West Hertfordshire Hospitals NHS
NHS Trust

Agenda Item 48/12

West Hertfordshire Hospitals Trust Annual Plan 2012/13

Draft

Version 0.4

Contents

1.0 Trust Profile

The following table provides a summary of key information on the Trust for 2011/12:

Finances[1]	
Income	£262.3m
Operating Expenses	£246.8m
EBITDA	£15.4m
Non Operating Expenses	£11.8m
Net Surplus (forecast)	£3.6m
Net Surplus after Impairments	£5.1m
Demographics	
Population served	Approx 500,000
Demographic Growth	0.64%
Workforce	
Number of WTE[2]	3,733
Staff turnover	12.1%
Staff sickness rates	4.1%
Volunteers	400 regular volunteers equal to 60 WTE
Activity[3]	
Emergency Admissions	42,400
Elective Cases	36,600
Outpatient Attendances[4]	397,600
A&E Attendances[5]	121,500
Births[6]	5,933
Other	
Number of sites	3
Number of beds[7]	641

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

Income and activity is shown against point of delivery and division in the tables below:

1 Note: Forecast based on outturn as at end of January 2012

2 Note: As at the end of January 2012

3 Note: Forecast based on outturn as at end of January 2012

4 Note: Excludes non face-to-face and procedures

5 Note: Includes Minor Injuries Unit and Urgent Care Centre

6 Note: Forecast based on outturn as at end of February 2012

7 Note: Bed numbers as at 2nd March 2012

Income by Point of Delivery

Range of services (including relative size) by activity and value				
Service by Point of Delivery 20011/12	**Activity**		**Value**	**% of Total**
	Unit	No.	£m	%
Elective	Spells	36,600	47.7	21
Emergency	Spells	42,400	79.2	34
Outpatient	Attendances	397,600	51.1	22
A&E – including Minor Injuries Unit + Urgent Care Centre	Attendances	121,500	11.4	5
Other Non PBR	Activities	2,859,000	40.6	18
TOTAL			**230.0**[8]	**100**

Income by Division

Range of services (including relative size) by value	£m	%
Surgery	79.2	35
Medicine	77.6	34
Women & Children	44.8	19
Clinical Support	10.8	5
Other	17.6	7
TOTAL	**230.0**	**100**

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 out patient services, in an environment of patient choice and contestability
- Ensure 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 as are maternity and paediatric services
- 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.

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

[8] Note: This is contract income only

2.0 Commentary on 2011/12

2.1 Summary

Headline achievements for 2011/12 are as follows:

Area	Achievement
Financial Targets	Expected to be achieved
Foundation Trust Status	Reactivated
Quality and Safety	CNST level 2 achieved
Emergency Pressures	Some of the shortest A&E waits in England in spite of significantly higher than expected demand
Emergency Infrastructure	Built and opened the additional emergency infrastructure on time
Patient Experience	Results from the latest outpatient survey show a dramatic improvement. Inpatient survey results show a clear improvement on 2010 performance
Staff Survey	Significant progress in the 2011 staff survey, in particular in the overall 'staff engagement'
Contract with Commissioners	The 2011/12 contract was signed on time and has been managed constructively and amicably between the Trust and the PCT during the year
Appraisals and Training	Very good progress made
Never Events	Demonstrable level of learning and changes in practice and service delivery achieved

More specific achievements are outlined in the sections below.

2.2 Clinical Quality Improvements

Key, selected clinical quality improvements delivered during 2011/12 are as follows:

	Target	Actual[9]	Performance
C Diff	<=34	11	Achieved
MRSA Bacteraemia	<=4	1	Achieved
MRSA – screening all elective patients	100%	98.4%	Near miss
MRSA – screening all emergency admission	100%	93.0%	Near miss
HMSR rolling 12 month average[10]	82 - 118	102	Achieved

The Trust has performed well against key clinical quality indicators and compares favourably with other organisations in the East Midlands.

The table below sets out the Trust's performance against Serious Incidents and Never Events for 2011/12:

Period	Serious Incidents	Never Events
April 11 to Feb 12	37	5

Although the intention is to reduce SIs a, specific target is not set because this would risk a distortion in the reporting process. The Trust has an active and explicit policy of encouraging the reporting of these events. This leads to a culture of openness and honesty, and maximises the learning from our mistakes.

[9] Data based on outturn at end of January 2012

[10] Figures from QIE show quarter 2, 2011/12

The Trust has sophisticated systems and processes associated with reporting, investigating, learning from and communicating the learning from Serious Incidents and Never Events. These systems and process have been further improved during 2011/12.

Within the 2010/11 Quality Account the Trust identified 8 priorities with a total of 11 targets. As at Q3 the Trust is reporting one target as red, four as amber and six as green. Details are below:

Indicator	**Sub-indicator**	**RAG Rating[11]**
Priority 1: Ensure that people are provided with appropriate levels of food and nutrition whilst they are in hospital.	Ensure that 80% of all patients receive a nutrition screen within 24 hours of being admitted.	Green
	Aim to ensure that all patients are weighed on admission and every seven days thereafter	Amber
	Ensure that all patients are identified on admission if they require additional support with eating and drinking	N/A
Priority 2: Reduce the number of patients who develop pressure ulcers whilst in hospital	Reduce to no more than four the number of avoidable hospital acquired grade 4 pressure ulcers	Green
	Adopt a zero tolerance approach to grade 3 pressure ulcers	N/A
	Reduce by 50% the number of grade 1 and 2 pressure ulcers	Amber
Priority 3: Reduce the number of occasions patients are not given their prescribed medicine whilst in hospital		Green
Priority 4: Ensure that complaints are dealt with in a timely way		Amber
Priority 5: Reduce the level of noise at night on wards	Undertake regular patient surveys to determine if they are being disturbed at night	Green
	Reduce the level of patient dissatisfaction reported in the national in-patient survey in respect of noise at night to 20%	N/A
Priority 6: Improve the delivery of pain relief services to patients whilst they are in hospital	Improve on the percentage of people who are happy with the level of pain relief provided whilst an in-patient	Amber
Priority 7: Ensure that all appropriate staff are trained to meet the needs of patients with dementia whilst they are in hospital	Train 150 staff within 2011/12 on the care of dementia patients	Green
	Maintain performance of no more than 25% of patients with dementia having more than one change of ward following their initial assessment	Green
Priority 8: Increase the number of women who have a normal birth	Increase by four percentage points the number of women who have a normal birth by reducing the level of Caesarean sections undertaken	Red

[11] RAG Ratings are as at the end of February 2012

2.3 Service Developments

2.3.1 Planned Service Developments

Selected service developments specifically detailed in the 2011/12 Annual Plan and progressed during the year are outlined below:

- Access to Fully Compliant Theatre Sterile Supplies Service
  The Trust continued to pursue an off-site Theatre Sterile Supplies service with the existing NW London NHS collaboration. Contractual issues delayed the progress of this development but the Trust has overcome these difficulties and expects to agree a contract in 2012/13.

- Repatriation of Minor Oral Surgery
  The PCT declined to commission this.

- Establishment of a Restorative Dental Service
  Currently patients travel to Eastman Hospital in Central London to access restorative dental services. This is both inconvenient to patients and expensive for the PCT. In order to improve the patient experience and reduce costs, the Trust has developed business case for the establishment of a local restorative dental service. The PCT has not commissioned this service.

- Moving the Urology Department from Watford to St Albans
  This project remains in the planning phase and is part of a much larger project associated with clinical efficiency and estates rationalisation. The Trust expects to do further work on this project during 2012/13.

- Extending the Enhanced Recovery Programme
  - Breast Surgery
    Preliminary work has commenced for ERP for breast surgery. The Trust expects this project to be fully implemented during the course of 2012/13
  - MSK Surgery:
    This project went live on 1st March 2010 and, to date, some 1,200 patients have been treated under the enhanced recovery pathway. Hips and Knees follow the pathway at Watford and the Trust is revisiting the #NOF pathway. A second enhanced Recovery Nurse will be appointed in early 2012/13 after which the pathway will be extended to cover Backs and Shoulders.

- Establishing a Non-Invasive Ventilation Service
  The PCT has not commissioned this service and discussions continue.

- Establishing a Radio Frequency Ablation Service
  The PCT has considered the business case and discussions continue.

- Establishing a Private Patient Unit
  Discussions were held with several potential private sector partners. Unfortunately, however, the last interested party pulled out in early 2012. The Trust is now exploring alternative options for taking this forward.

The following productivity and performance achievements should also be noted:

Development	2010/11	2011/12	Comment
Reducing Length of Stay for Emergency Patients[12]	5.10 days	4.78 days	This is a favourable reduction in LoS. LoS compares favourably with others and the Trust is not expecting to make significant further reductions over the next three years.
Develop Admission Avoidance Strategies in Partnership with NHS Hertfordshire	N/A	N/A	The Trust has worked with NHS Hertfordshire in implementing the Prior Approval Process in which formal, prior approval is required before surgery for certain procedures. In addition, BMI and Smoking constraints were implemented during the year. For hips and knees, these constraints applied from 1st September 2011. For all other elective surgery the constraint was implemented on 1st January 2012. As at March 2012, the combined impact of both strategies has reduced Decisions to Admit by 3%. This figure is derived by comparing the periods April to January in FY 2010/11 with the same period in FY 2011/12.
Reduce Unnecessary Use of Tests	N/A	N/A	Work was carried out throughout 2011/12 to address unnecessary use of tests with limited quantifiable success. The implementation of Ordercomms, which was to go live in early 2012 and which was expected to yield savings in Pathology, has been suspended pending the completion of the Pathology review. It is likely that the pathology changes will occur partway through 2012/13. This means the expected reduction in unnecessary use of tests will not have a full year effect.
Increase Day Case Rates[13]	81.3%	83.2%	This is a favourable increase and exceeds the recommended figure and local target of 80%.
Reduction in Length of Stay for Elective Patients[14]	3.77 days	3.63 days	This is a favourable reduction in LoS. LoS compares favourably with others and the Trust is expecting to make only a modest further reduction during 2012/13.
Shift More Elective Care to St Albans	38.7%	37.6%	This seemingly disappointing outcome is explained by the Prior Approval Process. This has resulted in a reduction in Decisions to Admit by 3%. The vast majority of this reduction in demand is in elective surgery which would have taken place in St Albans.
Improve Theatre Utilisation	N/A	N/A	The Trust has worked extensively with Meridian, a specialist in the field of productivity, to improve the process for optimising theatre utilisation. The improved process commenced towards the end of 2011 and benefits are already being seen although not yet quantified.

[12] Figures from Which Doctor include all lengths of stay. Analysis run on 15th March 2012

[13] Figures taken from Which Doctor on 7th March 2012

[14] Figures from Which Doctor include zero length of stay. Analysis run on 15th March 2012

Development	2010/11	2011/12	Comment
Improve Outpatient Services: Reduce follow ups[15]	1: 1.67	1: 1.68	This seemingly unfavourable increase in the follow up ratio, particularly given the effort and focus on reductions, is explained as follows: There have been significant demand management efforts within primary care. This has led to a reduction in referrals of those patients who would have been dealt with by a single outpatient appointment with no follow up. The result is that the follow up ratio has increased.
Improve Outpatient Services: Increase throughput per unit resource	N/A	N/A	The Trust has worked extensively with Meridian, a specialist in the field of productivity, to establish an improved process for monitoring and improving outpatient throughput. An information system has been developed to allow managers to view throughput efficiency for the coming week and for each of the next eight weeks. Throughput efficiency is broken down by specialty, consultant and clinic allowing significantly more active management. The new process commenced towards the end of 2011 and benefits are already being seen although not yet quantified.
Improve Outpatient Services: Improve quality as defined by patient experience	N/A	N/A	The Trust participated in the National Outpatient Survey in 2011. The survey results demonstrate significant improvements when compared to the previous survey in 2009. The Trust achieved a 25% improvement on the previous survey and practically eliminated 'red' scores: These reduced from 16 to one.
Develop Range of Services: Cardiology	N/A	N/A	The Trust has, and is, exploring the establishment of a Rapid Access Heart Failure Clinic and a Transient Loss of Consciousness Clinic. Discussions are continuing with the CCG and the Beds & Herts Heart and Stroke Network.
Develop Range of Services: Tablet packing unit	N/A	N/A	The Board confirmed a decision to close this unit in July 2011 and closure will be complete at the end of March 2012. The site will be sold as part of the Estates Rationalisation agenda.
Improve job planning process for consultants		£200k saving approx	The Trust has set up a more robust job planning process. Each Job Plan is reviewed and signed off by a Review Board comprising the Workforce Director and the Medical Director plus others. The in-year savings were less than expected but further savings are expected in 2012/13.

[15] Note: Which Doctor analysis on 13th March 2012 and includes only consultant activity.

2.3.2 Service Developments Not Specifically Described in the Annual Plan 2011/12

Emergency Capacity and Demand

During the winter of 2010/11 Watford had more swine flu cases than the rest of the East of England put together. This experience, and the stress it caused to the system, led the Trust to implement a rapid planning process to ensure a robust response to the winter pressures of 2011/12. The outcome of the rapid planning process was formalised into the Emergency Care Service Development Plan.

As the 2011/12 winter pressure developed from 'routine' into 'extreme', exacerbated by difficulties discharging patients, the Trust implemented the plan taking the following steps:

- Workstream 1: Maximising Existing Capacity
  The Trust created an additional 15 beds within the main hospital buildings by converting administrative space into clinical bed bays.

- Workstream 2: Changes to Clinical Practice: Opening the Clinical Decision Unit
  This workstream saw the creation of a Clinical Decisions unit (CDU) to improve the A&E pathway. A temporary CDU facility was installed at Watford in late 2011, with the permanent unit opened in mid January 2012.

- Workstream 3: New Build: Opening the Surge Unit
  The third element of the short-term capacity plan relates to the "Surge Ward", the new, and temporary 18 bedded unit adjacent to the AAU. It is intended that this unit will open only when the hospital is experiencing severe operational pressures. The Surge Unit has been rented for a three year period.

Alongside these workstreams, the Trust has committed to working closely with primary care and partner organisations in intermediate and Social Care, to ensure that suitable and sufficient capacity is available outside of the hospital setting for patients who no longer need an acute setting.

Reducing Temporary Staffing Costs

Towards the end of 2011/12, the Trust signed a contract with NHS Professionals to provide agency and bank staff. This is expected to yield reductions in agency temporary staff costs in 2012/13.

2.4 Delivering the Financial Plan

Financial details for 2011/12 are provided below:

£000s	**2011/12 plan**	**2011/12 FOT***	**Variance**	
Income	£000s	£000s	£000s	% of plan
Clinical income	227,180	230,036	2,856	1.3%
Non-clinical income	2,367	3,153	786	33.2%
Other income	29,240	29,069	-171	-0.6%
TOTAL INCOME	**258,787**	**262,258**	**3,471**	**1.3%**
Expenses				
Pay costs	161,438	166,076	4,638	2.9%
Non-pay costs	64,648	65,603	955	1.5%
Other costs	17,264	15,137	-2,127	-12.3%
TOTAL EXPENDITURE	**243,350**	**246,816**	**3,466**	
EBITDA	15,436	15,442	6	0.0%
Interest	630	1,284	654	103.8%
PDC dividend	3,106	3,206	100	3.2%
Depreciation	7,300	7,350	50	0.7%
Net surplus/(deficit)	4,400	3,602	-798	-18.1%
* Based on month 11 actuals plus one month's forecast.				

The Big Ask, the Trust's CIP, delivered a saving of £13.4m against a 2011/12 target of £15m. The total of non-recurrent savings was £4.2m. Of this, £2.7m has been converted into recurrent savings, the majority of which relates to conversion of fortuitous pay savings into permanent headcount reductions.

Offsetting this position there are full year effects of 2011/12 savings of c£1.0m. There were also non-recurrent cost adjustments of £0.75m in year.

The year-end estimate of capital spending is £5.8m invested as follows:

- Equipment: £0.7m
- Estates: £1.5m
- IT: £0.1m
- Staff: £0.3m
- Endoscopy at Hemel: £1.2m
- Capacity works including CDU, Red Suite and Maternity: £2.0m

During the year staffing levels have increased from 3,703 at the start of the year to 3,800 at the end of February 2012.

2.5 Performance Against Key Targets and Standards

The table below displays the key targets and standards achieved by the Trust in 2011/12:

	Target	Actual[16]	Performance
A&E – 4 hour target	>=95%	96.6%	Achieved
Cancer – 31 days subsequent treatment	>=96%	100%	Achieved
Cancer – 62 days from referral to first treatment	>=85%	89.4%	Achieved
Cancer – 62 days from screening to first treatment	>=90%	90%	Achieved
Cancer – 62 days from specialist to first treatment	>=90%	100%	Achieved
Cancer – 14 day from urgent referral to 1st OPA	>=93%	98.4%	Achieved
Cancer – 14 days for breast symptom patients	>=93%	92.2%	Near miss
Cancer – 31 days from diagnosis to treatment	>=96%	98.5%	Achieved
Max 18 weeks referral to treatment admitted	>=90% < 3 spec	93.1%	Achieved
Max 18 weeks referral to treatment non-admitted	>=95% < 3 spec	98.2%	Achieved

Early in 2011/12 the Trust experienced difficulties with the 'Cancer – 14 days for breast symptom patients' target. The difficulties revolved around the balance of capacity and demand, and the loss of clinics from holidays and other absences. This issue has been resolved by means of ensuring that absences are covered by colleagues and the Trust expects to maintain this standard into 2012/13.

The very high level of A&E attendances and non-elective admissions experienced from December 2011 until early March 2012 put pressure on the Trust to deliver the A&E waiting time targets. These pressures were addressed by means of a multifaceted strategy to manage the throughput of patients. This included the establishment of flexible 'surge' capacity.

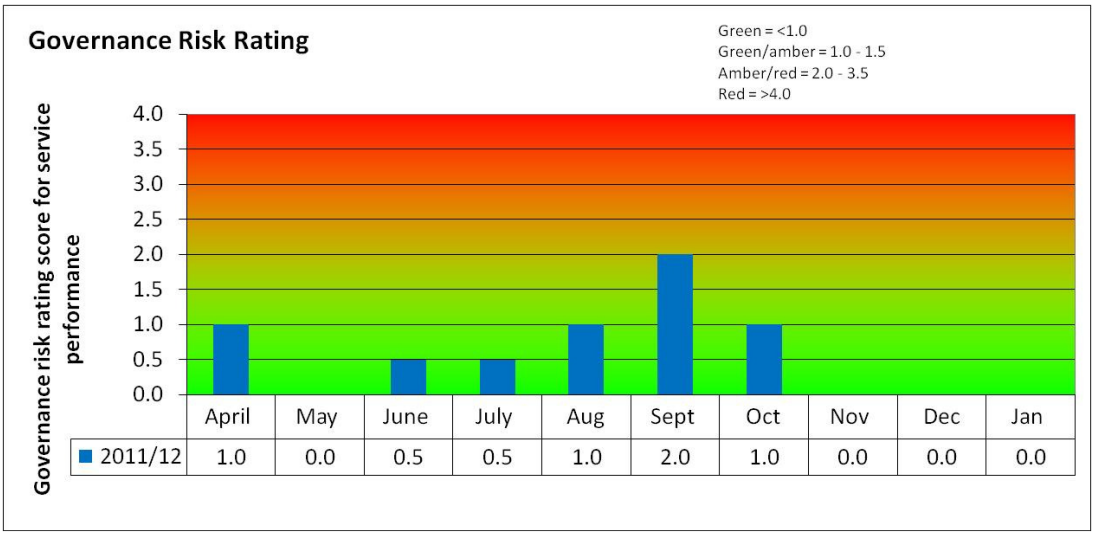
The higher than predicted level of emergency admissions put pressure, in turn, on the 90% admitted and 95% non-admitted elective referral-to-treatment targets. These pressures were addressed by means of a range of approaches including setting up additional lists and clinics, and support from the PCT. The Trust remains on course to deliver these targets in all specialties by the end of March 2012.

Overall the Trust has performed well with key performance indicators being substantially met. This performance is expected to continue into 2012/13.

The Trust has performed well against the Provider Management Regime Governance Risk Rating.

[16] Data based on outturn at end of January 2012

Performance during the year is illustrated below:



The Trust expects to continue this strong performance into 2012/13.

2.6 Commissioner Relations and Contract Delivery

Relationships between Trust and Host Commissioner have been positive throughout 2011/12.

The contract included a number of QIPP initiatives and whilst there has been a reduction in outpatient referrals and new attendances, activity in other areas has continued to increase. The Trust expects contract over-performance to be circa £6m for NHS Hertfordshire. Fortunately, the PCT has been in a position to support this from its overall reserves.

The PCT has also supported the Trust with Transformational Funds for a number of initiatives including changes for emergency care.

2.7 Board Development

There have been several changes to Board membership during the year as follows:

Post	Left the Board	Joined the Board
Non Executive Director	Stuart Lacey	Phil Townsend
Director of Partnerships	Nick Evans	Derek Bray*
Director of Partnerships	Derek Bray	Paul Jenkins*
Director of Communications and Corporate Affairs	David McNeil	-
Director of Communications	-	Elizabeth Rippon*
Director of Strategy and Infrastructure	Sarah Wiles	Louise Gaffney* (Interim)

* Non voting

The Trust Board has established the following Sub-Committees:

- Integrated Risk & Governance Committee (IRGC)
- Finance
- Remuneration
- Charitable Funds
- Audit
- Strategy

The Sub-Committees of the Board, all of which are chaired by Non-Executive Directors, provide scrutiny of the key areas of Trust business and meet statutory requirements. Sub-committees meet at regular intervals as agreed with each committee chairman. The full committee structure is shown on the diagram on page 17.

Over the last three years the Board has undertaken a series of Development Sessions focused on further developing its capacity and capability in preparation for authorization as a Foundation Trust. The Development Sessions take place every two months from 10.00 to 16.00 hours. The sessions include performance, finance and quality reporting in the morning, with a focused development session in the second half of the day. The sessions also include mandatory training slots (ie Risk Management, Information Governance, Health and Safety).

The Board participated, with senior Clinicians and Divisional General Manager, in an Away Day Strategy Development event in July 2011 which informed a full day Strategy Development Session with the full Board in October 2011.

As part of its progression towards Foundation Trust status, the Board will undertake a Board Governance Assurance assessment against the Board Governance Assurance Framework (BGAF) introduced by the DH in December 2011. The report produced as a result of this process will also inform the Board Development programme thereafter.

Whereas the BGAF programme develops the Board's understanding of the 5 leading indicators of effective Board Governance, the Chair has also identified the need to focus on the development of the Board attributes necessary to be effective across these indicators. This will build on previous work in developing Board capacity and capability in order to fully benefit from the skills and strengths that exist within the Board.

The Chair has determined that the Board will participate in a tailored programme of Board Development activities, designed and refined on an annual basis to support members to work as a body corporate. The annual programme will encompass high level facilitated workshops and master classes, together with annual review of Board effectiveness based on principles of 360 degree feedback. The programme will be delivered at the bi-monthly Board Development and Update Sessions and where relevant, off-site.

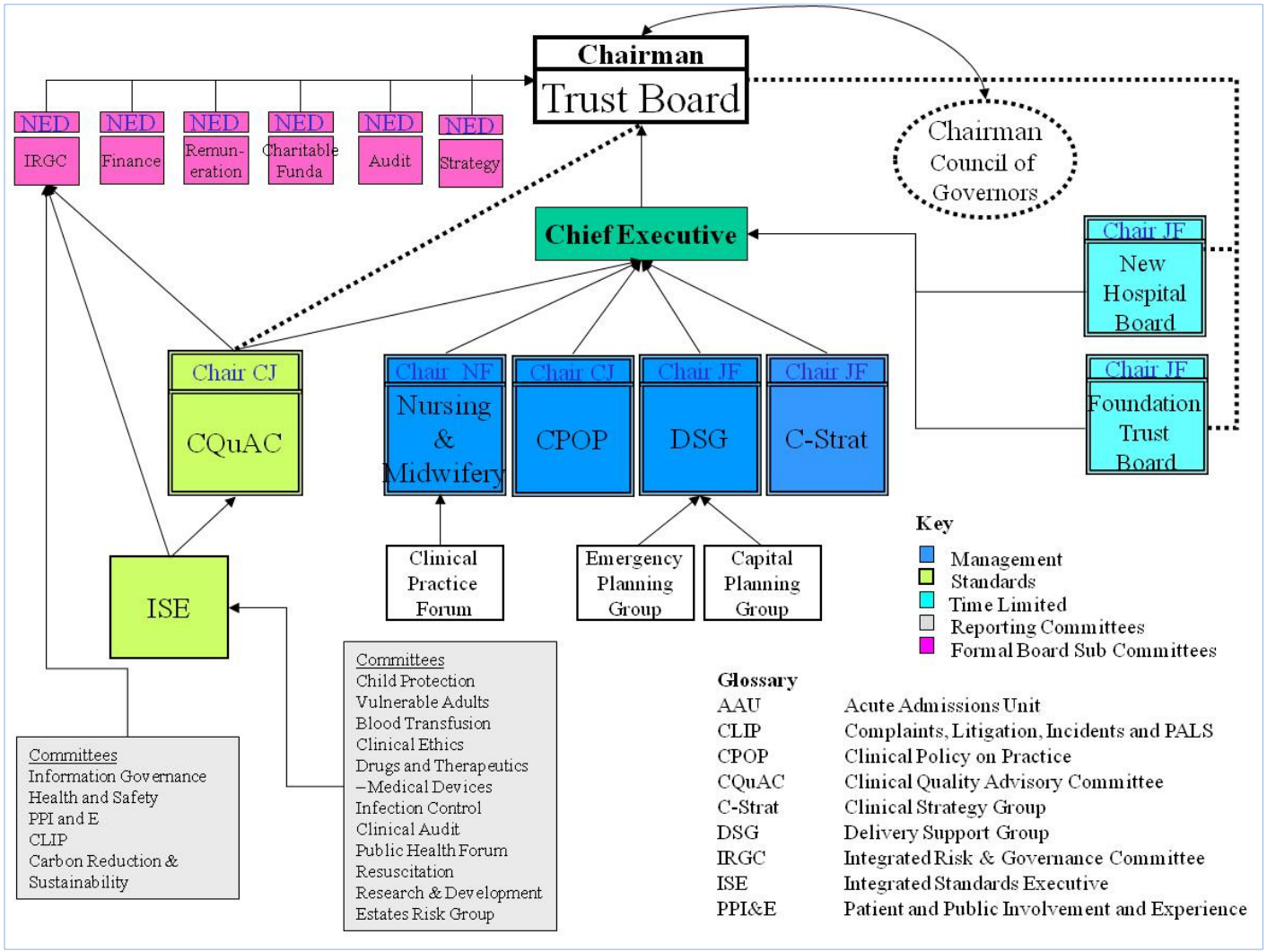
The programme will incorporate some key interventions such as developing relationships with a private sector Board to understand a wider operating context for Board developments. This may involve Board observation, joint and one to one meetings.

The 2012/13 programme will support the Board to refine its preparedness for authorisation as a Foundation Trust further.

2.8 Progress with the Foundation Trust Application

The Trust Tripartite Agreement was for the SHA to present to the DH on 1st March 2012. Following a Board to Board meeting it was agreed that the SHA would submit to the DH in April 2012, allowing for additional submissions from the Trust. It is anticipated that the Trust will achieve foundation status in late 2012.

Board Committee Structure



3.0 Strategy and Service Developments

3.1 Strategic Context: Inward Facing

The Trust's vision is as follows:

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

The Trust's objective is to provide consistently high quality emergency and elective care to its population. The vision for healthcare in the NHS Midlands and East Strategic Health Authority for the next decade is set out in '*Towards the Best Together – a clinical vision for our NHS, now and for the next decade*'. The vision is to provide the best health services in England. The Trust's vision reflects the determination to support this far reaching ambition.

The Trust has effectively positioned Watford General Hospital as a District General Hospital offering some specialist services, i.e. a Supra-DGH. The Trust has no aspiration to become a tertiary hospital, but recognises that it is well placed to be an exemplar in the provision of integrated secondary care, as is its Clinical Strategy. The following should be noted:

- The Trust has a large natural catchment population of approximately 500,000 people, giving an ideal critical mass to offer excellent sub-specialisation and the full range of services required to sustain 24/7 emergency care for the local population.

- The Trust has already reconfigured serivces into:

    - A centralised, acute site at Watford
    - A dedicated elective care centre at St Albans
    - An interim local general hospital at Hemel

  The Trust is now in a position to exploit this stability for further increases in productivity and service improvement.

- Much has already been realised from the recent reconfiguration and improvements in care as a result of the service reconfiguration, on a macro level, including improvements in quality, a £4m reduction in infrastructure costs at Hemel and avoiding the potential cost of £5m European Working Time Directive compliance. There are still significant savings to be achieved by the redesign of systems and processes at the micro level.

- Through service redesign resulting in improved pathway, productivity and efficiency the Trust will generate the surpluses required to address backlog maintenance and investment in IT required.

3.2 Strategic Context: Outward Facing

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 slightly 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

- Life expectancy is 7.4 years lower for men and 5.4 years lower for women in the most deprived areas of Hertfordshire compared to the least deprived parts.

- Notwithstanding the above, 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.

- 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

- An estimated 19.5% of adults in the county smoke with some 1,500 associated deaths per year. Prevalence is highest in Northwick ward (Three Rivers), Central ward (Watford) and Cowley Hill ward (Hertsmere)

- An estimated 21.4% of adults in the county are obese. This 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)

- There were 15,850 hospital stays for alcohol related harm in 09/10. (The figure for 11/12 is not yet available.)

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 population 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:

2011/12 Income by Commissioner

Commissioner	2011/12 (£m's)	Percentage
Hertfordshire	209.0	90.9%
Barnet	1.3	0.6%
Bedfordshire	1.5	0.7%
Brent	0.4	0.2%
Buckinghamshire	0.9	0.4%
Harrow	3.3	1.4%
Hillingdon	5.2	2.3%
Luton	1.7	0.7%
EoE Specialist Services Commissioning Group (SSCG)	3.9	1.7%
Non Contract Activity (NCA) etc	2.8	1.2%
Total	**230.0**	**100%**

NHS Hertfordshire has issued a key strategy document, *Integrated Plan 2012/2013: Our strategy for improving health and healthcare in Hertfordshire,* covering the period 2012/13 to 2014/15. The key elements of this strategy impacting on the Trust are discussed in Section 4.0 of this Annual Plan.

The market environment is changing with two Clinical Commissioning Groups beginning to emerge. These are:

- Herts Valleys (Dacorum, Watford, Hertsmere, Harpenden and St Albans
- Red House Group (Radlett)

The Trust has already established good working relationships with these groups. It should be noted, however, that the Red House Group serves a small population, circa 19,000, and its future as a separate entity is not confirmed.

There have been significant changes at the neighbouring East and North Hertfordshire Trust. E&N compromises two general hospitals, the Lister in Stevenage and the QE2 in Welwyn. Acute services are being centralised at Stevenage. Early data suggests this has resulted in a change in the flow of emergencies and an increase in attendances at Watford General Hospital A&E department.

3.3 Commissioning Arrangements

The Trust will explore managed service developments with CCGs/PCTs to assist care closer to home initiatives. The Trust will concentrate on improving activity recording to ensure we get paid fairly and to ensure PbR rules are followed and changes implemented. The Trust will work with its host commissioner to deliver QIPP and service redesign.

3.4 Long Term Strategic Objectives

The Trust has set itself seven strategic objectives which the Board will monitor year by year. These objectives focus on the consistent delivery of high quality, safe services whilst ensuring the organisation remains financially robust. These objectives are ongoing, and will continue to be validated every year. The Trust's strategic objectives are:

- To provide safe patient care
- To improve outcomes and quality of care
- To improve the patient experience
- To sustain and improve performance
- To be financially sound
- To work in active partnership
- To attract, retain and motivate an appropriately trained workforce

They are supported by a set of business objectives as follows:

- Core Objectives: To deliver the base case:
  - To sustain market share
  - To reshape and rationalise services to ensure financial viability
- Stretch Objectives: To deliver the upside
  - To increase market share at the periphery
  - To increase the range of specialist care provided locally
  - To deliver more care in community settings

The Trust has agreed to develop three enabling strategies:

- Relationships
- People
- Reshaping Services

These are to support the delivery of the strategic and business objectives.

The Trust will ensure that these objectives are delivered through a number of key change initiatives. These will be the service developments for the Trust. It should be noted that most of these developments are around the reshaping and reconfiguring of services and resources. They do not depend on additional income.

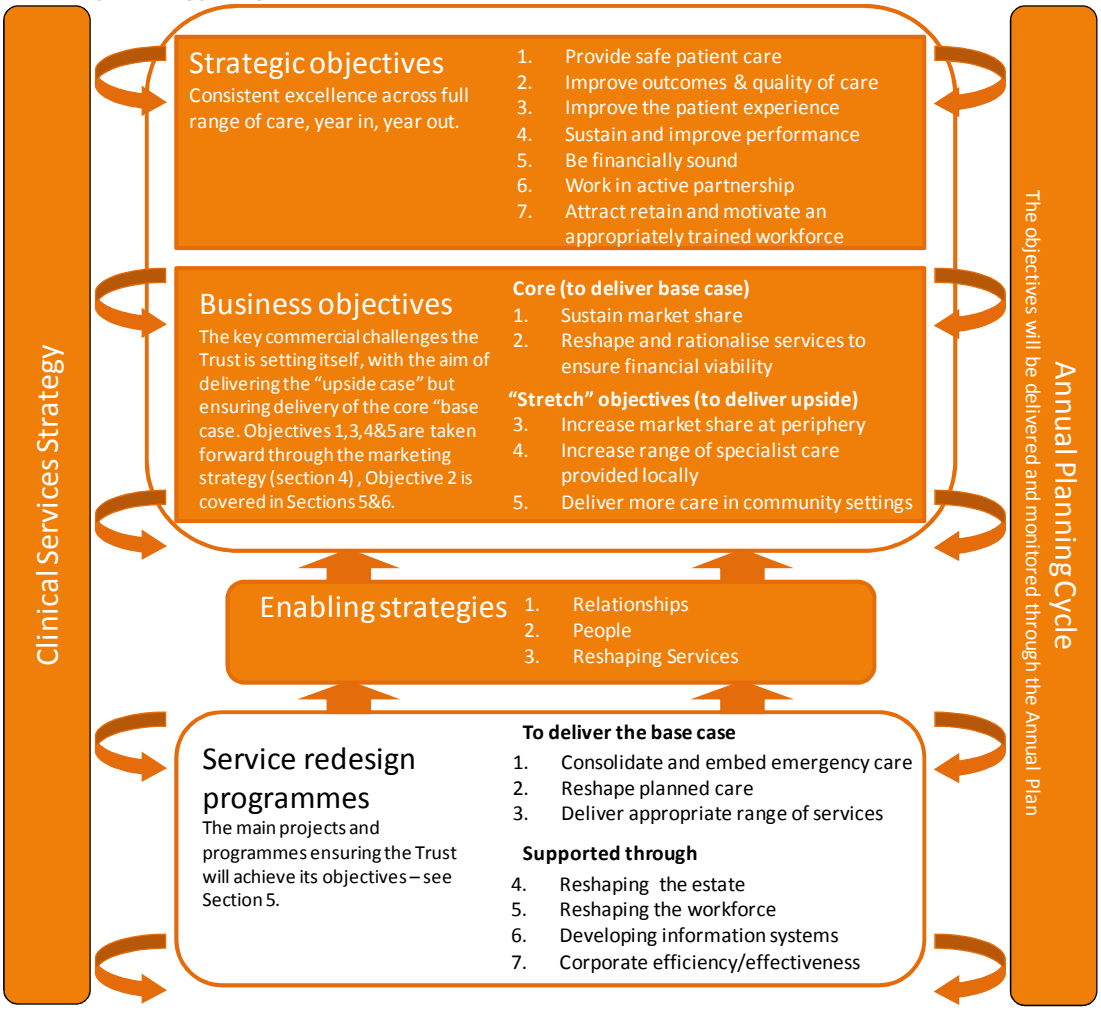
Organisational risks associated with the delivery of these objectives are managed through the risk process and reported to the Board via the Integrated Risk and Governance Committee and directly to the Board via the Board Assurance Framework. The diagram below summarises the objectives and change initiatives and shows how they relate to different elements of the Trust's strategy.

Midlands and East SHA Cluster has articulated five 'ambitions' as follows:

1. The elimination of avoidable grade 3 and 4 pressure ulcers by December 2012
2. Significantly improved quality and safety in primary care
3. Create a revolution in patient and customer experience
4. Making Every Contact Count through systematic healthy lifestyle advice delivered through front line staff
5. Ensure radically strengthened partnerships between the NHS and local government

Not every 'ambition' translates directly into actions for the Trust. For those that do, the Trust is fully supportive and actively working to address these ambitions.

Summary Strategy Diagram



3.5 Key Strategies in Place

The following key strategies are in place and are current.

- Clinical strategy
- People strategy
- Estates strategy
- IM&T strategy
- Capital and investment strategy
- Financial strategy

The essence of the various strategies is provided below:

Clinical Strategy

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

People Strategy

- To optimise the staff experience through implementing a People Strategy which touches every member of the Trust over the next three to five years including:
    - Delivering the Nursing & Midwifery strategy
    - Delivering the Health and Wellbeing at Work strategy
    - Developing a training programme from internal resources based on listening, being appreciative and empowering staff with the right resources
    - Involving ALL staff working in the Trust's hospitals in an internal programme of development based on values, improved communication, accountability and devolved responsibility
    - Developing a culture of learning from good practice, celebrating success and acknowledging achievements and journey – pride in 'working at West Herts Trust'
    - Delivering effective appraisals, mandatory training and follow-up reviews
    - Developing Talent Management and succession planning. Clarify roles of manager, identify and audit individuals with line management responsibility. Real time feedback, communications & staff engagement initiatives
- To attract, retain and motivate an appropriately trained workforce
- To use the workforce more effectively by :
    - Reduced use of divisional temporary staffing
    - Finance re-organisation
    - Improved management of temporary staffing
    - Reductions in admin staff
    - Review of management staff
    - Divisional workforce savings - Service redesign
    - Reduction in out of hours estates' costs
    - Estates restructure
    - More effective medical job planning
    - Cost reduction by use of shared services
- To continue to manage sickness effectively

Estates Strategy

- The Estates Strategy is currently undergoing annual review by the Board's Strategy Committee. This was delayed from January 2012 owing to the Trust commissioning an external estates expert to re-assess the backlog risk profile and help prioritise work and resources required. Further details relating to particular sites are provided below:

- **Watford General**

  The Trust remains fully committed to delivering improvements to the patient experience by seeking innovative and affordable ways to develop and enhance the estate. This is demonstrated by the Maternity, Clinical Decision Unit and 'Surge Ward' capacity increase in 2011.

  Previously, the Trust was focussing on a single-phase hospital, funded via PFI, which is unachievable in the current financial climate. The Trust is now planning for capital receipts from selling discrete elements of the estate to fund improvements in other parts of the existing estate, including some phased new builds. By targeting capital investment and cash surpluses including capital receipts, it will be possible to address many of the backlog maintenance issues associated with the estate to enable the delivery of the Trust's strategy. This may include small elements of new build in order to replace aging estate.

At Watford, potential also exists to work in partnership with the Borough Council to contribute to a major urban regeneration programme. This programme is known as the Watford Health Campus. It would allow the Trust to benefit from sharing the financial burden of major infrastructure and highway costs with its neighbours; in particular the cost of a new link road which would transform access to the hospital, bypassing the town centre. A master plan has been developed for the site for which outline planning permission has been granted, based upon the original single phase hospital development. There is, however, scope to adapt the planning permission if a phased approach was pursued.

- **Hemel Hempstead Hospital**
  The Trust is working jointly with the PCT to develop plans for the use of this site and to ensure that there is a net gain to the NHS in west Hertfordshire and that solutions for the site will benefit all stakeholders – patients, commissioners and providers.

  The Trust has taken expert advice to establish a preliminary site and service rationalisation plan and it is anticipated that a significant part of the 4.8 hectare site will become available for sale on the open market. The site rationalisation plan has identified a number of disposal options to maximise capital receipt.

  The Trust and the PCT have jointly commissioned a review of the medium term plans for the LGH within the new economic climate. Should the current building(s) be retained the Trust will explore the relative financial merits of transferring the freehold of the occupied premises to the PCTs LIFTCo or providing a long-lease

- **St Albans City Hospital**
  The Trust recognises that there are opportunities to further consolidate service provision into newer, more appropriate environments with fewer buildings on the St Albans site.

  HCT is currently consulting on an Intermediate Care Strategy. This is likely to significantly reduce the quantum of inpatient care provided at SACH. If this happens, the Trust would reconfigure the site to use the better quality accommodation currently occupied by HCT, enabling the Trust to vacate and dispose of redundant buildings on the site. Given previous economic assessments of the market value for housing developments in this area it seems very likely that the site would be attractive to developers and would achieve a significant capital receipt.

The Trust's backlog maintenance requirement is £40.4m. This level of backlog is a major challenge for the Trust and one the Board takes extremely seriously. In the light of the scale of backlog maintenance the Trust has commissioned an independent expert to re-assess the backlog risk profile and to help prioritise the work and resource required.

IM&T Strategy

- Following a board-level development session in October 2011, the Trust has commissioned a review of the IT strategy. *Channel 3* is currently interviewing Trust staff and external stakeholders to reassess the key priorities for the Trust, and to develop a plan to implement changes. Early indicators are that there is significant scope to use technology differently to improve efficiency and patient services. The Board will agree the new strategy in the first quarter of 2012/13.

Capital and Investment Strategy

- The Capital and Investment Strategy has been approved and signed off by the Board. The essence of the strategy is to target investment at areas of high risk. For 2012/13 this means investing in backlog maintenance of the Estate, decontamination at Watford and TSSG services

Finance Strategy

- Following discussions by the Finance Committee, the Board agreed a financial strategy in November 2011. This is being reflected in the Trust's financial planning as set out in the LTFM/IBP and the financial plan for 2012/13.

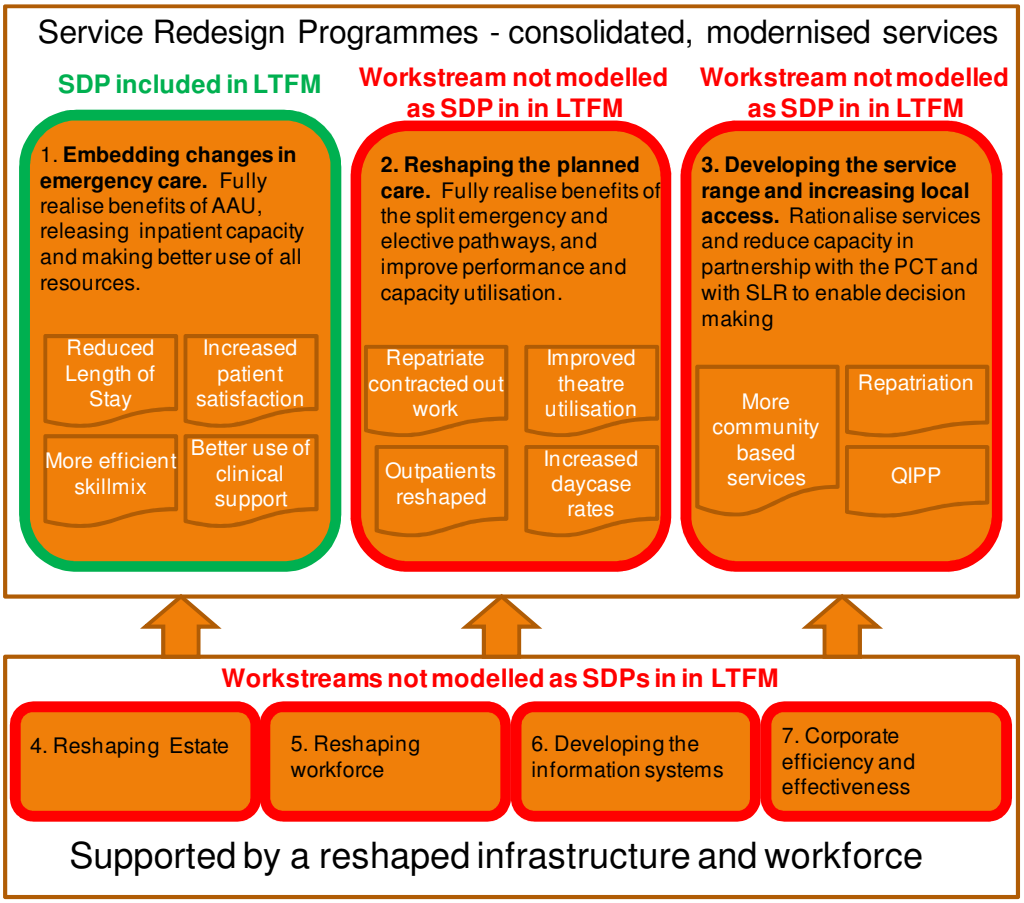
3.6 Objectives for 2012/13 and Service Development Plans

Specific objectives for 2012/13 include the following:

- Foundation Trust: Smooth progress of the Trust's FT application
- Finance: Achieving financial targets
- Emergency Admissions: Implement plans to ensure the Trust has a robust response to the 2012/13 winter pressures
- IT Strategy: Develop, agree and implement the strategy across the Trust
- Watford Health Campus: To progress the implementation of the Watford Health Campus
- People Strategy: To implement the people strategy across the Trust

The overall service development plan is neatly captured in the diagram below:

Service Redesign Programmes and SMP Summary Diagram



Key service developments for 2012/13 are as follows:

- **Achievement of Foundation Trust Status**
  - **Description**: Completion of process to become a Foundation Trust
  - **Timing**: Late 2012
  - **Financial Impact**: No direct financial impact
  - **Commissioner Support**: Full
  - **Key Risks**:
    - Political delay
    - Other delays to the process
    - Restructured loan
  - **Link to IBP**: Yes

- **Getting Better (Big Ask 2)**
  - **Description**: CIP/QIPP: Deliver savings of approx £11.5m
  - **Timing**: By March 2013
  - **Financial Impact**: A saving of £11.5m
  - **Commissioner Support**: Full
  - **Key Risks**:

        - 2012/13 contract value set below required level of funding, therefore higher CIP value
        - Standard risks associated with complex and sophisticated savings programme
    - **Link to IBP**: Yes

- **Emergency Admission Capability**
    - **Description**: The Trust will continue to develop its capability to deal with winter pressure peaks and with emergency admissions growth.

      There is a growing body of evidence to suggest that changes in the location of A&E facilities at East and North Hertfordshire Hospitals Trust has resulted in a growth in demand for emergency admissions at Watford. This evidence is not conclusive – there has been insufficient time and hence data since the changes – but it is highly suggestive.

      The Trust plans to run a pilot Navigator Project from April 2012. In the pilot a senior therapist/nurse will work with the on-call team to identify patients for whom there are alternatives other than admission. The current expectation is to turn around three or four patients per day into community services.

      A further part of the solution to pressures at the Watford site may be an increase in the use of St Albans for elective care. The planning for this is at an early stage and will develop, and be implemented if necessary, during the year.
    - **Timing**: Continuous
    - **Financial Impact**: At present this is unclear
    - **Commissioner Support**: Full
    - **Key Risks**:
        - Uncertainty associated with the cause of the growth in admissions. This risk will reduce as further data becomes available
        - The cost of new capacity if an increase in bed numbers proves to be the most effective solution
        - Bed pressure at the Watford site including pressure on elective beds
        - Increase in cancellations of operations
    - **Link to IBP**: Yes

- **Develop IT Strategy**
    - **Description**: The Trust is reviewing its IT strategy and will agree a revised strategy in the first quarter of 2012/13.
    - **Timing**: 2012/13 onwards
    - **Financial Impact**: Not known at present but implementation plan will have to demonstrate affordability
    - **Commissioner Support**: Full
    - **Key Risks**:
        - Resilience of aged infrastructure while agreed developments are implemented
        - Developments need to be affordable in light of very limited available capital
    - **Link to IBP**: Yes

- **Watford Health Campus: Road Infrastructure**
  - **Description**: The Trust expects to make progress on the development of the Watford Health Campus. In particular, the Trust will progress the road infrastructure
  - **Timing**: Commence in 2013 and complete in 2014
  - **Financial Impact**: £7m – funding available
  - **Commissioner Support**: Full
  - **Key Risks**:
    - Standard risks associated with a complicated construction project
    - Potential to confuse application for loan rescheduling
  - **Link to IBP**: Yes

- **Watford Health Campus: Combined Heat and Power**
  - **Description**: The Trust will also progress the Combined Heat and Power Plant at Watford
  - **Timing**: Start 2012 and complete in 2013
  - **Financial Impact**: £2.9m funding available. Expected savings of circa £790k per annum but dependent on fuel prices
  - **Commissioner Support**: Full
  - **Key Risks**:
    - Standard risks associated with a complicated construction project
  - **Link to IBP**: Yes

- **Reshaping Strategy**
  - **Description:** The Trust plans to continue its strategy of reshaping clinical services to improve efficiency and reduce costs
  - **Timing:** On going
  - **Financial Impact:** Consultancy costs across 2011/12 and 2012/13 of circa £360k
  - **Commissioner Support:** Full
  - **Key Risks**
    - Standard risks associated with service reshaping
  - **Link to IBP**: Yes

- **Ambulatory Care Expansion**
  - **Description**: The Trust plans to expand the Ambulatory Care Model in which patients are seen and treated as ward attenders rather than being admitted as emergencies. This reduces the demand for beds and reduces costs. At the end of 2011/12 an average of one patient per day was processed through this model. During the course of 2012/13 usage is expected to increase to five per day.
  - **Timing**: Continuous
  - **Financial Impact**: This development will result in cost savings. These savings, however, will not be accounted for separately; they will be rolled up into the Emergency Admission Capability development.
  - **Commissioner Support**: Full
  - **Key Risks**:
    - Normal risks associated with a change to pathways
  - **Link to IBP**: Yes

- **Pathology Transformation**
  - **Description**: Following the Carter Review, Midlands and East SHA initiated an intra-NHS pathology transformation procurement process during 2011 with the expectation that savings would be achieved through centralisation of pathology into three or four hubs within the East of England area. The Trust has formed a consortium, called Consolidated Pathology Services (CPS), with three neighbouring organisation: Luton & Dunstable Hospital Foundation Trust; Bedford Hospital Trust; and Princess Alexandra Hospital Harlow Trust.

    The CPS proposal is to provide direct access pathology for Bedfordshire and Hertfordshire GPs. All direct access pathology would be provided at a single location through a private sector subcontractor. A hot lab providing hospital blood sciences testing will be retained at Watford and also at the other acute hospital sites within CPS.
  - **Timing**:
    - Submission of response to ITT in March 2012
    - Award of contract expected in April/May 2012
  - **Financial Impact**: CPS Trusts have been supported by financial and legal advisers as this is a complex project with significant operational, HR, IT, financial and legal implications that needed to be evaluated. Whilst considerable financial analysis has been undertaken to support the bid, work on assessing the potential financial impact on each organisation is still in progress.
  - **Commissioner Support**: Supported in principle but further GP engagement needed
  - **Key Risks**:
    - Ability to achieve significant savings
    - Funding for one-off implementation costs
    - Uncertainty leads to loss of staff
    - Loss of control
  - **Link to IBP**: Yes

- **Theatre and Outpatient Efficiency**
  - **Description**: The Trust will continue in its drive to improve theatre and outpatient efficiency. There will be a further review of sessions and schedules for some specialties. The Trust will also update and develop Theatreman, the theatre scheduling application. This will allow more sophisticated reviews of utilisation and activity, and the development of more sophisticated functionality including 'white boards', etc.
  - **Timing**: Continuous
  - **Financial Impact**: TBA
  - **Commissioner Support**: N/A
  - **Key Risks**:
    - Normal project risk
    - Normal risks associated with software development
  - **Link to IBP**: Yes

- **TSSU/CSSD**
  - **Description**: The Trust is pursuing access to a fully complaint theatre sterile supplies service. It is participating in the NW London Collaboration for the provision of this service and seeks to establish a contractual relationship with a private sector supplier during 2012/13.
  - **Timing**: During 2012/13

  - **Financial Impact**: Capital investment – circa £2.2m.
  - **Commissioner Support**: Full
  - **Key Risks:**
    - Increased turn-around associated with an off-site service
    - Commercial risk of critical service provided by private sector
    - Disruption to the service during the transition
  - **Link in IBP**: Yes

- **Endoscope Decontamination**
  - **Description**: The endoscope decontamination facilities at Watford will be renewed during the course of 2012/13.
  - **Timing**: Operational in early 2013
  - **Financial Impact**: An investment of £1.5m
  - **Commissioner Support**: Full
  - **Key Risks**:
    - Normal project risks
    - Disruption to endoscopy services during the renewal
    - Delays to completion threaten Joint Advisory Group (JAG) accreditation
  - **Link to IBP**: Yes

- **Implementation of New Bank System**
  - **Description**: The Trust will implement a new bank system – NHS Professional
  - **Timing**: Throughout 2012/13
  - **Financial Impact**: Details of savings N/A
  - **Commissioner Support**: Full
  - **Key Risks**:
    - Normal project risk
    - Risk of reducing flexibility
  - **Link to IBP**: Yes

- **Medical Workforce Review**
  - **Description: T**he Trust will continue with the Medical Workforce Review during 2012/13 with a further detailed review of Job Plans, service requirements and productivity.
  - **Timing:** Throughout 2012/13
  - **Financial Impact:** Details of savings N/A
  - **Commissioner Support:** Full
  - **Key Risks:**
    - Low risk
  - **Link to IBP**: Yes

Other developments, currently in the planning phase, and which the Trust intends to progress during 2012/13 include:

- Medical Records: Changing the way the Trust manages medical records. This is an enabler for downstream savings
- Digital Dictation: Providing the infrastructure to dictate clinic letters, etc, to a digital medium accessible from anywhere within the Trust. This will improve efficiency and responsiveness
- Wireless Technology: The Trust intends to embrace this technology to deliver greater efficiencies

4.0 Alignment to Commissioners' Plans

The principles of the NHS Hertfordshire commissioning strategy to 2014 are rooted in the *Investing in Your Health* strategy document, 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 2010/11 to 16/17.

The key issues of relevance for this Trust stemming from the PCT's strategy are as follows:

- Potential development of services which will reduce emergency admissions to the acute hospital.
    - The Trust is working closely with colleagues in the PCT to minimise admissions and ensure patients who no longer need acute care are discharged quickly into an appropriate setting. Notwithstanding the intention to reduce demand in 2011/12, the Trust experienced significant winter pressure challenges. In case this pattern repeats itself during the winter of 2012/13, the Trust is developing plans to ensure a robust response. These are outlined in section 3.6.

- 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

- Support for the further development of Stroke Services at Watford General Hospital.

Taken together the overall theme is clear – an intention to reduce reliance on the core services provided by this Trust so that investment can be focussed more on the development of new services closer to people's homes. These PCT aspirations match those of most PCTs across the country and have been in place for some time. The Trust's experience to date has been that demand for its services has continued to rise, but recent initiatives on the part of the PCT with the support of local Clinical Commissioning Groups (CCGs) are expected to result in a reversal of this trend over the next few years. The market environment will change for the Trust as plans for new GP Consortia proposed by the Government in its White Paper "*Liberating the NHS*" are developed.

Currently there are two pathfinder groups – Red House Group (Radlett) and Herts Valleys (Dacorum, Watford, Hertsmere and Harpenden and St Albans). The Trust is ensuring that it responds to the clinical agenda of the current CCGs through the West Hertfordshire Clinical Partnership. This group of senior clinicians, with representatives of the two West Hertfordshire CCG 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:

- Demand management
- Falls prevention
- Prior approval and restrictions on access to surgery

The Trust is assuming that GPs will prove increasingly effective in linking primary care clinicians to the demand management agenda, and will assist the PCT in its plans to reduce in acute sector demand. This has been taken account of in the assumptions on future activity and income.

A more detailed assessment of the potential impact of commissioner plans on services is illustrated in the table below:

Service Area	Issue	Potential Impact
Maternity and new born	PCT aspiration for the further development of maternity and new born community based services	Some work currently provided from the acute hospital may transfer to the community – and be subject to a tender exercise. As a balance to this, it should be noted that midwife led community centres separate from the main hospital are an expensive model of care. This is likely to make PCTs cautious in pursuing this approach.
Long term conditions	Development of community based services	Proposed service model for long term conditions: diabetes; coronary vascular disease (CVD) including stroke; chronic obstructive pulmonary disease (COPD); kidney (renal) failure and long term neurological conditions would result in a reduction in care previously provided in both secondary outpatients and inpatient care settings. Opportunity for the Trust to develop outreach / partnership services
Children's health	Community paediatrics - development of community based services Development of own community branded services in line with national and sector models and development of the community based portfolio	This is a relatively small service. The Trust will support the development of more community based services and would look to develop a range of community based services effectively integrated with the services in a traditional acute setting. Equally PCTs will have the opportunity to use other providers such as PCT provider arms for this. This has not been modelled as discussions have not taken place with the commissioners and the service is currently provided by Hertfordshire Community Health Services (HCHS)
Planned Care	Market development plans of PCTs	Welwyn patients may shift to SACH and this has been modelled as a marginal patient increase in the upside
	Reduction of Elective Referrals	PCTs are seeking to reduce overall elective referrals through incentivising GP practices. This would impact on the number of outpatient appointments, but should not affect the overall level of elective treatment, as it should simply reduce the number of outpatient appointments that do not lead to treatment. Treatments of limited clinical value will be reduced following the PCT's introduction of a more robust prior approval process
	Commissioner desire to repatriate elective work from London centres and provide more local access	Much work that is not currently referred to the Trust from its core catchment is specialist/tertiary in nature. However, there will be a range of specialties and specific procedures where there will be opportunities for the Trust to expand the scope of work undertaken
Emergency Care	Reducing the growth of emergency care	The Trust is working with the PCT to ensure that the QIPP workstreams deliver the reductions required in emergency care flows
Pathology Transformation	Providing pathology Service for GPs	The Trust has bid for this work in a consortium with three other Trusts

The Trust is in the process of negotiating the Contract for 2012/13. To date this has involved weekly meetings with NHS Hertfordshire, who as main commissioner account for over 90% of activity.

The latest contract proposal made to NHS Hertfordshire is a value of £207.2m, including CQUIN achievement at 80%. This is based upon the 2011/12 forecast outturn and the 2012/13 tariff. This proposal also incorporates growth, 2012/13 counting and recording changes as well as the PCT's assumptions around QIPP.

The Trust received an initial contract offer of £199.7m from NHS Hertfordshire, which has since been increased to £204.4m. The main difference is the PCT is using lower baseline activity for 2012/13, which does not allow for recent increases in emergency care. The PCT also wishes to apply a non-mandatory tariff for adult critical care, which would cost the Trust c£1m. Discussions continue on the resolution of these differences.

The Trust has worked with NHS Hertfordshire to develop robust QIPP Plans for 2012/13. There remains, however, a risk that the £2.8m saving identified in the plan and deducted from the Trust's income, will not be delivered. The Trust is faced with the dilemma of cutting capacity (and costs) in the expectation of demand falling. If demand does not fall, the Trust will be challenged to achieve the Waiting Time Targets. The alternative is to leave capacity in place. If demand falls as predicted, the Trust would experience high costs and a reduced income. The track record of QIPP delivering demand reductions is limited.

At present no Contract is signed but the Trust anticipates meeting the deadline of 31st March.

In an effort to bridge differences for 2011/12, a marginal cost arrangement for over-performance in certain areas was agreed in addition to the national emergency threshold calculation. No fines have been levied to date, but there has been non-payment for:

- Re-admissions in line with national guidance;
- Failure to secure prior approval where required; and
- Never Events.

No Performance Notices have been issued. On a day-to-day basis good relationships are maintained with the host commissioner.

5.0 Key Risks

The key risks facing the Trust are outlined in the table below:

Top Risks: May prevent the organisation from delivering its key objectives in 2012/13					
	There is a "Risk" that…	Likeli-hood	Im-pact	Score	High Level Mitigating Actions Agreed / Planned
1	Unforeseen infrastructure failure resulting from the quality of Estates. (Estates risks)	5	5	25	• Detailed backlog maintenance programme being implemented according to a prioritised scheduled (linked to 5 year capital programme). • Review of internal maintenance procedures and performance data on-going. • Implementation of KPIs and regular performance review (DOH Benchmark data submitted to Board in 2010/11) • Standby generation procedures have been reviewed and statutory testing has started in accordance with national guidance. • Post internal review the essential backlog figure is £40.4m. Estates Management Plan in place
2	Sustained levels of high demand for emergency services will compromise the Trust's ability to deliver safe services that meet key quality metrics. (Clinical Risk)	5	4	20	• Internal mitigating actions in place and monitored. • Escalation arrangements in place. • Capacity expansion in 2011 has had a positive impact but current detailed analysis of demand will inform 2012/13 capacity plan.
3	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. (Clinical Risk)	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.

Top Risks: May prevent the organisation from delivering its key objectives in 2012/13					
	There is a "Risk" that…	Likeli-hood	Im-pact	Score	High Level Mitigating Actions Agreed / Planned
4	Inadequate resilience in core IT systems, coupled with inadequate fallback and disaster recovery arrangements will threaten the functioning of hospital information systems resulting in (I) threats to service delivery (ii) ability to provide assurance through performance & activity monitoring.	4	4	16	• Disaster recovery plan. • The tendering process for a contract for disaster recovery for the IT server rooms is being progressed. • New IT strategy and business case to support priority changes is being developed.
5	Cash levels will not be adequate to become an FT if loans are not rescheduled. Also risk of not being able to fund payments to suppliers/ staff	3	5	15	• Loan re-scheduling included in Tripartite Agreement • Control of budgets and delivering of savings • Discussions with SHA to ensure the £7m road funding does not confuse the issue.
6.	Risk to status of Trust as provider of postgraduate medical training from concerns raised following visit by East of England Deanery on 10 October 2011 and associated risk to safe care related to concerns raised.	3	5	15	Deanery Action Group convened to oversee Deanery Action Plan.
7	The Trust will not achieve a surplus of £2.8m at year-end 2012/13 and therefore achieve a financial risk rating of 3 if it fails to achieve agreed savings target (including delivery of 'BIG ASK 2' programme) NOTE: This is the current BAF risk 2286 modified to reflect 2012/13 (Financial Risk)	3	5	12	• Finalisation of Savings Plan • Agreement and control of budgets
8	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.
9	Transforming Pathology initiative results in financial loss, service compromise and loss of benefits derived from internally managed pathology services	3	4	12	• ITT submitted to SHA • Work continues to finalise assessment of financial consequences of success or failure in the bid
10	The PCT intention to reduce hospital based demand faster than reflected in IBP base case will result in a reduction in income without related reduction in capacity	2	5	10	• PCT contract monitoring • Weekly performance monitoring • Monthly PMO meetings with Finance and Divisions.

The Board Assurance Framework records the Trust's key risks to its strategic objectives and the top ten risks are detailed above reflecting clinical, financial and performance issues. The BAF is reviewed

at each meeting of the Trust's risk sub-committee, chaired by a 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 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 BAF reflects the risks identified in the IBP 'short list' and the downside content of the IBP.

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.

The highest scoring risk relates to the Trust's estate which presents considerable challenge to ensure ongoing compliance with CQC Outcome 10, the minimisation of service interruption due to estates-related failure and estates compliance issues emerging following reports commissioned in 2011.

A recent internal audit of divisional risk arrangements confirmed concerns in relation to the management of estates related risks that emerged during 2011. This has triggered a high level review of estates risk management which will inform revised processes in the division going forward. The Trust is also considering the potential for introducing a revised risk rating methodology that is emerging as more appropriate to the specific complexities of estates related risks.

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 continues to improve and the recent internal audit identified better consistency at divisional level in relation to risk management.

The Trust has also implemented a Business Risk Register to reflect operational risks that need to be monitored by the Risk Committee but may not merit Board review.

Estate Backlog & Risk Mitigation

The Trust's backlog maintenance requirement is £40.4m. This level of backlog is a major challenge for the Trust and one the Board takes extremely seriously.

It should be noted that the Estates Strategy developed in 2009 set out a backlog maintenance requirement of £66.4m. This has been reassessed to £40.4m. The reduction has been delivered as follows:

- A number of buildings on the Watford site with backlog maintenance have been or will soon be decommissioned: Cedar, Cherry Trees, Oak, H Block and the Admin Block.

- The backlog maintenance risk associated with the generator on the Watford Site has been mitigated as the Trust has secured funding for a Combined Heat and Power plant.

- The Trust would not expect to prioritise investment in non clinical areas. This does not compromise patient or staff safety.

In the light of the scale of backlog maintenance the Trust has commissioned an independent expert to re-assess the backlog risk profile and to help prioritise the work and resource required.

6.0 Improving Quality and Safety

Specific plans to improve clinical quality and safety are shown below:

Measure	Current Performance	Ambition for 2012/13	Plan and Comment
CQC Registration and Compliance	Compliant	Compliant	The Trust has a policy for maintaining compliance with CQC registration requirements and has instigated a regular update regime. Compliance Leads update the Provider Compliance Assessments which are reviewed by the Executive Lead. The Trust Board receives regular updates.
CQC Quality Risk Profile	Outcome 12, deemed non compliant, is showing high red.	Continuous improvement to achieve no risks scoring red or high amber.	The CQC Quality and Risk Profile is reviewed at each iteration against the Provider Compliance Assessment reports completed by Trust Outcome Leads.
NHS Litigation Authority	NHSLA Level 2 achieved in June 2011	Consolidate and maintain compliance across all standards at level 2	The Trust has analysed the standards against which it was non-compliant and has drawn up an action plan to remedy the non-compliance. This action plan is being rigorously implemented and the Trust has arranged an informal assessment for May 2012 to assess progress.
Number and Themes of Serious Incidents	44 incidents from Apr 11 to Feb 12 of which 7 were downgraded	< 37	Key themes as follows: • Issues with physical standard of notes • Communications • Environmental factors • Lack of standardisation • Lack of staff awareness regarding Never Events and Serious Incidents The Trust plans to continue its education programme encouraging open and honest reporting, and robust learning and communication of the learning. Specific improvement targets are not set because this risks compromising the willingness to report.
Number and Themes of Never Events	5 events from Apr 11 to Feb 12	Zero	The pattern of these events was as follows: • Retained tampon – 3 • Seasorb event – 1 • Wrong site discectomy – 1 Key themes were as per the Serious Incidents above. The Trust plans to continue its education programme encouraging open and honest reporting, and robust learning and communication of the learning.
Mortality Ratio: SHMI	101.4 as at Q1 2011/12	Continued good performance	The Trust will continue to maintain good practice in terms of caring for patients and in terms of the governance arrangements surrounding this care.

Measure	Current Performance	Ambition for 2012/13	Plan and Comment
HCAIs: C Diff	16[17] events against a ceiling of 33	To reduce the number of events	Continue with robust infection control measures
HCAIs: MRSA	1 event against a ceiling of 4	Zero	Continue with robust infection control measures
Pressure Ulcers	15 x grade 3 1 x grade 4	Zero	Continue with high quality nursing
Single Sex Accommodation Compliance	No breaches since May 2011	Zero	The last breach was in May. Significant work has been undertaken to address the systemic issues which allowed breaches. Matrons, ward managers and bed managers now work in a more coordinated manner to ensure patients are placed in appropriate beds. Work on emergency admissions has, and will continue, to provide the head room to ensure that the operational teams have a choice of beds for emergency patients.
VTE Assessment	96.1% YTD as at the end of Feb 2012 and greater than 97% for each of Dec, Jan and Feb	>= 98%	Continue high performance improvements with assessment and audit of implementation
Complaints: Respond within 40 days	60% - Q1 67% - Q2 83% - Q3 Trust target of 80%	>80% in all quarters	The Trust has raised the profile of complaints management and maximising the lessons drawn. This workstream now falls under the remit of the Director of Nursing and the response rate is monitored by the Board each month. This approach has proved successful in 2011 and will continue through 2012/13.
Patient Experience	Year-on-year improvement with room to improve further	To continue with the year-on-year improvement	Rigorous analysis of national surveys results leads to the development of Trust action plans to address identified issues. These plans are subject to a rigorous governance regime passing through Divisional Boards and the Trust's Patient Experience Working Group. These bodies monitor the implementation of the plans. Results from local surveys are all reviewed by the commissioning Division and actions are overseen by the Divisional Board with Trust's Patient Experience Working Group taking a corporate overview. In addition, the Trust has recently purchased a real-time patient survey/questionnaire programme to provide real-time patient

[17] As at 14th March 2012

Measure	Current Performance	Ambition for 2012/13	Plan and Comment
			feedback. The Trust will continue to commission local surveys, drawing out lessons and implementing changes to improve the patient experience
Advocacy: Net Promoter	N/A	N/A	As from Monday 5th March 2012 the Trust will be trialling a short patient survey which will ask all patients discharged within the Acute Admissions Unit the Net Promoter question. This will be evaluated after two weeks to determine whether any changes are needed in the methodology of seeking patient feedback with a view to implementing the questionnaire across all in-patient areas from 1st April 2012. As required by the SHA guidance this will be broken down by ward and specialty and be reported on monthly to the PCT.

The table below shows the Summary Hospital-Level Mortality Indicator for discrete areas within the Trust. The data is drawn from East Midlands Quality Observatory and relates to the first quarter of 2011/12.

Area	Value	National Mean	Comment
Stroke	86.7	100.0	Better then the national average
COPD	77.6	100.0	Better then the national average
MI	82.1	100.0	Better then the national average
Fractured NOF	82.5	100.0	Better then the national average
Pneumonia	103.1	100.0	Comfortably within the control limits
CHF	92.0	100.0	Better then the national average
Renal	86.8	100.0	Better then the national average
Diabetes	121.5	100.0	Comfortably within the control limits

The Trust is part way through preparing its Quality Account for 2012/13. The 'long list' of elements from which the Quality Account targets will be selected is as follows:

- Food and Nutrition
- Pressure ulcers
- Patients' hospital prescribed medication, including provision of take home medication and information on side effects
- Responding to complaints
- Responding to patient feedback
- Reducing the level of noise at night on wards
- Improve delivery of pain services
- Dementia, including diagnosis
- Reducing the level of caesarean sections
- Patients' property
- Transport
- Discharge planning
- VTE Assessment
- Use of the safety thermometer

- Carer's experience questionnaire – introduction and/or improvement in feedback from carers of Learning Disability patients

Once the 'short list' has been agreed, the Trust will set targets and milestones against the measure. While not confirmed, it is likely that the Quality Account targets will reflect the five 'ambitions' of Midland and East SHA Cluster.

7.0 Delivering Contractual and National Targets and Standards

The Trust has delivered against the vast majority of standards and targets despite activity being far greater than originally commissioned. The Trust has one of the highest levels of VTE Assessment and one of the lowest re-admission rates. Overall it expects to achieve at least 80% of its expected CQUIN level which is a considerable improvement over the year before.

Due to poor patient survey results in 2010 the Trust has made significant efforts to improve its patient focus. This has been rewarded by achieving 83% of the available CQUIN funding for 2011-12 compared with 0% for the previous year. In addition the Trust has won national awards for its efforts to improve face-to-face contact between staff and patients.

Overall the PMR ratings in the last 6 months have been green or amber/green. This has been particularly commented on by the SHA who view the performance as a good base for the Foundation Trust Application to move forward on.

The Trust continues to monitor quality and governance ratings internally on a weekly basis by the Exec Team and monthly by the Board. The bedrock for ensuring the targets continue to be met is in place but will be reviewed if there is any suggestion that performance might slip.

In view of the recent monthly performance against the PMR ratings, The Trust believes it will continue to report green against all categories throughout 2012-13.

8.0 Financial Plans

The budget for 2012/13 reflects an update on the IBP and LTFM as submitted to the SHA on 1st March 2012 due to timing issues. The FIMS plan matches the IBP. It is anticipated that the IBP and LTFM will be updated once contracts have been finalised and the Trust would like to have the opportunity to refresh the FIMS plan.

The planned surplus is £2.8m throughout the budget and IBP. This is necessary to generate the required 1% surplus in line with Monitor requirements and includes a modest margin for risk. The target surplus is based on anticipated lower loan repayments as a result of refinancing in September 2012, when authorisation as a Foundation Trust is expected.

8.1 Income

For the 2012/13, the Trust expects to achieve an income of £261.4m: £234m from contract income and £27.4m from other sources.

Details of the factors affecting income are set out below.

8.1.1 Tariff changes

Income for patient care is based on Payment by Results (PbR) guidance, using the national tariff and incorporating local agreements.

The LTFM planning assumptions for contract income in 2012/13 were based on the 2011/12 forecast outturn at September 2011. A 1.5% tariff reduction was assumed and, in line with previous years, CQUIN (Commissioning for Quality and Innovation) was included at 1.5%. Contract income in the Long Term Financial Model (LTFM) was £226.3m, of which £202.5m related to NHS Hertfordshire, the Trust's host commissioner.

Since then forecast outturn activity has risen and application of the 2012/13 tariff has shown a 0.2% reduction in PbR prices rather than the 1.5% anticipated. In addition, CQUIN in 2012/13 has increased by 1% to 2.5%, resulting in a further £2.6m of potential income. Non-PbR tariffs have been reduced by 1.8% on 2011/12 prices.

Trust planning assumptions include a 0.64% increase in demographic growth. The Trust has also assumed a number of changes in 2012/13 as a result of counting and recording changes, particularly within midwifery and cardiology. £2.8m of Quality, Innovation, Productivity and Prevention (QIPP) savings, as provided by NHS Hertfordshire, have also been incorporated into 2012/13 planning figures. For planning purposes, an assumption has been made that 80% of CQUIN targets will be achieved in 2012/13.

The result of this process is an assumed contract income figure of £234m.

8.1.2 Contract with NHS Hertfordshire

The latest contract proposal made to NHS Hertfordshire is a value of £207.2m, including CQUIN achievement at 80%. This is based upon the 2011/12 forecast outturn and the 2012/13 tariff. This proposal also incorporates growth, 2012/13 counting and recording changes as well as the PCT's assumptions around QIPP.

The Trust received an initial contract offer of £199.7m from NHS Hertfordshire, which has since been increased to £204.4m. The main difference is the PCT is using lower baseline activity for 2012/13,

which does not allow for recent increases in emergency care. The PCT also wishes to apply a non-mandatory tariff for adult critical care, which would cost the Trust c£1m.

Hertfordshire QIPP schemes are expected to reduce contract income by £2.8m. There are 10 QIPP schemes, including £1.1m relating to reduced elective activity from BMI & smoking restrictions and a £0.5m reduction relating to falls prevention strategies. Additionally, there is a further £0.25m reduction in respect of prescribing as well as a number of smaller schemes across both emergency and elective services. These are reflected in both the PCT's and the Trust's contract proposals.

Negotiations are ongoing and a further update will be provided at the Board meeting. For budgeting purposes, the Trust is using its contract value of £207.2m, as this represents the most realistic level of activity and income. Experience over the last two years has been that activity levels have been significantly above plan in most areas and the PCT accepts that any extra work will have to be paid for.

8.1.3 Other PCTs

Proposed totals in respect of the 8 other commissioners with whom the Trust holds contracts (7 PCTs plus the East of England Specialist Commissioning Group) have been calculated in the same way as that proposed to NHS Hertfordshire. The Trust has also assumed an additional £0.4m of non-elective obstetric income from these PCTs as a result of the maternity cap being removed. Additionally, a further £0.4m has been included within Trust assumptions to reflect extra neo-natal intensive care (NICU) income made possible by the expansion of capacity in 2011/12. Planned income from other PCTs equates to £27m.

8.2 Expenditure

8.2.1 Pay and Non-Pay Expenditure

Draft pay and non pay budgets for 2012/13 are based on recurrent outturn: forecast outturn adjusted for the impact of non-recurrent benefits and expenditure and the full year effect of cost improvement plans (CIPs) and agreed investments, for example £1.3m in relation to midwifery ratios, and increases in activity. Opening budgets also include, where appropriate, the impact of 2012/13 planned changes in activity, for example, PCT QIPP schemes at 50%, agreed cost pressures and 2012/13 CIP targets. The table below contains a summary of the budgets for 2012/13.

		Proposed 2012/13 Budget £m
Income	Contracts	234.0
	Other	27.4
Total Income		**261.4**
Expenditure	Acute Medical Care	69.6
	Surgery	53.4
	Women's and Children	30.7
	Clinical Support	24.9
	Estates and Hotel Services	24.9
	Corporate	27.2
Subtotal for divisions: Pay and non-pay		**237.3**
	Inflation & Local Pressures	6.7
	General Contingency	2.6
Total Expenditure		**246.6**
	EBITDA	14.8
	Depreciation	-7.6
	Dividend	-3.3
	Interest Payable	-1.1
Surplus		**2.8**

8.2.2 Cost Pressures

New cost pressures of some £2.4m are expected to occur in 2012/13. As in previous years, a number of these pressures reflect external requirements, for example, the Deanery report regarding medical cover in A&E, the Peer Review of Cancer services and costs attributable to achieving estates compliance. From a planning perspective a sum of £2.4m has been included in the 2012/13 budgets.

8.3 Cost Improvement Target 2012/13 – "Getting Better"

The delivery of cost improvements for 2012/13 and beyond has been the focus of some dedicated work over the course of recent months. The target has been reduced from £13m in the IBP to £11.5m, primarily because estimated contract income has increased. The current estimate is that £9m will be recurrent and £2.5m non-recurrent. The savings requirement, at approximately 4.4% of Trust turnover is challenging but lower than in recent years, e.g. the savings target in 2011/12

equated to 6.1%. The key drivers behind the savings requirement are efficiencies built into the tariff and local cost pressures.

The Chief Executive has asked the Director of Nursing to take on the leadership of the savings programme, supported by a new overall project manager. The savings programme will now be known as 'Getting Better'. This refreshed approach will place greater emphasis on changes in the way clinical services are being delivered, as well as continuing to deliver the workforce, procurement and corporate schemes that have been implemented through the "Big Ask."

CIP plans for 2012/13 and 2013/14 have been included in the IBP.

Since the initial plan for £13m of savings was developed, further work has been done to work up Project Initiation Documents (PIDs). This has shown that some of the initial ideas are no longer viable, for example the development of a private patients unit will not happen in 2012/13 and achieving cost improvements in A&E and Imaging may not be possible as a result of the increasing demands being placed on these departments. However, not only has the target reduced to £11.5m but, at the same time, other savings initiatives are being identified. The Trust will benefit in 2012/13 from the profit on the sale of the PPAS, which will not be completed until next year. Additionally there are opportunities to secure new best practice tariffs which will increase income and also improve patient care.

8.4 Capital Programme

The capital programme is funded from depreciation (£7.2m) and brought forward funds from 2011/12 (£2.4m). There may be some capital investment required to deliver the Trust's savings plan; there is £0.5m included in revenue reserves for one-off costs. Beyond that, any further investment will have to be a first call on savings.

Spend detailed in the Table 1 reflects unavoidable commitments; Table 2 lists proposals for prioritisation. The sum is 8% more than the total of £9.6m that is available but will be managed within resources through prioritisation and slippage.

Table 1

Areas Requiring Capital Investment for 2012/13	Indicative Revisions	Notes
A. Unavoidable / Committed Allocations	**(£)**	
Decontamination Compliance (TSSU)	1.0m	updated quote
Equipment to support TSSU Decontamination turnaround	1.1m	uplifted for additional equipment needed
Decontamination Compliance (WGH Endoscopy	1.7m	updated quote
Backlog Maintenance (inc Emergency Remedial works)	2.8m	uplift for Asbestos & Medical Gas Survey
Sub total	**6.6m**	

Table 2

Areas Requiring Capital Investment for 2012/13	Indicative Revisions	Notes
B. For Prioritisation 12/13		
Medical Equipment - Business Continuity	1.0m	Specific needs - CT/ ITU Ventilators
Backlog Maintenance Priorities	0.7m	Roof replacements
Infrastructure & IT improvements & risk reduction	1.5m	Options
Facilitating Service Redesign & Capacity Options	0.5m	Options
Sub Total	**3.7m**	of £10.45m potential schemes (Appendix A)

In addition the Trust has been authorised to access £2.9m of public dividend capital (PDC) to finance the combined heat and power project.

8.5 Cash Flow, Liquidity and Loans

Liquidity and cash continue to be key issues for the Trust; on a non recurrent basis the position is improved by the £7m received in 2011/12 as PDC for the link road. Maintaining a cash balance in excess of £6.9m or 10 days of operating expenses continues to be dependent on the Trust's loans being refinanced. This is planned in September 2012 at the point of FT authorisation.

The Monitor liquidity ratio is measured by the opening net current assets (excluding inventories) plus the working capital facility, divided by the planned operating expenses for the year. This is expressed as the number of days' cover that the Trust has for its operating expenses and is fixed for the year. As the Trust will have the £7m for the link road in its bank account on the 31 March, the liquidity ratio will be a rating of 3, i.e. the Trust will have over 15 days liquidity. The opening cash balance is expected to be £9.8m i.e. nearly 15 days of cash. However because the £7m is ring-fenced, this is a non-recurrent position. To maintain the Trust's longer term cash balance refinancing of the Trust's loans is essential.

The Trust's cash flow plan for 2012/13 shows that there are key repayment dates in September and March relating to the loans. In September the refinancing of the loans, as planned, will inject £9m cash into the Trust. This will ensure that 10 days of cash is sustained, provide for improved creditor payments and cover fluctuations in the level of cash due to the pace of capital spending and delivery of saving initiatives. It is important to note that, the refinancing will mean that the repayment will be over a longer period – 25 years compared to 10 currently. This means that annual principal repayments are reduced which in turn reduces the annual surplus needed to finance them.

The cash flow shows the £7m relating to the link road as being spent in November 2012. This is the earliest the public (Watford Borough Council - WBC) and private partnership, that will undertake the development, will be in place. The accounting treatment for this funding has not been agreed as yet; it is complicated and the Trust has engaged advisors in order to resolve this.

8.6 Financial Risk Rating (FRR)

The following shows the FRR in two scenarios: one including the £7m relating to the link road, the other excluding this funding. Both show the Trust achieving the minimum rating of 3 required by Monitor but the table demonstrates the link road funding is supporting an improved liquidity risk rating.

Financial Risk Ratings 2012/13

Criteria	Metric	Weight	5	4	3	2	1	Risk rating: Including £7m link road funding	Risk rating: Excluding £7m link road funding
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1	3	3
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50	4	4
Financial efficiency	Return on assets %	20%	6	5	3	2	<-2	5	5
	I&E surplus margin %	20%	3	2	1	-2	<-2	3	3
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	3	2
Average								3.5	3.25
Overriding rules	Overriding rules							-0.5	-0.25
Overall rating	Overall rating							3	3

8.7 Service Line Reporting

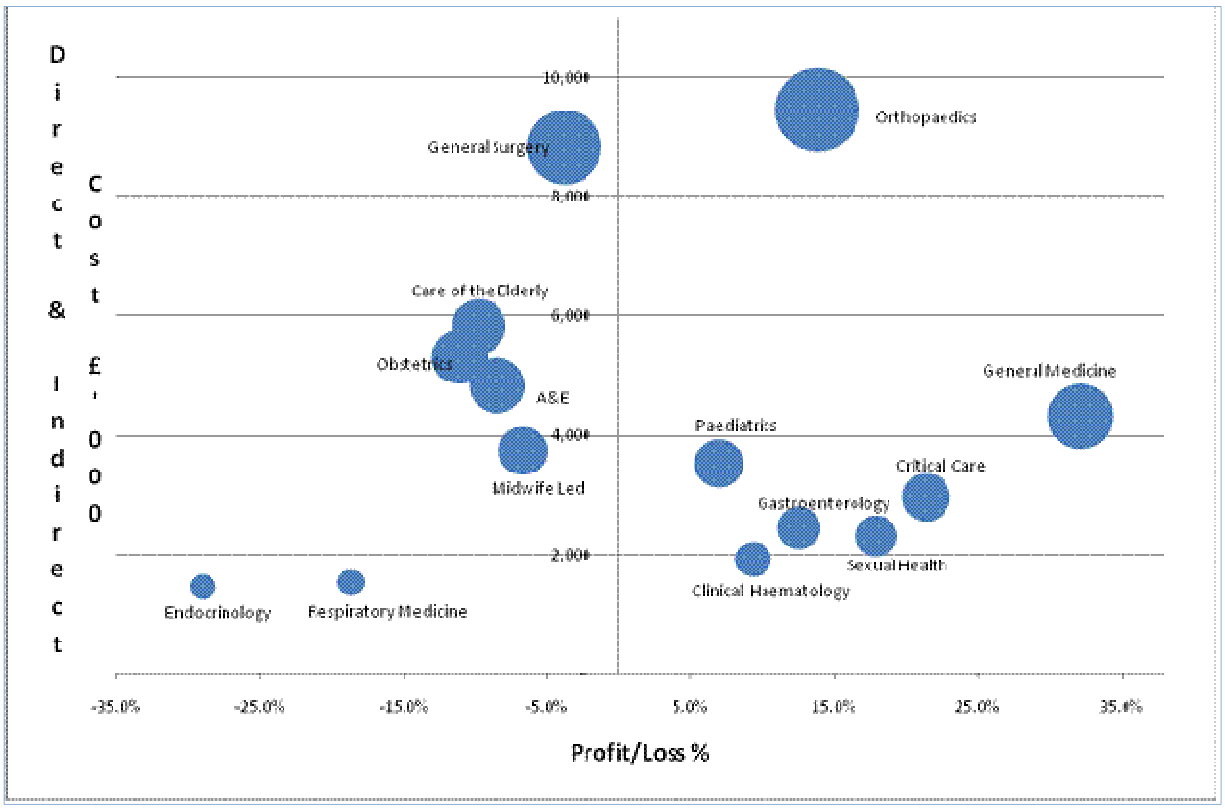
The Trust is progressing with the development and implementation of SLR and, having invested in the software and populated the system with data is now reporting on service line performance on a monthly basis and these reports are part of the monthly financial performance information presented to the Board. The decision was taken at the start to use a patient level costing approach as this would give clinicians the tools to examine variations in clinical practice and performance, challenge these and achieve clinical and financial benefits. However, in the short term the focus is on ensuring that specialty level data is realistic before focusing on patient level.

The Trust has identified pilot specialties (ENT, cardiology and endocrinology) with enthusiastic lead clinicians to test SLR data further and iron out any issues identified e.g. to do with methodologies. Giving greater visibility to the information, together with increasing the support to clinicians and clinical managers to help them develop appropriate skills, is starting to reap benefits. During 2012/13 the Trust aims to focus on increasing clinical engagement and make SLR a routine part of how business is managed within the Trust.

Moving to service line management is a longer term objective which will need to reflect the overall culture and management approach with the organisation.

Work so far has shown the areas of greatest contribution and those specialties receiving the greatest subsidy from other services in the Trust. As part of the savings programme the Trust will review the specialties to identify ways in which losses can be reduced. An overview of the specialty portfolio is shown below, covering the top 7 and bottom 7 specialties in terms of profitability or loss.

Service Line Reporting: Based on five months to August 2011



9.0 Workforce Plans

9.1 Workforce Profile and Development Strategy

9.1.1 Current Workforce Profile

The workforce profile is summarised in the table below:

Summary of Workforce (WTE) Current and Projected				
Staff Category	**2011/12**	**2012/13**	**2013/14**	**2014/15**
• Medical and Dental	491	497	442	423
• AfC Clinical	2170	2133	2053	1960
• AfC Managers & Administrators	964	894	846	810
• VSM (Very Senior Managers)				

The decrease in administrative staff is based on the centralisation of some back office functions and the introduction of improved IT systems.

2011/12 figures are based on establishment levels at the end of January. Forecast figures for 2012/13 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.

9.1.2 Succession Planning

Succession planning is summarised in the table below:

Staff Numbers and Age Profile of Current and planned workforce					
Age	**Staff 2011/12**	**%**	**Staff 2012/13**	**Staff 2013/14**	**Staff 2014/15**
• 16-21	61.5	%	59.3	56.7	54.2
• 22-35	1109.5	%	1069.6	1022.5	977.5
• 36-55	1865.7	%	1798.5	1719.1	1643.7
• Over 55	514.3	%	495.8	474	453.1
TOTAL	**3351**	**100%**	**3423**	**3272**	**3129**

The Trust's age profile and levels of staff turnover indicate that with the reductions in planned staffing numbers, future general staff shortages are not expected.

The Trust has a number of senior managers and directors on SHA-wide development programmes/talent management processes. The Trust's Leadership Academy Senior Leaders programme offers 60 credits at master's level. So far 51 of our senior leaders have attended this programme and the Trust has recently been accredited to offer this course up to 120 credits in-house with the option to top up to an MSc via a research methods module and a project.

Previously the Trust has contributed to the SHA talent mapping tool and placed senior leaders on the Aspiring Directors Programme, resulting in the successful appointment to director posts. This has

been replaced with Change Leaders and Provider Excellence programmes and the Trust currently has eight senior personnel participating on these programmes.

9.1.3 Bank and Agency Arrangements

The Trust plans to reduce significantly 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.

9.1.4 Appraisals, Vacancies and Staff Turnover

The current appraisal rate is 90% (February 2012). Appraisal monitoring is carried out by Division and Department in order to help ensure compliance improves. The Board approved target is 90% by the end of March 2012. This has been achieved early.

Monthly vacancy rates have varied from a high of 7.3% in January 2012 to a low of 4.5% for February 2012 with an average of 5.3%.

The staff turnover rate for February 2012 was 12.30%. This varied over the year from a low of 11.70% in June 2011 to a high of 12.40% in August 2011. The average was 11.98%.

The staff sickness rate for February 2012 was 4.10%. This varied over the year from a low of 3.50% in July 2011 to a high of 4.20% in December 2011. The average was 3.80%.

9.2 Workforce Development Strategy

Key strategic workforce development objectives are as follows:

1. To implement a 'People Strategy'
2. To embed core standards and competencies in relation to people management practice
3. To identify a list of key managers with people management responsibilities
4. To introduce a matrix working approach in corporate support departments to support divisions
5. To increase visibility of senior management and Board members
6. To refresh communication systems
7. To develop authentic staff engagement processes to improve the quality of the decisions the organisation makes.
8. To provide a vibrant learning environment for all staff groups
9. 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.
10. To become an employer of choice
11. To develop people management capacity and skills throughout the organisation
12. To develop external partnerships in health, education and the wider community that support effective acute services

Specific workforce objectives for 2012/13 are as follows:

- To reduce skills shortages in specific areas and reduce agency expenditure to 3%
- To reduce sickness to 3.5% in 2012/13
- To improve workforce productivity through more effective working, new roles and effective consultant job planning
- To continue to achieve the 90% target for Appraisals and Mandatory Training

9.3 HR Risks

The Trust has developed an HR risk register to ensure risk classification is completed and monitored, and that risk management actions are integrated into standard HR practices. Key risks are outlined below.

Top Workforce Risks					
	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 • Specialist OH Physio support to be employed

9.4 Valuing People: Equality and Diversity

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 promotes equality of access to all. An element of E&D is present in all policies, services, procedures and any other involvement by the Trust. The Trust regularly monitors the development of any changes and new practices in relation to E&D to ensure the effectiveness of implementing and mainstreaming E&D.

The Trust has continued to comply with the general and specific duties, which are now required by the Equality Act 2010 and has taken into account the new protected characteristics. The Trust has recently published its Public Sector Equality Duty Report and reviewed and updated policies in relation to bullying and harassment policy and grievance.

The vision of the Trust is to promote fairness, celebrate diversity and advance inclusion as enshrined in the NHS Constitution pledges for patients, carers and staff and in line with the public sector general equality duty. We will demonstrate leadership and we will help to embed fairness into the cultures and behaviours of our staff by:

- Championing and advancing equality , diversity and inclusion
- Implementing the NHS Equality Delivery System (EDS) framework to assess our performance for patients, carers and staff in partnership with local people and our staff
- Identifying local needs and priorities, particularly for those at risk of disadvantage and discrimination to help reduce local health inequalities
- Seeking the engagement of everyone in shaping local services to meet individual needs and achieve better health outcomes
- Help and support staff to understand the importance of personalisation, fairness and diversity in the planning and delivery of services
- Providing an environment where staff can thrive, are confident to be themselves, feel valued and treat each other with fairness, dignity and respect
- Work to ensure that all of our information, services and buildings are accessible for all
- Acknowledge and value the work of all our local partners who help us deliver fairness for patients and staff

We have undertaken an analysis of our workforce against the protected characteristics as follows:

Characteristic	**Commentary**
Age	As of 1st December 2011, the Trust employed 3,523 staff. Of these staff, 18.9% are under 30 years old, 52.6% are aged between 30-50 and 28.5% are 50 years or older
Disability	In terms of disability, only 0.6% of our staff reported that they have a disability and 64.8% stated they do not have a disability, leaving 34.6% of staff who have declined to inform us of their disability status. Compared to the local population we are employing fewer disabled people than we should be as the national figure is about 18% of the working population. However, there are significant numbers of staff who do not declare a disability status because of fear of stigma
Gender reassignment	As at 1 December 2011, none of our staff had reported being transgender. In view of the limited number of such cases expected, it would be inappropriate to report by pay band to avoid inadvertently identifying such employees
Marriage and Civil Partnership	The Trust holds reliable information on the marriage or civil partnership status of its workforce. Some 54.9% of our staff are married and less than 0.9% are in a civil partnership

Characteristic	Commentary
Pregnancy and maternity	Of the Trust staff who went on maternity leave during 201/12, only 14 did not return to employment with the Trust. This represented only 0.3% of all staff who went on maternity leave.
Race (i.e. ethnicity)	When using the census 2001 ethnic categories, the majority of our staff reported they are White (64.8%) with 60% reporting they are White British. Some 8.8% stated they are Black, with the largest group being of Black African origin. 18.2% of our staff declared that they were of Asian background, with the largest group being of Asian Indian origin. Some 1.7% of our staff are from a mixed ethnic background. The racial origin of 7% of our staff is unknown.
Religion and belief	The Trust holds personal data from its staff regarding their religious or other belief. Some 45% of our staff are of the Christian faith, 10% did not wish to disclose their faith and the belief or a third of our workforce is currently unknown. As part of a personal data exercise for staff in 2012/13, this information will be sought from staff and included within future workforce equality reports.
Sex (i.e. gender)	Compared to the local population we have more female staff than would be expected, perhaps indicating female-friendly employment practices in the NHS. However, as at 1st December 2011, with 76.8% of our workforce female, the proportion of female staff is higher than the national NHS picture which is usually around 75% female staff and 25% male staff.
Sexual orientation	The Trust currently only monitors recruitment information about the sexuality of its workforce. There was an 8% undisclosed proportion for both applied and shortlisted candidates. Approximately 2% of candidates who applied or shortlisted were LGBT (Lesbian, Gay, Bisexual, Transgender). 90% of applicants and 90% of candidates shortlisted were heterosexual.

A priority action for 2012/13 will be to complete a data cleanse of personal staff information, which will seek to raise the level of completed staff personal data. The Trust will then be better positioned to assess whether it has a truly representative workforce when compared to the population it serves, and agree actions to address and gaps/issues.

The Trust had stipulated that all policies, strategies and any service development plans should undergo and publish an EqIA as part of the continuous commitment to reduce inequalities and promote equality.

The Trust will comply with the public sector equality duty which supports good decision-making by ensuring public bodies consider how different people will be affected by their activities, helping them to deliver policies and services which are efficient and effective; accessible to all; and which meet different people's needs. The Trust will publish information about decision-making and the equality data which underpins our decisions.

9.5 Staff Surveys

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. In 2011 the Trust has, for the first time, surveyed all our staff to ensure the data/feedback we receive is truly representative.

The Trust has recently received the results from the latest staff survey carried out in the autumn of 2011. This shows significant improvements in the vast majority of the 38 indicators compared to last year's survey. The Trust has improved in 33 of the 38 indicators, seen no change in 2 and dropped scores in 3 areas.

Of particular interest is the '**overall staff engagement indicator'** which moved from being in the lowest 20% to being average. This indicator is put together by the Department of Health and is calculated by combining questions from the 3 following indicators:

- Staff reporting that they believe they can contribute to improvements at work which moved from being in the lowest 20% to above average
- Staff recommending the Trust as a place to work or be treated which moved from worst 20% to just below average
- Staff reporting motivation at work from below average to above average

The indicator reporting experience of harassment and bullying between staff has fallen from 19% to 16% which is average for acute Trusts.

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.

Survey details are provided in the tables below:

Staff Survey					
	2010/11		**2011/12**		**Org'al Imp't / Deter'n**
Response rate	**Trust**	**Nat Av**	**Trust**	**Nat Av**	
	46%	52%	52%	54%	Increase of 6% points

Staff Survey – Top 4 ranking scores					
Top 4 ranking scores	**2010/11**		**2011/12**		**Org imp't / Deter'n**
	Trust	**Nat Av**	**Trust**	**Nat Av**	
Percentage of staff receiving health and safety training in last 12 months	82%	80%	87%	Unknown	Increase of 5% points
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	8%	8%	6%	Unknown	Decrease of 2% points
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	96%	95%	Unknown	Unknown	Unknown
Percentage of staff reporting good communication between senior management and staff	26%	26%	25%	Unknown	Decrease of 1% points

Staff Survey – Bottom 4 ranking scores					
Bottom 4 ranking scores	**2010/11**		**2011/12**		**Org imp't / Deter'n**
	Trust	**Nat Av**	**Trust**	**Nat Av**	
Perceptions of effective action from employer towards violence and harassment	3.42	3.56	Unknown	Unknown	Unknown. Increase from 2009/10 to 2010/11
Percentage of staff using flexible working options	55%	63%	60%	63%	Increase of 5% points
Percentage of staff feeling there are good opportunities to develop their potential at work	33%	41%	36%	Unknown	Increase of 3% points
Fairness and effectiveness of incident reporting procedures	3.34	3.45	Unknown	Unknown	Unknown

9.6 Health and Wellbeing

Health and Wellbeing Champion is Barbara Leon-Hunt

Top 3 priorities:

- To achieve Staying Healthy at Work aSHaWd Accreditation
- Raising awareness of stress and offering tools to deal with it
- Raising physical activity and healthy eating levels

The Trust runs an active health and wellbeing programme of events across all three sites.

9.7 Talent and Leadership

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 sustains two key framework agreements:

- **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. Two new 30-credit Masters level modules will be commissioned in 2012-13; Business Skills, and Patient Experience providing a pathway to a full Masters degree.

- **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. The agreement has been used successfully to commission the CWG Staff Wellbeing Programme that commenced February 2011 and the NHS Midlands and East Provider Excellence and Change Leaders' programmes 2012 - 2013.

The success of the Leadership Academy is evidenced by two recent awards:

- Overall Winner and Category Winner, Healthcare People Management Association for excellence in organisational development; Developing Outpatient Services 2011
- Health Service Journal finalist for Staff Engagement, 2011

A new 'Developing the Organisation, People Strategy; 2012 - 2017' will be presented to the Trust Board for implementation from April 2012. The overall aim of the People Strategy is to develop the organisation and workforce to ensure high quality, responsive services for patients, carers and service users. Through staff engagement, wellbeing, development and support, every member of staff will be enabled to be the best they can be. The strategy is delivered through leadership at all levels. Investment in staff delivers demonstrable benefits for patients.

The People Strategy incorporates the NHS Leadership Framework, applies to all staff and is grounded in contemporary, high quality evidence, NHS Policy and best practice. The strategy embeds the Trusts' award-winning improvement work. Implementation of the People Strategy involves alignment of key strategies and plans; including Health and Wellbeing/Staff Support and the Equality Delivery System (EDS).

The People Strategy has four interrelated elements.

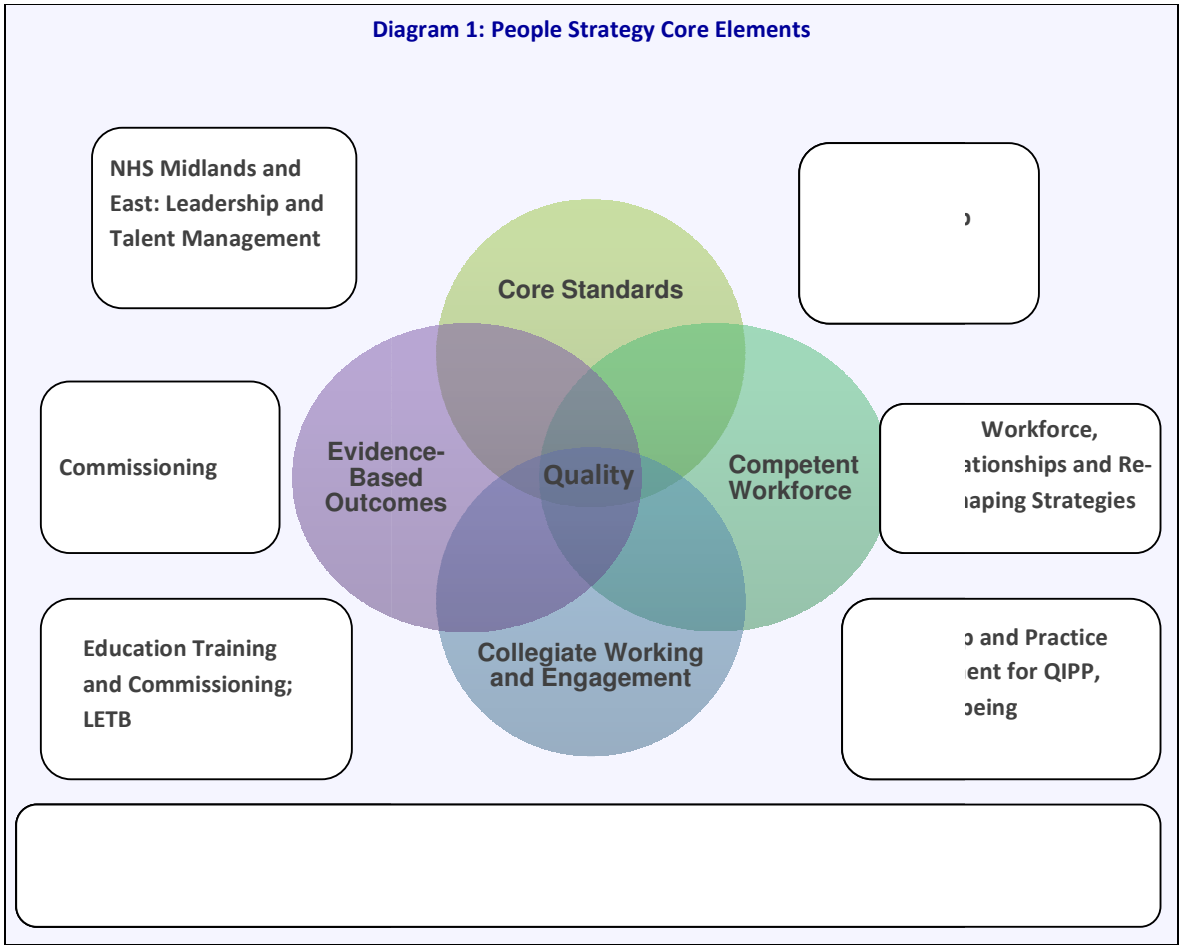
- Core Standards
- Competent Workforce
- Collegiate Working and Engagement
- Demonstrable Outcomes

Demonstrable success is when:

- All staff and patients say' "I really feel my needs are met"
- Staff describe how they contribute towards patient experience
- Staff skilfully embrace new roles and changing requirements
- Care-pathways create a quality experience for patients 24/7
- For staff, reduced staff sickness and turnover
- For patients, reduced number of harm events and patient complaints
- The Trust is rated within 3 years as average/above average across all patient and staff quality domains and still improving
- External funding through LTEB, commissioners and other sources maximised

The four interrelated elements of the People Strategy are shown in Diagram 1 below:

People Strategy Core Elements



The Trust will build skills and liberate talents through:

- Two new 30 Masters'-credits modules; Business Skills, and Patient Experience providing a pathways to a full Masters degree
- Cultural awareness training through/with local stakeholder groups
- Embedding coaching competencies in practice
- More 'Leadership Associates' facilitating coaching clinics, case-studies, coaching companions and 'communities of practice'.
- Staff enabled to embrace IM&IT, doing the best they can with the systems we have, to work smarter and more flexibly
- Role/service-shadowing to build understanding of cross-sector care provision
- A fully supportive environment, to translate learning into quality improvements

Application of enhanced skills includes:

- Use of the clinical portal that provides aggregated, real-time data from key systems relevant to the patient's pathway, accessible by all healthcare providers across care settings
- Supporting staff caring for patients with dementia, seeing the whole person and finding ways of connecting with them

- Blended development for clinical staff promoted into leadership roles, to enhance skills and make relational shifts required
- Addressing 'people issues' associated with diversity; for example ensuring food and nutrition is part of healing and wellbeing for patients across care settings, consistent with culture and religion
- Understand changing patient profiles and care needs e.g. migrant population
- Clinical staff using coaching techniques with their patients, to promote health awareness and enhanced self-management.

9.8 Communications

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, Annual 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.

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 Annual Plan will be communicated to staff via the divisional management structure and made available via the Trust's intranet.

10.0 Sustainability

The Trust is committed to achieving a 10% reduction in carbon footprint by 2015 associated with each of the following:

- Waste
- Energy
- Transport
- Procurement

The Trust's key priorities in addressing sustainability are:

- To manage the use of resources by:
    - Making energy and carbon savings
    - Minimising waste
    - Conserving water
    - Using information technology and telephony/communication technology efficiently
- To design sustainable buildings
- To promote low carbon transportation and active travel
- To purchase sustainable products and services

In order to **manage resources and make energy and carbon savings** the Trust commits to the following:

- Minimise resource use through efficient and innovative technology and upgrading of the Trust's estate
- Monitor, measure and report on energy use to improve understanding of consumption and promote efficiency
- Ensure compliance with sustainable legislation, such as the Carbon Reduction Commitment Energy Efficiency Scheme

The Trust will achieve this by:

- Install energy monitors on high consumption equipment
- Install motion sensors for lighting across Trust
- Invest in energy saving refurbishment projects
- Consider sustainability issues as part of equipment and product selection
- Explore the use of more sustainable technologies related to energy provision

The Trust will measure this by:

- Overall carbon emissions for the Trust (based on direct emissions)
- Sub-metering in key areas
- Energy consumed per member of staff per year
- Measurement of transportation and supply chain emissions

In order to **manage resources and minimise waste** the Trust will promote appropriate use of materials and sorting of waste and commits to the following:

- Reduce the materials we use
- Promote re-use of materials
- Promote proper waste disposal
- Empower staff to take action

The Trust will achieve this by:

- Improve awareness about responsible use of resources
- Recycle food waste
- Increase recycling facilities in public areas and toilets
- Find innovative ways to re-use waste materials
- Consider excess packaging during product and consumable selection

The Trust will measure this by:

- Percent of overall waste recycled
- Regular auditing of all waste streams
- Measure electronic waste sent for recycling

In order to **manage resources and conserve water** the Trust will promote efficient use and innovative solutions for conservation and commits to the following:

- Minimise resource use through efficient technology and upgrade of Trust estate
- Monitor, measure and report on water use to improve understanding of consumption and promote efficiency

The Trust will achieve this by:

- Water saving devices installed as standard in refurbishments and new builds
- Collection of rainwater to be used on grounds

The Trust will measure this by:

- Water used per member of staff per year
- Water used per square meter per year

In order to **manage resources and Improving the efficiency and reliability of information technology** the Trust will promote efficient use and innovative solutions for conservation and commits to the following:

- Provide technical solutions and support to reduce energy and material use
- Prioritise IT&T solutions that save resources and promote efficiency of use
- Recognise the role of IT&T in enabling sustainability

The Trust will achieve this by:

- Centralised "shut down" of idle PCs after specified time of inactivity
- Development of energy efficient data centres
- Increased use of IT&T solutions to reduce materials such as paper and printer toner
- Explore greater application of video conferencing technology

The Trust will measure this by:

- Sub metering of data centres, communications rooms and other high energy use areas
- Monitor energy consumed per year per staff member

In order to **design sustainable buildings** the Trust will ensure buildings, new and old, reflect sustainability aims and commits to the following:

- Integrate processes to ensure sustainability is prioritised when planning estate work
- Include for the effect of climate change on the design and operation of our buildings (Adapting for Climate Change)
- Develop innovative sustainable design standards for refurbishments and new buildings

The Trust will achieve this by:

- Project managers to complete sustainability evaluation for all major projects including life cycle costing
- Investment in resource saving refurbishments through building efficiency programme

The Trust will measure this by:

- Sustainability Impact Assessments
- BREEAM (Building Research Establishment Sustainable Assessment Method) rating for new buildings and large refurbishments

To **promote low carbon transportation and active travel**, the Trust will encourage active and sustainable travel for patients and staff and commits to the following

- Develop processes to promote sustainable transportation
- Promote health and well-being through improved information about and opportunities to participate in active and sustainable travel

The Trust will achieve this by:

- Develop a sustainable transport plan for each hospital site
- Improve the efficiency of Trust vehicles
- Offer green alternatives to travel i.e. the cycle salary sacrifice scheme

The Trust will measure this by:

- Track the number of staff using active travel options, such as cycling
- Staff and patient questionnaires
- Measure Trust vehicle miles fuelled by alternative sources
- Reduce total miles driven by Trust vehicles and patient transportation

To **buy sustainable products and services** the Trust will address sustainability in what it buys and the supply chain, and the Trust commits to the following:

- Consider whole life cycle costs of goods purchased, including origin, materials, efficiency, and end of life
- Encourage suppliers to reduce transportation, packaging and improve the sustainability of their products (focus on pharmacy, medical and surgical spend)

The Trust will achieve this by:

- Increase awareness of sustainability issues for Trust staff and key suppliers
- Further consolidate freight delivery to reduce transport emissions in the supply chain
- Increase services and food sourced from local suppliers
- Co-operate with supply chain to encourage low carbon production of materials and reduce packaging

The Trust will measure this by:

- Sustainability Impact Assessments
- Tracking the transportation supply chain
- Percent of procurement spend from the local community
- Good Corporate Citizenship Model
- Measure the number of purchases delivered by consolidated freight transportation

10.1 Delivering the Trust's Sustainable Development Management Plan

The Trust's Sustainable Development Management Plan was approved by the Board in September 2011. Feedback and recommendations were received from the Sustainability Development Unit (SDU) and these were incorporated into the Trust's approach as follows:

- The Sustainability Programme Board will hold its first meeting on 30th April 2012
- It will be chaired by one of the Trust's NEDs who is the Sustainability Champion.
- Sustainability and carbon reduction work streams identified with projects to reduce CO2 emissions
- The CEO is actively involved in sustainability work
- There is a programme of works identified in SDMP

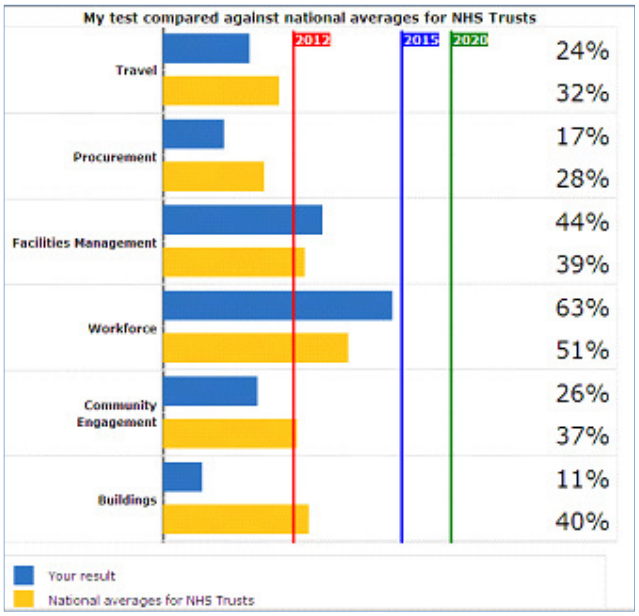
Key projects within the SDMP are as follows:

- Energy Efficiency: A programme of replacing light fittings, etc, with state of the art, low energy fittings thus reducing energy usage, cutting costs and reducing the carbon footprint
- Combined Heating and Power Plant: The Trust has received funding to develop a CHP plant for the Watford site. This will significantly improve energy efficiency, again reducing costs and reducing the carbon footprint
- Waste Minimisation: Currently the Trust recycles only 6% of waste. This will be increased to 50% by March 2014

- Roof Insulation: The Trust will shortly implement a roof insulation project to reduce heating costs, save energy and reduce carbon emissions
- Transport Reduction: The Trust aims to encourage staff to reduce the carbon emissions associated with travelling to and from work. Car share schemes, buses, encouraging cycling all have a part to play.

10.2 Good Corporate Citizen Assessment Tool

The Trust has undergone a number of assessments. The diagram below displays the Trust's position in relational to the national average for NHS Trusts. The Trust score improved during 2011/12 and there is an intention to match the national average by the summer of 2012. Within the East of England, further work is required to reach EoE scores but the Trust is confident that these are achievable within the same timeframe.



10.3 ERIC Data: Waste Minimisation and Management, and the Use of Finite Resources

ERIC return data is reported to the Trust Board annually. This information is used to identify future planning in terms of capital investment, carbon reduction, and backlog maintenance management, all of which have a demonstrable relationship to carbon reduction.

10.4 Preparing for the Carbon Reduction Commitment Energy Efficiency Scheme

The Trust is fully engaged with the CRC Energy Efficiency Scheme and works closely with AEA in compiling the Evidence Pack which will be signed off by the Chief Executive.

10.5 Good Practice

Examples of good practice in sustainability and on work to quantify savings linked to sustainability are as follows:

- Conversion of the Trust's boilers (in 2010/11) from heavy duty fuel oil to dual fuel (gas and light oil). This has led to a considerable saving in fuel costs, reduced carbon emissions and a significantly more resilient infrastructure.

- Trust membership of the 10:10 campaign to reduce 10% emissions in 2010
- Year-on-year cost and carbon savings through investment
- Active participation in *Sustainability Day* scheduled for 28th March 2012. The Trust will raise awareness in four key areas:
    - "Turn it off" campaign
    - "Recycle Recycle Recycle"
    - Car share day
    - Bike to work day
- Bike Week 2012
- Total waste management, energy savings schemes and Tiger waste solution being looked at to help reduce the Trust's carbon footprint and as part of CIPS programme

10.6 Emergency Preparedness

The Business Continuity and Recovery Plan will be reviewed by the Trust's Emergency Preparedness Group in April and by the Board in July 2012.

11.0 Delivering a Successful Foundation Trust Application

In accordance with the Tripartite Agreement, the Trust submitted a full application to the SHA in January 2012. Following a successful Board to Board meeting in February the Trust submitted additional information and the SHA are expected to submit the Trust's application to the DH in April 2012.

The first draft Board Governance Memorandum will be complete on 16th April 2012. KPMG have been appointed by the SHA as the external assurance partners.

12.0 Declarations and Self Certification

The Trusts confirms compliance with Monitor's proposed/retained 16 new Board statements. The statements are as follows:

Ref	Statement
1	Quality The Board is satisfied that, having used its own processes and having assessed against Monitor's Quality Governance Framework (supported by relevant information from the Trust and third parties such as the Care Quality Commission), it has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.
2	Finance The Board anticipates that the Trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.
3	Finance The Board is satisfied that the Trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.
4	Governance The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.
5	Governance The Board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the Trust have met the relevant registration and revalidation requirements.

Ref	Statement
6	Governance An Annual Governance Statement is in place pursuant to the requirements of the NHS Foundation Trust Annual Reporting Manual, and the Trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).
7	Governance The Board will ensure that the Trust remains at all times compliant with its terms of authorisation and has regard to the NHS Constitution.
8	Governance All current key risks to compliance with the trust's Authorisation have been identified (raised either internally or by external audit and assessment bodies) and addressed in a timely manner.
9	Governance The Board has considered all likely future risks to compliance with its Authorisation and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.
10	Governance The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability.
11	Governance The Board is satisfied that the management team has the capability and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan.
12	Governance The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations are implemented satisfactorily to the board.
13	Governance The Board will ensure that the Trust will at all times operate effectively within its constitution. This includes: maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; that all Board positions are filled, with plans in place to fill any vacancies; and that all elections to the board of governors are held in accordance with the election rules.
14	Service Performance The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds), and a commitment to comply with all known targets going forwards.
15	Quality The Trust has achieved a minimum of Level 2 performance against the requirements of its Information Governance Statement of Compliance (IGSoC) in the Department of Health's Information Governance Toolkit;
16	Authorisation For an NHS foundation trust engaging in a major Joint Venture, or Academic Health Science Centre, the board is satisfied that the NHS foundation trust has fulfilled, or continues to fulfil, the criteria in Appendix C4 of Monitor's 2011/12 Compliance Framework.