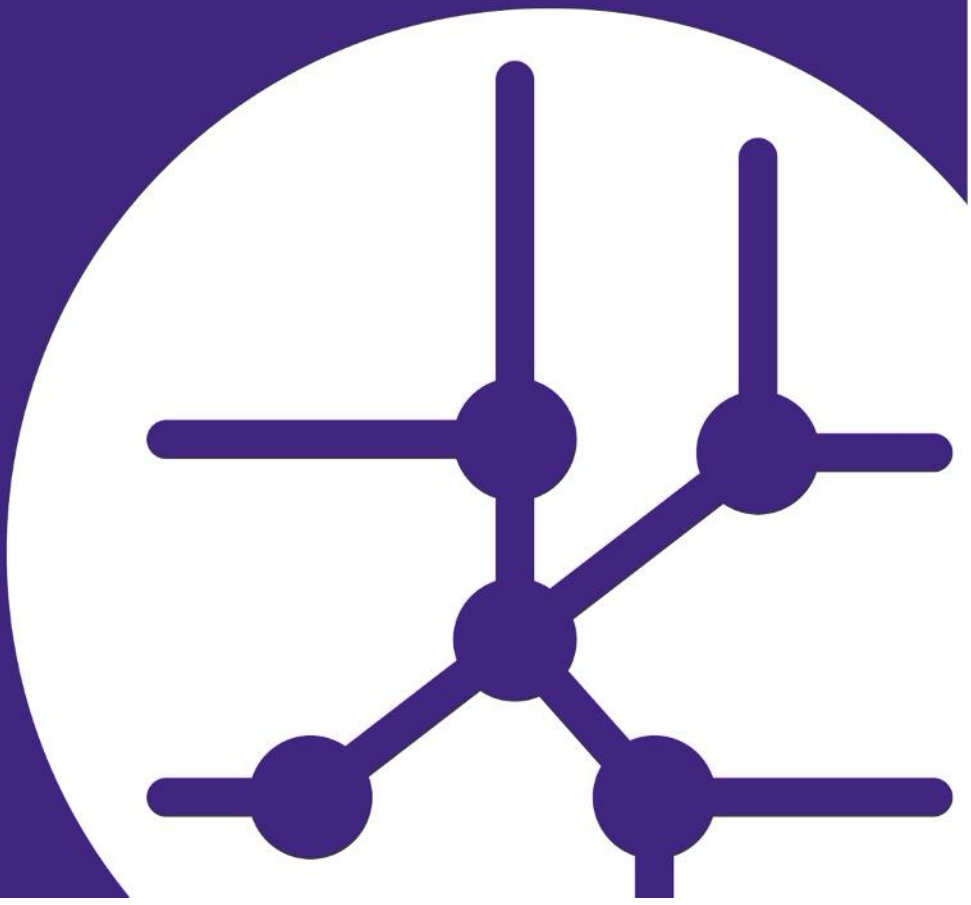
NHS
West Hertfordshire Hospitals
NHS Trust

Clinical Strategy

2021 – 2026

September 2021



Foreword

This clinical strategy is a celebration of the progress we have made over the last five years, and a firm promise for how we will continue to deliver the very best care over the next decade.

When we developed our previous clinical strategy in 2016 we were in special measures, with significant clinical challenges across many of our services. Now we are a thriving organisation with most of our services rated 'good' by the Care Quality Commission; we offer many services that are normally only available in much larger hospitals; we are aiming to achieve teaching hospital status and we have won multiple awards, including Employer of the Year in 2019. At the time of writing, the trust has four teams shortlisted in national awards for success in areas related to innovation and staff development.

We have an amazing, committed and skilled workforce, which has proven just how far they will go to provide the safest care for our patients curing the Covid-19 pandemic. They have also shown how they can constantly innovate in the face of adversity, with our nationally recognised Covid Virtual Hospital just one of many examples of how we have continuously improved our services to meet the needs of our patients.

Looking to the future, we are excited by the opportunity improve our buildings and in doing so create a unique purpose for each of our three hospitals. The way we organise our services, together with investment in new facilities, will result in a better experience for patients and staff.

The *NHS Long Term Plan,* which is reflected in our strategy, sets out a vision of the future NHS which focuses on population health and personalised care to keep people healthy and enabled to manage their own care. It also predicted how digital technology would deliver care differently and said that NHS organisations should work together to deliver more care out of hospital and ensure that the care that people receive is seamless.

This draft clinical strategy sets out the ways in which we will deliver the *NHS Long Term Plan* and how we will transform our services so that we will be ready to deliver 21st century services from our 21st century buildings. It has been developed with wide engagement from our clinical staff, and we are now keen to engage more widely with our communities, patients and other stakeholders to ensure that we are addressing the things that are most important to them. This document has a practical partner, our clinical brief, which describes how the changes we see as important can be delivered. We have engaged on both documents.

Michael van der Watt
Chief Medical Officer

Tracey Carter
Chief Nurse

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Executive summary

We have really brought our vision 'the very best care for every patient, every day' to life over recent years through the efforts and commitment of #TeamWestHerts. Huge progress has been made to improve services for our patients; we moved out of 'special measures', won a range of national awards, reduced our vacancies and have seen our staff morale hold strong through the most extraordinary circumstances of the pandemic. To build on this, our trust strategy 2020 to 2025 sets out how we will continue our successful improvement journey and deliver national and local priorities for the NHS.

Providing the very best care for every patient every day doesn't just mean providing great care for local people when they are ill and receiving treatment in one of our hospitals. We need to work to improve the health of our population, not just manage ill health. We also need to join up care and constantly ask ourselves whether we can redesign care with local health and care partners, including voluntary sector providers, to make it more responsive, person-centred and better coordinated. For people with complex needs or long term conditions we need to plan ahead and actively support people to manage their own health conditions at home or in primary and community care settings and, by doing this, prevent - as far as possible - the need for hospital care. There are also real opportunities to improve outpatient care by 'making every contact count'.

In this strategy we are setting clear ambitions for how we will improve our services. To deliver the very best care for every patient, every day we will:

- continue to provide the very best care to our local population by delivering outstanding services in a secondary care setting, with areas of excellence that provide a range of more specialist services to a wider population
- continue in our aim to deliver care close to home where possible, and in the lowest intensity setting that is clinically appropriate
- integrate pathways across primary, community and acute services to improve patient experience and get the best possible outcomes for our population
- be active leaders in our integrated care partnership, reaching outside of our traditional boundaries to help improve the health and wellbeing of our population and to keep people healthy
- personalise the care we deliver through shared decision making, taking account of the goals of the individual and providing appropriate information and support to enable people to manage their own care more effectively and take informed decisions about the care they receive
- standardise the way we deliver care to get consistent outcomes and timely and efficient pathways, using data effectively within a quality improvement culture and reducing unwarranted variation

- provide more 'one stop' and multidisciplinary clinics that enable rapid diagnosis and treatment, reducing the number of times that people have to travel to our hospitals
- encourage innovation and research, and will harness new technologies to enable us to continually improve the services that we offer.

This clinical strategy sets out how we propose to organise, deliver and develop our services over the next five years to meet these ambitions and deliver against our key aim of best care. However best care cannot be delivered in isolation, and much of this strategy will also describe how we will contribute towards our aims of great team and best value, as well as how we work with other health and social care providers. We will also describe how we see the delivery of care changing as we move into our new and redeveloped hospital buildings , supported by excellent digital technology to improve outcomes and patient experience.

The clinical strategy also sits within the wider strategic context of the Herts and West Essex integrated care system health and care strategy *A Healthier Future,* which brings together the challenges and opportunities faced by organisations in Hertfordshire and West Essex as they work together to improve health and wellbeing within the funds available.

We have engaged with the public on this clinical strategy as part of a wider public engagement *Your Care Your Views*. In respect of the strategy, the comments from the public were largely positive with particular support for our ambitions to move to a one stop clinic approach for outpatient and diagnostic services. While the benefits of virtual consultations and patient initiated follow up were recognised, there was some concern about whether they were appropriate for everyone, particularly people who don't have access to digital technology or people who might not want to bother their doctor and ask for an appointment. The strategy now clarifies that there will continue to be face to face options for people who do not wish to use virtual consultations; that we will only use virtual consultations where they are clinically appropriate; and that patient initiated follow up is subject to patient choice.

During the engagement, it was clear that there were concerns about access to and parking at our hospitals. We also had some (fewer than expected) questions about retaining our three site configuration. These issues are out of scope for this document; our response to feedback about travel and access is addressed in the communications and engagement paper (for information at the September 2021 board meeting); and the strategy is not site specific and so comments about our configuration do not impact on our clinical strategy.

1. Introduction

The trust strategy 2020 to 2025 sets out how we will continue our successful improvement journey and deliver national and local priorities for the NHS. It describes our four key aims:

Figure 1.1: The four key aims from the WHHT strategy 2020-2025

Our quality ambition is to match the highest performing NHS hospitals. In some areas our performance is comparable, for example, on mortality and harm-free care indicators. But there are others where we can improve, such as performance against waiting time standards. We want to ensure consistent high quality across everything we do, ensuring that our patients and their carers have a great experience of care.

Providing the very best care for every patient every day doesn't just mean providing great care for local people when they are ill and receiving treatment in one of our hospitals. We need to work to improve the health of our population, not just manage ill health. We also need to join up care and constantly ask ourselves whether we can redesign care with local health and care partners, including voluntary sector providers, to make it more responsive, person-centred and better coordinated. For people with complex needs or long term conditions we need to plan ahead more and actively support people to manage their own health conditions at home or in primary and community care settings and, by doing this, prevent - as far as possible - the need for hospital care. There are also real opportunities to improve outpatient care by 'making every contact count'.

Along with the rest of the NHS and other healthcare systems, we are now facing a very difficult set of challenges – most significantly, the need to transform healthcare to meet the needs of many more people living longer and epidemic levels of chronic conditions such as diabetes and heart disease. The recent pandemic has also shown us how vulnerable we are to viruses in the increasingly I connected and transient world we live in. At the same time,

scientific and clinical innovation is extending our ability to save lives and to improve people's quality of life through digital technology that allows people to manage their own care with reduced reliance on institutional settings.

We also have the challenge of delivering high quality care within a poor quality estate that is increasingly unfit for purpose. We have been lucky enough to secure capital funding to allow us to redevelop our sites, and we must ensure that we are able and ready to deliver 21st century care within our 21st century facilities by 2025 or soon after.

This clinical strategy sets out how we propose to organise, deliver and develop our services over the next five years to meet these challenges and deliver against our key aim of best care. However best care cannot be delivered in isolation, and much of this strategy will also describe how we will contribute towards our aims of great team and best value. We will also describe how we see the delivery of care changing as we move into our new and redeveloped hospitals, supported by excellent digital technology to improve outcomes and patient experience.

The strategy has been led by senior clinicians across the trust and draws on detailed evidence and input from a wide range of sources. We have worked with staff, service users and our partner organisations including Herts Valleys CCG, our local clinical commissioning group, to develop this draft strategy.

The clinical strategy is a core component of the trust's wider strategy. Its development has been guided by our organisational vision and strategic ambitions; in turn, it is influencing the development of other trust-wide strategies, such as those for estates, people and digital. Our clinical ambition is such that implementing the clinical strategy will require far-reaching transformation over the next five years, both within our own organisation and with our partners in primary care, community, mental health and social care.

The clinical strategy also sits within the wider strategic context of the Herts and West Essex integrated care system health and care strategy *A Healthier Future,* which brings together the challenges and opportunities faced by organisations in Hertfordshire and West Essex as they work together to improve health and wellbeing within the funds available.

2. Our starting point

2.1. Our services

The trust provides a wide range of acute emergency and planned services, with emergency care primarily provided at Watford General Hospital; planned surgical and outpatient services, including some cancer services at St Albans City Hospital; and outpatient, diagnostic and urgent care services provided at Hemel Hempstead Hospital. This three site arrangement supports local care provision, though the configuration of services across sites is in part a result of history and so creates some fragmentation.

Our future plans for our three hospitals are summarised briefly in section 2.12, and in more detail in our redevelopment 'clinical brief' which can be found at https://www.westhertshospitals.nhs.uk/about/redevelopment/documents/Clinical%20brief%20final.pdf.

Our main commissioner is Herts Valleys Clinical Commissioning Group (HVCCG), with nearly 90% of our patients residing in the Herts Valleys area, with residents of North West London making up most of the rest of our patient base. We provide the majority of elective and non-elective acute care for this population but also have strong links and established referral pathways into London and neighbouring hospitals when our patients need more specialist care than we are able to provide locally.

Not everyone living within Herts Valleys CCG uses our services, particularly those who live in Hertsmere for whom Barnet Hospital (run by the Royal Free London NHS Foundation Trust) is the closest acute hospital, and those living in Harpenden for whom Luton and Dunstable University Hospital (LDUH) is the closest hospital.

These different flows are important in the context of the South and West Herts health and care partnership (HCP), which will be responsible for all people registered with a GP in Herts Valleys, not just those who use WHHT acute services. More information on the development of the HCP is set out in section 2.8.

Our population

Herts Valleys CCG has a registered population of over 600,000; 35-59 year olds are the largest proportion of the population. 18.9% of the population are aged 14 years or younger and 16.1% of the population are aged 65 years and over. 14.6% of the population are from BAME backgrounds, with the majority being Asian or British Asian. Watford has the highest proportion of people from BAME backgrounds with 28.1%.

Generally, areas within the CCG are affluent; of all the districts within the CCG Watford and Hertsmere have the highest deprivation scores. Areas within Borehamwood, Hemel Hempstead and Watford have the highest proportion of children and young people, and older people living in poverty.

Life expectancy is similar to or higher than the average for England. Watford has the lowest life expectancy of the five districts within the CCG. Inequalities in life expectancy are highest in Dacorum and Hertsmere for males, and Dacorum, Hertsmere and St Albans for females.

Watford district has a higher than expected mortality rate for all cause, all age deaths. All age deaths are higher than expected for circulatory related, strokes, and respiratory deaths in Watford, and respiratory deaths in Hertsmere.

Hypertension (12.7%), depression (10.1%), obesity (8.3%), and diabetes (6.0%) have the highest prevalence within the population and 33.72% of the population in Herts Valleys CCG have multi-morbidity (two or more long term conditions).

The uptake of diabetic retinopathy screening, breast cancer and bowel cancer screening are above the target (or national average), but the uptake for cervical screening is below the national target. The uptake of the majority of childhood immunisations, and the flu vaccine in school aged children, people aged under 65 years with risk factors and pregnant women, and carers is below the national target.

A health needs assessment completed during autumn 2020 proposed the following areas of focus to improve health:

- antenatal and postnatal care
- integrated lifestyle programme
- long term conditions
- falls prevention
- mental health
- communicable diseases
- digital exclusion
- population health management.

The South & West Herts HCP is currently developing a clinical and care integration strategy, which will use the health needs analysis as a starting point. We will ensure that there is consistency between this clinical strategy and the final HCP clinical strategy.

2.2. Performance and achievements

We have a strong foundation on which to build our clinical strategy. From an organisation in special measures in 2015 with a CQC rating of ‘inadequate’, we have strengthened our services, leadership and governance so that we are now rated ‘good’ on the effective, caring and well led domains.

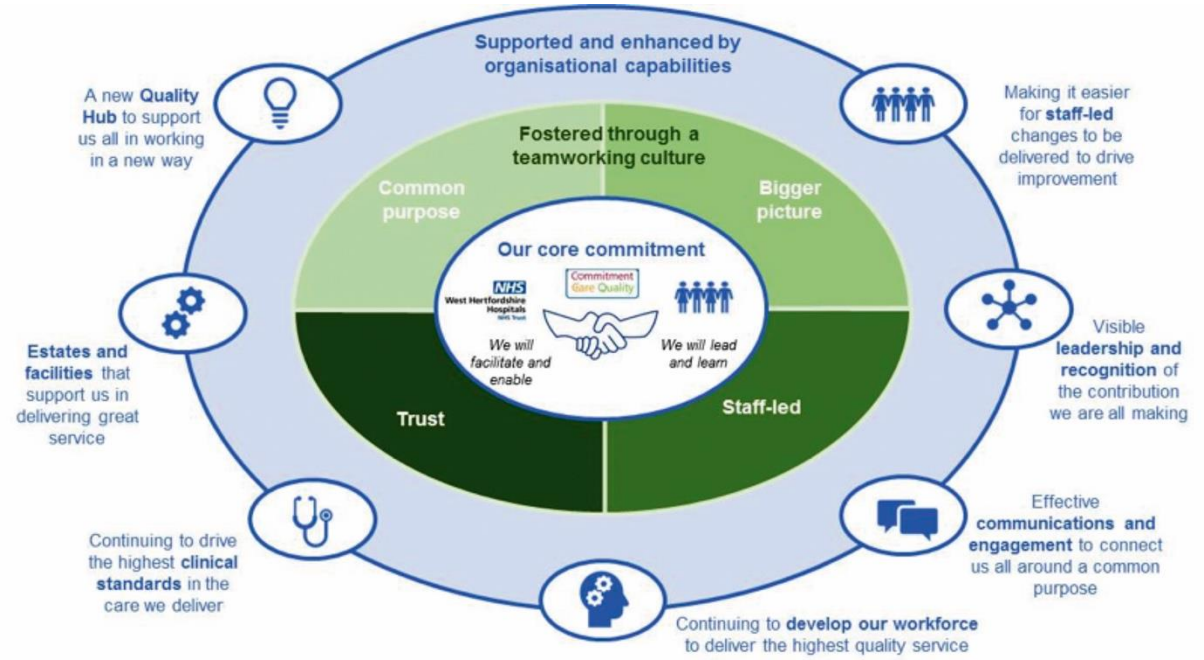
Figure 2.1: CQC ratings

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Watford General Hospital	Requires improvement ➔➔ Jun 2020	Good ➔➔ Jun 2020	Good ➔➔ Jun 2020	Requires improvement ➔➔ Jun 2020	Good ➔➔ Jun 2020	Requires improvement ➔➔ Jun 2020
St Albans City Hospital	Requires improvement ↑ Jun 2020	Requires improvement ➔➔ Jun 2020	Good ➔➔ Jun 2020	Good ↑ Jun 2020	Good ↑↑ Jun 2020	Requires improvement ↑ Jun 2020
Hemel Hempstead Hospital	Requires improvement ➔➔ Jun 2020	Good ↑ Jun 2020	Good ➔➔ Jun 2020	Good ↑ Jun 2020	Requires improvement ↑ Jun 2020	Requires improvement ↑ Jun 2020
Overall trust	Requires improvement ➔➔ Jun 2020	Good ↑ Jun 2020	Good ➔➔ Jun 2020	Requires improvement ➔➔ Jun 2020	Good ↑ Jun 2020	Requires improvement ➔➔ Jun 2020

We have a clear commitment to quality that is described in figure 2.2 and which supports a culture of teamwork driving continuous improvement in everything we do.

Figure 2.2: Our quality commitment



Historically we have not met emergency care or elective waiting times targets, but had made significant improvements before the Covid-19 pandemic. Elective waiting times improved from 80% to 87% against the 90% target from April 2019 to February 2020, while a pilot project involving medical consultant input in the emergency department (SMART - senior medics assessment, review and treatment) helped to move the trust from 112th out of 134 reporting providers that had a type 1 facility in January 2019 to 42nd of 118 reporting providers in December 2019. Like all trusts our elective waiting times and our elective capacity have been affected by the need to prioritise the treatment of Covid-19 positive

patients, and we will need to recover the ground lost as a key priority over the next two years.

2.3. Challenges

We identified a number of challenges for the trust that also need to be considered in relation to the clinical strategy:

- increasing demand: acute activity, particularly unplanned activity, is growing year on year at a rate that exceeds the capacity we have available. This has led to increased bed occupancy and reduced operational performance, and the capacity shortfall will worsen until we increase bed numbers as part of the redevelopment. We need to mitigate this growth by working with partners to help keep people well and supported in their own homes

- Covid-19 backlog: a shortfall of theatre capacity pre Covid had led to backlogs in some specialties and a reliance on outsourcing some work to the private sector. In common with other providers across the country we now have a significant backlog in elective patients including high numbers of people waiting 52 weeks. We need to improve theatre utilisation and increase theatre capacity to address the backlog

- physical infrastructure: 57% of the trust estate – and 80% of the WGH estate - is below Condition B, which is considered to be the minimum acceptable condition. We are currently developing the outline business case for our redevelopment and the clinical brief for how we will deliver services within the new and redeveloped hospital buildings

- electronic patient record: the trust does not currently have an electronic patient record, meaning that records are paper based. This leads to significant inefficiencies in the delivery of care and prevents us from integrating our records with those of other providers such as primary care, meaning we have less information available when treating patients which can lead to sub optimal patient experience. We have approved a full business case to invest in an electronic patient record before we redevelop the three hospitals

- workforce: we have made great progress in supporting and developing our workforce, as shown by significant reductions in nursing vacancy rates and improved scores in our staff survey. However, in common with the rest of the country we are experiencing recruitment challenges in areas where demand is growing such as radiography and radiology, and we have lower numbers of training doctors than some of our near neighbours in London which affects our longer term ability to recruit consultants. Covid-19 has also had an impact on our staff, both from a direct health and wellbeing perspective and how we are able to engage them across a range of key trust priorities

- patient and stakeholder engagement: we are working hard to build two-way relationships with our patients, the local community and wider stakeholders,

particularly as we embark on significant change. We have a vision for increased co-production with service users and have set up a co-production board and a redevelopment stakeholder reference group. We have engaged extensively in the virtual world, particularly as Covid-19 has affected our ability to engage in face-to-face environments

- funding: the NHS remains subject to significant funding pressures and WHHT has historically had a large deficit. Over the past three years, we have achieved over £40m of recurrent savings whilst meeting increased demand and improving quality and safety. In 2019/20, although we met financial targets set for us, our underlying deficit was £50m. Changes in the financial regime as a result of Covid-19 have increased our support funding from NHS Improvement to enable us to achieve a breakeven position. However, cost pressures are likely to outstrip NHS funding and we need to continue to deliver savings. Historically increases in funding have been at least 1% lower than general inflation. In addition NHS specific inflation and unfunded new service demands have necessitated an additional 3% per annum to maintain financial balance. If savings are made recurrently at 4% for the 2021/22 and 2022/23 years the need for further savings at this level should fall. However the new hospital redevelopment will change the need for savings to finance the charges applicable to the capital investment

- administration and management processes: as well as the lack of an electronic patient record, we have complex administration and management processes that reduce efficiency and impact on patient experience, such as multiple different places from which outpatient appointments are booked. We need to redesign our business processes as we change our digital and physical infrastructure

- utilisation: we do not optimise our utilisation of the space we have available, particularly in outpatients and theatres. We need to increase both the throughput through these spaces during existing hours and the number of hours when services are delivered.

2.4. Impact of Covid-19

The West Hertfordshire experience of the Covid-19 pandemic has been, and remains, similar to that of London. In wave one we saw very high patient numbers at an early stage of the outbreak, with numbers peaking at over 250 in the hospital during April 2020 and more than 350 during the second wave in January and February 2021. This was very challenging and often traumatic for staff to manage. The hospital estate is not well designed to deal with the challenges of separate patient pathways that need to be managed during an epidemic, and as we look to the new and redeveloped hospitals we will be considering how we take our learning from Covid-19 to influence the design. The need to focus on these patients has inevitably impacted on waiting times and access for our planned care patients, as referenced in section 2.3.

However, we saw significant innovation and leadership from our clinicians as part of our response to the circumstances we faced, including much closer and very effective working with our partners in community and social care, as well as delivering more care virtually

where it could be done safely. We were a national leader in developing a Covid virtual hospital which enabled us to safely manage the care of people in their own homes, avoiding hospital admissions. This model has now been adopted nationally and more detail is given on page 32. This strategy will build on this experience to continue to innovate, to improve the integration of our services with partners, delivering more joined up care for patients; and maximise the use of new digital technologies to support delivery of care at home, reducing the need for local residents to attend hospital or be admitted for inpatient care.

2.5. The NHS Long Term Plan

The NHS Long Term Plan was published in January 2019 and sets out the overall NHS strategy to improve health and health outcomes. The plan describes how the NHS will be:

- more joined-up and coordinated in its care
- more proactive in the services it provides
- more differentiated in its support offer to individuals.

Demand for NHS services continues to grow. Some causes are either desirable or unavoidable:

- **our growing and ageing population**, inevitably increasing the number of people needing NHS care and the intensity of support they require
- growing visibility and concern about areas of longstanding **unmet health need**, for example in young people's mental health services
- **expanding frontiers of medical science and innovation**, introducing new treatment possibilities that a modern health service should rightly be providing, for example, new cell and gene therapies.

But some demand drivers are potentially modifiable by:

- action so that people get the right care at the right time in the **optimal care setting**, for example, providing better support to people living in care homes to avoid emergency hospital admissions; providing better social care and community support to slow the development of older people's frailty; and fundamentally redesigning outpatient services so that both patients' time and specialists' expertise are used more appropriately
- improving **upstream prevention** of avoidable illness and its exacerbations. So for example, smoking cessation, diabetes prevention through obesity reduction, and reduced respiratory hospitalisations from lower air pollution. This can also be achieved through better support for patients, carers and volunteers to enhance 'supported self-management' particularly of long-term health conditions.

The Long Term Plan describes five key changes to the NHS care model.

1. We will **boost 'out-of-hospital' care**, and finally dissolve the historic divide between primary and community health services.

2. The NHS will **redesign and reduce pressure on emergency hospital services.**
3. People will get more control over their own health, and **more personalised care** when they need it.
4. **Digitally-enabled primary and outpatient care** will go mainstream across the NHS.
5. Local NHS organisations will increasingly **focus on population health** and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere.

This strategy document will describe how WHHT will achieve the ambitions set out in the Long Term Plan.

2.6. Hertfordshire and West Essex integrated care system

We are part of the Hertfordshire and West Essex integrated care system (ICS), which includes the following organisations:

- NHS commissioners: Herts Valleys CCG, East & North Herts CCG and West Essex CCG. The CCGs have a single management team and plan to merge by April 2022
- acute providers: East & North Herts NHS Trust and Princess Alexandra Hospital NHS Trust
- community and mental health providers: Central London Community Healthcare NHS Trust; Hertfordshire Community NHS Trust; Hertfordshire Partnerships NHS Foundation Trust; Essex Partnership University NHS Foundation Trust
- local authorities: Hertfordshire County Council and Essex County Council.

The ICS is working together in partnership to improve the health and wellbeing of the population of Hertfordshire and West Essex. Our approach is based on the principles of population health management, which is a way of targeting our collective resources where they will have the greatest impact, improving the quality of care through improved, affordable services. Our key priorities are to:

- meet people's health and social care needs in a joined-up way in their local neighbourhoods, whenever that's in their best interests - saving time and cutting out unnecessary tests and appointments. Health and care services will support people to live as independently as possible for as long as possible
- adopt a shared approach to treating people when they are ill and prioritising those with the highest levels of need, reducing the variations in care which currently exist
- place equal value and emphasis on people's mental and physical health and wellbeing in all we do
- drive the cultural and behavioural change necessary to achieve the improvements we need. Care professionals, service users, families and carers will understand the role they have to play in creating a healthier future

- ensure that we have the workforce, technology, contracting and payment mechanisms in place to support our strategy, delivering health and care support efficiently, effectively and across organisational boundaries.

The ICS has developed an integrated health and social care strategy, *A Healthier Future*, which all organisations have committed to delivering. The strategy can be found at https://www.healthierfuture.org.uk/sites/default/files/publications/2019/April/nm-summary-version-draft-hwe-integrated-strategy-executive-slide-deck-v71.pdf

2.7. South and West Herts health and care partnership

To deliver the ICS strategy we have agreed to form an integrated health and care partnership (HCP) with the other NHS and local government organisations that commission or deliver care for the population of west Hertfordshire. These partners are Herts Valleys CCG, Central London Community Healthcare NHS Trust; Hertfordshire Community NHS Trust, Hertfordshire Partnerships NHS Foundation Trust and Hertfordshire County Council.

The vision for the HCP is:

'All partners working effectively together to reduce health inequalities and improve the health and wellbeing of people in Hertfordshire.

This means that:

- *local people are supported to stay well and live healthy lives in their communities*
- *people who need care and support will have the same opportunities for a good life as people who do not*
- *people and carers of all ages are empowered to take an active part in directing their own care and support*
- *people will receive their care and treatment in the right place, from the right people at the right time*
- *people will experience high quality, joined up services*
- *people will receive care in a financially sustainable system.'*

Hospitals are, in the main, responsible for meeting the health needs of people who are ill and need specialist care and treatment. Payment has historically been on a case-by-case basis, but in an HCP model we will share responsibility with partners for preventing ill health, enabling earlier diagnosis and treatment and ensuring care is joined-up. The way we are funded is changing to reflect this, with a move towards 'fixed' or 'population' budgets.

2.8. Population health management

A 'population health' approach is a short-hand term to describe the aspiration of improving the overall health and wellbeing of a defined population – whether that's the whole population of a geographical area, such as Hertfordshire and west Essex, or a particular group of that population, such as children or frail elderly people.

The aims of population health are to:

- improve mental and physical health
- improve people's experiences of services
- reduce health inequalities - improving the health of those with the worst health, so that their health and wellbeing is more comparable with our healthiest residents
- lower costs
- improve the health and wellbeing of staff.

Population health management is an approach which enables us to target our collective resources where evidence shows there is the biggest problem and where we can have the greatest impact. Health and care partners in Hertfordshire and West Essex (HWE) have agreed to deliver joined-up services to defined groups of the population. In this way, we will prevent, reduce, or delay need before it escalates; and prevent people with complex needs from reaching crisis points.

The trust fully supports the aims of the HCP and delivery of a population health management approach and expects to play a key role in its development. We are committed to working in different ways to meet the needs of our population; working to improve health and reduce health inequalities as well as meeting the acute health care needs of our patients.

2.9. Royal Free London clinical partnership

Complementing our local HCP relationships, we also have a clinical partnership with the RFL group, which includes work on the clinical practice group (CPG) programme. This brings clinicians together to design and systematically implement best practice 'care pathways' for common clinical conditions, continuously testing and improving design and reducing variation in care using in-depth monitoring and analysis.

Our work with RFL on the CPG programme to reduce variation in care is a core element of our clinical strategy reflecting our commitment to deliver **consistent** high quality care for all our patients.

2.10. Digital transformation

We are also working with RFL on a joint electronic patient record programme with an ambitious programme to roll out a full electronic patient record within the next two years. This is one part of our broader 'digital strategy' which sets out in detail how we plan to improve our IT infrastructure and develop our digital capability to support care delivery.

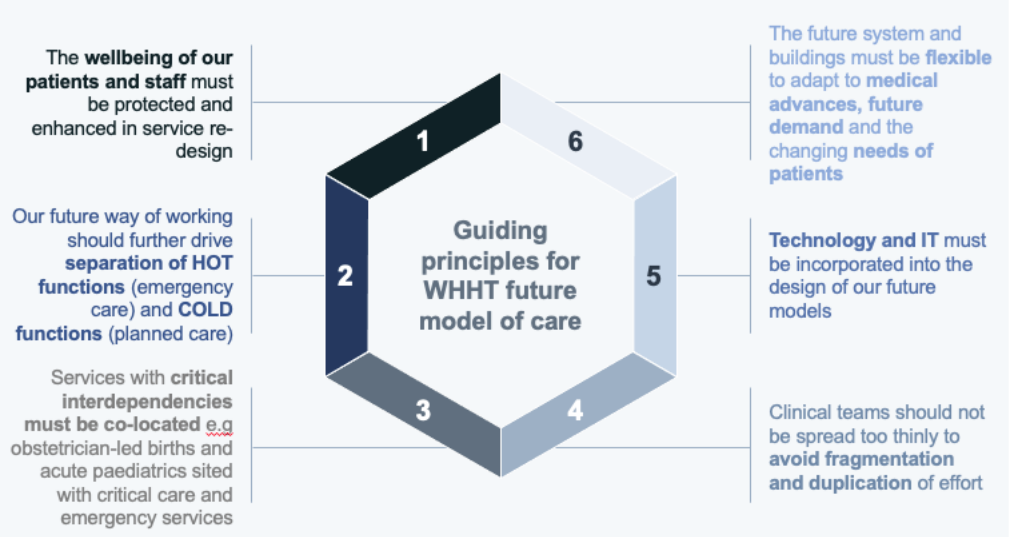
Our digital vision is that digital underpins every aspect of clinical innovation. We will provide the core digital foundation to empower the population of West Hertfordshire, support our staff to provide high-quality, safe, consistent and efficient care for every patient, every day. The digital strategy has five core themes, as shown in figure 2.3.

Figure 2.3: Core themes underpinning our digital strategy

2.11. Redeveloping our hospitals

Our current physical environment is not fit for the delivery of 21st century medicine, and our service configuration across our three sites is not optimal. We have been identified as one of the first group of trusts to receive capital funding through the Health Infrastructure Plan, and in parallel with this clinical strategy are working on the clinical brief and site strategy for the redevelopment. We have agreed six strategic underpinning principles for the clinical model which also underpin this strategy.

Figure 2.4: Strategic principles for the clinical model for the redevelopment



This strategy focuses on what we want to achieve clinically rather than on the location we expect to deliver it from, and the first five years of the strategy will be delivered in our existing estate ahead of the planned redevelopment. The strategy therefore links to and informs the redevelopment, but is independent of it.

We have developed a 'clinical brief' for our redevelopment – this sets out what services we plan to deliver from each of our three hospitals and informs the detailed design work undertaken by our architect-led design team. We will publish our clinical brief as a separate

document that complements this clinical strategy. The clinical brief is a 'live' document which will continue to develop over the next five years.

It is not possible to specify now exactly how services will be delivered in 5, 10 or 20 years' time so we plan to design our new and redeveloped hospitals to be as flexible as possible and adapt as services change and develop over time.

We have engaged with stakeholders over the draft clinical strategy and the clinical brief during the period February to July 2021 and have reflected the feedback from that engagement in this final strategy document.

We plan to continue to engage widely with stakeholders over the coming months and years and will adapt our clinical brief to reflect the latest thinking as our planning work progresses.

Specifically the brief will be reviewed at full business case (FBC) stage, before we finalise designs for new facilities.

3. Our strategic ambitions

The Trust Strategy 2020-2025 summarised the organisation's four key aims of Best Care, Best Value, Great Team and Great Place and associated ambitions for the next five years. This clinical strategy sets out how we will achieve our ambition of Best Care.

3.1. Clinical strategy framework

We have established a framework setting out the core elements of the clinical transformation that we need to achieve in order to deliver against the commitments in the NHS Long Term Plan and to ensure that our services are fit for purpose before we move into our new and redeveloped hospital buildings.

Figure 3.1: clinical strategy framework

To achieve our ambition of best care, we first need to be clear about what services we are best placed to provide and where we can achieve better patient experience or outcomes if care is delivered by other organisations or in alternative settings.

Secondly, we need to work with partners to develop our care model so that our services are better integrated, more personalised to the individual patient and their goals, and more consistent with less clinically unwarranted variation in care.

We then need to be clear how we ensure that we have the right people and infrastructure to enable us to be successful, as described through our enabling strategies.

The framework above summarises our approach and our ambition to provide consistently high quality services with areas of excellence, in line with our vision to provide 'the very best

care for every patient every day'. It will also support us to deliver against the new model of care set out in the NHS Long Term Plan.

1. **Boost 'out-of-hospital' care** – while this is primarily about primary and community services, our focus on integrated care will support delivery of care outside of hospital

2. **Reduce pressure on emergency hospital services** through a focus on emergency care pathway redesign and on more proactive integrated care for people with more complex and / or multiple health conditions or in the last two years of life

3. **More personalised care** and more active involvement of our patients in their own care through shared decision making and jointly agreed care plans

4. **Digitally-enabled outpatient care** supporting our focus on consistent care and improving access to our services.

5. **Population health** through our focus on integrated and personalised care and our joint work with partners in the HCP.

3.2. Our ambitions

We are setting clear ambitions for how we will improve our services. To deliver the very best care for every patient, every day we will:

- continue to provide the very best care to our local population by delivering outstanding services in a secondary care setting, with areas of excellence that provide a range of more specialist services to a wider population

- continue in our aim to deliver care close to home where possible, and in the lowest intensity setting that is clinically appropriate

- integrate pathways across primary, community and acute services to improve patient experience and get the best possible outcomes for our population

- be active leaders in our integrated care partnership, reaching outside of our traditional boundaries to help improve the health and wellbeing of our population and to keep people healthy

- personalise the care we deliver through shared decision making, taking account of the goals of the individual and providing appropriate information and support to enable people to manage their own care more effectively and take informed decisions about the care they receive

- standardise the way we deliver care to get consistent outcomes and timely and efficient pathways, using data effectively within a quality improvement culture and reducing unwarranted variation

- provide more 'one stop' and multidisciplinary clinics that enable rapid diagnosis and treatment, reducing the number of times that people have to travel to our hospitals

- encourage innovation and research, and will harness new technologies to enable us to continually improve the services that we offer.

To enable the delivery of our strategy, we will:

- support all our staff to develop a culture of compassionate leadership, providing the necessary mentorship and coaching
- support high quality education to all clinical learners in the trust including the support and development of new clinical roles, and providing training and development to all staff to meet the changing ways in which care is delivered
- use digital technology to enable effective and efficient service delivery that values the time of our patients and staff
- redesign our business processes to improve patient and staff experience and support the delivery of best care.

More detail on this enabling work is set out in our our digital strategy (2020) and people strategy (2019) which includes education,training and organisational development, the latter of which serves as the thread through which we will sustain and support our staff through the transformation of our services.

3.3. Our ambition for best care

We will continue to provide the very best care to our local population by delivering outstanding services in a secondary care setting, with areas of excellence that provide a range of more specialist services to a wider population

We will continue in our aim to deliver care close to home where possible, and in the lowest intensity setting that is clinically appropriate

Our first priority is to provide consistent, high quality local acute services to our population. This means that when people need planned care we will see, diagnose and treat them as quickly as possible, and that when people need urgent or emergency care they will have rapid access to someone who can make an early decision about what treatment they need and ensure effective treatment is initiated as quickly as possible to optimise outcomes and reduce time spent in hospital. We also want to make the most of our strengths by identifying a subset of our services that go beyond the normal scope of services within a local hospital to create areas of excellence that offer a wider range of services to our population, reducing the need for local people to travel into London and helping us to attract and retain more specialist clinicians.

An early ambition to support this goal is to achieve teaching trust status during 2021.

3.3.1 Improving emergency care

Part of our core services and function for the local community is to provide care to people who require emergency treatment, accessed via the emergency department (ED). In 2019/20 approximately 105,000 people attended the WGH ED department, with a further

54,700 accessing urgent care via the urgent treatment centre (UTC) at HHH or the minor injuries unit (MIU) at SACH. Of these, 48,000 people were admitted to the hospital for further same day or in patient care. This is an increase of 13% attendances and 15% admissions over the last three years.

The emergency care we provide is good, particularly for trauma patients where we see high volumes for a non-specialist centre. However as the number of people attending the hospital has increased, it has become harder to treat them within the national four hour target and our performance has consistently been below the national average, although we had seen some improvement before the Covid-19 pandemic began in 2020.

We have taken a number of steps to address this:

- opened an urgent treatment centre at WGH to manage people who do not require emergency treatment, freeing up our specialist ED consultants to focus on the most sick patients
- piloted a new model during the winter of 2019/20 (SMART) that put consultant respiratory physicians and cardiologists into the ED to provide early specialist input and assessment for people requiring admission to hospital. This both enabled some people to avoid admission and, by putting a care plan in place earlier in their stay, reduced the length of stay of people who were admitted
- increased the amount of same day emergency care that we are providing through an expanded emergency assessment unit (EAU) so that those people who are able to be discharged on the day of their admission access the care they need to enable them to go home without an overnight stay
- introduced a paediatric assessment unit (PAU) which reduces the number of children who need to be admitted to the children's ward for an inpatient stay
- during the Covid-19 pandemic, we introduced a Covid respiratory virtual hospital that allowed us to safely monitor and care for people in their own homes instead of admitting them to hospital
- during Covid-19 we also worked closely with partners to improve our discharge pathways out of hospital, which led to a reduction in the average length of stay.

West Herts Covid Virtual Hospital

In response to the Covid-19 pandemic we quickly developed and mobilised an integrated Covid virtual hospital (CVH) which uses a multidisciplinary team approach including respiratory consultants, respiratory physiologists, nurses, healthcare assistants and allied health professionals to enable a specialist model allowing admission prevention, early supported discharge and identification of wider holistic needs. The service is led by WHHT.

The CVH aims to provide care for patients out of hospital with Covid-19, relieving pressures on the existing hospital services by:

- reducing unnecessary admissions for patients who can safely be managed in the virtual setting, managing the care of patients diagnosed with Covid-19 out of the hospital setting
- facilitating rapid discharges and where appropriate providing integrated care with our community partner CLCH supporting the patients with home oxygen and enhanced clinical reviews.

A web-based referral form enables easy referral from the acute hospital interface. Patients are then followed up for 14 days and provide the monitoring clinicians with pulse oximetry results supplemented with clinical narrative to facilitate home monitoring. The service is for patients who require close follow up after hospital attendance but are safe to be discharged to the virtual hospital.

The service has managed over 4,000 patients since its inception. Readmission rates were lower than for patients not treated through the virtual hospital, showing better outcomes for the virtual hospital patients as well as a better experience that enabled them to stay safely in their own homes.

To further improve our emergency and non-elective inpatient services, we will:

- implement the national 'Think 111 First' approach to manage the number of people attending the hospital who don't require immediate emergency treatment, moving to a 'phone first' model with pre-booked appointments in our UTCs
- work with HVCCG to define the future model of urgent care for the St Albans and Harpenden population in line with the requirements of the NHS long term plan
- ensure people are seen quickly within our emergency department (ED), with rapid access to specialty opinion when needed so that decisions about their future care can be made promptly. This includes both medical and surgical opinion, delivered either in person or virtually if appropriate, building on our SMART and virtual SMART pilots
- further expand our emergency assessment unit capacity to bring together an integrated model for same day emergency care across all specialties and provide a permanent base for our frailty service, maximising the delivery of same day emergency care and avoiding inpatient admissions where possible

- develop and expand our virtual hospital model as our best practice standard, including other conditions and specialties that are clinically appropriate to avoid unnecessary admissions and keep people safe within their own homes
- review emergency surgical pathways and ensure we have enough ring-fenced emergency theatre capacity so that patients can receive timely care in accordance with agreed standards
- adopt a 'getting it right first time' (GIRFT) approach, to get the right patient to the right place for the care they need first time, reducing the number of times that a patient has to move within the hospital
- implement seven day working wherever it is clinically and financially sustainable
- continue to work with system partners to improve discharge pathways out of the hospital.

3.3.2 Improving planned care

We always strive to deliver high quality services, and we benchmark our outcomes against other hospitals and actively participate in the national GIRFT programme to support our approach to continuous improvement.

For most of our services we are justifiably proud of the care we provide to our patients, many of which are described further in section 3.3.3. However, we do have a number of challenges that we need to address:

- our waiting times for treatment are longer than the national standard of 18 weeks in some specialties
- the two week wait for cancer referrals is met consistently but we do not consistently achieve the 85% target 62 day wait for commencement of treatment, and have a small number of breaches of the 104 day maximum
- our processes for communicating with our patients are old fashioned, which often leads to a poor experience of our services, even when the care itself has been good. Poor communications is the main reason for complaints received by the trust
- some specialties employ only a small number of consultants, which makes it hard to deliver out of hours care and makes them more vulnerable to sickness or vacancies
- in some specialties or sub specialties, the level of activity being undertaken each year is lower than the evidence would suggest is required to achieve and maintain the skills required to deliver the best outcomes
- in some specialties we are reliant on care being delivered by consultants from other providers

- we have clinical pathways with a wide range of other providers, some of which are historical rather than based on the best pathway for patients or effective strategic or clinical partnerships.

To address the challenges above, we will:

- develop a more proactive understanding of needs, demand and capacity so that we can better respond to changes in demand and keep waiting times short
- increase planned surgery at SACH by improving utilisation of our theatres and providing an enhanced level of post-operative care so that patients with more complex needs can be treated at St Albans
- modernise our patient communication and booking processes, innovating to improve and constantly talking to and learning from our service users and their carers to make the patient experience as good as possible
- review the activity volumes undertaken in our smaller specialties, with the intention of improving outcomes for our population by either developing a network approach with another provider to strengthen and support our service or to stop delivering the service altogether
- review those specialties where care is delivered by third party consultants to ensure they best meet the needs of our patients, and change the delivery model where required
- review all of our existing clinical pathways to other providers to rationalise them where this is in the best interests of patients
- explore where we can further develop strategic partnerships to improve outcomes or address workforce challenges
- review the potential to work with partners to co-locate elements of cancer provision currently provided at Mount Vernon Cancer Centre onto the WGH site as part of our redevelopment plans. This is subject to the recommendations of the Mount Vernon Cancer Centre review currently underway and the outcome of a formal consultation on service change expected to be undertaken in 2021.

The recent Ockenden report into the failings in the maternity services at Shrewbury and Telford Hospitals NHS Trust requires all NHS maternity providers to immediately review and implement the seven immediate and essential actions contained within that report. We will improve our services for pregnant women by learning from and implementing the actions from the Ockenden report and the recommendations of the national strategy *Better Births,* to ensure all pregnant women and newborn babies receive the best possible care.

In all our work we will make full use of emerging digital technology with a culture that seeks and supports innovation.

3.3.3 Areas of excellence

As stated above, we are proud of the services that we provide, and we have many strengths upon which we want to build and capitalise:

- acknowledged leader for colorectal laparoscopic surgery
- nationally leading respiratory department offering a comprehensive range of respiratory services including the innovative Covid virtual hospital (CVH) and the endo-bronchial ultrasound service (EBUS) and the associated interventional fellowship and national training program
- comprehensive range of urology services with opportunity to bring some services back to SACH that are currently delivered in North London
- best practice medications safety huddles in paediatrics
- a wide range of cardiology procedures often only seen in tertiary care facilities including ICD insertion, complex device implant, on-site EP procedures, cardiac MRI and cardiac CT
- Integrated diabetes service that has significantly improved outcomes for people with diabetic foot disease
- integrated rheumatology services including shared care and rapid access for acute arthritides with two-way flow of patients from and back into the community
- nationally-leading joint advisory group (JAG) on GI endoscopy accredited gastroenterology department, with a complex diversified service and a large team of nurse-endoscopists
- large and high performing trauma unit
- excellence in medical education award for support of medical students
- extensive dermatology service.

Over time we have seen activity that has historically been undertaken in tertiary centres become more routine and able to be safely delivered locally. To build on our strengths and maximise the services that are locally available for our population, we will review where there are opportunities to repatriate activity that currently is undertaken by London (or other out of area) hospitals but which could be effectively and safely delivered on one of our trust sites.

We know that we have an ageing population, and that older people are the biggest users of our services. We will therefore expand and develop our care of the elderly service to better meet the needs of our patients, working closely with partners in the community to deliver care as close to home as possible.

3.3.4 Settings of care

Medicine has changed radically over the last 50 years and will continue to evolve as more technology becomes available. Surgeries that would previously have required several weeks' recovery in hospital can now be undertaken as day cases using keyhole surgery. Many procedures can now be undertaken safely in day case settings. These changes are more efficient for patients and staff and reduce the risk of post-surgery infections and complications.

Advances in telemedicine also enable people to be monitored in their own home, rather than needing to be in a hospital bed. The example of the Covid virtual hospital on page 30 shows how this can be better for the patient and reduce the need for hospital admissions.

As set out in section 4.3.2, we will redesign our services so that people only need to attend an acute hospital site if it is clinically necessary for them to do so, or if they are unable or do not wish to access virtual alternatives. We already deliver a high proportion of surgical procedures as day cases rather than inpatients and we will continue to shift care from inpatients to day cases and from day cases to outpatient procedures where it is safe to do so.

There are other ways in which we can improve people's experience of our services. As technology improves it becomes increasingly possible to undertake tests and provide diagnoses on the same day, reducing anxiety for patients. We also know that we have some pathways that require patients to attend more than one site on the same day, including on the day of surgery. We recognise that this is not a good experience for patients. We will always seek to innovate and to use new technologies to continuously improve the care that we can provide in the lowest intensity clinical setting available.

To deliver care as close to home as possible and to improve patient experience we will:

- provide people with a diagnosis on the day wherever clinically possible to reduce the period of uncertainty and anxiety
- increase the capacity of diagnostics available across our sites, including development of a rapid diagnosis centre at SACH
- increase the availability of multidisciplinary 'one stop' clinics
- remove same day multi-site pathways as quickly as it is clinically safe to do so.

4. Working in partnership to deliver new care models

We do not operate in isolation from other acute providers. In addition to our tertiary patient pathways to other providers, we are part of the Hertfordshire and West Essex integrated care system, which also includes East and North Hertfordshire NHS Trust (ENHT) and Princess Alexandra NHS Trust. We also have a clinical partnership with RFL, through which we are working to standardise our clinical pathways through the clinical practice group programme, and we are part of several specialist networks such as maternity and cancer. These relationships give us the opportunity to work with key partners in a more strategic way to improve patient care and address shared problems such as workforce shortages through networked approaches.

In addition, we are a key partner in the West Herts integrated care partnership (HCP), which is focused on improving health outcomes for the local population. There are many ways that we wish to work differently with our local partners going forward to improve the care that people receive from our services.

4.1. Integrated care

We will integrate pathways across primary, community and acute services to improve patient experience and get the best possible outcomes for our population

We will be active leaders in our integrated care partnership, reaching outside of our traditional boundaries to help improve the health and wellbeing of our population and to keep people healthy

When people need to use our services, their journey rarely starts and finishes at the front door of the hospital. People using elective services are normally referred by their GP or a community service, and are often followed up by the GP afterwards or between appointments. People using emergency services often attend the hospital by ambulance, and receive care from community providers or nursing homes after they are discharged. We need to remove the artificial walls between different parts of the NHS and social care so that our patients and carers experience seamless services.

The increasing number of people with long-term health conditions means that it is now vital for us to work with partners in primary, community and social care so that we understand and address the holistic needs of individuals, rather than viewing each encounter with the health service as a single, unconnected 'episode' of care. We have adopted the definition of integrated (coordinated) care set out by National Voices in 2013 following extensive engagement work:

'I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me'

Herts integrated diabetes service

The Herts integrated diabetes service (HIDS) was established in 2018 in response to a range of challenges:

- A three tier service – primary, acute and community – meant that patient flow was often disjointed with many delays, duplication, poor communication, and a large variation in care in primary care
- we were an outlier with regard to minor and major amputation, lacking a NICE compliant multidisciplinary footcare team and inpatient podiatry
- limited specialist service for complex patients
- poor mental health provision and connection (strong correlation of depression and diabetes and poorer outcomes associated)
- limited education opportunities for patients and primary care workforce.

HIDS is a partnership between WHHT, HCT and HPFT combining acute, community and mental health teams to deliver a joined-up end-to-end pathway enabling a smooth transition across services for patients, including a single point of access.

The service has led to shorter waiting times for structured education and to see diabetes consultants and podiatry. Admissions where diabetes is the primary reason for admission have reduced by two thirds, and patient satisfaction has increased from 80% to 89%. People are able to access mental health support to manage any anxiety and depression associated with their condition.

4.1.1 Integrated elective pathways

For people receiving elective care, their pathway starts with a referral from their GP practice into either the trust or a community service that subsequently refers to the trust. Care can be episodic or long term, depending on the condition.

For people requiring episodic care, we will review our pathways into the trust from primary care as set out in section 4.3.2 below, so that people are able to access specialist opinion when they need it. We will also work with the community providers to identify where pathways cause unnecessary delays to treatment and change them so that they are patient rather than organisationally-focused.

The greatest opportunity to integrate elective pathways is for people with long term conditions who are in ongoing contact with our services as well as with their GP and often with community, mental health and/or social care services too. Care is often fragmented, with insufficient sharing of information between organisations and a lack of co-ordination between specialist clinicians dealing with different aspects of a person's health conditions such as diabetes and cardiovascular disease.

We already have examples of great practice such as the integrated diabetes service, and we will build on our existing integrated care models to develop fully integrated models across a wider range of specialties, based on where the benefit to patients is the greatest.

More widely, international evidence points to ways in which care for higher risk people can be better joined up. An example is ChenMed, a primary care service based in the south east of the United States which focuses on people over 65 who are in receipt of Medicare (state

health funding). Primary care physicians are responsible for 400-500 people who are seen proactively on a regular basis (approximately monthly) in a multidisciplinary clinic setting. This means that there are specialists on hand to review patients when needed and to enable multidisciplinary conversations about and with patients to ensure optimum care. Observation trolleys are available if people are unwell, which often allows issues to be identified and addressed without the need for an ED attendance or hospital admission. People are educated in their disease so that they know which symptoms are a cause for concern, and know who to contact if symptoms occur. This enables issues to be managed early.

Evidence shows that the four elements that characterise good practice are:

- self-empowerment and education
- multidisciplinary teams (MDTs)
- care coordination
- individualised care plans.

We will work with our partners in the HCP to implement integrated care models that reflect good practice and are targeted to the needs of our population.

4.1.2 Integrated urgent and emergency care pathways

As with elective care, some people require urgent and emergency care following an unexpected one-off incident, while others require care as a result of an exacerbation of an ongoing health condition. For all patients, we will seek to integrate the pathway through common changes:

- integrate our new electronic patient record with primary, community, mental health and ambulance records so that information relating to the person's health is available to clinicians in all settings to support their decision making. This includes supporting the ambulance crew to decide whether or not a patient should be conveyed to hospital
- integrate social care, community and mental health support into the emergency department model
- on admission, develop and communicate with the patient and their family a clear plan for their discharge and any onward care they may require
- where applicable, ensure that patients are not assessed for future care needs within the hospital, and that they are discharged to be assessed within their own environment where a better understanding of their needs can be obtained and more appropriate care provided
- improve our communication with the patient and their GP on discharge, to ensure that any additional support required in the community is put into place, and we will

follow this up with a compassionate conversation within 24 hours of discharge to address any questions or issues that the person may have.

For those patients whose care needs result from an ongoing health condition, we will build on the pro-active model of integrated care described above which aims to identify people earlier so that they don't become as unwell. Our first priority population group is people with frailty, who are normally but not always over 65. Working with partners we will fully implement the ICS-agreed model of care for frailty, which will reduce admissions for this group and reduce length of stay through the use of rapid response services in the community.

4.1.3 Last phase of life

End of life care in the UK is ranked among the best in the world, but too many people still die in a place that is not of their choosing. A national survey of bereaved people by VOICES in 2014 identified that while 82% of people wanted to die in their own home, only 22% actually did so and 47% died in hospital. We want to shift the focus from considering end of life as the last few days or weeks to looking at the last one to two years of a person's life (last phase of life). The use of data to identify people in this phase, coupled with open and honest conversations about how their needs can be met, can improve their quality of life and reduce inappropriate admissions to hospital.

As part of our work with the West Herts HCP, we will use data and risk stratification to enable us to identify people in their last phase of life, and use an integrated care planning approach to discuss and agree with them how their needs will be met and what their goals are. This would include a shift away from more interventional medicine that adds limited value to the patient towards a more palliative approach that supports improved quality of life.

4.1.4 Improving health and addressing inequalities

Historically our focus has been within our hospitals, delivering care to the patient in front of us when they become unwell. However we now want to look wider than our traditional borders. Given that most of our patients live in west Hertfordshire, our ambition is to take a leading role within the South and West Hertfordshire health and care partnership (HCP), widening our responsibilities beyond the delivery of acute services to work with our HCP partners and the community to improve the health and health outcomes of our population. We want to move away from the current reactive system of care to a more proactive model that enables people to stay healthy by making changes to their lifestyle and taking an increased role in managing their own health.

The recent and ongoing Covid-19 pandemic has made everyone more aware of the inequalities that exist within our communities and the differential outcomes that people experience, whether this is due to deprivation, ethnicity, age or other issues. We will seek to understand these issues and adapt our services to reduce these inequalities, working in co-production with our local community to understand their needs and appropriately personalise care. Through our HCP we will also work with the community and a wider range of partners than we have traditionally worked with to address some of the causes of inequalities, and empower people to improve their own health and wellbeing.

4.2. Personalised care

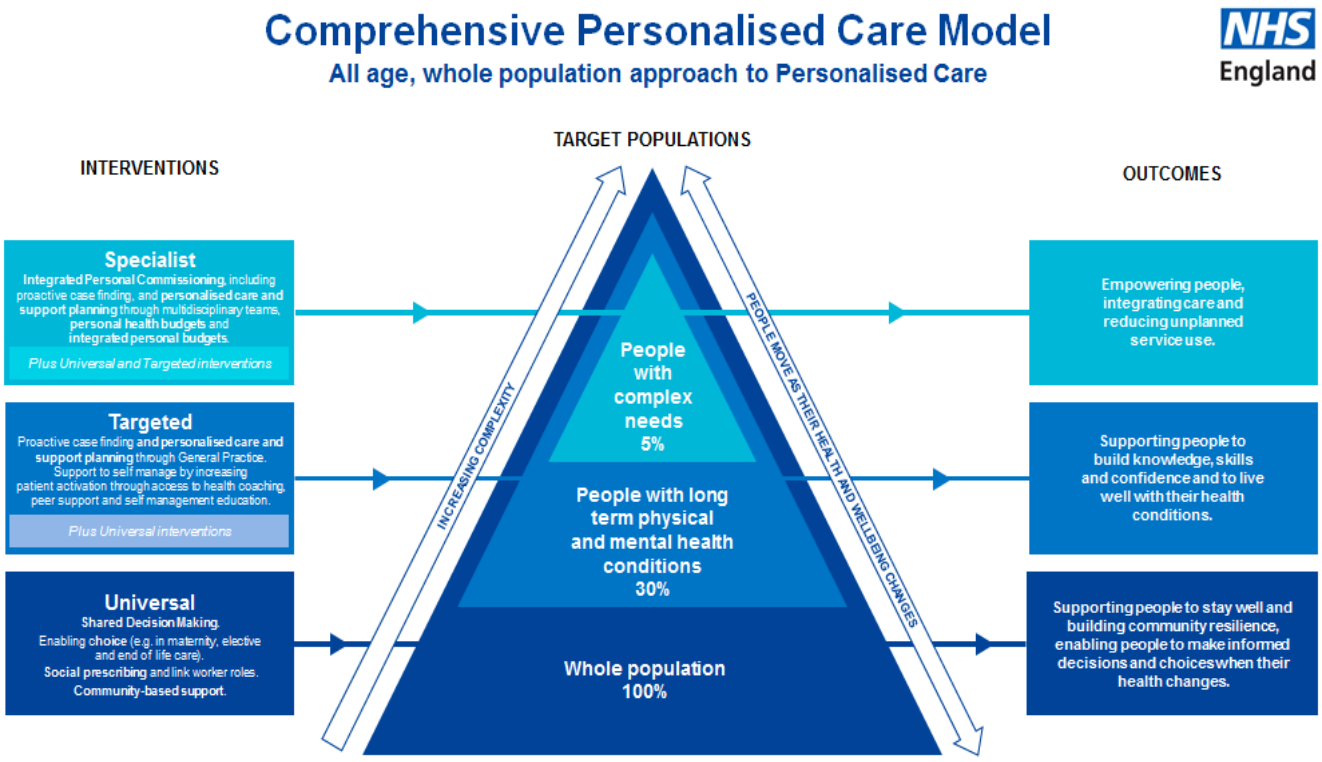
We will personalise the care we deliver through shared decision making, taking account of the goals of the individual and providing appropriate information and support to enable people to manage their own care more effectively and take informed decisions about the care they receive

Personalised care is one of the five major service model changes in the NHS Long Term Plan. Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths, needs and preferences. It involves supporting people to talk about the outcomes that matter most to them; encouraging and enabling them to take on as much responsibility as they are able to manage their own care, health and wellbeing; and acknowledging them all as experts in their own care and lives. This shift represents a new relationship between people, professionals and the health and care system and provides a positive change in power and decision making that enables people to feel informed, have a voice and be heard. Working with our partners in the HCP, we will increasingly personalise the care that our patients receive.

Figure 4.1 below shows the NHS England comprehensive personalised care model. It differentiates the type of intervention needed for different populations with differing health needs. These are:

- universal – for the whole population
- targeted – for the 30% of people with long term conditions
- specialist – for the 5% of people with the most complex needs.

Figure 4.1: NHSE comprehensive personalised care model



4.2.1 Universal personalised care

The direction of travel over recent years has been to ensure that people are given sufficient information to enable them to make informed decisions about the treatment that they receive, and while the experience of this is variable there are many examples of excellent shared decision making within the trust, with patients fully enabled to participate and to ensure that their goals and needs are taken into account in the way care is delivered. We now need to embed this consistently across the trust.

As described in section 4.1.4, we want to increasingly support people to stay healthy and manage their own health and wellbeing. This means that we need to consider how we can use the many thousands of contacts between our staff and our patients to 'make every contact count', engaging in wider conversations about the choices that people are making to increase their understanding of how to improve their health and wellbeing.

We know that people who have had an unplanned inpatient stay with us often have questions after they have been discharged about their health and what they should be doing. We have introduced 'compassionate conversations', where patients receive a phone call within 24 hours of their discharge to see how they are managing.

Compassionate conversations

In June 2019 a compassionate conversation post-discharge was introduced, delivered by ward managers, the nurse in charge or a designated registered nurse. This contact with patients was designed to be day one following discharge. The goals were to:

- ensure that people have arrived safely home and are happy with their medication, management plan, and know who to contact for further advice if required
- enable early identification of any new symptoms
- reduce readmissions
- show compassion and closure for patients.

An advisory script enables a focused conversation that facilitates the sharing of meaningful information without being drawn into a full review of care that was provided.

In February 2020 the trust reported that within a three month period, 3559 additional patient calls had been made. The majority of patients contacted praised the care they had received and were grateful for the phone call.

Feedback from the calls is discussed with wards, patient forums, the patient experience team and the new co-production board involving service users and actions implemented to improve our services in response to any areas of concern.

We will also improve the information that we provide to patients to help them to understand their treatment options and support informed consent. The report of the independent inquiry into the malpractice of Ian Paterson, a breast surgeon who carried out unnecessary invasive surgery on hundreds of women unchallenged by his colleagues or employer, was published in February 2020. We will learn from the report and its recommendations to increase the understanding of patients about their condition and to build in reflection time before patients consent to procedures to enable them to consider and raise any questions or concerns that they may have.

As part of our approach to personalised care, we will give consideration to how inequalities impact on individual patients, and tailor our approach appropriately. This could include how we support reasonable adjustments for people with additional needs such as learning disabilities, how we support carers, or how we adjust pathways to take account of known variations in outcomes for particular population groups.

4.2.2 Targeted personalised care

30% of the population have long term conditions, and targeted personalised care, through proactive case finding and the agreement of individual care plans, can help people to build the knowledge, skills and confidence to manage their condition effectively. While much of this care planning will take place in or be led by general practice, many of these people will also be in regular contact with at least one specialist as a result of their condition. As described in section 4.1.1, we will integrate our pathways for long term conditions with primary care, community and mental health settings to ensure that patients only have one care plan across all their providers and that it is jointly developed and shared, with everyone working together.

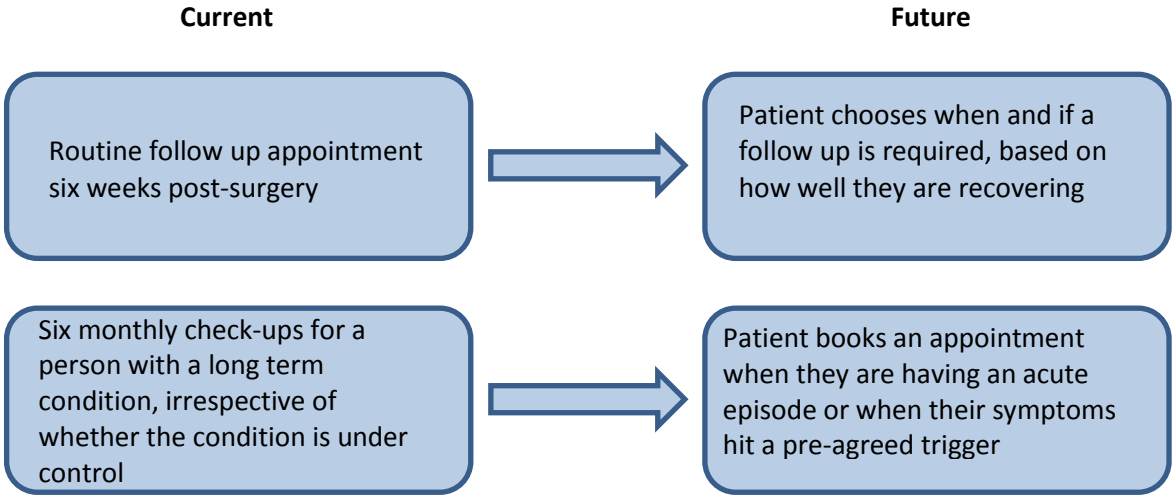
4.2.3 Specialist personalised care

For the 5% of people with the most complex needs, the targeted personalised care approach may be enhanced by giving them the ability to manage their own personalised health budgets. While this is again primarily led by general practice, these people will be in regular contact with secondary care and we will need to adopt a fully integrated approach to ensure that they are well supported.

4.2.4 Patient initiated follow-up

There were approximately 329,000 follow up outpatient appointments across WHHT in 2019/20. Traditionally, follow up appointments are initiated by the doctor or nurse providing the appointment. Patient initiated follow-up (PIFU) describes when a patient (or their carer) can initiate follow-up appointments as and when required, e.g. when symptoms or circumstances change. Figure 4.2 shows how this could change care pathways:

Figure 4.2: how PIFU could change care pathways



We will implement patient initiated follow-ups in all areas where it is clinically appropriate, working with patients to ensure that they are confident to manage their own condition and to know when they should request an appointment. Patient choice will apply and we will continue with the current model where patients are not comfortable to move to this new approach.

4.2.5 Precision medicine

Advances in precision medicine such as genomics also mean treatment itself will become increasingly tailored to individuals, and patients will be offered more personalised therapeutic options, particularly for cancer. The NHS Long Term Plan includes some specific commitments in this area.

- *'From 2019, begin to offer all children with cancer whole genome sequencing to enable more comprehensive and precise diagnosis and access to more personalised treatments*

- *We will focus targeted investment in areas of innovation that we believe will be transformative, particularly genomics. The NHS will be the first national health care system to offer whole genome sequencing as part of routine care. As part of the NHS' contribution to the UK government's broader aims to reach five million genomic tests and analyses over the same timeframe, the new NHS Genomic Medicine Service will sequence 500,000 whole genomes by 2023/24.'*

This is a new area of medicine for WHHT. We will use our existing strategic partnerships, particularly with University College London Hospitals NHS Foundation Trust (UCLH), to ensure that our population can access and benefit from advances in precision medicine, either delivered by us or available through our cancer network.

4.3. Consistent care

We will standardise the way we deliver care to get consistent outcomes and timely and efficient pathways, using data effectively within a quality improvement culture and reducing unwarranted variation

We will provide more 'one stop' and multidisciplinary clinics that enable rapid diagnosis and treatment, reducing the number of times that people have to travel to our hospitals

We will encourage innovation and research, and will harness new technologies to enable us to continually improve the services that we offer

The best performing hospitals in the country have developed really strong safety and quality improvement cultures which support and enable all staff to reduce harm, learn from mistakes and improve care. We have started this work and have many areas of good practice and pockets of excellence. Continuing to strengthen our quality improvement culture across all our services and improving how we use data and research to improve care is an essential element in delivering our 'best care' aim over the next five years.

We actively participate in the national Getting it Right First Time (GIRFT) initiative to ensure that we are getting the best outcomes for our patients through efficient services that are delivering sufficient levels of activity to ensure the skills of clincians are maintained. We will continue to participate in GIRFT and will build the recommendations into our ongoing strategic approach to deliver consistent, high quality care.

4.3.1 Clinical practice groups

We have an established partnership with RFL and partners to drive continuous improvement in care through the clinical practice group (CPG) programme. This brings clinicians together to design and systematically implement best practice 'care pathways' for common clinical conditions, continuously testing and improving design using in-depth monitoring and analysis. The rationale for this approach is that variation in clinical practice and process leads to worse patient outcomes at higher system costs, while consistently applied best practice pathways can reduce that unwarranted variation. In 2019, we began work on eight standardised best practice pathways and over the next five years we expect to implement at least another 40. This approach will be embedded in the design of our new electronic patient record system and the operation of our new hospital facilities.

The use of CPGs combined with rigorous use of clinical audit allows the data collected to demonstrate improvements in outcomes and challenge inconsistent practice. Pathways are advisory and can always be overridden by the clinician based on their own clinical judgement given the individual circumstances of the patient, as long as the reason for the alternative approach is documented. Over time this allows improvements in outcomes as a result of alternative practices to be agreed and embedded in the pathway, driving continuous improvement. However if data demonstrates worse outcomes as a result of non-compliance with the agreed pathway then this will be challenged and addressed.

We will use this approach to develop a series of approximately 80 pathways managing the most burdensome health issues that are continuously evidenced as being the most efficient and effective way of managing that condition. This will improve efficiency and reduce costs, as well as underpin an approach of continuous improvement through the use of data to evidence best outcomes.

4.3.2 Consistent access to specialist opinion

People are referred to the trust by GPs when they have symptoms that need more specialist review and diagnosis than the GP is able to provide. Nationally approximately one third of outpatient appointments do not result in any further diagnostic test or treatment, and in most cases the appointment could have been avoided if the GP had been able to request advice and guidance from a consultant. We have already redesigned the way in which outpatient care is delivered in several of our specialties, allowing GPs to request advice and guidance from consultants to better enable them to make the right decisions about the conditions that patients present with in primary care without the need for a face to face secondary care appointment. This model allows patients to access the advice or support that they require more quickly, reducing anxiety, and saves them the need to take time off work or to travel to a hospital site for an appointment.

Dermatology advice and guidance service

Each year around 24% of the population in England and Wales seeks medical advice for a skin condition, and approximately 6% of patients presenting with a skin problem are referred for specialist advice in secondary care. Tele-dermatology was the trust's first and most well-established advice and guidance model. This uses GP-initiated photos and associated clinical information, sent directly to the dermatologist, who will then give advice on diagnosis, investigations and management options within 72 hours. On average 70% of referrals that are made using tele-dermatology appropriately avoid an outpatient appointment.

Following the introduction of tele-dermatology advice and guidance the trust carried out a survey of the clinical users of the service (mainly GPs) and the results showed that:

- 95% felt sufficiently informed about the service to explain it to patients when making a referral
- 90% were clear on what action to take when the tele-dermatology report was received
- 100% followed the guidance given
- 95% received the report within the target time
- 90% said the management plan provided would assist in managing patients with the same condition differently in the future.

We have also implemented virtual consultation models as a result of Covid-19, and have shown that across a wide range of specialties a virtual model (telephone or video) can provide a safe alternative to bringing people into a hospital. While a virtual model will not be appropriate for everyone, and for some specialties and conditions there will always be a clinical need for face to face appointments, virtual consultations can be a convenient way for patients to speak to their consultant without needing to travel to the hospital or take time off

work. They also offer an opportunity to improve the efficiency of clinical pathways, reducing the number of diagnostic tests required by improving the information available to the consultant.

At the other end of the patient journey, many of our patients go on to receive tertiary care at another provider where they require more specialist care than we provide, or require multidisciplinary team (MDT) input e.g. for some cancer pathways. The way patients experience these pathways is often disjointed, and they are often not included in the MDT conversations that determine the care they receive.

To ensure consistent access to specialist opinion, we will:

- make timely advice and guidance services available to GPs across all our specialties
- maximise the clinically effective use of virtual consultation models
- redesign elective pathways to ensure that diagnostic tests are undertaken at the right point in the pathway to facilitate diagnosis without unnecessary tests being undertaken
- make our tertiary pathways seamless, and involve patients in multidisciplinary discussions about their care where they wish to be involved.

We will continue to make face to face appointments available where people are unable or unwilling to use virtual consultations or where a face to face appointment is clinically appropriate.

4.3.3 One stop and multidisciplinary clinics

The current patient experience of care is not optimal and often involves multiple journeys to our sites and contacts with different staff in a way that is not joined up. While we have some pockets of excellent practice where people are able to attend single clinics to have tests undertaken and see a consultant for a diagnosis, too often people have to travel for a test on one or more days, and then to see a consultant in outpatients on a different day. This is both an inefficient use of patients' time and also increases anxiety as people have to wait for results. While it will not always be possible to get a diagnosis on the same day as a test for clinical reasons, we will seek to consistently implement one stop clinics that enable test and diagnosis on the same day.

Similarly, people often have multiple long term conditions and are under the care of several consultants in different specialties who do not always work together to best manage the holistic needs of the individual. We will expand our range of multidisciplinary clinics, starting with the most common overlapping conditions, so that care is more joined up.

4.3.4 Innovation, research and new technologies

We will always seek to consistently provide best practice care. This means that we will encourage and support the expansion of research across our services and the testing of innovative approaches to the delivery of care, supported by effective evaluation and use of data to ensure that we are achieving the best possible outcomes for our population. We will

also seek to use new technologies wherever possible to improve care and reduce the intensity of the setting of care, allowing people to stay in their own homes wherever safe to do so with minimal disruption to their lives. Examples of the benefits of new technology include people with long term conditions who could have their condition monitored remotely to prevent unnecessary follow up appointments, or people who might otherwise need to be admitted to hospital for observation such as those successfully managed in the Covid virtual hospital. New technologies can also address poor business processes, improving efficiency for staff by automating routine administrative or clinical tasks and improving patient communications.

As we look towards the redevelopment of our hospitals, we will seek to use and embed new technologies as an integral part of our building and new ways of working.

5. Delivering our strategy - a five year plan

5.1. Context and outcomes

The Trust Strategy 2020-2025 lays out a set of ambitions and outcome measures that incrementally demonstrate how the organisation is moving towards its vision for 2025. Breakthrough objectives for the first two years of the strategy (2020/21 and 2021/22) were set and the board monitors delivery against these objectives on a quarterly basis.

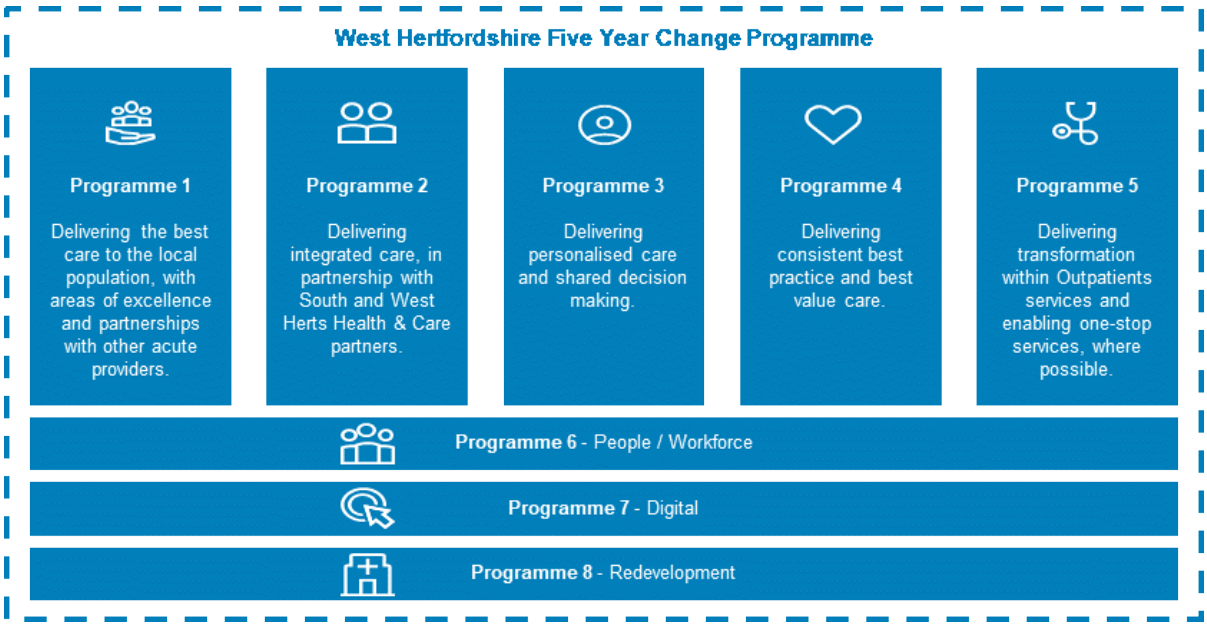
This clinical strategy supports the delivery of a number of those amibitions, particularly relating to Best Care. Following the approval of this clinical strategy we will review and update the outcomes and breakthrough objectives for the next two years of the Trust Strategy and the clinical strategy to ensure that we are able to monitor the delivery of our clinical ambitions. Once agreed, specific measures against each metric will be set, with further two year review points at April 23 and April 25.

To deliver on the full trust strategy we need to consider the clinical strategy alongside the key enablers of the other strategic ambitions – the People Strategy (Great Team); the Digital Strategy and the Redevelopment programme (Great Place) – all of which contribute with the clinical strategy to achieving Best Value. The strategy delivery plan is therefore focused on the overall delivery of all of these strategies as a single, overarching five year change programme.

5.2. Five year change programme

The West Herts Five Year Change Programme establishes eight programmes of work as laid out in figure 5.1. The first five programmes describe how we will deliver the clinical strategy.

Figure 5.1: Five year change programme



Within the five clinical programmes there will be a mixture of divisional, trustwide and systemwide projects. The trustwide and systemwide projects correspond to the intentions described in sections 3 and 4 of this strategy, and they have been prioritised to give an indicative delivery plan over the next five years although this remains subject to change, particularly for the later years.

The programmes of work map to the clinical strategy:

- Section 3 Best Care – primarily programme 1 though with some elements in the other programmes
- Section 4.1 Integrated care – programme 2
- Section 4.2 Personalised care – programme 3
- Section 4.3 Consistent care – programme 4. This also has a strong link to Best Value and the trust's financial improvement programme.

Programme 5 recognises the scale of transformation required across outpatients in terms of business processes, service transformation and digital transformation. A separate programme has therefore been created to bring together these different strands.

Senior executive and clinical responsible officers (SRO, CRO) will be appointed for each programme and will hold project managers to account for delivery of the individual projects. They will be supported to do this by the strategy delivery team and subject matter experts, who can ensure that issues are raised and resolution sought. Once we have developed and finalised outcomes, metrics, programme detail and confirmed the SRO's and support teams, we will undertake more detailed work to ensure appropriate governance across the programme.

We will set explicit success measures and identify financial and workforce implications for each project and the key actions we will undertake to deliver these. This will enable the development of a milestone plan by year which will feed into the annual corporate objectives for the trust and divisional business plans.

To deliver the strategy we will align corporate transformation resources with divisional operational resources to provide trust-wide leadership on whole trust change programmes and support for divisional teams where additional capacity is required. This support will be networked with embedded resources supporting the digital strategy and the development of the clinical and estates briefs for the new and redeveloped hospitals so that we deliver change in an integrated way, ensuring that our services are fit for purpose to move into our new and improved hospital facilities.

5.3. Delivery timescales

As referenced above, the intentions set out in sections three and four of this strategy will be delivered as projects which have been prioritised to give an indicative timescale over the next five years as shown in figure 5.2. This shows the projects in planning, development and implementation phases. The timescales will be further refined as the resources to

deliver them are identified and confirmed. Timescales will also be reviewed at the April 23 and April 25 review points.

Figure 5.2: Trustwide clinical strategy projects by year

Programme	Section ref	Project	Proposed Years				
			Year 1	Year 2	Year 3	Year 4	Year 5
Programme 1: Delivering the best care to the local population, with areas of excellence and partnerships with other acute providers.	**3.3.1**	Ensure people are seen quickly within our emergency department (ED), with rapid access to specialty opinion when needed so that decisions about their future care can be made promptly (SMART).					
	3.3.1	Further expand our emergency assessment unit capacity to bring together an integrated model to maximise same day emergency care across all specialties and provide a permanent base for our frailty service.					
	3.3.1	Adopt a 'getting it right first time' approach, to get the right patient to the right place for the care they need first time, reducing the number of times that a patient has to move within the hospital.					
	3.3.1	Implement 7 day working wherever it is clinically and financially sustainable					
	4.1.2	On admission, develop and communicate with the patient and their family a clear plan for their discharge and any onward care they may require					
	3.3.2	Review the activity volumes undertaken in our smaller specialties, with the intention of improving outcomes for our population by either developing a network approach with another provider to strengthen and support our service or to stop delivering the service altogether.					
	3.3.2	Review all of our existing clinical pathways to other providers to rationalise them where this is in the best interests of patients.					
	3.3.2	Review those specialties where care is delivered by third party consultants to ensure they best meet the needs of our patients, and change the delivery model, where required.					
	3.3.3	Review where there are opportunities to repatriate activity that currently is undertaken by London (or other out of area) hospitals but which could be effectively and safely delivered on one of our Trust sites.					
	3.3.4	Remove same day multi-site pathways as quickly as it is clinically safe to do so.					
	3.3.2	Improve our services for pregnant women by learning from and implementing the actions from the Ockenden report and the recommendations of the national strategy Better Births, to ensure all pregnant women and newborn babies receive the best possible care.					
	3.3.2	Explore where we can further develop strategic partnerships to improve outcomes or address workforce challenges.					
	3.3.2	Review the potential to work with partners to co-locate elements of cancer provision currently provided at Mount Vernon Cancer Centre onto the WGH site as part of our redevelopment plans.					
	4.2.5	Use our existing strategic partnerships to ensure that our population can access and benefit from advances in precision medicine.					
	4.3.2	Make our tertiary pathways seamless, and involve patients in multidisciplinary discussions about their care where they wish to be involved.					

Programme	Section ref	Project	Proposed Years				
			Year 1	Year 2	Year 3	Year 4	Year 5
Programme 2: Delivering integrated care, in partnership with South West Herts Health & Care partners.	3.3.1	Implement the national '111 First' approach.					
	3.3.1	Work with HVCCG to define the future model of urgent care for the St Albans and Harpenden population.					
	4.1.2	Integrate social care, community and mental health support into the emergency department model.					
	3.3.1	Develop and expand our virtual hospital model as our best practice standard.					
	4.1.1	Build on our existing integrated care models to develop fully integrated models across a wider range of specialties, based on where the benefit to patients is the greatest and reflecting best practice.					
	4.1.2	Where applicable, ensure that patients are assessed for future care needs in their home or future environment not within the hospital (Discharge to Assess).					
	4.1.2	Integrate our new electronic patient record with primary, community, mental health and ambulance records so that information relating to the person's health is available to clinicians in all settings to support their decision-making.					
	4.1.3	As part of our work with the West Herts ICP, use data and risk stratification to identify people in their last phase of life, and use an integrated care planning approach to discuss and agree their goals with them.					
	4.1.2	Working with partners fully implement the ICS-agreed model of care for frailty.					
	3.3.3	Expand and develop our care of the elderly service to better meet the needs of our patients, working closely with partners in the community to deliver care as close to home as possible.					
	4.1.1 / 4.2.2	Integrate our pathways for long term conditions with primary care, community and mental health to ensure that patients only have one care plan across all their providers and that it is jointly developed and shared.					
Programme 3: Delivering personalised care and shared decision making.	4.2.1	Give consideration to how inequalities impact on individual patients, and tailor our approach appropriately.					
	4.1.2	Improve our communication with the patient and their GP on discharge, to ensure that any additional support required in the community is put into place, followed up with a compassionate conversation within 24 hours.					
	4.2.1	Improve the information that we provide to patients to help them understand their treatment options and support shared decision making.					
	4.2.1	Increase the understanding of patients about their condition and build in reflection time before patients consent to procedures to enable them to consider and raise any questions or concerns that they may have.					

Programme	Section ref	Project	Proposed Years				
			Year 1	Year 2	Year 3	Year 4	Year 5
Programme 4: Delivering consistent best practice and best value care.	**4.3.1**	Use the clinical practice group (CPG) approach to develop a series of approximately 80 pathways managing the most burdensome health issues that are continuously evidenced as being the most efficient and effective way of managing that condition.					
	3.3.1	Review emergency surgical pathways and ensure we have enough ring-fenced emergency theatre capacity so that patients can receive timely care.					
	3.3.2	Increase planned surgery at SACH by improving utilisation of our theatres and providing an enhanced level of post-operative care so that patients with more complex needs can be treated there.					
	3.3.2	Develop a more proactive understanding of needs, demand and capacity so that we can better respond to changes in demand and keep waiting times short.					
Programme 5: Delivering transformation within Outpatients services and enabling one-stop services, where possible.	**3.3.2**	Modernise our patient communication and booking processes, innovating to improve and constantly talking to and learning from our service users and their carers to make the patient experience as good as possible.					
	3.3.4	Increase the capacity of diagnostics available across our sites, including development of a rapid diagnostics centre at SACH.					
	3.3.4	Provide people with a diagnosis on the day wherever clinically possible to reduce the period of uncertainty and anxiety.					
	4.2.4	Implement patient initiated follow-ups in all areas where it is clinically appropriate.					
	4.3.2	Make timely advice and guidance services available to GPs across all our specialties.					
	4.3.2	Maximise the clinically effective use of virtual consultation models					
	4.3.2	Redesign elective pathways to ensure that diagnostic tests are undertaken at the right point in the pathway to facilitate diagnosis without unnecessary tests being undertaken.					
	4.3.3	Consistently implement one stop clinics that enable test and diagnosis on the same day.					
	4.3.3, 3.3.4	Expand our range of multidisciplinary clinics, starting with the most common overlapping conditions, so that care is more joined up.					

Key:
Programme approach - planning phase
Programme approach - development phase
Programme approach - implementation phase

6. Divisional and service strategies

Our clinical services are delivered by five clinical divisions; each division will be responsible for implementing the ambitions and commitments within this clinical strategy. Key priorities and plans at a service level have been reviewed as part of developing this strategy to ensure we have the most accurate information and assumptions about future need, new models of care, opportunities for integration and collaboration, and potential in terms of education and research.

6.1 Emergency medicine

The emergency medicine division is responsible for the care of people requiring urgent or emergency attention and who either do not require admission or who stay in hospital for 48 hours or less. This includes the urgent treatment centres (UTC) and minor injuries unit (MIU); the emergency department (ED), the children's emergency department (CED) and clinical decision unit (CDU); the ambulatory care unit (ACU); the emergency assessment unit (EAU); and the short stay beds within the acute assessment unit (AAU). The EAU is for medical and surgical patients and from March 2021 for orthopaedic, frailty and some gynaecology patients as well.

The division has a number of partnerships with other organisations. These include Hertfordshire Partnerships Foundation NHS Trust (HPFT) which provides psychiatric liaison services within WHHT; Hertfordshire Urgent Care (HUC) which provides GP services to Hemel Hempstead UTC and the out-of-hours service; the East of England Ambulance Service; the Integrated Discharge Team and Imperial College Healthcare NHS Trust which runs the major trauma centre at St Mary's Hospital Paddington. Patients are also referred to other specialist providers depending on their needs.

The electronic patient record is a key enabler for the division, as early access to existing patient records (including primary care records) will facilitate decision making and the most appropriate management of patients. Recruitment is a key challenge, particularly to senior posts within the ED, for which a recruitment strategy has been agreed and commenced.

Integration

We will continue our joint working with HPFT and other system partners to provide specialist input and effective care pathways for people of all ages presenting with mental health needs.

The CDU will continue to allow time for relevant services and teams, such as the clinical navigators, physiotherapists and occupational therapists to work together to complete the patient pathway within ED and initiate the ongoing care needs for discharge into the community.

Effective implementation and delivery of an integrated community and acute service for frail people will be critical to avoid unnecessary attendances and admissions, including an integrated health and social care team working to avoid unnecessary admissions where care needs can be met in the community.

Personalisation

Priorities for personalisation with emergency care services include:

- improve how we care for vulnerable adults and children with additional needs including patients with mental health needs, dementia, learning disabilities or autism spectrum conditions, hearing difficulties and when English is not a first language
- deliver a robust pathway for the transition of children to adult services in conjunction with the child and their family.

Consistent care

The emergency medicine division will continue to focus on improving pathways and operational processes to ensure all patients are seen, assessed and treated in a timely way, in line with current (and future) emergency care standards and GIRFT recommendations.[1]

The division will work to implement standardised best practice pathways (as part of the joint CPG programme with RFL) for priority emergency care pathways.

6.1.1 Urgent treatment centres and the minor injuries unit

There is a UTC at WGH and HHH, and a minor injuries unit (MIU) at SACH. The provision of the UTC service at WGH is currently subcontracted to a third party with expertise in urgent care. This is a new service that went live in July 2020.

The requirements of the NHS Long Term Plan mean that the SACH MIU cannot continue under its current service specification. During 2021 we will work with HVCCG to agree the future service model for St Albans.

In line with national policy, we have implemented the NHS 'Think 111 First' programme at all sites, with patients expected to call NHS 111 before attending the UTC / ED, enabling an increasing proportion of attendances that are booked. This facilitates improved waiting times, reduces crowding and allows workforce/ demand models to be effective.

We will continue to work with the UTC provider to ensure the service at WGH is embedded to provide effective care within the UTC as well as ensuring pathways are effective from the UTC to other parts of the trust, or other services. We will also continue to work with third parties to ensure the good quality, effective service at Hemel Hempstead UTC is maintained.

[1] *emergency care access standards are expected to change during the lifetime of this strategy, once recommendations from a clinically led review of access standards are finalised following a pilot phase.*

6.1.2 Emergency department

The emergency department (ED) cares for patients of all ages with a high demographic of older adults and has an integrated children's emergency department looking after patients below the age of 16 years. The ED receives a high volume of ambulance conveyances and sees a large number of complex, high acuity patients including a significant number of major trauma patients.

The department continues to have an ethos that supports development throughout the workforce delivering high quality training to doctors in training, advanced care practitioners and nurses.

The delivery of care has changed during the Covid-19 pandemic with the need for separate patient streams and social distancing within the department. The longer term implications of this will need to be considered as part of the planning for the redevelopment.

Recognising the challenges of the current environment, an ED redevelopment project is underway as an interim measure to support the safe delivery of patient care.

Priority areas where we will improve care over the next five years are:

- deliver high quality care to patients attending the ED by working to meet current key performance indicators and new NHS access standards and GIRFT measures
- continue to work with system partners such as the North West London Trauma Network, HPFT and East of England Ambulance Service NHS Trust (EEAST) to continue to ensure high standards of care
- ensure that the ED is a centre of excellence in terms of training, for medical, nursing and allied health professionals. This will ensure continued workforce recruitment and retention and allow us to continue to build a team that meets the needs of the population
- work in partnership with specialty colleagues to develop pathways to ensure that all patients are seen by the right person at the right time including same day emergency care (SDEC)
- implement the electronic patient record and the integration of the trust IT with other providers to enable access to patient records from other health and care providers, with appropriate patient consents.

6.1.3 Acute medicine

Same day emergency care

Adult same day emergency care provides a service where patients are assessed and treated on the same day by senior clinicians. The service is provided in the ambulatory care unit and the emergency assessment unit. They can be referred from a UTC, ED or primary care.

The service will continue to work with clinical colleagues from other divisions, to develop and embed the new multi-specialty EAU model and will ensure that the model operates effectively and efficiently in an integrated way.

It will continue to strengthen links with the community rapid response team to optimise the use of community-based care.

In line with the national programme of 'Think 111 First' appointments will be booked to designated care pathways.

Acute assessment unit

The AAU is for patients who require admission for a short stay, usually less than 48 hours. Staff in this area also care for patients until a definitive specialty/ ward is identified.

The principles underpinning the AAU are that centralisation of acute medical admissions provides a focal point for early diagnosis and treatment of acutely unwell patients. Early involvement of the acute physician specialists supports clear patient pathways, prompt interventions and reduced length of stay. Patient care will follow evidence-based best practice and be protocol driven where appropriate. Engagement from the specialities at this early stage of the patient's journey will further support consistent and streamlined pathways.

The team will continue to work with partners to integrate community and social care services as a multidisciplinary team. This approach to the more complex patients will facilitate sending people home with increased confidence in the package of care in place to support them.

6.2 Medicine

West Hertfordshire offers a wide range of medical specialty care and demand has grown in response to the changing demographics of the population. People are living for longer and are also developing more long term conditions such as diabetes or COPD, often as a result of lifestyle factors such as smoking or obesity. As a result, people can often be in long term contact with several consultants across multiple specialties, as well as seeing their GP regularly and using community or mental health services. For these older people, and for those with long term conditions, care needs to be better integrated.

High quality services

The largest demand for inpatient beds comes from people who are acutely unwell and who need general medical input as well as specialist expertise. Our top priority is to ensure that people who require admission receive the best possible care, which includes early access to specialist opinion to agree a management plan and getting the person into the right bed where they can best receive the care they need. We will achieve this by delivering the SMART front door model as standard across all specialties, delivered virtually where this is clinically safe and using networked approaches with partner trusts where a larger scale is needed to achieve effective clinical rotas.

There are also many opportunities to manage these people more proactively in the community to avoid admissions. In addition to increasing same day emergency care as set

out in the emergency medicine section, we will expand the Covid respiratory virtual hospital model to manage a wider range of conditions and specialties until it becomes the standard way to manage people with escalating needs, using telemedicine to enable remote monitoring and keeping people safe in their own homes.

Advances in medicine also mean that more interventional medicine can be practiced, reducing the need for surgery. In these specialties (cardiology, gastroenterology, respiratory) we already offer a wide range of interventions on site and have joint appointments with some specialist London providers that give us access to tertiary expertise. We will further expand these services, enabling more people to receive care locally.

Our strategy to deliver consistently high quality services is therefore to:

- incorporate IMT3 (internal medical trainees) trained consultants into the medical take programme to support exceptional quality acute general medicine care as well as sub-specialty care
- integrate care for people with long term conditions, working with our HCP partners to deliver a more proactive model that identifies escalating need earlier so that more people can be managed at home or through ambulatory pathways and avoiding acute admissions where possible
- improve and integrate care for older people, enabling independent living where possible and delivering care that is most appropriate for their needs and phase of life
- repatriate complex services locally to deliver exceptional care locally
- diversify our consultant teams to include new specialities including infectious diseases and renal medicine
- look for new opportunities to integrate with oncology services and develop ‘one stop’ diagnosis and same day treatment services with positive impacts on key departments including haematology and rheumatology.

Integration

As set out above, integration will be a key theme for medicine. To better deliver care that is focused on the holistic needs of individual patients we will expand our multidisciplinary team working, focusing initially on common co-morbidities such as diabetes and cardiovascular disease. We will work with primary care to explore the opportunities to introduce models that bring together primary care with specialist expertise and voluntary sector input, focused on the needs of high risk patients and learning from best practice such as the ChenMed model (outlined on page 26). We will also review the care that the health and care system provides to people in their last phase of life, to ensure that their goals are understood and their needs met in the most effective way.

Personalisation

As set out above, we will implement a more integrated model that is better personalised to meet the needs of people with targeted or specialised interventions. Patient initiated follow-

ups will also be used effectively across the medical specialties to move away from people being regularly called back for follow up appointments when their condition is stable to a model whereby a person can book an appointment when there is an exacerbation in their condition that they need support to manage.

Consistent care

We are fully committed to the CPG approach to enable us to standardise pathways for common conditions and drive continuous improvement.

We already offer advice and guidance across several specialties and will expand this approach in line with the trust-wide strategy. We will work to redesign our outpatient care pathways to streamline care for patients, improve joint working with primary and community care colleagues and ensure we make the best use of the skills of our specialist workforce.

6.2.1 Dermatology

The dermatology department is the 15th largest dermatology provider in the UK seeing 38,000 patients per annum, 40% more than the national average. It offers a comprehensive range of services including general dermatology, 'one stop' two week wait skin cancer clinics, paediatric dermatology, path testing for contact allergy, minor surgery including day case surgery for flaps and grafts, phototherapy and photodynamic therapy. It also operates a range of joint clinics with vascular, urology and genitourinary medicine services. The dermatology department also supports emergency inpatient care with daily consultant-led ward rounds and hot clinics for urgent cases. GPs access our services through innovative tele-dermatology, advice and guidance and referral assessment services.

The GIRFT review 2019 recognised the excellent standard of care and provision, and the department has been successful in recruiting and retaining staff when dermatology recruitment nationally is difficult.

Tertiary skin care pathways are mainly to RFL and Lister Hospital. Plastic surgeons at these hospitals and oncologists from Mount Vernon Cancer Centre join our local and specialist skin cancer MDTs. We also refer small volumes of micrographic surgery to St Thomas' Hospital.

Priority areas where we will improve care over the next five years are:

- the service at WHHT is substantially larger than the other trusts within the ICS and there is an opportunity to explore an HWE ICS-wide hub and spoke model with WHHT as the hub
- explore the option of delivering more plastic surgery including Mohs micrographic surgery locally.

6.2.2 Diabetes

The trust is the lead provider for an innovative integrated diabetes model in partnership with Hertfordshire Community Trust and Hertfordshire Partnerships NHS Foundation Trust, delivering services within community settings. There are already a range of multidisciplinary

clinics through the integrated service, including psychologists, podiatrists and dieticians. This integrated model provides a potential blueprint for other integrated services.

Priority areas where we will improve care over the next five years are:

- continue to work with partners to develop the west Hertfordshire integrated diabetes service (HiDs) including strengthening an integrated primary care-led model with diabetic specialist input
- work with colleagues in other specialties to further integrate care within the trust through multidisciplinary approaches, particularly vascular surgery and obstetrics, the latter with combined antenatal clinics
- approximately one in five hospital inpatients have diabetes – we will review how we could enable the delivery of a consultant-led in-reach diabetes service across the hospital
- the latest GIRFT review identified that we are an outlier for length of stay for patients for surgery for diabetes - we will review this regularly with a view to reducing the length of stay.

6.2.3 Endocrinology

Endocrinology is primarily an outpatient-based service. There are a number of MDT networks, both with the local cancer network and with several London hospitals, the latter of which could be streamlined. The most recent GIRFT review identified many areas of excellent practice, including telephone advice and guidance to GPs, triage of all referrals, remote consultations, nurse-led clinics and best practice pathways.

A priority area where we will improve care over the next five years is to further utilise technology to enable more shifts in the way that care is delivered and to explore the potential for a networked approach with other providers to support a virtual SMART model.

6.2.4 Neurology

The neurology department provides local general neurology outpatient services for all neurological conditions, as well as daily acute neurology inpatient liaison and neurology clinics at WGH. Nerve conduction studies and electromyography are offered at HHH and WGH. The service benefits from several consultants having joint appointments with tertiary providers in London, where more complex neurological conditions are referred and managed.

Priorities for the next five years include:

- implement advice and guidance
- develop a neuroradiology MDT
- develop on-site electroencephalography (EEG)

- specialist nurses (e.g. epilepsy, multiple sclerosis (MS), Parkinson's disease (PD) to provide additional patient support and facilitate the management of stable chronic patients through specialist nurse-led services, including the use of telemedicine and admission-avoidance advice lines
- repatriate procedures such as elective lumbar punctures and Botox injections for dystonia from tertiary centres
- local delivery of MS disease-modifying therapies
- improve the inpatient journey for patients presenting acutely with neurological disorders
- work with community therapy and neuro-rehabilitation providers to improve continuity of care between secondary care and community settings.

6.2.5 Rheumatology

The rheumatology department manages a large proportion of complex diseases traditionally managed in tertiary care through a combination of local expertise combined with an award-winning regional virtual MDT conference network set up with eastern region tertiary care centres. A full range of complex immunosuppressive chemotherapies and biological therapies are administered through the support of this network and the chemotherapy unit at WGH.

The rheumatology department also runs a comprehensive osteoporosis service including DEXA scanning, bone health counselling and pharmacotherapy advice, and administers the latest innovative treatments for bone health maintenance. Unlike many general hospital rheumatology departments we are a training department with trainee specialist registrars, internal medical trainees (IMTs), core medical trainees (CMTs), senior house officers (SHOs), GP vocational training scheme (GPVTS) participants and foundation doctors (FY1s) rotating through our specialty department.

The department has developed good multidisciplinary working and has implemented new workforce roles to support care delivery. A biologic co-ordinator role has been developed in the last year to help facilitate and co-ordinate innovative and complex treatment regimes, and our current nurse-led rheumatology helpline service is being developed into a full rheumatology therapeutic and support service through the addition of GP sessions to provide more holistic healthcare advice, including pharmacist sessions for drug advice and guidance. This type of initiative will help break traditional divides between primary and secondary care services and support better integration focused on the patient.

Other examples of existing integration both internally and externally are links with internal medicine to provide seamless inpatient and outpatient care and allow for management of complex multisystem diseases; and working closely with locally commissioned community services such as the musculoskeletal (MSK) soft tissue rheumatism and pain management service (Connect).

Key strategic priorities for the service are:

- rationalise the elective service onto a single site in a centre for chronic disease management in order to improve staff cover, reduce inter-site travelling and promote service development. This would include development of an infusion and treatment centre in order to facilitate complex treatment delivery and enrolment of our patients into trials of new innovative treatments and would also act as a hub for development of patient education programmes and self-help groups for patients with chronic rheumatological diseases

- continued work with primary and community services to create a seamless rheumatology service with free two-way patient flow between community and hospital settings

- use digital technology to facilitate remote patient care through:
    - virtual patient appointments
    - virtual networks to discuss complex patients
    - virtual 'on calls' to cover rheumatology emergency care in multiple hospitals
    - virtual rheumatology therapy support services, utilising GPs with a specialist interest (GPWSI), pharmacists and nurses

- reduce follow-ups of patients with chronic inflammatory diseases such as rheumatoid arthritis through use of patient initiated follow-up or the development of stable patient follow-up services in the community

- expand the current model of elective rheumatology care from the traditional outpatient clinic to a combination of clinics, MDT conferences (face-to-face and virtual) and a 'one stop' approach to managing multisystem disease.

Most traditional tertiary care rheumatology activity is kept in-house however many patients with renal disease (especially vasculitis) are routinely transferred into London. There is an opportunity to manage this work locally with better local renal services.

Looking to the longer term, we anticipate a continued expansion of immunosuppressive treatment options for inflammatory diseases such as rheumatoid arthritis and novel treatments for diseases for which there have previously been little or no medical treatment options foreseen, e.g. disease modifying treatments that will slow the progression of osteoarthritis are likely. The expansion of the clinical trials portfolio is envisaged.

Imaging technology for rheumatological disease is likely to improve and the provision of in-house imaging such as MSK ultrasound during clinic appointments is likely to become the standard of care. The department will need to keep pace with this, developing the expertise and procuring the relevant diagnostics.

6.2.6 Care of the elderly

Care of the elderly services are seeing increasing demand as a result of the ageing population and people living longer with chronic medical conditions, as such this will be a key focus for integrating services going forward in order to reduce the number of admissions for this population and provide better care in the community. The trust has developed

several best practice services such as prompt frailty assessment in the ED to prevent unnecessary admissions, a delirium recovery pathway, and a dementia friendly ward.

However the delivery of these has been inconsistent due to bed pressures, staffing challenges and the impact of Covid-19, and re-establishing these on a permanent basis will be critical. The frailty service will be based in the newly expanded emergency assessment unit from February 2021.

Priority areas where we will improve care over the next five years are:

- work closely with partners, particularly community, social care and ambulance services, to strengthen support to care homes and the delivery of rapid response services to people in their own homes to reduce conveyances to hospital
- there is an opportunity for admission-prevention clinics which could form part of the wider ChenMed model that we want to explore
- the virtual hospital model introduced by the respiratory service could also provide a model to better support older people in the community, and the use of telemedicine and remote monitoring could help to reduce falls in high risk patients
- work with our HCP partners to develop a model of care for people in their last phase of life as set out in section 4.1.3.

6.2.7 Stroke

The stroke service includes a hyper acute stroke unit (assessment and immediate treatment) and an acute stroke unit (ongoing treatment and rehabilitation) on the WGH site. Key strengths of the service include multidisciplinary working with links to early supported discharge and neuro-rehabilitation services, and a seven day stroke therapy service.

Thrombolysis is provided 24 hours a day with established links to a tertiary thrombectomy centre at Charing Cross Hospital, though out-of-hours thrombolysis is dependent on the regional east of England telemedicine service. We also have a strong involvement in stroke research. During Covid-19 we saw surprising success with virtual follow-up appointments with positive patient feedback, indicating the opportunity for a greater use of virtual technology in the future.

The key challenges for the service are recruitment given our proximity to London, a lack of access to digital resources for patients and a lack of specialist therapy equipment. In addition, the inpatient neurology rehabilitation facility provided by CLCH has limited bed capacity.

The strategic priorities for the service are:

- use digital technology to improve how we deliver stroke rehabilitation and follow-up care
- increase the resources into early supported discharge

- improve links with the voluntary sector and improve integration between acute services and those in the community more generally, with greater in-reach and out-reach of services and ensure that after-stroke care enables people to self-manage and maximise their independence
- further develop joint consultant positions with tertiary centres
- in the longer term, develop sufficient capacity to enable in-house provision of out-of-hours thrombolysis
- improve access to specialist therapy equipment.

6.2.8 Cardiology

The cardiology service provides a full spectrum of diagnostic and interventional procedures including:

- stress echo/ bike tests and transoesophageal echocardiograms
- dedicated coronary CT
- dedicated cardiac MRI
- coronary intervention
- complex pacing (implantable defibrillator and biventricular pacemaker service)
- electrophysiology (EP) service
- specialist cardiac physiology team to support complex pacing/EP and imaging.

Six consultants are joint appointments with London tertiary centres which allows them to perform more complex procedures for West Hertfordshire patients within the tertiary settings through a hub and spoke model. This provides high quality services locally with the sharing of good practice and protocols, and a good patient pathway for both elective and emergency services. The wide range of local services means we have been able to get deanery support for five senior specialist registrar posts and encourages recruitment and retention of consultants. There is also a heart failure service provided in partnership with Central London Community Healthcare NHS Trust (CLCH).

There are however challenges with the recruitment and retention of some other staffing groups, particularly nurses for the coronary care unit (CCU) and cardiac physiologists. We need to develop a clear recruitment and retention strategy to address this.

The current physical location of the CCU does not meet the minimum requirements for a level two unit. Upgrading the unit to level two would both increase the range of patients that could be safely managed and form part of the recruitment strategy to attract nurses.

Demand for cardiology is expected to grow in line with both demographic changes and shifting settings towards cardiac CT, cardiac MRI and advanced imaging, which will drive increased demand for both increased staff and diagnostics capacity. There are opportunities

to train nurse specialists to perform a range of procedures such as Linq devices, angiography and direct current cardioversion (DCCV).

Priority areas where we will improve care over the next five years are:

- explore opportunities to expand the range of services provided at WGH, although this needs to be balanced against the capacity available to ensure there are no negative impacts on waiting times for current services
    - subcutaneous implantable cardioverter defibrillators (ICDs)
    - expand EP service – atrial fibrillation (AF) cryoablations
    - transcatheter aortic valve implantation (TAVI)
    - HIS bundle pacing
    - seven day service for non-segment elevation myocardial infarction (STEMI) heart attacks

- further work to improve integration between the hospital and the community heart failure service, working with the community heart failure (HF) team to provide day care diuresis and reduce heart failure hospital admissions. Cardiac rehabilitation would be ideally suited for closer community collaboration

- optimise the benefits of digital technology including:
    - digital notes for pacemaker patients
    - provide patients with pacemakers and implantable defibrillators with a remote monitor to allow scheduled remote follow-up and allow early detection of arrhythmias of device malfunction by a digital alert-based system, currently in excess of 5000 pacemaker checks per year
    - electronic database of cardiology investigations.

6.2.9 Gastroenterology

Gastroenterology is a cohesive and forward-thinking department that delivers an extensive range of specialist services, has a strong training and research capability and an excellent record for staff development and retention.

The unit is part of the east of England cancer network. The endoscopy unit is JAG (joint advisory group on GI endoscopy) accredited for service and national training and a regional centre for oesophago-gastro-duodenal and pancreatic endoscopic ultrasound and upper GI endoscopic mucosal resection. The department has trained and retained an exceptional number of nurse endoscopists and runs a high performing and commended bowel cancer screening service.

Outpatient services include a telephone assessment service for lower GI two week wait pathways and straight to test colonoscopy, and a range of nurse-led and virtual delivery models alongside traditional face to face outpatients. Services for inflammatory bowel disease include an inflammatory bowel disease (IBD) helpline, nurse-led services and multidisciplinary teams, and specialist inpatient ward rounds. Hepatology and hepatobiliary services have close MDT links with RFL and provide nurse-led viral hepatitis and fatty liver service, and non-invasive chronic liver diagnostics (Fibroscan) as well as providing a training position for an advanced endoscopy fellow.

The gastroenterology department has a wide range of links with other providers and tertiary centres, though few of these are formalised at present. Demand for services is expected to

grow in line with demographic trends and the expansion of the national bowel cancer screening initiative.

Capsule endoscopy services are currently outsourced to St Mark's Hospital and East & North Herts Trust and there is an early opportunity to build a service and repatriate the activity. The service is currently participating in a national pilot for capsule endoscopy as part of the NHS Covid-19 recovery plan.

Priorities and development opportunities for the next five years include:

- workforce development and expansion in line with increasing demand
- realise potential for additional specialist nurse roles in endoscopy, upper GI/nutrition, hepatology and IBD
- further explore integration with surgical pathways to manage GI conditions and potential for multidisciplinary clinics, for example in complex inflammatory bowel disease
- explore options to better integrate with primary care, community and mental health services, particularly in management of chronic health conditions, diatetics and improved psychiatric and psychological patient support
- review learning from Covid-19; work with primary care to ensure appropriate referral pathways, continue with screening of referrals and use of telephone assessment clinics to ensure patients are streamed appropriately. Continued use of virtual appointments where clinically appropriate
- develop a sustainable nutrition service, and review options following the resignation of the long-serving consultant in GI medicine who previously provided this service
- further develop and embed capsule endoscopy service following pilot phase
- work with system partners to integrate an assertive alcohol outreach service into the hepatology service
- explore the opportunity for dedicated day case capacity to support infusions (biologics and iron), ascitic drainage, liver biopsy and management of day-case patients to facilitate safer and earlier discharge
- develop anaesthetist supported endoscopy lists to allow use of propofol for patients who will not tolerate procedures under standard sedation, e.g. for complex procedures and patients with learning difficulties
- become a regional endoscopy training academy and extend our research portfolio.

6.2.10 Respiratory medicine

Respiratory medicine is a high performing specialty providing a wide range of specialist services such as cancer, tuberculosis, asthma, COPD, bronchiectasis, pleural disease, sleep medicine, pulmonary nodule, cardio-pulmonary exercise test, exhaled nitric oxide (FeNO),

acute respiratory care unit (ARCU - specialist unit for acute non-invasive ventilation (NIV)), interstitial lung disease and a number of specialist MDTs (lung cancer, pulmonary nodule, pleural and interstitial lung disease (ILD)). It seeks to continually innovate and improve its services.

The interventional portfolio offered by respiratory medicine is exemplary for a general hospital and includes a wide range of procedures delivered through the endobronchial ultrasound (EBUS/EUS), and an advanced inpatient and outpatient thoracic ultrasound guided pleural service. The EBUS service is supported by ROSE (rapid on-site evaluation) enabling same day diagnosis of cancer; again singling our service out as an national exemplar. The department also runs a national training course for EBUS, one of only seven centres in the UK.

The interventional portfolio also hosts a clinical fellowship programme with senior specialty trainee (ST5+) and a research fellow working in addition to the standard specialty trainee (ST5) allocation from the east of England deanery.

The specialty also reaches into the community through an integrated community respiratory service for planned care, jointly delivered with CLCH. As well as providing integrated care pathways for asthma, COPD, and bronchiectasis, the community respiratory service also supports a domiciliary oxygen assessment service, admission avoidance and pulmonary rehabilitation.

The department has excellent links with two cardiothoracic services: The Brompton and Harefield Hospital for cancer and interstitial lung disease services and UCLH for non-malignant pleural disease and complex airway disease.

The Covid respiratory virtual hospital (CVH) model was developed by our respiratory clinicians early in wave one of the pandemic and was the first operational CVH service in the UK. The West Hertfordshire model has been used to develop a national blueprint now mandated by NHSE/I for all acute hospitals. The CVH allows services to avoid unnecessary admissions and facilitate rapid (early) discharge. Collaboration with NHSX (a joint unit driving digital transformation of care) facilitated a more sophisticated model, incorporating the MedoPAd app and the integration of home monitoring.

The specialty is actively developing its research capacity and capability and is now collaborating with a range of partners across multiple studies. Recent publications include the development of a Covid-19 risk stratification score for use in the emergency department (Thorax, Feb 2021), and the proportion of aspirated material used for ROSE at EBUS in suspected malignancy (Cytopathology 2021). The team has also developed an evidence-based Covid-19 pathway for acute management.

Priorities for the service are:

- work with partners to review the model for the community respiratory service and opportunities to integrate its delivery with the wider delivery of the acute respiratory service. This includes an expanded ILD service, specialist asthma and sleep services

- improve data sharing with community and primary care providers to improve the safety and handover of patients moving between settings of care
- use innovation in digital medicine to expand the range of conditions treated through the virtual hospital model and to identify other virtual opportunities to better integrate care
- develop a range of specialist diagnostic services including medical fluoroscopy in partnership with radiology, cryobiopsy and regular airway (anaesthetic) supported lists for more complex patients
- join our gastroenterology colleagues to become a regional endoscopy training academy.

6.2.11 Clinical haematology

Haematology provides a variety of clinical and non-clinical services and works across both the medicine and clinical support divisions within the trust.

The clinical haematology service covers inpatient and outpatient work (including anticoagulation) across the trust's three sites: WGH, HHH and SACH.

Clinical haematology operates a busy day unit (The Helen Donald Unit) with more than 6,000 day unit admissions per year and nearly 2,000 cycles of chemotherapy per year (including intrathaecal chemotherapy). Apart from chemotherapy we administer biological treatment for other specialities patients, iron infusions and IVIg infusions. We provide supportive care with blood products for a variety of haematology and non-haematology patients, and central line care. Some of the haematology day case work (other than chemotherapy) is provided by CLCH, the community treatment unit at SACH including transfusions and IV treatment.

The haematology team provides specialist outpatient services at WGH and HHH. These include two week suspected haematological cancer referrals, and non-urgent referral pathways for a variety of haematological conditions.

The haematology team has inpatient beds on Tudor ward, shared with the endocrinology team. Since August 2020 the service now offers inpatient chemotherapy services for appropriate patients.

The clinical haematology team provides 24/7 clinical and advisory consultant-delivered service for West Hertfordshire patients.

Priority areas where we will improve care over the next five years are:

- further develop the inpatient chemotherapy service with intention to be the main provider of higher intensity chemotherapy service (chemotherapy for acute leukaemia or highly aggressive lymphoma patients) for the west Hertfordshire area. Most west Hertfordshire patients currently receive care at UCLH; development of a local service at WGH will improve patient experience through delivery of local care

- further develop the haematology day unit to be able to provide a variety of chemotherapy, biologicals and targeted therapy for West Hertfordshire oncology patients
- develop an out-reach chemotherapy service for certain haemato-oncology diagnosis/ age group patients in the West Hertfordshire community
- further develop nurse-led clinics / virtual clinics for certain haematology diagnosis such as chronic lymphocytic leukaemia/small lymphocytic lymphoma, low grade B cell non-Hodgkin's lymphoma, monoclonal gammopathy of undetermined significance, and myeloproliferative neoplasms (MPN). We provide this service for MPN patients already but there is a huge potential to increase this to other haematology diagnosis
- successful completion of repatriation of specialist registrar posts back to east of England and ability to recruit trainees into these posts in the long-term
- work with Mount Vernon Cancer Centre (MVCC) and UCLH colleagues to review opportunities for integrating haemato-oncology services, linked to the potential relocation of MVCC cancer services to the WGH site, dependent on the outcome of the current MVCC clinical review.

6.2.12 Other specialist services – areas for development

We have identified two areas where developing a local service would significantly enhance the offering to the local population. These are renal services and infectious diseases.

Inpatients currently receive a renal service via an in-reach model provided by a consultant from Imperial College Hospitals Trust, who also provides dialysis services on the Watford site (dialysis at the St Albans site is provided by East & North Herts NHS Trust). The in-reach service has limited capacity and our aim is to improve the support we can give to patients with renal disease by developing joint appointments between WHHT and one of the two specialist renal providers.

Similarly we do not currently have an infectious diseases service and we will produce a business case to develop a local service to address this gap.

6.3 Surgery and anaesthetics

West Hertfordshire delivers high volumes of surgical activity and is able to offer sub-specialty expertise across many specialties, enabling us to manage the majority of the needs of our patients locally. Our proximity to London means patients are able to access excellent tertiary care from the specialist London hospitals when it is needed.

Our key partnerships are the local cancer network (with East and North Hertfordshire NHS Trust and Luton and Dunstable NHS Foundation Trust, Mount Vernon Cancer Centre); Imperial College Healthcare NHS Trust for trauma and other specialist work; and Moorfields and the Royal National Orthopaedic Hospital for specialist ophthalmology and orthopaedic

work. Tertiary referrals for complex pelvic recurrence and bowel failure patients go to St Mark's Hospital.

High quality services

Most day case and elective activity is undertaken at SACH as the planned surgical site for WHHT. More complex surgery potentially requiring critical care support is undertaken at WGH. The future strategy as part of the redevelopment is to move the majority of elective surgery to the SACH site, supported by an enhanced 'high dependency' or 'extended recovery' care model to enable more complex patients to be managed safely. Waiting times for surgery vary, with some specialties easily achieving the 18 week maximum wait standard while others, particularly the larger specialties such as orthopaedics and urology, have longer waits. In the longer term the redevelopment will allow us to increase our theatre capacity to address the waiting list challenges and provide enhanced access to theatres in an emergency, but in the short term we will continue to use private sector capacity and additional weekend sessions to provide additional capacity.

GIRFT reviews and the application of GIRFT principles would indicate that in some areas the level of surgery being undertaken is below the level recommended to ensure the best outcomes. We will review all specialties over the next year to ensure they are clinically sustainable.

We have seen through the SMART pilot for medicine that increasing specialist support to the ED can improve decision-making, reduce admissions and reduce length of stay. The medical team are piloting a virtual SMART model and the surgical team will learn from the experience of medicine to implement a SMART or virtual SMART model to support the ED. Where specialties are too small to offer either in-hours or out-of-hours consultant cover, we will explore networked approaches with other local providers.

Integration

In common with other areas of the country, a number of community services have been introduced in recent years that manage low level problems that do not require surgical intervention. In these specialties, referrals to the trust come via the community services rather than directly from GPs, other than for agreed exceptions such as suspected cancer pathways. While some of these services operate well, in others the patient pathway is less efficient and can cause avoidable delay for those people who need surgical intervention. As part of our new integrated care partnership, we will work closely with the community providers to improve the pathways and ensure that they are patient-focused, efficient and effective.

Personalisation

The majority of the surgical care that we provide is episodic, in that people have a particular problem that can be remedied or mitigated by a surgical intervention. Unlike medical specialties, there are relatively few patients who have long term relationships with their consultants. This means that the main focus for surgery is on universal personalised care, and in particular ensuring that people have sufficient information to be able to make an informed choice about their care. We will build on our existing good practice relating to

informed consent and consider how the lessons of the Patterson report can be applied both to complex surgery and more widely.

The other key opportunity is patient initiated follow-up (PIFU), which can work very well post-surgery for people whose recovery is in line with expectations. We will implement PIFU in all areas where it is clinically appropriate to do so.

Consistent care

The national GIRFT initiative began in orthopaedics and uses data to show how variations in practice and low surgical volumes drive unwarranted variations in patient outcomes. As referenced above, we will apply the outcomes of GIRFT reviews and the GIRFT principles to review our specialties and address unwarranted variations in outcomes. We will also work to reduce unwarranted variation in care by implementing best practice surgical pathways as part of the CPG programme with RFL. Surgery has benefited from significant advances over the last 50 years, such as the introduction of laparoscopic surgery that enabled care to be shifted from inpatient to day cases. Technology continues to evolve, with robotic surgery and interventional radiology growing rapidly and being increasingly included in the standard training of new doctors. We will seek continuous improvement in the delivery of care, utilising new technologies where they lead to improved outcomes for patients.

Whilst most surgery is undertaken on a planned or semi-planned basis it is important that when emergency surgery is required that this is able to take place in a timely way in line with best practice guidance. We will review our theatre schedule and how we prioritise theatre capacity at WGH to enable the creation of additional ring-fenced trauma and 'CEPOD[2]' theatre capacity and improve turnaround times for emergency surgery for priority pathways. This links to our plans to increase planned care activity at SACH as this will reduce the number of 'Watford only' elective surgical patients thereby freeing up theatre capacity for emergency surgery as well as reducing waiting times for patients with more complex needs.

6.3.1 Anaesthetics

The anaesthetics department provides a service to seven theatres at WGH, six theatres at SACH and supports outpatient interventions requiring local anaesthetic. It is a flexible department with an emphasis on safety, and which provides good training and simulation opportunities. Workforce challenges within anaesthetics mirror the national shortfall and a robust and resilient workforce plan is required to address this. Recent initiatives have proven successful for staff grades but succession planning and continuation of the recruitment campaign is essential. Future opportunities to support the workforce include the development of non-medical anaesthetics associate roles. The EPR will improve safety, allowing access to the patient's previous anaesthetics records, and will support improvements in pre-operative assessment.

As more care shifts out of theatres into other settings, the need for anaesthetics input outside of theatres is likely to increase. The strategic direction for theatre provision lies in expanding elective services at the St Albans site. This involves an enhanced care model

[2] CEPOD (confidential enquiry into peri-operative deaths) – this is the term used to describe a ring fenced emergency theatre.

which started in 2018 but has the potential to expand. A comprehensive enhanced recovery suite with appropriate staffing levels and skill mix on the wards will allow for patients with more complex needs to receive their surgery on the elective site. This will significantly transform the service provision at SACH and reduce the demands on the Watford site.

6.3.2 Critical care

The critical care service at WHHT provides a 20 bedded intensive care unit providing level three, two and one critical care:

- level 3 (advanced respiratory support with at least two organ system support)
- level 2 (detailed observation including support for single organ)
- level 1 (patients at risk of deterioration, whose needs are met on an acute ward with critical care support or are ready for step-down).

Patients requiring specialist care are promptly transferred out to our partner trusts (trauma: St Mary's Hospital; non-trauma neurology: Queen's Square Hospital; renal: Hammersmith & Lister Hospitals).

The critical care service also provides a nurse-led critical care outreach 24/7 with daytime consultant presence and a hospital at night service providing clinical advice and support to clinical teams. These services deliver care on our general acute wards in managing deteriorating patients and identifying patients who may benefit from admission to the critical care unit.

Key priorities for the service for the next five years include:

- promote the health and well-being of the critical care team, providing support and 'after-care' for staff traumatised by their experience of delivering care during the Covid-19 pandemic
- workforce development – recruitment and retention strategy and development of enhanced roles including advanced critical care practitioners (ACCPs) to support delivery of level two and three critical care and advanced nurse practitioner (ANPs) roles within the outreach service
- further development of critical care support to enable more complex surgical case mix at SACH
- joint work with medical and surgical divisions to improve admissions pathways for critical care, ensuring that all patients who can benefit are identified, managed and transferred in a timely fashion
- joint work with the surgical division on opportunities for 'pre-optimisation' of patients undergoing emergency surgery
- develop a level one critical care facility incorporating speciality specific monitored beds for respiratory medicine (ARCU) and cardiology (CCU) patients.

6.3.3 Theatres

A refurbishment programme commenced for the WGH theatre facility in 2020 and is due to complete by 2022. This will result in one additional theatre and a treatment room with a dedicated paediatric recovery area following recommendations from the CQC. This will create additional theatre capacity for minor operative procedures and dedicated local anaesthetic lists.

The longer term aspects of refurbishment are to upgrade all theatres with modern IT hardware which will improve data capture in real time.

The division is committed to maximising the use of robotic technology to aid theatre productivity and clinical outcomes. The technology has applications in urology, colorectal surgery and orthopaedics and has demonstrated significant gains nationally and internationally.

6.3.4 Pain medicine

WHHT provides a pain service with a complement of four consultants and one psychologist. The service focuses on the treatment of chronic pain disorders largely in an outpatient setting.

A comprehensive review of the pain service is required, working with colleagues within the integrated care system to create a system wide pathway for our patients.

6.3.5 Trauma and orthopaedics

The orthopaedics department at WHHT sees high patient volumes but the British Orthopaedic Association has recognised WHHT has a relatively small number of surgeons for the size of the population. The current complement of 16 consultants has sub-specialty expertise including upper limb with hands, lower limb with foot and ankle and spine. The department has two dedicated trauma surgeons and 24/7 trauma provision with access to a dedicated trauma theatre. In common with most other providers, waiting times for orthopaedic services are a challenge and extensive demand and capacity modelling is required on an ongoing basis to manage the 18 week target.

Most tertiary links including cancer surgery are with the Royal National Orthopaedic Hospital at Stanmore, with linked MDTs for spinal patients. Elective paediatric orthopaedic surgery is provided at Stanmore as there is no service at WGH. The main trauma link is to the major trauma unit at St Mary's Paddington.

In line with GIRFT review findings and national standards the trust implemented ring-fenced orthopaedic beds on the Watford site in 2018. This has significantly reduced infection rates and improved the quality of care for all patients receiving surgery on the Watford site.

Nationally, orthopaedics was the first specialty to be reviewed by GIRFT, and as a result national thinking is more advanced about the scale and organisation of services to achieve best outcomes. The national direction of travel is towards a hub and spoke model, with the most specialist activity being undertaken at a hub site to ensure sufficient activity volumes to drive the best outcomes. Under this model it is likely that WGH and SACH would be spokes

with the hub at the Royal National Orthopaedic Hospital, Stanmore. Most activity would continue locally but WHHT consultants would provide specialist surgery from the Stanmore site. WHHT consultants may in the future provide specialist surgery from the Stanmore site. There are also opportunities to collaborate on the delivery of orthopaedic services with the new North Central London orthopaedic hub at Chase Farm Hospital.

Our priorities for the next five years include:

- work within the clinical network to support developments with the hub and spoke model include workforce design and clinical pathway ratification
- in keeping with the lessons learnt during the Covid-19 pandemic review our medical staff model to deliver optimal care to both trauma and elective patients in line with the findings of direct consultant-led virtual and face-to-face appointments
- work to improve integration with community musculoskeletal pathways
- improve pathways linked to the newly established MRI and CT provision at SACH
- explore the opportunity to work collaboratively with the emergency medicine and medical divisions in the management of 'silver trauma' (patients over 65) to improve overall care and rapid discharge of this vulnerable group of patients
- develop an integrated spinal surgery clinic with pain, rheumatology and neurology
- work collaboratively within the ICS to develop a systems approach to the management of the acute sciatica pathway.

6.3.6 General surgery (upper and lower gastro-intestinal surgery)

WHHT is nationally recognised as a centre of excellence for laparoscopic colorectal surgery. Clinical outcomes for patients treated within the trust lie within the top quartile nationally. In addition to this the trust offers a standard range of services in general surgery including lower and upper gastro-intestinal surgery and cancer interventions. The lower GI surgeons form an active part of the bowel cancer screening service.

Pathways and partnerships are well established with more specialist London providers, where clinical expertise is concentrated and with local providers nearer to the population that we serve. Nationally, a hub and spoke model has been introduced for GI services. WHHT acts as a spoke to the central London hospitals to include Hammersmith where WHHT consultants are an active part of the on-call provision for emergency upper GI surgery.

Improvements to general surgery will be enabled by the current theatre improvement programme which will provide improved facilities and free theatre time within main theatres. Over the next few years we would expect to see a shift towards more robotic surgery to replace current laparoscopic surgery in some areas. The GIRFT review for upper GI surgery recognises the need for provision of an acute service for emergency (hot) gallbladder patients. This will require the theatre refurbishment for additional theatre capacity as well as a dedicated on-call rota to provide provision of a surgical service.

Benchmarking against national peers indicates opportunity for improving patient pathways and workforce via specialist nurse provision. Extended scope practitioners would undertake independent clinics to free consultants for surgical activity, in particular the gall bladder service, and support waiting times.

GI services work collaboratively with the division of women and children (obstetrics and gynaecology) in the selection of patients for discussion in a joint MDT. This allows services to establish cases that should be undertaken by multiple teams in a single setting to improve the quality of surgery delivery. There is scope for further improvement in the multidisciplinary approach to patient interventions and care which will be implemented drawing on national examples of excellence.

Our priorities for the next five year include:

- improve the hot gall bladder pathway
- workforce redesign to develop specialist nurse / extended practitioner roles to improve pathways, reduce waiting times and free up consultant time for additional theatre sessions
- further develop multidisciplinary care model with obstetrics and gynaecology services.

6.3.7 Urology

This is a well-regarded department, offering a broad range of services across all three sites. The urology service sees a high volume of patients and manages all activity in-house. Established partnership arrangements are in place for cancer patients with ENHT. A nationally-supported review of the Mount Vernon cancer service is underway and may impact the partnership arrangements and patient pathways within urology in the future.

Priorities for the next five years include:

- develop a day surgery brachytherapy service which will improve our patient experience and outcomes along with reducing length of stay
- integrate with community partners, providing more telemedicine and community diagnostics as well as joint work to improve catheter care, with particular reference to difficult catheterisations
- detailed review of urology medical staffing model and implementation of an appropriate on-call rota in line with British Association of Urological Surgeons' recommendations
- there is an aspiration to create a urology 'one stop' centre at SACH. This would streamline the patient pathway, enhance the patients' experience and reduce waiting times. This would create an opportunity for WHHT to be the adrenal centre for the region.

6.3.8 Vascular surgery

Vascular surgery offers a standard range of general hospital services with 24/7 on-call provision for the increasing emergency admissions. The service is provided across the WGH and SACH sites and includes interventional radiology, a vascular lab providing 'one stop' clinics and a regional abdominal aortic aneurysm (AAA) screening programme.

The relocation and expansion of the vascular laboratory on the Watford site in 2020 helps future proof this service and enables it to absorb the growing demand, particularly for patients with deep vein thrombosis (DVTs), inpatients with diabetic feet and those requiring carotid diagnostics.

The complex nature of this patient group and frequent comorbidities such as diabetes provide opportunities for greater levels of integration. Through working closely with the medicine division we will improve patient pathways and service provision to match the growing demand within the diabetic, frail, elderly population with vascular disease.

A combined hub hosted by ENHT has been agreed with specialist commissioners and is designed to manage complex and emergency surgery, with the latter achieved through a treat and transfer model. All arterial surgery will move to ENHT, with less complex surgery retained by WHHT. Working closely within the ICS, we will be establishing the clinical pathways and operational processes to enact this ICS priority.

Priorities for the next five years include:

- work with partners to implement the vascular hub and spoke model
- work with the medicine division to improve pathways and meet growing demand within the diabetic, frail, elderly population with vascular disease.

6.3.9 Breast surgery

The department offers a comprehensive range of services standard to a general hospital with some elements of enhanced care that are well regarded by primary care colleagues and the local population. Examples are the fast track genetic urgent referrals managed by advanced nurse practitioners and the advisory MDT breast meetings for patients six weeks post-operation that include physiotherapy, lymphoedema and specialist nursing services.

Strong networks and partnerships are established across the London hospitals and more locally. The current patient pathway is geographically varied and wide ranging. The service is linked with Beds and Herts Breast Screening Service within the East of England Cancer Clinical Network, Mount Vernon oncology, RFL plastic surgery and NW Thames regional genetics service. The service will determine whether by rationalising these pathways it would be possible to improve on the existing arrangements.

There is opportunity to improve the surgical pathway which would improve the patient experience and outcomes. The aspiration is to have a 'one stop' service at the SACH but this requires infrastructure changes that are dependent on the hospitals redevelopment.

Other plans to improve the current service include:

- introduce patient initiated follow-up
- upgrade IT facilities for weekly multidisciplinary meetings and improved access to radiology reports for clinicians to allow off-site access in emergency situations
- adopt enhanced models for pre-operative preparation to ensure more accurate procedures using modern localisation technique (LOCalizer radiofrequency probe)
- review workforce model for oncoplastic surgery with the potential to create posts attracting dual trained clinicians in oncology and plastic surgery
- local delivery of level four clinical psychological therapy currently offered from Mount Vernon
- collaborative work with partners to create an enhanced community model allowing improved tissue viability and wound care support to primary and community care.

6.3.10 ENT

Ear, nose and throat (ENT) services manage high patient volumes, seeing circa 13,000 patients and operating on 1,500 patients yearly and working closely with audiology services. The department provides primarily elective surgeries and adopts latest specialty practices.

The department has a stable experienced workforce and patients report high levels of satisfaction in patient surveys. Consultants operate a shared rota with ENT consultants at ENHT, with out-of-hours care and emergency surgery performed at the Lister Hospital. Good partnership arrangements are in place with both ENHT and the wider cancer network including London North West Hospitals NHS Trust (LNWH) and LDUH for head and neck cancers.

Opportunities exist to repatriate some surgery locally, particularly thyroid surgery and benign head and neck surgery. This would be subject to confirmation that activity levels meet the recommended minimums per the GIRFT approach.

6.3.11 Ophthalmology

Ophthalmology is a relatively small service for the size of the local population, and is currently delivered across the SACH and WGH sites. Like many providers, WHHT have historically struggled with waiting times for ophthalmology, both for new and follow-up outpatients and surgery. Emergency services are provided in-hours, with emergency patients transferred to other providers out-of-hours although there are no formal arrangements to underpin this.

Priorities for the next five years include:

- better integrate pathways with community and primary care providers
- develop ‘one stop’ cataract clinics

- introduce virtual optical coherence tomography imaging to enable diagnosis
- create a vitreoretinal service locally.

The service will be reviewed to ensure that it is clinically sustainable over the medium to long term and to consider how expansion, networked approaches or other ways of delivering the service would support this. This review will include services for children, which are currently only delivered by one consultant. Key areas of focus include consideration of whether a 24/7 emergency service can be provided and / or how out-of-hours provision can be strengthened and whether there are additional services that should be provided locally.

6.3.12 Oral surgery

The oral surgery service combines dental and orthodontics services provided by trust clinicians with a maxillofacial service provided by consultants from Northwick Park supported by trust nurses. The dental and orthodontics services are outpatient-based. The maxillofacial service on site is relatively small though with high demand for both children and adults and comprises lymph node biopsies under local anaesthetic and extraction under deep sedation. Head and neck oncology services are provided at Northwick Park. Out-of-hours patients are transferred to Northwick Park for treatment as there is no on-call service, and patients requiring an overnight stay are also treated at Northwick Park. Improvements to the physical environment in which the service is provided would improve patient and staff experience and improve flow within the clinic.

Working within the ICS, a detailed review of the dental service provision is required, drawing on national learning and evidence of best practice care models. Through this it could be feasible to move the dental service into a community setting and to look at alternative methods of providing the maxillofacial service, including different providers or different sites. The aim would be to improve patient experience, reduce waiting times and improve the clinical sustainability of the service.

6.3.13 Paediatric surgery

The majority of paediatric surgery is undertaken as day cases at WGH with approximately 500 procedures a year and is mainly focused in ENT, general surgery, dental, urology and orthopaedics. Emergency complex activity goes into London, with the provider dependent on the nature of the emergency and bed availability. Emergency neurosurgery and urology go to Great Ormond Street Hospital (GOSH), and emergency orthopaedics for multi-trauma and septic arthritis in the under twos go to St Mary's. Emergency ENT goes to ENHT in common with adult ENT.

We will explore the potential to agree clear pathways for paediatric emergencies with a central London network.

The trust recognises the provision of paediatric recovery in the general recovery areas is not sufficient, as highlighted by the CQC. The theatre refurbishment programme, which is due to complete in 2022, will therefore create a dedicated paediatric recovery area.

6.4 Women's and children's

The women's and children's (WACS) division provides paediatrics (including neonatal), obstetrics, midwifery and gynaecology services. Paediatric services are a mixture of episodic care provided to mostly healthy children and long term specialist care for children with serious health conditions or physical disabilities. For the latter, personalised care throughout their childhood with a clear and effective transition into adult services is a top priority. There are also significant opportunities to integrate care for these children with community, primary care, mental health and social care services.

Similarly, women are in ongoing contact with trust services during pregnancy and after birth. In line with the national maternity strategy we will improve the continuity of care and the perinatal mental health support provided to women to ensure better outcomes for both the woman and her child.

6.4.1 Paediatrics

The paediatrics team delivers the majority of care for children aged 0 to their 16th birthday within the trust. As well as our acute cover to the children's emergency department (CED) the paediatric ward, and a large general paediatric outpatient clinic service, we cover almost all the medical specialities including: allergy, behavioural paediatrics, cardiology, endocrinology, gastroenterology, haematology & oncology, neurology, nephrology and respiratory. We liaise closely with our colleagues in tertiary care; at Cambridge University Hospitals, Great Ormond Street Hospital and other London specialist centres. There is also a safeguarding children team supporting the department and wider hospital with social care issues for the children in the service. We work with our colleagues in surgery, especially urology, orthopaedics, ENT and general surgery, to support the acute admissions to the children's ward.

The CED is run by the emergency medicine division but nursing staff are provided by the WACS division. A paediatric assessment unit (PAU) was introduced in 2019 which enables children who would otherwise have had a short inpatient admission to be managed safely in an ambulatory way, reducing their time in hospital.

There are many opportunities to work differently with primary care clinicians and community services to avoid the need for children to attend hospital. We have implemented advice and guidance for GPs across our service to better meet the needs of the 40% of children who are discharged following a first outpatient appointment. We have introduced virtual appointments where it is safe to do so and continue to work with community providers to enable the delivery of services such as blood tests and IV antibiotics outside of the hospital.

A key priority is to improve transitional care for adolescents as they move from paediatric to adult services. Paediatric services currently serve children up to the age of 16, with children 16 years and over seen in adult settings (ED, outpatients and wards). An in-reach service for 16-18 year olds on adult wards is provided, but our ambition is to deliver a best practice model across all hospital services that considers the personalised needs of each child as they transition to adult services.

We run a level two paediatric oncology shared care unit, the only unit of this level located in a general hospital within the North Thames Children's Cancer Network. This includes full inpatient supportive care and daycare bolus and infusional chemotherapy. Our ambition is to achieve level two 'enhanced' status during 2021. Achieving this will allow the unit to deliver inpatient chemotherapy, reducing the need to travel into London for this specialist treatment. Additionally we have been invited to be a pilot centre for the launch of the new Acute Lymphoblastic Leukaemia trial (ALLTOGETHER). Leukaemia patients account for 50% of our oncology patient cohort and so we will absorb new patients from other surrounding units who are not part of this trial, thereby growing the service. To achieve this aim, implementing electronic prescribing for chemotherapy is an essential priority.

Along with the East of England network we are also members of the Northwest London Hospitals Allergy Network and have been involved with active participation and hosting of regional meetings promoting better standardised practice and allergy education, including for primary care practitioners. We run a full skin prick testing, Serum IgE and oral food challenge service enabling assessment and diagnostic work-up for children referred from the local area and, increasingly, the surrounding area. As the service expands, we are doing more complex work, linking closely with the WHHT paediatric respiratory, gastroenterology and dermatology teams to ensure that patient care remains closer to home. Aspirations to support low risk drug allergy assessment and immunotherapy for aeroallergen sensitisation remain five year aims.

There are challenges in recruiting junior doctors in paediatrics and there are opportunities to address this through increasing the training opportunities for advanced clinical practitioners and physician associates.

The paediatric team have been involved in the CPG programme to implement consistent best practice care including implementation of a 'wheezy child' pathway in CED. The service is committed to the principles of the CPG programme and will continue to work with Royal Free London NHS Foundation Trust (RFL) partners on rolling out additional best practice pathways.

Our priorities for the next five years include:

- implement advice and guidance as part of redesigning our outpatient pathways and ensuring specialist expertise is focused on children with the most complex needs
- work with Hertfordshire Community NHS Trust (HCT) to improve access to home-based care to reduce the need for hospital admission (e.g. IV antibiotics)
- continue to improve transition arrangements for young people into adult services
- achieve level two 'enhanced' status for our paediatric oncology shared care service
- workforce redesign – create additional advanced clinical practitioner roles
- implement CPG pathways to support consistent delivery of best practice care.

6.4.2 Neonatal Services

Woodland Neonatal Unit is a designated local neonatal unit (LNU) within the East of England Operational Delivery Network. It currently provides 24 cots, though this may change in future following ongoing regional review of neonatal services. Our service provides short term intensive care, high dependency, special care for babies born >27 weeks of gestation and birth weight > 800 grams or completed 28 weeks for multiple births.

The service also has six dedicated transitional care beds within the postnatal ward. The purpose of this unit is to give supportive care to babies (34-36 weeks gestation) who are well enough to be with their mothers but still require clinical surveillance.

The unit caters for around 800 admissions per year (second largest LNU service in the region) and prides itself on less invasive care practices in line with current evidence. This approach to care has helped the unit achieve positive outcomes in the short and long term as shown in the national neonatal audit programme metrics.

The immediate priority for the service is to sustain levels of good quality care and invest more in the less invasive care philosophy. Other priorities for the next five years include:

- ensure unit complies with various recommendations in *Better Births* and *Saving Babies Lives Care Bundle v2* (SBLCBv2) - Right Place of Birth (RPoB) for extreme pre-terms, optimisation of antenatal interventions e.g. magnesium sulphate, corticosteroid compliance rates, deferred cord clamping and less invasive ventilation strategy
- provide a seamless, responsive and multidisciplinary service built around the needs of new-born babies and the involvement of families in their care
- further develop the expert neonatal workforce required and expanded roles for some allied health professionals to support clinical care such as speech and language therapists
- work collaboratively with maternity and across the network to provide high quality neonatal care and to improve outcomes for all families, provide safe expert care as close to their home as possible, and keep mother and baby together while they need care
- forge strategic relationships with Herts and West Essex local maternity and neonatal system (LMNS) to allow us to influence policy and care pathways for women within our patch and wider LMNS
- sustain reductions to term admissions to neonatal unit below 5%
- acquire accreditation under the BLISS baby charter scheme and the UNICEF baby friendly initiative to improve family experience and breastfeeding rates in accordance with national standards.

6.4.3 Maternity and obstetrics

Our maternity and obstetrics services deliver maternity care for local women across the full maternity pathway. The national strategy for maternity – *Better Births* – sets out clear goals

to improve the personalisation and continuity of care and to reduce still births, neonatal and maternity deaths. We are committed to delivering the strategy, working in partnership with the local maternity and neonatal system.

Our immediate priority is to reconfigure our midwifery teams to provide continuity of care across the antenatal, perinatal and postnatal pathway with an emphasis on BAME and vulnerable groups who currently have poorer outcomes. We are also appointing consultants with expertise in diabetes, perinatal mental health and maternal and fetal medicine to improve the care we can offer for more complex pregnancies. We will improve the links to wider medical specialties such as cardiology and neurology so that we can appropriately personalise the care for women who need additional input. This is in response to the recent Ockenden report and MBBRACE.

Implementing a revised perinatal quality surveillance model (December 2020) is a key priority and involves maternity and neonatal quality as they are inextricably interdependent. There are five principles for improving oversight for effective perinatal clinical quality to ensure a positive experience for women and their families. They integrate perinatal clinical quality into developing ICS structures and provide clear lines for responsibility and accountability for addressing quality concerns at each level of the system. Revisions to the local, regional and national quality oversight model for the NHS are currently underway as part of the development of ICS and the future system oversight framework.

Telemedicine will be utilised to enable the remote monitoring of women during pregnancy, reducing the need for some antenatal visits and allowing more effective monitoring of high risk pregnancies. We will also implement more ambulatory pathways and explore the opportunity for a day assessment model.

We have implemented a CPG pathway for induction of labour, which has already allowed us to use data comparison to identify an opportunity to reduce the length of time between induction and birth. We will continue to use the CPG approach to continuously improve the care we offer.

Our priorities for the next five years include the delivery of the targets in the national strategy:

- improve continuity of care in line with the national *Better Births* strategy
- progress against trajectory to deliver improvements in safety towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and 50% by 2025 and to reduce pre-term births from 8% to 6%
- deliver full implementation of the *Saving Babies' Lives Care Bundle* (v2) by 31st March 2021
- increase the number of women receiving continuity of the person caring for them during pregnancy, birth and postnatally so that by March 2021 more than 35% of women are booked on to a continuity of carer pathway. All reasonable endeavours must be undertaken to ensure that continuity of carer is provided to groups that experience the poorest outcomes, such as women from ethnic minorities and the

most deprived socio-economic groups. Continuity of carer should be delivered alongside ensuring high quality care maternity for all women

- progress against trajectory to deliver improvements in choice and personalisation through local maternity and neonatal systems so that by March 2021 all women have a personalised care plan and more women can give birth in midwifery settings
- in addition to the national strategy, implement CPG pathways to support consistent delivery of best practice care.

6.4.4 Gynaecology

Gynaecology services include the early pregnancy unit (EPU) and the gynaecology assessment unit (GAU) as well as traditional outpatient and inpatient services.

Care has shifted over time towards less invasive procedures, either laparoscopic day cases or outpatient procedures, and there is further scope to shift services in these ways, including more nurse-led clinics.

Gynaecology oncology surgery is currently provided by the trust but is not of optimum scale, particularly for ovarian cancer. There are different views as to whether this service should be expanded or stopped and consolidated across the local cancer network. We will review the volumes undertaken and the outcomes achieved and agree a clear direction of travel with the cancer network within the next year.

Our priorities for the next five years include:

- review pathways into the GAU to maximise the ambulatory care pathway, again shifting care into a less acute setting
- focus on the provision of ‘one stop’ and outpatients procedures and reduce the need for multiple attendances and in-patient beds
- we see high volumes of endometriosis surgery and our ambition is to be accredited as an endometriosis centre within the next two years
- work with the cancer network to review our gynae-oncology service and agree clear direction of travel for the future of the service
- work to become an accredited urogynaecology centre with the focus on local and regional networks. We aim to achieve this within a year.

6.5 Clinical support services

Clinical support services include pathology, radiology, pharmacy and therapies. Their services underpin the care delivered by all other specialties, and the range and scale of diagnostics, particularly radiology, is growing rapidly. Mirroring the activity of the hospital, clinical support services must be rapidly available to support ED and inpatient needs (acute services) and on a planned elective basis (elective services).

A new national strategy for diagnostics was published in early October 2020 which sets out significant ambitions to rapidly expand the scale, availability and responsiveness of diagnostics services. The key actions defined in the strategy are:

- acute and elective diagnostics should be separated wherever possible to increase efficiency
- acute diagnostic services (for ED and inpatient care) should be improved so that patients who require CT scanning or ultrasound from ED can be imaged without delay. Inpatients needing CT or MRI should be able to be scanned on the day of request
- community diagnostic hubs should be established away from acute (emergency) hospital sites and kept as clear of Covid-19 as possible
- diagnostic services should be organised so that as far as possible patients only have to attend once and, where appropriate, they should be tested for Covid-19 before diagnostic tests are undertaken
- community phlebotomy services should be improved, so that all patients can have blood samples taken close to their homes, at least six days a week, without needing to come to acute hospitals.

During 2021 we will develop a diagnostics strategy to reflect the national strategy, and which will build on and give more detail to the headline ambitions set out below.

6.5.1 Pathology

Currently there is a comprehensive laboratory service across the sites providing standard hospital services for both acute and elective services. The HWE ICS strategy for pathology is to consolidate and outsource all elective pathology services across the ICS (including GP initiated) through an ongoing procurement process being undertaken jointly with ENHT and Princess Alexandra Hospital. The ambition is for an ICS-wide provider and an overarching integrated network. There is an acknowledged risk that succession planning and recruitment could be problematic with the outsourcing of elective work unless there is a strong network with the ICS-wide service, which we will drive and champion.

Acute 'hot lab' services will remain on site but delivered through the ICS network pathology provider. Covid-19 has had a significant impact, requiring microbiology services on site as a 24/7 service rather than a five day service. The longer term consequences of this will need to be considered.

There are a number of ways in which technology will improve services. Point of care testing is expected to increase, and 'one stop' diagnostic pathways will be enabled by technology. Pre-diagnostic MDTs will improve patient experience by enabling all tests to be undertaken on the same day. Digital ordering and an electronic system that is integrated with the electronic patient record will allow both hospital staff and GPs to see what tests have been undertaken and when, reducing the duplication of tests and improving patient safety.

Phlebotomy services are currently provided on the hospital sites, but in line with the national strategy the ambition is to move the majority of the service within the community, reducing waiting times and providing care closer to home.

Pathology holds the contract for coroner post mortems across Hertfordshire.

Priorities for the next five years include:

- implement the HWE ICS-wide pathology network provider model
- increase point of care testing
- work with primary care to increase local access to phlebotomy services.

6.5.2 Radiology

Radiology services are provided across all three sites to meet urgent and elective needs. Imaging modalities provided are plain X-Ray, MRI, CT, nuclear medicine, mammography and fluoroscopy. DEXA is provided by rheumatology at SACH and PET CT and SPECT CT are fully outsourced to other providers. Out-of-hours emergency radiology reporting is also outsourced.

In line with national trends, activity is growing rapidly year-on-year and the complexity of scans is also increasing, but this has not been matched by equivalent increases in staffing or equipment, putting growing pressure onto services. Workforce constraints across all staffing groups are the key challenge facing the service, although ageing equipment is also a risk and a clear replacement programme will be a priority for the diagnostics strategy, particularly for MRI.

A new CT scanner has recently been implemented adjacent to the ED at WGH to improve urgent care services. To support recovery from Covid-19, an additional MRI and CT scanner have been sourced for the SACH site, enabling a Covid-safe service to be operated. These machines have allowed activity to be maintained at pre-Covid levels rather than enabled an increase in capacity at this time.

There is widespread agreement across the trust about the fundamental importance of diagnostics, including imaging, particularly as clinical indications for technology such as CT become broader. This is reflected in the emerging clinical adjacencies for the WGH redevelopment, which have imaging at the centre of the hospital. The ambitions for imaging reflect this and are consistent with the national report, including:

- increase capacity to meet demand across all modalities, including doubling CT and MRI capacity
- increase workforce to meet demand, including securing additional radiology training posts
- bring back in-house all outsourced activity where modalities are already provided, and consider the business case for providing other modalities on site

- join an IT-enabled radiology network with other providers to allow the sharing of data and digital imaging between providers, reducing duplication, and to improve out of hours support
- create a rapid diagnostics centre on the SACH site to enable a 'one stop' approach and to create a clear elective pathway away from the acute WGH site.

There is also a need to ensure that people only receive scans that are appropriate to them and which will impact on their clinical management, both to improve the patient experience and to reduce demand for imaging. This will be enabled by the new EPR and the CPG approach, which will use best practice pathways to ensure that people get the most appropriate diagnostic for their condition.

Interventional radiology is a medical specialty in which its trained clinicians perform minimally invasive procedures to diagnose and treat various diseases. These procedures have grown in popularity with both providers and patients; as an alternative to open surgery, interventional radiology procedures may reduce risk, pain and recovery time for patients.

There is a planned joint appointment for an interventional radiologist post with RFL to increase our existing capacity, and the strategy is to create a new interventional radiology suite at WGH. Interventional radiology network arrangements are being considered with neighbouring trusts, ideally consistent with the wider radiology network.

Priorities for the next five years include:

- develop a detailed diagnostics and imaging strategy (2021)
- develop a diagnostics / imaging IT strategy
- work with medical and surgical specialities to review diagnostic components of outpatient pathways to streamline care and improve patient experience
- recover activity backlog due to Covid-19 and maximise the benefits from new CT and MRI facilities at SACH
- upgrade our interventional radiology suite at WGH and continue to develop our interventional radiology service offer and workforce, including working with partners to strengthen out-of-hours interventional radiology provision.

6.5.3 Pharmacy

The pharmacy service primarily supports inpatient services, but also provides prescriptions for outpatients. In common with other providers the key challenges for the service are the transfer of medicines at the interface between settings as people move between hospital and GP services. A lack of a common IT system leads to poor communications and wastage, and changes in medication are not always understood meaning that people don't take the optimal drugs for their condition. Delays in TTAs (medications to take away) often also impact on the speed of discharges.

Our priorities for the next five years include:

- implement electronic prescribing, interoperable with both the new EPR and with primary care IT systems
- integrate the acute and primary care pharmacy teams to better join-up prescribing between different settings of care
- provide a new pharmacy robot to speed up dispensing within the hospital
- as part of the WGH redevelopment, we will also explore the possibility of an on-site fully owned pharmacy to replace FP10s and reduce the VAT burden.

6.5.4 Therapies

The therapies service provides physiotherapy and occupational therapy services to inpatients and outpatients. During Covid-19, 85% of outpatient services were delivered virtually and we expect to continue to provide a significant proportion of the service virtually over the longer term.

Covid-19 also changed the way that inpatient services were delivered, with less intervention at discharge and more therapy provided during the inpatient stay to support Covid-19 patients.

As part of the trust's ambition to maintain discharge to assess arrangements, there will be an increased need for the trust's team to integrate with OTs and physiotherapists from other HCP partners to deliver a single joined-up service on a trusted assessor model to remove duplication of assessments. This will increase the capacity to expand roles internally such as supporting ITU in turning patients.

In addition to integration, the other priority for the service will be to maximise the opportunities to expand the AHP role, developing both advanced practitioners and potentially consultant AHP roles that can take on more responsibilities in specialties such as orthopaedics.

6.6 Cancer

The trust works in partnership with other hospitals in Hertfordshire and West Essex (HWE) and in London to provide a wide range of cancer diagnosis and treatment.

A key partner is the Mount Vernon Cancer Centre (MVCC) which is the main provider of oncology treatment (including radiotherapy) for our cancer patients. Most cancer diagnostics are undertaken within the trust, however some specialist cancer diagnostics are also provided by MVCC / the Paul Strickland Cancer Diagnostics Centre as well as at other neighbouring trusts which provide more specialist diagnosis and treatment for some cancer pathways.

Our role in the key cancer pathways is summarised below. Clinical leadership and care delivery is led at speciality level. The trust's cancer team provides a leadership and co-ordination role, ensuring patients are tracked through their pathways, delivering clinical nurse specialist input into pathways and providing a specialist palliative care service. The cancer team also works with specialities to review pathways and support continuous

improvement in care delivery in line with best practice and provide a central co-ordination point for work with partners on improving cancer services across the health and care system.

Pathway / Tumour type	**WHHT diagnostics**	**Specialist diagnostics pathway**	**Oncology pathway**	**Surgery pathway**
Breast cancer	A comprehensive local breast cancer service is provided at SACH with one stop diagnostics		Chemotherapy and radiotherapy at MVCC	Surgery at WHHT. (SACH or WGH) Reconstruction surgery at Royal Free Hospital
Lower gastro-Intestinal cancers	Colonoscopy, MRI and CT undertaken at WGH and HHH	PET CT scans at Paul Strickland Scanning Centre	Chemotherapy and radiotherapy at MVCC	Surgery undertaken at WHHT. (WGH & SACH)
Upper gastro-intestinal cancers (oesophagic-gastric)	Staging laparoscopies and endoscopic ultrasound (EUS) at WGH (WHHT also provide to ENHT & L&D)	PET CT scans at Paul Strickland Scanning Centre	Chemotherapy and radiotherapy at MVCC	Surgery undertaken at Imperial (Hammersmith Hospital)
Upper gastro-intestinal cancers (hepabilliary)	Diagnostics at WHHT – endoscopic ultrasound (EUS) and ERCP (WHHT also provide to ENHT & L&D)	PET CT scans at Paul Strickland Scanning Centre Gallian PET CT at Royal Free Hospital	Chemotherapy and radiotherapy at MVCC	Surgery at Royal Free Hospital

Pathway / Tumour type	WHHT diagnostics	Specialist diagnostics pathway	Oncology pathway	Surgery pathway
Urological cancers (prostate, renal, testicular, penile and bladder)	Ultrasound and flexi cystoscopy at HHH, MRI and template biopsies at WGH & SACH Some MRI capacity outsourced to Spire Bushey	PET CT scans at Paul Strickland Scanning Centre	Brachytherapy at MVCC	Surgery at WGH & SACH for less complex cancers, specialist surgery at the Lister Hospital (ENHT is the specialist centre for Luton, South Bedfordshire and Hertfordshire)
Gynaecological cancer	Rapid access clinics at WGH and SACH Colposcopy at WGH and SACH, hysteroscopy at SACH	MRI at Paul Strickland Scanning Centre	Chemotherapy and radiotherapy at MVCC Complex chemotherapy at UCLH	Surgery at WGH (WHHT is the specialist centre for Luton, South Bedfordshire and Hertfordshire)
Haematological cancers	Lymph node biopsies and bone marrow undertaken at WGH	MRI and PET CT at Paul Strickland Scanning Centre.	Chemotherapy at WGH Complex chemotherapy at UCLH	
Head and neck (including ENT, thyroid and oral cancers)	Ultrasound FNA within WHHT	CT and MRI at L&D or Northwick Park Hospital	Chemotherapy and radiotherapy at MVCC	Some surgery can be done at WGH, but all specialist cancer surgery is done either at L&D or Northwick Park Hospital
Skin cancer	Skin lesion biopsies at WGH & HHH	Some more complex diagnostics at Royal Free Hospital or Lister	Chemotherapy at MVCC	Surgery at Lister or Royal Free

Pathway / Tumour type	WHHT diagnostics	Specialist diagnostics pathway	Oncology pathway	Surgery pathway
Lung cancer	CT, EBUS and bronchoscopies undertaken at WGH	PET CT at Paul Strickland Scanning Centre CT guided biopsies at Royal Free Hospital (Barnet) VATs biopsies and rigid bronchoscopies at Harefield	Chemotherapy and radiotherapy at MVCC	Surgery at Harefield
Paediatric cancer	Initial diagnostics at WGH dependent on clinical situation	GOSH for diagnostics for under 16s UCLH for diagnostics for teenagers and young adults).	GOSH and UCLH are the primary treatment centres WHHT provide a level two Paediatric Oncology Shared Care Unit at WGH to deliver some care, including less complex chemotherapy locally	Surgery at GOSH and UCLH

The trust has a good track record against the national cancer waiting time standards. However, Covid-19 has had a negative impact on both cancer waits and on the number of people being screened or referred for treatment on a suspected cancer pathway, which is likely to have a long term impact on the health of the local population. Over the next 12 months, meeting the cancer performance targets will continue to be challenging given the ongoing challenges of managing Covid-19, such as reduced capacity within radiology and for some procedures, the difficulties in supporting patients to attend hospital and the difficulties associated with self-isolation which delays pathways. Increasing capacity and recovering performance to pre Covid-19 levels and meeting the new 28 diagnosis standard will be an immediate priority along with continued improvements to pathways and a focus on integrated, personalised and consistent care.

We are committed to working with local partners through the Hertfordshire and West Essex integrated care system and the East of England Cancer Alliance to implement the National Cancer Strategy and NHS Long Term Plan cancer priorities as set out below:

- from 2019 start to roll out new rapid diagnostic centres across the country
- from 2019 begin to offer all children with cancer whole genome sequencing to enable more comprehensive and precise diagnosis and access to more personalised treatments
- in 2020 a new faster diagnosis standard for cancer will begin to be introduced so that patients receive a definitive diagnosis or ruling out of cancer within 28 days
- by 2020 HPV primary screening for cervical cancer will be in place across England
- by 2021 where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support
- by 2022 the lung health check model will be extended
- by 2023 stratified, follow-up pathways for people who are worried their cancer may have recurred. These will be in place for all clinically appropriate cancers
- by 2028 the NHS will diagnose 75% of cancers at stage one or two
- from 2028, 55,000 more people each year will survive their cancer for at least five years after diagnosis.

A key strategic priority is to develop a rapid diagnostics centre for cancer at SACH in line with the development of SACH as the planned surgical and cancer site for the trust. While this will be fully enabled by the redevelopment of the site, the introduction of CT and MRI services on the site this year will facilitate earlier implementation for some pathways. The ambition for the RDC is to enable people to attend once for tests and diagnosis wherever clinically possible, to reduce the time to diagnosis, improve patient experience, and enable quicker access to cancer nursing support and cancer information services.

Another longer term priority is responding to the findings of the Mount Vernon cancer review. We will be working with the MVCC review team to explore the potential to re-provide some of the specialist cancer services currently provided at Mount Vernon on the WGH site as well as opportunities to repatriate some activity from UCLH to provide a more local service. Our clinicians see this as a really exciting opportunity to improve cancer services for local residents.

Our other priorities include:

- work with partners to understand the drivers of inequalities in cancer outcomes between different population groups, and develop targeted actions to reduce those inequalities

- work with primary care colleagues to improve identification and referral of patients and ensure we have good systems in place to monitor and continuously improve the early detection of cancer
- strengthen our acute oncology service to support more patients with cancer admitted for emergency care
- improve pre-dying recognition and care, enabling people to die in the place of their choice and reducing deaths in hospital. More detail on priorities and plans to improve end of life care are set out in our *End of Life Care Strategy 2021 -2024*
- implement personalised care risk stratified follow-up care for key cancer pathways (first phase priority pathways are breast, colorectal and prostate, other pathways to follow in line with national guidance when confirmed)
- improve the lymph node biopsy pathway (haematological cancers)
- increase local provision of inpatient chemotherapy for haematological cancers
- increase oncology provision for lung cancer and bladder cancer pathways
- review diagnostics pathways for thyroid cancers to identify opportunities to deliver more diagnostics locally.

Glossary of abbreviations

AAA	Abdominal aortic aneurysm
A&E	Accident & emergency
AAU	Acute assessment unit
ACCP	Advanced critical care practitioner
ACU	Ambulatory care unit
AF	Atrial fibrillation
ANP	Advanced nurse practitioner
ARCU	Acute respiratory care unit
CCU	Coronary care unit
CDU	Clinical decision unit
CED	Children's emergency department
CLCH	Central London Community Healthcare NHS Trust
CPG	Clinical practice group
CT	Computerised tomography
CVH	Covid virtual hospital
DCCV	Direct current cardioversion
DVT	Deep vein thrombosis
EAU	Emergency assessment unit
EBUS	Endobronchial ultrasound service
ED	Emergency department
EEAST	East of England Ambulance Service NHS Trust
EEG	Electroencephalography
ENHT	East and North Hertfordshire NHS Trust
ENT	Ear, nose and throat
EP	Electrophysiology
EPR	Electronic patient record
EPU	Early pregnancy unit
EUS	Endoscopic ultrasound

FBC	Full business case
GAU	Gynaecology assessment unit
GI	Gastrointestinal
GPWSI	GP with a specialist interest
GIRFT	Getting it right first time
GOSH	Great Ormond Street Hospital
HF	Heart failure
HCP	Health and care partnership
HCT	Hertfordshire Community NHS Trust
HiDS	Hertfordshire integrated diabetes service
HMT	Her Majesty's treasury
HHH	Hemel Hempstead Hospital
HPFT	Hertfordshire Partnerships Foundation NHS Trust
HUC	Hertfordshire Urgent Care
HVCCG	Herts Valleys Clinical Commissioning Group
HWE	Hertfordshire and West Essex
IBD	Inflammatory bowel disease
ICD	Implantable cardioverter defibrillator
ICS	Integrated care system
ILD	Interstitial lung disease
IPC	Indwelling pleural catheter
JAG	Joint advisory group on GI endoscopy
LDUH	Luton and Dunstable University Hospital
LMNS	Local maternity and neonatal system
LNU	Local neonatal unit
LNWH	London North West Hospitals NHS Trust
MDT	Multidisciplinary team
MIU	Minor injuries unit
MPN	Myeloproliferative neoplasms
MRI	Magnetic resonance imaging

MS	Multiple sclerosis
MSK	Musculoskeletal
MVCC	Mount Vernon Cancer Centre
NIV	Non-invasive ventilation
PAU	Paediatric assessment unit
PD	Parkinson's disease
PIFU	Patient initiated follow-up
RDC	Rapid diagnostics centre
RFL	Royal Free London NHS Foundation Trust
ROSE	Rapid on-site evaluation
SACH	St Albans City Hospital
SDEC	Same day emergency care
SMART	Senior medics assessment, review and treatment
SOC	Strategic outline case
STEMI	Segment elevation myocardial infarction
TAVI	Transcatheter aortic valve implantation
UCLH	University College London Hospitals NHS Foundation Trust
UTC	Urgent treatment centre
WACS	Women's and children's services
WGH	Watford General Hospital
WHHT	West Hertfordshire Hospitals NHS Trust