing SLR and / or PLICS
Confirm when you will have all your services covered and your main barriers to overcome / actions.

The SLR/PLICS project is producing monthly reports. Reports at divisional and point of delivery level are now included in the board report pack. Point of delivery reports are included in the monthly performance management packs for each of the clinical divisions. However, further action to refine the charging of costs to specialties and to patients is required to develop the costing and reporting of the Trust's activity further. Sufficient computer programming resource has been put in place and this will be performed during early 2011/12. To be successful, the Trust needs to engage fully with clinicians. This is usually the most challenging part of all SLR/PLICS projects, and successful engagement is absolutely essential for the project to develop in a meaningful direction.

In addition to the above, further effort will be made to start to develop the Qlikview reporting package so that it covers the needs of both operational management and clinicians. This will require sufficient dedicated resource to develop Qlikview, and the input of both managers and clinicians. Clinical engagement is, again, paramount.

4.8 SUSTAINABLE DEVELOPMENT AND CARBON REDUCTION

For organisations registered for the UK's Carbon Reduction Commitment Energy Efficiency scheme (CRC), confirm you have made provision for the scheme following the amendments made following the Comprehensive Spending Review. eg. the non-recyclable element of CRC sale allowances**.**

The Trust has**:**

- Undertaken EUETS and CRC compliance projects
- Registered for the CRC and will continue to manage CRC requirements over the next three

years
- Established an Environmental Steering Group which has drafted a policy and strategy for the organisation
- Prepared a Draft Energy and Sustainability Policy for Trust board agreement
- Registered and completed two rounds of audit for GCCAM

CRC tax has been identified in the Trust's cost pressures for 2011/12.

The Trust is continually monitoring and targeting energy usage across all areas of work to identify and rectify areas of wastage, aiming to lower energy consumption progressively.

5. QIPP AND SYSTEM PLANNING

5.1 INVOLVEMENT IN SYSTEM QIPP PLANS

Outline your involvement in the development of the System QIPP Plans

The Trust has fully participated in the creation of the system-wide QIPP for Hertfordshire working alongside other members of the health economy. The Trust has executive director representation on the QIPP Programme Board and provides leadership to several workstreams.

What are the key priorities of the System QIPP Plan and your role in delivering these?

The Trust's key priorities and its role, in terms of financial deliverables, are set out in the table below. The table sets the context for the complete QIPP picture; the lines showing zero are opportunities being driven by the Trust's partner organisations elsewhere within the local health economy.

		2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m	Total £m
CHALLENGE: West Hertfordshire Hospitals NHS Trust		15.50	11.80	12.00	12.00	51.30
OPPORTUNITY						
	System Workstream					
1	Delivering sustainable care (urgent care, LTCs and planned care)	6.06	2.82	3.33	4.58	16.79
2	Improving mental health services	0.00	0.00	0.00	0.00	0.00
3	Improving end of life care	0.00	0.00	0.00	0.00	0.00
4	Delivering prescribing efficiencies	0.00	0.00	0.00	0.00	0.00
5	Transforming community services	1.20	0.92	0.92	0.92	3.96
6	Improving healthy lifestyles	0.00	0.00	0.00	0.00	0.00
7	Delivering specialised commissioning efficiencies	0.00	0.00	0.00	0.00	0.00
8	Improving ambulance services	0.00	0.00	0.00	0.00	0.00
9	Delivering acute workforce changes	5.16	4.00	4.20	4.20	17.56
10	Delivering collaborative procurement efficiencies	1.40	1.67	1.72	1.65	6.44
11	Transforming pathology services	0.63	1.74	1.17	0.00	3.54
12	Providing safe care	1.04	0.65	0.65	0.65	2.99
13	Improving adoption and spread	0.00	0.00	0.00	0.00	0.00
14	Running costs and estates					0.00
	Total Opportunity Identified	15.50	11.80	12.00	12.00	51.30

Have you formally signed off the System QIPP Plan?

Yes, on 17th February 2011

Confirm that your System QIPP Plan aligns directly with your Annual Plan
If not, explain how it differs and why

The Trust's Annual Plan aligns with the System QIPP Plan with the qualification that the Annual Plan is more recent, and reflects changes and developments within the Trust and the local health economy

since the production of the QIPP Plan on the 17th February 2011.

Are you leading on any Work-Streams?

The Trust provides specific leadership for the following QIPP workstreams:

- Unplanned Care
- Planned Care
- Delivering Acute Workforce Changes
- Delivering Collaborative Procurement Efficiencies
- Estates Rationalisation
- Back Office and Support Services Review

Of particular note is the fact that the Trust is leading the system-wide workstream to review back office and support services. This is led by the Trust's Director of Finance.

5.2 QIPP KPIS TO DEMONSTRATE QUALITY AND PRODUCTIVITY IS IMPROVED

KPIs you track to demonstrate QIPP

- Which **Key** Performance Indicators do you track?
- Include agreed targets for 2011/12 and current trajectory against plan.
- Label (where possible) each KPI as Quality, Workforce, Activity or Finance.
- How did you identify which of your performance indicates are "KEY".

KPIs as set out in the IBP are shown in the table below:

KPIs		Mar-10	Mar-11	Mar-12	Mar-13	Mar-14	Mar-15	Mar-16
Average Length of Stay (Elective incl Day Cases @ 1 day)	Days	1.53	1.54	1.52	1.48	1.45	1.45	1.45
Average Length of Stay (Elective excl Day Cases)	Days	2.88	2.70	2.51	2.33	2.33	2.33	2.33
Average Length of Stay (Non Elective)	Days	4.96	4.83	4.68	4.53	4.38	4.38	4.38
Average Length of Stay (Total incl Day Cases @ 1 day)	Days	2.82	2.84	2.72	2.59	2.59	2.59	2.60
Average Length of Stay (Total excl Day Cases)	Days	3.97	3.64	3.61	3.42	3.42	3.42	3.42
Bed Occupancy	%	82%	81%	81%	80%	80%	80%	80%
Theatre Utilisation	%	77%	78%	84%	86%	88%	88%	88%
Day Case Percentage (Day Cases/ Spells)	%	37%	37%	35%	33%	32%	31%	31%
New to follow up outpatient ratio	%	62.5%	62.5%	62.5%	62.5%	62.5%	62.5%	62.5%
New to follow up outpatient ratio	Ratio	1:1.7	1:1.6	1:1.6	1:1.6	1:1.6	1:1.6	1:1.6
Avg. number of consultant PA sessions	Week	11.5	11	10.5	10.5	10.5	10.5	10.5
Number of beds		654	654	624	594	564	564	564
Local population	000's	536	539	541	544	548	553	558
Staff turnover	%	12.30%	9.50%	9.00%	8.50%	8.00%	7.50%	7.00%
Staff sickness rates (long term rate)	%	2.30%	2.10%	2.00%	1.90%	1.80%	1.70%	1.60%
Staff sickness rates (short term rate)	%	2.10%	1.90%	1.80%	1.70%	1.60%	1.50%	1.40%
Percentage of vacancies	%	7.10%	7.10%	7.10%	7.10%	7.10%	7.10%	7.10%
Readmission rates (within 28 days)	%	4.10%	4.10%	4.10%	4.10%	4.10%	4.10%	4.10%
% of staff appraisals in last 12 months	%	70%	81%	100%	100%	100%	100%	100%

Detail the KPIs you track to demonstrate QIPP

- Explain how the Board is assured that Quality of individual services is being maintained or improved and that productivity is improving
- How is the Board assured regarding the quality of data underpinning your KPIs

The Trust Board will track the KPIs identified above to demonstrate QIPP as part of its overall performance monitoring process. In addition, the Trust's internal QIPP work streams (Big Ask) are monitored via the robust programme management arrangements that complement the Big Ask. These arrangements include a monthly executive Programme Board chaired by the Director of Strategy and Infrastructure and regular divisional review meetings that take place fortnightly. The progress of the various work streams is reported to the Trust Board on a monthly basis as part of the Finance Report.

The Trust has devised a rigorous gateway process which is used to ensure that schemes are not implemented without full consideration of the impact on patient care, safety along with other aspects of service in the Trust.

The Trust's data quality assurance framework is based on the individual assessment of data items against a data quality confidence level: high, medium and low. Data items with low confidence levels

are not used in the reporting of KPIs.

6. RISK ANALYSIS

6.1 ORGANISATIONAL RISKS

Top risks which may prevent the organisation from delivering its key objectives in 2011/12					
	There is a "Risk" that…	**Likeli-hood**	**Im-pact**	**Score**	**High Level Mitigating Actions Agreed / Planned**
1.	The Trust will not achieve a surplus of £4.4m at year-end 2011/12 and therefore achieve a financial risk rating of 3 if it fails to achieve agreed savings target. NOTE: This is the current BAF risk 2286 modified to reflect 2011/12	4	5	20	• Central controls on all expenditure. • Financial Recovery Plan in place and closely monitored
2.	The Trust will fail to achieve an adequate Monitor risk rating based on Trust liquidity levels if existing loans cannot be refinanced	4	5	20	• Application to DH for loan re-scheduling. • Central controls on all expenditure strengthened with a focus on liquidity. • Asset sales being explored.
3.	Seasonal peaks in emergency pressures will compromise the Trust's ability to deliver services within budget	5	4	20	• Internal mitigating actions in place and monitored. • Escalation arrangements in place.
4.	Inability to discharge patients when acute medical care is no longer required will affect the Trust's ability to deliver its elective workload and its ability to achieve A & E targets..	5	4	20	Internal strategies to mitigate including more focused discussions with patients/family to promote timely discharge. Discharge Review Group established with membership from PCT and Community Trust.
5.	Failure to achieve NHSLA Level II in June 2011 will result in reduced confidence levels in the Trust delivering safe care. This will affect CQC QRP and possibly consumer/purchaser confidence. Inability to reduce exposure to increasing subscription costs is also a cost pressure.	4	4	16	• Promotion of requirements throughout the year. • Communications Plan in place. • NHSLA walkarounds in place. • Scrutiny Panels scheduled for March 2011.
6.	Residual estate issues will be detrimental to the smooth delivery of services.	5	4	20	• Estates Management Plan in place • Detailed backlog maintenance programme underway linked to 5 year capital programme • Emergency Preparedness Plan in place.

Top risks which may prevent the organisation from delivering its key objectives in 2011/12					
	There is a "Risk" that…	**Likeli-hood**	**Im-pact**	**Score**	**High Level Mitigating Actions Agreed / Planned**
7.	Maternity staffing overspend (relating to complying with national maternity staffing ratios and key roles) will threaten achievement of Trust's financial targets.	4	4	16	Roll forward forecast model adopted to preserve quality but risks financial objectives.
8.	The Trust will fail to influence and work with partners to achieve affordable health care in a complex system.	4	4	16	Working with Clinical Conclave and QIPP programme to scope service re-design/re-configuration.
9.	The Trust will not be able to treat patients within the 18-week referral to treatment target because of a lack of capacity.	3	5	15	• In depth review of elective demand, led by Medical Director. • Internal solutions being progressed including progressing flexibility of beds off WGH site.
10.	The Trust will fail to recruit, retain and motivate appropriately trained workforce, which will result in threat to service quality, efficiency and cost effectiveness.	3	4	12	• Implement Workforce Development Strategy • Improve Job Planning.

Commentary on above table including confirming how often the risk register is presented to the Board.

The Board Assurance Framework captures the organisation's key risks to its strategic objectives and the top ten are detailed above. The BAF is reviewed at each meeting of the Trust's risk sub-committee, chaired by non-executive director and is presented for review at each meeting of the Trust Board. In addition the BAF is included on the agenda of each Audit Committee meeting. The BAF cross references each risk against CQC registration outcomes and, against each entry, reference is made to Board reports related to the risk. Each risk on the BAF is owned by an executive director of the Board who is responsible for ensuring the effectiveness of the controls in place to manage the risk.

The risks detailed above represent the ten highest scoring risks to the achievement of the Trust's strategic objectives and reflect clinical, financial and performance risks. The scores outlined reflect that the Trust has a significant appetite for risk but believes it has identified the key controls required to manage the risks, recognising both the financial and estates constraints it operates within. The Trust is working towards achieving Foundation Trust status and the financial risk scores reflect the importance of reducing financial exposure to achieve this.

Significant operational risks are captured via Divisional Risk Registers and these are reviewed at Divisional Integrated Standards Executive meetings. The scrutiny of risks registered on the Trust's risk database has significantly improved both divisionally and via improved central monitoring. This ensures that the Trust's risk management strategy is directing dynamic risk management.

6.2 SPECIFIC OTHER RISKS

6.2.1 SUSTAINABLE DEVELOPMENT

Outline the specific risks relating to climate change and delivering a 10% reduction in carbon dioxide emissions by 2015 on 2007 levels, and in meeting relevant legislation and regulatory requirements	
– Description of the risk	– Mitigating actions
Risk: Engagement and support Mitigating Action: Workshops and publicity are planned to mitigate this risk Risk: Moving targets Mitigating Action: Constantly reviewing current status, and monitoring and acting on new information Risk: Investment shortfall Mitigating Action**:** Planned investment through the Trust's capital programme	

6.2.2 IM&T

Comment on your organisational risks relating to IM&T	
– Compliance with national information governance requirements by July 2011 – Achievement of minimum "Level 3" in the National Infrastructure Maturity Model (NIMM) Foundation Assessment	– Implement electronic discharge, clinic and A&E letters within 24 hours using the NHS Number as the unique patient identifier
The Trust has an action plan in place to achieve compliance with all the national information governance requirements by July 2011. The National Infrastructure Maturity Model Assessment has not been undertaken in the last thee years and the Trust is unable to comment on its current achievement level. The Trust's IT systems support electronic discharge, clinic and A&E letters within 24 hours using NHS Numbers when available. The key risk associated with IM&T is that the IT work programme and disaster recovery requirements for the next 5 years will inevitably place pressures on the Trust's capital and revenue budgets. However, infrastructure replacement and development work streams must be completed within the 5-year timeframe if the Trust is to meet its aims to support clinical care and management, and deliver an Electronic Patient Record.	

7. QUALITY

7.1 CQC REGISTRATION

Registration with CQC on 1st April 2010		
Were you registered with CQC on 1st April 2010 without conditions?	Yes	
If "No", please explain below:		

Current status	
What is your current status with date last assessed)?	Registered with no conditions. No formal assessment of overall status. CQC issues, on a monthly basis, Quality and Risk Profiles against which the Trust reviews its compliance status.
If conditions still exist, explain what conditions and your planned actions: Detail you action plans and implementation of quality improvements following a CQC inspection?	

7.2 QUALITY ACCOUNTS 2010/11

Determination of your 2010/11 Quality Account (QA). Explain:

- How did you determine the "*measures that mean most to your patients*"?
- How do you "*review your services and engage with stakeholders in setting priorities for the future*"? (patients, public, governors, OSC, PCT and LINks
- Confirm you are already "*measuring performance over time and benchmarking against peers*".
- Has this information been presented to the Board recently?

The Trust determined the priorities for the 2010/11 Quality Account by bringing together several separate information sources, creating a 'long list' of possible measures, and whittling this list down through the interaction of patients, staff and members.

The Trust developed the 'long list' from an analysis of complaints, patient comment cards, feedback from PALs and the outcomes of national and local surveys. The Trust also held discussions with the County Council Overview and Scrutiny Committee and with LINKs and fed the intelligence gained into the process of developing the Quality Accounts.

Through its developing member network the Trust is creating opportunities to receive feedback on the services currently provided and those to be provided in the future. Additionally the Trust seeks views from people attending the hospital from the comment cards placed around the hospital. Where appropriate specific consultation events are held to seek views on service changes. The Trust meets regularly with NHS Hertfordshire, its GPs, the Overview and Scrutiny Committee and LINKs to discuss priorities for the future.

The Trust has in place a series of performance processes and measures that look at the performance of individual wards, divisions and the corporate organisation. Through regular division performance review meetings data is analysed and actions identified where appropriate in order to ensure that agreed performance measures are achieved. The Trust Board receives a regular performance report indicating performance against the national and locally agreed performance criteria.

The Trust produces a performance dashboard that forms part of the performance reporting to the Trust Board. Some of the indicators relate to the quality of care provided. However, as part of the process for reviewing the outputs agreed in the 2010/11 Quality Account a more specific quality dashboard will be developed.

Data quality of information underpinning the metrics included within your QA:

– Do you have a "Quality Dashboard" – What level does it drill down to i.e. at the point at which care is delivered e.g. ward level – What is the assurance process undertaken between point of delivery and reporting to Trust Board?
Quality metrics are reviewed at divisional board level prior to reporting to the Trust board.

7.3 QUALITY AND SAFETY PERFORMANCE

7.3.1 Hospital Standardised Mortality Ratio (HSMR)

Which provider of HSMR data do you use – Dr Foster, CHKS, other?
CHKS

HSMR by Quarter for the Whole Organisation						
2009/10				**2010/11**		
Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
103*	86*	92*	95*	102*	104*	N/A
78**	65**	68**	66**	66**	63**	63**

Note: * The figures above are from Quality Intelligence East, based on Dr Foster
** The figures above are from CHKS

Commentary on HSMR
The HSMR for the Trust is within expected limits. It is noted that the two sets of figures, Dr Foster derived and CHKS, are very different.

Provide the last four quarters HSMR for your outlying services / specialities in Q3 2010/11				
Service / Specialty with outlying HSMRs	**Q4 2009/10**	**Q1 2010/11**	**Q2 2010/11**	**Q3 2010/11**
Rheumatology	-	180	43	149
Haematology	107	81	-	140
Anaesthetics	93	86	109	138

Note: The figures above are from CHKS

For the specialties / services above, please explain:

– The reasons for the high ratios
– The target to be achieved during 2011/12 and by what date
– The actions taken by the Board to drive down HSMR in these services / specialities

The figures above are not statistically better or worse than the national average. The wide variation is associated with low numbers of spells in the sample. The table below shows the number of spells per specialty for each quarter.

Nr of Spells to Determine HSMR	Q4 2009/10	Q1 2010/11	Q2 2010/11	Q3 2010/11
Rheumatology	5	13	27	14
Haematology	13	23	27	34
Anaesthetics	75	69	70	42

7.3.2 Readmissions within 30 days

Re-admissions within 30 days						
2010/11					**Future Targets**	
Target 2010/11	**Q1**	**Q2**	**Q3**	**Q4**	**Target 2011/12**	**Target 2012/13**
No target	73	96	81	Est 60 to	No	No payment

				80	payment	

Comment upon delivery in 2010/11 against your target and your plans to achieve future targets
The Trust did not have a formal target for 2010/11. In 2011/12 the Trust will receive no remuneration for services provided to patients re-admitted within 30 days. There is no formal numerical target.

7.3.3 Single Sex Accommodation

Report how many breaches you had which were not clinically justified? Detail the financial penalties imposed for these breaches						
	Target 2010/11	**Q1**	**Q2**	**Q3**	**Q4**	**Target 2011/12**
Performance				4	N/A	
Financial Penalties Incurred	Nil	Nil	Nil	Nil		Nil

Comment upon delivery in 2010/11 against your target, the financial penalties incurred and your plans to achieve future targets
The Trust achieved reliable data capture only in the second half of the year. While not achieving a zero level of breaches, the Trust has demonstrated significant progress in developing systems to address this important target. Owing to the nature of the breaches, there were no financial penalties incurred as at mid-March 2011. The Trust's plans to achieve future targets by careful use of the bed and bay assets combined with increasingly sophisticated management of the flow of patients through the Watford hospital. The shortly-to-be-implemented electronic bed management system will assist in this. The governance structure for achievement of this target is a weekly meeting chaired by an executive director where breaches are subject to rigorous analysis and challenge, and where plans to address shortcomings are prepared in draft for later refinement and implementation.

7.3.4 Compliance with VTE

Performance in undertaking VTE risk assessments						
2010/11					Future Targets	
Org Target* 2010/11	**Q1**	**Q2**	**Q3**	**Q4**	**Target 2011/12**	**Target 2012/13**
Yr End 90%	55.7%	54.2%	65.4%	90% Est	100%	100%

* Link to CQUIN as appropriate

Comment upon delivery in 2010/11 against the target and your plans to achieve future targets What are your plans to audit compliance with the agreed patient management plan?
The Trust has made significant progress towards the achievement of the VTE target and expects to be compliant at the end of Q4. A dedicated nurse is now in place ensuring assessments are carried out, and data capture and analysis systems have been reviewed and improved. The Trust plans to achieve routine compliance by ensuring robust procedures at all points of entry for patients into the Trust. The governance structure for achievement of this target is a weekly meeting chaired by an executive director where breaches are subject to rigorous analysis and challenge, and where plans to address shortcomings are prepared in draft for later refinement and implementation.

7.3.5 Complaints

How many complaints did the organisation receive in 2010/11 (to month 11 if necessary) How is the Trust Board assured that the organisation is learning from complaints?
The Trust received 402 complaints during the first 11 months of 2010/11. There is a process within the Trust of divisional boards reviewing individual action plans that are written as a consequence of specific complaints. Only once action has been taken and agreed will this be signed of by the divisional boards as complete. There is a regular report to the board on complaints, litigation and incidents, and on the lessons learnt. Additionally the quarterly meeting of the Complaints, Litigation, Incidents and PALs (CLIP) meeting provides a forum for mainly clinical staff to review the actions they have taken within a specific division and to identify whether there is cross organisational learning that would be beneficial.

7.3.6 Serious Incidents and Never Events

Serious Incidents and "Never" Events		
	2009/10	**2010/11**
Number of Serious Incidents	14	38*
Number of "Never" Events	Not reported	3*

* As at the end of February 2011

Comment on the above table regarding S.I.s and Never Events
The Trust started reporting Never Events from April 2010. There were no incidents reported as never events in the preceding year. It will be noted that the number of serious incidents generally has increased within the Trust. This is attributed to: 1. Updated Serious Incident Policy. This was developed as a stand-alone policy providing greater clarity to staff on what constitutes a serious incident and includes details of Never Event incidents. The policy was updated following the NPSA's report following its consultation on the management of serious incidents. The policy was further adapted to reflect additional requirements detailed in the publication of the PCT's Serious Incident Policy. 2. The requirement from 1 November 2010 to report all Grade 3 and 4 pressure ulcers as Serious Incidents. Year to date, 6 grade 3 or 4 pressure ulcers have been reported. 3. The requirement to report infection control outbreaks was clarified only in-year. Previously only MRSA bacteraemia were reported as serious incidents. 4. A breakdown of incidents reported to date reveals: a. 3 Never Events, of which one was a 'moderate harm' and the remainder 'low harm' events with no detrimental impact on the patient b. 6 pressure ulcer incidents A full year-end analysis of themes identified from this year's Serious Incidents is currently being undertaken. 5. The Trust has improved its processes for managing serious incidents and a Serious Incident Co-ordinator appointed to ensure the correct processes are followed and that timelines are adhered to. This post also provides the key point of contact with the PCT on matters related to serious incidents. 6. A summary report on Serious Incidents is presented for review at each meeting of the Business Integrated Standards Executive, chaired by the Director of Patient Safety, the Medical Director. The closed session of the Trust Board also reviews a summary report on Serious Incidents and all Executive Directors are informed when a Serious Incident is declared.

7.4 PATIENT AND CARER EXPERIENCE

7.4.1 Compliance re Patient Experience

Confirm progress against:	
– CQC's Essential Standards – Outcome Framework (Domains 2 & 4) – National Surveys	– PROMS – Local patient and carer experience survey results

Patient and Carer Experience

The Trust remains compliant in respect of its Outcome 1 Regulation 17 – Respecting and Involving People who use the Service.

Patients who use the service, or those acting on their behalf, are involved and listened to in assessing, planning and carrying out individual care, treatment and support. They are also given the information needed to help them make choices about their care, treatment and support. This is done in an appropriate format (for example, large print, easy read, audio versions, appropriate language). Independence, privacy, and dignity needs are respected.

The Patients' Panel and LINks continue to support joint working within the Trust and to share good practice with local communities. The Trust has Named Nurses for Safeguarding Vulnerable Adults and for Safeguarding Vulnerable Children.

During 2010 the Trust participated in the following National Surveys:

- National Inpatient Survey 2010 – expected publication date April/May 2011
- National Cancer Patient Survey 2010 – published in December 2010
- National Maternity Survey 2010 – published in December 2010
- National Outpatient Survey 2009 – published in January 2010

In order to maximise the benefits to patients arising from patient surveys, the Trust has established a dedicated Patient Experience Working Group. This is chaired by the Director of Nursing.

Patient Reported Outcome Measures - PROMs

The Trust implements the mandatory PROMs collection at the point where the patient attends Pre Operative Assessment. Patients are sent their 2nd questionnaire by the DH designated analysts. During 2010 the Trust saw 1,571 patients who were eligible to complete the questionnaires. Of these 1,531 (97.45%) did so. This performance has ranked us 2nd in the country. The first two months of 2011 has shown a 100% performance. Very little data has, as yet, been returned and the Trust is unable to comment on the results contained within the PROMs.

Operating Framework Domain 2 & 4

Enhancing quality of life for people with long term conditions and ensuring that people have a positive experience of care

This is an integral part of the Trust's drive to improve services and is incorporated into everything the Trust does.

Local Patient and Carer Experience Survey Results

The Trusts undertakes local surveys carried out both by independent organisations and the Trust's own staff. In 2010 the Trust commissioned two further local outpatient surveys to monitor the impact of the significant effort to improve patient experience. Additional initiatives have also been set up to effect positive change for patients and carers through an AAU local survey and a 48hr post discharge telephone calls. The Trust also employs 15 Patient Experience Trackers (see below) situated across the Trust. In addition, the Trust uses Comment Boxes, Cards and Listening Boards.

Patient Experience Trackers

The Trust has captured local 'real' time patient data from its patients and carers by using Patient Experience Trackers (PET) purchased from Dr Foster. Fifteen of these electronic devices have been used across the Trust. The weekly reporting gives feedback to the ward/department PET leads and Matrons to drive improvements. Feedback was also given back to the patients, carers and members of the public by information posters situated within the relevant wards and departments.

48hr Post – Hospital Discharge Telephone Calls:

A team of staff telephone patients some 48 hours after their hospital discharge. These courtesy calls

were set up to provide direct and immediate feedback to the Trust.

Both the PET and 48hr Post Hospital Discharge call initiatives used questions linked to the five CQUIN target.

AAU Local Patient Survey:
This survey was carried out during the month of August 2010 with 900 responses. Trust staff from all areas were involved in surveying patients on both Levels 1 and 3 of the AAU with immediate feedback and action on the issues raised.

7.4.2 Recent Results

Bullet your most recent national/local Patient Experience results. To include:	
Top 3 areas	**Bottom 3 areas**
National Inpatient Survey 2009/10 – results for 2010/11 expected in May 2011	
• Cleanliness of wards	• Hospital discharge in respect of delays
• Hand-wash gel visible and available for patients and visitors to use	• Information received
• Overall rating of care was good or excellent	• Finding staff with whom to discuss concerns
National Cancer Survey 2010 - December 2010	
• Hospital staff gave information on getting financial help	• Always / nearly always enough nurses on duty
• Staff told patient who to contact if worried post discharge	• Nurses did not talk in front of patients as if they were not there
• Given clear written information about what should / should not do post discharge	• Always treated with respect and dignity by staff
Local Outpatient 'Picker' Survey 2009 – published in September 2010	
• Hospital environment and facilities	• Tests and treatments
• Overall with respect to the appointment	• Seeing another health professional
• Waiting	• Before the appointment
Local Acute Admissions Unit Survey – August 2010	
• Caring, friendly atmosphere	• Meal times – only sandwiches offered
• Impressed by cleanliness and very efficient	• Communication – Not enough information about treatment
• Much better than other emergency services	• Bored – More books, newspapers

What are your main areas for development as agreed by your Board
The Trust Board is focusing on organisational change to facilitate a new approach to supporting the patient experience and thus ensuring continuous improvement in the patient experience and hence in survey results.

7.4.3 Future Patient and Carer Survey Strategy

Outline your strategy to ensure appropriate systems are in place to capture the views of patients, service users and carers for ALL of your services. To include	
– Confirm whether ALL services will undertake a survey at least annually in future.	– Detail the key actions required to improve?

Patient satisfaction is driving the government's healthcare agenda and, increasingly, what patients think of services is the fundamental determinant of income flows. The Trust is required to use feedback from its local population to inform the decisions that it makes about services.
Monitor has also pointed to a future in which NHS Foundation Trusts and other trusts will act much more like commercial organisations - financially robust, and above all, customer focused.

In the past the Trust has been reliant on national inpatient survey results which, though valuable in benchmarking, provide results some six months after the patient experience. Patient Experience Trackers have been used to successfully gain live feedback, but are only serviceable within the hospital building and provide limited options for questions.

Currently the Trust seeks feedback from patients through surveys and questionnaires, phone calls and face-to-face discussions, all of which require much work to administer, analyse and review in order to put actions in place to improve services. The Trust's strategy going forward is to create a continuous cycle of real-time patient feedback, thus better understanding its patients' views, and enabling truly customer focused services. The Trust aims to design and administer surveys for all its patients. The Trust currently does not have a robust approach to collecting feedback from its youngest patients or the many patients for whom it provides day care. Using 21st century technology, however, will allow it to design appropriate and consistent surveys for patients that can be responsive to concerns, service changes or simply to audit progress on improvement initiatives.

7.4.4 Use of Advocacy (Net Promoter) Question

Do you use the 'Advocacy' (net promoter) question in patient surveys? Please indicate with an "X"							
YES – ALL		**MOST – NEARLY ALL**	**X**	**SOME**		**NO**	

Commentary on use of the Advocacy (Net Promoter) question: – Explanation regarding your above assessment
The Trust had the opportunity to use the Advocacy (Net Promoter) question regarding whether the patient would recommend the service to their friends and families on the Patient Experience Trackers (PET) and the Trust-wide Comment Cards. The question also forms part of the National Inpatient and Local Outpatient Survey questionnaires and the NHS Choices website feedback system. This feedback is examined on a regular basis and comments highlighted to the Divisions and reported to the Board.

7.5 RISK – QUALITY AND SAFETY

7.5.1 Quality & Safety Risks

Top 3 Quality and Safety Risks					
	There is a "Risk" that…	**Likeli-hood**	**Im-pact**	**Score**	**High Level Mitigating Actions Agreed / Planned**
1	Residual estate issues will be detrimental to the smooth delivery of services.	5	4	20	• Estates Management plan in place • Detailed backlog maintenance programme underway linked to 5 year capital programme • Emergency Preparedness Plan in place
2	Seasonal peaks in emergency pressures will compromise the Trust's ability to deliver services within budget	5	4	20	• Internal mitigating actions in place and monitored. • Escalation arrangements in place

Top 3 Quality and Safety Risks					
	There is a "Risk" that…	**Likeli-hood**	**Im-pact**	**Score**	**High Level Mitigating Actions Agreed / Planned**
3	Inability to discharge patients when acute medical care no longer required impacts upon the Trust's ability to deliver it's elective workload and its ability to achieve A&E targets	5	4	20	• Internal strategies to mitigate including more focused discussions with patients/family to promote timely discharge. • Discharge Review Group established with membership from PCT and Community Trust.

Commentary on the above table

The residual estates issue is a long term, inherited difficulty. The Trust has addressed the risk by means of implementing a multi-stranded mitigation action plan. This risk will continue to exercise the Trust into 2011/12 and beyond. The intention is to reduce the risk rating to 12 by means of the mitigating actions.

Seasonal peaks in emergency pressures are an inherent risk to acute trusts although the impact of flu over the winter of 2010/11 created very significant and unusually high pressures at Watford. The intention is to reduce the risk rating to 10 by means of the mitigating actions.

The discharge risk has been subject to considerable discussions with NHS Hertfordshire and significant progress has been made in partnership working. The intention is to reduce the risk rating to 10 by means of the mitigating actions.

What is your current NHS Litigation Authority Assessment Level
What are your plans to improve to the next level and by when. Include key milestones

NHSLA General Level 1 – Assessment at Level 2 scheduled for June 2011
CNST Maternity Level 2 – Assessment at Level 3 being planned for 2012.

7.5.2 Quality and Safety

Specific commentary on:

- Approach to reducing HCAIs
- Approach to management of Serious Incidents
- Implementing VTE prevention
- Closing the loop – compliance with recommendations
- Compliance with Secretary of State directions
- List the number of NPSA CAS Alerts which you have not complied with by the deadline with explanations.

HCAI Reduction

The Trust's Infection Control Committee oversees the implementation of the Trust's infection control strategy. This focuses on three key themes in the prevention and management of hospital acquired infections: cleanliness and hygiene, antibiotic prescribing, and human factors and processes (as expressed via reporting and learning from root cause analysis).

The committee reviews the on-going programme of infection control related audits and ward performance is monitored closely, and feedback provided.

Approach to Management of Serious Incidents

The Trust's Clinical Quality and Governance Committee oversees the management of issues arising, and the lessons learnt, from serious incidents. The focus is on ensuring that incidents are robustly investigated, lessons are learnt and that actions to implement changes are carried out in a timely manner.

VTE Prevention

The Trust, via the work of the Thrombolysis and Anticoagulation Committee, is working to achieve 100% of eligible patients being assessed for risk of VTE. Capturing the data has presented problems

during 2010/11 however on-going audits have demonstrated that patients are being assessed. The Trust is introducing Root Cause Analysis for all deaths resulting from PE and this will be extended to all hospital acquired DVT during 2011/12. VTE champions have been appointed aligned to departments and their role is to support and educate staff in VTE prevention.

Closing the loop
All recommendations emanating from serious incident investigations are pursued via scrutiny at divisional Integrated Standards Executive and monitored via the Serious Incident Review Group. A process is being piloted for complaints to improve assurance in relation to learning from complaints. A process will be developed for Solicitors' Risk Management Reports on Claims and where relevant, Rule 43 letters from the Coroner.

CAS Alerts
The Trust has significantly improved its processes for managing CAS alerts and achieving timely closure. Immediately an alert is issued work is initiated to achieve compliance as many alerts can be complex to implement and may require additional, unbudgeted resources. Thus, the Trust currently has 2 NPSA alerts which are still open:

2010-009 Reducing Harm from Omitted and Delayed Medicines in Hospital - all complete just waiting for the Trust Medicines Management Policy to be ratified on 14/3/2011. The deadline for this alert was 24/02/11

2010-015 Prevention of over infusion of intravenous fluid* and medicines in neonates - again it is hoped that this alert will be closed on 14/03/2011 at the Business Integrated Standards Executive.

7.5.3 Governance Risk Rating (GRR)

Governance Risk Rating (GRR)- Actual GRR for 2010/11 and predicted GRR for 2011/12		
	Actual 2010/11	**Predicted 2011/12**
Governance Risk Ratings (GRR)	Average at 1.7 over 11 months: Amber/Green	TBA
Comments on GRR		
The GRR varied across the year from 0.5 to 3.0 with an average of 1.7. Under the East of England Provider Management regime, this equates to a RAG rating of amber/green.		

7.5.4 Contractual Risk Rating (CRR)

Contractual Risk Rating (GRR)- (Red / Amber / Green)		
Actual CRR for 2010/11 and predicted CRR for 2011/12	**Actual 2010/11**	**Predicted 2011/12**
Contractual Risk Ratings (CRR)	Green	TBA
Comments on your predicted CRR		
The 2011-12 Contract has very challenging targets set by the host commissioner to manage demand down. Given that similar targets in 2010-11 were not fully achieved by the host commissioner there remains a significant risk that activity will not reduce creating over-performance that the host commissioner will not be able to afford.		

Detail the percentage and value of CQIUN achieved in 2010/11. If 100% has not been achieved, explain why not.
Only some 70% is expected to be achieved. Poorer than expected results from the National Patient Survey accounts for 10% of the shortfall. A further 10% is due to non-achievement of the target for Chlamydia screening. There are other smaller reductions around Stroke and Smoking Cessation targets.

Which of your contracted targets are most at risk in 2011/12? What are the financial implications of missing these targets? What are you doing to ensure you will ensure these contractual targets are met.
NHS Hertfordshire has set very challenging targets in terms of demand management, with an expectation that almost £9m of work will not be required in 2011-12 compared with 2010-11. As the Trust reduces capacity in line with demand reductions, there is a risk of demand fluctuations, or unexpected reversals in the demand reduction, putting pressure on the 18 week target. The Trust is working with the PCT to determine how such reductions might be made and the timescale for their delivery. There is also concern that due to extreme emergency pressures the SSA requirements are not always achievable.

8. WORKFORCE DEVELOPMENT

8.1 WORKFORCE PROFILE AND DEVELOPMENT STRATEGY

8.1.1 Current Workforce Profile

Summary of Workforce (WTE) Current and Projected				
Staff Category	**2010/11**	**2011/12**	**2012/13**	**2013/14**
• Medical and Dental	491	521	510	490
• AfC Clinical	2,092	2,164	2,054	1,972
• AfC Managers & Administrators	987	870	922	885
• VSM (Very Senior Managers)				
Total	**3,570**	**3,554**	**3,486**	**3,347**

Note: The table above shows the establishment workforce

Comment on the above table including your workforce planning process
The planned decrease in staffing numbers relates to the planned reduction in activity and plans to increase the number of staff working in community settings. These plans alongside drives to reduce capacity through achieving higher bed and theatre utilisation and improving length of stay and clinical productivity all impact on the number of clinical staff required. The decrease in administrative staff is based on the development of back office shared services and the impact of improved efficiencies from the implementation of IT systems. 2010/11 figures are based on establishment levels at the end of January. Forecast figures for 2011/12 onwards are in line with the Trust's Long Term Financial Model and reflect: forecast efficiencies, including reduction in sickness rates, the delivery of efficiencies and changes in capacity linked to commissioning.

8.1.2 Succession Planning

Staff Numbers and Age Profile of Current and Planned Workforce					
Age	**Staff 2010/11**	**%**	**Staff 2011/12**	**Staff 2012/13**	**Staff 2013/14**
• 16-21	35.7	1%	35.5	38.4	37.6
• 22-35	1,071.0	30%	1,066.2	1,023.3	1,002.2
• 36-55	1,892.1	53%	1,883.6	1,786.0	1,749.2
• Over 55	571.2	16%	568.6	520.9	510.1
TOTAL	**3,570**	**100%**	**3,554**	**3,368**	**3,299**

Note: Assumes that most IBP wte reductions will occur in the temporary workforce.

Comment on your age profile specific issues e.g. significant changes over time and how the workforce will meet the future growth / demand assumptions outlined in section 2.
The Trust's age profile and levels of staff turnover indicate that with the reductions in planned staffing numbers future staff shortages are not expected.

8.1.3 Continuity Planning - Temporary Staffing

Temporary Staff Usage in 2010/11– Bank, Agency and Locum (£000s)			
Staff Category	**Planned Spend**	**Actual Spend**	**% of WTE Workforce**
• Medical & Dental	347	4,020	2.5

• AfC Clinical	38	11,971	7.4
• AfC Managers & Administrators	147	2,170	1.3
• VSM (Very Senior Managers)			

Comment on the above table and future plans for use of temporary staffing

The Trust plans to minimise the use of agency spend through a series of initiatives relating to the planning of annual leave, and tighter booking and establishment control procedures. The levels of bank usage will also be reduced but will be maintained at a level that provides sufficient flexibility to support fluctuating demand and activity.

Forecast figures are based on actuals to the end of Month 10 extrapolated to M12. Although some temporary staff use is planned, the majority of temporary staffing is funded from vacancies in permanently budgeted posts.

2010/11 agency spend is forecast to equal 11.1% of the total pay budget. The Trust plans to reduce agency staffing to 9.5% of the 2011/12 budget and 2.8% of the 2012/13 budget.

8.1.4 Appraisal Rates

Detail your completed appraisal rate for 2010/11. Comment on the rate if there is poor performance in a particular staff group.
What is your Board approved target for 2011/12

The Trust has established a KPI of 80% appraisal compliance rate.

At Q2, internal auditors were able to report the Trust had achieved a compliance rate of 89% although the Trust was reporting a 48% compliance rate through its internal reporting processes.
Plans were put in place to strengthen internal reporting processes and this has resulted in the following compliance rates at Q3:

- 62% of Consultants and Senior Medical staff
- 80 % of junior medical staff
- 80% of staff within Clinical support Division
- 80% of staff within Estates & Capital Planning Division
- 80% of staff within Corporate Division

8.2 WORKFORCE DEVELOPMENT STRATEGY

Bulleted Key Elements of Your Workforce Development Strategy – refer to guidance

Key strategic objectives

1. To develop an integrated model, supported by service line management, to align clinical activity, income and workforce. This work needs not only to be within the Trust but also in partnership with colleagues in the wider local health system and increasingly with social care too.
2. To develop authentic staff engagement processes to improve the quality of the decisions the organisation makes.
3. To provide a vibrant learning environment for all staff groups
4. To develop new and enhanced roles both within and across professional groups and also across organisational boundaries. Any such new roles will in turn drive changes to learning and development.
5. To become an employer of choice
6. To develop people management capacity and skills throughout the organisation
7. To develop external partnerships in health, education and the wider community that support effective acute services

Specific workforce objectives for 2011/12 are as follows:

- To reduce skills shortages in specific areas and reduce agency expenditure to 3%
- To reduce sickness to 3.8% in 2011/12
- To improve workforce productivity through more effective working, new roles and effective consultant job planning
- To achieve targets for Appraisals and Mandatory Training

Bullet the key assumptions underpinning your workforce strategy

The Trust plans to reduce staffing numbers across all groups (see 8.1.1) and this assumption is based on a planned reduction in activity and plans to increase the number of staff working in community settings. These plans alongside the drives to reduce capacity through achieving higher bed and theatre utilisation and improving length of stay and clinical productivity all impact on the number of clinical staff required. The decrease in administrative staff is based on the development of back office shared services and the impact of improved efficiencies from the implementation of IT systems.

Local context for the workforce

The Trust is geographically positioned close enough to London for potential employees to commute easily to London trusts. It is known that a significant proportion of staff who leave move on to other local NHS employers where London weighting allowances are higher, or slightly further away from London where living costs are cheaper.

8.3 WORKFORCE RISKS

Top Workforce Risks (add more rows as necessary)

	There is a "Risk" that…	Likeli-hood	Im-pact	Score	High Level Mitigating Actions Agreed / Planned
1	Recruitment / Retention of key staff has an impact on service delivery	4	3	12	• Staff turnover/exit interview monitoring • Targeted recruitment drives • Action plan from staff survey including communication and heath and well being initiatives • Training needs analysis and design of training programmes to identify need.
2	Assessing and addressing poor productivity does not happen routinely and consistently	2	4	8	• Job Planning processes and annual leave policy being reviewed in addition to monitoring of activity for consultants • Investigation of the use of productivity metrics for other clinical staff
3	Reduction of sickness rates is not maintained thus pushing up agency and bank expenditure	2	4	8	• HR intensive support for line managers in monitoring absence • HR intensive support for line managers in implementing policy as appropriate • Well being at work initiatives in place and OH targeted support for

					stress and MSK conditions • OH physician input increased

Comment on above table
The Trust is developing an HR risk register to ensure risk classification is completed and monitored, and that risk management actions are integrated into standard HR practices.

8.4 VALUING PEOPLE

8.4.1 Equality and Diversity

Provide a statement of approach to promoting Equality and Diversity and progressing the requirements of the general, and specific, duties of the Equality Act 2010. In addition, confirm your readiness to meet the deadline of 31st July 2011
The Trust promotes equality and diversity through all services, policies and procedures. The Trust is committed to promoting an environment that values diversity. All staff are responsible for ensuring that all patients and their carers are treated equally and fairly and not discriminated against on the grounds of race, sex, disability, religion, age, sexual orientation or any other unjustifiable reason. The Trust recognises the need to work in partnership with and seek guidance from other agencies and services to ensure that all needs are met. The Trust's approach to promoting equality and diversity is to mainstream and embed this in all practices and ensure that systems are in place, which foster inclusiveness and promote equality of access to all. An element of E&D is presence in all policies, services, procedures and any other involvement by the Trust. Also the Trust will regularly monitor the development of any new changes and practices in relations to E&D to endeavour the effectiveness of implementing and mainstreaming E&D. The Trust has continued to comply with the general duties and specific duties, which is now required by the Equality Act 2010 and has taken into account the new listed protected characteristics. The Trust is currently writing a new Single Equality Scheme, which will incorporate the equality objectives (taking into account the new protected characteristics), producing an action plan of how this will be achieved over the next 3 years. Furthermore, the SES will be published along with workforce statistics and other equality data in relation to the services. The Trust has recently reviewed and updated policies in relation to bullying and harassment policy and grievance policy, which are accessible to all staff and all staff are made aware of these policies once they commence employment at the Trust.

Confirm you have undertaken an analysis of your workforce (against the categories in the guidance). Outline the key elements of the analysis and your plans to address any issues re diversity
The Trust has undertaken an analysis of the workforce and the key elements of the analysis were: • Disability- staff that have declared their disability. • Ethnicity- of all staff which has then been further broken down by payband • Age- Broken down by age group of all Trust staff • Gender- of all staff, which has then been further broken down by payband • Leavers- by age, gender and ethnicity The Trust has a representative workforce when compared to the population it serves. Initiatives being considered are developing more staff network groups and mentoring schemes. In light of the ethnicity and payband data analysis which demonstrated the "glass ceiling" when it comes to ethnic staff in bands 9 and above, the Trust is developing a mentoring programme for BME staff.

Confirm ALL your policies, strategies and service development plans have undergone EqIAs. If "No", explain. In addition, confirm that ALL EqIAs are made publically available.
As part of the new Single Equality Scheme Action Plan, the Trust has stipulated that all policies, strategies and any service development plans will undergo an EqIA as part of the continuous commitment to reduce inequalities and promote equality. In 2010, the Trust appointed an Equality and Diversity Manager who is co-ordinating and leading the new Single Equality Scheme. The Trust will adhere to legislation and good practice and will make all EqIAs available to the public and all staff to view.

8.4.2 Staff Survey

Briefly comment on your approach to staff engagement including Mechanisms to monitor and learn from staff feedback
The Trust uses the results of the staff survey each year to focus on the areas needing improvement in relation to staff and highlight where we are doing well. The Trust holds regular 'Open Door' sessions with Executive Directors where staff can ask questions and make any comments on the Trust and how it operates. Staff have also been encouraged to feedback to help shape Trust plans for staff health and wellbeing events in the Trust.

Staff survey					
	2009/10		**2010/11**		**Org'al Imp't / Deter'n**
Response rate	**Org**	**Nat Av**	**Org**	**Nat Av**	
	42%	55%	46%	?%	Increased by 4% points

Staff Survey – Top 4 ranking scores					
Top 4 ranking scores	**2009/10**		**2010/11**		**Org imp't / Deter'n**
	Org	**Nat Av**	**Org**	**Nat Av**	
KF37. Staff motivation at work	3.91	3.84	Unknown	Unknown	
KF18. Percentage of staff suffering work-related injury in last 12 months	15%	17%	Unknown	Unknown	
KF10. Percentage of staff using flexible working options	72%	70%	Unknown	Unknown	
KF2. Percentage of staff agreeing that their role makes a difference to patients	90%	90%	Unknown	Unknown	

Staff Survey – Bottom 4 ranking scores					
Bottom 4 ranking scores	2009/10		2010/11		Org imp't / Deter'n
	Org	Nat Av	Org	Nat Av	
KF12. Percentage of staff receiving job-relevant training, learning or development in last 12 months	68%	78%	Unknown	Unknown	
KF28. Perceptions of effective action from employer towards violence and harassment	3.4%	3.55%	Unknown	Unknown	
KF11. Percentage of staff feeling there are good opportunities to develop their potential at work	31%	42%	Unknown	Unknown	
KF19. Percentage of staff suffering work-related stress in last 12 months	34%	28%	Unknown	Unknown	

Comment on above tables
Only raw data currently available for 2010/11. This shows improvements in the numbers of staff undertaking training and development activities and in managers encouraging staff to suggest new ideas for improving services.

8.5 HEALTH & WELLBEING

Confirm you have a Health & Wellbeing Champion and the top 3 priorities for the year.
Health and Wellbeing Champion: Barbara Leon-Hunt Top 3 priorities: • Raising awareness of stress and offering tools to deal with it • Raising physical activity levels • Increasing attendance at work

Sickness Absence over last four quarters					
	2009/10	2010/11			2010/11
	Q4	Q1	Q2	Q3	NHS - Q3*
Overall Organisational Sickness Absence Rate	**3.7**	**3.2**	**3.8**	**3.9**	**4.2%**
• Medical and Dental	**1.9**	**1**	**1.3**	**0.5**	
• AfC Clinical	**4.3**	**3.6**	**4.3**	**4.8**	
• AfC Managers & Administrators	**3.8**	**3.4**	**4.2**	**4.2**	
• VSM	**0.1**	**0.1**	**0.7**	**0.8**	

* NHS data related to your sector

Include target for 2011/12 and comment on the above table	
Organisational Target for 2011/12	3.8%
Target for sickness is 3.5% from 2012/13	

8.6 KPIs AND PERFORMANCE MONITORING

Outline the workforce KPIs and performance metrics currently used. Detail how you demonstrate workforce productivity to frontline staff and to the Board
The Trust Board monitors staffing levels, bank and agency use, sickness and labour turnover. Divisional monthly performance reviews incorporate monitoring of the above data. In 2011/12 the Trust aims to improve its analysis and collation of meaningful productivity data. In doing this it will liaise with other Trusts in the region to benchmark and share results.

8.7 TALENT AND LEADERSHIP

Do you have a Board approved Talent and Leadership Plan?			
Do you have a Board Approved Plan?	YES	Date Board approved it?	Sept 2008

– If yes, bullet the key elements	– If no, what do you have as an alternative and how the Board is assured regarding future talent and leadership capability and capacity

In September 2007, the Trust Executive endorsed the establishment of the Leadership Academy which forms an integral part of the Trusts Workforce Strategy, 2008 – 2014.

The Trust continues to invest in staff development at all levels. The Academy places great emphasis upon developing front-line leaders, managers, teams and staff as well as senior and executive leaders. All development activities align to QIPP with a key focus upon improving patient and staff experience, communications, staff wellbeing and engagement.

The Leadership Academy has two key framework agreements in place.

Accreditation Agreement with the University of Hertfordshire: The Academy delivers accredited Masters Level programmes, with teaching, student support and assessment undertaken at the Trust. This has significant qualitative and cost-benefits; development is aligned to real-time service improvements, staff time away from practice is minimised, there is flexible, tailored support to learners with, sustainability of learning into practice.

Preferred Provider Agreement: In 2010, the Academy completed a full tender process to appoint 15 high quality leadership development providers to a flexible 3 year (renewable) 'draw-down' Agreement. External support, when required is utilised flexibly at significantly discounted rates. Through the Academy, other organisations in the EoE may utilise the agreement and this has been used successfully to commission the CWG Staff Wellbeing Programme that commenced February 2011.

The Academy also hosts an active programme of Organisation Development. In 2011-2012, the Leadership Academy team will work alongside the Director of Nursing and Director of Workforce to provide Trust-wide programmes to improve patient and staff experience. A key feature of these programmes is the active engagement of patients, patient groups and the Patient's Panel.

The Academy's Masters Level Senior Leaders' Programme was a finalist in the 2009 Health Service Journal Awards. The Trust has recently won a national Patient Experience Network Award in the category of 'supporting staff, carers and patients – strengthening the foundations'.

Academy programmes are aligned to the NHS LF. The Trust's approach to Talent Management includes utilising staff as Leadership Associates to harness existing talent and to provide staff with the opportunity to share learning and best practice. This approach extends the pool of experienced facilitators providing a sustainable, cost-effective model for development provision.

The Academy has a bespoke intranet site as a hub for learning and development resources. Options around extending e-learning and utilising multimedia will progressively offer blended development programmes.

In 2011 – 2112 Leadership Academy activities will be reviewed in context of ROI metrics.

Confirm if there is a member of the Board with responsibility for Talent Management and succession planning. Who is it?
Director of Workforce

Do you have a "Succession Plan" for Business Critical roles? If no, explain why not?
The Trust's Succession Plan is aligned to the East of England framework.

What are the main risks to delivering your Talent & Leadership plan Detail the key actions agreed to mitigate these risks?
The main risks to delivering the Talent and Leadership Plan relate to significant pressures on staff time, making it difficult to release staff for development and impact of work pressures upon staff morale, motivation, wellbeing and retention. The significant reduction in SHA funded CPD coinciding with a sharp increase in Higher Education fees results in cost-pressures across the system for all types of CPD, including leadership development. The Trust has long recognised the importance of investing in staff, particularly during a period of service transition and redesign. The Trust has sustained investment in the Leadership Academy and the Academy Business Plan for 2011 – 2012 is aligned to QIPP. The Leadership Academy model is cost-effective, adaptive and sustainable and is positioned to support the challenges of *Liberating the NHS: Developing the Healthcare Workforce.* It is planned to grow the Academy model taking account of the "East of England Approach to Leadership Development and Talent Management during Transition and beyond" and establishment of local Skills Networks.

8.8 LEADERSHIP PROGRAMMES

How many staff did the organisation put forward for NHS EoE Leadership programmes in 2010/11?
HS EoE Leadership Programmes: Aspiring Directors - 4 Coaching - 2 Breaking Through – 2 **Trust Accredited Leadership Programmes:** Middle Managers Programme – Total: 29 Women 23 Clinical Staff 14 Disabled Staff 0 BME Staff 11 Senior Leader Programme – Total: 29 Women 27 Clinical Staff 13 Disabled Staff 0 BME Staff 3 Clinical Management Programme – Total: 38 Women 35 Clinical Staff 33 Disabled Staff 0 BME Staff 18 Senior Medical Leaders – 18

What other leadership interventions have you assessed to meet identified capability gaps in your talent and leadership plan?
Planned development activities include Business Skills, Principles and Practice of Performance and Workforce Planning, Project Management.

Regarding Equality and Diversity, how many: Women; Clinical; Disabled; and BME staff have accessed Leadership Development in 2010/11
See the first table in this section

Have you undertaken Board development?	
– If yes, explain what programmes have your run	– If no, why? How have you identified the skills gaps of the Board and plan to address?
A programme of Board Development is aligned to preparation for Foundation Trust.	

8.9 COMMUNICATING YOUR STRATEGY

What practical steps do you take to ensure staff and other stakeholders are aware of your future plans?	
– Do you produce a Summary Business Plan? – How would you rate the relationship with your unions?	– Which 3 priorities would make union engagement more effective
The Trust feeds back staff survey results and themes from patient surveys. As part of this the Trust also informs staff of the main priorities in the workforce strategy and seeks staff views and ideas to inform future plans. The Trust is also working with divisions to identify the workforce implications of service developments. The Trust uses this work to inform the development of the broader Trust strategy. This process is also integral to the development and implementation of the Trust's Integrated Business Plan and the workforce plans that form part of it. The Trust views working in partnership with the unions as a fundamental principle underpinning the implementation of its workforce strategy. The Trust believes it has an effective and constructive relationship with staff-side and the unions and this has been demonstrated through successfully implementing "Delivering a Health Future". This was a major reconfiguration of acute services involving the redeployment of over 1000 staff. The Trust's three priorities for ensuring effective engagement with its staff-side are to continue to consult and communicate regularly on planned changes, work in partnership on development of policies and procedures through the Policy Sub Group, and ensure early involvement of staff side in designing future service changes. The Trust currently has a workforce strategy that covers the period 2008 – 2014.	

9. SUSTAINABLE DEVELOPMENT

9.1 DELIVERING SUSTAINABLE DEVELOPMENT AND CARBON REDUCTION

9.1.1 Sustainable Development Management / Action Plan (SDAP)

Progress in implementing your Sustainable Development Management / Action Plan (SDAP). Include:	
– Your CO_2 target (normally 2007 level) – Your current CO_2 level broken down by procurement, estate, travel and other. – How you will meet this by 2015	– Climate change adaptation plans linked to emergency preparedness, business continuity and resilience – For providers with a large fleet of vehicles please specifically outline your plans

As part of the Trust's energy saving proposals there are plans to move to natural gas from the HFO currently used and plans to reduce emissions from 5,596 to 4,212 tonnes of CO2, a benefit of 1,384 tonnes CO2.

By the end of March 2011, the Trust will have SDMP and Energy Policy available for Board consideration and approval.

The Trust plans to reduce CO2 levels by reducing energy consumption, improved estate efficiency, and investing in energy saving schemes over the next three years i.e. CHP, lighting.

9.1.2 Good Corporate Citizenship

Explain how you have used the Good Corporate Citizenship (GCCAM) Assessment model in developing your SDAP and if any elements of the model are not being followed
The Trust has completed the first stage of registering on the GCCAM and completed two rounds of review. The results of this are due to be presented shortly to the Sustainability Programme Board along with a list of actions to be completed to address the short comings identified in the report.

9.1.3 Estates Returns Information Collection (ERIC)

How does the organisation ensure robustness of ERIC data on waste minimisation and management and the finite use of resources (water and fossil fuels) to effectively measure and manage CO_2 reductions?
In accordance with best practice, the Trust carry out detailed ERIC return data entries every year to capture how we perform against other similar organisations. With respect to waste minimisation and management, the Trust employs an external consultant to advise and monitor on the disposal of waste to ensure that it is getting the best contract prices for this service. This monitoring also involves monitoring the internal facilities teams to ensure it is doing everything possible to minimise waste and costs associated.

9.1.4 Procurement and Supply Chain

Confirm that all contracts for procurement of goods and services take into account Sustainable Development and help achieve a reduction in CO_2. – Explain your approach to ensuring this? – If not all contracts do take SD into account, what proportion don't and explain your target and trajectory going forward
The Trust's has moved towards procurement and supply chain enabled Sustainable Development and CO2 reduction by the incorporation of the sustainability agenda into the procurement process. Suppliers are now required to take this agenda into account when responding to procurement invitations. This has been achieved by joint working with the Trust's Shared Procurement Service, HSMC. The Trust has gained additional reductions in CO2 as a result of the introduction of an electronic tendering process thus designing out the traditional fleet of vehicles delivering multiple copies of tender

documentation. Paper usage and transport-associated CO2 have, as a result, dropped. The Trust has also encouraged its procurement service to reach out to more local businesses thus gaining the environmental advantages of local suppliers.

10. NHS CONSTITUTION

10.1 COMPLIANCE WITH THE NHS CONSTITUTION

Are you compliant with the NHS Constitution? If not, explain. Provide a statement regarding compliance with the rights and pledges within the NHS Constitution and explain the performance for those areas which do not meet the standards.
The Trust is largely compliant with the NHS Constitution with the exception of the 18 weeks' referral-to-treatment guarantee. The Trust is working to the 90% admitted and 95% non-admitted standard while the guarantee sets a standard of 100%.

11. BUSINESS CONTINUITY

11.1 BUSINESS CONTINUITY SELF CERTIFICATION CHECKLIST

Detail below the name and designation of your Lead for Business Continuity
Sheena Gormley, Emergency Planning Manager

Please confirm (with an "X") the following for all in-patient areas:

	Criteria	YES	NO
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.		No
2	Test procedures are in place to cater for short and extended loss of utilities supply, and the maintenance of critical systems is in accordance with manufacturers recommendation and HTMs (Health Technical Memorandum)		No
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	

Comment on the above table where a "NO" has been entered
The Trust is fully aware of the shortcomings of its electrical systems and has a detailed plan to rectify this over the coming two years with investment of capital to improve resilience and compliance issues. The generators on all three sites are tested each month for a minimum of two hours in accordance with HTM 06. From 2011/12 the Trust plans to include the required annual 'blackout' test. Further works are due to take place over the next two years to improve coverage of generators to move the Trust to N+1 compliance on all three sites.

What was the last date the Board signed off the "Business Continuity and Recovery Plan" If more than 12 months ago, please explain the timeline for next sign off.
The Business Continuity and Recovery Plan will be reviewed by the Trust's Emergency Planning

Group in May and by the board in July 2011.

11.2 SERIOUS INCIDENTS

Detail any Serious Incidents in 2010/11 which resulted in loss of availability for significant areas of the estate
None

12. DECLARATIONS AND SELF CERTIFICATION

12.1 ANNUAL RISK RATINGS

SECTION 12 IS LEFT BLANK INTENTIONALLY AS PER INSTRUCTIONS FROM SHA

Risk Ratings	
Risk Ratings	**Rating**
GRR - Governance Risk Rating (RAG as per NHS EoE PMR guidance)	
FRR - Financial Risk Rating (Assign number as per NHS EoE PMR guidance)	
CRR - Contractual Risk Rating (RAG as per NHS EoE PMR guidance)	

12.2 **BOARD STATEMENTS -** SELF CERTIFICATION TEMPLATE

NB The Self Certification template will be issued separately in March following Monitors updated guidance. Please complete and attach below.

13. FORMAL SIGN-OFF OF THE ANNUAL PLAN

Date the Annual Plan was signed off by the Board	

13.1 ANNUAL PLAN SIGNED OFF ON THE BEHALF OF THE BOARD BY:

Name	Position	Signature	Date
Prof Thomas Hanahoe	CHAIR		
Jan Filochowski	CEO/ COO		