West Hertfordshire Hospitals NHS Trust

Operational Plan 2016/17

Agenda item 11/37
Contents

1. Introduction ... ... ... ... ... ... ... ... ... ... ... 3

2. Your Care, Your Future and WHHT clinical and organisational sustainability strategy ... ... ... ... ... ... ... ... ... ... ... 4

3. Ensuring our services are safe, effective and caring ... ... ... ... ... ... ... 5
   3.1. Our commitment to quality and care ... ... ... ... ... ... ... ... ... ... ... 5
   3.2. Our 2016/17 quality priorities ... ... ... ... ... ... ... ... ... ... ... ... 6
   3.3. Quality governance and assurance ... ... ... ... ... ... ... ... ... ... ... ... 7
   3.4. Continuing to develop our approach to quality improvement ... ... ... 7
   3.5. Key quality risks ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 8
   3.6. Quality impact assessment process ... ... ... ... ... ... ... ... ... ... ... 9
   3.7. Academy of Medical Royal Colleges’ guidance for taking responsibility ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 9

4. Ensuring our services are responsive ... ... ... ... ... ... ... ... ... ... ... ... 10
   4.1. Emergency care ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 10
   4.2. Cancer – 62 day standard ... ... ... ... ... ... ... ... ... ... ... ... ... 11
   4.3. RTT incomplete ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 12
   4.4. Diagnostics ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 13
   4.5. Seven-day services ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 13

5. Activity planning ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 14
   5.1. Activity and income planning ... ... ... ... ... ... ... ... ... ... ... ... ... 14
   5.2. Key capacity issues ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 15
      5.2.1. Emergency Care ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 15
      5.2.2. Planned care and cancer ... ... ... ... ... ... ... ... ... ... ... ... ... 17
      5.2.3. Women’s and children’s services ... ... ... ... ... ... ... ... ... ... ... 18

6. Workforce planning ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 18
   6.1. Introduction ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 18
   6.2. 2015/16 Highlights ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 18
   6.3. Our workforce strategy ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 19
   6.4. 2016/17 Workforce development priorities ... ... ... ... ... ... ... ... ... 20
   6.5. Reducing all agency staffing ... ... ... ... ... ... ... ... ... ... ... ... ... 22
   6.6. Planning our medical workforce ... ... ... ... ... ... ... ... ... ... ... ... ... 24

7. Financial planning ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 24
   7.1. Financial forecasts and modelling ... ... ... ... ... ... ... ... ... ... ... ... ... 24
   7.2. Efficiency savings for 2016/17 ... ... ... ... ... ... ... ... ... ... ... ... ... 26
   7.3. Capital planning ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 26
   7.4. Cash management ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 27

8. Planning, delivery, leadership and governance ... ... ... ... ... ... ... ... ... 28
   8.1. Planning approach ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 28
   8.2. Delivery and performance management ... ... ... ... ... ... ... ... ... ... ... 29
   8.3. Leadership ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 29
   8.4. Governance ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 30
   8.5. Triangulation and integrated performance reporting ... ... ... ... ... ... ... 30
   8.6. Board assurance framework and risk management ... ... ... ... ... ... ... 30

9. Summary ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... 31
1. **Introduction**

West Hertfordshire Hospitals NHS Trust is a large acute trust, providing hospital services to 550,000 people living in Hertfordshire and north London. We are one of the largest employers locally, with 4,400 staff and 446 volunteers. We run services across three sites at Watford, St Albans and Hemel Hempstead.

Following a Care Quality Commission (CQC) inspection in April 2015, the Trust was put into special measures. We submitted a quality improvement plan (QIP) to the CQC in October 2015. Over the course of the year, we have made significant progress in implementing our improvement plan and addressing the concerns raised by the CQC.

Following a sustained focus on improving mortality over the past three years, our mortality rates are now significantly below the expected level. We have also delivered significant improvements in operational performance in 2015/16 in relation to the delivery of 18 week Referral to Treatment standards (RTT), diagnostic waits and cancer 31 and 62 day standards.

Throughout the year we have continued to experience high levels of delayed transfers of care (DTOCs). This has placed pressure on our bed capacity and performance against emergency care standards has continued to be below the expected level. We are currently participating in the Emergency Care Improvement Programme (ECIP) and this will continue to be a priority focus for the Trust in the coming year. DTOCs/stranded patients’ continue to have a significant impact on quality, safety, patient experience, workforce and finance.

This operational plan builds on the QIP and on our 2015/16 Annual Plan and sets out our plan for 2016/17.

Our corporate aims are:

| Aim One | To deliver the best quality care for our patients |
| Aim Two | To be a great place to work and learn |
| Aim Three | To improve our finances |
| Aim Four | To develop a strategy for the future |

The operational plan is aligned with the five-year West Hertfordshire place-based Sustainability and Transformation plan which is currently being developed with our local health and social care partners¹ by Herts Valleys Clinical Commissioning Group (HVCCG).

---

¹ Herts Valleys Clinical Commissioning Group, Hertfordshire Community NHS Trust, Hertfordshire Partnership University NHS Foundation Trust, East of England Ambulance Service, Hertfordshire County Council
2. Your Care, Your Future and WHHT clinical and organisational sustainability strategy

The “Your Care, Your Future” (YCYF) Strategic Review was established by local health and social care partners in January 2015 with the following terms of reference:

| A | How well (how effectively and efficiently) are patients’ needs met by the current health and social care system across West Hertfordshire? |
| B | What are the opportunities to meet future health and social care needs of the West Hertfordshire population more effectively and efficiently? |
| C | How should health and social care services across West Hertfordshire be configured to realise these opportunities? |
| D | What organisational form(s) and commissioning / contracting model(s) best support the delivery of the preferred future configuration of services? |

A ‘case for change’ was developed and published in July 2015, following which, partners worked to develop a shared vision and ‘future model of care’ to address the challenges set out in the case for change. The YCYF ‘strategic outline case’ (SOC) sets out a whole system vision for developing more patient-focused, sustainable services for the future. All six participating organisations² have endorsed the SOC and are now working together to establish an implementation plan to translate the vision into action.

The key focus of the SOC and the future model of care is the development of locality-based networks of care that bring together primary, community and secondary care clinicians and social care professionals to provide preventative, proactive, personalised care as close to home as possible. In 2016/17, the priority focus is on developing new models of care for frail older people and on diabetes care. Additionally, the CCG is seeking to commission an integrated stroke pathway, including hyper acute stroke services and a tier three community gynaecology service.

In addition, the SOC recognises the importance of effective, sustainable acute hospital services for local residents and the urgent need to address the very poor estate and IM&T infrastructure from which the Trust currently provides services. YCYF confirmed that the future of Hemel Hempstead Hospital was as a local community hospital, with more specialist elements of acute care centralised onto one or two sites. An initial option appraisal shortlisted three options:

**Option 1** Consolidate all acute care services onto a single site at ‘another site’.

**Option 2** Consolidate all acute care services onto a single site at Watford General Hospital.

**Option 3** Consolidate acute, emergency and specialised care services at Watford General Hospital. Deliver the majority of planned care services at St Albans Community Hospital.

² Herts Valleys Clinical Commissioning Group, Hertfordshire Community NHS Trust, Hertfordshire Partnership University NHS Foundation Trust, East of England Ambulance Service, Hertfordshire County Council and West Hertfordshire Hospitals NHS Trust
The Trust is now working to finalise its own clinical strategy, in line with the vision set out in *Your Care, Your Future* and to develop a Strategic Outline Case for the redevelopment of its estates, building from the initial option appraisal undertaken in YCYF. The target timeline for completing the Trust SOC is December 2016. If formal consultation is required, this timeline will extend to June 2017.

HVCCG is now leading a process to develop a West Hertfordshire five-year sustainability and transformation plan that will set out, in detail, the road map to implement the *Your Care, Your Future* vision and future model of care. A thriving, sustainable local hospital service is an essential component of a thriving, sustainable health and care system. We will be working closely with partners as the plan is developed to ensure that the plan recognises the importance of sustainable hospital services and to ensure that our strategy and plans are fully aligned.

3. **Ensuring our services are safe, effective and caring**

3.1. **Our commitment to quality and care**

At West Hertfordshire Hospitals NHS Trust, we are committed to providing great care for the 550,000 people who depend on our healthcare services.

In 2014, it was identified that the Trust had significantly higher mortality rates than expected. The Trust has worked hard since that time to systematically drive through improvements to the quality and safety of its care, with a specific focus on improving mortality rates. This work has successfully delivered major improvements and our mortality rates are now amongst the lowest in the country.

In April 2015, the CQC undertook a full inspection of our three hospitals. Their report was published in September 2015. Whilst, as noted above, our mortality rates are better than expected when compared to other acute hospitals, the CQC identified a range of significant concerns in relation to how the Trust systematically ensures the quality and safety of our services. The CQC were particularly concerned about staffing levels, organisational culture and staff morale, the quality and suitability of some of our facilities and our overall governance and risk management processes.

On the basis of the CQC’s report, the NHS Trust Development Authority (NHS TDA) placed our hospitals in ‘special measures’. This has given us extra help and support to make the necessary improvements to our services.

Following the publication of the reports in September 2015 we developed a comprehensive quality improvement plan (QIP) under five key themes.
Overall the CQC were not assured that the Trust is providing safe care.

CQC review findings for the Trust

<table>
<thead>
<tr>
<th>Are services safe?</th>
<th>Are services effective?</th>
<th>Are services caring?</th>
<th>Are services responsive?</th>
<th>Are services well-led?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Inadequate</td>
</tr>
</tbody>
</table>

**WHHT IMPROVEMENT PLAN THEMES**

- **Our people** (4)
- **Getting the basics right** (1)
- **Patient focus** (3)
- **Infrastructure** (2)
- **Governance, risk management and decision-making** (5)

We have been making good progress in implementing the more than 200 actions set out in our quality improvement plan and expect the majority to be completed by June 2016.

A monthly Oversight Group, chaired by the TDA, brings together all partners to review the progress we are making and identify ways in which partners can support us with our improvement journey.

### 3.2. Our 2016/17 quality priorities

We are currently updating our Quality Account for 2016/17. This will summarise the quality improvements we have delivered in 2015/16 and set out our priorities and workplan for 2016/17. Our 2016/17 priorities build on our work this year, with a focus on sustaining and embedding the improvements we have made and continuing to engage all our staff in building a strong safety and quality improvement culture.

**SIGN UP TO SAFETY**

1. Putting safety first.
2. Continually learn.
4. Collaborate.
5. Being supportive.
Our quality priorities for 2016/17 are:

Priority One: Getting the basics right & Infrastructure ~ ensuring our services are safe and effective. We will continue to build a safety culture and relentlessly focus on reducing harm and delivering the very best outcomes for our patients. **Executive Leads:** Mike Van Der Watt, Medical Director and Tracey Carter, Chief Nurse.

Priority Two: Patient Focus ~ ensuring our services are caring and responsive. We will work to ensure our services are designed to deliver the best possible experience for our patients. **Executive Leads:** Tracey Carter, Chief Nurse and Lynn Hill, Deputy Chief Executive and Chief Operating Officer.

Priority Three: Our people & Governance ~ ensuring our services are well-led. We will develop and support our workforce and continue to strengthen our governance, risk management and decision-making processes. **Executive Leads:** Paul Da Gama, Director of Human Resources and Organisational Development and Helen Brown, Director of Strategy and Corporate Services.

3.3. Quality governance and assurance

We have robust safety, quality and risk management governance arrangements in place within the Trust. The Board and its sub committees are provided with comprehensive, integrated performance data to enable board members to appropriately assure themselves regarding the quality, safety and responsiveness of services provided.

A priority focus in 2015/16 has been strengthening risk management processes. The Trust risk register has been fully reviewed at corporate and divisional/departmental level. All sub committees are provided with regular updates on the key risks relevant to their area of responsibility. The Integrated Risk and Governance committee has overall accountability on behalf of the Board for ensuring that risk management processes are effective.

For further details see Section 8 - Planning, delivery, leadership and governance.

3.4. Continuing to develop our approach to quality improvement

We have taken a number of approaches to driving quality improvement over the past year. Our approach to quality improvement in 2016/17 will build on what we have learned and focus on embedding and sustaining the changes.

- **Clinical leadership and divisional ownership:** we will continue to ensure that our quality improvement programme is clinically led and owned at divisional and departmental level. Over the coming year we will provide our divisional leadership teams with the necessary development and resources to allow them to become more fully autonomous.

- **Staff engagement:** staff engagement is fundamental to providing high quality care; we will continue to use ‘Listening into Action’ to ensure all staff have a voice within the organisation and empower staff to make improvements to services. We have recently commissioned an external ‘medical engagement survey’ and will put in place actions to address the findings, including strengthening clinical leadership throughout the organisation.
Patient feedback – We will actively reach out to our patients and local communities to ensure we understand their experience of our care and use their expertise to help us drive improvements. We will continue to use ‘I want Great Care’ (iWGC) and the Friends and Family Test to get feedback and track our performance over time.

Safety Culture: we are currently undertaking safety culture surveys across the organisation to understand what progress we have made and what further work we have to do.

Data to drive improvement and reduce variation: over the past two years we have significantly strengthened the way we collect and analyse data at trust, division and departmental level to help us deliver consistently safe care across the organisation. We will continue to develop the way we use data to drive improvement.

Strong and well understood governance and risk management: in 2015/16 we have worked hard to strengthen and streamline governance arrangements and ensure that they are well understood by our clinical and managerial leadership teams. We will continue to focus on governance in 2016/17 to ensure that the improvements are fully embedded, with a focus on demonstrating how we are instilling a learning culture within the organisation.

Clinical and organisational partnerships: we will continue to work closely with local partners on ensuring that care is integrated and system risks are understood and managed. We are working with UCLPartners (UCLP) to explore opportunities for joint working and strengthening clinical pathways for more specialist elements of care, including cancer care.

Improvement methodologies: we are beginning to explore opportunities for shared learning and strengthening our approach to improvement with UCLP and the Royal Free Hospital, learning from best practice in quality improvement from across the UK and internationally.

3.5. Key quality risks

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency care pathway, patient flow and delayed transfers of care</td>
<td>Continue to work closely with partners through the system resilience group and escalate concerns to TDA and HVCCG as required.</td>
</tr>
<tr>
<td></td>
<td>Participate in the Emergency Care Improvement Programme and implement their recommendations.</td>
</tr>
<tr>
<td>Workforce retention and engagement</td>
<td>Our Workforce Strategy sets out our approach:</td>
</tr>
<tr>
<td></td>
<td>• Highly proactive recruitment campaigns both locally and overseas.</td>
</tr>
<tr>
<td></td>
<td>• Vision, values, clinical strategy development.</td>
</tr>
<tr>
<td></td>
<td>• Demand and capacity reviews, team job planning.</td>
</tr>
<tr>
<td></td>
<td>• Listening into Action and encouraging more ‘bottom up’ change.</td>
</tr>
<tr>
<td></td>
<td>• Improving the working environment for our colleagues.</td>
</tr>
<tr>
<td>Finance</td>
<td>Robust quality impact assessment process and ongoing monitoring. Continued focus on strengthening quality governance processes and embedding improvements to risk management.</td>
</tr>
</tbody>
</table>
3.6. Quality impact assessment process

The Trust is continuing with the Quality Impact Assessment (QIA) process that was proposed, agreed and initiated during 2014/15. The process was redeveloped as a result of the key findings of internal and external reviews.

The process mandates that a QIA has to be completed, and approved by the Chief Nurse and Medical Director, for all efficiency schemes prior to implementation. The QIA is initiated when the scheme reaches a degree of developmental maturity, that is, once it is accepted as viable, when plans are in development and initial costings have been completed.

The diagram below shows the development of cost improvement programmes (CIPs) through the QIA process, including mention of our quality, planning, implementation and delivery (QPID) process.

Quality is assessed across six areas (duty of quality / patient safety / clinical effectiveness / patient experience / prevention / productivity and innovation) using an impact / likelihood matrix. Following the initial impact assessment, relevant CIPs are reviewed at the Trust's Clinical Advisory Group (CAG). During 2015/16 there were no CIPs identified as posing a significant risk to the safety and quality of services.

In 2016/17, we will be establishing a formal QIA panel process, led by the Project Management Office (PMO), that will review the quality impact of CIPs. The Medical Director and Chief Nurse will continue to review and approve all QIAs and schemes. Where any risks to safety and quality are identified, these will be discussed at CAG. The CCG will also be notified via contract review meetings.

We have reviewed the National Quality Board’s Guidance on ‘How to Quality Impact Assess Provider Cost Improvement Plans’ and can confirm that our process meets the requirements set out.

3.7. Academy of Medical Royal Colleges’ guidance for taking responsibility

We adhere to the Academy of Royal Colleges’ Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients. We have boards above the patient’s
bed which identify the Responsible Consultant / Clinician for the duration of the patient’s stay and the Named Nurse for the current shift. This also links with the nursing paperwork where the Named Nurse signs for care each shift. We audit this documentation monthly and have developed care plans to support communication.

Handover is undertaken at the start and end of each shift with the finishing nurse / midwife and starting nurse / midwife communicating, so they can agree who is the named nurse or midwife for each patient.

4. **Ensuring our services are responsive**

We will continue to build strong partnerships with a wide range of organisations, individuals and groups in order to ensure local people and patients are engaged in the work of our hospitals. This includes Hertfordshire Healthwatch, Hertfordshire County Council’s Health Scrutiny Committee, Hertfordshire’s Health and Wellbeing Board, our own Patients’ Panel, local charities, educational establishments, MPs, local councillors, Dacorum Health Action Group and others.

4.1. **Emergency care**

We are currently implementing our Emergency Care Improvement Plan (ECIP), which will deliver improvements in the following three key areas:

<table>
<thead>
<tr>
<th>No.</th>
<th>Key Area</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Admissions avoidance / maximising ambulatory care</td>
<td>• Work with HVCCG and Herts Urgent Care to develop an Urgent Care Centre (UCC) model at Watford.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Implement the Frailty Service in partnership with Hertfordshire Community Trust, which will improve patient experience and outcomes by providing rapid access to specialist care of the elderly senior clinical review and help to prevent avoidable admissions and reduce length of stay.</td>
</tr>
</tbody>
</table>
| 2   | Safe, effective and timely emergency assessment and treatment | • Implement the ECIP recommendations to improve operational effectiveness including:  
  • strengthening the Emergency Department (ED) controller role;  
  • embedding ED escalation organisation-wide;  
  • developing a standard operating procedure for ‘pit stop’, the area where senior clinicians can assess ambulance arrivals and GP-heralded patients and start treatment plans early in the patient journey; and  
  • recruiting to a new healthcare assistant role within the team to support ambulance handovers.  
  • Ring-fence assessment capacity in the:  
  • Clinical Decisions Unit;  
  • Emergency surgical assessment unit;  
  • Ambulatory Care Unit, and  
  • Watford Children’s Observation Bay.  
  • Re-establish ring-fenced assessment beds on the Acute Admissions Unit (Purple). |
3. High quality effective inpatient care and timely discharge

- Implement the SAFER patient flow bundle on all medical wards.
- Implement the Twilight Hospital (re-profile and enhance staffing between 4pm and midnight).
- Confirm our finalised bed capacity and winter escalation plan.

2016/16 trajectory submitted to TDA as part of the Sustainability and Transformation plan:

<table>
<thead>
<tr>
<th>Percentage of A&amp;E attendances within 4 hours from arrival to admission, transfer or discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attendances</strong></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>11133</td>
</tr>
<tr>
<td><strong>&gt;4 hour</strong></td>
</tr>
<tr>
<td><strong>Percentage of A&amp;E attendances within 4 hours from arrival to admission, transfer or discharge</strong></td>
</tr>
</tbody>
</table>

We are committed to achieving 95% from September 2016. However, we will only achieve this if our system partners deliver on the following:

- **EoE Ambulance Trust** - adhere to agreed catchment areas and implement intelligent conveyancing;
- **HVCCG, HCT and HCC** - agree and deliver trajectory to reduce delayed transfers of care (DTOCS) to a minimal level, by developing primary, community and integrated models of care and alternative care pathways in the community, including the models of care for frail older people and for those with complex needs post-discharge;
- **HVCCG and Primary Care providers** – support to deliver improved primary / community urgent care offers on all three sites to reduce demand at A&E.

4.2. Cancer – 62 day standard

We have improved our performance against the 62 day referral to first treatment waiting times standard through the development of robust patient tracking lists, systems and processes. We have introduced weekly Cancer Access and Performance meetings attended by all relevant staff. We have developed a suite of information reports to support the accurate and timely management of the cancer waiting lists and which provide safeguards and process checks. We have delivered against seven of the eight Cancer waiting times improvement priorities.

We are committed to sustaining the 62 day standard. In order to do that, key things we need to do are:

- Implement best practice pathways, across all tumour sites and in particular, take specific actions for lung and colorectal as detailed in the Cancer Action Plan for 2016;
Deliver further data quality and patient tracking resilience, working with specialties and the Trust’s information team; progress has been documented and logged at biweekly cancer informatics meetings.

2016/17 trajectory submitted to TDA as part of Sustainability and Transformation plan:

| Percentage of patients with urgent GP referral to first treatment within 62 days |
|-----------------------------|-----------------|----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                             | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| Total patients seen         | 85  | 70  | 72  | 85  | 80  | 83  | 72  | 74  | 71  | 72  | 72  |
| Number >62 days             | 12  | 10  | 10  | 12  | 12  | 12  | 10  | 11  | 10  | 10  | 10  |
| Percentage of patients with urgent GP referral to first treatment within 62 days | 85  | 85  | 85  | 85  | 85  | 85  | 85  | 85  | 85  | 85  |

We need the continued support of our partners, including GPs, to work with us on:
- implementation of best practice pathways;
- reduction of patient choice cancellations.

### 4.3. RTT incomplete

In 2015/16, we significantly reduced the number of patients waiting over 18 weeks for treatment and achieved the national standard on incomplete referral to treatment pathways for a number of months over the summer and in to the autumn. This was not sustained during the winter months when increases in demand for some services, emergency care pressures, unplanned theatre closures related to ventilation and drainage problems and the impact of the junior doctor industrial action, resulted in loss of capacity.

We are committed to achieving full compliance with the RTT standards from June 2016, which will involve:
- Reducing the number of operations cancelled on the day for non-clinical reasons;
- Continuing the transformation of Outpatient services across all three sites at the Trust, including driving down the number of outpatient appointments cancelled by the hospital with less than six weeks’ notice;
- Maintaining the ring-fenced elective bed pool at Watford;
- Installing new CT and MRI scanners at Watford;
- Completing the Endoscopy expansion project.

2016/16 trajectories submitted to TDA as part of Sustainability and Transformation plan:

| RTT - Number of patients on an RTT pathway waiting over 52 weeks |
|-----------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                             | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| Total                       | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   |

| RTT - Percentage of patients on an incomplete RTT pathway waiting under 18 weeks |
|-----------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                             | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| Total                       | 19,315 | 19,412 | 19,422 | 19,227 | 19,420 | 19,225 | 18,841 | 18,935 | 19,030 | 19,125 | 19,221 | 19,317 |
West Hertfordshire Hospitals NHS Trust – Operational Plan 2016/17

4.4. Diagnostics

We note the excellent performance in 2015/16 and we are committed to sustaining the standard for 2016/17.

2016/17 percentage of patients waiting for a diagnostic test within 6 weeks

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total pathways</td>
<td>5,428</td>
<td>5,455</td>
<td>5,458</td>
<td>5,403</td>
<td>5,457</td>
<td>5,402</td>
<td>5,294</td>
<td>5,321</td>
<td>5,348</td>
<td>5,374</td>
<td>5,401</td>
<td>5,428</td>
</tr>
<tr>
<td>Total &gt; 6 weeks</td>
<td>27</td>
<td>27</td>
<td>27</td>
<td>27</td>
<td>27</td>
<td>27</td>
<td>26</td>
<td>26</td>
<td>26</td>
<td>26</td>
<td>27</td>
<td>27</td>
</tr>
<tr>
<td>Percentage of patients waiting for a diagnostic test within 6 weeks</td>
<td>99.50%</td>
<td>99.50%</td>
<td>99.50%</td>
<td>99.50%</td>
<td>99.50%</td>
<td>99.50%</td>
<td>99.50%</td>
<td>99.50%</td>
<td>99.50%</td>
<td>99.50%</td>
<td>99.50%</td>
<td>99.50%</td>
</tr>
</tbody>
</table>

4.5. Seven-day services

During 2015/16, we made good progress in implementing five of the 10 national standards for seven-day services. We put in place increased consultant cover at weekends and we have achieved our ambition of ensuring that there is no significant difference between weekday and weekend mortality. During 2016/17, we will:

- work with clinicians to implement **Standard 2 - Time to first consultant review** for paediatrics, gynaecology, surgery and orthopaedics by improving clinical documentation;
- continue to audit regularly to maintain **Standard 4 - Shift handovers**, including the recently implemented Hospital at Night. The Trust achieved 95% in all specialties at the last audit and will endeavour to maintain this in 2016/17;
- set up a Doppler Access Group in order to develop and centralise seven-day vascular diagnostic services (Standard 5 – Diagnostics) at Watford General Hospital (WGH), to support stroke and vascular services;
- work with commissioners to agree targets and KPIs for Children and Adolescent Mental Health Services (Standard 7 - Mental Health);
• continue to work closely (through the Seven-Day Partner Working Group) with partner organisations to develop a local system-wide seven-day plan. This plan will have particular emphasis on **Standard 9 - Transfer to community, primary and social care**, which is fundamental in improving patient flow;
• continue the work underway on the remaining five clinical standards - 1, 3, 6, 8 and 10. Scoping work was undertaken in 2015/16 and baseline data is now available for standards 6 and 8.

5. **Activity planning**

5.1. **Activity and income planning**

The starting point for our activity and income plan is the forecast outturn for 2015/16 as at month 9. Added to this, we have applied full-year effects to the 2015/16 forecast outturn to reflect in-year movements (e.g. the full year effect of a service change introduced part way through 2015/16) and made an adjustment to CQUIN at full compliance to the income plan. This process gives our baseline for 2016/17.

From this baseline, we have applied a tariff inflator of 1.1% and a 0.7% increase on tariff income to account for increases in the Clinical Negligence Scheme for Trusts (CNST). The activity and income baseline is increased by 1.2% for demographic growth, for population changes, and 0.6% for non-demographic growth, to reflect other demand-related changes. The level of these growth assumptions is subject to discussion and agreement with CCG colleagues and is based on assumptions in *Your Care, Your Future*.

Our counting and recording changes and the impact of CCG QIPP initiatives on Trust activity and income are discussed, challenged and agreed with commissioner colleagues to arrive at an activity and income plan for 2016/17. This reflects both recurrent and non-recurrent changes.

As at 7 April 2016, the Trust’s chargeable activity and income plan was as follows:

<table>
<thead>
<tr>
<th>2015/16 forecast and 2016/17 plan (as at 07/04/2016)</th>
<th>2015/16 forecast</th>
<th>2016/17 plan</th>
<th>%change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>£k</td>
<td>No.</td>
</tr>
<tr>
<td>Non-elective spells (G &amp;A)</td>
<td>44,372</td>
<td>76,154</td>
<td>44,705</td>
</tr>
<tr>
<td>Maternity spells</td>
<td>5,240</td>
<td>11,734</td>
<td>5,240</td>
</tr>
<tr>
<td>Total Non-elective</td>
<td>49,612</td>
<td>87,888</td>
<td>49,945</td>
</tr>
<tr>
<td>Elective inpatients</td>
<td>7,397</td>
<td>24,097</td>
<td>7,433</td>
</tr>
<tr>
<td>Day cases</td>
<td>33,366</td>
<td>26,727</td>
<td>35,990</td>
</tr>
<tr>
<td>Total elective</td>
<td>40,763</td>
<td>50,824</td>
<td>43,423</td>
</tr>
<tr>
<td>Outpatient first attendances(1)</td>
<td>121,366</td>
<td>23,512</td>
<td>129,207</td>
</tr>
<tr>
<td>Outpatient maternity pathways(2)</td>
<td>14,211</td>
<td>13,583</td>
<td>13,920</td>
</tr>
<tr>
<td>Outpatient follow-ups(3)</td>
<td>223,107</td>
<td>24,751</td>
<td>234,064</td>
</tr>
<tr>
<td>Other outpatients(4)</td>
<td>73,287</td>
<td>7,520</td>
<td>78,045</td>
</tr>
<tr>
<td>Total outpatients</td>
<td>431,971</td>
<td>69,366</td>
<td>455,236</td>
</tr>
<tr>
<td>A &amp; E attendances</td>
<td>112,587</td>
<td>13,697</td>
<td>114,839</td>
</tr>
</tbody>
</table>
West Hertfordshire Hospitals NHS Trust – Operational Plan 2016/17

| Critical care | 12,345 | 9,589 | 12,509 | 9,710 | 1.3% |
| High cost drugs | | 9,691 | 10,022 | | |
| Other activity(b) | 3,583,802 | 26,170 | 3,668,470 | 27,221 | 2.4% |
| CQUIN | 5,792 | 6,829 | |
| Total | 4,231,080 | 273,017 | 4,344,422 | 289,994 | |

Forecast @ M11 used for 2015/16
Figures per Trust plan @ 07 April 2016
1 Includes OP procedures which are firsts
2 Ante and post natal pathways
3 Includes OP procedures which are follow-ups
4 Non-face to face, unbundled outpatient imaging, OP activity in block - paediatric diabetes and MDT income
5 Various - therapies, audiology, devices, direct access, etc

5.2 Key capacity issues

5.2.1 Emergency care

Chargeable A&E activity has increased from 110,878 attendances to 112,958 in 15/16 (+2,080), an increase of 1.9%. This does not include Hemel Hempstead Hospital Urgent Care Centre.

Non-elective (excluding deliveries) spells have gone down in 15/16 – from 46,482 to 43,653 (-2,829 – 6.1%). During the second half of 2014/15, there was a change in the way in which certain ambulatory spells were being recorded. They are now being counted as ward attendances (within outpatients), hence a reduction in this activity. We have seen an increase of 1,593 ambulatory care ward attendances (Watford Emergency Ambulatory Care and Watford Emergency Surgical Assessment) between 2014/15 and 2015/16 and it would therefore, be reasonable to assume that approximately 1,600 of the 2,829 reduction in non-elective spells could be attributed to a change in recording.

These non-elective spells are reflected as bed usage in the table below.

2015/16 Non-Elective Emergency Bed Usage
The table shows beds used each month by non-elective admissions in 2015/16 and includes admissions to all three sites (Watford, Hemel Hempstead and St Albans). It excludes ambulatory care patients and admissions to outsourced/Hertfordshire Community Trust-managed wards.

Two key priorities for 2016/17 are a reduction in:

1) Inpatient admission rate. In order to achieve this, we plan to:
   - Ringfence capacity in Ambulatory Emergency Care (AEC) and Watford Children’s Observation Bay (WCOB). Activity through AEC reduced in Q4 due to use of the area for admitted patients. Ensuring that these areas are ringfenced to support the return to previous activity levels is a priority;
   - Implement the Frailty project, whereby patients meeting the frailty criteria are able to access a specialist care of the elderly assessment and treatment service.

2) Length of stay. This will involve:
   - Reducing delayed transfers of care and ‘stranded’ patients (i.e. patients who no longer need to be cared for in an acute medical bed but where there are delays in arranging ongoing care). We lost an average of 978 bed days to formal delayed transfers of care each month this year, the equivalent of over 32 beds. The figure would be two to three times higher if bed days lost to ‘stranded patients’ were factored in. A significant reduction in lost bed days will be essential to overall plan delivery in 2016/17.
   - Continuing to implement SAFER to continue to deliver consistently reduced lengths of stay for all admitted patients.

We will target a reduction in occupied bed days linked to (1) & (2) above and will be producing a detailed inpatient capacity plan. To the extent that we succeed in delivering a reduction in occupied bed days in 2016/17, this will contribute to the Trust’s targeted £14m efficiency programme.

In addition, we will be working to implement the Hyper Acute Stroke Unit model and provide services for all acute stroke patients at the Watford site, in line with HVCCG commissioning intentions. The CCG also recently agreed for the Trust to be the lead provider for Stroke and we will be working with our partners to develop an implementation plan.

We will be working with HVCCG to support demand management and the figures below are their initial expectations, however we have not reflected this full effect in our activity plans at this stage.

### Financial effect of HVCCG 2016/17 QIPP plans on unscheduled care

<table>
<thead>
<tr>
<th>Proposed reductions in income £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-elective admissions (net of mret penalties)</td>
</tr>
<tr>
<td>A&amp;E attendances</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
5.2.2 Planned care & cancer

The RTT performance trajectory is based on a consistent volume of referrals per working day and takes into account seasonal variation.

### Planned care & cancer 2016/17 growth assumptions

<table>
<thead>
<tr>
<th>Activity Line</th>
<th>15/16 Forecast Outturn</th>
<th>16/17 Plan</th>
<th>Growth Assumption</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Referrals (GP and Other)</td>
<td>146586</td>
<td>150729</td>
<td>2.8%</td>
</tr>
<tr>
<td>Consultant led Total 1st Outpatient attendances</td>
<td>152200</td>
<td>156498</td>
<td>2.8%</td>
</tr>
<tr>
<td>Consultant led Follow up outpatient attendances</td>
<td>234344</td>
<td>234705</td>
<td>0.2%</td>
</tr>
<tr>
<td>Total Elective admissions (spells)</td>
<td>45106</td>
<td>46349</td>
<td>2.8%</td>
</tr>
<tr>
<td>Total Endoscopy tests</td>
<td>10173</td>
<td>10455</td>
<td>2.8%</td>
</tr>
<tr>
<td>Total Diagnostic tests (excluding Endoscopy)</td>
<td>90413</td>
<td>92966</td>
<td>2.8%</td>
</tr>
<tr>
<td>Total Cancer 2WW referrals</td>
<td>13099</td>
<td>13467</td>
<td>2.8%</td>
</tr>
<tr>
<td>Total Cancer 62 day waits</td>
<td>883</td>
<td>907</td>
<td>2.7%</td>
</tr>
</tbody>
</table>

A number of services are challenged with significant increases in demand, including Cardiology, Pain and subspecialties within Trauma & Orthopaedics including Spinal Surgery and Hand Surgery.

There is a risk that demand grows beyond that anticipated by the CCG and we will be liaising with the CCG to monitor and mitigate this risk.

The same assumptions apply to maintaining the Trust’s compliance with diagnostic and cancer waiting times standards. The impact of new guidance for suspected cancer is likely to result in increased demand for some diagnostic services.

We will be working with HVCCG to support demand management and the figures below are their initial expectations, however we have not reflected this full effect in our activity plans at this stage.

### Financial effect of HVCCG 2016/17 QIPP plans on planned care

<table>
<thead>
<tr>
<th>Activity</th>
<th>Proposed reductions in income £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day case</td>
<td>145</td>
</tr>
<tr>
<td>Elective IP</td>
<td>786</td>
</tr>
<tr>
<td>OP first</td>
<td>1,003</td>
</tr>
<tr>
<td>OP follow-up</td>
<td>1,894</td>
</tr>
<tr>
<td>Other</td>
<td>273</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,101</strong></td>
</tr>
</tbody>
</table>
5.2.3 Women’s & children’s services

Maternity
- The number of charged NHS deliveries are down by 2.9% on 14/15 figures (from 5,370 to 5,214). This does not include any private patient activity or activity relating to fee-paying overseas visitors. The number of planned deliveries in 2016/17 is 5,327. Our current ‘market share’ for maternity is lower than expected and during 2016/17 we will be developing a strategy to grow activity through our obstetrics service.

Neonatal
- Despite a lower birth forecast, we are projecting a small increase in activity through our neonatal unit. This is linked to new clinical pathways that are being developed with a view to reducing transfers out to the level 3 Neonatal Intensive Care Unit at Luton & Dunstable Hospital.

Paediatrics
- The paediatric team are targeting activity growth in paediatric gastroenterology and allergy services in 2016/17.

Gynaecology
- The key change in Gynaecology is the introduction of the new tier three community gynaecology service. The Trust is working with Hertfordshire Community Gynaecology Service to develop a proposal for commissioners for a full service redesign including the potential for a capitated budget.

6. Workforce planning

6.1. Introduction

Our staff survey tells us that we need to do more to fully engage our people and we are committed to creating a workplace which our staff love and are proud to be part of. The one thing we can be sure of, is that our success depends on the continued commitment of all our people. We know we need to attract and retain excellent and capable people who will drive us forward and enable us to succeed.

6.2. 2015/16 Highlights

We have lots to be proud of. During 2015/16, we:

- Launched a new approach to engaging and unlocking the potential of our employees, Listening into Action (LiA), putting front line staff at the centre of change. We support staff to act on their ideas, knowledge and experience, and empower them to effect change in their own areas. Since May 2015, six staff-led ‘big conversations’ have been held with 250 staff and staff have launched 15 new initiatives to improve services. Our recent LiA temperature check showed the following percentage improvements:
  - Staff feel happy and supported ~ 3.08%;
  - Organisational culture encourages contribution to changes ~ 6.51%;
  - Managers and leaders seek views about improving the service ~ 12.3%;
  - Staff feel valued for the contribution made ~ 7.05%;
West Hertfordshire Hospitals NHS Trust – Operational Plan 2016/17

- Staff feel quality and safety of patient care is the organisation’s top priority ~ 7.26%;
- Staff understand how their own role contributes to the wider organisational vision ~ 6.3%;

- Reduced our vacancy rate to 12.7%, with recruitment of Band 5 nurses having been a notable success. From September 2015 to date, we recruited 251 new band 5 nurses and midwives, of whom 137 have been from overseas, resulting in a Band 5 vacancy rate of just over 8%. We are also seeing a fall in our turnover rate with our three month average rate now at 13.50% (February 2016), compared to 14.90% in December 2015. Prior to December 2015, we reported turnover on a rolling 12-month basis, with April 2015 at 17.3% and corresponding figures for January and February 2016 at 16.7% and 16.3% respectively;

- Started to see a fall in our agency costs as the impact of our recruitment drives becomes more apparent. In December 2015, our agency spend accounted for 17% of our staff budget costs. By February 2016 this figure had reduced to 15.4% and is on a downward trajectory. We have significantly improved the way in which we manage and recruit to our internal Bank by working more effectively with our partner, NHS Professionals (NHSP).

6.3. Our workforce strategy

In order to deliver high quality, sustainable care in the right way, we must address significant organisation and workforce challenges in the months and years ahead. To that end, we have developed a Workforce & Development (W&D) Strategy for 2016-2019 and this was approved by the Trust Board in February 2016.

In the W&D strategy, we have identified four key pillars that will determine our ‘people priorities’:

- Laying the foundations with the right people in the right roles, with the right leadership skills, doing the right things, in the right way - all adding up to the right culture;

- Helping us to recruit and retain a stable, competent, cost effective permanent and temporary workforce that is agile and future-flexible and which includes newly designed roles to help meet our organisational needs.;

- Supporting our people by looking after their wellbeing, listening to and recognising efforts, creating a better place to work, meaning people will stay and flourish;

- Developing our people with the knowledge and skills needed to do their jobs well, strengthening our leadership capability and offering great education and training. In particular, we want to develop the leadership and management skills of our clinicians to help us achieve our goal of becoming a clinically led organisation.

Within each of the four pillars, we identify four work streams and, as part our commitment to deliver this programme, we have outlined new governance arrangements, including a Workforce Transformation Board and progress against our strategy being managed through our new Programme Management Office.
We have also made a number of commitments as part of our Quality Improvement Plan, which was drawn up in the light of the CQC findings, following their visit in April 2015. As part of this programme, we will:

- Introduce new on-line systems for mandatory training which will make it easier for our staff to access training when and where they need it;

- Ensure staff are able to attend and carry out mandatory training, to care for and treat patients effectively, particularly regarding annual resuscitation training and Deprivation of Liberty Standards training;

- Ensure that all staff are effectively supported with formal clinical and operational supervision and appraisal systems and are able to access appropriate developmental training opportunities as required;

- Ensure that at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff to ensure that people who use the service are safe and their health and welfare needs are met. To that end, we will strengthen assurance processes for medical staffing to ensure we are actively reducing risks associated with any gaps in cover;

- Put in place a clear strategy for leadership development and clinical engagement at all levels, as a response to the recent Medical Engagement Survey which showed poor clinical engagement within the Trust. We have reviewed senior medical staff job plans and now have wide clinical engagement via a process that will, for the first time, use detailed activity assumption data to devise a team medical staff capacity plan (team job plan) for each clinical specialty area. These team job plans will inform individual job plans and identify medical staff capacity deficits (see Section 6.6 ~ Medical workforce planning and controls for more details).

We will ensure that our education and training plans align with Health Education England plans.

6.4. 2016/17 Workforce development priorities

As part of the system-wide West Hertfordshire health and social care collaboration, Your Care, Your Future (YCYF) and in line with the emerging Sustainability and Transformation Plan, we have worked and continue to work closely with our partners to develop / agree our 2016/17 priorities.

The diagram below shows operational pressures, demand and capacity issues and strategic redesign priorities, leading to workforce initiatives.

---

3 Herts Valleys Clinical Commissioning Group, Hertfordshire Community NHS Trust, Hertfordshire Partnership University NHS Foundation Trust, East of England Ambulance Service and Hertfordshire County Council
Key workforce priorities are as follows:

**Emergency Care:**
- **Medical staffing:** This continues to be a priority, particularly the need to strengthen the consultant workforce in ED and develop a more sustainable Acute Physician rota. There has been a growing reliance on a small team of doctors to cover increasing service hours into the evenings and at weekends. This has resulted in increasing levels of 'ad hoc' sessional work outside of job plans. The emphasis for 2016/17 is on review of all functions fulfilled by the team across the seven-day period (including on call and weekend commitments) and on determining the case for increased numbers and/or reallocation of specific tasks across the broader medical consultant body.
- **Frailty pathway redesign:** This is a system priority under *Your Care Your Future* and plans will include a new ‘front door’ alongside Watford General Hospital emergency department.
- **Hyper Acute Stroke Services:** This will involve improved staffing ratios for nurses and therapists and will ensure specialist expertise is available on-site, seven days a week. It will require significant workforce expansion including an additional dedicated stroke consultant which will impact on the general medical rota.

**Planned Care:**
- **Rapid access clinics:** We plan to open new clinics to support 2ww cancer pathways.
- **Surgery and Anaesthetics:** High numbers of funded vacancies have resulted in heavy reliance on locum staff and ad hoc consultant sessions. Meanwhile, the Theatres’ scheduling project, undertaken in 2015, has revealed scope for significant productivity gain by introducing two-session days. Resultant scheduling changes, including the introduction of an overseas trainee programme and conversion of locums to substantive staff, will enable significantly reduced reliance on agency staff and extra sessions.
- **Radiology:** Rapidly growing demand for the service has resulted in heavy reliance on employed consultants to provide additional ‘ad hoc’ and regular sessions not included in job plans. At the same time, the service - despite great effort - has struggled to recruit to vacancies. The service has devised a creative plan to recruit trainees and is also making very cost-effective use of agency locums, as a result of positive relationships with individual workers and the impact of capped rates. The emphasis for 2016/17 is to establish the trainee programme and to continue ongoing work to cover growing reporting requirements with reduced reliance on ad hoc sessions, where feasible.
West Hertfordshire Hospitals NHS Trust – Operational Plan 2016/17

- **Medicine**: The capacity planning work has revealed a broad range of challenges which are being addressed via pending business cases or review of team and individual job plans. Notably, historic capacity deficits in **Cardiology** are being addressed via a business case for additional doctors. This, in turn, will enable the team to devise a flexible team job plan to cover all generic and specialist service requirements without reliance on locum or ad hoc cover. A similar approach is being taken by **Gastroenterology** (as part of the planned service development), and in **Respiratory services** where detailed capacity and team job planning is already resulting in improved cover across the 52-week period and clear identification of capacity gaps. For the other medical sub-specialities, the emphasis is on fair and consistent application of the Trust’s job planning principles.

- **Diabetic service redesign**: This is a YCYF priority and will require a full review of the service in line with commissioner specification.

**Women’s & Children’s Services:**

- Some issues have been identified with the historic job plans for both Obstetrics and Gynaecology and Paediatric consultants and the emphasis for 2016/17 is to clearly align the plans to known service needs (both activity levels and 24/7 service cover).
- We plan to develop a new Gynaecology tier three community service in partnership with Hertfordshire Community Gynaecology service.

### 6.5 Reducing all agency staffing (nursing, medical, AHP and admin & clerical)

We have reviewed and strengthened our internal processes for managing temporary staffing and also worked with other NHS organisations across Hertfordshire and Bedfordshire to help drive down our agency and locum costs and thereby meet the requirements of the newly introduced temporary staffing caps. Herts Procurement (shared service) has led a process of re-competition with the nursing agencies to bring in service level agreements reflecting capped rates. They will continue this process through into medical and other staff groups. In this way, our combined market force will manage down the pay expectations of agency workers.

We have made real improvements in reducing our vacancy rates which we know, left unchecked, result in increased pressure of work and reduced staff engagement, which in turn means increased turnover and, inevitably, greater use of temporary workers to cover gaps.

Having started to see a reduction in our agency spend, during 2016/17, we will also:

- implement tighter controls on the booking of temporary staff in medical, allied health professional and admin & clerical roles, to complement the tight controls already in place with nursing & midwifery;
- continue to work with our partner, NHSP, to attract more workers to the bank;
- ensure that minimal use is made of interim staff, having successfully reduced the numbers from 70 at the start of the 2015/16 to 12 at the year end;
- review the business case for roll-out of e-Roster to staff groups beyond nursing & midwifery, after the e-Roster upgrade in April 2016;
- further reduce vacancy and turnover rates.

The table below shows a more detailed trajectory by staff group. The rationale is:
• **Nursing & Midwifery**: the trajectory is correlated with anticipated reduction in vacancy rates, based on the correlation between vacancy reduction and agency spend over the last 5 months;

• **Medical staffing**: the trajectory reflects a 2% reduction each month, based on the average reduction in agency spend over the last 5 months;

• **Other staff**: the trajectory shows a phased reduction to approximately 50% of current spend levels over the year, to be achieved by minimising non-clinical spend.

This results in an annual agency spend of £24.406m.

<table>
<thead>
<tr>
<th>Gross Employee Benefits Breakdown</th>
<th>2016/17</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Apr</td>
<td>May</td>
</tr>
<tr>
<td>Substantive Costs</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>Qualified Nursing</td>
<td>57,636</td>
<td>4,624</td>
</tr>
<tr>
<td>Medical</td>
<td>49,610</td>
<td>4,108</td>
</tr>
<tr>
<td>Other</td>
<td>76,038</td>
<td>6,002</td>
</tr>
<tr>
<td>Bank Costs</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>Qualified Nursing</td>
<td>4,949</td>
<td>388</td>
</tr>
<tr>
<td>Medical</td>
<td>3,713</td>
<td>313</td>
</tr>
<tr>
<td>Other</td>
<td>4,599</td>
<td>418</td>
</tr>
<tr>
<td>Total Bank</td>
<td>13,261</td>
<td>1,119</td>
</tr>
<tr>
<td>Agency / Contract Costs</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>Qualified Nursing</td>
<td>8,140</td>
<td>955</td>
</tr>
<tr>
<td>Medical</td>
<td>8,560</td>
<td>800</td>
</tr>
<tr>
<td>Other</td>
<td>7,706</td>
<td>1,031</td>
</tr>
<tr>
<td>Total Agency / Contract</td>
<td>24,406</td>
<td>2,788</td>
</tr>
<tr>
<td>Gross Employee Benefits</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>Qualified Nursing</td>
<td>70,725</td>
<td>5,907</td>
</tr>
<tr>
<td>Medical</td>
<td>61,883</td>
<td>5,221</td>
</tr>
<tr>
<td>Other</td>
<td>88,343</td>
<td>7,463</td>
</tr>
<tr>
<td>Total Gross Employee Benefits</td>
<td>220,951</td>
<td>18,641</td>
</tr>
</tbody>
</table>
We hold a weekly Nursing KPI meeting which aims to ensure effective rostering within budget. The meeting is led by the Chief Nurse and attended by matrons, all ward managers, finance and other senior managers. We are implementing a stricter control regime for medical locums, involving second tier authorisation at Divisional Manager/Divisional Director level and Medical Director approval for any rate cap breaches. We hold a bi-weekly Agency Spend Steering Group to co-ordinate and manage overall agency reduction.

6.6 Medical workforce planning and controls

To support the Trust's commitment to aligning business needs with clinical staff capacity, a new Request and Approval process for all 'ad hoc' clinical sessions will be introduced from April 2016. Approvals will only be given where the divisions can provide evidence that the sessions will generate additional income, or, in the case of vacancy cover, where there is a robust recruitment plan in place.

The Trust's model of clinical leadership will provide ongoing focus on aligning business and clinical staff capacity planning, with local accountability for reducing ad hoc and locum expenditure.

7. Financial planning

7.1. Financial forecasts and modelling

The Trust has, for a number of years, operated in deficit (expenditure exceeding funding). The size of the deficit increased in recent years, following a series of risk assessments undertaken by the Board and publication of the Francis report\(^4\).

Unfunded investment was made in quality, increased staffing and infrastructure costs. In 2015/16, costs have continued to rise, mainly due to the Trust having to create additional clinical capacity to accommodate increasing numbers of patients delayed in their transfer of care. As has been the case in the past, this new clinical capacity had to be supported by costly temporary staff. Increased costs also relate to corrective actions, following the Trust’s Care Quality Commission inspection.

The starting position for 2016/17 plan is the outturn deficit for 2015/16, adjusted for events unique to 2015/16.

A key change to the planning framework for 2016/17 was the conditional access to revenue to be made available from a national Sustainability and Transformation Fund. In January 2016, the Trust was notified that, if it could develop a plan for a deficit of no greater than £29.3m, it could access the fund to then reduce its deficit plan to £17.3m.

Based on high level assumptions, the Trust determined it could accept the offer and, at the beginning of February, submitted a compliant draft plan. The submission emphasised:

i) An above national expectation of savings required (£17.5m, about 5% of costs) and that further work was necessary to gain confidence this could be achieved.

---

\(^4\) Visit [www.gov.uk](http://www.gov.uk) search for Francis report
ii) Successful negotiation with CCGs regarding prices for emergency care, particularly as the Trust had been paid at a reduced rate for high levels of emergency admissions and not paid at all for some patients readmitted.

iii) In the event that the number of patients delayed in their transfer of care from hospital was above the average seen in 2015/16, the Trust required to be afforded the right to charge for the extra costs of continuing to care for these patients.

Since February, the Trust has developed a detailed 2016/17 plan, tracking variances from high level assumptions. The Trust (Board meeting 7th April) concluded risks of financial deficit not exceeding £17.3m as too high. Recognising deteriorating from £17.3m meant the loss of £12m from the S&T Fund, a deficit plan of £36.9m was recommended and approved.

The table below summarises changes between the Trust’s draft February position and the 2016/17 financial plan approved by the Trust’s Board.

<table>
<thead>
<tr>
<th>Notes</th>
<th>February Draft £000</th>
<th>Final Plan £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start position</td>
<td>(40,121)</td>
<td>(42,347)</td>
</tr>
<tr>
<td>Tariff uplift</td>
<td>5,536</td>
<td>4,563</td>
</tr>
<tr>
<td>Income adjustment</td>
<td></td>
<td>(439)</td>
</tr>
<tr>
<td>Cost inflation</td>
<td>(12,903)</td>
<td>(12,382)</td>
</tr>
<tr>
<td>Savings target</td>
<td>17,500</td>
<td>14,000</td>
</tr>
<tr>
<td>Additional costs</td>
<td>(4,500)</td>
<td>(4,500)</td>
</tr>
<tr>
<td>100% payment for emergency admissions &amp; no readmission penalties</td>
<td>5,900</td>
<td>4,205</td>
</tr>
<tr>
<td>Sustainability &amp; Transformation Fund</td>
<td>12,000</td>
<td>0</td>
</tr>
<tr>
<td>Contingency</td>
<td>(712)</td>
<td>0</td>
</tr>
<tr>
<td>Planned 2016/17 deficit</td>
<td>(17,300)</td>
<td>(36,900)</td>
</tr>
</tbody>
</table>

In approving the 2016/17 planned deficit, the Trust is aware the position may change because of:

- The outcome of national discussions relating to paying for readmitted patients.
- CCG proposals to manage patient demand for hospital care which could reduce Trust income by up to £9.8m. These relate mainly to reducing the volume of emergency admissions but also day case, elective operations, outpatient attendances and A&E attendances, to be able to afford the services the CCG wishes to commission. If this occurs the Trust will need to reduce
cost but it will take time and planning. There is insufficient detail of how reduction in patient numbers may occur for the Trust to currently plan on the basis of a lower level of capacity.

7.2. Efficiency savings for 2016/17

In order to plan for a deficit of no worse than £17.3m, the Trust stretched its strategic intent to save 4% each year derived from benchmarking Trust costs to current Upper Quartile levels, to 5%. This is 2.5 times that implied by national planning assumptions. Based on progress in developing schemes, the Trust has decided that achieving 4% is challenge enough. £9.2m of savings are identified, leaving a further £4.8m of schemes required towards limiting the deficit forecast to £36.9m.

The Trust intends to reduce its staff costs by £10m and its non pay costs by £4m. Staff savings are mainly delivered through compliance with the agency spending cap of £24.4m set by NHS Improvement. This will be achieved through compliance with agency rates agreed nationally, replacing agency staff through recruitment and reorganising hospital beds.

NHS Improvement has also set a cap on nurse agency spending. A plan to deliver safe health care within this cap, aims to reduce qualified nurse agency to, at most, 10% of nursing costs by autumn of 2016/17.

The Trust has an established process for scrutinising the essential use of agency staff and permanent staff are encouraged to register for additional hours. Hourly pay rates for agency staff are controlled through using NHS Professionals for all except additional sessional rates for medical staff, where a review of current processes is being undertaken. The Trust continues to develop recruitment campaigns for permanent staff to reduce the need for agency.

Lord Carter’s team has developed an index to measure the relative efficiencies of NHS Trusts (The Adjusted Treatment Index). Our score of 98 suggests the Trust is 2% more efficient than average. However, the work has highlighted a range of potential opportunities which the Trust has developed into an action plan to support delivery of £4m of savings.

In 2015/16, delivery of savings was supported by an external company which is in the process of being replaced by a dedicated internal team. In addition to Departmental responsibilities for savings, each Executive Director reviews a portfolio of initiatives concerned with their specialist area. Teams from across the Trust are established, as appropriate, to support delivery. Governance is through regular meetings designed to both support and challenge delivery.

7.3. Capital planning

Maintaining safety of infrastructure and meeting the capacity to care for patients is critical. To do this, capital investment similar to that made in each of the last three years, is required, shown in the table below.

<table>
<thead>
<tr>
<th>2016/17 planned capital</th>
<th>£000s</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depreciation</td>
<td>8,500</td>
<td></td>
</tr>
<tr>
<td>Less loan repayment</td>
<td></td>
<td>(3,782)</td>
</tr>
</tbody>
</table>
Initial funding is sufficient to complete projects that are in progress. These include replacement of equipment, adaptation to buildings towards coping with patient volumes, critical maintenance to buildings plant and machinery, information technology and clinical training facility improvement.

Additional funding is needed to replace equipment that becomes too expensive to maintain, or equipment that is no longer safe. Building and engineering refurbishment is also a continual process to ensure facilities meet standards and support provision of quality care. Improved patient facilities are planned to support the efficient throughput of increased patient volume.

Two major developments are underway, each of which is likely to cost £10m, with investment of £1m each in 2016/17. The first of these is redevelopment of the theatre suite at Watford Hospital. This will increase capacity to meet expected demand, as a minimum, for the next five years and equip them to modern standards. The second is redevelopment of the A&E department, again to keep pace with demand and improve patient facilities.

The Trust plans in 2016/17 to apply to NHS Improvement for £10.9m of new borrowing, presenting a strong case of need. However, as there are limited funds available nationally, award of the total is uncertain.

The Trust, with Watford Borough Council (WBC), is part funding the new road at the rear of Watford Hospital. This will provide an additional route for ambulances. The Trust’s plan includes borrowing the final £2m of the Trust’s £9m investment from WBC.

### 7.4. Cash management

The Trust’s cash management plans will need to manage the effect of the income and expenditure deficit, capital expenditure and the consequences of borrowing. A summary of cash management is as follows:

<table>
<thead>
<tr>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening cash balance</td>
</tr>
<tr>
<td>Forecast deficit</td>
</tr>
<tr>
<td>Add back non-cash items - Depreciation</td>
</tr>
<tr>
<td>Add other balance sheet changes</td>
</tr>
<tr>
<td>Add external finance – revenue support</td>
</tr>
</tbody>
</table>
Add external finance – approved capital loan 1.6
Add external finance – new capital loans 10.9
Other loans – WBC 2.0
Final contribution of £9m towards access road and associated infrastructure - Watford Health Campus -2.0
Loan principle repaid -3.8
Capital schemes brought forward -6.6
New high priority capital schemes -8.9
Strategic capital schemes -2.0
Closing cash balance 1.6

Clearly, the key risk is the ability to secure cash funding to cover the planned deficit and secure additional borrowing to finance critical capital schemes.

8. Planning, delivery, leadership and governance

8.1. Planning approach

We are continuing to develop and strengthen our internal planning processes to ensure clear alignment between activity / capacity / workforce and financial planning assumptions.

The financial plan for 2016/17 budgets has been developed utilising both a top down analysis of the activity and financial baseline which captures known changes for 2016/17 and a bottom up construction of divisional financial plans. The planning approach builds on 2015/16 activity, capacity and workforce recurrent baselines and models incremental changes into 2016/17.

As noted above, at this stage in the planning process, assumptions are having to be made regarding the final outcome of contract negotiations and efficiency plans are
yet to be finalised. There are also some material national positions to be confirmed – for example, the payment regime linked to readmitted patients and the precise workings of the sustainability and transformation funds.

The top down analysis provided a framework to challenge and confirm the bottom up plans developed at divisional and departmental level and the final plan is set, based on iterating bottom up vs top down planning assumptions.

Led by the Executive team, we have used the challenge and confirm method, incorporating sensitivity testing and lessons learned from previous years, to ensure divisions fully understand and own all the key assumptions within the 2016/17 plan. Clinical leads have been engaged in reviewing and signing off the activity, capacity, workforce, income and expenditure plans for their services.

8.2. Delivery and performance management

In 2016/17, the Trust will be strengthening in house PMO and project delivery capabilities to ensure that plan delivery is effectively tracked and risk managed, as well as providing additional capacity to support the delivery of major change programmes. A time-limited extension to external advisory support is currently being commissioned to support set up and skills transfer and ensure progress continues to be made at pace in Q1.

Monthly performance review meetings are in place to ensure progress at divisional level is maintained.

8.3. Leadership

In 2015/16, we continued to strengthen our leadership team with the appointment of a new Chairman, Steve Barnett in November 2015. We have a full complement of non executive directors who bring a range knowledge and expertise to the Trust.

We were not able to appoint a substantive chief executive in 2015/16 but continue to benefit from the skills and experience of Jacqueline Kelly, a highly experienced NHS leader, who joined the Trust as our interim Chief Executive in January 2015. All other Executive Director posts are now filled substantively, although our Director of Operations (unscheduled care) will be leaving the Trust at the end of April. An experienced internal leader has been seconded to cover this role whilst we put in place new substantive leadership arrangements within the Operations division.

We continue to work to strengthen clinical engagement and to support and empower clinical leaders within the Trust. Divisional triumvirates will play a key role in delivering the plan and will be held to account through a corporate PMO and performance review function, as described above.

A Board development plan is being put in place to respond to the Board’s self assessment against the “well led” framework and the findings of the external board capability review commissioned by the TDA, following the Trust being put into special measures. Additionally, the Trust will be working with the Royal Free Hospital through the ‘buddying’ arrangement, also put in place as part of the special measures support package. This work will focus on risk and governance (specialty dashboards), developing clinical leadership, end of life care and reviewing options for the future of pathology services.
8.4. Governance

During 2015/16, we have worked to strengthen our governance and assurance arrangements. The key aspects of our governance arrangements are summarised in the figure below.

WHHT Governance arrangements

8.5. Triangulation & integrated performance reporting

The Board receives a monthly Integrated Performance Report (IPR) that brings together quality, safety, workforce and finance metrics. We have substantially developed the IPR during 2015/16 (including, for example, the additional of ward scorecards and safe nursing staffing metrics) and will further strengthen our approach to reporting in 2016/17. We continue to refine the way that data is analysed and presented, to allow the Board and divisional leadership teams to triangulate activity, workforce, finance and quality data.

We are continuing to develop the IPR, with more detailed safety and quality and workforce reports being provided to the relevant committees. This includes data analysed at ward and departmental level. Divisional IPRs are produced to support monthly divisional performance review meetings.

8.6. Board assurance framework and risk management

We have reviewed and updated our Board Assurance Framework and identified 10 ‘principal risks’ to the delivery of our organisational aims and objectives. We have risk-rated our assurance around each risk and agreed a programme of work to strengthen controls and assurance against each of the identified risks. Our corporate
risk register provides a more granular view of specific risks within the organisation at divisional and departmental level and is monitored through monthly executive-led risk review meetings, reporting through to the Integrated Governance and Risk Committee.

### Principal Risks

<table>
<thead>
<tr>
<th>Principal Risk</th>
<th>Description</th>
<th>Executive Leads</th>
<th>Board assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>PR1</td>
<td>Failure to provide safe, effective, high quality care (quality governance and risk management)</td>
<td>HB, TC, MWDW</td>
<td>S&amp;Q</td>
</tr>
<tr>
<td>PR2</td>
<td>Failure to recruit to full establishments, retain and engage workforce</td>
<td>PDG</td>
<td>WK</td>
</tr>
<tr>
<td>PR3</td>
<td>Current estate and infrastructure compromises ability to deliver safe, responsive and efficient patient care</td>
<td>KH</td>
<td>S&amp;Q</td>
</tr>
<tr>
<td>PR4</td>
<td>Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care 4a) IM&amp;T 4b) information and information governance</td>
<td>LE</td>
<td>F&amp;P</td>
</tr>
<tr>
<td>PR5</td>
<td>Inability to deliver and maintain performance standards 5a) Emergency Care 5b) Planned Care (including RTT, diagnostics and cancer)</td>
<td>LH, JS, CL</td>
<td>F&amp;P</td>
</tr>
<tr>
<td>PR6</td>
<td>Failure to maintain business continuity</td>
<td>LH, CL</td>
<td>S&amp;Q</td>
</tr>
<tr>
<td>PR7</td>
<td>Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency Programmes</td>
<td>DR</td>
<td>F&amp;P</td>
</tr>
<tr>
<td>PR8</td>
<td>Failure to engage effectively with our patients, their families, local residents and partner organisations compromises the organisation’s strategic position and reputation.</td>
<td>HB, HR</td>
<td>Strategy</td>
</tr>
<tr>
<td>PR9</td>
<td>Failure to develop a sustainable long term clinical, financial and estates strategy compromises the organisations’ strategic position and reputation.</td>
<td>HB</td>
<td>Strategy</td>
</tr>
<tr>
<td>PR10</td>
<td>Failure to work with partners to successfully resolve system risks that adversely affect delivery of our organisational aims and objectives.</td>
<td>LH</td>
<td>F&amp;P</td>
</tr>
</tbody>
</table>

### 9. Summary

We have:

- Set out our corporate aims and linked them and our clinical and organisational strategy with the system-wide west Hertfordshire *Your Care, Your Future* strategic review and the emerging STP;

- Outlined our approach to quality, including providing assurance on the robustness our workforce plans. We have described how we are addressing the concerns of the CQC following their visit to the Trust in 2015, through our quality improvement plan;

- Included a summary of our plans for achieving NHS Constitution standards and demonstrated the capacity to meet this level of activity;
• Been 'stretching' from a financial perspective and have taken full advantage of efficiency opportunities, including those identified by Lord Carter and the new rules around agency;

• Outlined affordable, value-for-money capital plans that are consistent with our clinical strategy and which demonstrate the delivery of safe, productive services;

• Aligned our plans with commissioner plans, underpinned by contracts that balance risk appropriately;

• Strengthened, in this revised, final plan, the 'golden thread' between demand and capacity, activity, workforce and finance and ensured that activity, workforce and finance plans are internally consistent; and finally

• Summarised our approach to planning, governance and assurance.