Dartford and Gravesham NHS
NHS Trust

TRUST BOARD MEETING

(Formal meeting to which members of the public are invited to attend. Please note that questions from members of the public should be asked at the end of the meeting, and relate to one of the agenda items)

9.00am – 1.15pm THURSDAY 26TH JANUARY 2012

THE BOARD ROOM, LEVEL 4, TRUST HEADQUARTERS DARENT VALLEY HOSPITAL

A G E N D A – PART 1

Ref.	Item	Presenter	Enclosure
1-1	Apologies for absence	Chairman	Verbal
1-2	Standing order 12.1 - Declarations of Interest	Chairman	Verbal
1-3	Minutes of the Part 1 meeting of 20th December 2011	Chairman	1
1-4	To note outstanding actions from previous meetings	Chairman	2
1-5	To receive a Chief Executive's report	Chief Executive	3
1-6	**QUALITY**		
	Patient experience		
1-6.1	Self-assessment against areas to be covered in the recommendations from the Mid Staffordshire NHS Foundation Trust Public Inquiry	Director of Nursing	4
1-6.2	To receive a draft Dementia strategy	Director of Nursing	5
	Quality & Safety Committee		
1-6.3	To receive a summary of the meeting of 19th January 2012, including: ▪ An update on latest complaints cases; ▪ The monthly Infection Prevention & Control report	Committee Chair (Non-Executive Director) Director of Nursing Chief Executive	6 7
1-6.4	To receive the minutes of the meeting of 15th December 2011 (including the committee action log)	Committee Chair (Non-Executive Director)	8
	Organisational culture		
1-6.5	To receive an update on developments	Chief Executive	9
1-7	**INNOVATION**		
1-7.1	Emergency Department & ECIST – closure report	Director of Operations	10
1-7.2	To receive an update on the Cancer Intensive Support Team visit and resulting actions	Director of Operations	11
	BREAK		
1-8	**PRODUCTIVITY**		
1-8.1	To receive the Performance report (month 9, 2011/12) (to include Q3 self-certification against targets)	Director of Performance and Business Intelligence	12
1-8.2	To receive the Finance report (month 9, 2011/12)	Director of Finance	13
1-8.3	To receive the Quality, Innovation, Productivity & Prevention (QIPP) programme report (month 9, 2011/12)	Director of Finance / Director of Operations	14
	Finance Committee		
1-8.4	To receive a summary of key actions of meeting of 24th January 2012	Committee Chair (Non Executive Director)	Verbal
1-8.5	To receive the minutes of meeting of 20th December 2011	Committee Chair (Non Executive Director)	15 [1]

[1] This attachment has been circulated with the Part 2 (non-public) papers

Ref.	Item	Presenter	Enclosure
1-9	**ASSURANCE**		
	Audit Committee		
1-9.1	To receive the minutes of meeting of 13th January 2012	Committee Chair (Non Executive Director)	16
1-9.2	To approve revised Terms of Reference	Committee Chair (Non Executive Director)	17
	Partnership Board		
1-9.3	Receipt of The Hospital Company's statement of compliance re legal responsibilities	Chief Executive	18
1-9.4	To approve revised Terms of Reference	Chief Executive	19
	Council of Governors		
1-9.5	To receive the minutes of meeting of 16th November 2011	Chairman	20
1-10	**STRATEGIC**		
1-10.1	Consideration of Outline Business Case for location of pathology laboratories at Dartford and Gravesham NHS Trust & Medway NHS Foundation Trust	Deputy Chief Executive [2]	21 (& presentation)
	Proposed integration with Medway NHS Foundation Trust		
1-10.2	To receive an update on developments (including approval of proposed amendments to the Scheme of Delegation for the integration)	Deputy Chief Executive [3]	22
1-10.3	To approve the Terms of Reference and Membership of the Integration Programme Board	Deputy Chief Executive [3]	23
1-10.4	To approve the Outline Business Case for the integration *Please note that some of the content for this discussion is within the Part 2 papers*	Deputy Chief Executive [3]	24
1-11	**ITEMS FOR INFORMATION**		
1-11.1	To note the Trust Board forward programme of agenda items	Chairman	25
1-12	**TO CONSIDER ANY OTHER BUSINESS**		
1-13	**TO RECEIVE ANY QUESTIONS FROM MEMBERS OF THE PUBLIC**		
1-14	**To approve the motion that in pursuance of the Public bodies (Admissions to meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted**	Chairman	Verbal
	DATES OF FUTURE MEETINGS: ▪ 9 a.m. Thursday 23rd February 2012, Boardroom, Darent Valley Hospital ▪ 9 a.m. Thursday 29th March 2012, Boardroom, Darent Valley Hospital ▪ 9 a.m. Thursday 26th April 2012, Boardroom, Darent Valley Hospital ▪ 9 a.m. Thursday 31st May 2012, Boardroom, Darent Valley Hospital ▪ 9 a.m. Thursday 28th June 2012, Boardroom, Darent Valley Hospital ▪ 9 a.m. Thursday 26th July 2012, Boardroom, Darent Valley Hospital		

Sarah Dunnett,
Chairman

[2] The joint Pathology team will be in attendance for this item
[3] The Programme Director and Integration Director will be in attendance for these items

Dartford and Gravesham NHS
NHS Trust

DRAFT, FOR APPROVAL

MINUTES OF THE DARTFORD & GRAVESHAM NHS TRUST BOARD MEETING (PART 1) HELD ON TUESDAY 20TH DECEMBER 2011 AT DARENT VALLEY HOSPITAL

Present:	Sarah Dunnett	Chairman	(SD)
	Susan Acott	Chief Executive	(SA)
	Mick Bull	Director of Finance	(MB)
	Julie Hunt	Director of Operations	(JH)
	Stuart Jeffery	Director of Performance & Business Intelligence	(SJ)
	Jenny Kay	Director of Nursing	(JK)
	Gerard Sammon	Deputy Chief Executive (from item 12-8.2)	(GS)
	Brian Bowes	Non Executive Director	(BB)
	Bernie Holloway	Non Executive Director	(BH)
In attendance:	Kevin Rowan	Trust Secretary	(KR)
	David Brennan	Member of the public	(DB)

12-1 APOLOGIES FOR ABSENCE

Apologies were received from Andy Brown, Director of Human Resources (AB); Annette Schreiner, Medical Director (AS); Penny McCulloch, Non Executive Director (PMC); Kate Nightingale, Non Executive Director (KN), and Karen Taylor, Non Executive Director (KT).

SD clarified that although there were a number of absences, the Board was still quorate.

12-2 STANDING ORDER 12.1 – DECLARATIONS OF INTEREST

There were no declarations of interest.

12-3 MINUTES OF THE PART ONE MEETING HELD ON 24TH NOVEMBER 2011

The minutes of the previous meeting were accepted as an accurate record of the meeting, apart from the following amendments:

- Item 11-6.5, page 4 - replace "JK added that it should be recognised that there was far more standardisation on wards than previously…" with "JK added that it should be recognised that there was far more standardisation on wards than previously, for example…".
- Item 11-10.4, page 9 - replace "JK referred to the Sustainability action plan and asked SJ to ensure that she was kept informed of any plans to undertake patient surveys…" with "JK referred to the Sustainability action plan and asked SJ to ensure that she was kept informed of any plans to undertake community engagement…".

Action: Amend November minutes (Trust Secretary, December 2011)

12-4 TO NOTE OUTSTANDING ACTIONS FROM PREVIOUS MEETINGS

The circulated paper was noted. The following actions were discussed in detail:

- Item 8-7.1. SJ stated that he had pursued a response from CHKS, but had still not received a reply to his request regarding comparative data on best-practice tariff procedures.
- Item 11-6.4. JH stated that she and SJ had discussed this, and noted that best-practice tariff procedure data had actually been circulated in the Summer of 2011, but would be circulated again in the light of the comments received at the November Board meeting.

12-5 TO RECEIVE A CHIEF EXECUTIVE'S REPORT

SA referred to the circulated paper and highlighted the following:

- A clinical panel met on 28th November to consider a proposal from the pathology teams at Darent Valley Hospital and Medway Maritime Hospital regarding the future location of main ('cold') and hot laboratories across the two hospital sites. The recommendation made by the Clinical Directorate management teams was that Darent Valley Hospital hosts the main

laboratory and Medway Maritime Hospital retains a 'hot' laboratory. The panel accepted this recommendation and agreed that an Outline Business Case would be considered by both Trust Boards in January 2012. SA explained that a main/'cold' laboratory was primarily for GP work, as inpatient work would be undertaken by a 'hot' laboratory. SA stated that the decision was primarily related to relative costs, and noted that if the costs involved change by more than 10%, the decision may have to be reviewed.

- In December 2012, the Maternity Department underwent a CNST risk management standards assessment and retained level 1 status, but was unable to demonstrate compliance with level 2 requirements. SA stated that there will be a debrief in the new year to understand the reasons for this, and identify any lessons learned.
- The Trust is introducing "Every Thank You Counts" monthly staff awards, and the first awards, for October and November, were issued on 16th December. JK added that the staff had wanted to manage the awards in-house, rather than engage an external company.
- The NHS Operating Framework for 2012/13 has been issued.
- The Trust was likely to be subject to some media coverage in the coming days in relation to the a patient's care and treatment in 2009 (Mr Buck)

SD referred to the fact that a main laboratory was primarily for GP work, and asked which Trust would bear the risk in relation to such GP work. SA stated that the Business Case would be expected to cover this aspect.

SD asked whether there was any publicity for the "Every Thank You Counts" awards in the main hospital reception area. JK stated that there was no such publicity at present, but the awards would be formally launched in January 2012, and range of publicity was planned.

SD asked whether the Trust had met with the family of Mr Buck. JK stated that she and Sue Craven had met with the family at their home address, and JK had also spoken with Mr Buck's sons on 19th December 2011. JK continued that following the latter conversation, she had agreed to write to the family outlining the improvements that had taken place at the Trust since 2009.

SD referred to the Operating Framework changes, & asked whether there had been any analysis of Reference Costs. MB stated that a report on this will be submitted to the Finance Committee.

SD referred to the list of national performance measures for 2012/13 in Appendix 1 of the circulated paper, & asked SJ whether there was anything that caused him concern. SJ stated that it seemed as if the status of the 31-day Cancer wait target had been elevated, but this should not pose concern, as the Trust's performance on that target was in accordance with requirements.

12-6.1 TO RECEIVE A SUMMARY OF THE MEETING OF 15TH DECEMBER 2011, INCLUDING: AN UPDATE ON LATEST COMPLAINTS CASES

JK referred to the circulated summary and explained that the 'Never Events' on ITU referred to in the commentary for the 'Patient Safety Committee' were separate from the serious incident of child abuse, which was also referred to. JK clarified that the child involved in the abuse case was brought to the hospital for treatment, & the associated incident/s did not take place at the hospital.

JK also highlighted the following points:

- The Trust had established that it had misinterpreted the question posed by Dr Foster in relation to Consultant medical staffing at weekends, and have written to Dr Foster requesting a correction be made. SJ added that he is engaged in active e-mail correspondence with Dr Foster on this matter.
- The report from Radiology received at the Quality & Safety Committee was one of the better Directorate reports received by the Committee.

SD referred to the comment in the report that it will take two years to obtain full compliance with a new antibiotic prescribing policy, and asked whether SA was able to discuss this further with Clinical Directors. SA stated that she had met that morning with Dr Workman, the Director of Infection Prevention and Control, and stated that Dr Workman has a series of meetings scheduled with clinicians to discuss this. SA stated that she would ensure that Dr Workman's authority on this matter was clearly understood by Trust clinicians.

BB commented that the Quality & Safety Committee had been advised that it was very rare for two 'Never events' to occur, & that initial investigations indicated that there was no link between them.

SD clarified that the Quality & Safety Committee did not actually receive a Non-Medical Education report, despite this being stated in the circulated paper.

JK then referred to the circulated Complaints report, and highlighted the following:

- Following a request at the November Board, the 'reason for complaint' section now included data over the past 12 months;
- A&E complaints had reduced slightly in November, and EDWIC did not have any complaints for that month

SD referred to the A&E complaints report in Appendix 3, and stated that she could not make a link between the issues listed on page 10 and the rest of the text. BH added that the A&E report lacked structure, and many of the points listed under the 'conclusion' section did not appear to actually be conclusions. JK acknowledged the points and stated that she had not edited the Directorate report as she has done on previous occasions, as she wanted the Directorate to take more responsibility for their report. JK added that she recognised that some coaching/mentoring in report-writing skills was required in certain Directorates.

THE MONTHLY INFECTION PREVENTION & CONTROL REPORT

SA referred to the circulated paper and highlighted the following:

- The Trust had now had 20 cases of clostridium difficile, which was the maximum allowed for the 2011/12 year;
- A review of each clostridium difficile case is undertaken to identify any lessons learned;
- The Antimicrobial Stewardship Group was due to meet in February 2012, but SA had asked Dr Workman to bring the meeting forward to January 2012;
- E coli cases were discussed at the December Quality & Safety Committee, and it was noted that the infection control leads in Kent are reviewing the situation, as there were a large number of pre-48 hour (i.e. community-acquired) cases across Kent

JK clarified that the E coli cases occurring in Kent were not of the 0157 strain i.e. the most dangerous strain of E coli.

BB asked why the Trust was performing so well regarding preventing Norovirus outbreaks. JK stated that this was likely to be the result of a number of factors, including the policy of ensuring staff do not attend work for 72 hours following symptoms of diarrhoea or vomiting.

SD asked whether the Board should also receive contextual information on activity as well as the number of clostridium difficile infections. SJ stated that previously, the Board had received information of the number of cases per 10,000 admissions. It was agreed that the Board should routinely receive the rate of clostridium difficile cases per 10,000 admissions in future reports.

Action: Include the rate of clostridium difficile cases per 10,000 admissions within future infection control Board reports (Chief Executive, January 2012 onwards)

SA asked whether SJ had made any progress in relation to the Trust having an amended clostridium difficile trajectory. SJ stated that as yet there had been no agreement to raise the trajectory, but he was continuing to pursue this.

12-6.2 TO RECEIVE THE MINUTES OF THE MEETING OF 17TH NOVEMBER 2011 (INCLUDING THE COMMITTEE ACTION LOG)

The circulated minutes were noted.

12-6.3 THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY – BRIEFING ON EXPECTED FINDINGS AND RECOMMENDATIONS

SD referred to the circulated paper and noted that the Kent and Medway PCT Cluster had highlighted that the Public Inquiry had indicated the areas in which it was likely to make recommendations, when the Inquiry report is issued in 2012. JK added that since the report had

been circulated, she had discussed the matter with the Strategic Health Authority, who expected the main recommendations of the Inquiry to be directed towards external regulatory agencies.

JH referred to the text for number 7 on the list in the circulated paper and queried whether some words were missing, as the text did not read correctly.

[Post-meeting note: The wording of the text for number 7 in the circulated report ("The engagement of healthcare generally in the 2 leadership and management of their organisations") has been confirmed as correct in that it reflects the verbatim wording from the transcript of the Public Inquiry proceedings].

JH highlighted that the area listed for number 13 ("The potential adverse consequence of structural reorganisations and the requirements for addressing these") was likely to be of particular importance to the Trust, given the proposed integration with Medway NHS Foundation Trust.

SD noted the importance of patient experience to the Inquiry, and asked JK for an update on the work being undertaken by the external facilitator that had been engaged, Kate King. JK stated that Ms King had undertaken work on 2 wards, Maple and Ebony. JK continued that on Maple, good progress had been made, and Ms King had undertaken observations of care and individual coaching, and has now left the ward for them to continue their progress. JK noted that for Ebony, progress had not been as advanced, primarily due to the recent absence of the Ward Sister, and therefore Ms King wished to continue her work on that Ward. JK also explained that as the work on Ebony and Maple has been discussed via the 'Clinical Friday' meetings, the impact of the work is likely to be felt on other wards too.

SD proposed that the Ward Sister for Maple attend the Board within the next 3 months, to share what has been learned via Ms King's work. The proposal was agreed.

Action: Arrange for the Sister for Maple Ward to attend the Board before March 2012, to share what has been learned via the work of the external facilitator engaged to assist in improving patient experience (Director of Nursing / Trust Secretary, December 2011 onwards)

12-7.1 TO RECEIVE AN UPDATE ON THE CANCER INTENSIVE SUPPORT TEAM VISIT

JH referred to the circulated paper, and highlighted the following:

- The action plan contained actions that the Trust had already developed before the Intensive Support Team's (IST) visit, in addition to the actions recommended by the IST;
- The timescales listed in the plan were probably generally unrealistically optimistic given that most should be completed this month. JH will suggest that the Macmillan Lead Cancer Nurse asks the Cancer Services Committee to reconsider some of the resolution dates;
- There are emerging concerns related to colorectal cancer around pressure in histopathology due to sickness, the forthcoming public awareness campaign to be launched in January 2012 and the recently-agreed age extension for bowel cancer screening. JH stated that the public awareness campaign and age extension will increase the demand for a service which in the early stages of improvement, and noted that this will need constant monitoring to ensure improvement is sustained.
- For Histopathology, one of the Trust's Consultant Histopathologists was on sickness absence, and the Trust was exploring the acceleration of the move to Maidstone Hospital, which was scheduled for April 2012.

SA noted that most of the actions recommended by the IST were rated as green or amber, but those related to the trust original action plan were rated as red. SA stated that the Trust needed to consider whether it should move to 42-week capacity planning. SJ acknowledged the suggestion.

BH asked what the process was for developing the action plan, & whether actions were considered in terms of their relative priority. JH stated that the plan was developed & owned via the Cancer Services Committee, & the priority was for actions that aimed to improve patient waiting times.

SD commented that the action plan was complex, and queried the benefit of including non-IST-related actions. SD stated that there was no need for the IST and non-IST actions to be split into two separate action plans, but explained that she was seeking assurance that there was sufficient

resource available to implement all the actions listed. JH stated that she will provide feedback on that point to the Macmillan Lead Cancer Nurse.

Action: Continue to monitor progress of the Cancer plan & in particular report back on the emerging concerns re histopathology (Director of Operations, December 2011 onwards)

BB asked whether meeting the waiting times targets led to quality issues further along the patient pathway. JH confirmed this was not the case. SA added that there was very clear national guidance that patients should not be placed under pressure to be treated quicker than they wished.

12-8.1 TO RECEIVE THE PERFORMANCE REPORT (MONTH 8, 2011/12)

SJ referred to the circulated paper and highlighted the following

- The A&E 4-hour wait performance target was met in November, and the Trust had now established a system enabling SMS text messages to be issued to selected personnel every hour, outlining key information on wait times, breaches etc;
- The Midwife to birth ratio was 39 in November, and although significant recruitment of midwives is in progress, the Trust was still 20 midwives below its establishment. SJ stated that it was expected to take a few more months to recruit to full establishment, but once this had occurred, the ratio would drop to the target of 34;
- There had been a rise in the number of grade 3 and 4 pressure ulcers in November;
- Phase 4 of the Emergency Department redesign is scheduled to take place in January 2012

JK stated that some of the pressure ulcer cases had been subject to Root Cause Analysis, but highlighted that some of the cases were atypical.

SD referred to the emergency admissions target, and asked what the Trust's performance needed to be for the rating to be green. SJ stated that he believed the rate of emergency readmissions would need to drop to 4% from the current level of 5%.

SD referred to the report highlighting an apparent lack of engagement of the Urgent Care Board with efforts to reduce emergency readmissions, and asked JH for her views on this. JH stated that for the PCT and Clinical Commissioning Groups, their priorities were likely to be the areas that would have the most significant impact on finances, and emergency readmissions did not meet this criterion. JK commented that this was a frustrating situation, and noted that a number of recommendations for schemes that would reduce emergency readmissions had been made at a recent PCT-led meeting, but these had not been recorded in the notes of the meeting. SA stated that this needed to be raised with the PCT.

JK also highlighted a recent case that had been brought to her attention, which involved admissions to numerous care providers, and which illustrated the apparent lack of an integrated approach to managing patients with long-term conditions. SJ stated that he believed the 2011/12 Operating Framework required PCTs to specify how they planned to spend the funds received from non-payment of emergency readmissions, and stated that if this was the case, he would make a request to the PCT to state how they planned to spend such funds.

MB stated that following his attendance at recent meetings with his counterparts in the local health economy, he believed that the Trust needed to be more direct in making the cases for schemes that would reduce emergency readmissions, and outline the financial benefits of such schemes. SA stated that she would follow-up this issue with the Chief Executive of the PCT Cluster, as there was a disconnect between strategic intent and actual practice. SA added that the Trust needed to consider what areas it regarded as the key priorities that would have an impact, and which needed to be pursued at a strategic level. SA proposed that these areas were palliative care; liaison psychiatry; and intermediate care.

BH asked why A&E 4-hour wait performance was forecast to be worse at year-end than current performance. SJ stated that the year-end forecast anticipated the impact of winter pressures.

JH brought the Board's attention to a request for an A&E divert from Queen Elizabeth Hospital, which was seemingly accepted by London Ambulance Service (LAS) without the agreement of this Trust. JH stated she would be discussing this matter with LAS. SA suggested that JH also discuss this with Queen Elizabeth Hospital.

SD referred to VTE assessment and asked SJ whether 95% performance was as good as the Trust could expect to achieve. SJ stated that the Trust was aware of the areas it needed to focus on to achieve the required next step-change.

12-8.2 TO RECEIVE THE FINANCE REPORT (MONTH 8, 2011/12)

MB referred to the circulated paper and highlighted the following key points:

- The report was scheduled to be discussed in detail at the Finance Committee which will take place at 2pm that day;
- Income has risen, which is related to the fact that the Trust has undertaken some planned extra Saturday waiting list activity;
- Pay costs have risen, related to November being a 5-week month, and also some back payments in Radiology;
- The non-pay expenditure trend is similar to the previous month;
- The year-end forecast was for a break-even position (excluding IFRS adjustment), but this was dependent on the Trust receiving £3m of support related to its PFI. MB stated that the indications are that such support is not likely to be received via central sources, but could be received from within the local health economy. MB added that if the Trust does not receive this support until the end of March 2012, this will result in pressures on the cash position, and a paper on this issue has been submitted to the Finance Committee;
- The challenge for the remaining months of the year was to ensure control totals are complied with in full;

SD asked whether MB had received anything in writing regarding a commitment for the £3m of PFI-related support. MB confirmed that nothing had yet been received in writing, but he had received verbal commitments which he had included in written correspondence to the PCT Cluster. SA added that the SHA did have a potential source of funding for such support, and the SHA recognised that the Trust had a legitimate claim for such support.

12-8.3 TO RECEIVE THE QUALITY, INNOVATION, PRODUCTIVITY & PREVENTION (QIPP) REPORT (MONTH 8, 2011/12)

MB referred to the circulated paper and stated that QIPP performance was good, with the year-end performance forecast to achieve 110% of plan. MB added that the QIPP report needed to be updated to capture all the schemes that are being put in place, which will improve the position stated in the circulated report.

12-8.4 TO RECEIVE THE MINUTES OF THE FINANCE COMMITTEE MEETING OF 22ND NOVEMBER 2011

BH referred to the circulated minutes and noted that the minutes contained an error that would be corrected at the Finance Committee that was scheduled to take place later that day.

JK referred to the update on the Bed Management contract discussed at the meeting, and commented that the overspend was caused by the additional repair work that the new contractor, Linet, had to undertake, to ensure the existing bed stock was at the required standard. JK stated that this cost was therefore non-recurrent. SD commented that the cost of such repair work should have been identified via the due diligence that Linet would have undertaken prior to accepting the contract. JK acknowledged the point, but stated that the Trust also had responsibilities regarding the state of the existing bed stock.

12-9.1 TO RECEIVE AN UPDATE ON DEVELOPMENTS OF THE PROPOSED INTEGRATION WITH MEDWAY NHS FOUNDATION TRUST

GS referred to the circulated paper and highlighted the following points:

- The production of the Outline Business Case was continuing, and the intention remained to submit this to the Integration Programme Board (IPB) in January 2012;
- Communications and engagement activity was continuing apace, including liaison with the SHA, PCT, GP commissioners, the Cooperation and Competition Panel, and Monitor

- The impact of the Operating Framework for 2012/13 on the Long Term Financial Model (LTFM) for the integrated Trust was being considered, and appeared to lead to a slightly improved 'bottom line' position

BH referred to the Organisational Development (OD) strategy, and asked whether this would include details of the organisational structure of the integrated Trust. GS replied that the strategy would not contain such details, as these would be within the business case / plan. SA explained that the post-integration structure would be within the post-transaction implementation plan (PTIP), whilst the OD strategy would contain the vision and cultural aspirations for the integrated Trust. SA also noted that the Trusts had already committed to maintaining the existing Clinical Directorate structures for a period after integration.

SA noted that at Medway Health & Adult Social Care overview & scrutiny committee, a question had been asked as to how the Trusts would know when they had engaged with sufficient members of the public. GS stated that there were a number of metrics that could be used to assess this, such as levels of local media coverage, the number of 'hits' on websites and social media. GS continued that standards had not previously been set for such metrics, but will now be set.

BH referred to the revised LTFM, and asked whether the pay inflation calculations included provision for Agenda for Change incremental drift. GS confirmed that this had been taken into account. SA added that it had been recognised that there were differences between how the Trusts budgeted for incremental drift, and it was intended to reconcile such differences.

JK highlighted that in relation to CQUIN payments, it was important to be clear whether CQUIN was available as part of annual out-turn, or on top of out-turn. MB acknowledged this was an important point.

12-9.2 APPROVAL OF SCHEME OF DELEGATION FOR INTEGRATION

GS referred to the circulated paper and invited questions.

BH referred to the decision listed in 10.e., and asked what exactly would be contained within the Organisational Development Strategy for the integrated organisation. SA explained that this Strategy related to the values and vision, rather than organisational structure. BH then asked whether the Board would have sufficient influence over the structure of the integrated organisation, given that the Scheme noted that the 'determination of Executive Management structure and appointment of the Executive Director roles…' was a decision reserved for the Chief Executive Designate (14.f). KR explained that the business case / plan for the integrated organisation would contain details of the proposed organisational structure, and the Board would be expected to approve these, which were covered in the circulated paper under 10.c and 10.d.

BB asked whether the Scheme of Delegation had been validated by external legal advisors. KR stated that a legal opinion had not been sought, but the M&A advisors, Pricewaterhouse Coopers, had reviewed the Scheme, and had been present at the Integration Programme Board meetings at which it had been discussed.

The Scheme of Delegation was approved as circulated.

12-10.1 TO NOTE THE TRUST BOARD FORWARD PROGRAMME OF AGENDA ITEMS

The forward programme was noted.

12-11 TO CONSIDER ANY OTHER BUSINESS

There was no other business.

12-12 TO RECEIVE ANY QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions were received.

Dartford and Gravesham NHS
NHS Trust

TRUST BOARD MEETING – JANUARY 2012

1-4 LOG OF OUTSTANDING ACTIONS FROM PREVIOUS MINUTES CHAIRMAN

Actions due

Ref.	Action	Person responsible	Deadline	Progress
8-7.1 (Aug 11)	Aim to include comparative data on performance against best-practice tariff procedures within future 'Facing the Future' programme reports to the Trust Board	Director of Performance & Business Intelligence / Director of Operations	November 2011 onwards	**In progress** (the Trust does not have access to such data, so a request has been made to CHKS to provide this. A response is awaited)
8-8.2 (Aug 11)	Write to the Department of Health regarding the identified gap in the Trust's income position for 2011/12 (and request that the local MP also writes to the Department)	Chairman	August 2011 onwards	**In progress** (It is proposed to await the final outcome of the Department of Health-led review of PFI hospitals before sending a letter, as the review outcome may negate the need)
9-7.5 (Sept 11)	Establish how the role of 'Patient Safety Ombudsman' (or equivalent) operates at Brighton and Sussex University Hospitals NHS Trust	Director of Nursing	October 2011 onwards	**Completed** (discussion held with Brighton and Sussex University Hospitals NHS Trust. It is felt that the Chair of the Patient Safety Committee is fulfilling a similar role, so it is not proposed that this role be introduced at Darent Valley Hospital)
10-5 (Oct 11)	Arrange for an informal afternoon session to be held with Dartford, Gravesham and Swanley Clinical Commissioning Group	Trust Secretary	November 2011 onwards	**Completed** (the CCG have accepted an invitation to attend a session on the afternoon of the March 2012 Board meeting)
10-6.5 (Oct 11)	Refine the Quality Standards in accordance with comments made at the Trust Board and re-submit for consideration	Chief Executive / Director of Operations	November 2011	**Completed** (This will be considered at the January 2012 Board meeting)
11-6.2 (Nov 11)	Provide the Board with assurance regarding the management of medical devices (particularly in relation to the risk of equipment loss)	Medical Director / Director of Finance	November 2011 onwards	**In progress** (the matter was discussed at the Medical Devices Committee)
11-9.1 (Nov 11)	Expand the level of detail provided within the Board report on infection	Director of Infection Prevention &	November 2011 onwards	**In progress** (this information is included in the report submitted to the

Item 12-4. Attachment 2 - Log of actions from previous minutes

Ref.	Action	Person responsible	Deadline	Progress
	prevention and control, to include: benchmark data (i.e. performance of other Trusts in the local health economy); context (including any relevant national information); and details of action taken	Control		January 2012 Board meeting)
11-13 (Nov 11)	Submit a paper to the Board to enable ratification of any decision regarding the future location of 'cold' laboratory facilities for Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust	Chief Executive	January 2012	**Completed** (An Outline Business Case has been submitted to the January 2012 Board meeting)
8-9.1 (Aug 11)	Attend the Board in January 2012 to provide an update on progress	Director of Infection Prevention and Control	January 2012	**Completed** (The DIPC actually attended in November 2011, and it was agreed that the DIPC would attend the Board on a quarterly frequency. DIPC attendance in 2012 has therefore been scheduled for February, May, August and November)
10-7.2 (Oct 11)	Submit a 'closure' report relating to implementation of the ECIST recommendations to the Board in January 2012	Director of Operations	January 2012	**Completed** (report submitted to January 2012 Board)
10-10.4 (Oct 11)	Investigate, via the Charitable Funds Committee, why the Dartford and Gravesham NHS Trust Charitable Fund carried forward a £200k balance into 2011/12, and report the outcome to the Board	Chair of Charitable Funds Committee / Trust Secretary	January 2012	**In progress** (The Charitable Funds Committee will consider this matter when it next meets, on 1st February 2012)
12-3 (Dec 11)	Amend November minutes	Trust Secretary	December 2011	**Completed** (minutes amended)
12-6.1 (Dec 11)	Include the rate of clostridium difficile cases per 10,000 admissions within future infection control Board reports	Chief Executive	January 2012 onwards	**Completed** (data comparing the 4 Kent Trusts against a rate per 100,000 bed days is included in the Infection Prevention and Control report to January's Board)
12-6.3 (Dec 11)	Arrange for the Sister for Maple Ward to attend the Board before March 2012, to share what has	Director of Nursing / Trust Secretary	December 2011 onwards	**In progress** (a clinical presentation on 'orthogeriatric services' is being arranged for April.

Ref.	Action	Person responsible	Deadline	Progress
	been learned via the work of the external facilitator engaged to assist in improving patient experience			The Matron for Maple will attend for that presentation, and include details of the learning and its effect on patient experience)
12-7.1 (Dec 11)	Continue to monitor progress of the Cancer plan & in particular report back on the emerging concerns re histopathology	Director of Operations	December 2011 onwards	**In progress** (There is a strategic plan which will ensure the future viability of the Histopathology service)

Outstanding actions not yet due

Ref.	Action	Person responsible	Deadline	Progress
8-6.3 (Aug 11)	Submit a report on the progress on actions taken to address the issues raised by the Care Quality Commission to the March 2012 Board	Director of Nursing	March 2012	**In progress** (item added to forward programme)
8-6.7 (Aug 11)	Ensure the medical and non-medical education and learning annual reports are submitted to the Quality & Safety Committee (and not the Trust Board, unless requested by the Quality & Safety Committee)	Medical Director / Director of Human Resources / Trust Secretary	April 2012	**In progress** (items removed from Board forward programme)

Dartford and Gravesham NHS
NHS Trust

TRUST BOARD MEETING - JANUARY 2012

Item 1-5. Attachment 3 - Chief Executive Report

1-5 CHIEF EXECUTIVE'S REPORT CHIEF EXECUTIVE

As is often the case at this time of year the hospital has been under extreme pressure. In part this is due to the usual high winter demand but other factors have contributed this year including:

- Reduction in the number of acute beds in the local area – a combination of our reduced bed numbers, (50+ reduction since last year at the same time) and the loss of the QMHS beds.
- Ambulance transfers from London – whilst the increase in number has been relatively stable since the surge last year the different operating policies of LAS have created some challenges for us
- The criteria for use of the Community Hospitals remains restrictive allowing us to transfer a lower number of patients than we could.
- Discharge delays for Bexley patients where onward rehabilitation is required and complex packages of care.

A number of measures have been put in place to address these including opening of all on-site escalation areas and the use of the virtual ward beds at Priory Mews Nursing Home. The criteria for the Livingston Community Hospital and the Sapphire Unit at Gravesend have been flexed to accommodate additional patients. Additionally we have amended the Consultant/Doctor responsibilities across the outlier wards for medical patients to maximise efficient, safe working. Discussions have been ongoing with colleagues in Health & Social Care in Bexley and with London Ambulance to address issues arising form South East London. West Kent issues continue to be addressed via the local Urgent Care Board. The pressures have impacted on performance for the first 2 weeks of January which we are currently working to redress although we have minimised this as far as possible and remain on track to achieve year end target positions.

I had hoped that work on the **A&E car park extension** would have been well underway by now. Unfortunately the Hospital Company needed approval from the Bond Holder via the Technical Adviser and this has taken longer than expected. Construction tenders have been received and Vinci are using the time to ensure they secure the best price. It is still likely that works will start on site before the end of January. Contingency plans are being put in place to use the main site roads and the temporary car park to accommodate overspill parking during the works to the car park.

Jenny Kay, Annette Schreiner and I presented to the PCT's Quality and Safety Committee recently, concluding the "**Deep Dive Assurance Framework**" process, which is being applied to all provider organisations in the Cluster. The process involved reviewing the Trust's quality processes, outcomes and capability (within patient safety, patient experience & clinical effectiveness) against a series of questions. Each question required a response supported by evidence, which was then scrutinised by senior PCT staff within a series of meetings. The conclusion of the review was positive, allowing a joint assessment of the Trust's approach to quality on a variety of measures. This will inform future work with the PCT through the usual quality performance meetings and also help to inform the Trust's quality plan for 2012/13. A presentation will be given to the February Quality and Safety Committee on the overarching themes and the Trust's response to these.

I am pleased that Sue Craven has arranged an opportunity for colleagues to review our progress in the **Enhancing Quality programme**, with posters which will be on display in the Board Room and Philip Farrant Education Centre. The programme is celebrating its first year of achievements and quality improvements at a major conference in Gatwick on the 25th January. The Dartford and Gravesham EQ teams, including specialist nurses Michelle Yeadon (Hips and Knees), Tendai Zinyengere (Pneumonia) & Julia Gladman (Myocaridal Infarction & Heart Failure) will be attending and showcasing their achievements and progress to colleagues from the South of England.

Myself and Mark Devlin hosted an evening event with the **Heads of Nursing / Matrons** from Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust on 17th January. The

event was informal, and designed to develop relationships between these groups of senior clinical leaders. This builds on earlier work between the two DoN and gives an excellent opportunity to build learning, develop ideas and create innovation.

A 'Heads of Agreement' has been reached on the proposed scheme design for the **NHS Pension Scheme** to be introduced in 2015. The next steps are that the unions have agreed to take to this to their Executives. Further work on the remaining details will take place in the new year, and Union Executives will consult members as appropriate. The agreement includes a commitment to suspend any further industrial action while the final details are resolved and Unions are consulting their members (though Unite's NHS executive has voted to reject the offer). Further details can be accessed at: www.dh.gov.uk/health/2011/12/pensions-agreement/. On 19th January, the Trust held a pensions advice session for staff, delivered by pensions experts of the Kent and Medway NHS Payroll Services. A further session is scheduled for 15th February 2012. A separate session for medical staff is scheduled for 25th January (with the British Medical Association)

The Secretary of State for Health has announced that the date for the establishment of **Local Healthwatch**, the new local health bodies set to replace Local Involvement Networks (LINk), will now be April 2013 (it had originally been planned to establish Local Healthwatch in October 2012). Healthwatch England will continue to be established in October 2012, as the national body providing leadership and support to Local Healthwatch organisations. Local Healthwatch will have several functions including: gathering views and understanding the experiences of patients and the public; making people's views known; promoting and supporting the involvement of people in the commissioning and provision of local care services and how they are scrutinised; recommending investigation or special review of services (via HealthWatch England or directly to the Care Quality Commission); & providing advice and information about access to services and support for making informed choices. The Board will be aware from my report in August 2011 that Kent and Bexley are among the 75 Local HealthWatch 'pathfinders' that were announced last year.

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Information

Equality Impact Assessment initial screening applicable to this report? No

This report provides information on the following annual objectives (delete as required)**:**

- To improve patient experience and patient safety, and achieve the best health outcome for patients, through implementation of the Quality Plan for 2011/12;
- To maintain the highest standards of cleanliness and reduce healthcare associated infections, maintaining a zero tolerance approach to infections acquired within Darent Valley Hospital;
- To develop productive relationships with emerging GP Consortia, local authorities, and other new partners, in order to provide sustainable services for the community, and achieve a sustainable local health economy;
- To recruit excellent staff, and develop, manage, lead and support our staff fairly, to ensure they are motivated to deliver high quality and excellent services;
- To deliver the objectives set out in the Financial Plan for 2011/12, including the delivery of a Quality, Innovation, Productivity and Prevention (QIPP) programme that develops patient pathways which provides care closer to patients' homes, and improves the efficiency of the services the Trust provides, thereby saving resources and releasing capacity

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors understanding of the Trust & its performance

Dartford and Gravesham NHS
NHS Trust

TRUST BOARD MEETING - JANUARY 2012

Item 1-6.1. Attachment 4 - Francis Inquiry assessment

1-6.1	**THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY – ASSESSMENT AGAINST EXPECTED FINDINGS AND RECOMMENDATIONS**	**DIRECTOR OF NURSING**

The Mid Staffordshire NHS Foundation Trust Public Inquiry was announced, following the Statement to the House of Commons on 9th June 2010 by the Secretary of State for Health.

The Inquiry was tasked with examining the commissioning, supervisory and regulatory organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009. It was also asked to consider why the serious problems at the Trust were not identified and acted on sooner, and will identify important lessons to be learnt for the future of patient care.

The Inquiry closed its proceedings on 1st December 2011, and is scheduled to issue its final report in 2012.

Counsel to the Inquiry summed up the findings and conclusions which are likely to feature in the final report. Also, in his closing address, the Chairman of the enquiry, Robert Francis QC, highlighted 20 areas where he is likely to come to conclusions and make recommendations in that final report

This paper summarises the issues that emerged from these documents, and assesses the potential impact for Dartford & Gravesham NHS Trust

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Information and discussion

Equality Impact Assessment initial screening applicable to this report? No

This report provides information on the following annual objectives (delete as required)**:**

- To improve patient experience and patient safety, and achieve the best health outcome for patients, through implementation of the Quality Plan for 2011/12;
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Trust Board, January 2012

Briefing on the emerging findings from the Francis Inquiry

Introduction

The Mid Staffordshire NHS Foundation Trust Public Inquiry was announced, following the Statement to the House of Commons on 9th June 2010 by the Secretary of State for Health.

This second phase of the Inquiry was tasked with examining the commissioning, supervisory and regulatory organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009. It was also asked to consider why the serious problems at the Trust were not identified and acted on sooner, and will identify important lessons to be learnt for the future of patient care.

The Inquiry closed its proceedings on 1st December 2011, and is scheduled to issue its final report in 2012. The Government will then need to respond to any recommendations, so it may be some time before the direction of policy becomes clearer.

Since the time, the previous Government published its High Quality Care for All document in 2008, outlining a new approach to quality, including a definition involving a three pronged approach to patient safety, patient experience and clinical effectiveness. It also introduced a requirement on Trusts to publish annual quality accounts. In the meantime the Healthcare Commission, which carried out the original review into Mid Staffs hospital, has been replaced by the Care Quality Commission.

In addition, the new Government in 2010 indicated a radical reform of the existing PCT and SHA structure, with the emergence of new Clinical Commissioning Groups at local level, as well as a review of regulators and arms length bodies etc. Much of this change is still in 'transition', but it does mean that Francis will be commenting on a system that will not exist for very much longer.

It is clear that the Francis report will be a seminal publication for the NHS, and will influence the way the NHS oversees quality of patient care in future. This paper explores likely policy development that may be included in the final report.

1) Role of the supervisory, regulatory and commissioning organisations:

The Counsel to the Inquiry summed up the findings and conclusions which are likely to feature in the final report. This 88 page 'Conclusions' document is strongly worded and sets out the following themes:

- Failure of the healthcare management system, which should be there to identify problems and put them right

- Lack of knowledge - no-one in the 'system' recognised the seriousness of the experience of patients at the Trust

- The supervisory bodies did not react constructively to the few indicators that were available, that should have prompted concern…. (e.g. complaints, staffing levels, mortality)

- Regulators, commissioners, 'supervisory bodies' (SHA) did not act together or coordinate information

It is likely that Francis will make recommendations regarding the function and responsibilities of these bodies in supervising the healthcare system, and in working together to share information. It is highly likely that the relationship between these bodies and providers (NHS Trusts and NHS Foundation Trusts) in monitoring quality of care will become clearer and potentially more challenging as a result.

2) Specific key policy issues:

Meanwhile, in his closing address, the Chairman of the enquiry, Robert Francis QC, highlighted 20 areas where he is likely to come to conclusions and make recommendations in that final report (though he also pointed out that the list of 20 was not exhaustive, and that no significance should be attached to its ordering). These themes also feature prominently in counsel's conclusions.

These issues can be grouped into the following themes:

- Workforce – staffing levels, skill mix, regulation of support workers, training in elderly care, regulation and training for senior managers

- The role of regulators in setting standards for safety and quality and clinical governance

- 'System management' of the healthcare system and role of commissioners, including the balance between performance management approach to finance, performance and quality and safety

- Risk of organisational turbulence – transition

- The patient voice – how do we listen to patient views? Especially complaints and patient experience, role of governors and public involvement bodies. The duty of candour, openness re Serious Untoward Incidents

- The collection, sharing or information and data – sharing between education, commissioners, regulators, supervisory bodies (including coroners)

- Protection of whistleblowers

What does this mean for Dartford and Gravesham NHS Trust?

I have set out a self assessment against the 20 points in the attached table.

Theme	Issue	Self assessment of current situation	Possible likely future change for Dartford and Gravesham NHS Trust
1) Workforce	a) Staffing levels, likely recommendation for minimum or model ward nurse staffing levels and skill mix. a(i) Also A&E staffing, especially doctors.	a) Historically low nurse:bed ratio and low doctor: bed ratio. Ward nursing: Recent audit commission benchmarking review demonstrates improved nurse:bed ratio, low costs but some concern still re registered: unregistered mix. a (i) A&E – recruitment continues for permanent middle grades.	a) Need to work towards an improved registered ; non registered skill mix. a (i) Need to keep A&E medical staffing under close review and continue to improve.
	b) Support workers: likely recommendation for national regulation, and national standards of recruitment, induction and training.	b) Training and competence frameworks are in place, but not universal for all nursing assistants and will need to be mandated for all nursing assistant staff. Career development between Band 2, 3 and 4 roles and to registered nursing career will need to be clearer.	b) Propose a new mandatory programme for ALL nursing assistants, one week refresher competence training to be completed by all staff over a two year period. Trainer post will need to be funded. Review use of NVQ programme as currently ad hoc and not systematic.
	c) Training in elderly care	c) Some training provision in house, plans to increase programme next year.	c) Will need to review training for all registered nurses and allied health professional staff. c) Also need to discuss pre registration training with the University of Greenwich
	d) Regulation and training for Directors and senior managers	d) Most senior managers and Clinical and Executive Directors have had access to some specific leadership and / or management training. No national standardisation or specification, as yet, but this may be expected following the Francis review. NHS Institute run leadership programmes but these are voluntary, not mandatory.	d) Review with individual PDRs
2) Regulators' roles	Regulators need to be more proactive and seek out issues, (e.g. by better communication with other agencies) rather than await problems	The Trust has always worked with regulators as required.	Relationships are likely to become more frequent and challenging, the Trust will need to respond openly and be prepared to share information which is relevant to the regulator's role.
3) System management for quality	Quality will need to be performance managed by commissioners and SHA in the same way as finance and performance	The Trust has always worked with its commissioners as required. Quality meetings are becoming more meaningful now local GPs are participating. The current PCT 'Deep Dive' may represent a new way of working	The Trust will need to be proactive, open and helpful in its relationship with commissioners and SHA, sharing information that is relevant. Quality account needs to be honest, balanced, informative and reflective in reporting on quality achievements and challenges. Quality plan needs to be strategic and focussed on improvement.

Theme	Issue	Self assessment of current situation	Possible likely future change for Dartford and Gravesham NHS Trust
4) Risk of organisational turbulence and 'transition'	Problems with organisational memory as key organisations and individuals change roles.	Risk for Dartford and Gravesham during potential integration process with Medway – also through changes in commissioner roles and organisations.	D&G needs to ensure risks are on the integration risk register, with specific work to mitigate risks of integration through formal programme management approach, including clinical quality, clinical due diligence and clinical governance as part of the project plan. D&G working closely with local commissioning bodies, including GPs to ensure communication channels are open and honest.
5) Openness about patient views	a) Governors roles – Governors knowledge of what they should challenge, and knowledge of patient experience, ability to escalate concerns to the Board	Council of Governors is active in monitoring patient quality and experience. Examples including the work on nutrition, patient experience committee, etc.	Governors may need to be more challenging. Need to actively seek patients' views independently of the organisation. Need to escalate concerns more proactively to the Chairman.
	b) Complaints – too few people knew about the complaints, or acted upon information available. No Board reports for three years. Responses were late, defensive and not sympathetic to the patient's experience.	Chief Executive sees all complaints and responses. Ensures standard of complaints responses is appropriate and apologetic where appropriate, also to check for action on improvement. Board sees the detail of all complaints and performance on timeliness etc. No Ombudsmans' enquiries as generally the Trust aims to resolve complaints locally, including offers of independent reviews. Local resolution meetings often involve the Medical Director or Director of Nursing. Non exec director has recently reviewed 'reopened' complaints to check if any weaknesses in the process. Timeliness of complaints handling now more efficient.	Will need to be increasingly open with regulators and commissioners regarding content of complaints, themes and issues. Board reporting needs to continue to focus on action taken to improve, and address any long-standing issues. Some Directorates need to oversee the management of complaints responses more actively, with more coordination of responses for complex complaints and more urgent responses from some consultants and other staff.
	c) Public involvement organisations roles – Francis indicates that these organisations were not challenging enough and did not recognise the problems patients were experiencing.	The Trust generally has good relationship with Links etc (see last year's quality account).	Need to ensure good relationship continues, and transition to new arrangements (Healthwatch) are positively managed
	d) Duty of candour with patients when things go wrong.	The Trust is open with families when things go wrong. Recent guidance has been issued by the	This 'candour' needs to extend to ALL serious untoward incidents, even if the patient is unaware.

Theme	Issue	Self assessment of current situation	Possible likely future change for Dartford and Gravesham NHS Trust
		Department of Health.	
	e) Openness re SUI with commissioning organisation.	The Trust currently declares all SUIs with its commissioners through the STEIS system. It is rated as a good reporter through the NPSA system. It has recently reviewed definitions and reporting arrangements, and there are now weekly meetings to review progress and timeliness of reports. The Trust has recently focussed on reporting of serious complications post operatively as SUIs with surgical colleagues.	Need to maintain vigilance that all untoward incidents are reported.
6) Collection and sharing of information between organisations	This recommendation is likely to be that regulators, including the CQC, educational institutions, royal colleges, unions and coroners all share information regarding organisations that may cause one of them concern.	The Trust cooperates with any external reviews and reports the findings to the board or Quality and Safety committee publically, so the information is available.	Increased transparency and openness with ALL organisations. May increase regulator's requirements from the Trust unless well coordinated by them.
7) Protection of whistleblowers		Whistleblowing policy in place	We will need to review whether this needs strengthening, and whether concerns which are picked up through informal and formal channels are dealt with sufficient urgency and seriousness.

Dartford and Gravesham NHS
NHS Trust

TRUST BOARD MEETING – JANUARY 2012

Item 1-6.2. Attachment 5 - Dementia strategy

1-6.2 DRAFT DEMENTIA STRATEGY **DIRECTOR OF NURSING**

This brief paper describes the background to improvement in dementia care across West Kent and within the hospital. It also sets out future plans for improvement in 2012.

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
For information and discussion

Equality Impact Assessment initial screening applicable to this report? NO

This report provides information on the following annual objectives (delete as required)**:**

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Dartford & Gravesham NHS Trust

Draft Dementia Strategy

Paper for the Trust Board

January 2012

Introduction

This brief paper describes the background to improvement in dementia care across West Kent and within the hospital. It also sets out future plans for improvement in 2012.

Background

The West Kent Dementia Strategy 2010 – 2015 set an ambition to improve care for patients with dementia across the West Kent area. This was a 'whole systems' approach, commissioned jointly by Kent County Council social services and by the NHS West Kent PCT. The vision is:

'that people with dementia receive timely diagnosis and support that promotes their independence and helps them 'live well' with dementia, and that all services and support are provided to the highest possible standards: promoting dignity, respect and choice'.

The strategy included the following objectives, all relevant to acute care:

- **a)** Early identification and support of clients with dementia
- **b)** Maintain independent lifestyles for clients with dementia where possible
- **c)** To provide crisis support and 'intermediate' care facilities to avoid hospital admission and to support hospital discharge
- **d)** To improve care for dementia patients, in terms of privacy and dignity and responsiveness of staff, across the patch in all settings (care homes, hospital etc)
- **e)** Excellent end of life care
- **f)** Monitoring and measurement of the impact of these changes

Progress and challenges

Dartford & Gravesham NHS Trust has participated actively in the NHS West Kent Dementia Strategy programme, with the leadership of Sarah Parsons (Senior Nurse, Improvement and Modernisation) and Dr Senussi Hussein (Clinical Lead, Elderly Care and Trust dementia lead). We are also very grateful for the support of a number of key staff from a variety of professions and partner organisations, and also specifically Emma Hanson, our PCT / KCC commissioning lead who has supported this work.

This leadership has led to the following improvements and agreed action (listed under the headings above):

a) Early identification and support of clients with dementia

- There has been improved identification, diagnosis, care and treatment advice, with joint working with the old age consultant psychiatrists from the Jasmine Unit and elderly care psychiatric liaison nurse (KPMT).

- The CQC, in its inspections in 2011, noted that documentation regarding assessment of mental capacity and management of challenging behaviour were not always well documented. The medical and nursing admissions documents are being amended currently to include 'trigger' questions to identify patients who may have signs of early unidentified dementia.

- Improved orthogeriatric and psychiatry liaison support for patients with fractured neck of femur (many of whom suffer from dementia).

- **Action for 2012:**

- Continued development of liaison psychiatry service (Cquins likely to include incentives to develop this)

- Continued development of documentation and pathways including ECAS, My EDN, medical admissions pathway etc.

b) Maintain independent lifestyles for clients with dementia where possible

c) **To provide crisis support and 'intermediate' care facilities to avoid hospital admission and to support hospital discharge**

- Admission prevention. There is evidence that the West Kent Care Homes project and the new Crisis Support service have resulted in reduced admissions of elderly patients from care homes, including patients with dementia – there has been a decrease from 90 non elective admissions from care homes per month 2010/11; reduced to 76 in 2011/12 (M8). A&E attendances from care homes have reduced from an average of 121 per month during 2010/11 to 105 per month 2011/12 (M8). This is welcome and suggests that care has improved in the care home sector.

- Regarding discharge, the West Kent strategy noted that too many patients with dementia were being discharged to 'long term' care without a formal assessment of their ability to go home with rehabilitation or support. A review of referrals to the crisis support team on discharge show, of 16 referrals from DVH, 12 were for patients who required enablement to regain independence, 1 was for a patient who was deemed unsafe to be on their own, and 3 were to support carers who were emotionally distressed. The intermediate care strategy aimed to provide a 'step down' facility (Gravesham Place) where a fuller assessment could be made. This is still reported by staff as problematic in some cases.

- While there have been improvements generally in discharge of complex Kent patients as a result of the 're-ablement' funding, there are still difficulties in discharging Bexley patients.

- The 'Burkeway' project has examined pathways for complex elderly patients and is due to report on its findings and progress in February.

- **Action for 2012**

- Focus on pathways for Bexley patients

- Work with PCT and KCC on strengthening discharge planning into suitable intermediate care placements.

- Review the evaluation of the 'Burkeway' project.

d) To improve care for dementia patients, in terms of privacy and dignity and responsiveness of staff, across the patch in all settings (care homes, hospital etc)

- Improved knowledge and skills of staff:
    - Nursing and AHPs: over 100 staff have attended various relevant training events, run by the University of Canterbury Dementia Centre and by the University of Greenwich, also relevant mental capacity act training etc.
    - Medical staff: dementia is now a standard item on all junior doctor induction, and Dr Beirne from the Jasmine Unit is supporting Dr Hussein on further medical education

  However the approach to training has been opportunistic and ad hoc. A training strategy is required and this is being drawn up currently.

- The CQC highlighted 'moderate' concerns regarding dignity and nutrition in their March 2011 inspection. The situation had improved to 'minor' concerns by the July 2011 inspection. Significant nursing leadership has been shown in improving dignity and nutrition, including the removal of window beds (allowing patients with dementia to sit at the window, for example, and eat meals at tables). The 'protected mealtimes' initiative has been successful, as has the re-launch of the red tray policy to support patients who need help to eat, and the introduction of red lids for patients who need help to drink. The Trust has signed up to the Patients Association 'Care' campaign – Care, Assist (with toileting, ensuring dignity), Relieving Pain, Encourage Adequate Nutrition. A retired Director of Nursing has been working in a targeted way with two specific wards, this has been very successful on one ward, less so in the other (which already has another complex elderly care pathway project in place).

- Recent observational audits have shown improvements in privacy, dignity and basic nursing care for patients with dementia on three selected wards in the hospital (Maple, Spruce and Oak ward).

- A policy relating to managing challenging behaviour is under review, with assistance from the Psychiatry Liaison Team in 'borrowing' pathways from East Kent.

- Early findings from the Enhancing Quality audit indicate low anti-psychotic prescribing for dementia patients. However this is very early, data will need to be confirmed.

- An elderly care nurse specialist has been appointed (not yet in post) who will lead on quality of care for dementia patients as part of her role.

- Patients with dementia needs to be kept busy, stimulated with suitable activities. This is very difficult in hospital. A volunteer dementia buddy scheme is being tendered currently. Activities for dementia patients are also being devised (e.g. memory boxes) for wards. Volunteers are also being recruited to aid with feeding and 'befriending' on the wards.

- **Action for 2012**

- Need to develop a coordinated training needs assessment and training strategy, maximising opportunities from the various education and training providers.

- Continue the targeted work with the Retired Director of Nursing during the spring and summer, on specific wards.

- Engage with the NHS Institute 'Productive Older People's project (details still to be established, signed up in principle).

- Nursing leaders will continue to focus on basic dignity, nutrition and 'essence of care' standards, especially for patients with dementia. (cross reference Nutrition strategy and Patient Experience Strategy).

- Continue Enhancing Quality project in dementia care.

- Support the dementia buddy scheme and develop the in house volunteer scheme more comprehensively (e.g. with a rota for volunteers to ensure cover).

e) Excellent end of life care

- Recent National Audit of the Dying report shows that a high percentage of patients subject to the audit died with a primary diagnosis of dementia at DVH (14%) higher than other Trusts (4%). This may indicate that there is a good awareness of palliative care in non cancer patients, including dementia, however this may indicate also that more patients with dementia die in hospital, rather than home or care home setting. It may also be an indicator of inconsistent coding practice.

- **Action for 2012**

- Review findings of National Audit. Workshop on end of life care planned for end of March, which will include dementia.

- Trust has been allocated end of life training monies to be used by June, and the Ellenor Team will take on a facilitation role.

- Continue whole systems work with nursing homes etc on improving end of life care in the community.

g) Monitoring and measurement of the impact of these changes

- Participation in the National Dementia Audit, which has allowed us to collect baseline data on a number of measures, including length of stay, quality of staff interactions with patients, nutritional support etc. It has also focussed attention on action and improvements needed, which have been led through the Audit Steering Group.

- Participation in Enhancing Quality project (looking at anti-psychotic prescribing

- The Dementia Steering Group has been set up to oversee these developments, with Director of Nursing as Chair and Consultant Geriatrician Dr Hussein as Vice Chair.

- **Action for 2012**

- The National Dementia audit is due to be repeated in April 2012.

- Continue EQ audit

- Dr Hussein to work with coders on improving coding.

Jenny Kay
Director of Nursing
January 2012

Dartford and Gravesham NHS
NHS Trust

TRUST BOARD MEETING – JANUARY 2012

1-6.3	SUMMARY OF QUALITY AND SAFETY COMMITTEE MEETING, 19TH JANUARY 2012	COMMITTEE CHAIRMAN (NON EXECUTIVE DIRECTOR)

Item 1-6.3. Attachment 6 - Summary of QSC meeting, 19.01.12 (incl. complaints data)

Key Discussion Points:

- **Resuscitation report** Improvement in CPR training rates but unlikely to meet 85% target due to lack of CPR Trainer capacity. Consultants not countersigning DNAR forms – Q&S Committee decision was that must be a Consultant responsibility to sign - need for further assurance on this issue.
- **Infection Control** C. diff target now breached 25 vs target of 20. MRSA still on trajectory, 2 cases vs target of 3. Targets for 2012/13 are C. diff – 22, MRSA 3. Antimicrobial guidance reviewed and to be rolled out across hospital. Will need active support from Consultants to embed into clinical practice.
- **Outpatients and Therapies** Good progress on case note tracking problem – 41% reduction in hours wasted. Increase in PALS issues regarding fracture clinic. Most complaints received in Outpatients are around waiting times. Results of National OP Survey due out 14/02/12.
- **Pathology** Full CPA accreditation for all departments except Microbiology that requires clearance visit in March 2012 to confirm status. In Mortuary the Designated Individual for the Human Tissue Act is retiring March 2012 and a replacement needs to be identified. Changes in staffing in Blood Transfusion may signal MHRA inspection of department.
- **CQUIN progress** Current progress suggests achievement will be £1.75 million against a target of £2.1 million. Two hourly rounding is being rolled out on wards and is well received by patients but will not influence National Inpatient survey results this year.
- **Vital signs** All indicators comparable with peer, some concerns regarding Trauma and Orthopaedic mortality. Since July 2011 the fractured Neck of femur data has improved and this more recent data is starting to feed into figures. Stillbirth rate lower than previous year.
- **Complaints** volume of complaints lower than previous month. November had 40 complaints and December 25 complaints. Complaint response times from some Directorates have improved but not in all.
- **Clinical Audit** South Coast Audit internal audit review concluded 'limited assurance'. Two areas for improvement (a) lack of an effective database – should be updated by 31st March, and (b) the forward plan for audit being unsustainable - Action plan underway with the aim to complete by April 2012. 29 abandoned projects/audits reported.
- **Non-Medical Education** Essential training meeting 85% target except Infection Control – but this is improving since being included in the mandatory study day once again. Moving and Handling training – not good in some areas. Core induction at 98.3% attendance, Local induction at 79.5%. Risk of target numbers slipping whilst change from PROMPT to OLM system is on Risk Register. Q&S Committee requested quarterly updates.
- **Patient Safety Committee** Three 'Never Events' discussed, two on ITU and the third occurred at an independent provider under contract. All under investigation with action plans to be produced.
- **Risk Register** Eight new risks added to Risk Register with five closed. Several risks highlight the need for significant capital investment. Anomaly in timing of reports noted i.e. the Risk Register report that goes to Audit Committee is prepared before the monthly Risk Register meeting, and the Risk Register report for Q&S reflects the most recent meeting. The Medical Director or Director of Nursing will attend to update the Audit Committee.

Directorate reports received from:

- Out-patients and Therapies
- Pathology

Reports received:

- CQUIN Quarterly Update
- Monthly Complaints report

- Vital Signs Report
- Clinical Audit and Effectiveness Committee
- Non – Medical Education Report
- Resuscitation Committee
- Patient Safety Committee Report
- Infection Prevention and Control Report
- Trust Risk Register Report

Policies for ratification: None

Key decisions made:
- Consultant involvement in Do Not Attempt Resuscitation (DNAR) decisions and signature on DNAR form is essential.
- Non-medical Essential Training Report to be received quarterly (rather than biannually).

Actions for the Board: To note the report

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Information

Equality Impact Assessment initial screening applicable to this report? No

This report provides information on the following annual objectives (delete as required)**:**
- To improve patient experience and patient safety, and achieve the best health outcome for patients, through implementation of the Quality Plan for 2011/12;
- To maintain the highest standards of cleanliness and reduce healthcare associated infections, maintaining a zero tolerance approach to infections acquired within Darent Valley Hospital;
- To develop productive relationships with emerging GP Consortia, local authorities, and other new partners, in order to provide sustainable services for the community, and achieve a sustainable local health economy;
- To recruit excellent staff, and develop, manage, lead and support our staff fairly, to ensure they are motivated to deliver high quality and excellent services;
- To deliver the objectives set out in the Financial Plan for 2011/12, including the delivery of a Quality, Innovation, Productivity & Prevention (QIPP) programme that develops patient pathways which provides care closer to patients' homes, & improves the efficiency of the services the Trust provides, thereby saving resources and releasing capacity

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors understanding of the Trust & its performance

Board Complaints Report – January 2012

1. Volume of complaints

There were a total of 26 formal complaints for the month of December 2011; a decrease of 15 in the number of complaints received in November 2011.

2. Reason for complaint

The prominent themes identified are:

- Nursing care – 8 complaints (remains the same as November)
- Medical care – 7 complaints (decrease of 2)
- Clinical treatment (operative) – 2 complaints (increase of 1)
- Attitude – 4 complaints (decrease of 3)
- Waiting (OPD appointment) – 1 (remains the same as November)

A copy of the latest Complaints Committee Minutes (November 2011) are attached. This highlights the themes and actions taken at Directorate level. The next meeting is due to take place on 31 January 2012.

3. Departments - Complaints received in December 2011

Ref	Dept / Ward	Incident date	Complaint received	Severity / RAG
C11/12/22	A/E	9-Nov-2011	22-Dec-2011	GREEN
C11/12/23	A/E	20-Dec-2011	28-Dec-2011	AMBER
C11/12/12	A/E	4-Dec-2011	14-Dec-2011	AMBER
C11/12/20	A/E	10-Apr-2011	12-Dec-2011	RED
C11/12/17	BEECH	31-Oct-2011	12-Dec-2011	AMBER
C11/12/27	BEECH	20-Nov-2011	28-Dec-2011	AMBER
C11/12/19	BEECH	8-Sep-2011	15-Dec-2011	RED
C11/12/15	CARDRE	25-Feb-2010	14-Dec-2011	GREEN
C11/12/07	CEDAR	18-Oct-2011	5-Dec-2011	AMBER
C11/12/24	EARPG	18-Oct-2011	28-Dec-2011	GREEN
C11/12/16	LAUREL	14-Nov-2011	14-Dec-2011	AMBER
C11/12/21	LINDEN	18-Jul-2011	20-Dec-2011	AMBER
C11/12/14	OBSWD	23-Nov-2011	14-Dec-2011	AMBER
C11/12/25	ORTHOF	9-Nov-2011	28-Dec-2011	RED
C11/12/03	ORTHOF	10-Nov-2011	5-Dec-2011	GREEN
C11/12/26	PAEDOF	5-Nov-2011	29-Dec-2011	RED
C11/12/04	RHEUMA	5-Oct-2011	1-Dec-2011	GREEN
C11/12/11	ROSEWD	26-Oct-2011	8-Dec-2011	AMBER
C11/12/10	ROWAN	3-Jul-2011	9-Dec-2011	AMBER
C11/12/06	ROWAN	13-Dec-2009	5-Dec-2011	AMBER
C11/12/08	SURGDI	15-Mar-2011	2-Dec-2011	GREEN
C11/12/13	SURGDI	5-Dec-2011	14-Dec-2011	BLUE
C11/12/09	THEATR	27-Apr-2010	2-Dec-2011	AMBER
C11/12/02	WILLOW	11-Nov-2011	1-Dec-2011	GREEN
C11/12/18	XRYDVH	19-Jul-2011	12-Dec-2011	AMBER
C11/12/05	XRYDVH	10-Oct-2011	2-Dec-2011	RED

No of Green:	7	27%
No of Amber:	13	50%
No of Red:	5	19%
No of Blue	1	4%

4. Complaints Department Performance

The Complaints Department received 41 complaints in November 2011. Performance for acknowledgement of complaints within 3 days over November was 100% and issue of a final response within target was 85%.

5. Verbal Complaints

The Complaints Department received 4 verbal complaints in December.

A total of 61 informal complaints or enquiries have been received by PALS over this period, which is a decrease of 39. Principle themes for this period related again to A&E and also Fracture Clinic.

6. Re-opened complaints

There were no re-opened complaints in December.

7. Local resolution meetings

There were no local resolution meetings in December

8. Independent reviews

There were no independent reviews in December.

11. Parliamentary and NHS Ombudsman

There were no new referrals to the PHSO in December.

Rob Thompson, Assistant Director Service Development (Governance)
Kerrie Loudwell, Complaints & Claims Manager

January 2012

TRUST COMPLAINTS MANAGEMENT COMMITTEE

Minutes of the meeting held on Wednesday 30 November 2011 at 10:00
In the Boardroom – Level 4, HQ

In attendance:

Jenny Kay (Chair)	(JK)	-	Director of Nursing & Workforce
Sue Cox	(SC)	-	Matron, Cardiology
Linda Dorian	(LD)	-	Facilities Management (for Dean Ruck)
Julie Freel	(JF)	-	Radiology Services Manager
Deborah McAllion	(DM)	-	Head of Midwifery
Alison Moulton	(AM)	-	Pharmacy Technical Manager
Annette Schreiner	(AS)	-	Medical Director
Sue Symmons	(SS)	-	Matron, A&E
Rob Thompson	(RT)	-	Assistant Director of Service Development
Jane Riker	(JR)	-	Complaints Secretary (taking notes)

Apologies:

Julie Cook	(JC)	-	Assistant Complaints Manager
Sue Hornshaw	(SH)	-	PALS Officer
Kerrie Loudwell	(KLL)	-	Complaints & Claims Manager
Carol Stone	(CS)	-	Public Governor, Dartford Borough
Michael Brand	(MB)	-	Governance Manager
Karen Costelloe	(KC)	-	GM, Outpatient, Therapies & Women's Services
Pam Dhesi	(PD)	-	Assistant Director of Emergency Medicine
Sophie Glew	(SG)	-	General Manager, Pathology
Christine Keep	(CK)	-	Operations Manager, Adult Medicine
Jane Meek	(JM)	-	Operations Manager, Adult Medicine
Alex Tan	(AT)	-	General Manager, Surgical Specialties
Joanne Woodey	(JW)	-	Complaints Officer

1. Welcome and Introductions

JK welcomed everyone to the meeting.

2. Minutes of Previous Meeting

Reopened Complaints

RT explained that reopened complaints were reviewed each week as part of the weekly spreadsheet meeting and, at present, there was only one reopened complaint. JK added that the Board had asked Kate Nightingale to review a sample of reopened complaints, as this could be a good indicator of whether the initial response is of good quality.

Board Report

RT confirmed that the Board Report was being emailed to members of the Committee every month.

Meetings with Adult Medicine

SC explained that meetings had not been taking place on a regular basis but that they would be put in place. JK reminded the Committee that the point of these meetings were to go through the complaints management process and to discuss

who complaints should be sent to since it was the responsibility of the directorate to control them.

Action: Weekly complaints meetings to be arranged with Sue Cox.

Complaints Survey

The complaints management survey would be carried out again in January 2012 for July to December 2011 and JK hoped that the results would be better, given the improved turnaround and quality of responses.

Action: Complaints Management Survey to be carried out for July to December 2011.

3. Complaints Report

Overall Trust wide Themes

- Main themes identified were nursing/medical care and staff attitude.

- A&E had received 23 over the period, representing 28% of the total. A&E had since reported separately to the Board in relation to the surge in their complaints which related primarily to failures in diagnosis and negative experiences in EDWIC.

    i. EDWIC should be returning to main A&E in the New Year.
    ii. SC added that middle grade staffing was improving.
    iii. A Lead Radiographer Reporter had been appointed – a new role for the Trust and not one common to other trusts – to work closely with A&E to improve skill sets. Dylan Jenkins had been on the interview panel, as Clinical Lead for A&E. Changes to the whole diagnostic pathway were underway.

- Directorate reports were included from surgery and outpatients, which would be sent out after the meeting.

- Nutrition was a theme attracting particular attention from the Board and a workshop had taken place on 9th November, followed by a review. The hospital's red lid and tray policy was just about to be launched, which should help to ensure assistance was provided to those patients who needed help with eating and drinking.

- Fracture clinic

    KC is undertaking a review of the way the clinic runs. It was agreed that these on-the-spot complaints should be handled by PALS and a supply of leaflets would be made available to the department. JK added that the focus should be on managing the problems within departments rather than encouraging complaints. RT to discuss a contingency plan with KC.

Action: RT to discuss contingency plan for Fracture Clinic with KC. Board reports to be circulated to Committee between bi-monthly Complaints Meetings.

4. PALS Report

SH provided a verbal report: Themes: trauma, A&E and surgical. Calls covered areas such as

- waiting times in clinic; the number of people coming through; and staff attitude, mostly in relation to Fracture Clinic.
- A&E, SH remarked that Dylan Jenkins was very proactive in phoning people. SH explained that PALS calls relating to EDWIC mainly concerned waiting times and cramped conditions. Some patients had remarked that EDWIC was packed with no seating while A&E remained empty.
- SH explained that there were criteria governing which patients were referred to EDWIC and SS added that, when trigger points were activated, patients should be referred round to main A&E, although this relied on the patients giving the right answers.

JK explained that the Trust Board were becoming much less tolerant of complaints and were looking for solutions, not reasons. The management of particularly busy periods would be discussed by General Managers.

5. Directorate Report

<u>Maternity</u>

- One tangible difference had been the introduction of overnight stays for fathers, which gave the whole family a 24 hour perspective and influenced communication.
- However, the department had just received two new complaints, one of which related to child protection, and one had gone to an LRM, having been answered in June 2011, relating to post-natal, triage and diagnosis of labour.
- Staff were being educated not to encourage women to write formal complaints but to take responsibility for escalating concerns accordingly, providing the same quality of written response but managing them informally.
- A patient had experienced a stillbirth in July and part of her family's concern was about the manner in which this was managed and this had lead to a policy change.
- There had also been increased recruitment which gave each midwife more time at bedsides.
- A CNST Assessment would be taking place in December, a requirement of which was to do a summary review of all complaints over the preceding 12 months. Once this was done the department would feed into audit and draw lessons with which to inform the board report.

Action: Maternity's report to Board to be brought forward to February.

Medicine

- SC pointed out that the compliments received by Medicine far outweighed the number of complaints. Medicine tended to receive around one or two per month, representing around 0.1% of patients treated.
- Rheumatology, who had appeared to be doing well, had done poorly in September and it was reported that some of that was in relation to letter writing and management of clinics.
- SC added that, since two hourly rounding was introduced, Beech ward had received no complaints.
- It was agreed that, from now on, the relevant Matron would be included in every LRM, unless otherwise indicated. This would allow them to assist with any unresolved grief on the part of the patient's family, which was a common theme in those complaints which went to Local Resolution Meetings. The important of clear and sensitive communication with families of deceased patients, or these with end of life conditions was highlighted.
- JW remarked that similar issues sometimes arose in surgery, when 'spoken to family' had been added to the patient's notes, reflecting a very quick end-of-bed conversation, which was not the same thing as being taken aside and spoken to quietly.

Radiology

- Themes arising over the course of October were areas of perception, what was available to GP or patient, and results not being available.
- There had been an incident involving gynae and JF had worked with RT/KP to dig deeper into the chain of events around communication with patients. She will get Radiation Protection Advisory Service to provide training to increase staff confidence, also covering looking at cancellations on system and links with PAS.
- A communication skills workshop had been held for admin staff, as a pilot through the National Patient Advisory Group, prior to rolling out to other staff groups. Feedback had been very positive. JF planned to meet with Stephen Mulvaney to give feedback, which would also be shared with General Manager colleagues.

A&E

- SS took over as A&E Matron the previous September when complaints were a big concern, since when they had been steadily reducing in number. The recent spike in the number of complaints in September had been in relation to different themes:
- Attitude: Fewer complaints recently re the attitude of reception staff. Some were about medical staff, whom patients felt were dismissive of their concerns. In relation to nursing staff, patients felt that they were not being kept informed during long waiting times. In response to complaints raised, nursing and medical staff were now more visible and the need for communication was being actively reinforced.
- There had been a few complaints relating to diagnosis and/or treatment from medical staff and all issues raised had been taken up with mentors and reflected in the relevant staff training programmes.

- A theme had arisen of nurses being encouraged to be more confident to question poor medical decisions on behalf of their patients.
- SS agreed that waiting times had been an issue, particularly in EDWIC. The department now had a system whereby when there were 10 people waiting, receiving staff could decide whether the patient needed triage or whether they could go straight to the clinician.
- Training in Dementia Care would also be provided to Band 5 as had already been provided for Bands 6/7.

Pharmacy

Pharmacy had received one complaint the previous month, which had now been resolved, relating to a dispute over the appropriate dose for the patient's medication. It was agreed that it was more helpful for colleagues to complete complaints response templates in the form of a letter, rather than bullet points in order to reflect the feeling of the response.

Carillion

Carillion had received no complaints over the past few months as far as LD was aware. JK remarked that there had been a few relating to the quality of food and one in A&E regarding a blood spattered wall. This latter was addressed at the cleanliness meeting the previous day.

Surgery and Outpatients

Surgery were not represented, but had provided their Board report which summarised the issues and themes, as had Outpatients, and action taken. JK would remind AT that he must have someone represent surgery at the next meeting.

6. Any Other Business

No other business was raised.

7. Date of Next Meeting

Tuesday 31 January 2011 at 10:30 in the Boardroom

Dartford and Gravesham NHS
NHS Trust

TRUST BOARD MEETING – JANUARY 2012

Item 1-6.3. Attachment 7 - Infection Prevention & Control report

1-6.3 INFECTION PREVENTION & CONTROL REPORT CHIEF EXECUTIVE

The enclosed report provides information on …

- Mandatory reporting of infections with trajectories for MRSA and C difficile;
- We are within trajectory for MRSA , but breached our target for C diff;
- The reason for the breach and specific actions to prevent further cases is included in the report;
- The report also provides comparable rates/100,000 bed days for the Kent and Medway Acute Trusts and highlights the objectives for MRSA and Clostridium difficile for 2012-13

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

Equality Impact Assessment initial screening applicable to this report? No

This report provides information on the following annual objectives (delete as required)**:**

- To improve patient experience and patient safety, and achieve the best health outcome for patients, through implementation of the Quality Plan for 2011/12;
- To maintain the highest standards of cleanliness and reduce healthcare associated infections, maintaining a zero tolerance approach to infections acquired within Darent Valley Hospital;

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors understanding of the Trust & its performance

Infection Control Update for Trust Board

Mandatory Surveillance

Surveillance report as of 16 January 2012:

Clostridium *difficile*													
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
Pre 72 Hour	*5*	*3*	*2*	*5*	*3*	*2*	*1*	*9*	*3*	*1*			*34*
Post 72 Hour	**1**	**1**	**1**	**2**	**2**	**5**	**1**	**6**	**2**	**4**			**25**
Post 72 Hour Trajectory	1	1	2	1	2	1	2	1	2	2	2	3	**20**
MRSA Bacteraemia													
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
Pre 48 Hour	*1*	*1*	*3*	*1*	*0*	*0*	*0*	*1*	*2*	*1*			*10*
Post 48 Hour	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**			**2**
Post 48 Hour Trajectory	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**3**
Non Trajectory Mandatory Data													
E-COLI Bacteraemia													
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
Pre 48 Hour	—	—	*13*	*6*	*21*	*15*	*19*	*14*	*24*	*6*			***118***
Post 48 Hour	—	—	2	2	1	0	0	4	2	1			12
MSSA Bacteraemia													
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
Pre 48 Hour	*4*	*2*	*5*	*4*	*3*	*4*	*3*	*5*	*1*	*1*			*32*
Post 48 Hour	**0**	**0**	**1**	**0**	**1**	**2**	**0**	**2**	**3**	**0**			**9**
GRE Bacteraemia													
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
Pre 48 Hour	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*			*0*
Post 48 Hour	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**			**0**
CAUTI Surveillance													
(Catheter associated urinary tract infections)													
							Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
Number of Urinary Catheters							*49*	*63*	*56*	*54*			*222*
Number of CAUTI's							**1**	**1**	**0**	**1**			**3**

The Trust has had 25 cases of Clostridium *difficile* (CDT) associated diarrhoea to date (16/01/2012) this is the total number of cases in the 2011-12 trajectory. The new Clostridium *difficile* Policy requires that more samples are now sent for testing. The Trust has devised an action plan to deal with the breach in its Clostridium *difficile* trajectory, the points of the action plan being:

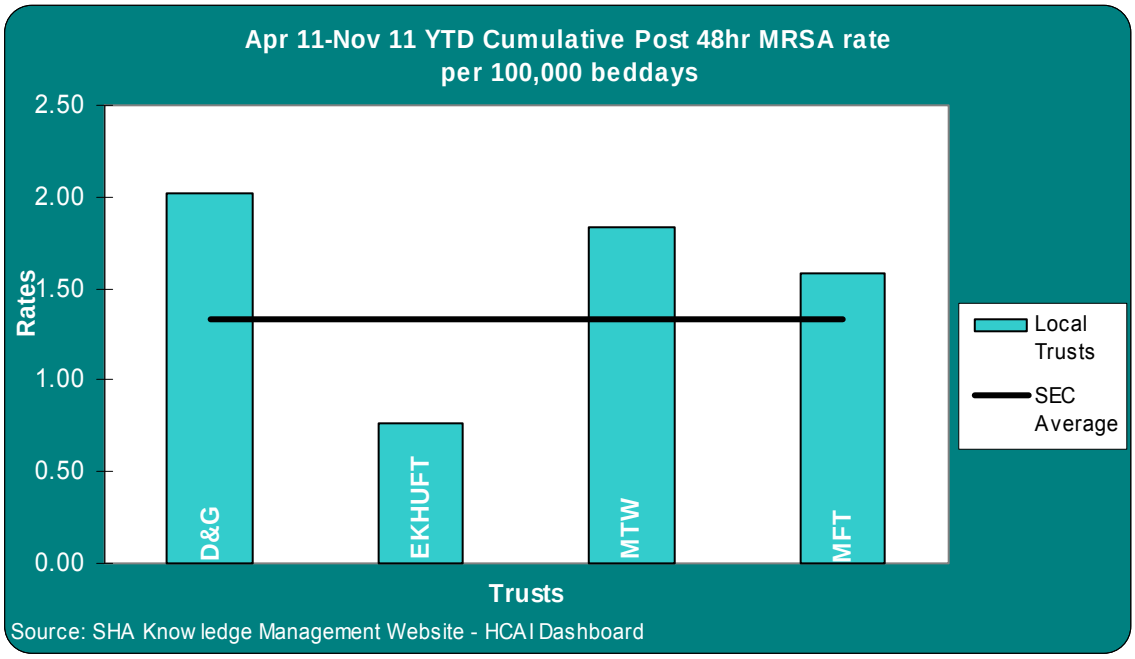
- Directorates are undertaking patient reviews on each case to recognise best practice and to identify any lessons learnt. These are then presented at the Infection Control Committee.
- Infection Prevention and Control Team to audit compliance with patient management of all CDT cases.

- Training and education of ward and department staff on the risk assessment process/isolation/stool specimen collection.
- Review of Antimicrobial Guidelines and Antimicrobial Stewardship. These will be reviewed at the January Stewardship Group. This Group is now chaired by the Director of Infection Prevention and Control.
- Compliance with Antimicrobial Guidelines needs to be improved.

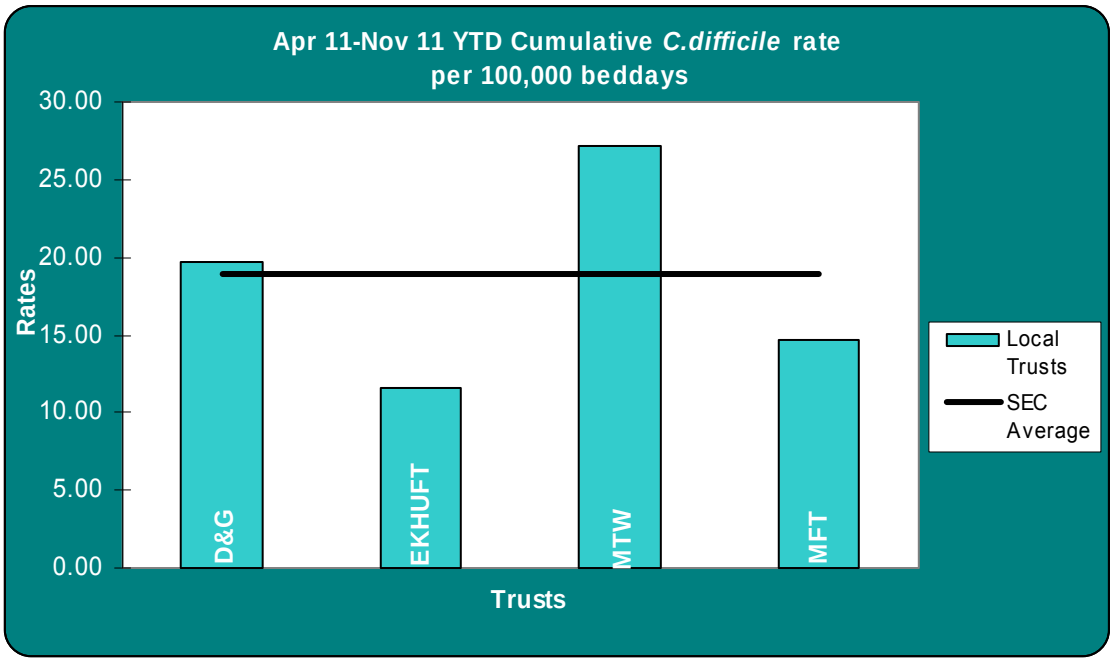
Performance with MRSA continues to be on trajectory, the MRSA Policy has been rolled out and early screening data is encouraging, audit enables a targeted approach by the Infection Prevention and Control Team.

The Team have met the Commissioners and the Community Trust to develop a plan to address concerns around the large number of patients with pre 48 hour E-Coli Bacteraemias which are being seen throughout Kent.

Comparable Mandatory MRSA and C.*difficile* data across Kent & Medway



D&G NHS Trust currently has the highest rate per 100,000 bed days (data as verified November 2011).



The rate of Clostridium *difficile t*oxin associated diarrhoea for D&G NHS Trust is the second highest in Kent & Medway per 100,000 bed days.

New Objectives for MRSA bacteraemia and Clostridium difficile for 2012-13

Trusts have been given challenging targets for 2012-13 with the aim of further improvements particularly for organisations with the highest rates. These targets have been based on the actual performance for the period, October 2010-September 2011- actual 7 cases, MRSA target 2012-13 is 3.

Clostridium difficile performance for the period October 2010-September 2011 was actually 27, against an ambitious target of 22. For 2012-13 this has been stretched to 20 in order to prevent the trajectory being higher than the previous year.

Outbreaks of Infection

There were no outbreaks of infection during December 2011. Staff are being reminded of the need to remain vigilant concerning Norovirus as cases are occurring in the community, early suspicion, risk assessment and isolation are essential in the containment and control to prevent outbreaks occurring.

Beech ward was closed from 03/01/12 until 07/01/12 with suspected Norovirus. A total of seven patients were affected and one staff member.

Dartford and Gravesham NHS
NHS Trust

MINUTES OF QUALITY & SAFETY COMMITTEE MEETING HELD ON THURSDAY 15TH DECEMBER 2011

Item 1-6.4. Attachment 8 - Minutes of QS Committee, 15.12.11

Present:

Ms Karen Taylor, Non-Executive Director (Chair) **(KT)**
Mr Brian Bowes, Non-Executive Director **(BB)**
Mr Bernie Holloway, Non-Executive Director **(BH)**
Ms Sarah Dunnett, Trust Chairman **(SD)**
Ms Susan Acott, Chief Executive, **(SA)**
Ms Jenny Kay, Director of Nursing **(JK)**
Dr Rella Workman, Director of Infection Control **(RW)**
Mr Rob Thompson, Asst. Director of Service Development **(RT)**
Dr Michael Brand, Governance Manager **(MB)**
Ms Denise Thompson, Governance Manager **(DT)**
Ms Deborah McAllion, Head of Midwifery **(DMcA)**
Ms Sue Craven, Assistant Director of Governance **(SC)**

Apologies:

Ms Annette Schreiner Medical Director **(AS)**
Dr Winston Martin, Chairman of Patient Safety Committee **(WM)**

Invitees:

Dr Dylan Jenkins, Clinical Director, A&E **(DJ)**
Ms Julie Freel, General Manager, Radiology **(JF)**
Ms Karen Costelloe, General Manager, OPD & Therapies **(KC)**
Mr Mike Jones, Chair of Clinical Audit & Effectiveness Committee **(MJ)**
Ms Eileen Brookson, Macmillan Specialist Dietician **(EB)**

In Attendance:

Ms Sarah Flanagan, Lead MacMillan Nurse, Cancer Services **(SF)**
Dr Paul Key, Director of Medical Education **(PK)**
Mr Davinder Kullar, Management Trainee **(DK)**

2.	**MINUTES OF THE MEETING HELD ON 17TH NOVEMBER 2011** The minutes were agreed as accurate record.	**Action**

3.	**ACTIONS FROM MEETING OF 17TH NOVEMBER 2011** Some of the outstanding actions were noted – see action log. **RESOLVED ACTIONS ARISING FROM MINUTES OF 17TH NOVEMBER 2011** **4. Vital Signs Report** MB reported that following further review of the re-admission rates there is no real difference between us and our peers. He added that he plans to ask Amanda Hastings of CHKS to look in more detail at this issue as part of the next quality laboratory meeting for medicine and paediatrics as their admission rates appear to be a little high. Medicine is due to meet on 6th January and Paediatrics on 10th January. KT requested that the outcome of those meetings be reported back to the Committee. MB to provide report. **ACTION: MB to provide a report on the outcome of the two quality lab meetings.** JK informed the meeting that the Dr Foster report has been released and that for D&G it found that re-admission mortality rates are high but that since then #NOF rates have improved. She added that the mortality rate is shown as an outlier. A few other key areas were highlighted such as an increase in weekend mortality rates and concerns over weekend staffing levels. SA stated that she is trying to get the report on staffing levels amended as it is not correct. MJ asked who checks the quality of the data that is given. JK stated that a company provide the data and it is then checked by and Executive Director but unfortunately the section on staffing levels got missed. SA added that there is a lack of non-hospital beds which may account for the high in hospital mortality and that she is in discussions about this with the PCT. **5. Sub-Committee Reports** **Medical Devices Committee** DB will ensure that more information is available in future reports on risks to patients through lack of equipment. **Medicine Management Committee** WM unable to attend meeting so to be added to outstanding action log. **ACTION: Add to outstanding action log** **6. Directorate Reports** **Cancer Services** See Agenda Item 4a of minutes	**MB** **EA**

	Adult Medicine JK informed the meeting that she had had a conversation with JR and agreed that there is a lapse in time and that the Matron's check weekly. The Pharmacist check is every three months. **7. NICE Report** See Agenda Item 8 of minutes. **10. 2nd Quarter Quality and Safety Report** JK still investigating into the reduction in the number of patients who spend 90% or more of their time on the stroke unit, this item will be added to the outstanding action log. **ACTION: Add to outstanding action log** DT is currently working on the new template for Directorate reports. This item will also be added to outstanding action log. **ACTION: Add to outstanding action log** **11. Risk Management Strategy** This action was discussed at the recent Trust Risk Register meeting and DT has been asked to review and produce a report. **19. Any Other Business** CQC action plan has been added to agenda under item number 5.	**EA** **EA**
4.	**<u>DIRECTORATE REPORTS:</u>** **a) Cancer Services** SF briefed the meeting on the report and highlighting that the Trust is currently not meeting its 62 day target but has now reviewed its TOR and produced an action plan. She stated that there has been an increase in complaints relating to Rosewood ward (3 written and 1 verbal) and that upon investigation she is unable to find a link, she has written to all staff to ensure awareness and ownership of the problems and has asked that everyone contribute to an action plan. JK asked if the continuing role of the Macmillan Psychosocial worker within the team, which was under review by KSS, had been resolved. It is still outstanding. BH requested that when numbers of pressure ulcers are reported that they are separated into community acquired and hospital acquired. **b) Radiology** JF gave a brief summary of the report. JK felt that JF had produced a very good report and JK added that following a recent HSE visit it was reported that the radiology department matched the best 25% in the country. SA	

	enquired about delays in reporting. JF stated that this has been highlighted as a risk. BH asked JF how she handles sickness with a small number of staff. She felt it is a risk but she works around it by moving people from different areas of the hospital.	
5.	**CQC ACTION PLAN** JK informed the meeting that there was a more up to date action plan than the one submitted and she will send this out with the draft minutes. SD requested that the action plan shows evidence around policy and training. JK informed the meeting that at a recent nutrition workshop there was a very good mix of staff including ward sisters, matrons, carers and governors. At the workshop they explored what the Trust was doing well and not so well and an action plan is in progress. **ACTION: JK to provide up to date report to EA for her to send out with minutes**	**JK**
6.	**CARE QUALITY COMMISSION REPORT** RT updated the meeting on his report. He added that the mock CQC inspections will continue. SD raised concerns as to whether the protected meal times were well balanced. JK stated that this item is discussed at the weekly matrons meetings. SD asked how well the Trust trains staff in caring for the elderly; JK replied that there is a lot of ad-hoc training given on the ward and at the bedside. KT felt that this area should be covered in the non-medical education report which is to be brought to the next Q&S meeting in January. **ACTION: JK & AB to provide non-medical education report at January's meeting** RT informed the meeting that the zero tolerance policy has been re-written. KC felt that there was a problem with incidences not being reported. AL asked about reported instances of bullying. JK said that AB is working on two areas – harassment contacts and leadership behaviours. DM noted that few incident forms are received and felt that any action had to be at Directorate level. BB observed that reports are more meaningful when they contain more numbers. He would like to have known the number of feeding volunteers, for example.	**JK/AB**
7.	**MONTHLY COMPLAINTS REPORT** JK gave a verbal report. She stated that there were 41 complaints last month and that 73% have been responded to within the timescale. KT enquired about the quality of the response in the letter JK felt that some department's responses were good but some not. SA added that most complaints are dealt with quickly but some take a bit more time as sometimes there is a need to contact other members of staff to obtain reports in connection with the complaint.	

	SD asked why the complaints performance has slipped. RT stated that this was due to staff sickness, volume of complaints and complexity of complaint which consequently adds pressure on admin staff. SD felt that the Trust needs to be more focused as to which directorate delays replying to complaint. DT said that the quarterly dashboard would highlight this.	
8.	**NICE REPORT** MB briefed the meeting on his report. He added NICE guidelines are now sent electronically. He informed the meeting that out of 23 guidelines outstanding he has received back 21 which make the Trust 91% compliant. The two departments who have not responded he has chased on several occasions along with AS. SD suggested that the two department's clinical directors be asked to attend the next Q&S meeting to discuss further. **ACTION: KT to request the two department's clinical directors to attend January's meeting.** MB recommended that departments report on compliance and non-compliance in their quarterly reports to the committee. JK felt that it would be wise to meet with MB to discuss NICE quality standards. **ACTION: MB and JK to meet to discuss quality standards.**	**KT** **MB/JK**
9.	**MEDICAL EDUCATION REPORT** PK gave a summary of the report. MB informed the meeting that in relation to page 7 of the report 'Access to Research' in the summer he was asked to provide a talk on this subject and the attendance was disappointing. This was scored poorly by trainees and reflected their desire to actually be able to undertake research. SA felt that changes in the clinical tutor has made a difference and there is an improvement, she added that the committee need to provide support to the clinical tutor when changes are made. PK stated that the Trust is very low on the number of trainees, he and SA endeavoured to recruit the trainees from Sidcup but they have been moved the London as Sidcup is part of South East London trust. KT congratulated PK and the Medical Education Department on the positive aspects of the report.	
10.	**NON-MEDICAL EDUCATION REPORT** This report is deferred to January's meeting	
11.	**NEW GUIDANCES** There were no new guidances to discuss.	

12.	**NATIONAL CONFIDENTIAL ENQUIRIES** **"**Knowing the Risk" MB informed the meeting that a new confidential enquiry has been released and that the areas highlighted were nutrition, critical care report, HDU report, consent process and medical notes. SA suggested that if this is the same as the Royal College report then the joint leads for Anaesthetics and Surgery should review the enquiry report and report back to the committee. MB will speak to clinical leads asking them to review report. KT asked what headlines the report highlighted; MB felt that pre-op and pre-admission management were the main areas. SA felt that post op management is an area to be looked into. EB suggested that the PCT should be involved as a GP referral point. JK suggested that Dr Relwani be the person to review pre and post assessment. **ACTION: MB to make contact with clinical leads for anaesthetics and surgery.** **ACTION: JK to discuss with Dr Relwani about pre & post assessment**	**MB** **JK**
13.	**NEW INTERVENTIONAL PROCEDURES** There were no new procedures to discuss.	
14.	**PATIENT SAFETY COMMITTEE REPORT** JK informed the meeting of two 'never events'. Both are under investigation. SA questioned if, because there had been two ITU 'never events', this was something that should be looked into. JK felt that both incidents were not related. SD asked where the 'never events' incidents are recorded. JK confirmed that these incidences are very rare but when they do occur will be shown in the quarterly dashboard. SD felt that the report submitted did not show enough detail for this committee. JK suggested that the newsletter be added to the report in future. SA would like the report to show what lessons had been learned and actions taken, also that staff have reported a lack in feedback following RCA investigations - that staff were not being kept informed of the follow-up from the incidents they have reported. DT suggested that at each directorate meeting the incidents are reviewed and the outcomes cascaded to staff. KT would like more detail as to what actions are being taken to assure the committee that this is happening. It was suggested that ITU be invited to attend the next meeting to discuss the 'never event' **ACTION: SC to invite ITU to next meeting** SA requested assurance that the Directorate Governance meetings are fit for purpose. The GMs are to be asked to ensure that these meetings are minuted and that a copy of the minutes is sent to the Chief Executive.	**SC**

	ACTION: SC to contact General Managers	**SC**
15.	**INFECTION PREVENTION AND CONTROL** RW gave a verbal report. She confirmed that an action plan is in place with regard to *C.Diff* testing. She also plans to review the antimicrobial guidelines but thinks it will take some time to complete probably about 2 years. SD asked with regard to *C.Diff* testing not happening at weekends is there a way the Trust can have an arrangement with another lab. RW thought that this could be arranged but at a cost. SA felt it was a balancing act in connection with staffing and finance. KT enquired if it was just a case of having the test available. RW stated that it was the equipment. SD asked what the impact is to the patient. RW advised that procedures are in place to put the patient in a side room and treated as if they have *C.diff* until testing is available. RW has developed a Trust antibiotic policy but it is proving difficult to roll it out in all areas, she is meeting with the CDs. RW predicts that it will take up to a year to achieve full compliance with the antimicrobial guidelines. The committee members felt this was too long. KT asked if there is a problem with compliance with the antibiotic protocol is it to possible to restrict the provision of antibiotics from pharmacy to assist compliance. . A representative from pharmacy was unable to attend the meeting so this item would need to be followed up outside of the meeting. **ACTION: MS to discuss with RW** SD enquired whether it would be possible to obtain benchmarking data from other peer groups. RW replied that she would be able to obtain information other Trusts in Kent& Medway. KT requested that the benchmarking data is obtained and brought to the committee. **ACTION: RW & AS to obtain benchmarking data**	**MS/RW** **RW/AS**
16.	**TRUST RISK REGISTER** MB reported on behalf of AS. He informed the meeting of four new risks, three risks that have been closed and of one risk which has had it risk score increased. SA asked with regard to the #NOF whether it was on the risk register if not it needs to be. MB assured her and the rest of the committee that it is on the risk register. BH asked about risk 1086 which has a score of 20. MB informed him that this was discussed at the last meeting and that JK has arranged a meeting with the Theatre Manager and GM on Monday 19th December. KT asked if JK will discuss their performance assurance and staff appraisal. JK will discuss this and report back to the committee at the next meeting. JK observed that there appeared to be a risk around theatre staff being available to attend mandatory training. It was requested that information on	

	the PDR rate for theatre staff and their attendance level at mandatory training be included in the next Directorate report. MB will take this back to the Directorate Governance meeting. **ACTION: MB to discuss at the surgical governance meeting** **ACTION: JK to report back to committee after meeting with Theatre Manager and GM on 19th December.** KT indicated that the 'never events' should be included in the Risk Register. **ACTION: MB to ensure that the 'never events' are included on the risk register**	 **MB** **JK** **MB**
17.	**ANY OTHER BUSINESS** **National Outcomes Framework** JK requested that National Outcomes Framework added as a regular agenda item under Clinical Effectiveness section. This was agreed. **ACTION: To be added to agenda.** **Mortality** SD expressed concern that the Trust does not have a good grasp on mortality, she feels that the Trust is re-active rather than pro-active and suggested an analysis be completed by departments and then reported in their directorate report which occurs on 6 monthly basis. **ACTION: Mortality analysis to be included in directorate reports. KT to discuss with AS** **CNST Assessment** DMcA informed the meeting that the department had recently been assessed and unfortunately did not obtain level 2 but have retained level 1. When she receives the report she will bring it to the meeting for the committee to review.	 **EA** **KT/AS**
20.	**DATE OF NEXT MEETING** Thursday 19th January 2012 at 12.30 – 3.30pm in the Boardroom, Trust Headquarters.	

QUALITY AND SAFETY COMMITTEE

Outstanding Actions – Thursday 15th December 2011

Agenda Item	Action	By Whom	By when	Comments/Progress
6 **Jun 16**	**PATIENTS GROUP DIRECTION – DIABETES** Once policy written to be brought to the CGRC meeting	JK JK	20/10/11	18/08/11- JK update - a policy awaited from diabetes team. JK will prompt. 20/10 –Committee requested a resolution asap. 17/11 – Meeting arranged for 16th December JK will report back at next meeting in January.
10 **Aug 18**	**SUB-COMMITTEE REPORT** **a) Resuscitation** Communication of end of life decisions not always discussed with patient/family. Agenda for Matrons' meeting (SCox), Surgical Directorate (JM), Palliative Care Team (RM)	 SCox, JM, RM JK/EA MB	 15/11/11	 18/08/11 KT requested new senior palliative care nurse to do presentation to CGRC on her evaluation of what is working well and where further action is required, including communicating DNAR. 17/11 – JK to give EA name of senior palliative care nurse for her to arrange for her to attend next meeting to discuss DNAR. MB to check with sue Lockwood that she has up to date audit information for Surgery.
15	**LINE SEPSIS ACTION PLAN** Once Line Sepsis figures available. JK proposed that she and PO produce and action plan to be submitted to September meeting.	 JK/PO JK	 15/09/11	 JK & LD met to discuss action plan. LD to speak to the infection control team, PO to do practice work in wards. Action plan awaited. 17/11 – Still waiting for action plan JK to chase
5 **Nov 17**	**MEDICINE MANAGEMENT COMMITTEE** WM to report back at meeting in January	 WM	 19/01/12	
10 **Nov 17**	**2ND QUARTER QUALITY AND SAFETY REPORT** JK to investigate the reduction in number of patients who are spending 90% or more of their time on stroke unit. New template to be produced for Directorate reports	 JK DT	 19/01/12 19/01/12	

Dartford and Gravesham NHS
NHS Trust

TRUST BOARD MEETING - JANUARY 2012

Item 1-6.5. Attachment 9 - Organisational culture update

1-6.5 ORGANISATIONAL CULTURE – UPDATE CHIEF EXECUTIVE

The last update was given to the Board in October 2011. At that meeting, a generic set of quality standards was presented, and comments were received.

Since then, and following further discussion, it is proposed that the Trust should start to apply the 'pillars of quality' that emerged from the Quality 'Away Day' session held in July 2011, which were:

- Visionary leadership;
- Intellectual and technical ability;
- Good decision making;
- Clear communication;
- Collaboration and team work;
- Detailed data collection and audit;
- Reflection and review;
- Agreed standards and their consistent application;
- Accountability and responsibility;
- Personal commitment and involvement;
- Patient experience and using it to learn and design services; and
- Commitment to innovation and research

These pillars are a part of the leadership behaviours developed by the Director of Human Resources.

The Trust will also be maintaining its 'professional care, exceptional quality' 'strapline', and has recently issued a newly-printed 'patient service standards' booklet to staff to reinforce this. The booklet outlines key values ('kind'; 'excellent'; 'professional'; 'improving') and standards ('welcoming'; 'helpful'; 'respectful'; 'clean'; 'on stage'; 'speak up'; 'communicate'; 'compassionate'; and 'timely').

In addition, a more developed pre-interview process for Consultant recruitment has been agreed, to enable existing staff within multi-disciplinary teams to meet candidates, and participate in the process to assess their communication and clinical skills. This new process will be applied for the recruitment of two Consultant Obstretricians.

Work will also be undertaken regarding Clinical Director development, to increase the focus on patient safety.

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Information and discussion

Equality Impact Assessment initial screening applicable to this report? No

This report provides information on the following annual objectives (delete as required)**:**

- To improve patient experience and patient safety, and achieve the best health outcome for patients, through implementation of the Quality Plan for 2011/12;
- To maintain the highest standards of cleanliness and reduce healthcare associated infections, maintaining a zero tolerance approach to infections acquired within Darent Valley Hospital;
- To develop productive relationships with emerging GP Consortia, local authorities, and other new partners, in order to provide sustainable services for the community, and achieve a sustainable local health economy;
- To recruit excellent staff, and develop, manage, lead and support our staff fairly, to ensure they are motivated to deliver high quality and excellent services;
- To deliver the objectives set out in the Financial Plan for 2011/12, including the delivery of a Quality, Innovation,

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors understanding of the Trust & its performance

Productivity and Prevention (QIPP) programme that develops patient pathways which provides care closer to patients' homes, and improves the efficiency of the services the Trust provides, thereby saving resources and releasing capacity

Dartford and Gravesham NHS
NHS Trust

TRUST BOARD MEETING – JANUARY 2012

1-7.1	ECIST PROJECT PROGRESS REPORT	DIRECTOR OF OPERATIONS

Summary:
This report provides the final implementation report against the action plan arising from the recommendations made by the Emergency Care Intensive Support Team (ECIST) for improving the Emergency Access Pathway within Darent Valley Hospital.

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
For information

Equality Impact Assessment initial screening applicable to this report? No

This report provides information on the following annual objectives (delete as required)**:**

- To improve patient experience and patient safety, and achieve the best health outcome for patients, through implementation of the Quality Plan for 2011/12;
- To recruit excellent staff, and develop, manage, lead and support our staff fairly, to ensure they are motivated to deliver high quality and excellent services;
- To deliver the objectives set out in the Financial Plan for 2011/12, including the delivery of a Quality, Innovation, Productivity & Prevention (QIPP) programme that develops patient pathways which provides care closer to patients' homes, & improves the efficiency of the services the Trust provides, thereby saving resources and releasing capacity

Item 1-7.1. Attachment 10 - Emergency Department & ECIST (closure report)

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors understanding of the Trust & its performance

A final report on the implementation of recommendations made by the Emergency Care Intensive Support Team (ECIST)

The ECIST visited the Dartford and Gravesham NHS Trust on the 30 March 2011 to walk and talk through the processes, issues and known system constraints with current emergency care pathways at the Trust.

A paper was then produced capturing the observations and discussions held on the 30th March which offered a series of recommendations for the Trust to consider.
Whilst there are a wide range of issues facing the local healthcare community this paper focused on internal opportunities to maximise the potential of existing resources in the Dartford and Gravesham NHS Trust.

The Trust set up working parties in April 2011 within the Emergency Department, the Clinical Decisions Unit and General Medicine to address these issues.
This report is a final summary of the progress made within the Trust in response to these recommendations.

Accident & Emergency/Urgent Care Centre (ED)
Project Leads: Dr Jenkins/Sue Symmons

ECIST Recommendations:

- **Merge Minors and Urgent Care Centre Activity**
- **Reallocate a working environment for the merged minors and urgent care centre flow.**
- **Match skilled resources to demand (nursing and medical)**
- **Develop and implement internal standards that are approved and signed off by every member of the ED team**
- **Implement a 'see and treat' model for minors and 'rapid assessment and treatment' model for majors with clear time periods when these will be in operation and a clear contingency process when they are not in place.**
- **Develop reporting processes in 'PIGEON' to support leadership in the ED**
- **Develop criteria based discharge for the Short Stay Assessment Unit to increase patient flow.**
- **Release Consultant time from the SSA back to the majors area (Hayley Lingham/Debbie Coulton)**

All of these recommendations have been completed.

Merge Minors and Urgent Care Centre Activity.
Reallocate a working environment for the merged minors and urgent care centre flow.
Match skilled resources to demand (nursing and medical).

Minors merged with, and reallocated to, the Urgent Care Centre (Now known as the Emergency Walk-in Centre) on the 4 May 2011.
All patients arriving on foot now go directly to the Walk-in centre.
Patients bought in by ambulance and paediatric patients go directly to the main A&E department.

Minor's staff were transferred with the service to the Walk-in Centre with flexibility regarding whether they stay there or assist in the main emergency department dependent on need.

Although the current re-allocation of the EDWIC to be nearer the main Emergency Department has helped with the integration of both departments the final phase 4 of the A&E structural re-design project commences on the 9 January 2012 and is expected to take 4 weeks to complete. The EDWIC will then relocate into the main Emergency Department and both departments will become fully integrated.
Benefits will include an increase in capacity to manage the current overflow of patients in EDWIC; additional sharing of resources such as staffing, education, supervision, skills and equipment throughout the department, ensuring that patients receive a high standard of quality care regardless of acuity; allowing the Emergency Department to be more proactive in meeting and maintaining efficiencies improving the quality of patient flow and experience.

Develop and implement internal standards that are approved and signed off by every member of the ED team.
Develop reporting processes in 'PIGEON' to support leadership in the ED.

In addition to the 8 Department of Health (DOH) quality indicators which are monitored monthly via PIDGON, the Emergency Department has set 4 internal standards:

Internal Emergency Department Standards

	Standard	**Responsible person**
1a **1b**	Time to antibiotic therapy for admitted patients (sepsis) within 1 hour. Time to antibiotic therapy for all other admitted patients within 2 hours	Dr Jenkins/Sue Symmons
2	Analgesia for patients presenting with pain as part of symptomatology within 20 minutes	Dr Jenkins/Sue Symmons
3	IV fluid therapy within 1 hour of admission	Dr Jenkins/Sue Symmons
4	Completion of nursing template within 30 minutes	Sue Symmons

These have been implemented, and anecdotally an improvement has been made. It is intended to audit these standards as part of the Emergency Department's governance and report back by June 2012.
Implement a 'see and treat' model for minors and 'rapid assessment and treatment' model for majors with clear time periods when these will be in operation and a clear contingency process when they are not in place.

A streaming model is in operation in minors with those that are suitable seen in the see and treat stream. The contingency is that if there is a wait of 20 minutes or more a rapid assessment is done and appropriate pain relief offered.
Those that are not suitable for see and treat have a rapid assessment with brief history taking, vital signs recording and appropriate pain relief offered.
A rapid assessment model for Majors and Resus has successfully been in operation for the last six months and was entered for the Nursing Times Awards for 2011.
These models will continue to be reviewed and adapted to meet need and demand of the patients and department

Develop criteria based discharge for the Short Stay Assessment Unit to increase patient flow.
Release Consultant time from the SSA back to the majors area.

The newly redesigned 12 hour Short Stay Area (SSA) was reopened on the 30 September with new pathways and the implementation of criteria led discharge linked to ambulatory care pathways.
Staffing has also been reviewed on SSA and reduced. Skill mix is flexible and dependent on the acuity of the patients, which releases nursing staff back to the main emergency department and provides more flexibility with the staffing resource. (Currently winter pressures are affecting the appropriate use of this area).
With the exception of unplanned re-attendances (which have remained consistent) all of these initiatives have contributed to an improvement in meeting DOH performance indicators since the project commenced in March 2011:

Fig. 1

Performance Indicators	March 2011	December 2011	Reduction of	Reduced by
Unplanned re-attendances	7.0%	7.3%	-	
Total time in dept (95th %)	5.32 hours	4.00 hours	1.32 hours	(25%)
Left without being seen rate	5.4%	4.2%	1.2%	(22%)
Time to initial assessment (95th %)	0.92 hours	0.68 hours	0.24 hours	(26%)
Time to treatment in dept (median)	1.22 hours	1.02 hours	0.20 hours	(14%)
4 hour wait	91.2%	95.6%	4.4% (increase)	(4.7%)Improved by

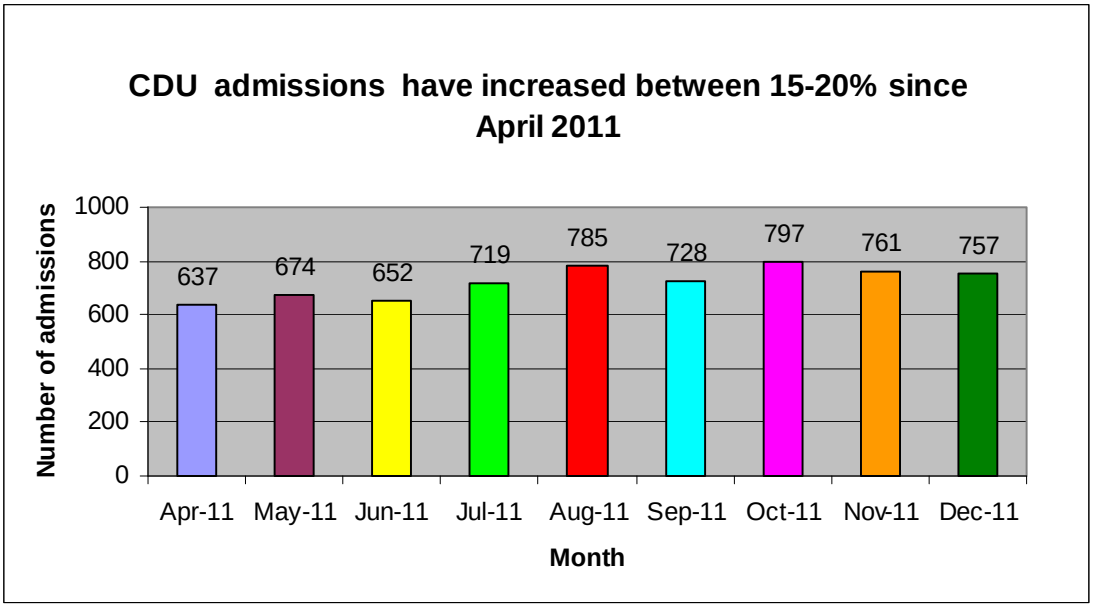
Clinical Decisions Unit (CDU)
Project Leads: Dr Ismail/Julia Walsh

ECIST Recommendations:

- **Review the medical model for the Clinical Decision Unit**
- **Eliminate batch processes in patient care**
- **Match skilled resources to demand (nursing and medical)**
- **Develop and implement internal standards that are approved and signed off by every member of the CDU**
- **Develop reporting processes in 'PIGEON'**
- **Develop ambulatory care pathways**

Review the medical model for the Clinical Decision Unit
Eliminate batch processes in patient care

Fig 2.



With regards to reviewing the medical model for CDU, Dr. M. Ismail remains the CDU lead consultant.
The new on call rota provides a senior presence on the ward giving CDU more access to senior decision making with new patients throughout the day.
Dr. Affam and Dr. Shamim (Registrars based on CDU) continue to provide senior decision making for patients who have been seen on the post take round and also any other patients where there are concerns.

There remain some issues to work through regarding junior cover and their clashes with annual leave/study leave/on call rotas which is currently being reviewed.

The on call teams now work from CDU assessing GP referred patients pulled from the Emergency Department and they assist with jobs outstanding from the post take ward round.

Direct GP admissions had been occurring since September, however for the last 2 months this has not been consistently achievable due to capacity issues across the Trust.
CDU have converted a 3 bedded bay into a trolley area, and where possible patients are converted from beds to trolleys to provide capacity in the mornings. (The CDU team constantly work towards providing 3 to 5 beds before 10:00hrs.)

New pathways are now in situ for the Emergency Departments to utilise so they can direct the correct category of patient to CDU.

Specialist consultants from cardiology, respiratory and elderly care continue to assess patients within their speciality when needed.

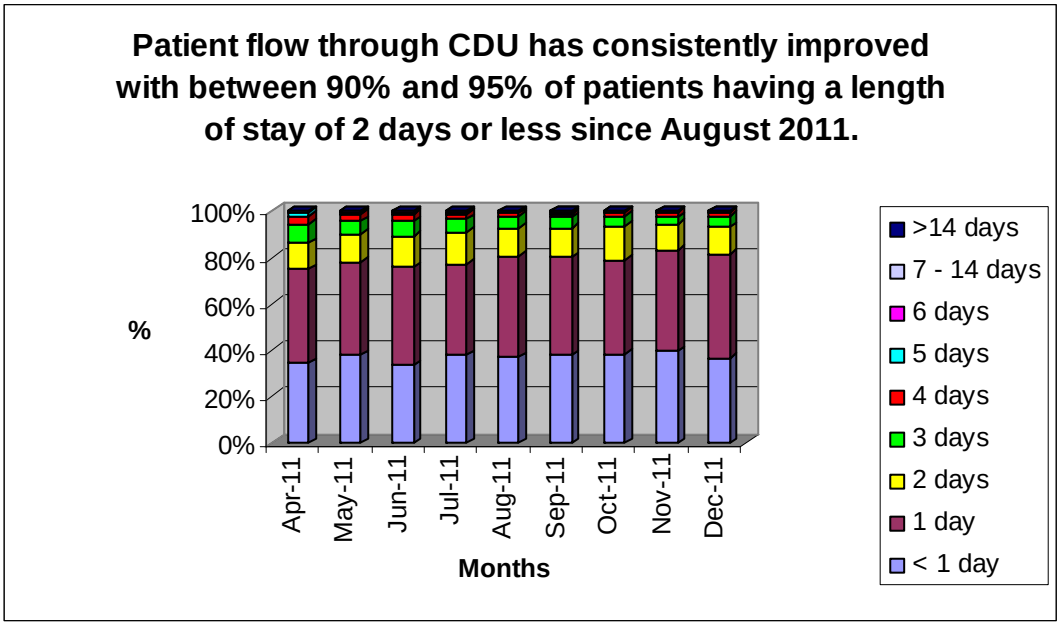
Develop and implement internal standards that are approved and signed off by every member of the CDU.

The operational policy for CDU has been reviewed and amended and is currently on ADAGIO.

Internal standards were agreed and implemented in May 2011, including time to initial assessment and time to senior review. These are monitored on a monthly basis.

CDU continues to improve its length of stay and patient flow consistently over the past with over 90% of patients consistently only staying on CDU for 2 days or less since August 2011 despite an increase in activity of between 15-20% since April 2011.

Fig 3.



A daily senior multi-disciplinary white board round has been introduced at 9 am every morning to quickly discuss plans. These plans are then prioritised and actioned. Feedback is given at midday during a virtual ward round and action planning. This has improved communication of discharge plans and is attended by the medical and nursing teams on CDU.
At 1.15pm the co-ordinator hands over to the physio, OT and social services and updates any plans there.

Match skilled resources to demand (nursing and medical).

A new band 6 Junior Sister has been appointed in addition to the CDU Co-ordinator role. This nurse works 8am to 4pm and attends the post take round, chases up actions from this round and then also pulls patients from the Emergency Departments. This role is still in its infancy but so far this nurse has built good networks with other departments and this has had an impact on CDU wait times for investigations in a positive way.
Due to calibre of candidates, it has not been possible to recruit to the new band 5 post as yet, which would support rapid access and direct GP referrals, however recruitment continues.

Junior doctor posts continue to be reviewed as part of a larger Trust-wide review, regarding cover for annual and study leave.

A new band 7 Occupational Therapist (OT) post was agreed for CDU from the re-ablement monies. OT cover to CDU, A&E and SSA has now been increased, including weekends.

The OTs are seeing patients before they are medically fit and response time is within 2 hours.

The physiotherapy department has received specific funding to provide mobility assessments for the Clinical Decision Unit (CDU) for patients deemed ready for discharge during the weekend. This service also provides assessments to A&E for referrals during these service hours. The service should also have capacity to provide mobility assessments to medical, surgical and orthopaedic inpatients who have been deemed ready for discharge.

Ambulatory care pathways.

Phase 1 of ambulatory care condition specific care pathways have been developed and implemented including social care and COPD. Phase 2 pathways have been identified and are currently being developed with a completion target of March 2012.

CDU remains the main provider of patients to the Hospital at Home team.

Both Bexley and West Kent social services are now present at white board rounds. West Kent PCT also attend white board rounds.

General Medicine

Project Leads: Dr Mushtaq/Pam Dhesi

- **Monitor discharges by day of week and time of day**
- **Move to daily consultant ward/board rounds.**
- **Introduce one stop ward rounds.**

Monitor discharges by day of week and time of day

Some work regarding this had already been completed prior to the ECIST review:

- ✓ Medical Case Mix Analysis
- ✓ 7-14 day Length of Stay Audit

A mapping event facilitated by NHS ELECT was held on the 29 June mapping the medical patient pathway and identified some areas for improvement of patients who are ‘non complex’ and admitted for 7- 14 days within Medicine. These were delegated and actioned successfully.

Additionally a Complex Elderly Care Pathway Project was commissioned from re-ablement monies in July, aimed at improving the implementation and monitoring of discharge processes and pathways. It is currently being piloted on Ebony Ward and is due to be reported on in February 2012.

Discharge activity has been monitored and it was identified that weekend activity regarding this was poor. Services supporting discharges at weekends were reviewed and have since been increased (Physio, OT, Social Services) and a subsequent review to evaluate the impact of this will take place in February 2012.

Move to daily consultant ward/board rounds.

Some wards, such as Spruce, Chestnut and Oak Ward were already having some form of daily board round/patient review with senior medical clinicians.

A pilot of daily board rounds was performed on Linden Ward for 3 months and proved useful in improving effective decision making and improving communication.
Ward sisters were tasked with rolling the system out across the remaining Medical Wards. It was agreed that senior decision-making presence on the rounds was essential and with regards to Medical involvement this was defined as Consultant or Registrar level. It was also agreed that approaches may differ but that the common aim is consistent senior decision-making.

All medical wards now have a daily board round system in place with multidisciplinary involvement.
Currently work is ongoing to standardise the information presented on the white boards across the Trust.

Introduce one stop ward rounds.

One-stop ward rounds were also piloted on Linden Ward, but because of varying levels of junior doctor presence due to on call, annual and study leave commitments, success proved variable.
It has therefore been agreed that prioritisation of essential tasks that would impact upon patient flow should occur during the ward round to distinguish between those that could be done later and that this will be guided by the ward sisters.

One Stop Elderly Care Rapid Access clinics launched on the 12 September in partnership with the Kent PCT. This project will also be supported by the newly appointed Elderly Care Specialist Nurse once in post who will assist in diverting appropriate patients from the Emergency Department.

Develop and implement internal standards that are approved and signed off by every member of the team

Internal standards for the following areas have been developed and implemented:

- ✓ Multidisciplinary handovers
- ✓ Physio
- ✓ Occupational Therapy
- ✓ Daily Consultant Ward rounds
- ✓ Documentation

Key Performance Indicators to measure the success of the new initiatives have been agreed. These will be quality indicators that are already collected such as length of stay, complaints, and patient satisfaction surveys. It was also agreed that compliance should be measured and that the target should be 80% compliance with the board rounds occurring across the medical wards.

The social assessment proforma has been revised as a result of the findings of a social care audit carried out as part of an ECIST work stream.

Each proforma uses tick boxes is to be filled in within 24 hours of the patient's admission to a medical ward by the nursing staff and is a record of their status PRIOR to admission. It is hoped that this will ensure that information required to initiate the discharge process is obtained at an early stage in the patient's admission. It will be kept on the front of the nursing folder.

Conclusion

All of the recommendations from ECIST have been reviewed and either trialled or implemented. It should be acknowledged that the progress that has been achieved by this project is because of the leadership, support and hard work of the steering group members and their teams.
The CDU working group has recently been merged with the CDU Operational Meeting which will continue to develop and monitor the service.

In response to a steady increase in the number of patients with a length of stay of 30 or more days between June and September 2011 it was recognised that the initial momentum regarding the ECIST project had waned and had to be maintained to continue to the project forward and impact on length of stay.

Additionally, the Complex Discharge Team audited, and found a substantial number of patients admitted to hospital from care homes with a change of need who then had to go through the assessment processes for new placement needs which delayed discharge.
Subsequently, a joint project was undertaken with the Dementia Commissioner and the Complex Discharge Manager, identifying the top five reasons for Nursing Homes sending patients to hospital unnecessarily and encouraging the use of the community services available, rather than automatically sending patients to A&E, making better use of both the District Nurses and Ellenor Teams. A care plan and booklet for end of life discussions was also produced by PCT colleagues and has been promoted around the district.

Although still above June's activity the number of patients with a length of stay of 30 days or more has decreased since September 2011 and has remained consistent over the past 3 months. Non-elective length of stay has continued a downwards trend with a total decrease of 15% since April 2011.
It is believed that further work in 2012 aimed at educating and developing pathways for residential homes will further impact favourably on length of stay.

Fig 4.

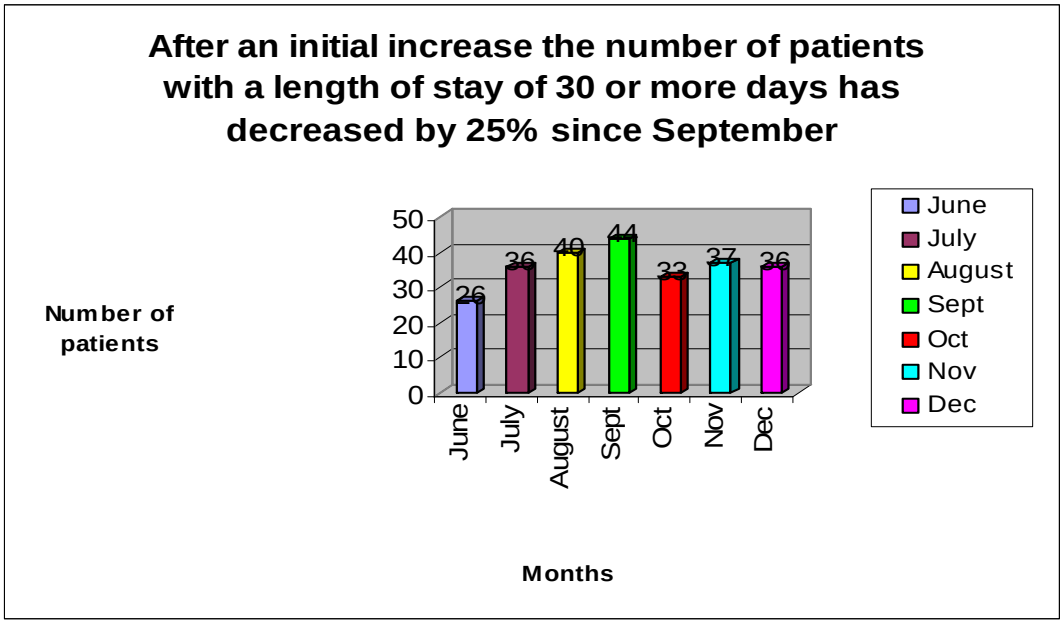
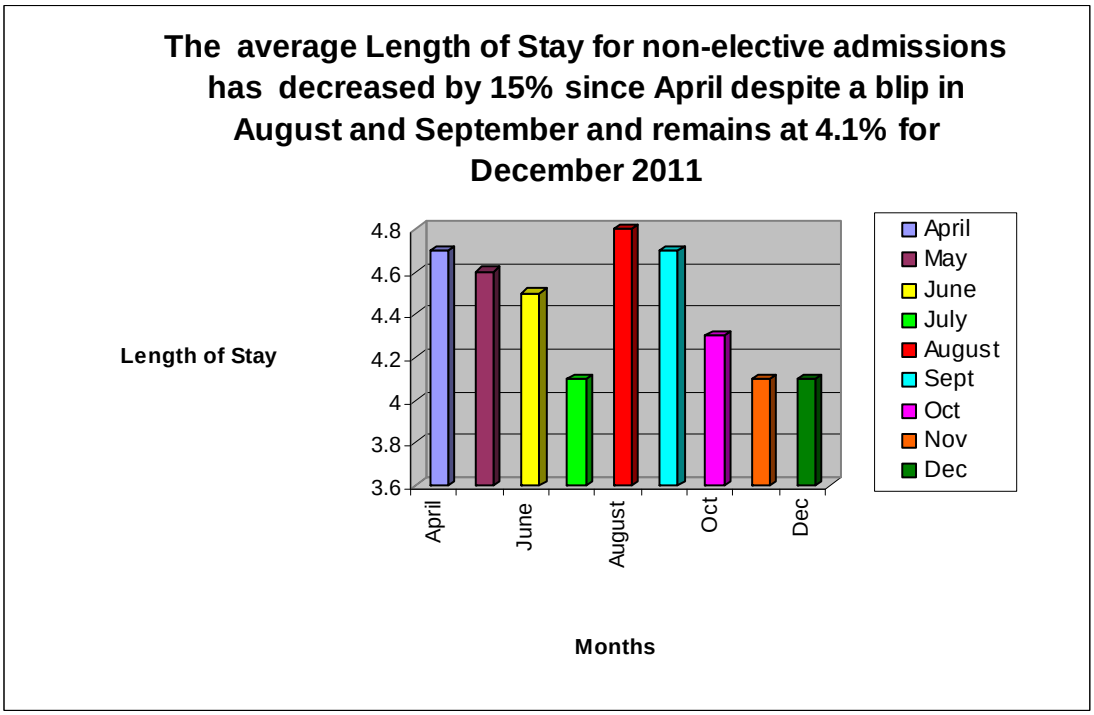


Fig 5.



The impact of some of the changes which have been made is already evident with consistent improvements in quality and performance indicators, which have been maintained going into the winter months.

Recommendations

Continue to monitor impact of changes as a result of implementation of recommendations from ECIST via existing forums such as the CDU Operational Group and the Facing the Future Steering Group.

Sarah Parsons (Project Lead) & the ECIST Working Parties
11 January 2012

Dartford and Gravesham NHS
NHS Trust

TRUST BOARD MEETING – JANUARY 2012

1-7.2	UPDATE ON THE CANCER INTENSIVE SUPPORT TEAM VISIT	DIRECTOR OF OPERATIONS

The November 2011 Board received the final report of the Intensive Support Team's visit (IST).

An action plan for improving the pathway for patients with a suspected cancer has been developed in response to the report. This was discussed and agreed at the Cancer Services Committee on 25th November.

The attached action plan is a combined plan including internally required developments and those identified by the IST team, the latter are highlighted in tan.

Some of the timescales within this updated action plan have been extended following comments at the December Board discussion and propose an ambitious but more realistic plan.

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

Equality Impact Assessment initial screening applicable to this report? No

This report provides information on the following annual objectives (delete as required)**:**

- To improve patient experience and patient safety, and achieve the best health outcome for patients, through implementation of the Quality Plan for 2011/12;
- To develop productive relationships with emerging GP Consortia, local authorities, and other new partners, in order to provide sustainable services for the community, and achieve a sustainable local health economy;
- To recruit excellent staff, and develop, manage, lead and support our staff fairly, to ensure they are motivated to deliver high quality and excellent services;
- To deliver the objectives set out in the Financial Plan for 2011/12, including the delivery of a Quality, Innovation, Productivity and Prevention (QIPP) programme that develops patient pathways which provides care closer to patients' homes, and improves the efficiency of the services the Trust provides, thereby saving resources and releasing capacity

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors understanding of the Trust & its performance

Areas	Issues	Planned Solutions	Lead	Resolution Date	Actions & Status
Administration 1.0	It would appear that patients are attending Outpatient appointments without all the necessary results available to the clinicians which hinder the consultation process.	Process for clinic preparation to be investigated and reviewed	Pippa Miles	January 2012	Interim measure for visiting Oncologists consists of Pine Therapy staff/Cancer Manager checking results available prior to clinic. Further discussion needed with radiology re time frame for resolution of this issue. Achieved.
1.1	Intertrust referrals for Upper GI add at least a week to the pathway. Upper GI MDT at DVH Monday, MTW MDT Wednesday. This causes a huge challenge to the MDT Co-ordinator in ensuring slides are available prior to MTW MDT cut off point.	To work with Cancer Centre to agree an improved process.	Sarah Flanagan	December 2011	Process now appears to be significantly improved. Completed
1.2	Communication appears to be a problem with cancer centres. Often outcomes from centre MDTs and OPAs are not forwarded back to the MDT Co-ordinator, CNS or Consultant. Have to email Consultant or ring CNS on mobile to get results back. We currently do not receive clinic outcomes from King's.	Work with Cancer Centres to agree how/when feedback arrangements should occur, ie via NHS.net accounts, etc.	Pippa Miles	February 2012	PM awaiting response and solution from Kings, Guys & St Thomas and MTW. Improvements seen at MTW, and Guys and St Thomas'. IT issues remain at Kings.
1.3	Would support for MDT Co-ordinators be improved if they were located together? Would this facilitate sharing of best practice and improved management of the pathway?	Work with executive lead to highlight appropriate office space.	Sarah Flanagan	January 2012	MDT co-ordintors and CNS's located together where possible. Others have changed working practices to improve communication processes Completed

Areas	Issues	Planned Solutions	Lead	Resolution Date	Actions & Status
Administration Cont 1.4	Urology oncology clinics – MTW Secretary unable to provide adequate turnaround times for letters to be typed. Concerned this is affecting the patient pathway.	Options to be investigated. ? Secretarial support at DVH. ? Tape to be couriered to MTW after oncology clinc.	Sarah Flanagan	December 2011	This issue has now been resolved.
1.5	At the moment when patients have been seen in the colorectal clinic there is a delay of a week or so before the clinic letter is typed. This delays referrals being sent to the Oncology Centre.	Work with Surgical GM and secretarial supervisor to discuss resolution.	Sarah Flanagan/ Alex Tan/ Mr Bhardwaj	February 2012	Action plan to be agreed with Gm's at meeting on the 5th Jan Interim arrangements in place
1.6	Getting referral letters typed urgently can be delayed due to lack of secretarial support. Most Trust secretaries work part-time hours. However, no cover systems seem to be in place, or phone messages indicating who can help in their absence. This means wasted time tracking down alternative staff members to help, and often offices without cover for substantial periods of the day. This can cause delays in referrals/clinic letters and information gathering and sharing.	Work with GM's on a solution to this	GM's/Lead Clinicians	February 2012	Action plan to be agreed with Gm's at meeting on the 5th Jan Interim arrangements in place

Areas	Issues	Planned Solutions	Lead	Resolution Date	Actions & Status
1.7	Haematology has no formal 2 week wait booking system – it is the only site that does not facilitate the Cancer Services booking line. It is completely dependent on the consultants/secretaries to alert the MDT Co-Ordinator to new referrals/new cancers/copy her into referrals and the system is not 100%. The MDT Co-Ordinator is not currently receiving copies of all referrals, which has an impact if the patient later has a confirmed cancer.	To review Haematology secretaries working practices.	Sarah Flanagan	December 2011	This issue has now been resolved. Completed
1.8	Inappropriate referrals not being flagged to Pippa by colorectal surgeons	To discuss with surgeons process for reporting them	Pippa Miles/Mr Bhardwaj	December 2011	MDT Co-Ordinator will give copies of inappropriate referrals to PM. Completed
1.9	To hold monthly meetings for the MDT Co-Ordinators and Admin support staff to enable them to discuss and share their knowledge of the Cancer Waiting Times standards.	Cancer Manager to source a suitable room and provide refresher training on GFOCW.	Pippa Miles	December 2011	Currently meeting weekly. Completed
1.10	To review the TOR for the Cancer Service Committee so that attendance at these meetings could be improved	For Trust Lead Cancer Clinician, Lead Cancer Nurse and Cancer Manager to review and amend where necessary.	Pippa Miles	December 2011	To be signed off at Cancer Services meeting on 25th November 2011 Completed
1.11	To extend the hours that patient can be contacted by the Appointment Staff to offer them Rapid Access appointments.	To review current staffing and working hours to accommodate .	Sarah Flanagan	November 2011	Pine reception staff have reviewed working practices to support the Rapid Access Team in achieving this. Completed

Areas	Issues	Planned Solutions	Lead	Resolution Date	Actions & Status
1.12	The Trust and PCT to work together to unblock barriers to GP's utilising Choose and Book.	Work with GP Lead, Medical Adviser and Sustainability Lead NHS Kent and Medway, Systems & Software Manager DVH	Jamie Workman/ Mike Parks GP Lead/Pippa Miles	April 2012	Tumour sites accessible via Choose and Book are, Breast, Lung, Colorectal, Urology and Gynae. This is work in progress. Further discussion with GPs planned to facilitate use fo CAB
Diagnostics 2.0	Currently there is no access to a true One Stop Clinic for symptomatic breast patients.	Discuss at next Breast implementation meeting, agree Action Plan for Radiology Access and Histology turn around times and incorporate into the Teams' Annual Work plan.	Seema Seetharan/ Sarah Flanagan/ Alex Tan/ Julie Freel/ Jane Meek/ Sophie Glew	Business case to be completed by end of January 2012. Service in place by April 2012	Business Case in progress
2.1	EGFR, KRAS and HGR testing – Currently causing a delay in the pathway. Although new process being piloted.	Work with Alan Wondzinski to monitor improvement in turnaround time and ensure Barbara within Pathology is fully aware of process and fully supported.	Pippa Miles	December 2011	Issue has been resolved.
2.2	The 6 week wait for an MRI post TRUS biopsy is causing a huge problem in the urology pathway.	Work on new TRUS biopsy one stop linked to MRI and MDT to strengthen turnaround time and process	Sanjeev Madaan/ Fay Fawke/ Julie Freel/Alex Tan	February 2012	Currently this timescale cannot be avoided therefore team trying to proactively manage the patients to prevent the minimum number of breaches.
2.3	Bone Marrow reporting a problem. Currently there is no gold standard	Discussed with haematologist agreed	Sarah Flanagan	December 2011	Haematology team have achieved a 3 week turnaround time aiming for 2

Areas	Issues	Planned Solutions	Lead	Resolution Date	Actions & Status
	turnaround time.	turnaround time of 2 weeks.			week turnaround time.
Diagnostics Cont 2.4	Some clinical teams are not marking all 2WW investigations as high priority.	For Lead clinicians and CNS's to re-iterate the importance and urgency of this to junior staff.	Lead Cancer clinicians and CNS's	January 2012	Lead Clinicians and teams have been informed of the importance of this. Process currently being monitored.
2.5	Cystoscopy. Continuity of informing the MDT Co-ordinator of a suspicious lesion found during the procedure appears to be a problem. Also trying to decipher handwriting in notes to determine any actions or outcomes is time consuming,	Discuss with urology Lead clinician and suggest using electronic reporting as all the other sites use I.e. Endoweb	Sanjeev Madaan/ Pippa Miles/Di Pearce	February 2012	Currently under investigation.
2.6	When biopsies for Flexi Sig or Colonoscopy are taken pots are not being labelled as 2WW, therefore pathology not aware of the need for Urgent reporting.	To ask Wendy in admin office to print the daily clinic lists, highlight the RA patients and take down to out-patients to be given to the doctors so they can see which patients investigation requests need fast tracking through.	Pippa Miles/ Rakesh Bhardwaj/ Alan Wondzinski/ Matron for Endoscopy	January 2012	Lead Clinicians and teams have been informed of the importance of this. Process currently being monitored.
2.7	To investigate the issue of late collections of samples by porters often resulting in the sample being left over the weekend. To ensure clinical teams are aware of process for organising samples to be collected.	Discuss with Carillion. Day Care staff and clinical teams.	Pippa Miles/ Matron for Endoscopy/ Theatre	January 2012	Pilot process with the portering service currently in progress. To be reviewed at the end of the month. No issues reported currently

Areas	Issues	Planned Solutions	Lead	Resolution Date	Actions & Status
Cancer Centre 3.0	Oncology cover – major issue, no cover for holiday and study leave. There is no action plan in place if patients require an appointment with an Oncologist during periods of leave. Patients have to wait until consultant returns before being seen in clinic, could be waiting up to 3 weeks.	Discuss with General Manager at the Cancer Centre to agree more robust cover arrangements.	Sarah Flanagan/ Emma Yale	March 2012	SF awaiting response and action plan from MTW.
3.1	Process to refer to an Oncologist is time consuming and has multiple steps prior to an appointment being given. (Fax has to be sent to Cancer Tracker who passes to Oncologist's Secretary for review and to decide appointment date. Information then passed to Maidstone Registration department) Fax can be up to 10 pages long as all results need to be sent. Staff feel strongly that if the patient is a DVH patient and we are using DVH notes in clinic why should there be a need to send so much documentation to MTW prior to consultation. There also appears to be a problem with contact arrangements within Oncology Registration after 14.30	Resolution to be agreed with lead clinicians, Oncologists and General Managers and incorporated into Service Level agreement.	Sarah Flanagan/ Emma Yale	January 2012	SF awaiting response and action plan from MTW.
3.2	Some Oncologists at MTW will only review referrals once a week which again can delay the patient pathway.	Discuss with General Manager at the Cancer Centre and incorporate agreements within SLA.	Sarah Flanagan/ Emma Yale	January 2012	completed

Areas	Issues	Planned Solutions	Lead	Resolution Date	Actions & Status
In Health PET 4.0	PET scan – Capacity at Maidstone is insufficient to accommodate DVH patients and therefore patients have to travel to Canterbury. There is lack of clarity as to which organisation is responsible for organising and paying for patient transport for PET scanning, no one accepting responsibility. Average scan request waiting time is 2 weeks. Every lung cancer patient requires a PET scan.(Averaging 4 patients per week) Unfair for patients to be expected to get to Canterbury)	Work with Network and PCT to find a suitable solution. (when service was with Guy's & St Thomas's this was not an issue)	Pippa Miles/ Jane Hubert	February 2012	PM spoken with In-Health who are reviewing situation. Discussions in progress – capacity sufficient but predominantly at Canterbury
Governance 5.0	Clinic outcomes for oncology – Nothing being written in DVH patient notes and currently unable to access KOMS. Consultants have access to KOMS therefore teams questioned why there was a need to courier MTW notes to DVH for clinics	Agree timescale for KOMS being installed at DVH with MTW. Discuss change in process with Cancer Centre	Pippa Miles/ Jenny Lewis Sarah Flanagan/ Emma Yale/Oncologists	November 2011 November 2011	KOMS now in place, all Oncologists documenting in DVH notes.
Chemotherapy 6.0	If there is significant delays in the pathway the Pine Therapy Unit and patient may only be given 2 days notice before start of chemotherapy treatment.	Work with all Tumour site specific teams to ensure timely referral. Process to be implemented within Pine to ensure improvement.	Sarah Flanagan	November 2011	There have been significant improvements in all pathways this appears to be less of an issue but is being closely monitored.
Capacity 7.0	Unsustainable capacity within out-patients for new and follow-up patients, particularly Colorectal (New and Follow-up), Lung (New) and Urology Follow-up)	To work with General managers and Consultants to look at	GM's/IST/Pippa Miles/ Sarah Flanagan	March 2012	Capacity and Demand work to be undertaken. Being discussed with IST Lead on

Areas	Issues	Planned Solutions	Lead	Resolution Date	Actions & Status
	Choose and Book – a challenge on the rare occasion they try to book apps on breast and lung clinics. Surgeries then fax referrals through to Rapid Access but appointments still not available.	Clinics and protected slots. Use Capacity and Demand Tool.			the 5th Jan Discussed – schedule of specialities being developed – to commence with endoscopy from January
7.1	Consultant Haematologist visits to King's on a Thursday cause problems with cover and capacity.	To be discussed with Consultants and CD to find a suitable resolution for all	Sarah Flanagan/ Tariq Shafi	March 2012	Out-standing
7.2	Urology theatre capacity is an issue at Medway The Trust to ensure that there is senior support to resolve the out-standing issues with Medway capacity for the Urology patients.	This should improve as Mr Madaan now has x 2 days a week. Work with General Managers on both sites to monitor.	Sanjeev Madaan/ Alex Tan/ Sam Goldberg	January 2012	This appears to have improved since SM has had an extra session.
7.3	Consultants appear to be pulled from clinics to cover surgical lists at short notice which adversely affects the patient pathway.	Work with Surgical GM and Consultants to resolve.	Alex Tan	January 2012	To be discussed at working group arranged by Julie Hunt on 18th Jan
7.4	Patients requiring cryotherapy do not currently have dedicated theatre space.	To facilitate appropriate number of sessions per month to accommodate these patients.	Alex Tan/ Mr Sriprashad	April 2012	Out-standing – in progress and links with capacity and demand work
7.5	Use Capacity and Demand tool to review current capacity for theatres and Endoscopy.	To work with GM's to utilise Capacity & Demand tool.	Trish Banniister/Kevin Gray/Sarah Flanagan/Pippa Miles	March 2012	Capacity and Demand work to be undertaken to be discussed with IST Lead on the 5th Jan Discussed – schedule of specialities being developed – to commence with endoscopy from January
Forward Planning 8.0	Currently not all teams actively plan their annual leave, BH and MDT cover	Working with the Clinical Leads, CD and Executive	Clinical Leads/ GM's	Meetings commence Mid	To be discussed in 'One to One' meetings commence

Areas	Issues	Planned Solutions	Lead	Resolution Date	Actions & Status
	arrangements. They do not have policies in place to recommend how they would like the service to be facilitated if colleagues are unavailable. ie reduction in clinics, only seeing new patients, no follow ups. Clinics are not always cancelled when consultants are on leave	Lead to pre plan and incorporate planning at the beginning of each year. Develop a more robust process for cancelling clinics		January 2012	mid January
8.1	Escalation process for extra clinics or overbooking not robust. Currently no turnaround time. Response required within 24 hours so that the 2WW team have sufficient time to contact patients to arrange appointments.	Work with General Managers and Clinicians to agree process that works for all.	Clinical Leads & GM's	December 2011	To be discussed at 'One to One' meetings
8.2	Medical Audit on a Tuesday or Thursdays means that Bronchoscopies are cancelled.	To discuss appropriate resolution with all involved to incorporate extra sessions so that capacity is not lost.	Majid Mushtaq/ Alex Tan/ Pam Dhesi	Meetings commence Mid-January 2012	Currently discussing action plan needed that can be incorporated into work load planning this year and documented in Operational Policy Alternative arrangements identified.
8.3	The Trust to ensures that there is appropriate level of attendance at a senior level at external meetings	Discuss with Trust Lead Cancer Clinician, MDT lead Clinicians how this can be managed	Walter Melia and Cancer Leads	January 2012	To be discussed at 'One to One' meetings commence mid January
8.4	The Trust to review and make improvements to consultant leave policy to ensure that adequate cover is in place so that capacity is not lost.	Discuss with Clinical Leads and Medical Director	Executive Team/CD's/ Clinical Leads	Meetings commence Mid-January 2012	To be discussed at 'One to One' meetings commence mid January

Areas	Issues	Planned Solutions	Lead	Resolution Date	Actions & Status
Performance 9.0	To ensure that a copy of the Trust Board Performance Report is sent to the Cancer Manager each month so that performance against the cancer standards can be reviewed by the Cancer Management Team and clinical Leads.	Ask June to send a copy each month or directs the Manager where it can be found electronically.	Pippa Miles/ June Greenslade	December 2011	Currently published on Adagio following the Trust Board meeting (last week of the month)
9.1	To engage General Managers to meet weekly with the Cancer Management Team to discuss any capacity issues or restraints which will affect meeting the targets and discuss performance levels and also share the performance reports and cancer PTL with them.	For Julie Hunt to write to the GM's and invite them to attend Cancer Management PTL meetings.	Pippa Miles/ GM's	December 2011	Pm attends weekly PTL meeting.
9.2	To review all internal cancer pathways for each tumour site and include appropriate internal milestones which have been agreed and set within reasonable timescales to ensure that the pathways are timely, efficient and compliant.	Work with GM's for each directorate and Lead Clinicians.	Sarah Flanagan/ Pippa Miles/Lead Clinicians	February 2012	Colorectal pathway has been reviewed; work currently being undertaken with Burkeway to pilot electronic progress with pathway improvements. Other sites for this to be discussed at 'One to One' meetings.
9.3	For the site specific MDT Lead Clinician, CNS, MDT Co-Ordinator, Trust Lead Cancer Clinician, Lead Cancer Nurse and Cancer Manager and associated GM to agree how to address any issues that will affect the patient pathway and	Lead Cancer Nurse and Cancer Manager to write to Leads to organise meetings.	Walter Melia/ Sarah Flanagan/ Pippa Miles/ Associated GM	December 2011	Agreed at the Cancer Services meeting on the 25th November. Timetable of meetings distributed to all teams.

Areas	Issues	Planned Solutions	Lead	Resolution Date	Actions & Status
	how to review Performance and breaches for each team.				
Radiology 10.0	Capacity within CT scanning is currently insufficient to ensure all urgent cancer CTs can be accommodated within 10 working days to include a verified report. Capacity can be divided between access to CT scanning and reporting.	Work with Paul Holder (CD Radiology) and Julie Freel (GM Radiology) to resolve.	Paul Holder/ Julie Freel	April 2012	Identify patients at time of referral on 2ww pathway. Timely booking of known urgent patients. Risk around scanning raised to Exec's through radiology Action Plan. Additional consultant capacity agreed through business case but not currently fully funded remains a high risk. 2 new consultants will replace vacancies with 1 additional consultant from January 2012.
10.1	There are currently insufficient Radiologists with a special interest in breast imaging to either facilitate a robust 'One Stop' service or consistent cover for the Breast MDT.	Work with Paul Holder (CD Radiology) and Julie Freel (GM Radiology) to resolve.	Paul Holder/ Julie Freel	April 2012	Increased funding for consultant AHP. Achieved status of consultant practitioner 2011. Access to One Stop funding and development of business case to support facilities underway. Increase in consultant pay for single breast radiologist to cross cover AHP consultant leave.
10.2	Interventional radiology cover for CT guided biopsies, prostate and Lung in particular are a challenge during annual leave and study leave etc.	Work with Paul Holder (CD Radiology) and Julie Freel (GM Radiology) to resolve.	Paul Holder/ Julie Freel	January 2012	Lung - can now be performed by Dr Hadi and Dr Batarji, Dr Constantiecu and Dr Serafimov Prostate – Dr Holder, the

Areas	Issues	Planned Solutions	Lead	Resolution Date	Actions & Status
	MDT radiology cover is also an issue during periods of annual leave and study leave. Delay to UGI MDM and therefore the start of the Colorectal MDM is delayed which impacts on pm clinics and theatre lists.				advanced practitioner and one other Consultant radiologist will be providing this service in the future. Pathway to be reviewed with SM/JF/PH/AT and supported re booking as a day case procedure. This will continue to be a challenge but review of Consultant A/L rota by JF and PH has highlighted the need for planning to include cross cover for MDT working. A recently appointed Consultant Dr Serafimor will be supporting the Upper GI MDM Dr Holder will continue to support the Colorectal MDM. It is hoped that this additional support will improve time keeping in the MDM's - RESOLVED
10.3	Currently the team are unclear as to radiology reporting turn around times and what they believe is achievable, skeletal surveys are a particular problem (3 weeks – 1 month).	Work with Paul Holder (CD Radiology) and Julie Freel (GM Radiology) to resolve	Paul Holder/ Julie Freel	January 2012	Discussion with the GM for Radiology has led to the suggestion that skeletal survey patients will be imaged on attendance rather than given an appointment and allocated to Dr Menon for reporting within the same working week

Areas	Issues	Planned Solutions	Lead	Resolution Date	Actions & Status
	Urology reporting can be up to 4 weeks. Equally there is currently inconsistency with reports being verified prior to the MTD even when lists are provided 48hours prior to the MDT				Dr Constantesi to support urology reporting Inconsistency of reporting being verified must be discussed and resolved with the clinical lead for radiology and the Lead Cancer Clinician for each MDT Position improving and escalation process in place
10.4	The process for agreeing and organising further radiological investigations if a Radiologist deems it necessary needs to be implemented with the specific MDT thereby reducing delays. Radiologist should be able to request tests if they feel they are required.	Agree an efficient process with CD for radiology and MDT leads. This should be minuted and signed up to through the Cancer Services Committee.	Lead Clinican and Radiology Lead for MDT	February 2011	CD for radiology to discuss with individual radiologists and Leads, suggested solution radiologist refers directly onto further imaging at the point of reporting and to work with the CNS and MDT Co-Ordinator re contacting the patient and tracking.
10.5	Designated slots for CT and MRI works well for lung cancer pathway. Could it help with particular pathways like bowel screening or other site specific teams.	Work with Radiology to resolve this issue.	Paul Holder/ Julie Freel	February 2012	To review this possibility when the Capacity and demand work has been completed with the IST Work scheduled – to commence with endoscopy
10.6	MRI request form does not currently have a box to put in the date for when the TRUS biopsy was done which makes it difficult to incorporate the correct 6 week wait date when MRI will be optimum.	To discuss appropriate resolution with all involved.	Julie Freel/ Fay Fawke	January 2012	Please can Clinicians document in the clinical details the date of the TRUS biopsy. In progress

Areas	Issues	Planned Solutions	Lead	Resolution Date	Actions & Status
10.7	Barium Enema's taking up to 2 weeks to report, also when the person reporting is on leave no one reports on them.	Work with radiology to resolve this issue.	Paul Holder	January 2012	This is a radiographer led service, checked by a radiologist. Delays when radiologist not available due to A/L etc. More than one radiologist to be allocated for this service in the future. Ongoing monitoring
10.8	The Trust to develop an action plan to address the issues in radiology, to include timescales to reduce waiting times to acceptable limits. The radiology team to assess and to communicate exactly how appointment of the new consultants will impact positively on delivery of cancer services within the organisation.	Work with GM's and CD for radiology to resolve these issues.	Paul Holder/ Julie Freel	January 2012	GM developed an action plan in April and took forward to the business case committee. Some additional funds were made available and there was executive support for an increase in radiology capacity, there remains a financial risk and service risk around funding fully the staff and equipment needed. CD for radiology to feed back on performance and workplans of new consultants and any outstanding issues re reporting and MDM cover.
Patient Pathways 11.0	Not all CNS's currently involved at the investigation stage of the pathway to	Work with CNS's to agree generic processes	Sarah Flanagan/All CNS's	December 2011	All CNS's now actively involved in the rapid access

Areas	Issues	Planned Solutions	Lead	Resolution Date	Actions & Status
	ensure continuity, compassion and professionalism.	that work for teams and patients.			process for their patients. New Macmillan Oncology CNS will help provide additional support.
11.1	There would appear to be an issue with upgrading Ultrasound prioritisation. MDT Co-ordinators often have difficulties if their clinical team have not marked the referral as 2WW or urgent.	Discuss with consultants and teams to ensure accurate prioritisation and ask radiology to audit prioritisation and present findings to Cancer Services Committee.	Pippa Miles/ Pauline Mellor	December 2011	Pippa meeting with Pauline Mellor but believes this has now been resolved with CNS present at the Rapid Access clinics.
11.2	Patients diagnosed through the bowel screening programme have significant delays which may cause them to breach.	Work with Bowel Screening team to improve pathway.	Lee Adams	January 2012	Improvements made in tracking progress. Complete and ongoing monitoring
11.3	The Trust to audit whether there is a genuine difference in pathway for patients seen by a consultant and those seen by a registrar. The Trust to review the role of registrars in the management of cancer patients.	Cancer Manager and Cancer Lead Nurse to ask MDT Co-Ordinators for sample of patients and work with the audit dept to analyse and differences. Discuss with MDT leads.	Lead Cancer Clinicians	January 2012	To be discussed at 'One to One' meetings commencing mid January

***The areas highlighted are those that the Intensive Support Team has recommended that we address.**

Dartford and Gravesham NHS
NHS Trust

TRUST BOARD MEETING – JANUARY 2012

1-8.1	PERFORMANCE REPORT, MONTH 9 2011/12	DIRECTOR OF PERFORMANCE & BUSINESS INTELLIGENCE

Item 1-8.1. Attachment 12 - Performance report (month 9, 2011-12)

The attached report sets out performance against national and local targets for the year from April to December.

The Board is asked to note:

- The A&E 4 hour target was met in December: 95.6%.
- There were 2 cases of C Diff in December. The Trust has exceeded year-end maximum of 20 cases with 21 YTD.
- Sustained performance in Non-elective length of stay: 4.1 in December.
- We have met the 62 day cancer target in December: 98.4%.
- Performance against the inpatient stroke target in December at 83%, and expected to meet target year end.
- We have met the TIA target in December: 60%
- The midwife to birth ratio is 38 in December, with a decrease in 1:1 care at 81.3% and the 12 week / 1st appointment performance dropped in December to 87%. Significant recruitment of midwives is in progress.
- VTE assessment target has been achieved in December at 91%.

The Board is asked to note the commentary provided against the national priorities and existing commitments that we are required to meet and to decide whether it has assurance to provide self-certification against the statement that:

"all targets and indicators have been met (after the application of thresholds) over the period and that sufficient plans are in place to ensure that all known targets, which will come into force during 2011-12, will also be met"

The Board is also asked to confirm for quarter three "that it is satisfied that, to the best of its knowledge and using its own processes and having had regard to Monitor's *Quality Governance Framework* (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS foundation trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients".

Reason for receipt at the Board (decision, discussion, information, assurance etc.)
Discussion and assurance.

Equality Impact Assessment initial screening applicable to this report? No

This report provides information on the following annual objectives:

- To improve patient experience and patient safety, and achieve the best health outcome for patients, through implementation of the Quality Plan for 2011/12;
- To maintain the highest standards of cleanliness and reduce healthcare associated infections, maintaining a zero tolerance approach to infections acquired within Darent Valley Hospital;
- To develop productive relationships with emerging GP Consortia, local authorities, and other new partners, in order to provide sustainable services for the community, and achieve a sustainable local health economy;
- To recruit excellent staff, and develop, manage, lead and support our staff fairly, to ensure they are motivated to deliver high quality and excellent services;
- To deliver the objectives set out in the Financial Plan for 2011/12, including the delivery of a Quality, Innovation, Productivity & Prevention (QIPP) programme that develops patient pathways which provides care closer to patients' homes, & improves the efficiency of the services the Trust provides, thereby saving resources and releasing capacity

Dartford and Gravesham NHS Trust

Dartford & Gravesham NHS Trust

Month 9

Board Performance Report

16th January 2012

Contents:

1. Executive Summary

The report is divided into quality and resource domains reflecting the NHS Performance Framework. The overall score on the NHS Performance Framework is 2.6 which equates to the top rating of 'Performing' in December.

Quality Measures

- A&E 4 hour performance improved in December to 95.7%.
- 91.0% of admitted patients and 98.2% of non-admitted patients were treated within 18 weeks in December. Both remain above the year-end target.
- We met the 62 day target in December achieving 98.4% against the target of 86%. We also met the 14 day cancer target. Breast two week performance dropped to 88% in December due to patient choice; however performance continues to be above the target, year to date.
- There were 2 cases C Diff in December. The Trust has exceeded year-end maximum of 20 cases with 21 YTD.
- 4 cases 3 & 4 grade pressure sores in December. A Root Cause Analysis is being undertaken for each case and a meeting is booked for 24th January. Close monitoring and early escalation continues.
- Admitted stroke care performance is just below trajectory at 79%, year to date. There is still confidence that performance will meet the target across the full year as weekly breach meeting have commenced and are showing positive improvement.
- TIA clinic performance met the target in December at 60%, but remains below target for the year to date. Clinic times have been changed to reduce the number of people waiting through the weekend and patients are being phoned by a clinician to encourage them to attend urgently.
- 12 week booking of women to see a midwife: performance in December at 87%, and remains below year- end target. This is primarily due to late bookings but also with low capacity until recruitment is complete in March.

Resource Measures

- Overall, activity is above plan.
- Choose and Book utilisation remains low. All first attendance slots are open on C&B.
- Average non-elective length of stay has remained low at 4.1 in December.
- Delayed transfers of care increased from 3% in November to 4.7% in December with discharging Bexley patients a key factor. Length of Stay for elderly emergency patients for Bexley is 20% higher than for the equivalent group from West Kent.
- Energy use continues to fall, down 6% in December.
- 1:1 labour care and midwife to birth ratios remain below plan, however investment has been made into recruiting extra midwives and active recruitment is on-going. Birth ratio projection for January down to 36.

2. Exception Report

The following targets are highlighted as being rated red or amber and are shown with the actions being taken.

Target:	A&E 4 Hour Wait	RAG: Current	Forecast
Threshold:	95%	A	A
Lead:	Julie Hunt		
Performance:	95.7% YTD		
Actions	• There is continued focus on A&E performance to ensure its sustainability through the final crucial months of the year.		

Target:	Cancer 62 Day	RAG: Current	Forecast
Threshold:	86%	R	R
Lead:	Julie Hunt		
Performance:	80.7% YTD		
Actions	• Feedback session for the Intensive Support Team report took place on 25th November. • Significant improvements in performance seen over past 2 months		

Target:	HCAI – C Diff	RAG: Current	Forecast
Threshold:	20 for 11/12	R	R
Lead:	Susan Acott		
Performance:	21 YTD - 2 in December		
Actions	• Rise in cases has been seen regionally. • Full year target has been exceeded.		

Target:	Activity	RAG: Current	Forecast
Threshold:	PCT plans	A	G
Lead:	Stuart Jeffery		
Performance:	Generally more than 5% above plan		
Actions	• Capacity requirements being closely monitored.		

Target:	Hospital Acquired Pressure Sores – grades 3&4	RAG: Current	Forecast
Threshold:		A	A
Lead:	Jenny Kay		
Performance:	27 YTD 4 in December		
Actions	• Root Cause Analysis being undertaken for each case. • Meeting arranged for 23rd January and early escalation for future cases.		

Target:	Emergency Readmissions	RAG: Current	Forecast
Threshold:	25% reduction required	R	R
Lead:	Stuart Jeffery		
Performance:	No change over past 12 month		
Actions	• Penalty agreed with PCT for 11/12		

Target:	Stroke TIA assessment	RAG: Current	Forecast
Threshold:	60%	R	R
Lead:	Stuart Jeffery		
Performance:	42% YTD		
Actions	• Extra slots Friday pm for high risk referrals received Thurs pm and Friday am • Performance has improved over the past two months		

Target:	Stroke 90% stay on unit	RAG: Current	Forecast
Threshold:	80% YTD	A	G
Lead:	Stuart Jeffery		
Performance:	79% YTD		
Actions	• Sustained improvement in performance in December. • Weekly breach meetings continue.		

Target:	Maternity Midwife to birth ratio	RAG: Current	Forecast
Threshold:	34	R	G
Lead:	Jenny Kay		
Performance:	39 YTD 38 in December		
Actions	• Phased recruitment from November through to March with 20 wte posts to appoint. • Projection down to 36 in January. • Ratio will reduce to 34 once fully established.		

Target:	Maternity: 1 to 1 care ratio	RAG: Current	Forecast
Threshold:	90%	R	A
Lead:	Jenny Kay		
Performance:	81.6%		
Actions	• Phased recruitment from November through to March with 20 wte posts to appoint.		

Target:	Maternity: Seen in 12 weeks	RAG: Current	Forecast
Threshold:	90%	A	G
Lead:	Jenny Kay		
Performance:	88%		
Actions	• Phased recruitment from November through to March with 20 wte posts to appoint.		

Target:	Choose and Book	RAG: Current	Forecast
Threshold:	Utilisation: 90%; Slot issues 0%	R	R
Lead:	Stuart Jeffery		
Performance:	35% and 21%		
Actions	• All first attendance appointments open on C&B • Capacity issues monitored via waiting list meeting • Letter to commissioners sent		

3. Corporate Scorecard

				2011														
Domain	**Measure**	**Priority**	**Indicator**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**FYTD**	**Plan/ Target**	**RAG**
Quality	A&E	Headline	Unplanned Re-Attendance	6.7%	6.8%	7.0%	7.2%	8.2%	7.3%	7.5%	7.8%	7.8%	7.3%	7.4%	7.3%	7.5%	5.0%	R
			Total Time in A&E (95th %)	6.85	4.80	5.32	4.18	3.93	3.95	3.97	4.37	4.95	4.00	4.00	4.00	4.00	4	A
			Left Department Without Being Seen Rate	6.4%	4.3%	5.4%	4.7%	3.3%	3.6%	3.5%	3.2%	3.9%	3.2%	3.7%	4.2%	3.7%	5.0%	G
			Time to Initial Assessment (95th %)	1.40	1.02	0.92	0.85	0.52	0.42	0.62	0.68	0.73	0.60	0.65	0.68	0.64	0.25 Hrs	R
			Time to Treatment in Department (Median)	1.27	1.08	1.22	1.00	0.87	0.98	0.97	0.85	1.07	0.93	1.03	1.03	0.97	1 Hour	G
		Local	A&E 4 Hour Wait	83.7%	93.2%	91.2%	94.4%	98.7%	98.0%	97.5%	94.4%	92.6%	95.2%	95.2%	95.6%	95.7%	95%	A
	Cancelled Operations	Local	Cancelled Operations	1.8%	1.1%	0.7%	0.7%	0.3%	0.1%	0.6%	0.4%	0.7%	1.2%	0.8%	0.2%	0.6%	<0.8%	G
	Cancer Waits	Headline	2 Week Wait (All Urgent Referrals)	93.9%	95.4%	94.5%	92.7%	90.8%	91.8%	92.8%	94.8%	94.5%	95.3%	96.8%	94.5%	93.8%	93%	G
			62 Day Wait (All Referrals)	81.1%	79.2%	83.9%	90.0%	72.0%	71.2%	62.7%	76.8%	83.7%	79.2%	93.2%	98.4%	80.7%	86%	R
		Supporting	Seen <2 Weeks (GP Referral)	94%	95%	94%	91%	90%	91%	93%	95%	94%	96%	97%	96%	94%	93%	G
			Seen <2 Weeks (Breast)	95%	86%	97%	100%	94%	93%	93%	97%	97%	93%	97%	88%	94%	93%	G
			Seen <62 Days - GP	76%	74%	80%	84%	70%	64%	60%	73%	83%	81%	93%	98%	78%	85%	R
			Seen <62 Days (Screening)	100%	100%	92%	100%	100%	100%	80%	100%	83%	71%	100%	100%	92%	90%	G
			Seen <62 Days - Upgrade	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		G
			First Seen <31 Days	100%	100%	100%	100%	97%	100%	98%	100%	99%	100%	100%	100%	99%	96%	G
			Subsequent <31 Days (Surgery)	100%	100%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	99%	94%	G
			Subsequent <31 Days (Chemotherapy)	100%	100%	100%	100%	100%	91%	86%	100%	100%	100%	100%	100%	97%	98%	A
	Falls	Local	Fractures	0	2	0	3	1	3	3	1	1	2	2	1	2	<1.8	A
	HCAI	Headline	HCAI - MRSA bacteraemia	3	0	1	1	0	0	0	0	1	0	0	0	2	3	G
			HCAI - CDI	2	2	6	1	1	1	2	2	5	1	6	2	21	20	R
		Local	HCAI - MSSA	2	0	2	0	0	1	0	1	2	0	2	3	9		
	Maternity	Supporting	% Women seen midwife (12wks/6days)	89%	90%	89%	87%	90%	89%	87%	88%	85%	87%	90%	87%	88%	90%	A
	Mixed Sex Acc.	Headline	Mixed Sex Accom. Breach Rate	111	89	22	2	1	2	0	0	0	0	0	0		0	G
	Mortality	Local	Mortality Rates (RA 2011) Trust	94	95	95	95	96	95	95	93	93	92	86	84	92	94	G
			Mortality Rates - SHMI			109												
	Patient Experience	Headline	Patient Experience Survey		73													
	Pressure Sores	Local	Grade 3&4 - Hospital Acquired	1	6	7	1	5	8	0	1	0	3	5	4	27		A
	Readmissions	Headline	Emergency Readmissions	9.3%	8.6%	8.5%	10.2%	10.2%	9.1%	9.4%	8.0%	8.3%	9.2%	10.3%	10.1%	9.4%		A
	Referral To Treatment	Headline	Admitted Time (95th %)	22.0	22.9	19.0	24.0	23.0	21.7	21.7	20.4	20.6	22.3	22.9	21.9	22.0	23 wks	G
			Non-Admitted Time (95th %)	17.0	17.1	14.0	13.0	14.0	13.3	14.3	12.9	15.6	15.9	13.3	17.1	14.4	18.3 wks	G
			Incomplete (95th %)	17.0	18.6	17.0	15.0	16.0	16.4	16.7	16.3	17.0	17.6	16.9	16.7	16.5	28 wks	G
		Local	18 Weeks Admitted %	87.8%	82.7%	93.7%	90.6%	91.4%	91.2%	93.4%	92.5%	93.0%	91.9%	91.5%	91.0%	91.7%	90%	G
			18 Weeks Non-Admitted %	97.7%	96.0%	96.6%	98.3%	98.6%	96.8%	98.1%	97.5%	97.8%	98.0%	98.1%	98.2%	97.8%	95%	G
		Supporting	RTT - Admitted median (weeks)		16.1	12.0	10.0	12.0	12.9	12.0	12.7	14.1	13.6	13.9	11.4	12.5	11.1 wks	A
			RTT - Non-Admitted median (weeks)		8.9	3.0	3.0	4.0	3.9	4.6	4.5	5.9	6.0	6.2	6.1	4.9	6.6 wks	G
			RTT - Incomplete median (weeks)		4.6	4.0	5.0	5.0	4.9	4.9	5.3	5.3	5.0	5.0	5.6	5.1	7.2 wks	G
	Stroke	Supporting	90% Stay on Stroke Ward	70%	58%	76%	86%	84%	82%	76%	71%	68%	76%	84%	83%	79%	80%	A
			TIA Assess within 24 Hours	36%	67%	47%	59%	62%	58%	26%	12%	30%	32%	67%	60%	42%	60%	R
	VTE	Supporting	% Adults VTE Risk Assessed	73%	81%	81%	80%	82%	84%	92%	93%	93%	93%	91%	91%	89%	100%	G

				2011														
Domain	**Measure**	**Priority**	**Indicator**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**FYTD**	**Plan/ Target**	**RAG**
Resources	A&E	Supporting	A&E Attendances	7845	7002	8169	8125	8277	7954	8410	7779	8213	8372	8084	8097	73311	71901	A
	Activity	Headline	Non-Elective Spells	2665	2344	2692	2605	2597	2600	2641	2384	2412	2857	2793	2943	23832	21954	A
		Supporting	Number Follow-Up Attendances	12396	11958	14141	11535	12795	13314	12601	12643	13900	12909	14101	11850	115648	-0.8%	A
			Daycase Rate	78%	76%	78%	77%	78%	78%	75%	81%	77%	77%	79%	79%	78%		
			GP Written Referrals	3562	3576	4086	3390	3704	4122	3643	3727	3754	3781	3896	3182	33199		
			Other Referrals	3163	2837	3198	2816	3140	3307	3084	3061	3335	3152	3310	2978	28183		
			GP Referrals First Outpatient Attends	4115	3957	4535	3636	3984	4524	4095	4100	4536	4435	4526	3723	37559		
			First Outpatient Attends	4839	4738	5256	4298	4712	5287	4802	4696	5193	5171	5327	4412	43898	49727	A
			Elective Spells	1802	1974	2292	1814	1885	2054	1957	1933	1981	1957	2146	1894	17621	14960	A
			Elective Inpatient Spells	417	463	514	400	425	458	471	393	442	438	457	394	3878	3841	G
			Daycase Spells	1385	1511	1778	1414	1460	1596	1486	1540	1539	1519	1689	1500	13743	11116	A
	Activity (by PCT)	Local	West Kent GP Referrals	2890	2960	3268	2774	3064	3345	3044	3027	3095	3145	3231	2650	27375		
			Bexley GP Referrals	498	459	602	455	486	546	412	520	449	475	483	395	4221		
			Choose & Book Slot Issues	7%	16%	24%	34%	14%	19%	22%	28%	18%	17%	18%	20%	21%		
			Choose & Book Utilisation	47%	41%	41%	31%	42%	41%	35%	34%	36%	35%	31%	29%	35%		
			West Kent ELIP Spells	337	362	418	300	324	355	362	300	338	318	349	317	2963	3025	G
			West Kent Daycase Spells	1149	1250	1470	1176	1216	1336	1237	1301	1268	1253	1396	1220	11403	9198	A
			Bexley ELIP Spells	40	46	40	56	49	54	61	54	54	64	63	48	503	374	A
			Bexley Daycase Spells	128	143	178	143	156	163	141	153	171	160	176	166	1429	935	A
			West Kent NELIP Spells	1914	1694	1935	1878	1903	1856	1856	1685	1710	2082	1998	2108	17076	14095	G
			Bexley NELIP Spells	563	498	564	549	515	548	570	525	528	569	612	645	5061	3741	A
	Capacity	Headline	Bed State - Available Beds	506	506	506	469	469	453	453	443	443	443	443	443	451		
		Local	Average Non-Elective LoS (+ 501,560)	5.2	5.0	4.9	4.7	4.6	4.5	4.1	4.8	4.7	4.3	4.1	4.1	4.4	4.34	G
			LoS > 30 Days	64	64	53	49	42	26	36	40	44	33	37	36	38	-10%	G
	Delayed Transfers of Care	Supporting	DTOC Rate	5.4%	4.8%	3.7%	3.1%	3.2%	5.0%	3.7%	2.9%	2.1%	2.4%	3.0%	4.7%	3.4%	<3.5%	G
	Energy	Local	Energy Usage (RA in GJ)	8663	8553	8600	8599	8581	8533	8507	8504	8477	8363	8225	8178			G
	Maternity	Local	Midwife To Birth Ratio	35	36	36	37	38	40	41	40	39	41	39	38	39	34	R
			1:1 Labour Care	81.2%	81.6%	80.5%	82.9%	83.0%	81.0%	79.4%	83.0%	81.5%	82.0%	79.7%	79.3%	81.3%	90%	R
			Births	465	364	407	379	409	411	450	428	442	430	376	437	3762		
			West Kent Births	270	237	269	239	274	243	282	264	276	278	230	262	2348		
			Bexley Births	118	92	88	110	95	130	128	124	121	104	100	126	1038		
	Referral To Treatment	Headline	RTT Incomplete Pathway	6291	5500	5581	6059	6644	6932	6857	7027	6887	6552	7215	6783			
	Workforce	Local	Temporary Staff - Agency	1.0%	1.2%	1.3%	1.0%	0.3%	0.4%	0.3%	0.4%	0.1%	0.1%	0.2%	0.2%	0.3%		G
			Vacancies	7.3%	7.2%	6.9%	6.4%	8.7%	8.2%	9.0%	9.1%	8.8%	9.3%	8.6%	8.9%	8.6%	<7%	A
			Turnover	7.3%	7.2%	6.9%	6.4%	6.9%	5.9%	6.1%	6.3%	6.3%	6.5%	6.2%	6.2%	6.3%	5-12%	G
			Training (Mandatory) - Nursing				83%	84%	85%	86%	87%		86%	86%	87%	85%	85%	G
			Training (Mandatory) - Medical				67%	72%	74%	76%	79%		62%	71%		72%	85%	R
		Supporting	Total Workforce (FTEs)	1915	1939	1965	1973	1972	1982	1970	1979	2003	2013	2032	2034			
			Staff Absences (Sickness)	4.0%	3.6%	4.0%	3.6%	3.3%	3.0%	3.0%	2.8%	3.2%	3.1%	3.6%	4.2%	3.3%	<3.75%	G
			Clinical Workforce	1291	1311	1335	1341	1344	1353	1352	1357	1380	1388	1402	1402			
			Non-Clinical Workforce	623	627	630	631	629	629	617	622	622	624	629	633			

4. National Targets and self-certification

4.1 Self-certification and Monitor's quarterly requirements

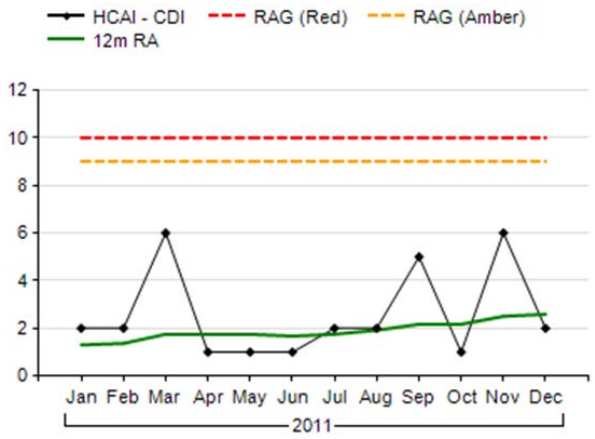
- Monitor's approach to ensuring that NHS Foundation Trusts comply with their terms of Authorisation is risk-based. They require NHS Foundation Trust boards to self-certify their anticipated compliance with their Authorisation in their annual plans.
- Monitor also requires each Foundation Trust Board to self-certify on a quarterly basis that "all targets and indicators have been met (after application of thresholds) over the period and that sufficient plans are in place to ensure that all known targets which will come into force will also be met".
- The quality statement has changed in 2011/12 and the Board is asked to confirm for quarter three "that it is satisfied that, to the best of its knowledge and using its own processes and having had regard to Monitor's *Quality Governance Framework,* its NHS foundation Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients."
- The latest Compliance Framework issued by Monitor takes account of the revised Operating Framework for 2011/12, and the relevant targets and indicators within that are listed below (1-12), along with a confidence RAG rating of forward compliance. The Board should note that additional statements have been added to this list (10), in accordance with the Department of Health's requirements, and the Trust's own objectives
- The Board is asked to consider the information below, as well as more detailed information on each indicator within the report, and consider it can certify that "all targets and indicators have been met (after the application of thresholds) over the period and that sufficient plans are in place to ensure that all known targets, which will come into force will also be met."

Summary of forecasts by national target:

Target covered by the statement that "all targets and indicators have been met (after the application of thresholds) over the period and that sufficient plans are in place to ensure that all known targets, which will come into force during 2011-12, will also be met"	**Confidence rating of forward compliance**
1. Cdiff – meeting the Clostridium difficile objective	**Red**
2. MRSA – meeting the MRSA objective	**Green**
3. Maximum waiting time of two weeks from referral to date first seen for all urgent suspected cancer referrals	**Green**
4. A maximum 31-day wait for subsequent treatments for all cancers	**Green**
5. A maximum 31-day wait from diagnosis to treatment for all cancers	**Green**
6. A maximum 62-day wait from referral or consultant upgrade to treatment for all cancers	**Red**
7. 95th percentile of patients for non-admitted hospital treatments waiting no more than 18.3 weeks	**Green**
8. 95th percentile of patients for admitted hospital treatments waiting no more than 23 weeks	**Green**
9. A&E 5 indicators divided into two groups: timeliness and impact – compliance required to meet threshold for at least one indicator in each group.	**Green**
10. Minimising delayed transfers of care.	**Green**
11. Data completeness above required thresholds for identifiers and outcomes.	**Green**
12. Compliance with requirements regarding access to healthcare for people with a learning difficulty.	**Green**

5. Quality and Assurance

HCAI – C Diff	RAG:	Current: Red	Forecast: Red



Comments / Actions / Assurance:

2 cases in December, 21 YTD. The Trust has exceeded the target of 20 cases by year end.

Rise in cases has been seen regionally

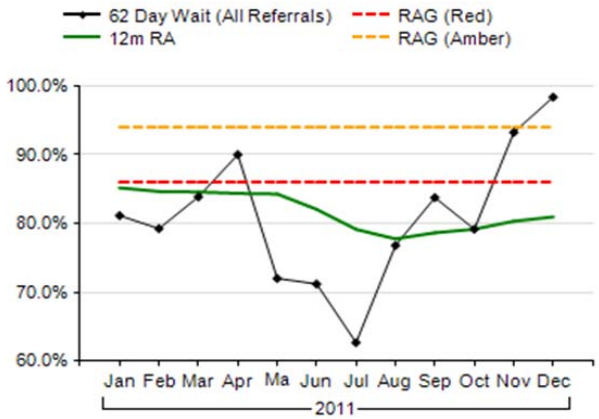
Actions:

- Early testing of patients is being encouraged.
- High profile public & staff awareness campaign related to visiting.

Assurance: The Trust has a robust infection control action plan in place including a strengthened Infection control team; however the full year target has been exceeded and will not be met.

Executive: Susan Acott | **Manager:** General Managers

Cancer 62 Day waits – all referrals	RAG:	Current: Red	Forecast: Red



Comments / Actions / Assurance:
Significant improvement in month exceeding the target with 98.4% for December. However, YTD position remains below target at 80.7%

As of 1st December a new risk has been identified that may impact the pathway:

- Age extension for bowel screening and a Bowel Awareness Campaign commencing in January may impact capacity for scopes – elsewhere in the country there has been an increase 30 – 50% activity.

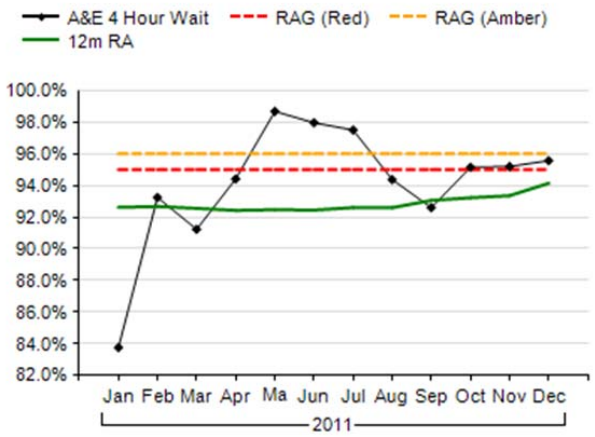
Actions:

- Feedback session for the Intensive Support Team report took place on 25th November.
- Backlog continues to fall – close monitoring on-going.
- Positive impact seen from Cancer PTL improvements.
- Back fill cover pathologist position until their return.
- Strengthening accountability of the Cancer Services Committee.

Assurance: The Trust has an action plan in place to support achievement of the target by the end of Mar 2012; however the full year target cannot be met.

Executive: Julie Hunt | **Manager:** Sarah Flanagan

A&E 4 Hour Wait



RAG:	Current: Amber	Forecast: Amber

Comments / Actions:

December performance held at 95.6%.

Currently 95.7% YTD on target against plan

.

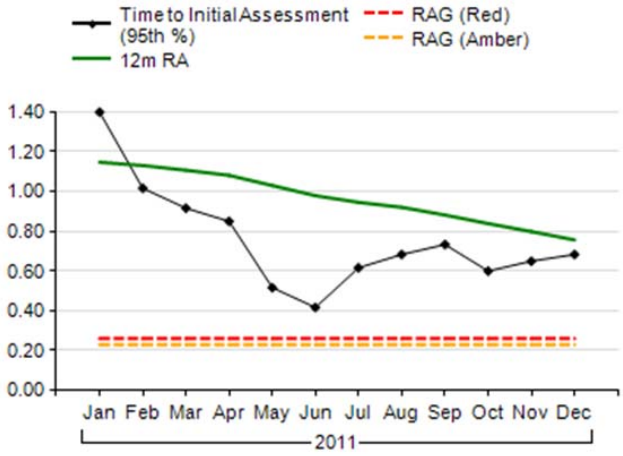
Actions:

- There will be continued focus on A&E performance to ensure that the year-end target is met.

Executive: Julie Hunt

Manager: Pam Dhesi

A&E Time to Initial Assessment (95th centile)



RAG:	Current: Red	Forecast: Red

Comments / Actions:

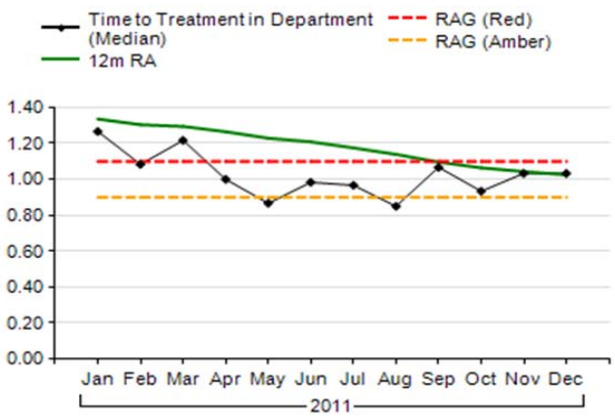
Time to assessment (ambulance patients) reflects main / full assessment of patients rather than initial assessment at handover by ambulance crew. Progress:

- Improvement against this measure has been part of the ECIST work and significant improvements have been demonstrated.
- Fortnightly MDT commenced in A&E.

Executive: Julie Hunt

Manager: Pam Dhesi

A&E Time to Treatment (Median)



RAG:	Current: Green	Forecast: Green

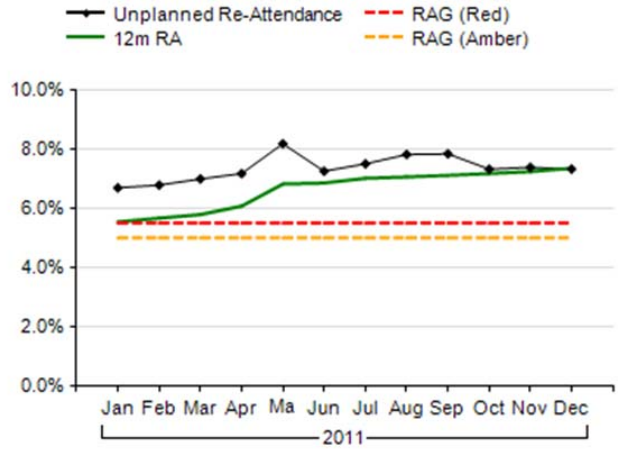
Comments / Actions:

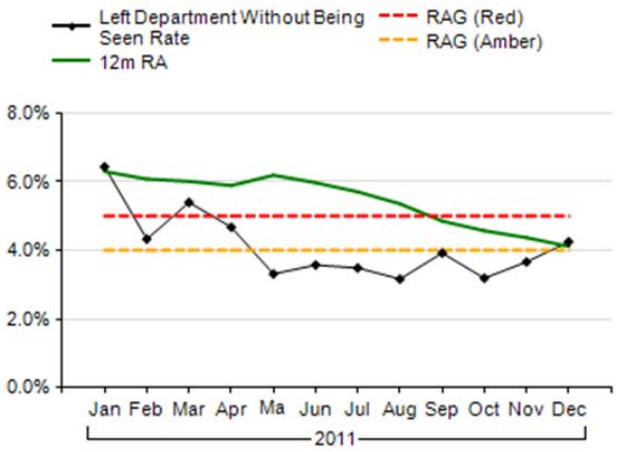
The Trust is currently within the target of one hour.

Assurance: Indicator within "Timeliness" group. Threshold met and compliant with measure in quarter 3.

Executive: Julie Hunt

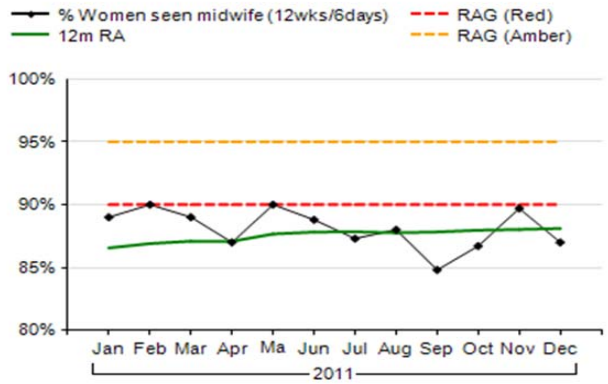
Manager: Pam Dhesi

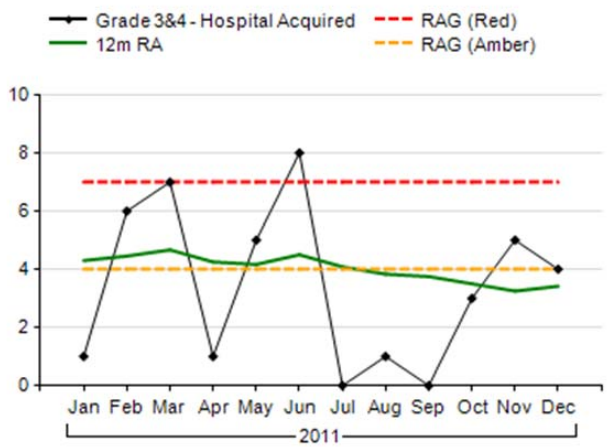
Unplanned re-attendance within 7 days	**RAG:**	**Current: Red**	**Forecast: Red**
	**Comments / Actions:** Currently 7.5% against 5% plan, although there are national discussions about the exact measurement method. Action: • Implement flagging systems for discharged patients who attend A&E. • Fortnightly MDT commenced with A&E looking at all re-attendances at patient level.		
Executive: Julie Hunt	**Manager:** Pam Dhesi		

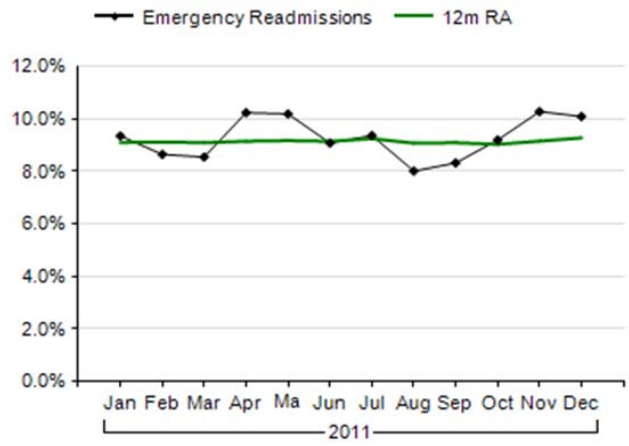
Left Without Being Seem	**RAG:**	**Current: Green**	**Forecast: Green**
	**Comments / Actions / Assurance:** Performing well since ECIST plan implementation. *Assurance: Indicator within "Patient Impact" group. Threshold met and compliant with measure quarter 3.*		
Executive: Julie Hunt	**Manager:** Pam Dhesi		

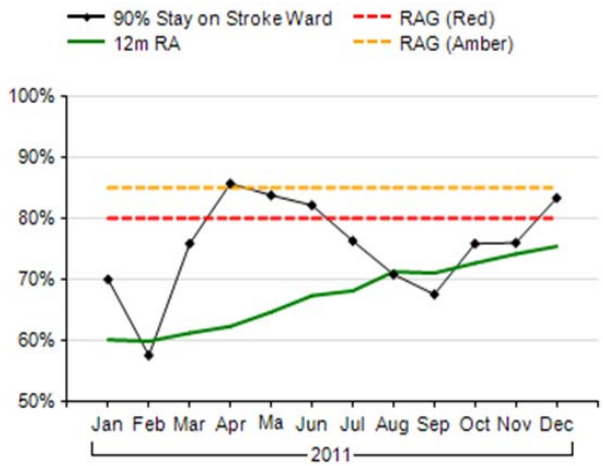
Summary progress of the implementation of recommendations made by the Emergency Care Intensive Support Team (ECIST)

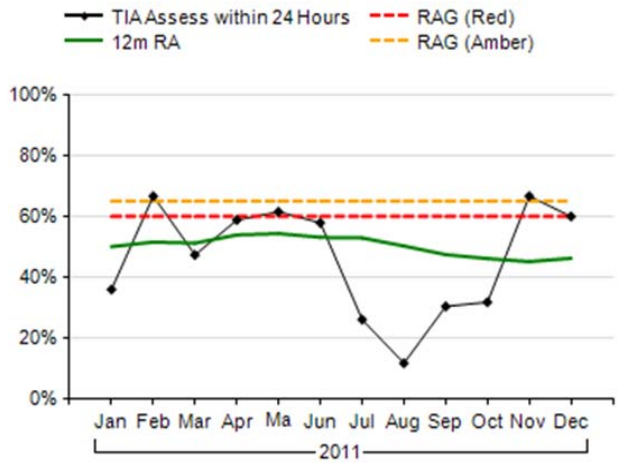
There is a separate 'closure' paper for the ECIST project recommendations submitted to the January Board.

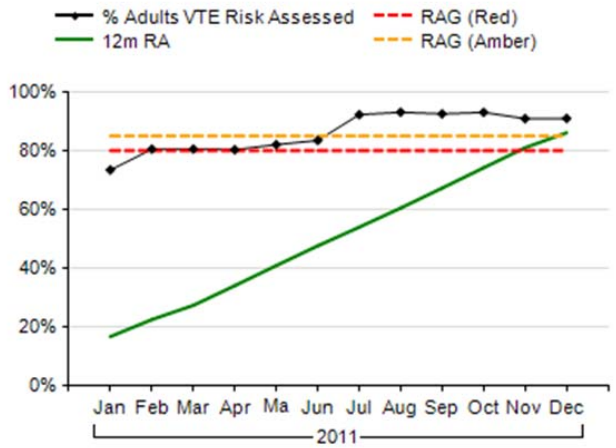
Maternity: Seen in 12 weeks	**RAG:**	**Current: Amber**	**Forecast: Green**
	**Comments / Actions:** Performance in December at 87%; YTD 88%. Actions: • Phased recruitment from November through to January with 20 wte posts to appoint.		
Executive: Jenny Kay	**Manager:** Karen Costelloe		

Grade 3 & 4 – Hospital Acquired Pressure Sores	**RAG:**	**Current: Amber**	**Forecast: Amber**
	**Comments / Actions:** 4 cases reported in December. Reported cases are across specialities and various wards. Actions: • Root Cause Analysis being undertaken for each case. • RCA meeting scheduled for 23rd January. • Close monitoring continues and early escalation if further cases arise.		
Executive: Jenny Kay	**Manager:** General Managers		

Emergency Readmissions	**RAG:**	**Current: Red**	**Forecast: Red**
	**Comments / Actions:** Readmissions at 30 days are stable overall. The financial impact for 11/12 has been agreed with the PCT at the plan figure.		
Executive: Julie Hunt	**Manager:** General Managers		

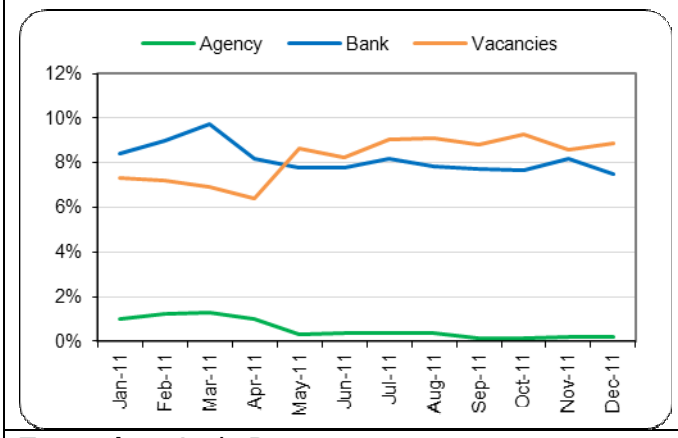
Stroke 90% stay on unit	RAG:	Current: Amber	Forecast: Green
	**Comments / Actions:** Sustained the significant improvement in performance into December with 83% in month; YTD 79% Actions taken: • Stroke pathway review by external Consultant underway. • Weekly breach meetings continue and exception reports completed. • High profile with A&E, site and Stroke teams ensuring direct referral for Stroke ward. • Maintain a designated Stroke bed at for direct admissions.		
Executive: Stuart Jeffery	**Manager:** Pam Dhesi		

TIA Assessment within 24 hours	RAG	Current: Red	Forecast: Red
	**Comments / Actions:** Met the target in December at 60%; YTD 42% against the target of 60%. Bank Holiday weekends resulted in a small number of breaches. Actions taken: • Extra weekly Friday pm slots for high risk referrals received Thursday afternoon and Friday mornings. • Exception report completed – patient choice a key element with patients refusing to attend. • Stroke Nurse to contact patients and bring in sooner – clinic template changed. • Transition team explore shared TIA service with Medway. • Telemedicine clinic is working well. • Stroke pathway review by external Consultant underway.		
Executive: Stuart Jeffery	**Manager:** Pam Dhesi		

VTE Risk Assessment	RAG:	Current: Green	Forecast: Green
	**Comments / Actions:** Exceeding 90% target.		
Executive: Annette Schreiner	**Manager:** Clinical Directors		

6. Resources

Agency/Bank Usage	RAG:	Current: Green	Forecast: Green



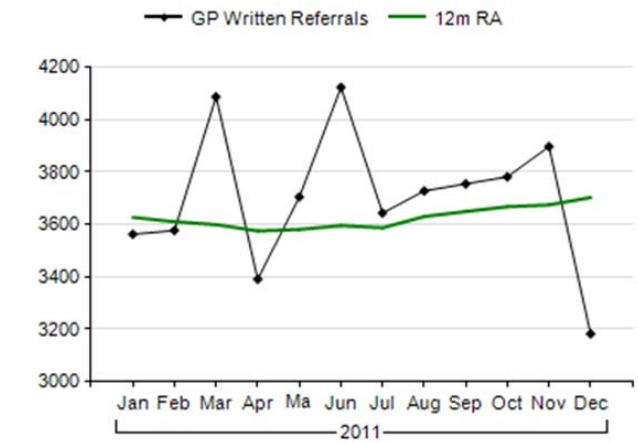
Comments / Actions:

Agency use remains minimal.

Executive: Andy Brown

Manager: General Managers

GP Referrals	RAG:	Current: Amber	Forecast: Green



Comments / Actions:

GP referrals and first outpatient attendances have been stable overall for the past few months, despite continuing increased flows from Bexley.

In month GP referrals have dropped across Bexley and West Kent due to reduced working days in December over the holiday period.

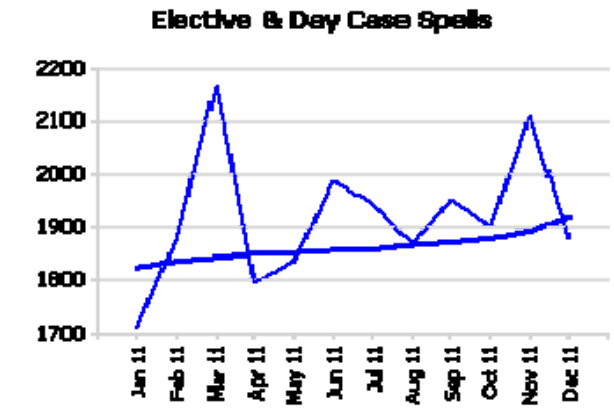
Actions:

- Repatriation of West Kent referrals to London providers through active marketing and collaboration with GP Consortia.
- Marketing / repatriation plans identified and commenced.

Executive: Julie Hunt

Manager: Karen Costello

Elective Spells	RAG:	Current: Amber	Forecast: Green



Comments / Actions:

Numbers of elective spells (including day cases) have been stable for the past 12 months.

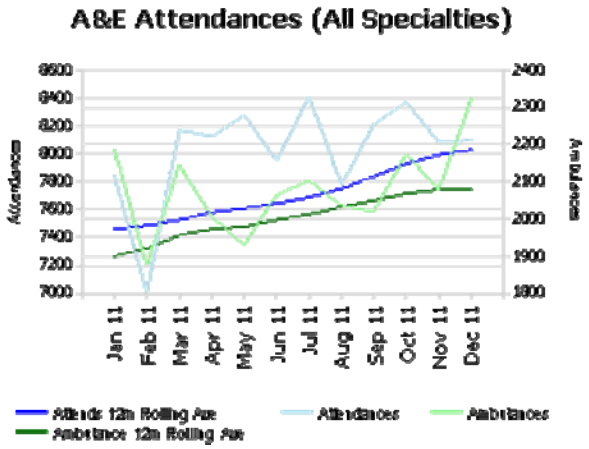
Actions:

- Marketing plan as above.

Executive: Julie Hunt

Manager: Alex Tan

A&E Attendances



RAG:	Current: Amber	Forecast: Green

Comments / Actions / Assurance:

An increase in Ambulance conveyances is evident in December, demonstrating a rolling average increase of 9.9% against December 2010.

Several days over 80 ambulances and on one occasion hit 94 in 24 hours.

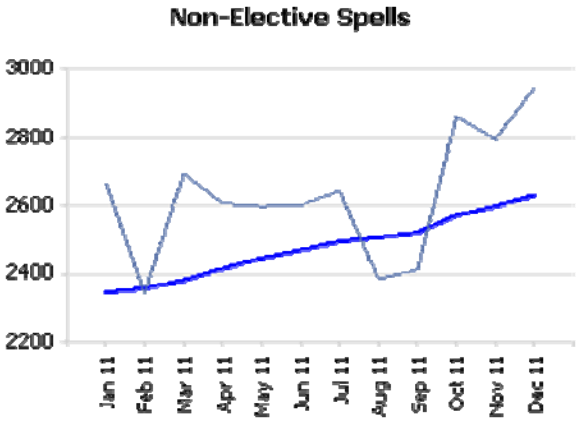
Increasing numbers of walk in patients are being seen with an increase 5% evident on this time last year's activity.

Activity is in line with overall Trust plan.

Executive: Julie Hunt

Manager: Pam Dhesi

Non-Elective Spells



RAG:	Current: Amber	Forecast: Green

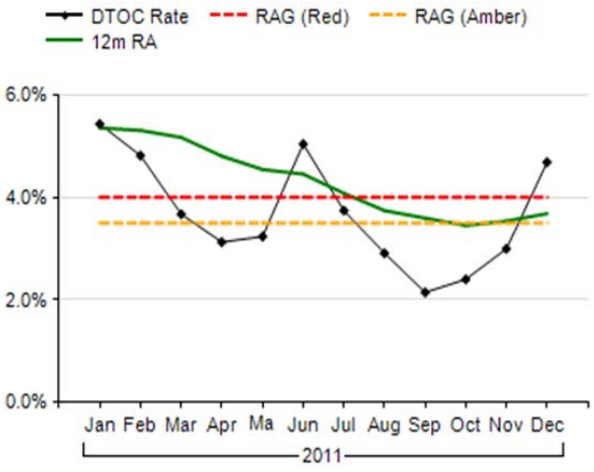
Comments / Actions / Assurance:

Non-elective spells have increased in December, illustrating an increase 12.5% against December 2010.

Executive: Julie Hunt

Manager: Pam Dhesi & Alex Tan

Delayed Transfers of Care



RAG:	Current: Green	Forecast: Green

Comments / Actions / Assurance:

Delayed transfers of care demonstrated an increase from 3% in November to 4.7% in December.

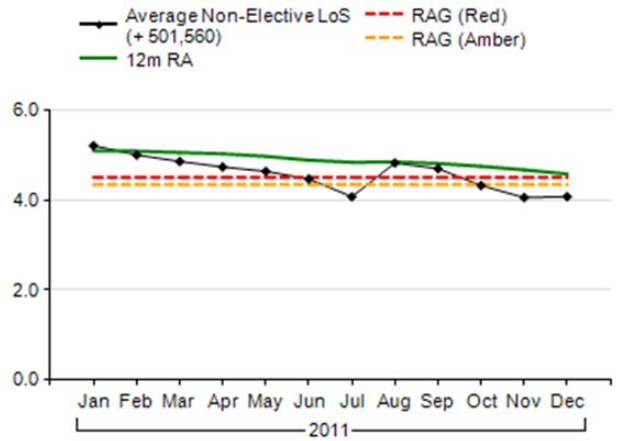
Delays experienced discharging Bexley patients requiring community care or social support. Actions:

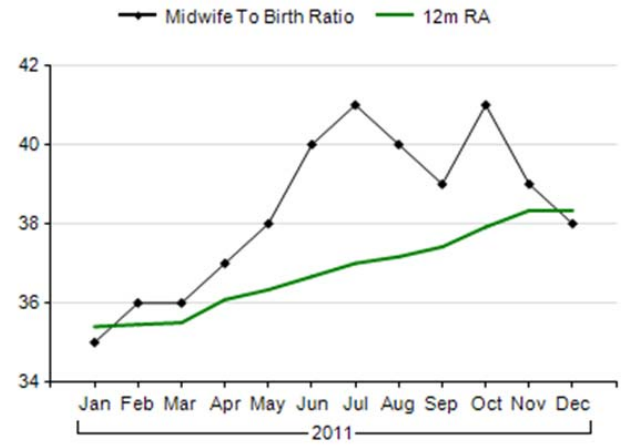
- Escalated to CEOs, Urgent Care Board and Director Social Services.
- Virtual ward beds in Priory Mews for Bexley patients awaiting community beds support.

Forecast year to date remains below target at 3.4%.

Executive: Julie Hunt

Manager: Pam Dhesi & Alex Tan

Non-Elective Length of Stay	RAG:	Current: Green	Forecast: Green
	**Comments / Actions / Assurance:** Non-elective length of stay has held in December at 4.1 days. Enhanced focus on discharges within Medicine continues to have a positive impact. Forecast year to date slightly above plan at 4.4 days.		
Executive: Julie Hunt	**Manager:** Pam Dhesi		

Maternity Midwife to birth ratio	RAG:	Current: Red	Forecast: Green
	**Comments / Actions:** The midwife to birth ratio is 38 in December with a decrease in 1:1 care at 81.3%. Births up in December, with Bexley, the third highest on record. Actions: • Phased recruitment from November through to January with 20 wte posts to appoint. Projected midwife to birth ratio 36 for January. Current establishment 125 wte, therefore once fully established the maternity midwife to birth ratio will reduce to target 34.		
Executive: Jenny Kay	**Manager:** Karen Costelloe		

Stuart Jeffery
Director of Performance and Business Intelligence

Dartford and Gravesham NHS
NHS Trust

TRUST BOARD MEETING – JANUARY 2012

Item 1-8.2. Attachment 13 - Finance report (month 9, 2011-12)

1-8.2 FINANCE REPORT (MONTH 9, 2011/12) FINANCE DIRECTOR

This report summarises the financial performance of the Trust to the end of December 2011.

- The Trust has a trading deficit of £86k in the month, which is worse than the plan by £84k. The year to date position is a trading deficit of £1,458k, which represents an adverse variance of £1,250k against plan. The position includes technical adjustments of £1,161k in respect of the additional costs of PFI under International Financial Reporting Standards (IFRS) which do not count against the Trust's break-even duty.
- The Trust's year to date operating position (Earnings before Interest, Taxation, Depreciation and Amortisation - EBITDA) is £13,257k, which is 11.3% of turnover and £1,250k worse than the year to date plan.

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
For Information and Discussion

Equality Impact Assessment initial screening applicable to this report? No

This report provides information on the following annual objectives (delete as required)**:**

- To improve patient experience and patient safety, and achieve the best health outcome for patients, through implementation of the Quality Plan for 2011/12;
- To maintain the highest standards of cleanliness and reduce healthcare associated infections, maintaining a zero tolerance approach to infections acquired within Darent Valley Hospital;
- To develop productive relationships with emerging GP Consortia, local authorities, and other new partners, in order to provide sustainable services for the community, and achieve a sustainable local health economy;
- To recruit excellent staff, and develop, manage, lead and support our staff fairly, to ensure they are motivated to deliver high quality and excellent services;
- To deliver the objectives set out in the Financial Plan for 2011/12, including the delivery of a Quality, Innovation, Productivity and Prevention (QIPP) programme that develops patient pathways which provides care closer to patients' homes, and improves the efficiency of the services the Trust provides, thereby saving resources and releasing capacity

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors understanding of the Trust & its performance

Dartford and Gravesham NHS
NHS Trust

Finance Board Report

Month 9

December 2011

Mick Bull

Interim Director of Finance

10 years of excellent healthcare

Professional Care, Exceptional Quality

Executive Summary

Dartford and Gravesham NHS Trust

- This report summarises the financial performance of the Trust to the end of December 2011.

- The Trust has a trading deficit of £86k in the month, which is worse than the plan by £84k. The year to date position is a trading deficit of £1,458k, which represents an adverse variance of £1,250k against plan. The position includes technical adjustments of £1,161k in respect of the additional costs of PFI under International Financial Reporting Standards (IFRS) which do not count against the Trust's break-even duty.

- The Trust's year to date operating position (Earnings before Interest, Taxation, Depreciation and Amortisation - EBITDA) is £13,257k, which is 11.3% of turnover and £1,250k worse than the year to date plan.

- The total income in December of £13,564k was better than plan by £487k, increasing the year to date over recovery to £1,701k. Of this, £1,946k is accounted for by an over performance on PCT patient income, offset by under recoveries in other income.

- Expenditure has increased in the month focused in non-pay areas due to an increase in high cost ICDs and potential stocking up over the Christmas period on MSSE consumables. Although pay expenditure was lower than the previous month (as forecast) and in line with the previous year's trend, it was c£50k above the control total set due to increased usage of agency staff within Emergency Medicine.

- Directorate operational expenditure at EBTDA level is adverse to plan by £1,250k (8.6%) and can be analysed as follows:

    - Pay - £1,441k (2.1%)
    - Non Pay - £1,775k (9.4%)
    - Drugs - £287k underspend (-6.6%)
    - PFI facilities cost - £42k (0.5%)

Executive Summary

Dartford and Gravesham NHS Trust

▪The Trust QIPP (Quality, Innovation, and Productivity) is achieving the plan of £5.3m for the year to date. The latest forecast indicates that the Trust should overperform the year end target by 112% after taking account of the additional remedial actions put in place to improve the financial position.

▪The Board is reminded that the Trust's income and expenditure plan in 2011-12 assumes that £3m of income support for the Trust's PFI costs are to be funded. The funding source remains uncertain, although the Trust has been assured that the issue is recognised by the Kent and Medway PCT Cluster to be addressed through the Health Economy Recovery Plan. Discussions are underway between the cluster and the Trust to agree year-end income levels taking into account the PFI support.

▪The cash balance at the end of December is £3.1m, which is £1.7m higher than planed due to an advance of SLA monies received from West Kent PCT (£2.3m). However, the full cash balance will be utilised over the coming months to meet liabilities. Whilst the cash position has improved over the last few months, due to cash advances now totalling £4.3m from West Kent PCT, cash continues to be under significant pressure and the ability to continue to make progress in reducing creditors will be dependent on receipt of the full £3m PFI funding. The Trust has applied for a working capital loan in order to meet obligations to the year-end should the money not be received by the end of the financial year.

▪The Capital Programme budget is £3m and includes a contingency of £167k, which is expected to be utilised in full. The year to date spend is £25k over plan. The majority of the programme is now committed and expenditure will therefore occur over the remaining months of the year, which will put further pressure on the cash position.

▪Service Line Report Summary: The in month position reflects the Trust deficit of £86k and the deficit for the period to date of £1,458k. The deficit in the month is focussed on Emergency Medicine which has increased by £198k (increase in medical staffing costs), with General & Elderly Medicine (£107k) and Nephrology (£106k) being the main hot spots. The deficit on Trauma & Orthopaedics increased in the month by £87k, whilst the deficit on Cancer Services increased in month by £80k. On a Directorate basis, the EDITDA performance varies from 7% (Emergency Medicine) to 16.7% (Women & Children) across the Directorates.

Executive Summary

Dartford and Gravesham NHS Trust

▪The Trust is aiming to achieve a technical deficit of £1.55m, which is equivalent, in NHS Performance terms, to a break-even position after taking account of the adjustment for IFRS.

▪ The forecast remains at break-even subject to receipt of the full £3m PFI funding with the agreement of the Kent & Medway PCT cluster and this assumes that income levels are in line with the Trust's forecast based on current activity levels. The cluster is assuming that activity significantly reduces over the last 3 months which presents a risk to the Trust's financial position given only marginal savings would be achievable to offset the income loss. The Trust must also manage emerging cost pressures including, winter pressures, whilst maintaining performance standards over the remaining months of the year.

Income and Expenditure Position and Financial Metrics

Dartford and Gravesham NHS Trust

I&E Position

- The Trust has delivered a YTD deficit of £1,458k at month 9, compared with a YTD plan of £208k deficit (inc. IFRS). This represents a £86k deficit in month 9.
- The deficit for the period to date against the break-even duty (excluding the technical IFRS adjustments) £297k.
- EBITDA % delivered = 95.9%, EBITDA margin = 11.3%
- I&E surplus margin = -1.2%

	Current Month			Year to Date			Full Year	Full Year
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Forecast £000
Income	13,077	13,564	487	115,663	117,364	1,701	156,692	158,250
Expenditure								
Pay	(7,852)	(8,037)	(185)	(69,939)	(71,380)	(1,441)	(93,591)	(95,657)
Non-Pay	(2,173)	(2,539)	(366)	(18,845)	(20,619)	(1,775)	(25,003)	(28,276)
Drugs	(517)	(529)	(13)	(4,335)	(4,048)	287	(5,886)	(5,405)
PFI	(891)	(908)	(17)	(8,018)	(8,060)	(42)	(10,691)	(10,691)
Reserves	0	0	0	(19)	0	19	(3,320)	
Total Directorate expenditure	(11,433)	(12,013)	(581)	(101,156)	(104,107)	(2,951)	(138,491)	(140,029)
EBITDA	**1,644**	**1,551**	**(94)**	**14,507**	**13,257**	**(1,250)**	**18,201**	**18,221**
PFI Financing Cost	(1,123)	(1,113)	10	(10,001)	(9,990)	11	(13,474)	(13,474)
PFI Depreciation	(217)	(217)	0	(1,953)	(1,953)	0	(2,601)	(2,601)
Depreciation Charge and profit on sale of asset	(187)	(187)	0	(1,683)	(1,683)	0	(2,241)	(2,241)
Interest receivable	1	1	(0)	9	7	(2)	12	12
Interest Payable	0	0	0	0	(10)	(10)	0	(20)
Dividend Payment	(120)	(121)	(0)	(1,087)	(1,086)	1	(1,447)	(1,447)
NET SURPLUS / (DEFICIT)	**(2)**	**(86)**	**(84)**	**(208)**	**(1,458)**	**(1,250)**	**(1,550)**	**(1,550)**
TECHNICAL IMPACT OF IFRS	**(129)**	**(129)**	**0**	**(1,161)**	**(1,161)**	**0**	**(1,550)**	**(1,550)**
NET SURPLUS / (DEFICIT) AGAINST BREAKEVEN DUTY	**127**	**43**	**(84)**	**953**	**(297)**	**(1,250)**	**0**	**0**

Monitor Financial Metrics

The 5 Financial Risk Rating metrics give a weighted average score of 3.0.

In addition, there is the Prudential Borrowing Code (PBC), which is breached due to the Trust's PFI. This breach means that the Trust would report a score of 2 if it operated in Monitor's regime

Financial Criteria	Metric to be scored	Weight	Rating categories 5	4	3	2	1	Trust YTD figure	Score	Weighted score
Underlying performance	EBITDA margin %	0.25	11%	9%	5%	1%	<1%	11.3%	5	1.3
Achievement of plan	EBITDA % of plan achieved	0.10	100%	85%	70%	50%	<50%	95.9%	4	0.4
Financial Efficiency	Return on Assets	0.20	6%	5%	3%	-2%	< -2%	-0.9%	2	0.4
	I&E surplus margin	0.20	3%	2%	1%	-2%	< -2%	-1.2%	2	0.4
Liquidity	Liquidity ratio (days)	0.25	35	25	15	10	<10	20	3	0.8
Financial Risk rating is the weighted average of financial criteria scores after applying adjustment factors. This gives an indicative risk rating of:									**3**	**3.2**

Directorate Expenditure Analysis

Dartford and Gravesham NHS Trust

	Current Month			Year to Date			
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000
Directorate Expenditure							
A&E	(644)	(781)	(138)	(5,819)	(7,030)	(1,210)	(7,760)
Adult Medicine	(1,935)	(2,022)	(87)	(16,543)	(16,706)	(163)	(22,228)
Surgical Services	(2,314)	(2,601)	(287)	(21,408)	(23,026)	(1,617)	(28,282)
Women & Children	(1,497)	(1,500)	(3)	(12,795)	(12,867)	(72)	(17,359)
Radiology	(452)	(484)	(31)	(3,926)	(4,151)	(225)	(5,282)
Operations (inc. Therapies)	(1,252)	(1,248)	4	(10,950)	(10,550)	400	(14,722)
Cancer Services	(255)	(275)	(20)	(2,286)	(2,266)	20	(3,052)
Pathology	(595)	(572)	23	(5,440)	(5,648)	(208)	(7,224)
Chief Executive	(115)	(106)	8	(1,000)	(937)	63	(1,344)
Human Resources	(142)	(107)	35	(1,279)	(1,152)	127	(1,706)
Nursing	(68)	(79)	(10)	(530)	(650)	(120)	(734)
Private Patients Exp	(21)	(17)	4	(185)	(130)	55	(247)
Governance	(435)	(459)	(23)	(3,904)	(3,856)	47	(5,233)
Service Development	(234)	(221)	13	(2,002)	(1,919)	83	(2,703)
Finance (excl PFI Financing Costs & FM services	(598)	(658)	(61)	(5,181)	(5,377)	(196)	(6,777)
FM services	(877)	(883)	(7)	(7,889)	(7,843)	46	(10,519)
Reserves	0	0	0	(19)	0	19	(3,320)
Total Directorate Expenditure	**(11,433)**	**(12,013)**	**(581)**	**(101,156)**	**(104,107)**	**(2,951)**	**(138,491)**
Add							
* PFI Financing Cost	(1,123)	(1,113)	10	(10,001)	(9,990)	11	(13,474)
Adjusted Total Expenditure	**(12,555)**	**(13,126)**	**(571)**	**(111,157)**	**(114,097)**	**(2,940)**	**(151,965)**

• In A&E, the year to date adverse position continues to be driven by the premium cost of filling middle grade medical staff vacancies with agency staff and the unfunded cost pressures relating to GP cover from 8pm to midnight and for Paediatric doctors. High levels of sickness and leave in December has led to medical agency expenditure above forecast levels, however a reduction in agency rates has been implemented which is marginally offsetting the increased usage. A&E has exceeded it's control target by £100k for the period and is forecasting to exceed it by £187k by year-end.

•Adult Medicine is overspent year to date due to activity driven drugs and MSSE expenditure along with medical staffing pressures including high levels of medical agency expenditure in the current month. Other in month overspends include ongoing MSSE and drugs activity related costs as well as substantive medical staffing (currently under review). Adult medicine has met it's control target for the period and is forecasting to achieve it at year-end.

•The Surgical Services in-month adverse budgetary overspend is driven by the non-achievement of commissioner demand management schemes, additional Fawkham Manor activity as well as Orthopaedic direct costs and a range of issues within Critical Care including potential stocking up of consumables for the Christmas period. For the cumulative year to date period, in addition to the issues highlighted above, the Surgical Services adverse position has been driven by additional lists in anaesthetics and main theatres, ITU nursing pay and non pay overspends as well as endoscopy and urology consumable overspends. Redwood Ward is overspent due to being partially open during months 3-6, when expected to be closed as a QIPP saving, General Surgery & Urology medical staff are overspent due to agency staff covering for SHO vacancies at a premium rates. Orthopaedic nursing costs (Cherry & Maple Wards), prostheses and medical staff agency premiums. Surgical Services has marginally overspent it's control total (£21k) to month 9 and is forecasting to hold this position to the year-end.

•Operations is underspent for the year to date due to a significant increase in high cost drugs in the year which are rechargeable to the PCT.

•Pathology is overspent year to date predominantly due to outsourced test costs and other non-pay consumables. These costs have been offset by a rebate from the blood authority relating to previous periods.

•Radiology is overspent year to date due to agency staff premiums and unmet demand management as well as a range of non-pay pressures including nuclear medicine, PACS maintenance and isotopes costs.

•Finance is overspent year to date due to overspends on uniforms, stationery, postage, energy and audit fees as well as costs relating to Voluntary Services posts transferred from Trust Funds.

Dartford and Gravesham NHS
NHS Trust

Performance against Control Totals

Performance versus Control - YTD and Forecast

18/01/2012

Directorate	Month 9 Control YTD £000	Actual Month 9 YTD £000	Var £000	Forecast Control £000	Current Forecast £000	Var £000
Trauma & Orthopaedics	5,345	5,334	11	7,210	7,199	11
General Surgery	5,718	5,688	30	7,560	7,530	30
Critical Care	11,940	12,002	(62)	15,836	15,898	(62)
Surgical Services Sub Total	23,003	23,025	(21)	30,605	30,626	(21)
A&E	6,936	7,036	(100)	9,103	9,289	(187)
Adult Medicine	16,707	16,707	(0)	22,648	22,648	(0)
Emergency Medicine Total	23,644	23,743	(100)	31,751	31,938	(187)
Obstetrics and Gynaecology	8,575	8,594	(19)	11,693	11,712	(19)
Paediatrics	4,231	4,273	(42)	5,788	5,831	(42)
Women & Children Total	12,806	12,867	(61)	17,482	17,543	(61)
Radiology	4,102	4,150	(48)	5,575	5,639	(64)
Operations (inc. Therapies)	10,528	10,547	(18)	14,175	14,194	(18)
Pathology	5,658	5,648	10	7,499	7,481	17
Chief Executive	966	936	30	1,285	1,265	20
Human Resources	1,170	1,153	17	1,595	1,578	17
Nursing	643	654	(11)	867	878	(11)
Private Patients	114	129	(15)	147	162	(15)
Governance	3,873	3,856	17	5,366	5,349	17
Cancer Services	2,231	2,266	(35)	2,972	3,032	(60)
Service Development	1,892	1,919	(27)	2,507	2,577	(69)
Finance (excl PFI Financing Costs	13,121	13,220	(99)	17,414	17,426	(11)
Integartion Costs				130	130	0
Contingency				500	500	0
Directorate Total	**103,752**	**104,113**	**(360)**	**139,871**	**140,318**	**(445)**

•Surgical Services has marginally exceeded its control total by £21k to month 9 and is forecasting that this position will be held to year-end.

•Emergency Medicine has exceeded its control total by £100k for the period and is forecasting an adverse position of £187k by year end. Additional measures will now be put in place to improve the control of expenditure within the Directorate.

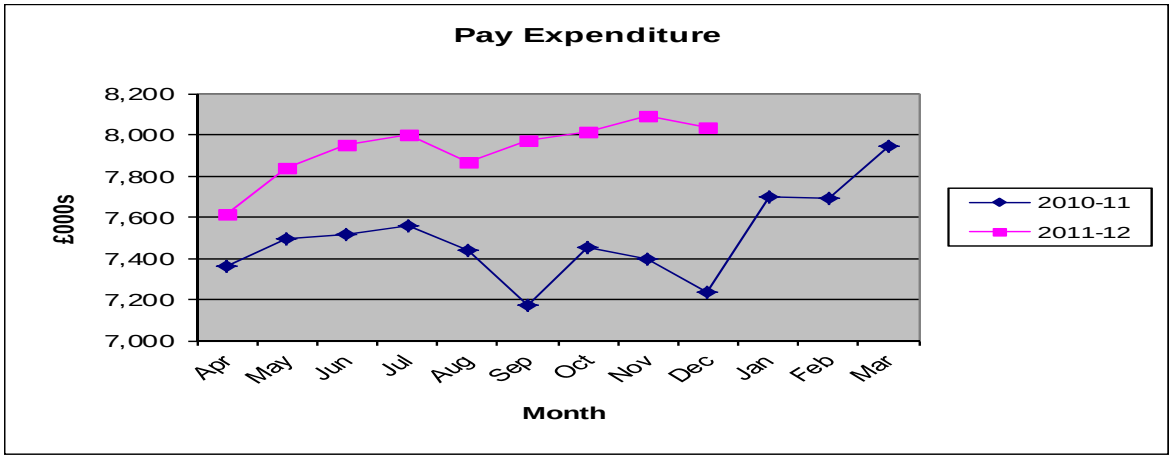
•W&CH is £61k over the control total for the period and is forecasting that this position will be held to the year-end.

•Finance has exceeded the control total for the period due to a rephasing on a large accrual – the Directorate is forecasting that it will essentially recover the position by the year end.

Financial Performance - Pay

Dartford and Gravesham NHS Trust

Pay Group		Actual April 1 £'000	Actual May 2 £'000	Actual June 3 £'000	Actual July 4 £'000	Actual Aug 5 £'000	Actual Sept 6 £'000	Actual Oct 7 £'000	Actual Nov 8 £'000	Actual Dec 9 £'000	Difference (-) adverse mth 8 to 9 £'000
	Pay										
Medical	Substantive	1,737	1,802	1,803	1,830	1,858	1,839	1,856	1,849	1,895	-46
	Locum	148	172	291	178	175	173	185	235	188	47
	Agency	251	311	249	315	325	307	279	237	299	-62
	Sub Total Medical	**2,135**	**2,285**	**2,342**	**2,323**	**2,358**	**2,320**	**2,320**	**2,321**	**2,382**	**-61**
Nursing	Substantive	2,410	2,431	2,544	2,484	2,489	2,539	2,557	2,640	2,588	52
	Bank	220	304	238	314	212	297	269	263	240	23
	Agency	103	10	27	36	20	15	13	6	9	-3
	Sub Total Nursing	**2,732**	**2,744**	**2,809**	**2,834**	**2,721**	**2,852**	**2,838**	**2,909**	**2,837**	**72**
Scientific & Ther.	Substantive	850	849	847	870	870	858	887	901	903	-2
	Bank	16	12	9	11	11	14	10	10	10	0
	Agency	22	28	24	48	18	28	40	27	29	-2
	Sub Total STT	**888**	**889**	**879**	**929**	**899**	**900**	**938**	**938**	**942**	**-4**
HCAs/Support	Substantive	658	674	682	676	651	683	683	689	668	21
	Bank	121	153	124	150	116	147	140	133	127	6
	Agency	0	0	0	0	0	0	0	0	0	0
	Sub Total Support	**778**	**826**	**806**	**826**	**767**	**831**	**823**	**822**	**795**	**27**
Sen. Managers A&C	Substantive	1,064	1,067	1,088	1,049	1,095	1,037	1,063	1,072	1,059	13
	Bank	17	26	23	34	28	30	27	28	22	6
	Agency	0	0	0	2	0	0	7	2	2	0
	Sub Total STT	**1,081**	**1,093**	**1,111**	**1,086**	**1,122**	**1,067**	**1,097**	**1,102**	**1,083**	**19**
	Total pay	**7,615**	**7,837**	**7,948**	**7,998**	**7,868**	**7,969**	**8,016**	**8,092**	**8,039**	**53**



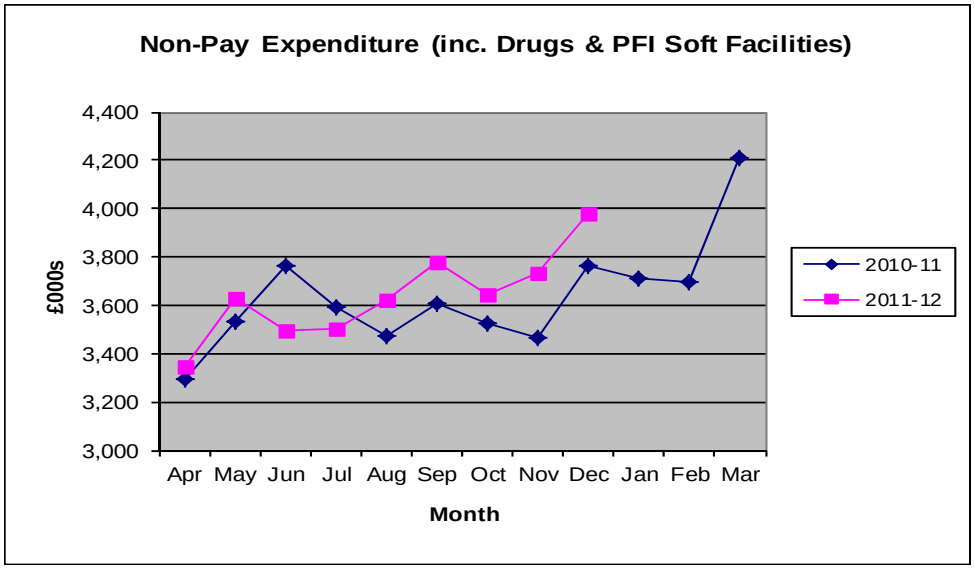
Pay decreased by £53k in the month compared to month 8 levels. This decrease is in line with the previous year's trend for the December period. Within the position, agency medical costs increased by £62k, mainly within Emergency Medicine.

The pay spend control total is expected to come under pressure in month 10. The control of agency usage over the remaining months of the year will be crucial to securing the break-even position.

Financial Performance – Non-Pay

Dartford and Gravesham NHS
NHS Trust

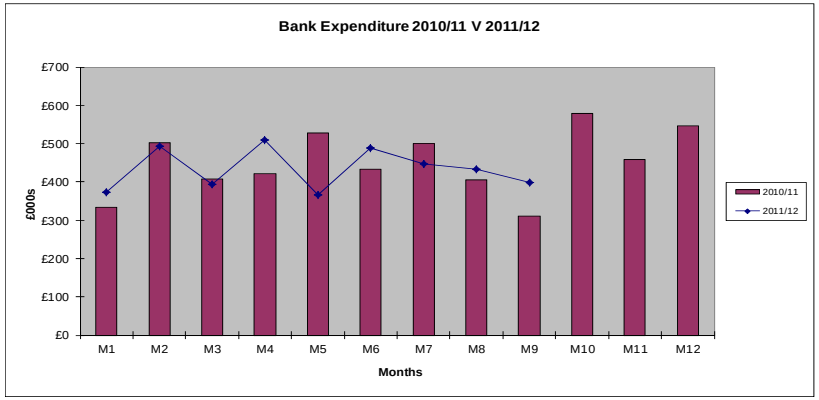
Non - Pay										
Medical & Surgical Supplies	706	799	936	891	880	870	964	866	1,000	-134
Laboratory Consumables	233	242	259	236	233	278	267	265	198	67
Travel & Training	62	79	58	83	53	73	87	66	73	-7
Computer consumables	164	176	206	171	146	157	297	35	179	-144
Hire & Maintenance of Equipment	120	120	105	122	129	144	41	261	134	127
Clinical Negligence Scheme & Consultar	288	418	349	347	379	357	363	379	425	-46
Other	301	328	247	339	374	358	300	446	419	27
Energy, Rates & Insurance	245	241	251	226	239	244	259	267	270	-3
Drugs	454	463	341	358	619	470	363	452	530	-78
PFI	887	896	881	890	869	885	874	903	899	4
Direct credit income	-116	-136	-129	-161	-297	-57	-172	-209	-152	-57
Total Non Pay	**3,344**	**3,626**	**3,503**	**3,503**	**3,623**	**3,778**	**3,643**	**3,731**	**3,975**	**-244**

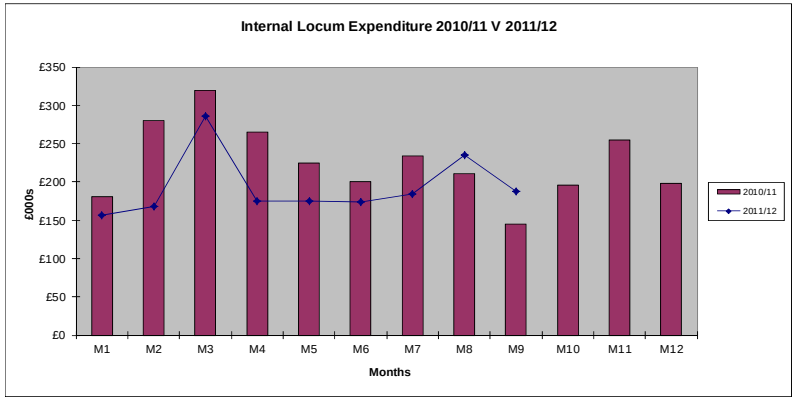


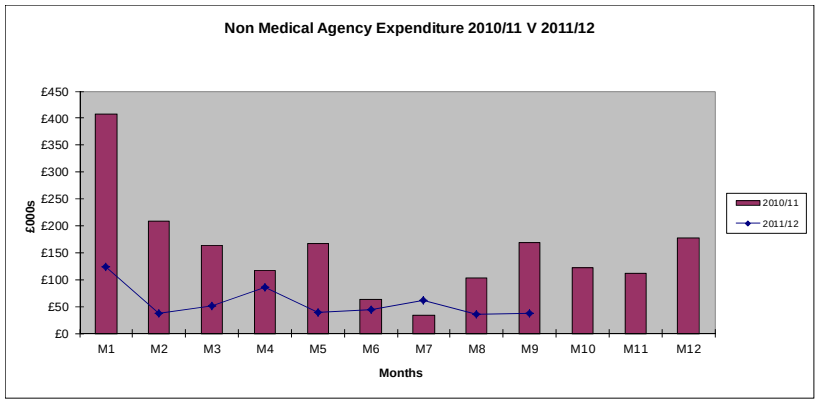
Non-pay expenditure (including drugs & PFI soft facilities) increased in the month by £244k. The main issues were increased MSSE consumable costs, potentially due to stocking up for December, an increase in high cost ICDs (£50k) and adjustment to an accrual for audit fees (£50k).

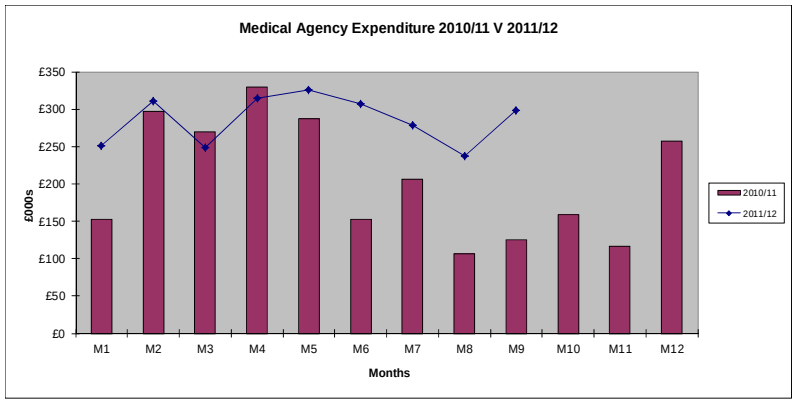
Temporary Staffing

Dartford and Gravesham NHS Trust









• Bank expenditure in month 9 has reduced compared to month 8 and is lower than the YTD average monthly bank expenditure (which would be expected in December), which is also below the average for 2010-11.

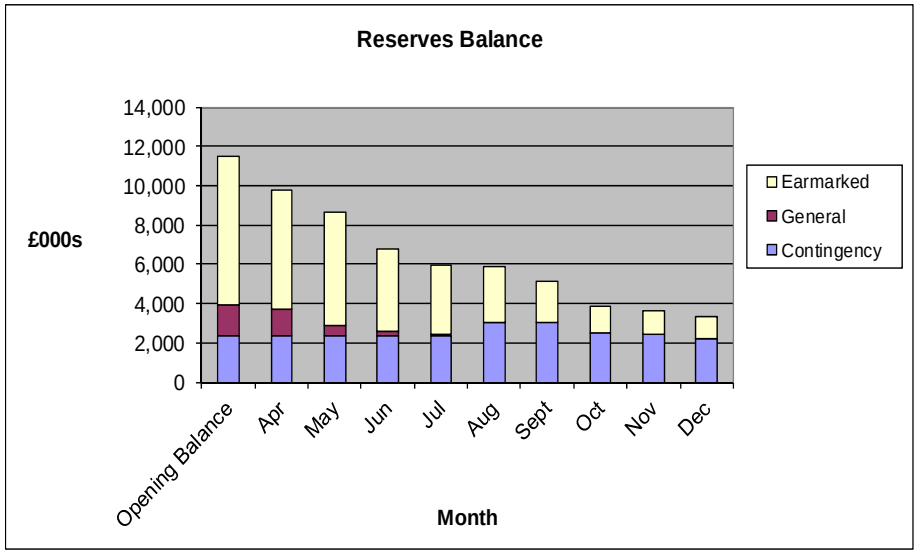
• Locum expenditure in month 9 has reduced from month 8 and is below the average locum expenditure YTD as well as being below the average monthly spend for 2010-11.

• Non medical agency costs are in line with the costs incurred in month 8. Non-medical agency average monthly expenditure YTD is only 37% of the average monthly cost for 2010-11.

• Medical agency costs increased in month 9, largely due to high usage in A&E. Medical agency average monthly expenditure YTD is 40% higher than the average monthly medical agency expenditure in 2010-11.

Reserves 2011/12

Dartford and Gravesham NHS Trust



Since the start of the year, £9.7m has been issued to budgets from reserves to deal with activity and other cost pressures. A contingency balance has been set aside to deal with income contractual challenges. However, any reserve contingency will only be available if expenditure is controlled within issued budgets.

Month 9 Directorate Budgets and Reserve Balances

Directorate	Month 8 B/Fwd £'000	Activity linked £'000	Business Cases £'000	Re-ablement £'000	Other £'000	QIPP £'000	Month 9 B/Fwd £'000
Surgery	28,263				13		**28,277**
Emergency	22,152	55		25			**22,233**
A&E	7,761						**7,762**
Women & Childrens	17,302		53		8	-4	**17,359**
Other Clinical Areas	30,385		73		70		**30,529**
Corporate	29,012				5		**29,016**
Total	**134,874**	**55**	**126**	**25**	**96**	**-4**	**135,175**
Reserves							
Contingency	2,420	-55	-65		-78		**2,222**
General	-						**-**
Earmarked	1,180		-61	-25	-18	4	**1,080**
Sub Total Reserves	**3,600**	**-55**	**-126**	**-25**	**-96**	**4**	**3,302**

Income Analysis by PCT

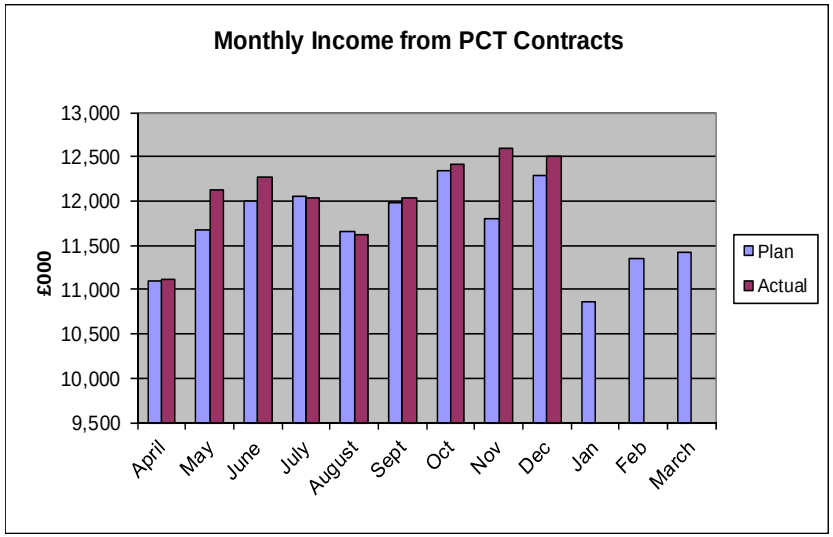
Dartford and Gravesham NHS Trust

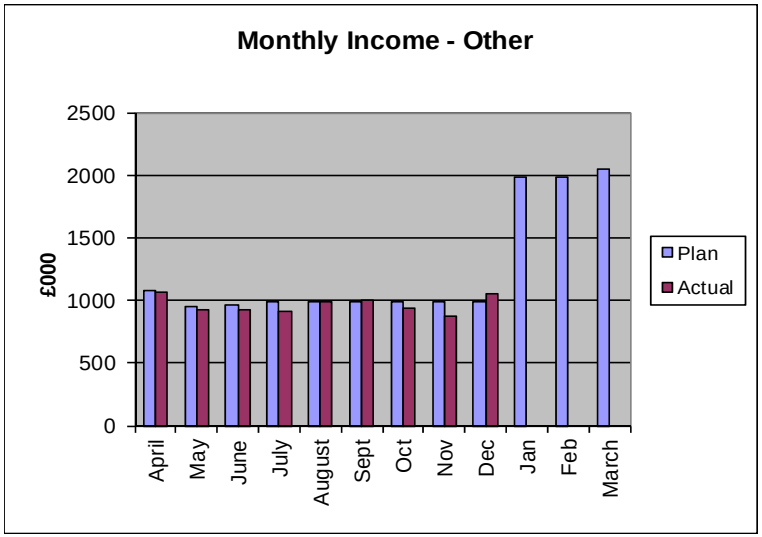
Income Performance to the 31st December 2011

PCT CONTRACTS	Annual Plan £000	YTD Plan £000	Actual Income £000	Variance £000
West Kent	110,600	82,280	84,522	2,242
Medway	3,460	2,580	2,781	201
Bexley	21,545	17,011	18,901	1,890
Greenwich	953	708	1120	412
S W Essex	2,169	1,614	1,261	-353

The PCT contract performance to the end of December is shown in the Table opposite. With the exception of SW Essex PCT, all contracts are over performing. Monthly reconciliation of challenges are being completed. A provision for penalties, challenges and prior year adjustments is being made, to date this amounts to £2,209k. The DoF has now agreed the level of year end challenges with West Kent PCT at £1,155k to give more certainty over the year-end income levels. Invoices for the Q2 over performance have now been raised.

Activity Performance	Plan	Actual	Variance	
Elective	17,077	18,437	1,360	7.96%
Non Elective	33,554	33,994	440	1.31%
First Outpatients	49,728	50,827	1,099	2.21%
Follow Up Outpatient	113,395	119,924	6,529	5.76%
A&E	71,902	73,311	1,409	1.96%





Income Analysis by Point of Delivery

Dartford and Gravesham NHS Trust

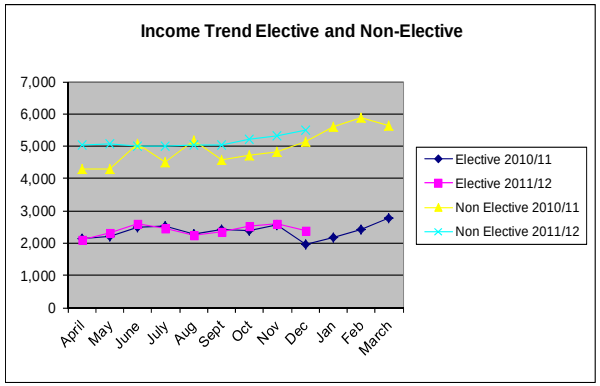
Income Performance to the 31st December 2011

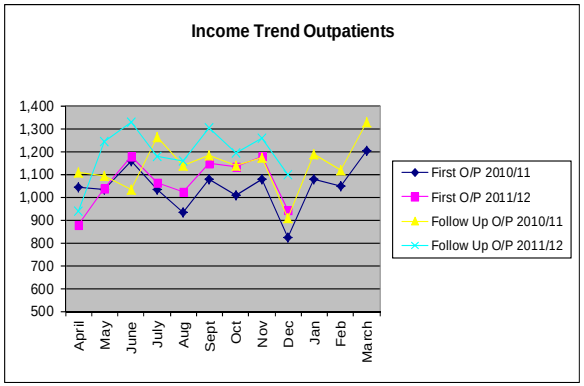
PCT CONTRACTS (By Point of Delivery)	YTD Plan £000	Actual £000	Variance £000
Elective	20,548	21,623	1,075
Non Elective	45,604	46,219	615
First Outpatient Attendance	8,828	9,577	749
Follow Up Outpatient Attendance	11,216	10,692	-524
A&E	7,031	7,747	716
Other	5,664	6,403	739
Block	7,858	6,434	-1,424
Other - Over Performance	0	0	0
TOTAL	**106,749**	**108,695**	**1,946**

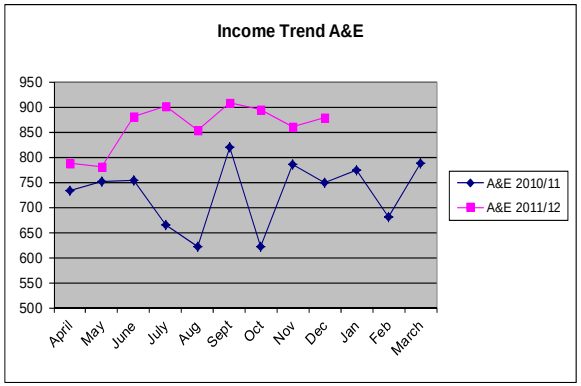
The Table opposite details by POD the overall Trust income against Plan to the end of December. After making a provision for potential in year challenges and prior year adjustments of £2,209k, the net over performance is £1,946k.

The financial under performance against Plan for Follow Up outpatient attendances continues to relate to under activity against Plan in T&O and General Medicine.

The Block variance to the end of December is a technical variance as this relates to Chemotherapy planned allocation having been included in the actual chemo activity and income being recorded in the other POD categories.







Statement of Financial Position (Balance Sheet) at 31 December 2011

	Opening as at 01/04/2011 £000	As at 31/12/2011 £000	Plan 31/03/2012 £000
Non-Current Asset			
Property, Plant & Equipment	113,355	111,465	111,544
Current Assets:			
Inventories	2,052	2,231	2,052
Trade & Other receivables	12,410	12,423	12,410
Other Current Assets	0	0	0
Cash & Cash equivalents	876	3,136	876
Total Current Assets	**15,338**	**17,790**	**15,338**
Total Assets	**128,693**	**129,255**	**126,882**
Current Liabilities:			
Trade & Other payables	(16,602)	(19,560)	(17,832)
Other Liabilities	(53)	(53)	(53)
DH Capital Loan	(300)	(150)	(300)
Borrowings: PFI Liability	(938)	(235)	(1,037)
Current Provisions	(226)	(204)	(102)
Net Current Assets/Liabilities	**(2,781)**	**(2,412)**	**(3,986)**
Total Assets less current liabilities	**110,574**	**109,053**	**107,558**
Non-Current Liabilities			
Borrowings: PFI Liability	(65,507)	(65,507)	(64,470)
DH Capital Loan	(750)	(750)	(450)
Non-Current Provisions	(329)	(329)	(253)
Other Liabilities	(1,053)	(1,053)	(1,000)
Total Assets Employed	**42,935**	**41,414**	**41,385**
Financed By:			
Public dividend capital	41,654	41,654	41,654
Retained Earnings	(25,283)	(26,741)	(26,833)
Revaluation Reserve	26,259	26,259	26,259
Donated Asset Reserve	305	242	305
Total Equity	**42,935**	**41,414**	**41,385**

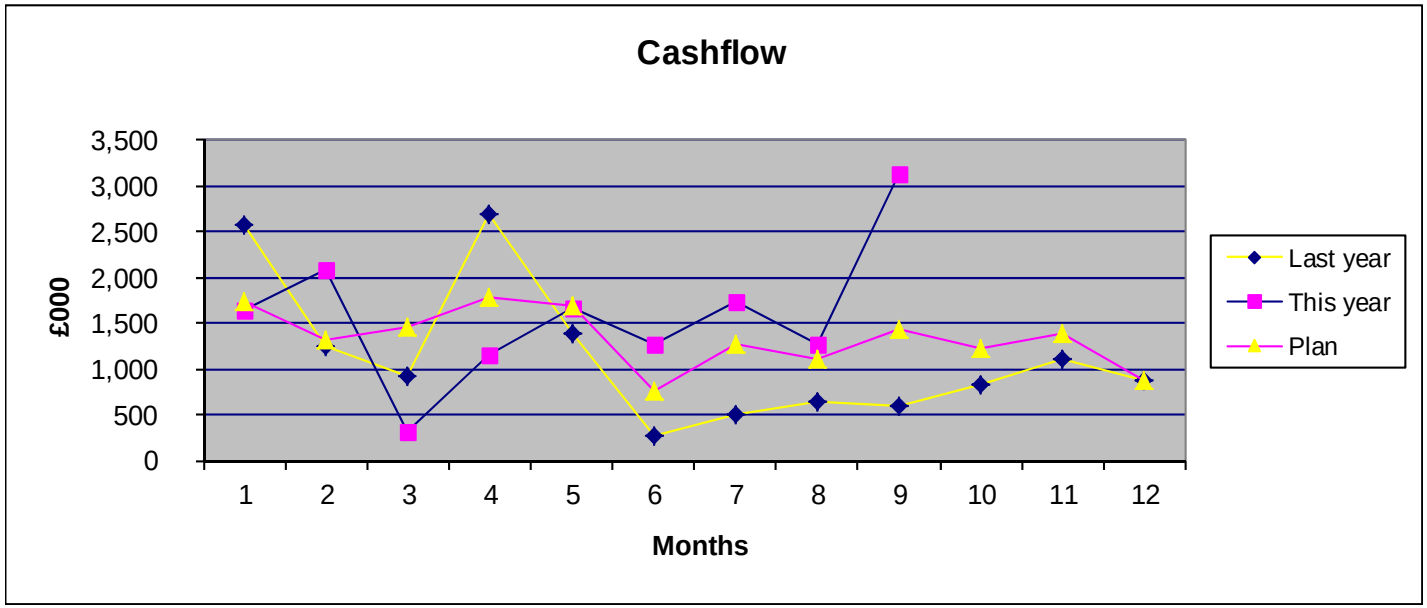
Dartford and Gravesham NHS
NHS Trust

- With regard to the Statement of Financial Position (SoFP) the following points should be noted:
- The Statement of Financial Position for 2011/12 now fully reflects the adoption of IFRS and the changes in the categorisation of assets and liabilities.
- Under IFRS the Trust is required to account for the PFI asset as being on SoFP as a non current asset with a corresponding liability.
- The Trust's current liabilities exceed current assets by £2.4m at 31st December 2011.
- Detailed information on the Trust working capital balances are reported to the Finance Committee. The Trust is reliant on receipt of the £3m PFI monies in the latter part of the year to reduce creditors and improve BPPC performance. Without this funding a working capital loan will need to be considered.
- The Trust took a capital loan in 09/10 of £1.5m to support its capital programme and is required to repay £0.3m in 2011/12 (mth 6 and mth 12).
- The revaluation reserve balance reflects the revaluation of the PFI asset in 2009/10 of £21m.

Cash flow 2011/12

Dartford and Gravesham NHS Trust

	Actual Apr £000	Actual May £000	Actual Jun £000	Actual Jul £000	Actual Aug £000	Actual Sep £000	Actual Oct £000	Actual Nov £000	actual Dec £000	Forecast Jan £000	Forecast Feb £000	Forecast Mar £000
BALANCE B/F	876	1,650	2,094	322	1,068	1,596	1,195	1,655	1,282	3,136	2,756	2,607
RECEIPTS	13,755	14,333	12,372	14,963	15,531	15,294	14,487	14,594	16,408	14,027	13,905	12,950
PAYMENTS	12,767	13,684	13,794	13,202	14,962	14,405	13,874	14,912	14,328	14,263	13,911	13,714
CASH FROM OPERATIONS	988	649	(1,421)	1,761	569	890	613	(318)	2,080	(236)	(7)	(764)
CAPITAL ITEMS	215	205	351	1,015	41	1,290	153	55	226	144	142	967
NET INFLOW/OUTFLOW	773	444	(1,772)	746	528	(401)	460	(373)	1,854	(380)	(149)	(1,731)
BALANCE C/F	1,650	2,094	322	1,068	1,596	1,195	1,655	1,282	3,136	2,756	2,607	876
Plan	1,729	1,321	1,452	1,781	1,688	765	1,277	1,104	1,425	1,238	1,398	876
Last year	2,577	1,254	913	2,687	1,386	265	501	633	591	825	1,122	876



- The cash balance at the end of December is £3.1m. This is £1.7m above plan and due to the cash advance received from West Kent PCT of £2.3m
- Debtors are actively pursued to maximise the cash available to the Trust.
- Cash continues to prove a challenge for the Trust in both timing and resource. The future cash flows assume that £3m PFI monies will received in full.
- The rate of capital spend will increase over the latter part of the year, which will put further pressure on the cash position.
- A proposed cash handling strategy has been developed and presented to the Finance Committee.

Capital Programme

Dartford and Gravesham NHS Trust

1 Capital expenditure **2011-12 Month 9 December**

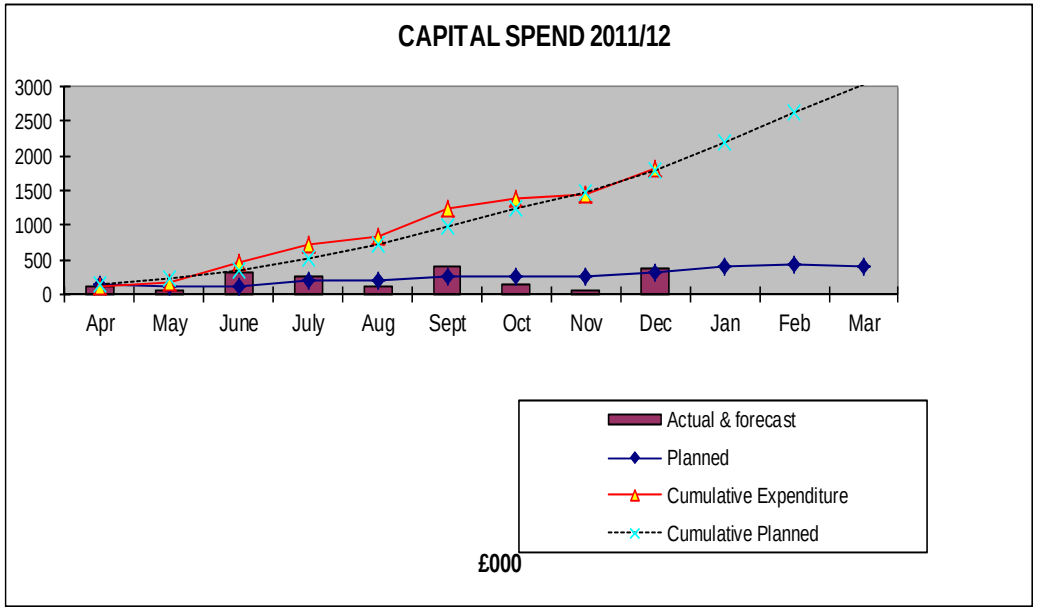
Category	Allocation £000	Allocation of Contingency £000	Spend as at 31/12/11 £000	F/Outturn 31/03/12 £000
Buildings	1,275	-85	936	1,190
IM&T	650	20	277	670
Medical Equipment	560	139	448	700
Other	246	58	159	304
Contingency	300	-132	0	167
Grand Total	**3,031**	**0**	**1,820**	**3,031**

The Trust's Capital Resource Limit (CRL) is £3m. Expenditure to date is £1.82m against plan of £1.80m.

The forecast utilisation of resources, including repayment of capital loan £300k will be £3.3m. To date £132k has been allocated from contingency. The contingency balance stood at £167k at the end of month 9.

2 Source & Application

	£000
Depreciation	2,241
Management of Working Capital	377
2010/11 Underspend brought forward	713
Total Resource	**3,331**
Buildlings	1,190
IM&T	670
Equipment	700
Other	304
Contingency	167
Spend as above	3,031
Repayment of Capital loan taken in 09/10	300
Total Application	**3,331**



QIPP Performance

Dartford and Gravesham NHS Trust

Directorate	Target QIPP 11/12	Year to Date Plan	YTD M9 Actual	Variance	Forecast 1112 Savings	Projected Recurrent Savings (FYE)
	£000s	£000s	£000s	£000s	£000s	£000s
Cancer Services	296	222	148	74	296	296
CEO	54	41	58	(17)	78	74
Corporate Held	498	374	237	137	498	47
Facilities	88	66	109	(43)	138	119
Finance	95	71	100	(29)	100	74
Governance	77	58	51	6	77	77
HR	110	83	135	(52)	182	131
Income	1,134	851	850	0	1,134	1,134
Nursing	21	16	14	2	21	26
Operations	597	448	588	(141)	749	563
Pathology	296	222	201	21	296	171
Procurement	200	150	127	22	151	79
Surgical Specialties	1,305	979	903	76	1,297	867
Radiology	458	344	299	45	457	352
Women & Children	644	483	604	(121)	816	821
Adult Medicine	811	608	616	(7)	813	620
A&E	322	242	400	(159)	745	747
Service Development	101	75	71	4	107	52
Total	**7,107**	**5,330**	**5,511**	**(181)**	**7,956**	**6,249**
% of plan achieved			**103%**		**112%**	**87.9%**

As at month 9, the Trust has achieved £5.5m of QIPP savings compared to a YTD QIPP plan of £5.3m (103% achieved). The Trust has an annual QIPP target of £7.1 million for 2011-12 and is currently forecasting to achieve £7,956k (112%) but there are risks to delivery.

Service Line Report Summary

Dartford and Gravesham NHS Trust

		Month 8 (Deficit) / Surplus	Month 9 (Deficit) / Surplus	Month 9 Variation	Month 9 Contribution	Month 9 YTD T/O	Surplus %	Contribution %	EBITDA
General Surgery	100	513	580	67	4,897	13,866	4.2%	35.3%	2,296
Urology	101	(289)	(297)	(8)	1,502	5,817	-5.1%	25.8%	423
Trauma & Orthopaedics	110	(122)	(209)	(87)	4,737	14,727	-1.4%	32.2%	1,613
Pain	191	(4)	(12)	(8)	109	385	-3.1%	28.3%	36
ITU	ITU	(309)	(274)	35	762	3,705	-7.4%	20.6%	184
TOTAL SURGERY		**(211)**	**(212)**	**(1)**	**12,007**	**38,500**	**-0.6%**	**31.2%**	**4,552**
Accident & Emergency	180	(815)	(815)	-	2,397	10,784	-7.6%	22.2%	519
General & Elderly Medicine	300	(979)	(1,086)	(107)	6,915	23,687	-4.6%	29.2%	1,845
Diabetic Medicine	307	77	79	2	277	619	12.8%	44.7%	156
Cardiology	320	(100)	(45)	55	1,653	4,953	-0.9%	33.4%	568
GUM	360	(105)	(134)	(29)	372	1,814	-7.4%	20.5%	90
Nephrology	361	(288)	(394)	(106)	(150)	630	-62.5%	-23.8%	(316)
Neurology	400	(85)	(117)	(32)	3	450	-26.0%	0.7%	(61)
Rheumatology	410	102	121	19	481	1,168	10.4%	41.2%	266
TOTAL EMERGENCY MEDICINE		**(2,193)**	**(2,391)**	**(198)**	**11,948**	**44,105**	**-5.4%**	**27.1%**	**3,067**
Paediatrics	420	426	539	113	2,466	4,944	10.9%	49.9%	1,151
Obstetrics	501	1,086	1,236	150	5,242	13,529	9.1%	38.7%	2,910
Gynaecology	502	(380)	(427)	(47)	1,191	4,879	-8.8%	24.4%	177
SCBU	SCBU	(221)	(241)	(20)	461	2,210	-10.9%	20.9%	32
TOTAL WOMEN & CHILDRENS		**911**	**1,107**	**196**	**9,360**	**25,562**	**4.3%**	**36.6%**	**4,270**
Cancer Services	370/303	(375)	(455)	(80)	916	4,180	-10.9%	21.9%	62
ENT	120	(21)	(78)	(57)	183	691	-11.3%	26.5%	7
Ophthalmology	130	(34)	(38)	(4)	109	170	-22.4%	64.1%	(17)
Oral Surgery	140	(93)	(98)	(5)	262	720	-13.6%	36.4%	(9)
Dermatology	330	(46)	(54)	(8)	(25)	44	-122.7%	-56.8%	(49)
Dietetics	654	61	67	6	102	116	57.8%	87.9%	81
Radiology	810	122	135	13	235	279	48.4%	84.2%	170
Direct Access	DA	507	559	52	1,980	4,564	12.2%	43.4%	1,124
TOTAL OTHER		**121**	**38**	**(83)**	**3,762**	**10,764**	**0.4%**	**34.9%**	**1,369**
TRUST TOTAL		**(1,372)**	**(1,458)**	**(86)**	**37,077**	**118,931**	**-1.2%**	**31.2%**	**13,258**

Surgical Services		
Turnover	38,500	
Deficit	(212)	**-0.6%**
Contribution	12,007	**31.2%**
EBITDA	4,552	**11.8%**

Emergency Medicine		
Turnover	44,105	
Deficit	(2,391)	**-5.4%**
Contribution	11,948	**27.1%**
EBITDA	3,067	**7.0%**

Women & Children		
Turnover	25,562	
Surplus	1,107	**4.3%**
Contribution	9,360	**36.6%**
EBITDA	4,270	**16.7%**

Other		
Turnover	10,764	
Surplus	38	**0.4%**
Contribution	3,762	**34.9%**
EBITDA	1,369	**12.7%**

Financial Action Focus

Dartford and Gravesham NHS Trust

Internal Actions	Progress
Deliver QIPP Stretch target	• Delivery to month 9 in line with plan • QIPP meetings moved to fortnightly • Additional schemes requested for all areas projecting slippage – progress being made • Forecast currently showing stretch target will be achieved
Control and reduce discretionary expenditure	• Pay and non-pay controls in place although more central initiatives required and being sought
Review/slip Business cases and amend reserves	• Bridge work has considered business case performance • Further work needs to be done to identify forecast position on each business case versus income and original plans – this will be done to inform business planning 2012/13 • Business case assumptions included in control total forecasts
Confirm and agree monthly Directorate expenditure control targets including mitigating actions	• Financial Delivery Strategy in place – but controls being exceeded • Detailed monthly forecasts received from all Directorates and performance will be kept under review with additional measures being put in place for "hot spot" areas.
External Actions	
Confirm £3m PFI funding source	• Funding source not confirmed • Letter has been sent to StHA and PCT Chief Executive confirming current assumptions • As a contingency measure - £3m confirmed as being included as part of Health Economy Recovery plan by PCT - end of year control total being discussed with cluster including support
Agree year end SLA control total with PCTs and SHA	• DoF met with PCT Cluster – settled challenges and 2010/11 cashing up • Full end of year settlement being discussed
Agree Trust to Trust Provider values and disputed balances	• Action plan with key leads being developed to address all disputed balance issues
Consider working Capital loan to support cash pressures	• Cash scenario planning undertaken for worst, likely and best possible • The Trust has submitted working capital loan application as contingency action

Risk Schedule

Dartford and Gravesham NHS Trust

KEY FINANCIAL RISKS as at MONTH 9 2011/12

Key Risk	Description	Estimated Risk Month 7	Estimated Risk Month 8	Estimated Risk Month 9	RAG	Mitigating Action	2012/13 Risk
INCOME AND EXPENDITURE RISKS		£m	£m	£m			
PFI Additional Income	£3m requested to cover the additional cost of PFI	*3*	3	3	R	Written to the DoF StHA and PCT Chief Executive - await confirmation of potential solution following DoH review. Included in Health Economy recovery plan - end of year settlement being negotiated to include PFI support	3
PCT Legacy issues	The PCT are expecting a final settlement above Trust assumed levels	*0*	0	0	G	Agreed - 2010/11 settlement £2m, challenges £1.15m	0
PCT Challenges	Trust currently holds a challenge provision to offset losses of income through successful PCT challenges	*0*	0	0	G	Agreed for K&M - no challenges received for Bexley for first 6 months	0
PCT QIPP Schemes	The PCT have identified QIPP schemes totalling £6m for 2011/12 that could reduce Trust income	*1*	1	0.8	A	No evidence that demand management schemes impacting to date - Trust would have to identify marginal cost savings if schemes successful - PCT forecasting £3.1m reduction for 3 months.	6
Projected Activity Levels	The Trust has forecast that non-elective activity levels will increase on current levels over the winter months (based on previous years trends) elective activity level will remain high. The risk is that trends are different or impacted by severe weather or the PCT imposes restrictions to elective work	*1.5*	1	1	G	Activity kept under detailed review each month and forecast updated	0
QIPP	The assumption is that current QIPP delivery levels are at least maintained through out the winter months and the £7.1m target is achieved	*0.5*	0.2	0.2	G	Weekly QIPP meetings in place and delivery kept under close review - currently forecasting to exceed £7.1m	0.5
Directorate Control targets	The current Directorate control targets do not achieve the required break-even position and include further savings measures that carry risk	*0.7*	0.7	0.8	R	Special measures implemented for Emergency Medicine - mitigating action requested where Directorates exceeding control totals.	0.7
Disputed Balances	The agreement of balances exercise will be undertaken in the last quarter of 2011/12. There are currently a number of disputed balances relating to previous years that need to be resolved and further disputes could be received towards the year end. The current assumption in the year end forecast is that disputed balances will be no more than £500k.	*0.5*	0.3	0.3	A	Progress made in resolving disputed balances - remaining risk remains unchanged	0.3
CASH FLOW RISKS							
PFI Additional Income	The Trust's cash flow projections are dependent on the additional £3m PFI monies being received in cash by March at the latest	*3*	3	3	R	The Trust has applied for a working capital loan if £3m not received - the timing of a potentail application will be discussed with the StHA. Other mitigation is being considered including PCT advance	3
NHS Debtors	The Trust is owed significant sums by other NHS organisations whom have cash flow issues. Assumptions have been made regarding the level of payment over the coming months in the current cash flow plans - the risk is that these payments are not made	*1*	1	1	A	The Trust will write to all of the main debtors requesting a payment plan. The position is being escalated to Directors of Finance	1
Achievement of year end balance	The cash flow forecast assumes that the Trust will achieve break-even in 2011/12 - any deficit will require further mitigating action	*0.5*	0.5	0.5	A	Further work to agree Directorate control targets, QIPP targets and close monitoring of income levels	0..5

Note:
The assessment of the financial risk value is based of the potential difference from current assumptions being made in the year end forecast break-even achievement.

Dartford and Gravesham NHS
NHS Trust

TRUST BOARD MEETING – JANUARY 2012

1-8.3	**QIPP PROGRAMME REPORT (MONTH 9, 2011/12)**	**DIRECTOR OF FINANCE / DIRECTOR OF OPERATIONS**

The enclosed report updates the Board with the progress to date in the delivery of the Quality, Innovation, Productivity & Prevention (QIPP) programme for 2011/12.

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Discussion

Equality Impact Assessment initial screening applicable to this report? No

This report provides information on the following annual objectives (delete as required)**:**

- To deliver the objectives set out in the Financial Plan for 2011/12, including the delivery of a Quality, Innovation, Productivity and Prevention (QIPP) programme that develops patient pathways which provides care closer to patients' homes, and improves the efficiency of the services the Trust provides, thereby saving resources and releasing capacity

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors understanding of the Trust & its performance

QIPP Report – Month 9

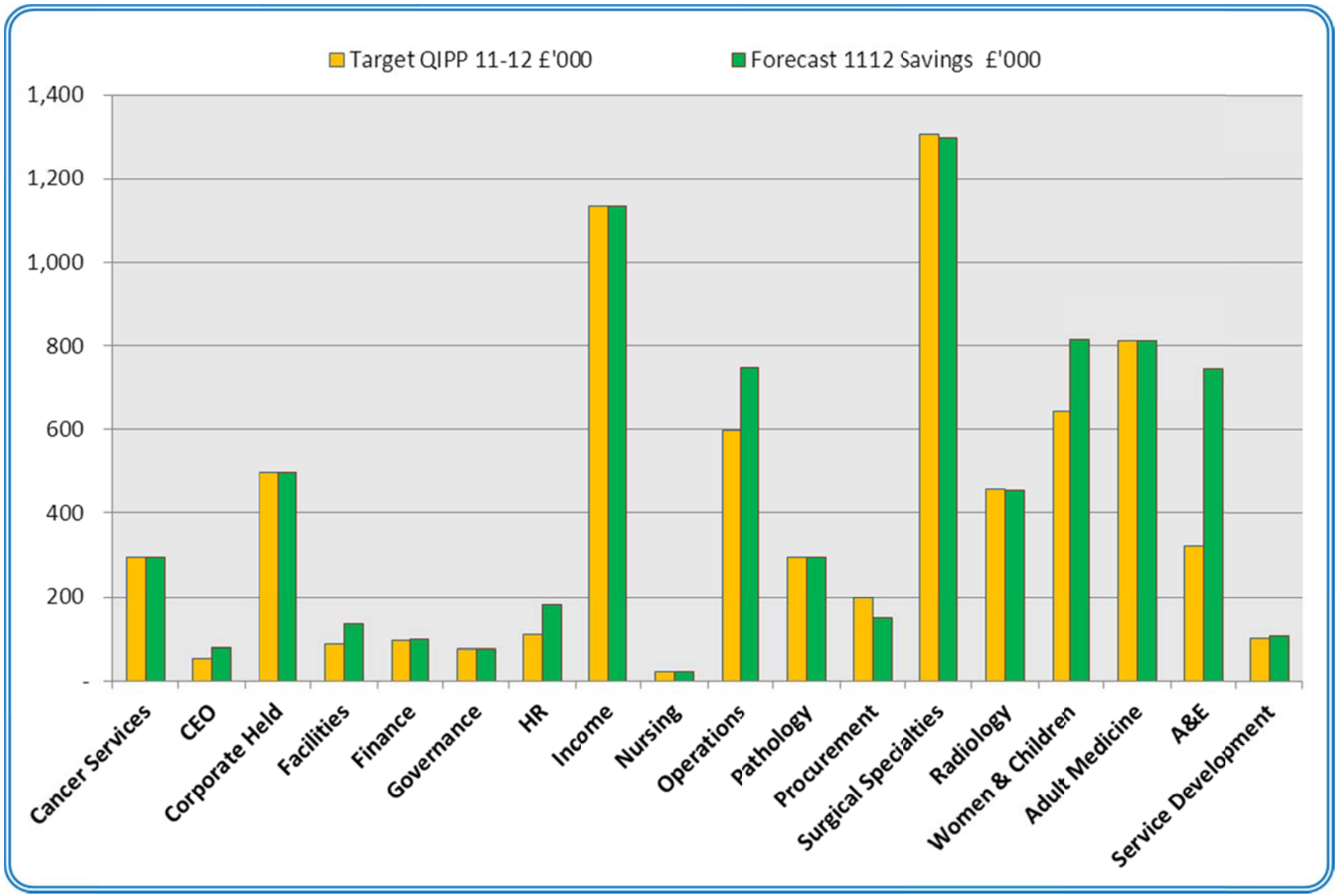
1. Month 9 – December 2011

Table 1 below details the position reported to the SHA for month 9 by finance, followed by the forecast performance against target at Directorate level in graphical format. Year to date 103% of plans have been achieved equating to £5.5m. The achievement of the stretch target is also being exceeded with an expected 112% delivery equating to £7.9m. Project recurrent savings remain around the 88%.

Table 1

Directorate	Target QIPP 11-12 £'000	Year to Date Plan £'000	YTD M7 Actual £'000	Variance £'000	Forecast 1112 Savings £'000	FYE Variance £'000	Projected Recurrent Savings (fye) £'000	Quality £'000	Innovation £'000	Productivity £'000
Cancer Services	296	222	148	74	296	-	296	-	-	296
CEO	54	41	58	(17)	78	24	74	-	-	78
Corporate Held	498	374	237	137	498	0	47	22	-	476
Facilities	88	66	109	(43)	138	49	119	85	-	52
Finance	95	71	100	(29)	100	5	74	-	-	100
Governance	77	58	51	6	77	-	77	-	-	77
HR	110	83	135	(52)	182	72	131	-	-	182
Income	1,134	851	850	0	1,134	-	1,134	-	-	1,134
Nursing	21	16	14	2	21	-	26	-	10	11
Operations	597	448	588	(141)	749	152	563	-	46	703
Pathology	296	222	201	21	296	-	171	-	36	260
Procurement	200	150	127	22	151	(49)	79	-	-	151
Surgical Specialties	1,305	979	903	76	1,297	(8)	867	161	-	1,137
Radiology	458	344	299	45	457	(2)	352	-	10	447
Women & Children	644	483	604	(121)	816	172	821	19	655	142
Adult Medicine	811	608	616	(7)	813	2	620	28	-	785
A&E	322	242	400	(159)	745	423	747	39	634	73
Service Development	101	75	71	4	107	6	52	-	-	107
Total	**7,107**	**5,330**	**5,511**	**(181)**	**7,956**	**848**	**6,249**	**353**	**1,392**	**6,211**
% of plan achieved			**103%**		**112%**		**87.9%**			

Forecast performance by Directorate.



2. Directorates currently forecasting to not achieve their QIPP plans.

Table 2 sets out the areas that are currently forecasting to not fully achieve their QIPP target, this has reduced significantly over the past few months.

Table 2

Directorate	Shortfall £'000	Comment	Lead Director
Procurement	-49	The original plans for efficiencies in EBME have slipped significantly and are now unlikely to be delivered in this financial year. Mitigating schemes are being worked on. Update M7: EBME issues may be lralted to growth. Meeting with BCAS arranged to discuss T+C's and negotiate more favourable rates. Contract review group being established with support of Leaseguard to consider current maintenance contract levels. Review of retrospecitve discounts underway. Reviewing photocopying, printing and stationery spend and contract. Update M8: Gap has reduced by 19k, work continues on above projects to mitigate further. **Update M9: The gap has reduced by a further 22k and work continues on above projects to mitigate further**	Director of Finance
Surgery	-8	High risk now with regard Redwood Closure and maintaining the level of QIPP originally planned. Other schemes are also not delivering as expected. Mitigations will need to be found to offset the current shortfall and the risk around Redwood. Meetings planned when GM returns from leave. Update M6: Redwood now funded as Medical Ward so risks with regard remainder of QIPP reduced. Mitigating schemes to be found to offset QIPP lost to date. Update M7: Gap has been reduced by £34k and work continues to meet the full target. Update M8: Gap remains broadly the same as last month but still expected to be met fully over the next few months. **Update M9: Gap has reduced by 29k with an expectation target will be fully met by year end.**	Director of Operations
Radiology	-2	Additional sessions required to reduce clinical risks have been partly funded from vacancy slippage which had been given an original QIPP plan which is now forecasting to not deliver. Mitigation schemes need to be identified. Meetings planned when GM returns from leave. Update M6: Small reduction in gap from last month. Work continues to identify schemes, likely to be income based. Update M7: An income scheme has been indentfied to close the gap pending assurance work currently underway. Update M8: Gap has been closed but awaiting final confirmation from Finance to update spreadsheet. **Update M9: Gap has reduced by £69k with alocation from the signifacant overperformance of the direct access work. Expectaiton is the remaining £2k will be met by year end.**	Director of Operations
Total	-59		

3. Quality Initiatives

In addition to the 11/12 plans identified in section 1 above which are either cash releasing or income generating there are also a number of Quality Initiatives which act as enablers. (See Appendix A)

4. QIPP Process and Plans for 2012/13

Whilst the processes and governance of the QIPP Programme has been highly successful during 2011/12, with the expected Due Diligence review, a more traditional matrix approach will be adopted for 2012/13.

The new arrangements include Exec Level ownership for each of the QIPP themes, along with detailed monitoring of KPI's and milestones.

To support the programme going forward consideration is being given to the development of an Innovation Team, utilising a few key staff with the enthusiasm, drive and skills to progress the more complex changes required to deliver the programme next year.

The team would be managed by the QIPP Lead as part of the PMO.

5. Summary

Performance against the stretch target remains robust and continues to exceed expectations, for which the Directorate leads and those supporting them should be congratulated.

Plans are being formulated for 12/13 and will be reported on in more detail in February's report. It is recognised that this will prove a more challenging year for delivery which we are trying to address with greater support to those making the tough decisions.

Leslieann Osborn
Assistant Director – QIPP
13th January 2012

Appendix A

Directorate	Details of Scheme	Investment	Benefits	Progress / Issues	Enables	Saving / Income
Adult Medicine	EQ and CQUIN - Dementia Pathway Work	Elderly care specialist nurse agreed, also EQ business case to be considered	Reduces In hospital mortality, LoS, Complications and 30 day mortality. Improves patient outcomes.	EQ- Performance Indicators finalised. Dr Hussein confirmed as clinical lead.Second draft of the Dementia data collection forms distributed for consultation. Need to identify who will be collecting data. National Dementia Audit results reported on and actions developed in response. Dementia Care Steering group now meeting monthly chaired by Jenny Kay. Dementia Awareness education programme under review. 104 staff through 1 day study day so far. Funding obtained for Dementia Buddy Scheme- aim to commence in October once funding released. New psych Liaison Model. Average LOS for the medical care of patients with Dementia has decreased from 27.8 days (April 2009-March 2010) down to 21.8 days (April 2010- March 2011). A reduction of 6 days.	Ward closures	£32.5k – already in income baseline - will be withdrawn if target not met
	Admission Avoidance from Care Homes		Reduces unnecessary admissions, frees up capacity, reduced risk of infection	Monthly meetings with local large nursing home provider discussing the use of community based resources before considering transfer to the emergency department. Reduction in admissions from 23 in Jan to Mar to 6 in May to July. Advanced care plans and care pathways for residential and nursing home use have been developed and implemented (led by Emma Hanson). Representatives from SECAMB, OOH teams, PCT, WKMHT,palliative care, community nurses and the homes themselves. GP attendance at some meetings. Individual cases timelined and costed if it is decided that other action would have been appropriate.	Ward closures	
	Cellulites Pathway			Increased the awareness within the hospital based MDT and CLT. No real impact as yet.		
	EQ – AMI Pathway	EQ business case to be agreed	Reduces In hospital mortality, LoS, Complications and 30 day mortality. Improves patient outcomes.	Pathway under review. Working on closer links with MINAP data collection system. Data collection and data entry dependent on one part time staff member.Needs to be above 96% and this should be achieved.	Ward closures	£97.5k – already in income baseline - will be withdrawn if target not met

Directorate	Details of Scheme	Investment	Benefits	Progress / Issues	Enables	Saving / Income
	EQ – Heart Failure Pathway and Readmission Rate	EQ business case to be agreed	Reduces In hospital mortality, LoS, Complications and 30 day mortality. Improves patient outcomes.	Can be difficult finding HF pts if not admitted to Chestnut, CQUIN specifically attached to reducing readmissions for 2011/112. Dependent on close working with Community HF team. Needs a 4% improvement on last year - currently RAG rated at Amber. Daily e-mail is now received with information on all patients admitted the previous day with diagnosis of HF. Achievements this year have dipped during the last month or so due to shortages in CCN staff. New staff have been recruited and Matron Cox is also seeing patients so situation should improve. Two CCNs also due back from Mat. Leave in October/November	Ward closures	£130k – already in income baseline - will be withdrawn if target not met
	EQ – Pneumonia Pathway	EQ business case to be agreed	Reduces In hospital mortality, LoS, Complications and 30 day mortality. Improves patient outcomes.	Large patient numbers, seasonal variation. One specialist nurse responsible for data collection. Specific CQUIN attached to reducing mortality in 2011/12. 1. Timely antibiotic initiation in consultation with A/E. 2. Sepsis trolley: improve the care of patients with sepsis (including pneumonis). The trolley contains antibiotics, blood culture bottles and other relevat items needed for management of patients with sepsis. This improves access and also helps to ensure better complaince with sepsis guidelines. Currently in use in CDU and it is hoped that we will have it in A/E once the building work is completed. 3. Sepsis management guidelines updated in collaboration with ITU team to bring our guidelines in line with "Surviving Sepsis campaign". 4. Smoking cessation advice: various strategies are being tried to improve our outcome and documentation. 5 Education of junior doctors re. guidelines for management of pneumonia/sepsis. 6. CURB 65 scores: education of juniors, audit (presented May 2011) which it is hoped will improve documentation/management.	Ward closures	£130k – already in income baseline - will be withdrawn if target not met
	EQ - Dementia Pathway		Acute trust is one part of Dementia pathway. Specifically, when pt admitted there must be a review of antipsychotic medications and reduction where possible.	Pathway launched with first data collection being July patients. Pts will be identified retrospectively through coding. Uncertain how many will be picked up. No person identified to manage data collection and entry.		£32.5k - already in income baseline - will be withdrawn if target not met

Directorate	Details of Scheme	Investment	Benefits	Progress / Issues	Enables	Saving / Income
	CQUIN - LOS Reductions		Frees up bed capacity	ECIST- A&E remains on target to meet quality indicator standards with downward trends in: time to initial assessment; median time to treatment; and the A&E 4 hour wait. The structural re-design work in the main Emergency Department is on target: Timeline for completion is 16 September. Criteria led discharge pathways for SSA are currently being developed and there are plans to replace the beds within SSA with reclining chairs to support target length of stay of 12 hours. The new model will be launched when SSA reopens in September.The Medical Model for CDU remains under review in light of recent changes to Consultant Cover. Senior decision making has been strengthened. Post for Acute Medical Physician advertised. Average of 88% patients have LOS less than 48 hrs on CDU. Ambulatory pathways are being reviewed and developed (Phase 1 by end of August).The mapping event was well attended- workstreams identified.. One Stop Elderly Care Rapid Access clinics are to launch on the 12 September in partnership with the Kent PCT. This project will also be supported by the newly developed Elderly Care Specialist Nurse post (Shortlisted). Aim to develop criteria led discharge for use particularly at weekends with an implementation target in September.The pilot of daily Consultant Board rounds and one-stop ward has been reviewed and is beginning to roll out to other wards. Morning daily multidisciplinary handovers are occurring on each of the medical wards in the mornings with twice daily handovers on CDU. All window beds within the Trust remain closed for past 8	Ward closures	
Cancer Services	Acute Oncology Service		Admission avoidance	Currently the service is flagging, supporting and seeing approximately 25/30 patients per week, organising day case proceedures and out patient appointments to prevent admissions, linking closely with the Specialist Palliative Care new 7 day service to ensure patients are in the most appropriate place of care and ensureing newly suspected Cancer patients are investigated and discussed at the appropriate site specific MDT in a timely manner.	Ward closures	As identified in admitting directorate plans, enables reduction in LOS and ward closures.

Directorate	Details of Scheme	Investment	Benefits	Progress / Issues	Enables	Saving / Income
Corporate Held	CQUIN - VTE Assessments		Reduced LOS	Focus on daycare will improve overall Trust rates 90% Achieved for August.	Ward closures	Already in income baseline - will be withdrawn if target not met
	CQUIN – Patient Surveys		Reduced complaints	Patients will already have been admitted for this years survey	Service improvement	Already in income baseline - will be withdrawn if target not met
	EQ – Development of Patient Experience Measures	EQ business case to be agreed	Reduced complaints	Trust represented at initial meeting and member nominated to be part of working group.	Service improvement	£32.5k – Already in income baseline - will be withdrawn if target not met
	EQ – Trust contribution and engagement to new or replacement pathway developments	EQ business case to be agreed	Better clinical outcomes for patients.	Acute Kidney Injury (AKI) pathway launches 12/10/11 with workshop to develop metrics. Trust has indentified Consultant to be Clinical Lead for pathway. Representatives will attend launch workshop. Pathway will require specialist nurse input – resources not identified at present.	Service improvement / reduced LOS	£65k – Already in income baseline - will be withdrawn if target not met
	EQ – Data Quality Assurance Audits		Improves quality and completeness of data to enable payments.	EQ Programme includes annual, on-site, audit of data submitted to the independent informatics partner (previously Premier Inc now Clarity Informatics) for data accuracy and quality. Last audit was done April 2011.		£32.5k – Already in income baseline - will be withdrawn if target not met
	EQ - Successfully engage in shared learning opportunities	EQ business case to be agreed	Better clinical outcomes for patients.	Heart Failure and Pneumonia teams participated in Collaborative learning events. Orthopaedic Collaborative 22/09/11 – no participation from Orthopaedic doctors.	Service improvement / reduced LOS	£32.5k – Already in income baseline - will be withdrawn if target not met
	Psyciatry Liason Team to be based at DVH		Will enable early identfication of patients with mental health issues and enable reduced length of stay and admission avoidance.	Room allocated, IT and office supplies being sorted out.		Enabler for incresased through put

Directorate	Details of Scheme	Investment	Benefits	Progress / Issues	Enables	Saving / Income
Facilities	Dignity Gowns		Patient dignity	Completed - patient gowns now protect dignity.		
	Hand wipes supplied to wards with meals		Infection Control, CQC Standards	Completed - these are available on the wards	Patients to clean hands before meals, allows CQC standards to be met	
Governance	Infection Control Team - MRSA reduction	£65,000	Patient safety		Reduced LOS and cost savings	
	C-Diff Target - Prudent Antimicrobial Prescribing		Patient safety		Reduced LOS and cost savings	
HR	Ongoing monitoring of the recruitment service. 3 Rapid Improvement Workshops, using Lean Thinking techniques	£7,000	Reduction in recruitment timescales. Improves quality of service delivery to all users.	The focus on recruitment has been to reduce the over all timescales in the process. Over the last year the following reductions have been made: Duration from post closing on NHS Jobs to interview date: an average saving of 9 days Duration from interview pack returned to offer letter sent: an average of 11.1 days Duration for reference to be returned; an average of 20.7 days CRB's returned: an average of 21.66 days Duration from the date the conditional offer letter was sent to start date: average of 5.09 days	Service improvement. Quicker start dates for new candidates	Reduction in Bank and agency use
Nursing	Funding to full Establishment	£500,000	Continuity of care, improved quality and productivity	Posts now in funded establishments, (or once recruited to) (may need to check)	Reduction in bank and agency costs	
	Productive Ward		Efficiency gain of nursing time		Nurse Led Breakfast Service	£30k Identified in Facilities QIPP plan for last two wards
Pathology	Cell Path Voice Recognition / Electronic Authorisation of Results	£25,000	Supports turnaround times of reports. Cost avoidance of additional clerical staff to support increased Consultant base..	Existing establishment of clerical staff have been able to keep up with the pace of reports without delays or the need for additional hours. Electronic authorisation has realised the benefit of enabling reports to be released without delay which supports turnaround time of reports.	Service Improvement	Cost avoidance approx £13-15k.
	Management Information System		Improved SLR, live apportionment, prove sources of activity. Monitor trends and throughputs. Identfied Mortuary issues.		Correct apportionment on SLR. Improves data for commissioning negotiations.	Additional income of £300k over 3 years.

Directorate	Details of Scheme	Investment	Benefits	Progress / Issues	Enables	Saving / Income
	Staff not backfilled whilst working Pathology Alliance Programme		If funding released from SHA then would become an income QIPP		Prgression of Pathology rationalisation	Dependant upon funding - £60k
Radiology	Booking process redesign		Reduction in waits for patients, increased choice, enahnced perception of quality of service. Supports delivery of national and Trust targets including 6ww for diagnostic, cancer pathway and 18ww.	Post filled and initial work commenced June 2011. Obs/ Gynae area first to change as big problem with paper backlogs and delays. Booking for patients now onto CRIS Directly with paper diary now removed. More admin staff trained to book and support the area, roll out of training on going. Feedback from Maternity has been excellent. Waiting list pending booking is significantly reduced. Reduction in phone calls and complaints. Planned roll out to other modalities over next 6 months	Reduce hand offs and waits; increase patient choice; reduce cancellations	Reduction in admin costs identified in Directorate plan.
	Increase Sonographer WTE	£54,000	Reduced waits for non obstatric U/S. Improved access and quality of service for obstetrics U/S. Reduced risk of onward referral for alternative imaging. Better support for EPU and Gynae services.	Unable to recruit at last advert. Re advertising October 2011. Use of agency cover for EPU cost pressure in radiology as funds not released until substantive post filled	Improve access for Ultrasound patients.	Cost avoidance £30k in directorate plan. Enables W+C income generation from Bexley and West Kent
	Increase Consultant WTE and outsource reporting	£300,000	Improve service and safety; Reduce risk of delays in diagnosis and reduce LOS. Interventaional Radiology will be available in and out of hours on-site in line with national guidelines.	Reporting outsource to Medica for AE imaging has started in Sept 2011. Two Consultants due to start in October . Income from interventional work done in house will need to offset procedure costs. Risk of outsourcing patients will be reduced.	Enhanced AE pathway. Better support for referring teams and patients. Repatriation of internventioal procedures from Kent and London.	Possible LOS saving of @ £250k – would enable further ward closures or increase productivity
Service Development	E-Comms		Reduces legibility risks, reduces paper costs, improves timeliness of information	EDNs Sent Electronically since 2008, Radiology & Pathology Results already sent via eComms, Patient Text Msg Reminders, Plan to send OPD Correspondence by Mar 2012.	Faster communication with GP and part of EPR	

Directorate	Details of Scheme	Investment	Benefits	Progress / Issues	Enables	Saving / Income
	Order Communication		Reduces legibility risks, reduces duplication,	Acute OCM implemented for Radiology/Pathology/Physio/Transport.	Quicker discharge and improved pathways, staff reductions	Taken as part of last years QIPP from Pathology
	GP Order Comunications		Reduces legibility risks, reduces duplication,	GP Path Order Comms being Procured, Go Live Planned for Mar 2012. There is No current Trust Decision to extend to Radiology or other services.	Faster communication with GP and part of EPR	
	E-CAS Card		Reduces legibility risks, can be emailed to GPs, part of EPR	Being Developed, Planned for Go Live By Dec 2011		
	E-Discharge Summary		Reduces legibility risks, can be emailed to GPs, part of EPR	Inplace, Since 2006		
	Clinical Documentaiton		Reduces legibility risks, reduces manual input, part of EPR	Templates with Patient Demographics Available via PAS since 2008, Plan to Move Key Documents such as CAS Card, Elect Pre Operative Assesment into an electronic form by 31 Mar 2012	Improves productivity	
	SMS Text Appointment Reminders		Reduces DNA rates	Implemented – In place since 2009		
	OPD Prescribing		Reduces Cost Of Drugs, Controlls Prescribing Patterns inline with DH OPD Prescribvbing Guidance	Pharmacy Led Initiative, being delivered by extending the TTO function of trustNET to OPD with a single sign on via PAS. Pharnacy to create Clinic/Clinic Approved Drugs. Clinical Buy In via CAG & Medical Director and variousl OPD Clinicians. Plan to Go LKive by Mar 2012	Reduced Cost	
	Inpatient Referalls Portal		To provide a standard solution to manage the inter Team Inpatient Referallas and associated Comms	Solution Wire Frame Created, Requires Clinical Teams to Be identified and request templates created. Pilot Planned for PEG & Cardio Late 2011, with gradual roll out to wider teams through 2012	Improved Productivity, Patient Satisfaction,	
Surgical Specialties	EQ – Hips and Knees Pathway		Reduces In hospital mortality, LoS, Complications and 30 day mortality. Improves patient outcomes.	Large patient numbers. Elective with some trauma. Lack of consensus re post -op VTE prophylaxis. New protocal awaiting confirmaton from British Orhtopaedic Society,	Ward closures	£97.5k – Already in income baseline - will be withdrawn if target not met
	Enhanced Recovery Programme		Quicker discharges, better patient outcomes, reduced LOS	Commenced 18th July in Colorectal, other specialties being reviewed.	Ward closures	
	Expansion of Bridging Team		Quicker discharges, better patient outcomes, reduce infection, care closer to home	2 additional nurses recruited and started. New pathway agreed with Consultants.	Ward closures	
	80% same day POA		Improved patient pathways enabling delivery of 18ww target	As at end July at 65%. Change in management will further improvements.	18ww performance	

Directorate	Details of Scheme	Investment	Benefits	Progress / Issues	Enables	Saving / Income
	CEPOD Business Case	£198,000	Increaeased theatre capacity, better patient outcomes, improved theatre utilisation	Commenced 20th July, efficiences happening with regard clearance of CEPOD patients same day	18ww performance, ward closure	
	Theatre Utilisation and Improvements Project		Increases capacity, reduces cancellations, improves productivity, reduces costs, enables delivery of 18ww pathways	SAL introduced, theatre sessons start on time, introduction of weekly theatre slot review	Additional through put of work at minimal cost, reduces risk of penalties	Various - identified in Surgery QIPP plan
	Surgical Site Anti-sepsis	£32,000	Reduced risk of surgical infection, reduced LOS	Is now being used by General Surgeons	Ward Closure	
	Best Practice Pathways; Hernia, Breast, Lap Chole		Reduces LOS, Improves patient safety, additional income	Pathwya introduced for each area, Lap Chole currenly at 58%.	Ward closure	Identifed in Surgery QIPP plans Ward closure £492k Additional BPT income £78k
Therapies	Telephone Triage	£2k from SHA Quick Win Funding	Increase patient satisfaction; More effective triage service, ensuring acute patients are identified earlier; Patients are able to contact the department when convenient for them and start their rehabilitationor get answers to questions immediately on referral. Saves time when booking appointments as reception can fill last minute cancellations quicker and easier. Treatment can be tailored at a much earlier stage and decreased postal costs as patients are now given a Telephone Triage letter when they bring their referral into the department.	Waiting times have reduced from 17 to 12 weeks and continues to fall thus assisting with 18ww pathways. Additional software was required to reduce admin time for Phyio's.	Reduction in WL, better patient pathways, improved outcomes	
Women & Children	EPU Development	£600 from PCT Enablement Funds	Reduced length of stay and ensures women are seen in the place at the right time for treatement.	"Business case" developed and submitted to PCT - agreement in principal to proceed - all staffing in place and plans to open in Sept	Bed closures possible in the future, but mainly enables dedicated bay to prevent patients waiting and improve quality of care - may reduce LOS	In future will reduce overspend on Mulberry as currently unfunded.
	Reduce C Section Rates		Reduced length of stay	C/s rate is reducing slightly but problematic this month due to high risk caseload of women and numbers of women through unit	Increasing capacity for additional demand	£650k – identified in plan

Directorate	Details of Scheme	Investment	Benefits	Progress / Issues	Enables	Saving / Income
	1-2-1 Care in Labour		Quality care – reduced complaints	Dependent on recruitment of additional midwives - current ration = 1:40 which reduces 121 care women can receive	Compliance to CNST	See below
	CNST Risk Midwife	£45,000	Reduces risks in Obstetrics and assures Quality and safety	Post commences 5th august 2011	Reduced CNST payments 12/13	Circa £100k – for 2012-13
	Safeguarding Liaison Role		Quality and Safety of service	In post since Feb 2011 - ensures all children from A&E and UCC are screened for safeguarding issues		
	Nurse Led Infertility Clinic		Increases capacity for Nurse Practitioners in place of Consultants	In post and weekly clinic commenced	Reduction of New-Follow up ratio	Reduces risk of penalties / non pay
	Endometrial Cancer - Improvements in pathways		Local service provision	Dependent on recruitment of interventional radiologist with required skills - part of integration strategy with MFT	Income gains through Interventional Radiologist	Will be identified in Radiology once post recruited to
	Gynae Nurses Trained for U/S Scanning		Quality of service and one-stop service, enables EPU development.	EPU nurse completed training in USS in July - now doing required number of scans for competence - vital for the development of the EPU where women will be able to access one-stop service for scans and treatment	Frees up capacity in Radiology	
	Total Investment To Date	**£1,226,000**				

Dartford and Gravesham NHS
NHS Trust

UNAPPROVED

MINUTES OF THE AUDIT COMMITTEE HELD ON 13TH JANUARY 2012 AT DARENT VALLEY HOSPITAL

Present:	Penny McCulloch	Non Executive Director and Chairman of meeting	(PMC)
	Brian Bowes	Non Executive Director	(BB)
	Bernie Holloway	Non Executive Director	(BH)
In attendance:	Andy Brown	Director of Human Resources (for items 1-7 & 1-14)	(AB)
	Mick Bull	Director of Finance	(MB)
	Sara Cocklin	Corporate Development Assistant	(SC)
	Lee Gunner	Health & Safety Officer (for items 1-7 & 1-14)	(LG)
	Julie Hunt	Director of Operations (for item 1-13)	(JH)
	Kevin Rowan	Associate Director, Corporate Development (Trust Secretary)	(KR)
	Jenny Still	Assistant Finance Director	(JS)
	Janet Dawson	Partner, Pricewaterhouse Coopers LLP	(JD)
	Giles Parratt	Head of Internal Audit, South Coast Audit	(GP)
	Sarah Preston	Senior Associate, Pricewaterhouse Coopers LLP	(SP)

1-1 APOLOGIES FOR ABSENCE

Apologies were received from Karen Taylor (KT), Non Executive Director.

1-2 DECLARATIONS OF INTEREST

There were no declarations of interest.

1-3 MINUTES OF THE PREVIOUS MEETING HELD ON 11TH NOVEMBER 2011

The minutes of the meeting were agreed as an accurate record of the meeting, subject to following amendment:

- Item 11-11, page 5: Replace "…the expected reduction of 1.5% is now unlikely to be unachieved…" with "…the expected reduction of 1.5% is now unlikely to be achieved…"

The following matters were also discussed:

- Item 11-6. MB reported that he was still in discussion with JD regarding PWC's 2011/12 audit fee. PMC requested that MB inform the Committee of the fee once it was finalised.

  Action: Inform the Audit Committee of the 2011/12 external audit fee once finalised (Director of Finance, March 2012)

- Item 11-7. GP noted that Angela Eldridge had not yet met with the Chair of the Quality & Safety Committee regarding the findings of the Clinical Audit Effectiveness Internal Audit review.

  Action: Provide feedback on the outcome of the meeting between the SCA Audit Manager and the Chair of the Quality & Safety Committee (Head of Internal Audit, March 2012)

- Item 11-19. PMC queried whether it was possible to re-schedule the June 2012 Audit Committee / Trust Board meeting from the provisional dates of 6th or 8th June 2012. JS stated that the timescales were challenging and therefore it was unlikely that the date could be moved to the preceding week. PMC acknowledged this, but requested that further consideration be given to the possibility of re-scheduling.

  Action: Consider whether it is possible to reschedule the June 2012 Audit Committee / Trust Board meeting from the provisional dates of 6th or 8th June (Assistant Finance Director / Trust Secretary, January 2012 onwards)

1-4 OUTSTANDING ACTIONS FROM PREVIOUS MEETINGS

The actions log was noted.

BH referred to item 7-13/11-4, and requested to see a copy of the letter which Andy Brown (AB) proposed to send to staff that have exceeded sickness absence triggers. KR noted that AB would be attending today's meeting and he would ask him to bring copies for committee members to see.

BH asked MB for an update on action 9-23. MB stated that it was unlikely that there would be any income for PFI support for 2011/12, but it was possible such support would be obtained in 2012/13.

1-5 REVIEW OF AUDIT COMMITTEE'S COMPLIANCE WITH ITS TERMS OF REFERENCE

PMC referred to the circulated paper and highlighted that it had been identified that, strictly speaking, the committee was not fully compliant with its stated duty to receive "Reports and assurance from the Directorates and Managers on their systems of governance, risk management, together with indicators of their effectiveness". GP commented that he felt this duty was being met via the annual internal audit review of the Assurance Framework. KR stated that he did not regard such reviews as being covered within the duty as stated.

A discussion was held regarding the appropriateness of the Audit Committee receiving routine reports from Directorates. JD stated that some of PWC's PCT clients have introduced Directorate 'governance statements', which require each Directorate to submit evidence of assurance in particular areas of governance and risk. KR stated that he understood that Medway NHS Foundation Trust has introduced a similar approach, as a response to them being considered to be in breach of their terms of authorisation. KR explained that although Monitor may well approve of such an approach, this was a choice made by Medway, & should not be considered to be a model that required adoption by other Trusts. KR continued that he had previously worked at Trusts where a similar approach was in place in relation to compliance with the 'standards for better health', & although there were some benefits in the approach, careful thought needed to be given before introducing it at the Trust, as it would inevitably involve some duplication of the reports that Directorates were currently required to submit to the Quality & Safety Committee. BB added that the committee should be cautious in considering any new reporting processes at the present time, given the proposed integration with Medway NHS Foundation Trust, and the forthcoming need to align such processes. PMC acknowledged the point, but suggested that she, JD and KR explore the potential for Directorate reports on internal control and risk management to be submitted to the Audit Committee, and consider the matter further at a future Audit Committee. This was agreed.

Action: Explore the potential for Directorate reports on internal control and risk management to be submitted to the Audit Committee (Audit Committee Chairman / PwC Partner / Trust Secretary, January 2012 onwards)

PMC proposed that, in the meantime, the aforementioned duty be amended to state "Reports and assurance from the Directorates and Managers on their systems of governance, risk management, together with indicators of their effectiveness, should the committee consider it necessary". This was agreed.

It was also agreed to amend the penultimate paragraph under the 'other matters' section, to correct the grammatical error i.e. delete the word 'monitor'.

Action: Amend the Terms of Reference to reflect the agreements at the Audit Committee, and submit to the Trust Board for approval (Trust Secretary, January 2012)

KR referred to the query made by one of the Audit Committee members on the cover page of attachment 3, and stated that although the Audit Commission appoints the Trust's external auditors, the Trust, via its Audit Committee, could make representation to the Audit Commission regarding such appointment, if, for example, it was dissatisfied with the service provided. KR continued that given this, the text in first bullet point under the 'external audit' section was accurate.

1-6 COMPARISON OF TERMS OF REFERENCE WITH THE INTEGRATED AUDIT COMMITTEE OF MEDWAY NHS FOUNDATION TRUST

PMC referred to the circulated paper and stated that KR had undertaken a comparison between the Terms of Reference (ToR) of the Trust's Audit Committee and that of Medway NHS Foundation Trust's 'Integrated Audit Committee'. PMC said that she felt that the ToR were not dissimilar, and stated that she will share the findings of the comparison with her counterpart at Medway.

BB and BH queried the frequency of the 'Integrated Audit Committee', and in particular whether the committee actually meets as infrequently as the minimum number stated in its ToR. KR stated he was unsure of this, but would find out.

Action: Establish the actual frequency of meetings of the Integrated Audit Committee at Medway NHS Foundation Trust (Trust Secretary, January 2012 onwards)

PMC asked which committee oversees the Trust committee structure at Dartford and Gravesham NHS Trust. KR stated that no single committee oversaw this, but the Board oversees its own sub-committee structure, and then each Board sub-committee is free to establish its own sub-committees, to support the achievement of its ToR. KR continued that on occasion, a wider review is undertaken, and noted that such a review took place when the Clinical Governance & Risk Committee was changed into the Quality & Safety Committee.

It was noted that there were some differences between the ToR of the two committees, not least the consideration of clinical audit by Medway's committee, but it was agreed that no amendments should be made to the Audit Committee's ToR at this time.

PMC suggested that it would be beneficial to compare the forward programme, and the minutes, of the two committees. It was agreed that KR would obtain and circulate the forward programme and a set of minutes of Medway's Integrated Audit Committee.

Action: Obtain and circulate the forward programme and a set of minutes of Medway's Integrated Audit Committee (Trust Secretary, January 2012 onwards)

1-7 DETAILED SCRUTINY OF THE MANAGEMENT OF RISKS TO THE FOLLOWING OBJECTIVE:

4.8 (ENSURE THE TRUST DELIVERS ITS HEALTH AND SAFETY COMMITMENT BY COMPREHENSIVE COMPLETION OF RISK ASSESSMENT, USING THEM TO ENSURE SAFE WORKING PRACTICES, TRAINING STAFF TO WORK SAFELY, AND PROMOTING HEALTH AND SAFETY)

AB and LG joined the meeting. AB referred to the circulated paper and stated that since the previous report in September 2011, there had been some progress but not as much as hoped.

AB stated that since the September 2011 Audit Committee meeting there had been a full inspection by the Health and Safety Executive (HSE). AB added that a report had not yet been received but feedback had been provided by the HSE, as follows:

- In radiation protection, the Trust was amongst the top 25% of all Trusts for compliance;
- Good practice was noted in the management of sharps and needlestick injury;
- It was noted that progress on proactive health surveillance around staff using latex gloves had not advanced as expected since the HSE's previous visit to the Trust. An Improvement Notice will be issued to ensure that the Trust introduces the health surveillance scheme as planned.
- An Improvement Notice will also be issued for insufficient training of senior management, including the Executive Director responsible for health and safety.
- A further Improvement Notice will be issued in relation to the Trust's system for staff to be able to access competent health and safety advice. AB explained that the HSE's view was that the service provided under a Service Level Agreement (SLA) by Medway NHS Foundation Trust should be considered a consultancy, and therefore adhere to the Occupational Safety and Health Consultants Register. AB added that the HSE had acknowledged the peculiarity in this recommendation, in that that if the two Trusts integrate as planned, the same advisor would be working across both hospitals, and there would be no need to consider the Occupational Safety

and Health Consultants Register. AB continued that despite this, he has agreed a re-draft of the SLA, but was awaiting the final HSE report before signing.

BB commented that he felt that the Trust seemed to have tried to embed health & safety on several occasions during his time on the Board, without success, and asked what was stopping the Trust from achieving better results. AB replied that there had not been a concerted effort to embed health and safety since his time at the Trust, and although he accepted responsibility for that, he was now committed to address the issue. AB continued that the overall impression given by the HSE of their conclusion from their inspection was a Trust that was performing below average, but was not operating in an unsafe manner.

BH expressed concern at the issuing of 3 Improvement Notices and asked if this number was normal for such inspections. AB stated that he understood that the other 2 acute NHS Trusts in Kent had also received Improvement Notices following HSE inspections.

BB asked whether the HSE made any comment regarding the health and safety structure. AB stated that comment was made regarding the involvement of Trade Unions, but he was not expecting a specific recommendation from the HSE regarding this.

PMC added to BB's earlier point, and commented that the Trust seemed to be good at carrying out risk assessments but was less successful at following up with required action to manage the risk.

BH queried whether it was appropriate that the Director of Human Resources should be the lead for health and safety, as it implied that a corporate department would undertake all the required action. PMC acknowledged the point, but stated that at BT, the senior lead for health and safety was also the Director of Human Resources.

PMC also noted that the circulated paper listed the number of staff who had attended the risk assessment training, but did not indicate how many staff were expected to attend such training. AB stated that the intention was to train at least 1 member of each department, and therefore the coverage was currently approximately ¾ complete.

PMC asked whether health and safety was covered in the national NHS staff survey. AB stated that there were 2 questions: 1 concerning health and safety training received in the past 12 months, and 1 concerning injury sustained at work. AB continued that the Trust performed poorly on the training question, as it delivered its health and safety training every 2 years rather than annually, but stated that he did not recall the Trust being an outlier on the question about injuries.

PMC then referred back to item 7-13/11-4, and asked AB to circulate the letter he proposed to send to staff that have exceeded sickness absence triggers. AB tabled the draft letter. PMC commented that this appeared to be good flag for staff, but queried whether, as part of the same process, a check could be made with other local Trusts as to whether anyone in receipt of such a letter had been working at those Trusts whilst they were on sickness absence at this Trust. AB stated that he would liaise with the Local Counter Fraud Specialist (LCFS) to explore this.

Action: Liaise with the Local Counter Fraud Specialist to explore the possibility of introducing a check with other local Trusts as to whether anyone in receipt of a sickness 'trigger' letter had been working at those Trusts whilst on sickness absence at this Trust (Director of Human Resources, January 2012 onwards)

GP queried whether the letter would be more successful if it was issued from Directorates. AB stated that it was considered to be more practical to be issued by Human Resources. BH questioned whether the principle of having trigger points per se was correct, as it was possible that unscrupulous staff would deliberately ensure their sickness absence was below the stated levels and therefore avoid being detected. AB acknowledged the point, but stated that the fact was that such trigger points did exist in the Trust's existing policy.

PMC proposed that AB submit some analysis of the impact of the letter to the Audit Committee meeting in May 2012. This was agreed.

Action: Arrange for the May 2012 Audit Committee to receive analysis of the impact of the sickness absence 'trigger' letter (Director of Human Resources / Trust Secretary, May 2012)

1-8 WAIVER OF TENDERING PROCEDURES

MB referred to the circulated paper and stated that there was more work to be done regarding the waiver of tendering procedures. MB elaborated that there was a need to educate staff in the Trust's tendering process and acknowledged that the Procurement department had not been very proactive in the past. MB stated he intended to present a procurement governance paper to the March Audit Committee.

MB continued that a company, Leaseguard Ltd, had been engaged to review tendering and securing better value, which included the consolidation of contracts, and the identification of alternate suppliers. MB also noted that it was intended to synchronise the start date of all the Trust's maintenance contracts to 1st April, to enable improved management and review of such contracts, by it being apparent clear when contracts were due to expire / be renewed.

1-9 TO RECEIVE AN UPDATE FROM THE EXTERNAL AUDITORS

JD referred to the paper circulated which included an update concerning the independence and compliance with regulatory and professional bodies, which was requested at the November Audit Committee.

PMC queried PWC's suggestion of £150,000 as a level of "triviality" for the 2011/12 accounts and asked how many unadjusted misstatements were identified during the 2010/11 audit. JD confirmed that there were no such issues identified. It was therefore agreed that the level of "triviality" for the 2011/12 accounts should remain at the level set for 2010/11 i.e. £50,000.

1-10 TO RECEIVE A PROGRESS REPORT ON THE CURRENT PLAN FROM INTERNAL AUDIT

GP referred to the circulated paper, and highlighted the following points:

- The report contained a proposal for the actions to be taken following the review / survey of internal audit. The committee approved the proposed action points as circulated.
- The report contained a commentary on compliance with NHS Internal Audit standards, which was requested at the November Audit Committee.
- The report contained the Internal Audit reporting protocol, which was due an annual review. No changes were proposed. The committee approved the protocol as circulated.
- An initial Internal Audit plan for 2012/13 was presented, for discussion and comment

BH asked what the status of the 2012/13 plan, & noted that the plan included a significant increase in days compared to the 2011/12 plan. MB noted further refinement was required.

BH asked what the 'standards of business conduct' review would achieve. GP explained that the intention was to compare what was in place at the Trust with practices that were successful at other Trusts, to test whether the Trust's processes were robust.

PMC referred to the 'Operating Framework' review, and noted that some text was missing from the circulated document. GP acknowledged that it appeared as if some of the cells in the spreadsheet had been hidden. PMC requested that an electronic copy of the plan be circulated, to enable Audit Committee members to see the missing text.

Action: Circulate an electronic copy of the initial Internal Audit plan for 2012/13 (Trust Secretary, January 2012)

PMC referred to the 10 days that had been allocated to 'contingency', and proposed that this be removed or allocated to reviews i.e. to not allocate any days to 'contingency'. PMC explained that if it was felt than an unplanned review was required in-year, the Audit Committee could judge which

of the planned reviews could be deferred or dropped, to enable the unplanned review to be undertaken. This was agreed.

Action: Remove the 10 days for 'contingency' from the initial Internal Audit plan for 2012/13 (Head of Internal Audit, January 2012 onwards)

PMC also proposed that the plan be divided into the following:

- reviews that should be undertaken before the proposed integration with Medway NHS Foundation Trust (or be undertaken only if the proposed integration does not proceed); and
- reviews that should be undertaken only if the proposed integration with Medway NHS Foundation Trust proceeds;

This was agreed. It was also agreed to re-circulate the 2012/13 plan to Audit Committee members once this exercise had been completed.

Action: Divide the initial Internal Audit plan for 2012/13 into the categories agreed by the Audit Committee, and circulate to Audit Committee members (Head of Internal Audit, January 2012 onwards)

1-11 TO RECEIVE A COUNTER FRAUD UPDATE

The circulated update was noted. No questions were received. PMC asked GP to pass on the Committee's thanks to Steffan Wilkinson.

1-12 REGISTER OF EXTERNAL ASSESSMENTS UPDATE

KR referred to the circulated paper and highlighted the following:

- The CNST Risk Management Standards (Maternity) Level 2 assessment had taken place in December 2011. The Trust did not achieve the score required to achieve Level 2, but did score enough to retain Level 1.
- The General Pharmaceutical Council premises inspection had taken place the previous day. The inspection had a positive outcome. KR stated that he had been advised that some minor amendments to Standing Operating Procedures (SOPs) were required, but no significant concerns had been identified.
- The Patient Environmental Action Team (PEAT) inspection would take place on 23rd February and for the first time there was a requirement to have an external validator as part of the inspection team.

PMC asked whether it was possible to add a rating of the severity/impact of each assessment to future reports. KR stated that this had been discussed at the November Audit Committee, and it was noted that this would essentially be a judgement, but agreed to add such a rating.

Action: Add a rating of the severity/impact of each assessment to future 'external assessment' reports to the Audit Committee (Trust Secretary, March 2012)

1-13 DETAILED SCRUTINY OF THE MANAGEMENT OF RISKS TO THE FOLLOWING OBJECTIVE:

- **1.1 (TO DEVELOP AND IMPROVE CARE PATHWAYS FOR PATIENTS ATTENDING THE EMERGENCY DEPARTMENT, GIVING FASTER ACCESS TO DIAGNOSTIC INVESTIGATIONS IN THE MANAGEMENT OF EMERGENCY ADMISSIONS)**

JH joined the meeting, referred to the circulated paper and highlighted the following:

- The recommendations of the ECIST team were being implemented and the Board had been updated regularly. The final report would be reported to the January Trust Board.
- The A&E target of 95% had consistently been met since April 2011, but had been a challenge to meet at the end of 2011 due to a very busy department and the building works.
- Phase 4 of the A&E building work commences w/c 16th January.
- Staffing has been increased to reduce the levels of locum doctors. The last middle grade doctors had now started so the department is now fully staffed.

PMC commented that she was aware that there had been efforts via local radio to direct the public to the most appropriate health services, and asked whether this campaign had any impact on

activity seen by the Trust. JH stated that there had been no impact, as a more important factor was the reduction in acute beds across Kent, which included the reduced number of beds at the new Tunbridge Wells hospital, the closures at Queen Mary's, Sidcup, and reductions in beds at Darent Valley Hospital itself.

1-14 TO DETERMINE WHETHER FURTHER SCRUTINY OF HEALTH AND SAFETY IS REQUIRED AT THE AUDIT COMMITTEE (AND IF NOT, WHETHER A NED LEAD FOR HEALTH AND SAFETY IS REQUIRED)

KR explained that item was linked to item 1-7, and reminded that committee members that in 2011, the Board became concerned at the overall situation regarding health and safety management at the Trust, which culminated in the Board receiving monthly update reports from AB. KR continued that when the Board agreed it was not concerned enough to continue to have monthly updates, it asked the Audit Committee to seek the necessary assurances, and to determine the point at which detailed scrutiny could/should cease. KR noted that the method the Audit Committee chose to do this was to propose that a new annual sub-objective, related to health and safety, be agreed, which could then be part of the BAF, and be included in the established BAF scrutiny process at the Audit Committee.

KR added that a new objective was duly agreed (objective 4.8), and the September 2011 Audit Committee meeting received an overview presentation from AB and LG, and agreed that further scrutiny, of the new BAF objective, would take place at the January 2012 Audit Committee, with a decision made at the same meeting as to whether further scrutiny was required, & whether a named NED lead for health and safety was required.

PMC proposed, on the basis of information received at the meeting, that the Audit Committee review progress against objective 4.8 at its March 2012 meeting. This was agreed.

Action: Arrange for the Audit Committee to review progress against objective 4.8 at the March 2012 meeting (Trust Secretary, January 2012 onwards)

The following agreements were also made:

- There was no need to identify a NED lead for health and safety;
- The final report of the HSE inspection, plus the action plan produced in response, should be circulated to Audit Committee members, when available

  Action: Circulate the final report of the HSE inspection, plus the action plan produced in response, to Audit Committee members, when available (Director of Human Resources / Trust Secretary, January 2012 onwards)

- The general issue of concern regarding following-up risk assessments (raised under item 1-7) should be highlighted at the Trust Board

  Action: Highlight the general issue of concern regarding following-up risk assessments at the Trust Board (Audit Committee Chairman, January 2012)

1-15 REVIEW OF THE BOARD ASSURANCE FRAMEWORK

KR referred to the circulated paper and highlighted that the November 2011 Trust Board approved a revised Risk Management Strategy, which removed the previously-stated requirement for the 'principal risks' listed on the BAF to be subject to detailed risk assessment.

KR also highlighted that the new text inserted under the 'gaps in assurance' column for objectives 2.1 - 2.4 should actually be under the 'gaps in control' column.

A discussion was held regarding the level of risk assessment that should be applied to risks listed on the BAF, and it was agreed that no changes should be made to the format of the 2011/12 BAF, but consideration should be given regarding format changes for the 2012/13 BAF.

PMC referred to objective 3.2, and asked why the ratings had deteriorated so markedly from those given for the year to date. KR explained that the Director of Operations had requested that the objective be made more specific to Bexley re-ablement funds. PMC noted this, but stated that in

order to enable proper assessment of the changing situation, the objective should have been left as worded, with an additional objective included in relation to Bexley. KR acknowledged the point.

1-16 TO CONFIRM WHICH OBJECTIVES FROM THE BAF WILL BE SUBJECT TO DETAILED SCRUTINY AT THE MARCH 2012 AUDIT COMMITTEE

It was agreed that the following objectives should be scrutinised that the March Audit Committee:

- 1.2c – Achieve zero avoidable fractures related to fall in hospital; and
- 5.5 – Demonstrate a reduction in emergency readmissions from 2010/11 levels

Action: Arrange for the March 2012 Audit Committee to scrutinise objectives 1.2c and 5.5 (Trust Secretary, January 2012 onwards)

1-17 REVIEW OF THE HIGHEST RISKS FROM THE CORPORATE RISK REGISTER

PMC referred to the circulated paper and proposed that it would be beneficial for future reports to include the guidance that accompanies the 5x5 risk matrix, to enable better understanding of the risk ratings applied to the risks. This was agreed.

Action: Arrange for the guidance that accompanies the 5x5 risk matrix to be included in future 'highest risks' reports to the Audit Committee (Trust Secretary, March 2012)

PMC commented that the general theme that emerged from reading the circulated report was a lack of updates. PMC also referred to the comments made by the Chair of the Quality & Safety Committee in its meeting of 15th December that 'never events' should be included in the Risk Register, and queried how this could be achieved. KR explained that each 'never event' had a series of controls that would be expected to be in place to prevent their occurrence, so there could be a specific risk assessment undertaken for the occurrence of each of the 20 or so relevant 'never events', which could then lead to an overall risk assessment for such events. BB noted that he would be chairing the next Quality & Safety Committee, and agreed to request that assessments to be undertaken against the controls expected to be in place for each of the 20 or so relevant 'never events', with the outcome to be received at the Quality & Safety Committee.

Action: Ask that assessments be undertaken against the controls expected to be in place for each of the 20 or so relevant 'never events', to be received at the Quality & Safety Committee (Chair of the Quality & Safety Committee, January 2012)

The following risks were discussed:

- 1086 (2nd ODP not available on site out of hours). BH commented that the level of urgency that has been applied to the management of the risk did not accord with the language used in the risk description. BH also commented that the 'actions underway' did not have any deadlines listed, against which progress could be tracked. PMC noted that the latest entry, in December 2011, referred to a meeting to be organised to discuss the risk, but it was not apparent that such a meeting had been held. It was agreed that BB would escalate concerns regarding the management of risk 1086 to the Quality & Safety Committee.

  Action: Escalate concerns regarding the management of risk 1086 to the Quality & Safety Committee (Chair of the Quality & Safety Committee, January 2012)

- 1095 (midwife to birth ratio). PMC commented that she would have expected the risk of maternal and/or neonatal death to be listed among the risk description.

  Action: Feedback the Audit Committee's comments on potential omissions from the 'risk description' for risk 1095 (Trust Secretary, January 2012)

- 1096 (capacity to safely deliver an increasing number of women). PMC referred to the comment under 'actions underway' to increase home birth options and queried how this would assist in managing the risk. KR stated that he understood that the Trust's community midwives would not ordinarily support in-hospital births, but he would clarify.

  Action: Clarify how increasing home birth options will assist in managing risk 1096 (Trust Secretary, January 2012)

1-18 MINUTES OF THE QUALITY AND SAFETY COMMITTEE MEETING OF 15TH DECEMBER 2011

The minutes were noted.

1-19 MINUTES OF THE QUALITY AND SAFETY COMMITTEE MEETING OF 17TH NOVEMBER 2011

The minutes were noted.

1-20 MINUTES OF THE FINANCE COMMITTEE MEETING OF 20TH DECEMBER 2011

BH referred to the circulated paper and highlighted that the main risk concerns income. MB concurred, and added that the lack of financial flexibility in the health economy was threatening the PCT's ability to pay the Trust for its activity. MB also highlighted that the PCT are maintaining their ambitious assumptions regarding demand management.

1-21 MINUTES OF THE FINANCE COMMITTEE MEETING OF 22ND NOVEMBER 2011

The minutes were noted.

1-22 MINUTES OF THE FINANCE COMMITTEE MEETING OF 25TH OCTOBER 2011

The minutes were noted.

1-23 APPOINTMENT OF EXTERNAL AUDITOR

The circulated paper was noted.

PMC highlighted the issue of MB's impending departure. MB explained that he was scheduled to leave the Trust on 31st March 2012, but there was an arrangement with his new employer for him to return to the Trust to ensure the 2011/12 accounts were complete. MB elaborated that the formal agreement was for him to return for 5 days, but this could be extended if necessary.

PMC asked who would sign the 2011/12 accounts. MB clarified that it would need to be the Trust's incoming Director of Finance. PMC asked JD whether she had any concerns regarding this situation. JD stated that she was concerned regarding the level of continuity, and the personal risk being accepted by the incoming Director of Finance. KR stated that it should be recalled that a precedent had been set at the Trust for the 2008/9 accounts, as the Director of Finance had left in April 2009, with his replacement starting that month. KR continued that although the accounts were signed by the new Director of Finance, the previous Director of Finance had presented the accounts to the Audit Committee. PMC proposed that a similar approach be adopted. This was agreed.

Action: Ensure the existing Director of Finance attends and presents the 2011/12 accounts at the joint Audit Committee / Trust Board meeting that will approve the accounts (Director of Finance / Trust Secretary, January 2012 onwards)

1-24 QUALITY ACCOUNTS 2010/11: FINDINGS FROM AUDITORS' WORK AT NHS TRUSTS & FOUNDATION TRUSTS (AUDIT COMMISSION REPORT)

The circulated report was noted. KR stated that he had provided those responsible for the production of the Trust's Quality Account with a copy of the report.

1-25 AUDIT COMMITTEE FORWARD PROGRAMME OF AGENDA ITEMS

The forward programme of agenda items was noted.

1-26 ANY OTHER BUSINESS

There was no other business.

Audit Committee – Forward programme of agenda items

Heading	16th March 2012	18th May 2012	6th or 8th June 2012 (TBC)	13th July 2012	14th September 2012	16th November 2012	January 2013
Statutory financial reporting		▪ Draft Annual Report & Accounts 2011/12, including SIC (Chief Executive to attend) ▪ Accounting policies for 2011/12 accounts ▪ Update on 2012/13 financial plan	▪ Endorsement of Annual Accounts 2011/12				
Statements & disclosures	▪ Draft Annual Plan 2012/13 financial statements ▪ Waiver of tendering procedures	▪ Losses and compensations (annual data) ▪ Waiver of tendering procedures	▪ Endorsement of Statement on Internal Control 2011/12 (within Annual Accounts)	▪ Waiver of tendering procedures	▪ Waiver of tendering procedures	▪ Waiver of tendering procedures	▪ Waiver of tendering procedures
Compliance issues	▪ Register of external assessments update	▪ Register of external assessments update		▪ Register of external assessments update ▪ Annual report on compliance with Policy and procedure for the management of external assessments and inspections	▪ Register of external assessments update	▪ Register of external assessments update	▪ Register of external assessments update
Board Assurance Framework / Corporate risks review	▪ Scrutiny of the management of risks to selected objectives from the BAF: o 1.2c (Achieve zero avoidable fractures related to fall in hospital) o 5.5 (Demonstrate a reduction in emergency readmissions from 2010/11 levels) ▪ Review of progress against objective 4.8 (ensure the trust delivers its health and safety commitment…) ▪ Board Assurance Framework review ▪ Review of highest risks from Corporate Risk Register	▪ Board Assurance Framework review (to include selection of item for scrutiny at next meeting) ▪ Review of highest risks from Corporate Risk Register ▪ Consideration of methods of scrutiny of BAF for the year ahead ▪ Review of Trust objectives for 2011/12		▪ Scrutiny of the management of risks to selected objectives from the BAF ▪ Board Assurance Framework review (to include selection of item for scrutiny at next meeting) ▪ Review of highest risks from Corporate Risk Register	▪ Scrutiny of the management of risks to selected objectives from the BAF ▪ Board Assurance Framework review (to include selection of item for scrutiny at next meeting) ▪ Review of highest risks from Corporate Risk Register	▪ Scrutiny of the management of risks to selected objectives from the BAF ▪ Board Assurance Framework review (to include selection of item for scrutiny at next meeting) ▪ Review of highest risks from Corporate Risk Register	▪ Scrutiny of the management of risks to selected objectives from the BAF ▪ Board Assurance Framework review (to include selection of item for scrutiny at next meeting) ▪ Review of highest risks from Corporate Risk Register
Internal Audit (general)	▪ Progress report ▪ To approve final Internal Audit Plan 2012/13 (Chief Executive to attend)	▪ To consider draft Head of Internal Audit Opinion ▪ Progress report	▪ Internal Audit Annual Report 2011/12 (including final Head of Internal Audit Opinion)	▪ Progress report ▪ Quarterly review of Internal Audit Plan 2011/12	▪ Progress report ▪ Outcome of review/survey of internal audit service	▪ Progress report ▪ Response to review/survey of internal audit service 2011 ▪ Quarterly review of Internal Audit Plan 2011/12	▪ Progress report ▪ Annual review of internal audit reporting protocol
Internal Audit (reviews) [1]	▪	▪		▪	▪	▪	▪
External Audit	▪ Update on activity	▪ Update on activity	▪ International Standard on Auditing (ISA) 260 report ▪ Opinion on financial statements and audit certificate 2011/12	▪ Update on activity ▪ Audit of Quality Account 2011/12 (Director of Nursing to attend)	▪ Update on activity ▪ Annual Audit Letter 2011/12	▪ Update on activity ▪ Agree External Audit Plan and fees or 2012/13	▪ Update on activity
Counter fraud	▪ Counter fraud update (written report without LCFS attendance)	▪ To receive draft Annual Report 2011/12 ▪ Formal approval of Annual Plan 2012/13 (LCFS to attend)		▪ Counter fraud update (written report without LCFS attendance)	▪ Counter fraud update (written report without LCFS attendance)	▪ Mid-year progress report (LCFS to attend)	▪ Counter fraud update (written report without LCFS attendance)
Clinical items	▪ Quality & Safety Committee - minutes of previous meetings	▪ Quality & Safety Committee - minutes of previous meetings ▪ Annual report from Quality Laboratory ▪ Review of Quality Account 2011/12 (Director of Nursing to attend)		▪ Quality & Safety Committee - minutes of previous meetings	▪ Quality & Safety Committee - minutes of previous meetings	▪ Quality & Safety Committee - minutes of previous meetings	▪ Quality & Safety Committee - minutes of previous meetings
Finance Committee	▪ Minutes of previous meetings	▪ Minutes of previous meetings		▪ Minutes of previous meetings	▪ Minutes of previous meetings	▪ Minutes of previous meetings	▪ Minutes of previous meetings
For endorsement	▪ Review of Standing Financial	▪ Audit Committee Annual Report		▪ Review of Audit Committee	▪ Review of Standing Financial		

[1] Internal audit reviews are primarily reported via a summary report from Internal Audit

Heading	16th March 2012	18th May 2012	6th or 8th June 2012 (TBC)	13th July 2012	14th September 2012	16th November 2012	January 2013
	Instructions	2011/12		Terms of Reference	Instructions ▪ Review of Scheme of Matters Reserved for the Board and Scheme of Delegation ▪ Review of Standing Orders		
Other items	▪ Audit Commission's Payment by Results audit 2011/12 (Director of Performance and Business Intelligence to attend)	▪ Analysis of the impact of the sickness absence 'trigger' letter (Director of HR to attend)	▪	▪	▪ The Audit Commission's report 'NHS Financial Year 2011/12: A summary of auditors' work' ▪ Away day (to include self-assessment, via discussion, and review of compliance with its Terms of Reference) – to take place after the main Audit Committee meeting		▪
For information	▪ Forward planner	▪ Forward planner	▪ Forward planner	▪ Forward planner	▪ Forward planner	▪ Forward planner	▪ Forward planner

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TRUST BOARD MEETING – JANUARY 2012

Item 1-9.2. Attachment 17 - ToR for Audit Committee

1-9.2	TO APPROVE UPDATED TERMS OF REFERENCE FOR THE AUDIT COMMITTEE	COMMITTEE CHAIR (NON-EXECUTIVE DIRECTOR)

At its meeting in January 2012, the Audit Committee reviewed its compliance with its Terms of Reference, and considered whether any amendments to the Terms of Reference were required.

Two minor amendments were agreed.

The revised Terms of Reference are presented for Board approval, in accordance with the Trust's Standing Orders (9.1.2 and 9.4.1).

Proposed additions are highlighted in yellow on the pages below. Proposed deletions are indicated via ~~strikethrough~~.

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Approval of revised Terms of Reference for the Partnership Board

Equality Impact Assessment initial screening applicable to this report? No

This report provides information on the following annual objectives (delete as required)**:**

- To maintain the highest standards of cleanliness and reduce healthcare associated infections, maintaining a zero tolerance approach to infections acquired within Darent Valley Hospital;
- To deliver the objectives set out in the Financial Plan for 2011/12, including the delivery of a Quality, Innovation, Productivity and Prevention (QIPP) programme that develops patient pathways which provides care closer to patients' homes, and improves the efficiency of the services the Trust provides, thereby saving resources and releasing capacity

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors understanding of the Trust & its performance

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AUDIT COMMITTEE – TERMS OF REFERENCE

CONSTITUTION

The Trust Board has established an Audit Committee to provide assurance to the Board in relation to a) the effectiveness of controls to minimise or mitigate the principal risks to the Trust and b) its regulatory compliance obligations.

MEMBERSHIP

The committee will be comprised of no fewer than four independent Non-Executive Directors, one of whom should have recent and relevant financial experience.

One member shall be elected as Deputy Chair of the committee.

QUORUM

At least three members of the committee, one of whom must be Chair or Deputy Chair should be present to provide a quorum.

ATTENDANCE

All attendees to the committee do so at the invitation of the committee. However, the Director of Finance or deputy, Internal audit, External audit and NHS Counter Fraud representatives should attend the committee regularly.

The Chairman, Chief Executive, and other Executive Directors or Managers may be invited to attend at the request of the committee, particularly when the Committee is discussing areas of risk or operation that is the responsibility of that Director / manager.

The Head of Internal Audit and representatives of External Audit should attend the committee without Trust staff or other Trust Board members being present at least annually.

The Chief Executive should be invited to attend at least annually to discuss the process for assurance that supports the Statement of Internal Control. The Chief Executive should also attend when the committee considers the draft internal audit plan and the annual accounts.

The minutes will be taken by the Trust Secretary (Associate Director, Corporate Development).

MEETINGS

The Audit Committee will meet no fewer than five times a year. The times and dates of meetings will be set prior to the end of the preceding year, although additional meetings may be convened by the committee chairman at his or her discretion. The External Auditor or Head of Internal Audit may request additional meetings as they consider necessary.

Members are expected to attend all meetings, but required to attend at least three meetings per year.

AUTHORITY, ACCOUNTABILITY AND RESPONSIBILITY

The Audit Committee is a sub-committee of the Board, and has no executive powers other than those specifically delegated within these Terms of Reference.

The Audit Committee is authorised by the Board to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the committee. The Committee is authorised by the Board to obtain external legal or other professional advice and/or to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The minutes of the Audit Committee shall be formally recorded and submitted to the Trust Board.

The Chairman of the Committee shall draw to the attention of the Board any issues of significance to the Trust.

The Committee will formally report to the Trust Board annually on its work, including, inter alia, in support of the Statement of Internal Control, Board Assurance Framework, risk management processes, and governance arrangements.

MAIN DUTIES

GOVERNANCE, RISK MANAGEMENT AND INTERNAL CONTROL

The Committee shall review the adequacy and effectiveness of the following (and challenge where necessary):

- The strategic processes for an effective system of governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) in support of the achievement of the Trust's objectives.
- The effectiveness of controls in place to minimise or mitigate the principal risks to the Trust
- The underlying assurance processes (as set out in the Assurance Framework) that indicate the degree of achievement against the strategic objectives
- All disclosure statements (in particular the Statement of Internal Control and Annual Report) together with any accompanying Head of Internal Audit statement, external audit opinion or other independent assurances, prior to acceptance or approval by the Board.
- Policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.
- Reports and assurances from the Directorates and Managers on their systems of governance, risk management, together with indicators of their effectiveness, should the committee consider it necessary.
- All relevant external assessments that may be either published or arise in the course of an inspection from external organisations, as set out in the Trust's register of external assessments.
- The activity related to fraud and corruption as set out in Secretary of State Directions and as required by the local NHS Counter Fraud and Security Management Service
- The Audit Committee will provide minutes of each meeting to the Trust Board.

INTERNAL AUDIT

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit standards and provides independent assurance to the Audit Committee, Chief Executive and Trust Board. This will be achieved by:

- Consideration of the provision of the internal audit service, costs of the audit and any questions of resignation and dismissal.
- Review and approval of the internal audit programme of work ensuring that it is consistent with the Trust's needs, identified through the Board Assurance Framework.
- Consideration of the major findings and management response to issues identified by audit activity, ensuring coordination between the internal and external auditors to optimise resources.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust
- An annual review of the effectiveness of internal audit

EXTERNAL AUDIT

The Committee shall review the work and findings of the External Auditors and consider the implications and management responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
- Discussion and agreement with the External Auditors, before the audit commences, of the nature and scope of the audit as set out in the Annual Audit Plan, ensuring coordination with other External Auditors in the local health economy
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review of all External Audit reports including the 'report to those charged with governance', agreement of the annual audit letter, prior to submission to the Board including the appropriateness of the management responses and any work carried outside of the audit plan.

FINANCIAL REPORTING

The Committee shall review the Annual Report and Financial Statements prior to submission to the Board, focusing particularly on:

- Changes in, and compliance with, accounting policies, practices, and estimation techniques,
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Letter of representation
- The wording in the Statement on Internal Control and other disclosures relevant to the Terms of Reference of the Committee.

AGENDA ITEMS

The Committee will be supported by an agreed timetable of Agenda items which will reflect the Annual Business cycle. All other agenda items must be submitted to the Trust Secretary at least 10 days prior to the meeting.

SUB COMMITTEES or SPECIALIST REPORTS TO THE AUDIT COMMITTEE

The Audit Committee has no sub-committees, but the Trust Quality & Safety Committee will submit its minutes to every meeting of the Audit Committee. In addition the Finance Committee will share all minutes and other significant items as necessary.

OTHER MATTERS

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

The Committee will ~~monitor~~ complete an Audit Committee annual report, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the Trust, and the robustness of the processes behind the Quality Accounts. The Committee's annual report will be submitted to the Trust Board (in accordance with the NHS Audit Committee Handbook).

The Committee will also undertake an annual self-assessment (in accordance with the NHS Audit Committee Handbook).

REVIEW OF TERMS OF REFERENCE

The Committee will review its Terms of Reference annually.

REVISION HISTORY

Revised July 2006
Approved by Audit Committee February 2007
Revised April 2007
Revised September 2007
Revised September 2008
Approved Audit Committee and Trust Board September 2008
Revised July 2009 (Audit Committee) and August 2009 (Trust Board)
Revised May 2010 (Trust Board)
Revised July 2010 (Audit Committee) and July 2010 (Trust Board)
Revised July 2011 (Audit Committee) and July 2011 (Trust Board)
Revised January 2012 (Audit Committee) and January 2012 (Trust Board)

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TRUST BOARD MEETING – JANUARY 2012

1-9.3 RECEIPT OF THE HOSPITAL COMPANY'S STATEMENT OF COMPLIANCE RE LEGAL RESPONSIBILITIES — CHIEF EXECUTIVE

The first annual statement of compliance from The Hospital Company was received at the Trust Board in October 2009. An updated version was received in November 2010.

The statement is overseen and scrutinised by the Partnership Board, and a further updated version of the statement was received at the Partnership Board on 30th November 2011.

It was agreed at the Partnership Board that further work was required on the statement in relation to health and safety responsibilities, and The Hospital Company's advisor was asked to meet with the Trust's Executive lead for health and safety (the Director of Human Resources). It was also requested that the qualifications of the responsible person for each area be added to the statement, and that a date of review be included, to ensure that compliance does not expire.

The statement is intended to be used as a tool to enable the in-year monitoring of risks, and an updated version is intended to be received at the April 2012 Partnership Board meeting.

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

Equality Impact Assessment initial screening applicable to this report? No

This report provides information on the following annual objectives (delete as required)**:**

- To maintain the highest standards of cleanliness and reduce healthcare associated infections, maintaining a zero tolerance approach to infections acquired within Darent Valley Hospital;
- To deliver the objectives set out in the Financial Plan for 2011/12, including the delivery of a Quality, Innovation, Productivity and Prevention (QIPP) programme that develops patient pathways which provides care closer to patients' homes, and improves the efficiency of the services the Trust provides, thereby saving resources and releasing capacity

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors understanding of the Trust & its performance

Darent Valley Hospital – Annual Compliance Assurance Statement Nov 2011

1.0 Context:

The Trust has requested an annual statement of compliance from the Hospital Company to provide assurance to the Trust Board that all Estates related legislative requirements are being met in accordance with the provisions of the Concession Agreement.

2.0 THC's obligations:

These are outlined in Schedule 21 of the Concession Agreement (Service Level Specifications) chiefly in Clause 12 of the Estates and Maintenance section. These requirements are passed on to FMCo via the FM subcontract.

2.1 General Responsibilities –

The Estates & Maintenance SLS (in para 2.2) contains an overarching clause which provides that:

…in addition to the service(s) set out (in the service specification) ConcessionCo shall comply with all provisions of the Legal Requirements relevant to the service.

"Legal Requirement"	means any law, regulation, bye-law, directive, statute, statutory instrument, or other legislative measure having the force of law, and any request, requirement, guideline, recommendation or instruction of any competent person (including, without limitation, the Department of Health, the National Health Service Executive or equivalent body or NHS Estates or equivalent body) whether or not having the force of law but, if not having the force of law, the compliance with which is in accordance with the general practice of persons to whom the request,

2.2 Specific Responsibilities –

The E&M SLS details specific responsibilities for the Estates and Maintenance service under 10 subheadings:

Service	Para	Scope
Landscaping	5	Grounds and Gardens
Infrastructure	6	Water, electricity and gas (all test certificates and records to be updated and available for inspection)
External fabric	7	All external parts of buildings to be maintained and safe.
Internal fabric	8	All internal building elements (including Hospital Equipment) to be maintained and safe.
Mechanical services	9	Inter alia, distribution, heating and cooling systems.
Electrical services	10	Inter alia electrical distribution network, communication systems, transportation systems, moveable Hospital

Service	Para	Scope
		Equipment and electrical plant
Specialist services (e.g. steam sterilizer, medical gases)	11	Sterilisers, boilers, pressure vessels, water distribution and treatment plant (Legionella testing), portable electrical equipment, piped medical gases and BMS. All records to be updated and available for inspection.
Estates information and property management	12	Site records, waste management, radioactive materials, food premises, registration, alcoholic beverages licencing, fire certification, water extraction, effluent/sewerage, transport operator's licence, television/radio licence, Building and Planning regulations, Medicines Act (Operating Environment), Petroleum Regulations, Computer systems operating licence. Ensure compliance with NHS/HSE guidance or regulations, DoH guidance, Doe regulations, Home Office instructions, Substabce regulations, EEC directives, HTMs, Management of the Estate Concode, Firecode, Fire Precautions Act 1971 as amended, Trust SFIs, maintenance schedules, Hazard notices. All information to be updated and available for inspection.
Fire safety	13	Inspections ,drills and audits to ensure compliance with Trust Fire Safety procedures and Policy, Fire Code Regulations, Local Authority Regulations, Fire Dept Regulations and any other Legal Requirements as may be in force, fire training (all staff), testing and repair of fire detection/alarm/suppression systems
Energy efficiency	14	Minimise consumption of utilities (fossil fuels, electricity, gas and water)

3.0 The purpose of this report

THC/Carillion have a wide range of estates responsibilities. The potential scope of assurance reporting is therefore very wide.

The Trust has requested an annual statement of compliance from THC/Carillion to provide assurance to the Trust Board that it's own corporate responsibilities (in respect of 13 estates management aspects) are being adequately discharged through the Concession Agreement/FM subcontract. A framework has been drawn up[2] which is intended to meet the Trust's requirements[3]

The intentions are:

1) That the statement will be updated annually and presented to the Trust Board via the Partnership Board.

2) Compliance status and responsibility will be clearly indicated in columns 3 and 5 respectively.

3) Columns 7 & 8 can then be used by the Partnership Board to assess any risk rating associated with partial or non compliance and identify further action required.

[2] See Appendix 1

[3] The list of requirements set out in column 2 (Compliance Area') was compiled by an independent Estates management consultant employed by the Trust specifically for the purpose.

4) The assurance statement will ‘stand alone’ as a reporting mechanism – all supporting documentation to be available for inspection/audit as indicated.

Compliance status can be easily audited by reference to Carillion’s integrated management system which is a bespoke database containing full records and other documents relating to compliance.

Some of the items listed in the framework are not within THC/Carillion’s scope of responsibility and the Trust must therefore ‘assure itself’ (albeit with assistance from THC/Carillion) of the status of these items. They have been listed separately to avoid confusion.

Appendix 1

Estates Management Assurance Statement
Services Provided by The Hospital Company (THC) November 2011

THC / shared responsibilities

	Compliance Area	Status	Method of Monitoring	Responsibility	Comment	Risk Rating	Outstanding Actions
1	**Fire**						
1.2	Nominated Fire Safety Advisor to take the lead on all fire safety activities and training of all DVH staff	Compliant.	Training records are available for inspection/audit in Carillion offices.	THC	Dave Collins of ATC Fire Safety is the appointed specialist.		
1.3	Effective fire safety management strategy as outlined in HTM 05-01	Compliant	Fire Risk Assessment is undertaken annually and reviewed by FSC. Copies of records are kept by Carillion and the Trust.	THC/Trust	THC through Carillion and the Trust work jointly to review the Fire Safety Policy as part of the annual Fire Risk Assessment		
2	**Overall Estate Management**						
2.2	Nominated Senior Operational Manager to deliver the services outlined in the PFI contract	Compliant	Records are available for inspection/audit in Carillion offices.	THC	Dean Ruck is Carillion's Senior Operational Manager responsible for the delivery of the service.		
2.3	Nominated Authorising Engineers with appropriate professional qualifications and a range of competent persons	Compliant	Records are available for inspection/audit in Carillion offices.	THC	Carillion nominate Authorising Engineers in the following areas: • Electrical • Medical gases • Legionella • Pressure vessels • Refrigerant gases • Fire damper testing • Lightning protection • Emergency lighting		
3	**Emergency Preparedness & Contingency Planning**						
3.1	Ensure that the FM provider has a plan in line with HTM 2070	Compliant	Plans are available for inspection/audit in Carillion offices.	THC	Carillion maintains contingency plans in the following areas: • BMS • Medical gases		

	Compliance Area	Status	Method of Monitoring	Responsibility	Comment	Risk Rating	Outstanding Actions
					• Electricity • Gas • Water • Telecoms • Waste management • Patient feeding • Linen and laundry		
4	**Medical Gas Pipeline Systems**						
4.2	The Executive manager has designated the Authorised Person (MGPS) with external verification	Compliant	Records are available for inspection/audit in Carillion offices.	THC	Carillion have appointed an Authorised person Steve Banks. To comply with HTM requirements, this appointment requires ratification by the Trust Chief Executive (via the Trust appointed Authorising Engineer [Trust Medical Gases Committee]).		
4.3	A back-up Authorised Person (MGPS) is also designated along with the operations manager	Compliant	Records are available for inspection/audit in Carillion offices.	THC	Carillion have appointed a Responsible Person – Adrian Prior in line with this requirement.		
5	**Control of Legionella and Water Quality**						
5.1	A Responsible Person has been identified and ratified by the Trust in line with HTM 04 and HSE ACOP L8	Compliant	Records are available for inspection/audit in Carillion offices.	THC	Carillion have appointed an Authorised Person. In addition to this, Feedwater have been appointed by THC/Carillion to carry out an annual Legionella Risk Assessment.		.
5.2	A risk based Policy for the Control of Legionella is in place and updated at least every 2 years	Compliant	Records are available for inspection/audit in Carillion offices.	THC	See above.		
5.3	Maintenance schedules, plans and records are audited annually by an independent Authorising Engineer in line with HTM 04 and HSE ACOP L8	Compliant	Records are available for inspection/audit in Carillion offices.	THC	See Above		

	Compliance Area	Status	Method of Monitoring	Responsibility	Comment	Risk Rating	Outstanding Actions
6	**Lifts**						
6.1	Annual insurance inspections are undertaken and checked by THC	Compliant	Records are available for inspection/audit in Carillion offices.	THC			
6.2	Designated Person identified to ensure lifts operate properly and maintain full records in line with HTM 2024	Compliant	Records are available for inspection/audit in Carillion offices.	THC			
	Competent Person appointed and 6 monthly checks in line with HTM 2024	Compliant	Records are available for inspection/audit in Carillion offices.	THC			
7	**Electrical Services & Infrastructure**						
7.1	Authorised engineer for electricity appointed and ratified by the Trust	Compliant	Records are available for inspection/audit in Carillion offices.	THC	Authorising Engineer Paul Deacon		
7.2	Maintenance and PPM schedules and records are in line with HTM 06 and signed off by THC and Trust annually	Compliant	Records are available for inspection/audit in Carillion offices.	THC			
7.3	Emergency power systems maintained and tested in line with HTM 06	Compliant	Records are available for inspection/audit in Carillion offices.	THC			
8	**Sterilizers**						
8.2	The competence of the Authorised Person is validated annually	Compliant	Records are available for inspection/audit in Carillion offices.	THC	Review of the register of Authorised Persons undertaken annually by the Trust and Carillion.		
8.3	Annual maintenance and inspections, in line with HTM 2010, are undertaken and signed off by the Authorised Person	Compliant	Records are available for inspection/audit in Carillion offices.	THC			
9	**Asbestos**						
9.1	All buildings are certified Asbestos free, any potential	Compliant	N/A. The hospital buildings were erected	THC	Some buried asbestos has been found in the hospital grounds.		

	Compliance Area	Status	Method of Monitoring	Responsibility	Comment	Risk Rating	Outstanding Actions
	asbestos will be from previous structures.		in 1998 – 2000. No asbestos was used in the construction.		THC and the Trust to review any further potential developments and undertake a joint risk assessment		
10	**Food Hygiene Regulations**						
10.1	All food preparation areas are inspected at least annually or otherwise required by an EHO	Compliant	Details of the inspection regime and any exception reports are available for inspection in Carillion offices.	THC	Annual Visit by EHO Patient feeding – 5 Star rating Retail restaurant – 4 Star rating		
10.2	Confirmation that the HACCP plan is reviewed after each menu/service change	Compliant	Records are available for inspection/audit in Carillion offices.	THC	Undertaken by Catering Manger		
11	**Confined Spaces**						
11.1	That the policy and permit to work system is in place, reviewed at least every 2 years	Compliant	Records are available for inspection/audit in Carillion offices.	THC			
12	**Disability Discrimination Act**						
12.1	Regular audits to ensure ongoing compliance		Annual DDA compliance audit (suggested by THC).	Trust/THC	The buildings met all DDA requirements in 2000, when it was opened. Any future developments must meet the latest standards. THC and the Trust to review any further potential developments and undertake a joint risk assessment and DDA compliance review		
13	**Safe management of Healthcare Waste**						
13.1	Regular audits to ensure ongoing compliance	Compliant	Annual audits reviewed by the Waste Management Committee	Trust/THC	The Trust is ultimately responsible for the safe management of waste. THC and their FM provider are responsible for the collection and storage of waste. External audits to be undertaken by the		

	Compliance Area	Status	Method of Monitoring	Responsibility	Comment	Risk Rating	Outstanding Actions
					Trust to review this and reported through the Waste Management Committee		

Trust Responsibilities

	Compliance Area	Status	Method of Monitoring	Responsibility	Comment	Risk Rating	Outstanding Actions
1	**Fire**						
1.0	Fire safety policy covering all occupied buildings	Compliant	Regular reviews at the Fire Safety Committee and an annual report to the Trust Board	Trust	The Trust Fire Safety Policy is the baseline for THC/Carillion's involvement through the Fire Safety Committee.		
1.1	Nominated Board level director accountable to the Chief Executive for fire safety	Compliant	Report to the Trust Board to demonstrate compliance with HTM 05	Trust	Andy Brown is the Lead Director for Fire Safety.		
2	**Overall Estate Management**						
2.1	Nominated Board level director accountable to the Chief Executive who acts as the Designated Person	Trust Issue	N/A	Trust	Mark Hope , Interim Director of Estates is the designated Board lead for estates issues		
4	**Medical Gas Pipeline Systems**						
4.1	The Executive Manager is nominated by the Chief Executive			Trust	The responsibility for nominating the Executive Manager rests with the Chief Executive of the Trust		
4.4	MGPS Operational Policy, in line with HTM 02-01 part B and that it has been reviewed within the last 2 years	Compliant		Trust	The Policy should be ratified by the Medical Gas Committee, which will have Trust and THC and FM provider membership		
4.5	The Quality Controller (MGPS) has been designated by the Trust			Trust	The Trust should identify the Quality Controller (MGPS) and this should be ratified at the Medical Gas Committee		
8	**Sterilizers**						
8.1	The Trust should ratify the Authorised Person in line with HTM 2010			Trust			

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TRUST BOARD MEETING – JANUARY 2012

Item 1-9.4. Attachment 19 - ToR for Partnership Board

1-9.4	TO APPROVE UPDATED TERMS OF REFERENCE FOR THE PARTNERSHIP BOARD	CHIEF EXECUTIVE

The Partnership Board agreed revised Terms of Reference at its meeting in on 30th November 2011, as part of the required annual review. A number of changes were agreed.

The revised Terms of Reference are presented for Board approval, in accordance with the Trust's Standing Orders (9.1.2 and 9.4.1).

Proposed additions are highlighted in yellow on the pages below. Proposed deletions are indicated via ~~strikethrough~~.

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Approval of revised Terms of Reference for the Partnership Board

Equality Impact Assessment initial screening applicable to this report? No

This report provides information on the following annual objectives (delete as required)**:**

- To maintain the highest standards of cleanliness and reduce healthcare associated infections, maintaining a zero tolerance approach to infections acquired within Darent Valley Hospital;
- To deliver the objectives set out in the Financial Plan for 2011/12, including the delivery of a Quality, Innovation, Productivity and Prevention (QIPP) programme that develops patient pathways which provides care closer to patients' homes, and improves the efficiency of the services the Trust provides, thereby saving resources and releasing capacity

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors understanding of the Trust & its performance

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PARTNERSHIP BOARD – TERMS OF REFERENCE

Purpose	The Partnership Board has evolved from the PFI Project Board and is the forum where representatives from the Trust, The Hospital Company (Dartford) Limited and Carillion Health meet to discuss the Strategic and Operational development of the site and its services together with PFI Contractual issues.
Membership	Trust: ▪ Chief Executive (Chairman) ▪ ~~Chief Executive or Director of Operations (Deputy Chief Executive)~~ ▪ Director of Nursing (or Director of Operations) ▪ ~~Deputy Director of Finance~~ ▪ Director of Estates ▪ Director of Finance (or Director of Operations) ▪ Non-Executive Director ▪ Facilities Monitoring Manager
Attendees	The Hospital Company (Dartford) Limited (THC): ▪ General Manager ▪ Assistant General Manager Carillion Health: ▪ Facilities General Manager
Members roles and responsibilities	Not applicable.
Attendees	Other Members may be co-opted by the Partnership Board for either a fixed period of time or for undertaking a specific project.
Frequency of meetings	Meetings will be held bi-monthly. At the discretion of the chairman, other meetings may be held to fulfil its main functions
To receive reports from	The Committee may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the committee. However, Board committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Trust Board.
Public admission	Not open to the public.
Reporting procedures	▪ The minutes of the Committee will be reported to the non-public Trust Board meeting ▪ In addition to the members, minutes will be sent to the Chairman, Chief Executive, Director of Performance and Service Development, Director of Nursing, and Director of Human Resources.
Quorum	The quorum will be two members and two attendees (one THC, one Carillion Health).
Duties	The Committee has the following duties and functions: ▪ To consider proposals for the Strategic Development of the Site. ▪ To determine the impact on the services provided to the Trust by The Hospital Company (Dartford) Limited and its sub-contractors from the Strategic Development of the Site. ▪ To review the work of the Operational Estates Group ~~Operational Development of Darent Valley Hospital~~ and implications of this on the Facilities Management service provisions. ▪ To review the performance of the Facilities Management Services provided

	to the Trust via exception reports. ▪ To oversee the Steering Group which organises the annual Patient Environment Action Team (PEAT) inspection. ▪ To discuss contractual issues that impact on the Concession Agreement. ▪ To oversee compliance and assurance issues on behalf of the Trust Board. ▪ To monitor and review compliance with the appropriate national standards, legislative requirements and regulations. ▪ To support and participate in the Trust's energy and efficiency initiatives
Authority	As a committee of the Trust Board, it will make recommendations to the Board, where necessary. The Board delegates the above functions to the committee. The Board also delegates decisions not of a significant nature. In practice what is significant will depend on the judgement of members but committees must refer the following types of issue to the full Board. Any matter which will: ▪ Change the strategic direction of the Trust. ▪ Conflict with statutory obligations. ▪ Contravene national policy decisions or governmental directives. ▪ Have significant revenue implications. ▪ Have significant governance implications. ▪ Be likely to arouse significant public or media interest. The Committee is authorised to investigate any activity within the terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request which in the opinion of the Chairman of the Committee is properly made by the Committee.
Review	The Terms of Reference will be reviewed annually. Any proposed changes to these terms of reference will need to be approved by the Trust Board, The Hospital Company and Carillion.
General matters	▪ Agendas and papers shall be distributed in advance of the meeting. ▪ The Director of Finance secretary will take minutes of meetings.

February 2010
Reviewed and revised at Partnership Board, February 2011
Approved at Trust Board, February 2011
Reviewed and revised at Partnership Board, November 2011
Approved at Trust Board, January 2012

Dartford and Gravesham NHS
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UNAPPROVED

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON WEDNESDAY 16TH NOVEMBER 2011, 4 P.M. AT DARENT VALLEY HOSPITAL

Present:	Sarah Dunnett	Chairman	(SD)
	Ann Aldous-Dunn	Public (Gravesham Borough)	(AAD)
	Ron Bowman	Public (Gravesham Borough)	(RB)
	Tanya Croney	Staff (AfC 1-4)	(TC)
	Cecil Fontaine	Staff (AfC 5-6)	(CF)
	Leslie Hills	Public (Gravesham Borough)	(LH)
	Pat Harvey	Appointed (University of Greenwich) (from item 11-6)	(PH)
	Eric Huxley	Public (Dartford Borough) (from item 11-7)	(EH)
	Paul McCulloch	Appointed (The Hospital Company (Dartford) Ltd.)	(PMC)
	Melanie Norris	Appointed (Kent Thameside Delivery Board)	(MN)
	Vinay Sangar	Appointed (Kent County Council)	(VS)
	Tony Searles	Public (Sevenoaks District)	(TS)
	Sri Sriprasad	Staff (Doctors)	(SS)
	Diane Steltner	Public (Gravesham Borough)	(DS)
	Carol Stone	Public (Dartford Borough)	(CS)
In attendance:	Susan Acott	Chief Executive	(SA)
	Sara Cocklin	Corporate Development Assistant	(SC)
	Pam Dhesi	Deputy Director of Operations (for item 11-5)	(PD)
	Kevin Rowan	Associate Director, Corporate Development (Trust Secretary)	(KR)

Item 1-9.5. Attachment 20 - Minutes of Council of Governors, 16.11.11

11-1 APOLOGIES FOR ABSENCE

Apologies were received from Gill Pearson (Public: Sevenoaks District); Stephen Mulvaney (Staff: AfC 7-9); John Smith (Public: Relevant Districts and Boroughs of Greater London, Kent, Medway & Essex); and Val Hampson (Public: Dartford Borough).

SD welcomed VS to the meeting, and asked him to introduce himself to the Council. VS explained that he was Head of Service for Adult Social Services for Dartford, Gravesham & Swanley locality.

SD noted that Dartford Borough Council had been reminded of the meeting and they had said they would be sending a representative. SD also noted that she had received a letter of resignation from Lorraine Wade (LW) (Public: Dartford Borough) and that technically speaking there is now a vacancy. KR stated that under the Constitution the options are a) hold another election, b) ask the person who was next in line in the last election to fill the post, or c) keep the post vacant. KR added that given the position around the proposed integration with Medway, the preferred option would be to keep the post vacant until the end of the extended term. This was agreed.

SD thanked LW for her contribution to the Council of Governors

11-2 DECLARATIONS OF INTERESTS

There were no declarations of interest.

11-3 MINUTES OF THE PREVIOUS MEETING HELD ON 13TH SEPTEMBER, AND CONSIDERATION OF ANY MATTERS ARISING

The minutes of the previous meetings were agreed as an accurate record.

SD reported that all actions from the previous meeting had either been completed or would be covered on today's agenda.

11-4 TO REVIEW THE TERMS OF REFERENCE FOR THE COUNCIL OF GOVERNORS

SD referred to the Terms of Reference circulated with the agenda and reported that there were no changes proposed. The Terms of Reference were agreed as circulated.

11-5 TO RECEIVE AN UPDATE ON OPERATIONAL MATTERS (INCLUDING THE EMERGENCY DEPARTMENT REDEVELOPMENT & ECIST)

SD welcomed PD to the meeting, who referred to the circulated paper & highlighted the following:

- Phases 1, 2 and 3 of the building works had now been completed and work on the Emergency Department Walk in Centre (EDWIC) would commence soon, it is anticipated that this work will take approximately 4 weeks and should be completed by end of January;
- Performance on the A&E 4-hour wait target in October was 95.2% (against a target of 95%) and is on track for November;
- A new chest pain protocol has been developed with Dr Winston Martin, Consultant Cardiologist, and a training programme will be introduced;
- September was a very busy period for the department and there have been some challenges around complaints for this time;
- General Medicine – daily board rounds have been introduced and improvements to the discharge process have been made;
- The complex elderly care pathway project continues to be on target and it is proposed that there will be a re-design of the geriatric service;
- 'Window beds' remain closed (63 beds were removed from the Trust's capacity);
- A review of cancer services has been undertaken by the Department of Health's Intensive Support Team (IST) and there is confidence that the Trust will improve around cancer targets

AAD commented that she had had reason to visit the A&E department the previous week and congratulated PD on the service.

CS asked PD for clarification of the term "board round". PD explained that this was where the clinical team meets to discuss the care of each patient that are in the department (i.e. all those on the 'board').

VS asked whether the Trust has a breakdown of all complaints. PD explained that the Trust Board receives the complaints report at an individual patient level on a monthly basis.

LH referred to readmissions and stated that he had heard concerns from individuals that they have been prematurely discharged and queried whether patients were discharged too early, given the pressures on capacity. SA stated that the Trust strives to reach a balance and monitors readmission rates by ward/illness.

CS added that there is a very real issue but reassured LH that the whole health economy is working collaboratively to ensure that patients who should not be admitted to hospital are cared for in the community. VS stated that he felt that inter-agency relationships are stronger now than ever.

SD concluded by saying that the Board receives and monitors readmission rates on a monthly basis, as does the Quality and Safety Committee and that the Trust are penalised financially when patients are readmitted.

11-6 PATIENT EXPERIENCE COMMITTEE:

- **TO RECEIVE THE MINUTES OF THE MEETING OF 19.10.11**

RB referred to the circulated minutes and reported that the meeting in October had flowed better and there had been a lot more involvement by Committee members. RB also noted that the Committee had agreed for RB to continue as Committee Chair until the completion of the proposed integration with Medway NHS Foundation Trust.

VS referred to the Carers Report and noted that Kent County Council were finalising a Carers' Strategy.

- **TO APPROVE REVISED TERMS OF REFERENCE**

RB referred to the Terms of Reference and highlighted the proposed changes. The Terms of Reference were approved as circulated

11-7 PROPOSED INTEGRATION WITH MEDWAY NHS FOUNDATION TRUST:

- **UPDATE ON DEVELOPMENTS**

SA updated the Committee on the developments of the proposed integration and reported that the next stage is for the two Trusts to submit a business case to the Cooperation and Competition Panel (CCP) who have to consider whether the integration is in the interests of patient choice.

RB asked SA how she felt with regard to the publicity around the integration. SA replied that she felt that on the whole the responses were positive and the feeling from MPs and GPs alike was that there would be a reduction in administration and overheads.

SA reported that she had meetings with the Kent LINk and their feedback was positive and only had concerns around travel. SA stated that the formal engagement process would take place over the next few months.

VS asked what the views of the Clinical Commissioning Groups (CCG) were. SA replied that they were very supportive and their concerns were around access for their patients. SA added that they are supportive of service developments to enable patients to be treated locally rather than in London, for example Renal services.

SS commented that staff across both Trusts understand that larger units will survive and that the integrated Trust will be able to provide services which until now have only been provided by the London Hospitals.

- **INITIAL PROPOSALS FOR THE GOVERNOR ARRANGEMENTS OF THE INTEGRATED TRUST**

KR referred to the paper circulated with the agenda and highlighted the following points:

- Medway currently have 26 governors and Darent Valley have 21 and that there are some fundamental differences between the two Trusts;
- All Foundation Trusts must have a majority of public governors;
- The terms of office for governors can be staggered which is the approach currently taken by Medway, however the downside of this is that elections need to be held every year;
- Amendments to Medway's Constitution and the amendments would technically need approval of the Medway Council of Governors, but the amended constitution would also be approved by both Trust Boards and then by Monitor
- It is proposed that all current governor positions for both Trusts be disbanded and elections held, and new stakeholder organisations identified for the 'appointed' Governor positions.

The five proposed principles were agreed.

KR asked that if any Governor had any queries or views that they direct them to himself or SD.

- **GOVERNORS ROLE IN ENGAGEMENT PLAN**

SD reported that the Transition Team is open to Governors having an active role in the engagement process and asked for Governors to contact her if they would be interested.

SD also suggested that it might be good for both sets of Governors to meet on both sites to understand how each other works.

11-8 TO RECEIVE AN UPDATE ON PROGRESS WITH THE COMMITTEE OF ENQUIRY ON FOOD

MN reported that a draft report was being finalised, and would be submitted to the December Patient Experience Committee meeting. MN stated that the Committee had concluded that there was no problem with the quality of the food but that there were problems regarding delivery and presentation. MN continued that the Committee had prepared a nursing questionnaire and asked whether they could issue them for feedback. It was agreed that the Nursing Survey should be issued. SD thanked MN, AAD and EH for their time and efforts.

SA noted the Director of Nursing was arranging a Nutrition Workshop in December & suggested it would be beneficial if members of the Committee of Enquiry were to attend. This was agreed.

Action: Arrange for members of the Governors Committee of Enquiry on food to attend the Nutrition Workshop scheduled for December 2011 (Trust Secretary, November 2011)

11-9 TO RECEIVE DETAILS OF TRUST BOARD CHANGES

SD updated the Committee on recent Trust Board changes:

- Mick Bull had been appointed as Interim Finance Director and had started at the Trust 1st October;
- Andrew Ling, Non Executive Director had left the Trust on 27th October as he had been appointed Chairman of Kent and Medway NHS and Social Care Partnership Trust;
- Penny McCulloch had returned as Non Executive Director until the end of July 2012, and will take over as chair of the Audit Committee. Bernie Holloway, who is currently chair of the Audit Committee, will take over as chair of the Finance Committee

11-10 TO NOTE THE QUARTERLY SELF-CERTIFICATION FOR QUARTER 2, 2011/12

The circulated report was noted.

11-11 TO RECEIVE AN UPDATE ON TRUST MEMBERSHIP DEVELOPMENTS

The circulated report was noted.

TS asked whether there had been any progress on reporting Membership numbers by constituency. KR stated that technical issues with the Membership software had prevented such data being provided, but he was continuing to seek a resolution to the issue.

11-12 TO RECEIVE NOTIFICATION OF ANY PLANNED SERVICE CHANGES

KR stated that there was nothing further to report.

11-13 TO NOTE THE DATES & FORWARD PLANNER OF TRUST BOARD MEETINGS

The circulated programme was noted.

11-14 TO CONSIDER ANY OTHER BUSINESS

TS asked whether the Trust had issued any ‘gagging orders’ to staff following the cessation of their employment, to prevent them raising concerns regarding clinical care. SA stated that to her knowledge, the Trust had not issued any such orders.

[Post-meeting note: Compromise agreements issued upon the cessation of an employee’s employment term will normally include a confidentiality clause relating to the content of the agreement, and will sometimes (often at the other party's request) include an agreement not to make derogatory comments about each other. Compromise agreements also include a clause along the following lines "Nothing in this clause shall prevent the Employee from disclosing information which he is entitled to disclose under the Public Interest Disclosure Act 1998, provided that the disclosure is made in accordance with the provisions of that Act and the Employee has complied with the Trust's policy from time to time in force regarding such disclosures". Anyone signing a compromise agreement must take legal advice before signing to make the agreement is legitimate. All agreements are drafted by the Trust's solicitors. Agreements we have used in the last three years have been designed to preserve confidentiality of the agreement, but still allow the employee/ex-employee to raise concerns under the Public Interest Disclosure Act if appropriate - i.e. they are not gagged from raising concerns about corporate or clinical governance after they have signed the agreement]

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TRUST BOARD MEETING - JANUARY 2012

1-10.1	**CONSIDERATION OF OUTLINE BUSINESS CASE FOR LOCATION OF PATHOLOGY LABORATORIES AT DARTFORD AND GRAVESHAM NHS TRUST & MEDWAY NHS FOUNDATION TRUST**	**DEPUTY CHIEF EXECUTIVE**

This Outline Business Case (OBC) sets out the rationale, options appraisal and future plan for the centralisation of pathology services at Darent Valley Hospital (DVH) and Medway Maritime Hospital (MMH). This business case develops the Option that the main laboratory should be located at DVH and a "hot" laboratory at MMH.

The OBC contains an option appraisal and economic and financial assessments which recommend that the main laboratory should be located at DVH and a "hot" laboratory at MMH (Option B). This option offers the highest return per pound invested on the Profitability Index (PI) over 5 and 10 years. Given the constraints on the availability of capital funds the lower capital spend at DVH is beneficial and it is only after 10 years that the Net Present Value (NPV) favours MMH. DVH also provides further opportunities for further reconfiguration within its current footprint. The changes at

DVH can be introduced more easily than at MMH whilst normal operations are maintained, and provide the best alignment with the integrated Estates Strategy.

Subject to Board approval, further detailed work is required to develop this OBC into a Full Business Case (FBC). There is a requirement for a set of accurate tendered costs for the capital developments and plans at both sites requiring architects and project management capabilities to develop the design and to tender for the building and refurbishment work. Agreement is sought from both Trust Boards to support this project and to commit £50k each from their 2012/13 capital plans towards the preparatory work required for the FBC.

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
To consider and approve the Outline Business Case and to agree to commit £50k from the Trust Capital Programme to support the preparatory work required for the FBC

Equality Impact Assessment initial screening applicable to this report? No

This report provides information on the following annual objectives (delete as required)**:**

- To improve patient experience and patient safety, and achieve the best health outcome for patients, through implementation of the Quality Plan for 2011/12;
- To maintain the highest standards of cleanliness and reduce healthcare associated infections, maintaining a zero tolerance approach to infections acquired within Darent Valley Hospital;
- To develop productive relationships with emerging GP Consortia, local authorities, and other new partners, in order to provide sustainable services for the community, and achieve a sustainable local health economy;
- To recruit excellent staff, and develop, manage, lead and support our staff fairly, to ensure they are motivated to deliver high quality and excellent services;
- To deliver the objectives set out in the Financial Plan for 2011/12, including the delivery of a Quality, Innovation, Productivity and Prevention (QIPP) programme that develops patient pathways which provides care closer to patients' homes, and improves the efficiency of the services the Trust provides, thereby saving resources and releasing capacity

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors understanding of the Trust & its performance

Dartford and Gravesham NHS
NHS Trust

Medway NHS
NHS Foundation Trust

PROGRAMME DOCUMENTATION

OUTLINE BUSINESS CASE (OBC) FOR THE CONSOLIDATION OF PATHOLOGY SERVICES AT MEDWAY MARITIME HOSPITAL AND DARENT VALLEY HOSPITAL

Release: Final

Date: 13th January

Authors: Pathology Project Team

1. Executive Summary

1.1. This Outline Business Case (OBC) sets out the rationale, options appraisal and future plan for consolidation of pathology services at Darent Valley Hospital (DVH) and Medway Maritime Hospital (MMH).

1.2. In September 2010, the Pathology Strategic Alliance Project (PSAP) was created to investigate the practicalities, benefits and risks of a combined Pathology service across the Dartford & Gravesham NHS Trust (DGT) and Medway NHS Foundation Trust (MFT).

1.3. In November 2010, the PSAP presented its report to a clinical panel comprising of the two Trust Chief Executives, two Trust Medical Directors and Clinical Directors from both organisations. The recommendation of this panel was that an OBC should be developed and presented to both Trust Boards in January 2012.

1.4. This OBC is set within the context of modernisation and transforming Pathology Services that has been part of national and local healthcare policy since early 2000. The project was started ahead of any formal Trust integration decision because of a clear strategic and business requirement to modernise and consolidate Pathology Services and maximise efficiencies which are essential to the Quality, Innovation, Productivity and Prevention (QIPP) programme.

1.5. This Pathology Strategic Alliance Project's proposal seeks to:

- Ensure an effective, patient-focused and cost efficient service which can be maintained and aligned to the vision of the Kent & Medway Pathology Network;
- Maximise strategic opportunities for growth in income from other sources, including for example activity in South London;
- Explore and consider the repatriation of tests from third party laboratories to improve lead times for patient results; and
- Improve and sustain quality and efficiency in service provision to become a 'best in class' Pathology Service.

1.6. Both hospitals will retain 24/7 emergency support with no reduction in current service provision. This project will deliver improvements in lead times and assist the introduction of electronic order communications. Dedicated Inter-Trust transport will be provided ensuring the timely processing of specimens at the main laboratory and all GP direct access activity. It is proposed to introduce a single management structure and supporting clinical frameworks to enable the delivery of a top performing Pathology Service. This service will be fully modernised in terms of automated processing and associated skill mix changes.

1.7. The OBC outlines the option appraisal and economic and financial assessments for consolidation. The first option was to locate the main laboratory at MMH and the hot laboratory at DVH. The second option was to locate the main laboratory at DVH and the hot laboratory at MMH. Key Financial Indicators from this assessment are summarised in the table below.

Measure		**Main Laboratory**	
	Do Nothing	**MMH**	**DVH**
Capital Spend (10 years)	(£703k)	(£2,207k)	(£1,363k)
Revenue (cost)/saving – run rate	(£143k)	£968k	£758k
Net Present Value – 5 Years (Adv)/Fav	(£1,124k)	£907k	£1,140k
Net Present Value – 10 Years (Adv)/Fav	(£1,368k)	£4,587k	£4,022k
Profitability Index – 5 Years (Adv)/Fav	£1.64	£0.41	£0.84
Profitability Index – 10 Years (Adv)/Fav	(£2.39)	£2.08	£2.95
Payback on capital spend (months)	N/A	44	36

1.8. The options appraisal and assessments recommend that the main laboratory should be located at DVH and a “hot” laboratory at MMH. This option offers the highest return per pound invested on the Profitability Index (PI) over 5 and 10 years. Given the constraints on the availability of capital funds the lower capital spend at DVH is beneficial and it is only after 10 years the Net Present Value (NPV) favours MMH. DVH also provides greater opportunities for further reconfiguration within its current footprint. Furthermore, the changes proposed at DVH can be introduced more easily than at MMH whilst normal operations are maintained, and provide the best alignment with the integrated estates strategy.

1.9. Further detailed work will need to be undertaken to develop this OBC into a Full Business Case (FBC), subject to the approval to proceed by both Trust Boards. In order to progress further to a FBC there is a requirement for a set of accurate, tendered costs for the capital developments and plans that manages what amounts to a 35% shift of activity between sites. At DVH, there will be a requirement to fund THC (Dartford) Ltd., for architects and project management capabilities to develop the design and to tender for the building and refurbishment work. Similarly, at MMH this process also needs to be completed to develop a “hot” laboratory. Agreement is therefore sought from both Trust Boards to support this project and to commit £50k of capital funding from each organisation’s 2012/13 plans towards the preparatory work required for the FBC.

1.10. A Project governance structure will be established to support this work. The Trust Boards of MMH and DVH as the Investment Decision Makers will approve the FBC. The Chief Executives of MMH and DVH will nominate a Senior Responsible Officer (SRO) who will be responsible to them for producing the FBC and delivering its stated benefits following approval of the OBC.

1.11. The timetable of high level key milestones currently demonstrate that the main laboratory will be in place at DVH in February 2013 and at MMH, the “hot” laboratory will be completed in May 2013.

2. Introduction

This Outline Business Case (OBC) sets out the rationale, options appraisal and future plans for the consolidation of pathology services at Darent Valley Hospital (DVH) and Medway Maritime Hospital (MMH). This process began in September 2010, as the Pathology Strategic Alliance Project (PSAP), to investigate the practicalities, benefits and risks of a combined Pathology service across the Dartford and Gravesham NHS Trust (DGT) and Medway NHS Foundation Trust (MFT).

The option of a main laboratory at one site and a “hot” laboratory at the other hospital was investigated in depth by a project team with assistance from external and internal subject matter experts, and these views have been used in this OBC. In November 2011, the PSAP presented its report to a clinical panel consisting of the two Trust Chief Executives, both Medical Directors and two Clinical Directors from each hospital who recommended the development of an OBC.

This OBC is set within the Five Case Model which consists of the following sections:

- Strategic Case: This makes a robust case for change.
- Economic Case: This section focuses upon value for money and how it can be optimised. This part of the Business Case includes an Option Appraisal.
- Financial Case: This section shows whether the proposal is financially affordable.
- Commercial Case: This section focuses upon the procurement strategy required to deliver the proposal.
- Management Case: This section describes the project management processes required to deliver the project successfully.

3. The Strategic Case

This OBC is set within the context of modernisation, and transforming Pathology Services that been part of national and local healthcare policy and agendas since early 2000. The following studies and reports have been produced and justify the need for change in how pathology services are configured and delivered:

- Pathology Modernisation agenda of early 2000;
- Formation of the Kent and Medway Pathology Network in 2002;
- Creation of a Strategic Outline Case (SOC) by Ove Arup in 2006 to develop a managed pathology network across Kent;
- Carter of Coles first report in 2006 setting out the strategic case for change in pathology for the NHS;
- Carter of Coles second report in 2008;
- OBC by Medical Mosaic and Methods Consulting in 2009 for the consolidation of pathology in Kent;
- Full Business Case (FBC) by Collinson Grant in 2010;
- Changes in the commissioning framework with the formation of clustered Primary Care Trusts (PCTs); and
- The intention to introduce GP-led commissioning groups.

The PSAP commenced with the specific remit to propose a new joint operating framework for Pathology across both Trusts. The project was started ahead of any formal Trust integration discussions because of a clear business requirement to modernise pathology services and maximise efficiencies which are essential to the delivery of the Quality, Innovation, Productivity and Prevention (QIPP) programme requirements. As a consequence of the policy drivers listed above, and also as a result of proactive relationships between Dartford and Medway Pathology Departments, the project was established to begin the process of fundamental change in how Pathology Services were configured and delivered with the key aims of:

- Ensuring an effective patient-focused and cost effective service which could be maintained and aligned to the vision of the Kent and Medway Pathology Network;
- Maximising strategic opportunities for growth in income from other sources including, for example, Trusts in South London.
- Exploring and consider the repatriation of tests from third-party laboratories to improve lead-time for patient results.
- Improving and sustain quality and efficiency in service provision to become a top performing Pathology Department.

There were further developments which included the establishment in April 2011 of the Integration Feasibility Programme Board (IFPB) following the agreement of both hospital Trust Boards to work more formally towards the integration of the two organisations. A key benefit of integration is the opportunity to consolidate clinical support service. This benefit has subsequently been adopted as a key strategic objective in the clinical integration strategy.

A further aspect of the integration proposal is the development of an integrated estates strategy. The reconfiguration of Pathology services provides opportunities to release space at the MMH site which could be utilised by a relocated back office function. Similarly, this same strategy proposes that the DVH site is utilised more effectively for profitable clinical activity.

3.1. **Key Principles and Issues**

The section considers the key principles and issues underpinning this OBC.

The creation of the “main” laboratory at one site and a “hot” facility at the other hospital will enable the centralisation of all microbiology testing, including support for infection control, and the majority of routine blood sciences to be located at the main laboratory.

Both hospitals will retain 24 hour 7 days per week emergency support with no reduction in current service provision under the proposed service reconfiguration. It is expected that this project will deliver improvements in lead-times and assist the introduction of electronic order communications.

Dedicated Pathology inter-Trust transport will be provided which will ensure the timely processing of specimens at the “main” laboratory and all GP direct access activity will be collected and taken directly to the main laboratory.

MFT outsourced Histopathology and non-gynaecological cytology activity to Maidstone and Tunbridge Wells NHS Trust (MTW) in 2010. DGT also outsourced gynaecological cytology (cervical screening) to MTW. To enable this reconfiguration of pathology services it requires the outsourcing of all remaining Cellular Pathology from both MFT and DGT which is a critical dependency for this project. There are a number of key reasons for this vital change to occur:

- There is insufficient space for the “main” laboratory at either site if cellular pathology is retained
- The centralisation of a cellular pathology centre at MTW would benefit patients and service users through the concentration of skills and the ability to support the sub-specialisation of Consultants
- The requirements of the Cervical Screening Programme Quality Assurance process for all participating laboratories, and the capacity to manage annual case loads of greater than 35,000
- The existing oncology pathways and support arrangements in the North and West of Kent, would be significantly affected if diagnostic Pathology tests were managed elsewhere

3.2. **Key Dependencies**

Tangible and non-tangible benefits can be delivered from the creation of a centralised Pathology service under a single management structure and supporting clinical frameworks. There are also other key enablers that will directly affect the degree of Pathology modernisation possible as well as lead times and the level of cash-releasing benefits. These enablers, that sit outside this project’s scope, include:

- Electronic order communications for direct access users
- Interfaces to the Medway Patient Administration System (PAS) from laboratory systems which will further enable electronic order communications for Trust users

- The cost of high quality, dedicated data connections between the two hospital sites and introduction of a common PAS across both sites
- The future use and cost of redeveloping vacated space at the “hot” laboratory site

3.3. **Project Critical Success Factors**

This project will also contain the following Critical Success Factors which will feature within the post-project evaluation framework:

- Clients, customers and users of the reconfigured pathology service will be unaffected by the changes – i.e. the reconfiguration of the pathology laboratories should be invisible to the end users.
- Services will be maintained fully throughout the period of change; disruption will be minimised or avoided completely.
- A top performing, sustainable and more economically efficient pathology service will be provided to both Trusts and third party customers.
- This change can be delivered affordably.
- The reconfigured pathology service will be fit for purpose, will continue to meet current standards fully and will have in-built resilience to be flexed to meet future service change.
- The pathology service will be fully modernised both in terms of automated processing and the associated skill mix changes and which will enable optimal work flows.

3.4. **Service Delivery Principles**

This section describes the services which will be provided by the Pathology Departments:

- Provision from the Main Laboratory
    - All microbiology activities including infection control;
    - All direct access work from GPs and other commissioners;

  - Routine outpatient activity from both hospitals;
  - Routine ante-natal group and saves from both hospitals; and
  - Cell-pathology specimen reception (service: out-sourced).
- Provision from the “Hot” Laboratory
  - Urgent (“hot”) activity for blood sciences from site;
  - Urgent blood transfusion from site;
  - Cell pathology specimen reception (service: out-sourced);and
  - Inpatient activity from site.
- Urgent and on-call microbiology
  - All urgent requests e.g. CSF specimens and blood cultures will be sent urgently to the main laboratory.
  - For out-of-hours, the on-call BMS will be called when the requirement is first known.
- Dedicated Inter-Trust Pathology Transport.

3.5. **Service Dimensions and Current Facilities**

The service dimensions, high-level overview of the existing pathology service provision and the current facilities provided at DVH and MMH are outlined in Appendix One.

4. The Economic Case

4.1. Options Appraisal

The Core Pathology Team has undertaken a detailed Options Appraisal to establish the preferred site for the location of the “main” and the “hot” laboratories. This work was undertaken in two phases.

Two options were appraised as follows:

Table 1: Options

Option A	
Medway Maritime Hospital - MAIN • Centralised microbiology • Centralised blood sciences “cold” laboratory • “Hot” blood sciences (Medway only) • Blood transfusion (urgent Medway activity and all routine ante-natal group and saves) • Cell Pathology reception only (service at Maidstone and Tunbridge Wells NHS Trust).	Darent Valley Hospital – “HOT” • Hot blood sciences (DVH only) • Blood transfusion (urgent DVH activity only) • Cell Pathology reception only (service at Maidstone and Tunbridge Wells NHS Trust)
Option B	
Medway Maritime Hospital – “HOT” • “Hot” blood sciences (Medway only) • Blood transfusion (urgent Medway activity only) • Cell Pathology reception only (service at Maidstone & Tunbridge Wells NHS Trust)	Darent Valley Hospital - MAIN • Centralised microbiology • Centralised blood sciences “cold” laboratory • “Hot” blood sciences (DVH only) • Blood transfusion (urgent DVH and all routine ante-natal group and saves) • Cell Pathology reception only (service at Maidstone and Tunbridge Wells NHS Trust)

The following assumptions were made when generating these options:

- The full schedule of accommodation required could be fitted into the available space.
- The existing laboratory space was considered as the location for the main and “hot” laboratories. No other locations were considered on either hospital site.
- The Pathology service would remain in-house.
- All laboratories would be automated to the appropriate level to gain the maximum financial benefit and operational effectiveness.
- Both laboratories would need some adaptation to ensure that work flows are optimally efficient.

- High quality service provision would continue to be delivered wherever the main laboratory is located.
- Direct access service delivery would be unaffected (i.e. same collection times, same test turnaround times) by either of these options.

The options were evaluated against 6 weighted criteria, as follows:

Table 2: Criterion and Weightings

Criterion	Weighting
Cost: including capital and revenue costs for building, equipment, logistics and IT	50%
Income implications: the potential to increase/lose third party income	15%
Access: specifically for deliveries of supplies and specimens to the site	5%
Laboratory Accommodation: location and clinical adjacencies, and potential to accommodate increased activity	5%
Staffing: the impact on existing staff, recruitment and retention	10%
Estates issues: likely duration of building works, potential alternative uses for empty accommodation	10%

A detailed evidence pack was produced for each criterion to facilitate scoring. These included outline designs and capital costs for the development of “hot” and “cold” laboratories on each site, based on an agreed schedule of accommodation.

Each criterion was scored between 1 and 5; these scores are described below:

Table 3: Criterion Scores

1=Does not meet the criteria
2=Less than satisfactory
3=Satisfactory
4=More than satisfactory
5=Excellent

4.2. **Option Appraisal Outcome**

The scores from the Core Team members were checked and collated and are set out in the table below:

Table 4: Option Appraisal Scores

	Option A (MMH as the main laboratory)	Option B (DVH as the main laboratory)
Totals	9,855	9,525

Although the result of the Option Appraisal was that Medway Maritime Hospital should be the main site for the main laboratory and DVH the site for the “hot” laboratory, both options were subject to further assessment, particularly as the difference between the scores was so small (330, or 3%) and very sensitive to small changes in criterion weightings.

Following discussion and agreement with both Trust Chief Executives, additional Team Members were co-opted onto the Core Team to consider both the building and renovation costs of the options in more detail. An important aspect of this work was the creation of a “User Requirements Specification” for a Pathology Service, and from this process several issues were identified at the Medway site and are described below:

Because of the location of the existing laboratory (level 4), a dedicated lift facility would be required for efficient and effective access to the specimen reception for the increased volume of supplies and GP specimens and waste, which would increase both the cost of the project and the timescale for implementation.

At the Medway site, it was also noted that ingress and egress of the building contractors whilst maintaining effective security to the department and segregating patients, staff and the public would be difficult. It could be overcome by constructing a dedicated access point but this would add both cost and time to the delivery of the project.

It was found on further detailed examination that the outline design proposal produced for the Medway laboratory during the Option Appraisal exercise had avoided major refurbishment and capital investment, but at the expense of the required improvements in work flows. On review, significant moderations were required on the Medway site to reconfigure the available space including relocating and replacing the autoclave.

The modifications required on the Medway site would require at least five phases; some of these phases would require significant building work at two or more sites in the Pathology department concurrently. This assessment concluded that the degree of disruption to existing levels of service and associated risks would be high.

From the Option Appraisal exercise and subsequent post-Option Appraisal assessment it was concluded that both options required further financial appraisal in order to reach a common decision, and details are provided in the economic appraisal and financial case below.

5. Economic Appraisal and Financial Case

The indicative capital cost for the main laboratory at MMH is £2.2 million and at Darent Valley Hospital £1.3 million in the first three years. The MMH proposal includes a dedicated passenger and materials lift at an outline cost of £500k.

Key financial indicators are shown in the table below and are RAG-rated with green indicating the more favourable position of the two options.

Table 5: Key Financial Indicators

Measure		Main Laboratory	
	Do Nothing	MMH	DVH
Capital Spend (10 years)	(£703k)	(£2,207k)	(£1,363k)
Revenue (cost)/saving – run rate	(£143k)	£968k	£758k
Net Present Value – 5 Years (Adv)/Fav	(£1,124k)	£907k	£1,140k
Net Present Value – 10 Years (Adv)/Fav	(£1,368k)	£4,587k	£4,022k
Profitability Index – 5 Years (Adv)/Fav	£1.64	£0.41	£0.84
Profitability Index – 10 Years (Adv)/Fav	(£2.39)	£2.08	£2.95
Payback on capital spend (months)	N/A	44	36

5.1. Net Present Value and the Profitability Index

Net Present Value (NPV) takes into account the time value of money and discounts future cash flows associated with the project to the current value if incurred now. The discount rate is aligned with the NHS Rate of Return target of 3.5%.

Although the NPV is more favourable at DVH, MMH becomes the more favourable option at year seven. However, because there is limited capital availability for investment, the DVH option shows a higher rate of return per pound invested over both five and ten years. The Profitability Index (PI) works on the principle of the net revenue saving achieved per amount of capital invested.

5.2. Payback

Payback, the period in which the revenue savings payback the capital investment, is shortest in the DVH option at 36 months compared to 44 for the MMH option.

Capital costs of reusing vacated space is not part of OBC. However, there are no requirements of the Integrated Estates Strategy to relocate services to the current footprint of pathology at DVH that would increase income whilst release of space at MMH would be used for disposal planning purposes.

5.3. Revenue Savings

The table below shows that there are tangible financial benefits from providing a main laboratory at one hospital site and a "hot" laboratory at the other.

Table 6: Cost of Current Services against Proposed Laboratory Locations

	Current Cost			Proposed Main Laboratory Location			
	DVH	MMH	Joint	DVH	Difference with Joint Current Cost	MMH	Difference with Joint Current Cost
Pay	£4,497,794	£3,821,678	£8,319,472	£8,291,565	£170,407	£8,051,047	£380,925
Non-Pay	£2,868,237	£5,759,449	£8,627,686	£8,088,241	£539,445	£8,088,241	£539,445
Non-tariff income(*)	-£231,200	-£544,291	-£775,491	-£823,959	£48,468	-£823,959	£48,468
Total	£7,134,831	£9,036,836	£16,171,667	£15,525,847	**£758,320**	£15,315,329	**£968,838**

(*) Note: There is an assumed increase of 25% built in to non-tariff income over four years. In addition to existing income levels, £48,000 has been included due to GP 'electronic order communications' and business retention and growth. It is assumed that there will be increased income from the mortuary and RPI in Service Level Agreements.

Compared to current annual expenditure, there is increased annual revenue saving at MMH mainly due to High Cost Area supplements on staff. This is reflected within the higher project NPV in the longer term. However despite this, the DVH option shows significant savings of £758k and in relation to the amount of capital required to achieve financial savings, the PI is far higher at DVH.

5.4. Assumptions

The following assumptions were made in developing this Outline Business Case:

- Total service provision will be similar or improved upon current performance across the Trusts.
- The anticipated income levels from direct access activity will not reduce significantly.
- Total cellular pathology services for both Trusts will be outsourced to MTW.

- Capital costs remain with a ±20% sensitivity limit which will be considered further at Full Business Case (FBC) stage and how it could impact upon the preferred option. At FBC stage, there will be firmer cost certainty.

- A high quality data connection between the two hospitals will be required although the cost of it has been excluded from this OBC because it is a pre-requisite for Trust integration and will feature as part of the business case supporting that particular development.

- Electronic order communications will be introduced after the implementation of this project to enable the planned reductions in staff currently allocated to manual ordering processing. This will be developed further within the FBC submission.

5.5. Conclusion

From the economic and financial appraisals, and the constraints on the availability of capital funds Option B requires less capital investment and offers the highest return per pound invested on the PI over 10 years. DVH provides greater opportunities for further reconfiguration within its current footprint. Furthermore, the changes proposed at DVH can be introduced more easily than at MMH whilst normal operations are maintained. Option B also provides the best alignment with the integrated Estates Strategy.

Option B is therefore recommended as the preferred solution.

6. The Commercial Case

The commercial case outlines how this project proposal is to be delivered and which procurement method is favoured should there be a commitment to implementing this proposal.

Option B will be considered in detail by the respective Estates Teams at MMH and DVH. The refurbishment/building works at DVH will be undertaken through a PFI Variation by THC (Dartford) Ltd., and its Facilities Management Provider, Carillion PLC. At MMH, the scheme will be tendered by a design team according to the Trust's Standard Financial Instructions. The MMH project will be managed by the Capital Projects Team throughout the process.

There is currently a sensitivity of ±20% built into the capital costs of this project at this point of business case development. In order to progress this further to FBC stage it requires funding for a set of accurate, tendered costs for the capital developments and plans to make the changes that amounts to a 35% shift in activity between the sites. At DVH, there will be a requirement to fund THC (Dartford) Ltd., for architects and project management capabilities to develop the design and to tender for the building and refurbishment work. Similarly, at MMH this process also needs to be completed to develop a "hot" laboratory. It is estimated that £100k is required to fund this work programme.

Funding for this project will be provided from the Capital Programmes of DVH and MMH respectively, and project set-up requirements are outlined in the management case below.

7. The Management Case

The purpose of this management case is to demonstrate that the project will be managed effectively and can be implemented successfully within budget and timescale.

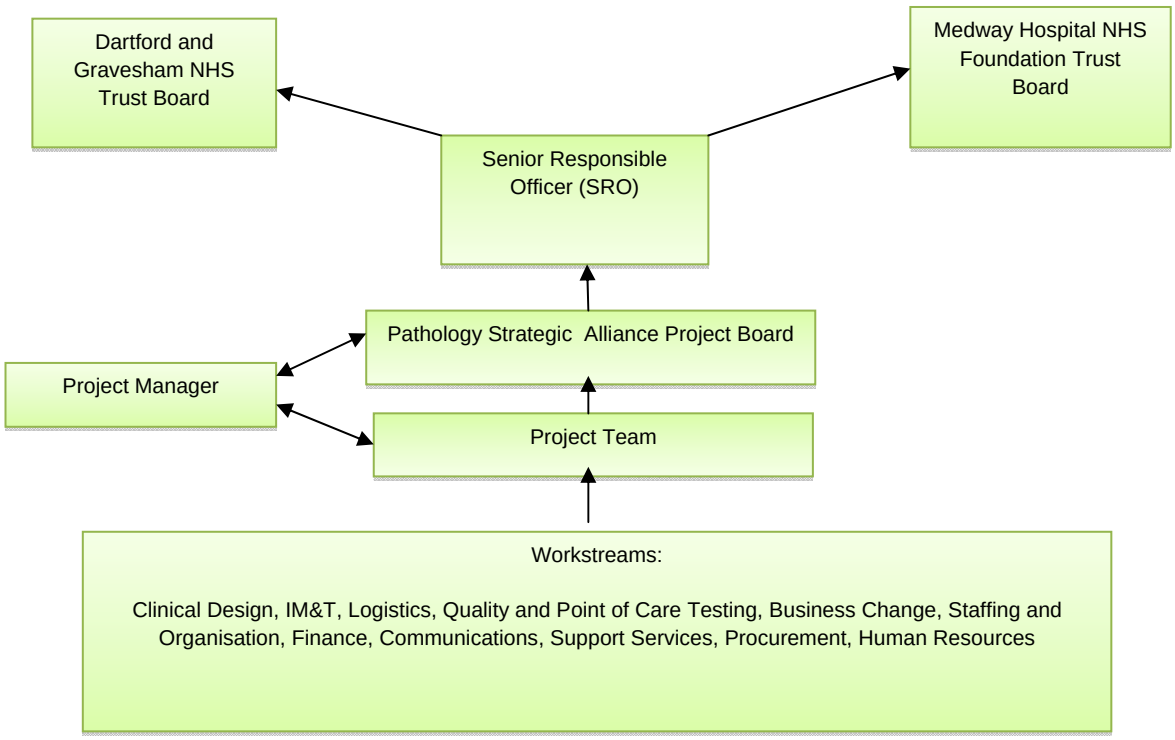
The following section describes the project management structure being followed by the Trusts for this business case.

7.1. Trust Board and Project Sponsor

7.1.1. Project Sponsors and Project Director

The Trust Boards of MMH and DVH as the Investment Decision Makers will approve the FBC. The Chief Executives of MMH and DVH will nominate a Senior Responsible Officer (SRO) who will be responsible to them for producing the FBC and its stated benefits following approval of the OBC.

7.1.2. Project Organisation Structure



Robust project management is recognised as essential for delivering a project of this complexity. This project organisation structure, shown in the diagram above, has been

developed to reflect the need to secure the contributions of key staff from across the Trusts to deliver this project effectively.

The overall project will be overseen by a Project Board which consists of the SRO, both pathology Clinical Directors, General Managers and Project Manager. Project management arrangements from the inception of the project will be developed as the project proceeds through the Full Business Case (FBC) stage, and implementation of the planned stages of development.

The Project Board will provide the overall direction and management for the project. The Project Board is accountable for setting the scope of the project, and for overseeing its successful delivery, and resolving conflict wherever necessary. The Project Board will approve all major plans and authorise any major deviation from agreed milestones. The Project Board will meet every month or more frequently when required, receiving Project Exception Reports where necessary.

A summary of key issues and risks are attached as appendix Two and a timetable of key milestones is attached as Appendix Three. It schedules the main laboratory to be in place at DVH in February 2013 and at MMH, the “hot” laboratory completed in May 2013, with the completion of the project set for July 2013.

A Project Team will be established to take forward the day-to-day management of project activities, on behalf of the Project Board to which it will account for its activities. It will effectively own the business case and ensure that value for money is achieved, the service specification is adhered to and the project milestones are achieved. The project will be broken down into stages with clearly identified deliverables attached to each. Completion and approval of a formal review for each stage of the project will be a pre-requisite for proceeding to the next stage. The Project Team will be held weekly or fortnightly as determined by the Project Manager. A PRINCE 2 project management methodology will be adopted to deliver this project.

The Project Team will be supported by key Workstreams as follows:

- Clinical Design;
- IM&T;
- Logistics;
- Quality and Point of Care Testing;

- Business change (including “lean” methodology);
- Staffing and Organisation;
- Finance;
- Communications;
- Support Services;
- Procurement; and
- Human Resources.

7.1.3. Benefits Realisation Plan

The realisation of identified benefits will be a major task of the Trust and one that will need to be managed successfully if the objectives of the project are to be achieved.

A draft Benefits Realisation Plan will be developed as part of the Full Business Case and will concentrate on the measurable benefits from this project taking into account the Project Critical Success Factors.

The following information will be documented:

- Description of the benefit
    - Project objective(s) to which it is related
    - Nature of the benefit
    - Quantifiable aspects of each objective
    - Qualitative aspects of each objective
    - Monitoring mechanism or performance indicator to be used to track delivery of the benefit
    - Review date to assess the realisation of the benefit

8. Conclusion

This project will be developed further and delivered in difficult macroeconomic circumstances. There are constraints on the availability of capital funds and Option B offers the highest return per pound invested on the PI over 10 years. DVH provides greater opportunities for further reconfiguration within its current footprint. Furthermore, the changes proposed at DVH can be introduced more easily than at MMH whilst normal operations are maintained. Option B also provides the best alignment with QIPP priorities.

This OBC therefore recommends that Option B is developed further as the preferred option, and for this to happen more detailed financial, service and estates plans will be required to produce the FBC.

APPENDIX ONE: SERVICE DIMENSIONS AND CURRENT FACILITIES

Current Pathology Service at Darent Valley Hospital (DVH)

DVH has an active and busy Pathology department serving not just the demands of the hospital but 41 GP practices. Activity levels for 2010/11 are shown in table 1.

Table 1: Darent Valley Hospital Pathology Activity 2010/11

	Hospital IP	Hospital OPD	Direct Access	Other	Total	% DA	Cold IP work	Hot IP work	Total cold work
Biochemistry	370,881	110,894	396,172	33,226	911,173	43.48	208,827	162,054	**749,119**
Haematology	170,327	62,864	120,959	11,832	365,982	33.05	87,700	82,627	**283,355**
Transfusion					36,862		25,127	11,735	**25,127**
Microbiology	53,479	50,753	65,322	11,960	181,514	35.99			**181,514**
Histopathology	253	12,225	8,266	1,381	22,125	37.36			**22,125**

(source: DVH Pathology Department, 2011) NB Includes immunology tests sent away

The Department has 92.92 whole time equivalents (WTE) including Consultant medical staff. The pay bill of the Department is currently £4.49m per annum. Non-pay budgets are £2.87m and non-tariff income is £231k. The pathology laboratories at DVH are located on Level 3 East. They are located close to the main inpatient theatres and Sterile Supplies Department and across the corridor from the Surgical Wards. The overall laboratory size is 1,206m^2 and 1,800m^2 with circulation and general space included.

The laboratories are served by a pneumatic tube system to deliver samples from hospital wards and departments. The current facility has been well maintained and there are no outstanding maintenance issues.

The existing layout of the laboratory is functionally suitable and effective although the main entrance and specimen reception could be improved. Gynaecology cytology services have transferred to MTW and two laboratory spaces have been left empty although one has been used for temporary body storage.

There is limited potential for the laboratory to expand physically; on one side, it adjoins inpatient theatres and SSU and both of these facilities are unlikely to move. Two external walls are on the other side and on an upper floor. There is currently accommodation within the laboratory which is allocated to non-laboratory purposes (clinical haematology offices, control of infection offices, the cytology secretariat, and redundant on-call rooms)

and all of which could be relocated elsewhere in the hospital releasing space for clinical purposes. The blood sciences laboratory is large and in excess of the requirements for a centralised laboratory if automated which offers a further area in which to develop the laboratory further.

Current Pathology Service at Medway Maritime Hospital (MMH)

The Pathology Service at MMH performs high volumes of activity each year, and direct access services feature as a significant part of its workload. MMH serves 89 GP surgeries, four prisons and the Army Barracks located in Chatham.

Table 2: Medway Maritime Hospital Pathology Activity 2010/11

	Hospital IP	Hospital OPD	Direct Access	Other	Total	% DA	Cold IP work	Hot IP work	Total cold work
Biochemistry	469,597		633,534	31,159	1,134,290	55.9	313,213	143,054	991,236
Haematology	337,122	141,743	9,192		488,057	29.0	109,040	112,461	375,596
Transfusion	29,963		10,032	158	40,153	25.0	11,025	12,121	28,032
Cytology	1,192		24,666	0	25,858	95.4			25,858
Microbiology	254,000		93,952	3,745	351,697	26.7			351,697
Immunology	9,230		2,865	368	12,463	23.0			12,463

(source: MMH Pathology Department, 2011) NB All immunology sent away

The Department has 93.63 whole time equivalents (WTE) working in it at the time of preparing this OBC and this manpower figure includes Consultant medical staff. The pay bill of the Department is £3.82m per annum currently. Non-pay budgets are £5.76m and non-tariff income is £544k. Pathology at MMH is located on level 3 in the Red Zone of the main hospital. The laboratories are connected to the maternity department secretariat via a fire door, which is only used as a means of escape. The overall laboratory size is 1,247m^2 which excludes circulation space. The laboratory has a pneumatic tube system to deliver samples from hospital wards and departments.

There is only one entrance to the pathology laboratory and all deliveries and people use this entrance. The laboratory is on two different levels with a scissor lift and stairs between the two.

The current laboratory is relatively new but has suffered from a lack of maintenance. The existing layout of the laboratory is not ideal with improvements required to the main

entrance, blood bank and specimen reception areas. Histology services have transferred to another Trust leaving two laboratory spaces vacant.

There is little potential for the laboratory to expand physically. One side of the facility adjoins the maternity unit and the other sides have two external walls. The laboratory is located on the top floor of the hospital. Currently some accommodation within the laboratory is allocated to non-laboratory purposes (offices) which could be relocated elsewhere in the hospital releasing space for clinical purposes.

APPENDIX TWO: TIMETABLE OF KEY MILESTONES

PATHOLOGY CENTRALISATION PROJECT	VERSION 2: 10.01.12																			
Key milestones = black diamonds																				
	Duration/date	**Jan-12**	**Feb-12**	**Mar-12**	**Apr-12**	**May-12**	**Jun-12**	**Jul-12**	**Aug-12**	**Sep-12**	**Oct-12**	**Nov-12**	**Dec-12**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Jul-13**
TASKS																				
Outline Business Case Produced	6 weeks																			
Approval by Trust Boards and funding allocated to proceed to FBC	24/01 26/01	◆																		
Project Governance																				
Establishment of Project Governance Structure																				
Appointment of Project Manager																				
Agreement of PID																				
Workstream leads agreed and work commenced																				
Capital alterations - DVH workstream																				
Submission of Variation enquiry and appointment of architects	1 month																			
Development of detailed brief	1 month																			
Design period	2 months																			
Tendering	2 months																			
Costs available for the FBC							◆													
Capital alterations - MVH workstream																				
Appointment of architects	1 month																			
Development of detailed brief	1 month																			
Design period	2 months																			
Tendering/pre-tender estimate	2 months																			
Costs available for the FBC							◆													
IT Workstream																				
Overall timescale	12-18 months																			
Detailed assessment of costs for inclusion in FBC							◆													
Introduction of systems to support centralised microbiology														◆						
Introduction of systems to support centralised blood sciences														◆						
Completion of overall IT project																				◆
Staffing workstream																				
Finalisation of new workforce plan	2 months																			
Costs available for the FBC	1 month				◆															
Consultation	3 months																			
Implementation possible from this date												◆								

PATHOLOGY CENTRALISATION PROJECT	VERSION 2: 10.01.12																			
Key milestones = black diamonds																				
	Duration/date	**Jan-12**	**Feb-12**	**Mar-12**	**Apr-12**	**May-12**	**Jun-12**	**Jul-12**	**Aug-12**	**Sep-12**	**Oct-12**	**Nov-12**	**Dec-12**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Jul-13**
TASKS																				
Logistics workstream																				
Development of spec for new transport service and assessment of costs	3 months																			
Costs available for the FBC	1 month					◆														
Tendering	3 months																			
Implementation possible from this date												◆								
Communications workstream - continuous from OBC approval																				
Enabling project - relocation of histopathology	3 months																			
Costs available for the FBC				◆																
Procurement of automated bood sciences system	12 - 18 months																			
Identification of costs for inclusion in the FBC							◆													
Production of FBC	5 months							◆												
Approval by Trust Boards	**Jul-12**							◆												
Capital alterations - DVH workstream																				
THC approvals	1 month																			
Service decants if required	1 month																			
Mobilisation	1 month																			
Construction	4 months																			
Works complete															◆					
Centralisation of Microbiology	**Feb-13**														◆					
Centralisation of Blood Sciences (Date defined by Managed Service Procurement)	**Mar - Aug 13**														◆					
Capital alterations - MVH workstream																				
Decant following centralisation of microbiology																				
Construction																				
Works complete																		◆		
Hot lab complete	**May-13**																	◆		

APPENDIX THREE: KEY ISSUES AND RISKS

Dartford and Gravesham NHS Trust & Medway NHS Foundation Trust
Location of the Main and "Hot" laboratories at Medway Maritime Hospital and Darent Valley Hospital

RISK REGISTER: VERSION 1: 9.1.12

Risk Manager: Project Director

Number	Description/effect	Identification /cause	Date	STATUS	Probability score	Impact score	Combined score	Mitigation plan	Risk Owner
1	Delay	Implementation may be delayed due to pressures on service managers due to operational responsibilities and the integration of the Trusts	10.1.12	Potential	4	4	16	Appointment of an external project manager and back filling key staff where required	SRO
2	Delay	Implementation may be delayed due a lack of specialist support in procurement	10.1.12	Potential	3	3	9	1. Meetings with MTW to review their process 2. Early Dialogue with suppliers 3. Early dialogue with Heads of Procurement 4. Use of external consultancy if required	Project Director
3	Delay	Implementation may be delayed due to the development and tendering of building solutions	10.1.12	Potential	3	4	12	1. Early issue of a Variation Enquiry to the PFI Company at DVH 2. Early request for input from MFT Estates department 3. Robust Project Management	Project Director
4	Delay	Implementation may be delayed due to a lack of IT connectivity	10.1.12	Potential	4	4	16	1. Urgent Review by Lead Director at D&G 2. Development of interim plans as well as long term solutions	SRO
5	Delay	Histology may not relocate in time	10.1.12	Potential	4	4	16	1. Escalation to Director of Operations at D&G	D&G Lead Manager
6	Delay	Capital funding may not be available to commence the design and procurement work streams in accordance with the project plan	10.1.12	Potential	3	4	12	1. Submission of capital business case at D&G 2. Notification of capital requirement to capital planning function at MFT	Project Director
7	Costs	It may prove too costly to relocate histology	10.1.12	Potential	3	4	12	1. Escalation to Director of Operations at D&G	D&G Lead Manager
8	Costs	The capital costs may be higher than anticipated, undermining the viability of the project	10.1.12	Potential	2	4	8	1. Early issue of a Variation Enquiry to the PFI Compnay at DVH 2. Early request for input from MFT Estates department 3. Robust Project Management	Project Director
9	Costs	The costs of the managed service provision may be higher than anticipated, undermining the viability of the project	10.1.12	Potential	3	4	12	1. Early Dialogue with suppliers	Project Director
10	Costs	Staffing costs may be higher than anticipated, undermining the viability of the project	10.1.12	Potential	3	4	12	1. Finalisation of workforce plans 2. Costing of workforce plans	Work stream Lead
11	Costs	Equipment requirements may have been underestimated	10.1.12	Potential	3	4	12	1. Production of equipping schedules	Work stream Lead
12	Finance	The trusts may lose some direct access pathology	10.1.12	Potential	4	4	16	1. Stakeholder Analysis 2. Stakeholder Management Plan 3. Communications Plan 4. Marketing Strategy	Work stream Lead
13	Staffing	Some staff may not wish to work in a centralised laboratory and may leave	10.1.12	Potential	3	4	12	1.Communications Plan	Workstream Lead
14	Stakeholder management	Internal stakeholders may not support the plans for centralisation	10.1.12	Potential	3	4	12	1.Communications Plan	Workstream Lead
15	Stakeholder management	External stakeholders may not support the plans for centralisation	10.1.12	Potential	4	4	16	1.Communications Plan	Workstream Lead
16	Stakeholder management	Patients and the public may not support the plans for centralisation	10.1.12	Potential	2	4	8	1.Communications Plan	Work stream Lead
17	Planning	The new lab may prove to be too small for the combined workload	10.1.12	Potential	2	4	8	1. Detailed planning	Work stream Lead
18	Planning	The new lab may prove to be too large for the combined workload	10.1.12	Potential	2	4	8	1. Detailed planning	Work stream Lead
19	Service Disruption	Service quality is disrupted during the centralisation	10.1.12	Potential	3	4	12	1. Robust Project Management on both sites	Project Director
20	Service Disruption	Other clinical services are disrupted due to the construction projects	10.1.12	Potential	3	4	12	1. Robust Project Management on both sites	Project Director

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TRUST BOARD MEETING – JANUARY 2012

Item 1-10.2. Attachment 22 - Update on proposed integration with Medway NHS FT

1-10.2 UPDATE ON PROPOSED INTEGRATION WITH MEDWAY NHS FOUNDATION TRUST — DEPUTY CHIEF EXECUTIVE

This paper provides a brief update on the key areas of the integration. The Terms of Reference for the Integration Programme Board (IPB), and the Outline Business Case (OBC) for the integration are to be considered as separate agenda items.

Clinical Strategy

- The latest series of clinical strategy meetings that were scheduled for quarter 3 have now been completed. Each specialty has a completed service vision and plan which include activity, income and resource implications. The detail of these has been shared with the clinical directors and general managers for the non-admitting specialties to identify and plan for the impact on their services.
- Clinical Directors from both organisations discussed their service vision and plans with the GP commissioning leads from Dartford and Medway during a round table clinical discussion about integration during December. A Clinical Directors' away day is scheduled for the 27th January 2012. Clinical Directors will present their own service vision and plans to each other.

Cooperation and Competition Panel (CCP)

- An informal meeting with the CCP's Inquiry Director took place in December 2011. A list of initial questions and an indication of a start date for phase one was provided. The CCP will not begin phase one in January 2012 as previously anticipated due to the delays in cases they are currently dealing with and constraints they have matching their resource with the amount of submissions they are currently receiving.

Strategic Health Authority (SHA) and Commissioners

- A series of meetings with the PCT Cluster and SHA continue to take place. The Outline Business Case (OBC), once approved by both Trust Boards, will be submitted to the SHA. The delay in the start date was highlighted as a risk in delivery of the timelines agreed as part of the Tripartite Formal Agreement (TFA) with the SHA, however, movement of the integration date despite events outside of the Trust's control is not taken into account by the Department of Health.

Organisational Development Strategy

- Following meetings with Trust Board members throughout December, the organisational development strategy and implementation plan will be shared with the IPB in March. However, the key features are presented in the OBC.
- A plan to develop the Trust Board and wider organisation structure will be shared with the Designate Chair upon appointment, and before being submitted to the IPB and Boards.

Communications

- MFT and DGT Chief Executives, clinical staff and the Transition Team have now met with over 590 members of the public face to face. Further stakeholder events are scheduled during January and February and are being widely advertised. Briefings will be provided to Borough Councils over the next quarter.
- An analysis of comments, questions and concerns is being undertaken and detailed updates for publication in local newspapers will be provided in February and March. There is a commitment to circulate good news stories via a variety of communication channels. Integration news will be weaved into the story wherever possible.
- The public events diary is regularly circulated to Governors and is on both Trusts' websites and integration events are being advertised on the Trust's Facebook page.
- During December, MFT and DGT Chief Executives attended the Medway Health & Adult Social Care (HASC) overview & scrutiny committee and they have been invited to attend again in

March 2012.

- At the end of last year, Kent and Medway LINks submitted over 200 comments and questions to us, raised at their events. Responses have been published on the websites of both trusts' and Kent and Medway LINks. Three key themes of concern raised by attendees were transport, finances and clinical issues.

IM&T

- A draft IM&T strategy was presented to the IPB on 18th January by the Director of Performance and Business Intelligence at Dartford and Gravesham NHS Trust.

Finance & Long-Term Financial Model (LTFM)

- Over the past month finance teams at both sites have worked with the transition team to revise the LTFM for integration purposes. This has included incorporating the impact of the Operating Framework for 2012/12, clinical directorate strategies and capacity plans as well as revised 2011/12 year-end forecasts for both Trusts. The updated model is contained in the OBC.

Mitigation Plans

- The LTFM prepared for the OBC has taken into account a range of downside modelling assumptions that the Trusts' advisors' Pricewaterhouse Coopers have advised on. Details of the impact of these can be found in the OBC.

Due Diligence

- Clinical due diligence reports are being finalised by each organisation. They will then be shared and a jointly agreed final report produced which will contain the recommendations for the future governance arrangements of the new organisation. Estates, finance and legal due diligence is currently being commissioned. Workforce due diligence will take place internally.

New Governor arrangements

- Further proposals for the Governor arrangements were issued, for comment, to the Governors at both DGT and MFT on 13th January 2012. Following the consideration of comments received, the proposed arrangements will be considered at the Council of Governors at MFT on 25th January, before being considered by the DGT Council of Governors on 15th February.
- The proposals will then be considered for approval at the Trust Board meetings on 23rd February (DGT) and 28th February (MFT);
- In the meantime, two joint-Governor events have been scheduled (for February 1st and 15th), to enable existing Governors to network, and receive a tour of the two hospital sites.

Amended Scheme of Delegation for the integration

- The Scheme of Delegation agreed by the Board in December 2011 has been amended to reflect comments made following discussion at the Medway NHS Foundation Trust (MFT) Board meeting on 20.12.11.
- MFT's Board approved the Scheme subject to the following amendments:
  - Amend one of the decisions allocated to the Chief Executive Designate to read 'The determination of Executive Management structure and appointment to Executive Director roles of the integrated organisation (jointly with the Designate Chair) *and through the existing Nominations & Remuneration Committee procedure*.' (new text is in italics)
  - Make it explicit that the Post-Transaction Implementation Plan (PTIP) should be approved by the Board rather than the IPB
  - The transfer of the following decisions from the IPB to the Trust Boards (jointly):
    - Approval of the IPB's terms of reference; and
    - Approval of plans and strategies for stakeholder engagement and/or consultation
- A revised Scheme of Delegation was submitted to the IPB on 16th January 2012, and duly agreed. In the interests of brevity, the full Scheme of Delegation has not been re-circulated, but the Board is asked to consider and approve the amendments listed above. Full copies of the amended Scheme of Delegation are available from the Trust Secretary on request.

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
For information and assurance, and to approve the proposed amendments to the Scheme of Delegation for the integration

Equality Impact Assessment initial screening applicable to this report? No

This report provides information on the following annual objectives (delete as required)**:**

- To improve patient experience and patient safety, and achieve the best health outcome for patients, through implementation of the Quality Plan for 2011/12;
- To maintain the highest standards of cleanliness and reduce healthcare associated infections, maintaining a zero tolerance approach to infections acquired within Darent Valley Hospital;
- To develop productive relationships with emerging GP Consortia, local authorities, and other new partners, in order to provide sustainable services for the community, and achieve a sustainable local health economy;
- To recruit excellent staff, and develop, manage, lead and support our staff fairly, to ensure they are motivated to deliver high quality and excellent services;
- To deliver the objectives set out in the Financial Plan for 2011/12, including the delivery of a Quality, Innovation, Productivity and Prevention (QIPP) programme that develops patient pathways which provides care closer to patients' homes, and improves the efficiency of the services the Trust provides, thereby saving resources and releasing capacity

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors understanding of the Trust & its performance

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TRUST BOARD MEETING – JANUARY 2012

Item 1-10.3. Attachment 23 - ToR for IPB

1-10.3 TERMS OF REFERENCE FOR THE INTEGRATION PROGRAMME BOARD (IPB) — DEPUTY CHIEF EXECUTIVE

The updated Memorandum of Understanding between Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust led to the establishment of the Integration Programme Board (IPB), which has met monthly since October 2011.

The Terms of Reference (ToR) for the IPB were agreed by the IPB in November 2011. Since then, during consideration of the Scheme of Delegation for the integration by the Board of Medway NHS Foundation Trust, it has been proposed that the IPB ToR be approved by both Trust's Boards (rather than being approved by the IPB itself). This issue is covered within item 1-10.2 (attachment 21).

The ToR are therefore presented for approval.

The enclosed ToR will also be submitted to the Board of Medway NHS Foundation Trust, for approval, on 31st January 2012.

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
To approve the Terms of Reference and membership of the Integration Programme Board

Equality Impact Assessment initial screening applicable to this report? No

This report provides information on the following annual objectives (delete as required)**:**

- To improve patient experience and patient safety, and achieve the best health outcome for patients, through implementation of the Quality Plan for 2011/12;
- To develop productive relationships with emerging GP Consortia, local authorities, and other new partners, in order to provide sustainable services for the community, and achieve a sustainable local health economy;
- To recruit excellent staff, and develop, manage, lead and support our staff fairly, to ensure they are motivated to deliver high quality and excellent services;
- To deliver the objectives set out in the Financial Plan for 2011/12, including the delivery of a Quality, Innovation, Productivity & Prevention (QIPP) programme that develops patient pathways which provides care closer to patients' homes, & improves the efficiency of the services the Trust provides, thereby saving resources and releasing capacity

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors understanding of the Trust & its performance

Integration Programme Board (IPB)

Terms of Reference

1. Purpose, role and aims

To oversee and ensure the delivery of the Integration Programme on behalf of the Boards of Dartford and Gravesham NHS Trust (DGT) and Medway NHS Foundation Trust, in line with the requirements of the updated Memorandum of Understanding (MoU), agreed by both Boards – MFT (29.11.11) and DGT (24.11.11). In keeping with DGT's proposed timeline for achieving FT status, the IPB will facilitate the necessary step to enable the integration of the two Trusts by August 2012.

Specific tasks:

Governance:

1.1 To oversee the Integration Programme and its governance arrangements.

1.2 To oversee the work of the Transition Team and provide this Team with the required reporting, governance and guidance to deliver the requirements of the updated MoU

1.3 To oversee and scrutinise the development of the Integration Case [2].

1.4 To ensure that the programme undertakes all appropriate steps to achieve integration via the acquisition of DGT by MFT in accordance with Monitor's Compliance Framework, the NHS Transactions Manual and taking account of Monitor's Risk Evaluation of Investment Decisions (REID) guidance.

1.5 To ensure that the programme develops a post-transaction integration plan (PTIP) which meets required external standards, and which will deliver the identified benefits of the integration.

1.6 To ensure the integration is managed as that of between two organisations of equal standing, with the intention that staff and patients will experience an integration of equals with neither Trust acting as the dominant partner.

1.7 To oversee plans for stakeholder engagement with the public, staff, commissioners, local authorities and other NHS partner organisations.

2: Accountability

2.1 The IPB will report to both Trust Boards on a monthly basis, but should not be considered one of the formal sub-committees of either Board.

2.2 The IPB is authorised to make decisions regarding the management of the integration programme, providing that such decisions do not materially affect the strategy, governance or management of the individual Trusts prior to integration.

2.3 Any decisions related to the integration programme that materially affect the strategy, governance or management of the individual Trusts prior to integration must be reserved to the individual Trust Boards. The IPB is however authorised to make recommendations to the Trust Boards in relation to such decisions.

[2] The details of the Integration Case will be employed to fulfil a range of internal and external requirements, including the 'Business Case' for the dissolution of DGT; the submission to the Cooperation and Competition Panel for NHS-funded services (CCP); and the Integrated Business Plan (IBP) for the integrated organisation, which will be considered by Monitor as part of its process for assigning indicative risk ratings to the integration.

3: Membership

3.1 Chair: The IPB will be chaired by the Chairman of D&G and MFT (alternating) each month. In the absence of one Chairman, the other will take the Chair.

3.2 Members:
- Chairs – D&G and MFT
- Chief Executives – D&G and MFT
- 1 Non Executive Director from D&G and 1 from MFT
- Medical Directors – D&G and MFT
- Programme Director and Core Members of the Transition Team

3.3 Attendees:
- NHS South of England representative (observer status)
- Others may be co-opted to attend for either a fixed period of time or for specific meetings

4: Meeting Frequency

4.1 The IPB will meet monthly.

4.2 At the discretion of the Chair, other meetings may be held to fulfil its tasks.

5: Quorum

5.1 The IPB must have at least one Chief Executive, one Chair, one Medical Director and one member of the Transition Team present at each of the meetings, and there should be at least one member from both Trusts present

6: Review and approval

6.1 These Terms of Reference will be approved by the Trust Boards of DGT and MFT

6.2 Any significant amendments to the Terms of Reference or membership require the approval of the Board at both Trusts.

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TRUST BOARD MEETING – JANUARY 2012

1-10.4	OUTLINE BUSINESS CASE FOR INTEGRATION WITH MEDWAY NHS FOUNDATION TRUST	DEPUTY CHIEF EXECUTIVE

The enclosed Outline Business Case (OBC) describes the rationale for the integration of Dartford and Gravesham NHS Trust (DGT) and Medway NHS Foundation Trust (MFT). It sets out the strategic drivers, the future vision and the benefits that the integration provides.

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
To approve the Outline Business Case

Equality Impact Assessment initial screening applicable to this report?
Yes

This report provides information on the following annual objectives (delete as required)**:**

- To improve patient experience and patient safety, and achieve the best health outcome for patients, through implementation of the Quality Plan for 2011/12;
- To maintain the highest standards of cleanliness and reduce healthcare associated infections, maintaining a zero tolerance approach to infections acquired within Darent Valley Hospital;
- To develop productive relationships with emerging GP Consortia, local authorities, and other new partners, in order to provide sustainable services for the community, and achieve a sustainable local health economy;
- To recruit excellent staff, and develop, manage, lead and support our staff fairly, to ensure they are motivated to deliver high quality and excellent services;
- To deliver the objectives set out in the Financial Plan for 2011/12, including the delivery of a Quality, Innovation, Productivity and Prevention (QIPP) programme that develops patient pathways which provides care closer to patients' homes, and improves the efficiency of the services the Trust provides, thereby saving resources and releasing capacity

N.B. Some of the content of this paper has been redacted, due to its commercial sensitivity. The redacted content is indicated within the document.

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors understanding of the Trust & its performance

PROGRAMME DOCUMENTATION

OUTLINE BUSINESS CASE (OBC) FOR THE ACQUISITION OF DARTFORD AND GRAVESHAM NHS TRUST (DGT) BY MEDWAY NHS FOUNDATION TRUST (MFT)

INTEGRATION PROGRAMME

Release: Final

Date: 19th January

Author: Transition Team

Owner: Jeremy Moon

Dartford and Gravesham NHS Trust

Medway NHS Foundation Trust

OUTLINE BUSINESS CASE FOR THE ACQUISITION OF DARTFORD AND GRAVESHAM NHS TRUST BY MEDWAY NHS FOUNDATION TRUST

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Redacted due to commercial sensitivity

Redacted due to commercial sensitivity

Redacted due to commercial sensitivity

Redacted due to commercial sensitivity

1 Introduction and Background

The Outline Business Case (OBC) describes the reasoning and plan for Medway NHS Foundation Trust (MFT) to acquire Dartford and Gravesham NHS Trust (DGT). It sets out the strategic drivers for the acquisition; the vision for the future organisation, the benefits that the integration enables and how they will be delivered.

The OBC recognises the similarities of the healthcare profiles of the local population and also a number of synergies that exist between MFT and DGT that are shown below:

Existing synergies between MFT and DGT:

- Shared community health profile (as illustrated in deprivation ranking described below)
- Common core clinical business as small to medium sized general hospitals
- Existing clinical relationships at a number of levels including hosted services, shared patient pathways and junior doctor rotations
- Differentiation opportunities at a subspecialty level
- Consolidation opportunities at a clinical support level
- Combined estate and equipment flexibility to enable clinical developments
- Secondary markets that do not overlap and growth opportunities at both ends of the local health economies

The newly created organisation will be shaped through the delivery of an ambitious healthcare vision and strategy known as ‘Better Care Together’. This vision and strategy has been designed around a number of key principles that involve exceeding expectations, relentlessly innovating and improving and becoming an organisation that staff, patients and stakeholders are proud of and want to recommend. A programme of communication, leadership

development and behaviours will be central to the development of the culture required to ensure the vision of the new organisation becomes a reality.

1.1 Purpose of this document

The Outline Business Case (OBC) is a detailed document that describes the plan for Medway NHS Foundation Trust (MFT) to acquire Dartford and Gravesham NHS Trust (DGT). The OBC is intended to be a living document which will evolve and further develop into the full business case (FBC) (also known as the integrated business plan, IBP).

The document has been prepared for consideration by the MFT and DGT Trust Boards and subsequently NHS South of England. It has been developed in light of the guidelines prepared by HM Treasury on the development of the OBC. The document will inform the reader of progress to date on integration and clearly outline what information is not currently available but can be expected before the full business case is submitted to the relevant authorities.

Following consideration of the strategic outline case and rigorous assessment of feasibility in September 2011, the submission of the OBC to MFT and DGT Trust Boards is designed to give Board members further opportunity to set the direction and pace of travel towards integration. Following Board approvals, the OBC will be submitted to NHS South of England who will be invited to consider and approve the OBC before receiving the FBC.

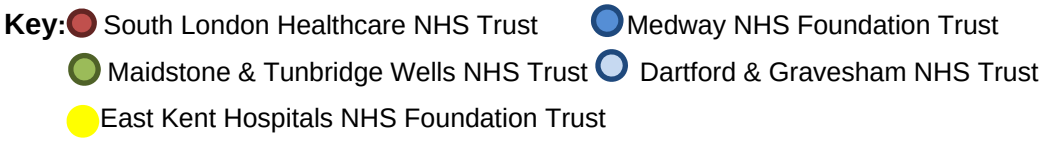
2 Current Service Profile of both Trusts

This chapter describes the current service profile of Medway NHS Foundation Trust (MFT) and Dartford and Gravesham NHS Trust (DGT) and the health economies they serve.

2.1 North Kent Local Health Economy

There are four NHS acute Trusts in Kent – The Medway NHS Foundation Trust, Dartford and Gravesham NHS Trust, East Kent Hospitals NHS Foundation Trust and Maidstone and Tunbridge Wells NHS Trust. The other nearest NHS acute trust is South London Healthcare NHS Trust which comprises Queen Mary's Sidcup, Queen Elizabeth Hospital, Woolwich and Bromley Hospitals. The other nearest acute provider is Basildon and Thurrock University Hospitals NHS Trust that is based in South West Essex. Both MFT and DGT have clinical links with London through a variety of tertiary relationships notably with Guys & St Thomas' NHS Foundation Trust and Kings College Hospital NHS Foundation Trust. Travel links with London benefit from a high speed rail link to London from Ebbsfleet International.

Figure 3: Map of Local Acute Hospitals



The commissioning structure has significantly changed during 2011/12. At the beginning of 2011/12 there were four distinct commissioning PCTs that commissioned with DGT and MFT: NHS West Kent; NHS Medway; Bexley Care Trust and NHS Eastern and Coastal Kent. A Kent wide commissioning PCT cluster has now been formed, and Clinical Commissioning Groups (CCG's) formed in Medway and Dartford, Gravesham and Swanley who both have obtained pathfinder status.

Medway NHS Foundation Trust and Dartford & Gravesham NHS Trust are situated within their local communities and are 16 miles apart, well connected by road and bus routes. Relationships between the Trusts are good, strengthened by the appointment of the former DGT Chief Executive to MFT in early 2010. There are a number of existing partnerships and joint services, including: Ear, Nose and Throat (ENT), Urology, Audiology, Dermatology, Rheumatology and Pathology. MFT have provided ENT and Audiology services at Darent Valley Hospital for over 10 years.

2.2 Dartford & Gravesham NHS Trust

Dartford and Gravesham NHS Trust was legally established on 1st November 1993, and is based at Darent Valley Hospital (DVH), in Dartford, Kent. It offers a comprehensive range of acute hospital based services to around 270,000 people in Dartford, Gravesham, Swanley and Bexley. DVH opened in September 2000 and now has 463 inpatient beds. The hospital building is run as part of a Private Finance Initiative (PFI). This means that the building is owned by The Hospital Company (Dartford) Limited, a private sector company, from which the Trust leases the building. The Trust is commissioned primarily by West Kent Primary Care Trust (now part of the West Kent and Medway commissioning cluster) and Bexley Care Trust (now part of the NHS South East London commissioning cluster).

DGT provides a comprehensive range of services and works with partners to provide a limited range of specialist services such as renal dialysis in partnership with Kings College Hospital, London. The Trust has invested significantly in keyhole surgery and other non-invasive technologies such as laparoscopes, cryoablation therapy and lasers. This advanced practice has enabled the provision of specialist treatments including kidney stones, prostate cancer and coronary angioplasty.

Following the closure of Queen Mary's Sidcup A&E and maternity services at the beginning of 2011 as part of the implementation of South East London's 'A Picture of Health' initiative DGT has increased its percentage of clinical income from this area from 8% in 2010/11 to 17% in 2011/12, and continues with its aim to be the local acute provider of care for the Bexley population.

The Trust employs approximately 2300 members of staff. Estates and facilities services are provided by Carillion Health, as part of the PFI contract.

The table below presents the Trust's services, activity & clinical income for 2010/11 (excluding excess bed days, but including ward attenders, and outpatient procedures in outpatients). The Trust's total income for 2010/11 was £157m.

Figure 4: DGT Services, Activity and Clinical Income for 2010/11

Dartford & Gravesham NHS Trust 2010/11					
Services	**Spells (Inpatient)**	**Attendances (Outpatient)**	**Income (IP) £000s**	**Income (OP & Block) £000s**	**Total Clinical Income £000s**
General Surgery	7,780	18,211	£13,202	£3,665	**£16,867**
Urology	4,220	14,744	£4,657	£2,228	**£6,885**
Trauma & Orthopaedics	4,300	34,112	£14,625	£4,603	**£19,228**
ENT	0	0	£0	£0	**£0**
Intensive Care / HDU (bed days)	3,419	0	£4,370	£0	**£4,370**

Accident & Emergency	4,281	90,320	£4,558	£8,716	**£13,274**
General and Elderly Medicine	11,692	18,564	£26,000	£3,063	**£29,063**
Cardiology	1,228	13,014	£3,389	£2,354	**£5,743**
Paediatrics	4,761	6,324	£4,607	£1,597	**£6,204**
Obstetrics	5,350	42,586	£10,318	£5,173	**£15,491**
Gynaecology	2,560	13,654	£3,560	£1,891	**£5,451**
NICU/SCBU (cot days)	3,806	0	£1,997	£0	**£1,997**
Cancer Services / Medical Oncology	2,124	7,782	£1,656	£2,889	**£4,545**
Other	0	0	£899	£9,110	**£10,009**
Total	**55,521**	**259,311**	**£93,838**	**£45,289**	**£139,127**

2.3 Medway NHS Foundation Trust

Medway NHS Foundation Trust started life as a naval hospital. Medway Maritime Hospital (MMH) transferred to the NHS in the late 1960s and now serves a population of 360,000 across the communities of Medway and Swale. The Trust provides a comprehensive range of district general hospital services, employs around 3,800 staff and achieved Foundation Trust status in April 2008.

MFT currently provides a number of specialist services for the wider Kent population including: level 3 neonatal intensive care; West Kent Urology Cancer Centre; West Kent Vascular service; interventional radiology; level 2 oncology service, and angiogram and implantable cardiac defibrillator services.

MFT was until recently commissioned primarily from NHS Medway (now part of the West Kent and Medway commissioning cluster). Medway Council is a unitary authority.

Details of MFT services, activity and clinical income for 2010/11 has been redacted due to its commercial sensitivity.

3 Strategic Context for integration

This chapter describes the future vision and the strategic aims for the newly created organisation. This vision, known as Better Care Together, has been created in response to a number of key strategic drivers which are also illustrated in this section. It concludes with a summary analysis of the strengths, weaknesses, opportunities and threats related to the integration.

3.1 Vision and Strategic Aims

Providing Better Care Together

Clinical leadership is at the heart of delivering a successful acute integration. There is a strong belief at both Trust Board and at Clinical Director level that bringing two trusts together will create a whole that is greater than the sum of the parts. It is from here that the vision and strategy known as **Better Care Together** was created. The fundamental success of the integration is built upon the desire to deliver an ambitious healthcare strategy for the communities of North Kent which will see the delivery of excellent acute healthcare services.

Principles

To achieve such an ambitious strategy, strong principles have been developed. They are designed to focus on key outcomes, clearly declaring the level of ambition that the new organisation wishes to attain, and explicitly communicating to patients and staff, what they can expect from the creation of the new organisation:

We will exceed your expectations: We will care for you, not just treat you.

We will always innovate and improve: We will be a top performing hospital and we will strive to make sure that our care and treatment compares with the very best.

We will be an organisation to be proud of: Our staff and patients will want to recommend the services that we provide to you. We will attract the best and the brightest to join us so that we can continually provide excellent care.

A programme of communication, leadership development and behaviours will be central to the development of the culture required to make the principles upon which the organisation is based, a reality, and deliver the **Better Care Together** vision.

Strategic Aims

The overarching strategic aims; to provide **high quality core services** and develop appropriate **enhanced specialist services** is central to the integrated organisation's vision to provide **Better Care Together**. These aims have been developed and shared with stakeholders, including commissioners, GPs, voluntary organisations, patients and the public. Diagram 1 provides a visualisation of the **Better Care Together** strategy.

Figure 6: Better Care Together

Excellent Health Outcomes: Local people deserve access to the very best healthcare. The clinical strategy establishes how the integrated organisation will achieve excellent quality and safety outcomes through initiatives such as modernisation, driving innovation, developing unified models of clinical care and harnessing patient feedback to make improvements. The integrated Clinical strategy is supported by other key strategies notably in areas such as Organisational Development, IM&T and Estates to ensure excellent health outcomes are consistently delivered and remain at the heart of what the new organisation aims to achieve.

Modern & Sustainable Services: There is a deep commitment to protect and sustain core services (including, accident and emergency, maternity, paediatrics, and ambulatory care) on both hospital sites ensuring that they remain accessible to local people and fit for purpose to deliver 21st century healthcare. The benefits the integration provides in both scale and resilience underpin this commitment. Moreover, the population size the new organisation will serve enables the enhancement and expansion of more specialist services and in turn provides the basis for retaining and attracting the very best clinical workforce to deliver care. The integration also provides significant opportunities to make transformational changes that could not otherwise be achieved staying as separate organisations. Creating economies of scale, reducing duplication and consolidating non patient facing services, such as clinical support services, and corporate functions, such as Human Resources and Finance, release efficiencies to invest in front line clinical services.

Top Performing: The integrated organisation will become one of the top performing organisations in its field in key quality, safety, productivity and efficiency indicators. Benchmarks for the new organisation in performance across quality and efficiency have been set to mean that it will be one of the very best acute healthcare providers in the country. Local people deserve a local health service that they can be proud of and a service that competes with the very best.

Engaged Local Communities: A strong and effective membership base is an essential requirement of a successful Foundation Trust. The integrated organisation will build on the excellent membership base and working relationships with governors already in existence. The inclusive approach to the integration process has already begun and local people are already involved in shaping plans for the integrated organisation in new and innovative ways. The integrated organisation is committed to working and actively listening to key stakeholders to make improvements and shape future clinical services to meet their needs.

Innovative Partnerships: Strong relationships with commissioners and with other provider services, in both health and social care is crucial to the success of the integrated organisation, but more importantly, crucial to improving the health of our local populations. Patient centred care remains at the core of what the integrated organisation aims to achieve and it is recognised that creating excellent services for local people is dependent upon seamless pathways across services. Partnership working is an explicit intention of the integrated organisation.

3.2 Key Strategic Drivers

There are a number of drivers which make the strategic case for integration between DGT and MFT a compelling one:

Key Strategic Drivers:

- Sustainability issues for small to medium sized general hospitals
- Financial viability
- Policy context
- Current and future commissioning intentions
- Local demographic and health profile

- **Key Strategic Driver: Sustainability issues for small to medium sized general hospitals**

Evidence suggests that to sustain a full range of clinical services, a population size of 0.5 million is required. For example in 'Delivering High-quality Surgical Services for the Future'[2], the preferred catchment population size for an acute general hospital providing the full range of facilities, specialist staff and expertise for both elective and emergency medical and surgical care is 450,000–500,000. There is a trend towards sub-specialisation where individual clinicians move away from being more "generalist" and focus on developing specialist areas of expertise, conducting higher numbers of similar procedures. Evidence demonstrates that this improves outcomes and the integration will provide excellent opportunities for clinicians to sub-specialise, both improving the delivery of current services and providing the opportunity to develop services which are currently not available locally.

The long term sustainability of smaller acute hospitals is also threatened by national policy publications such as the introduction of Improving Outcome Guidance (IOG) in cancer services[3] and 'High Quality Women's Health Care: A proposal for change'[4]. Such documents are examples of the national trend towards reconfiguring different types of services to provide safer, high quality and more timely care to larger populations.

MFT and DGT are surrounded by much larger organisations that serve populations well in excess of 0.5 million. As standalone entities, MFT and DGT would not have either the population size or the infrastructure required to sub-specialise further, and therefore would not have the ability to compete on the grounds of quality. Poorer clinical outcomes and an inability to invest in infrastructure required will lead to local people choosing to access services elsewhere, which could gradually erode services for local communities.

[2] Delivering High-quality Surgical Services for the Future, The Royal College of Surgeons of England (2006)
[3] See www.nice.org.uk/Guidance/CSG/Published
[4] See www.nice.org.uk/Guidance/CSG/Published

Linked closely to population size and subspecialisation is the need to sustain medical rotas and educational needs compounded by the current imperative of European Working Time Directive (EWTD) standards. Specialities, such as paediatrics and emergency medicine, are already facing a shortage of middle grade doctors and a combined medical workforce will mean that there is a larger pool of clinicians to call upon. A combined Trust will build in an element of resilience that standing alone, neither hospital can achieve. It also becomes more attractive to new and existing consultants who will have the opportunity to pursue their sub-speciality interest and in some instances an on call rota that will be on par with surrounding hospitals rather than one that is more onerous.

- **Key Strategic Driver: Financial viability**

The economic downturn has placed unprecedented pressure on the public sector to ensure best value for money and is demanding that service models are delivered more innovatively. According to the 2009 Department of Health Annual Report the NHS is facing a significant financial challenge, with an estimated funding gap of £15–20 billion that needs to be resolved by 2014. The impact of this will be felt across all healthcare providers and clinical specialties. Transformation and service redesign will be essential, if the efficiency aims of the Quality, Innovation, Productivity and Prevention (QIPP) agenda are to be realised, while improving the quality of care delivered.

Therefore, as the challenge of delivering clinical services in a difficult financial climate continues the efficiency and productivity of clinical services will come under even more intense scrutiny. There are a number of opportunities through clinical service integration that can be best taken forward working more collaboratively. This allows the funding available in the system to be used more effectively and prioritised for the front line provision of clinical services for patients.

The NHS Operating Framework for 2012/13 adds further financial pressure to the system and it is recognised that both Trusts will need to respond

strategically to the challenges set out within it through the application of incentives for delivery. The full business case will model through the full implication of tariff changes, when the detail is known.

- **Key Strategic Driver: The policy context**

The Health and Social Care Bill 2010/11 presents a number of key drivers, notably the reduction in clinical income for acute hospitals as a result of an increase in less complex clinical work being managed in primary care. The approach to addressing greater demand from an increasingly elderly population is to manage chronic diseases more effectively in the primary care setting, rather than the default position of hospital care. This will be spearheaded more effectively as a result of clinical based commissioning, which advocates the lead role of GPs and other clinicians. Ensuring that care is provided closer to home, therefore, remains a key theme, as does the principle of patient choice and qualified providers entering the marketplace.

The principle of all hospitals achieving Foundation Trust status also remains, with the indicative date of this being achieved by 2014, given that there has been due clinical consideration to this timeline being viable. In the case of DGT, the status of the Trust's PFI arrangements means that the Trust would not meet the minimum financial metrics required to become a Foundation Trust. On this basis, the Trust agreed a Tripartite Formal Agreement with the Department of Health, the Kent and Medway PCT cluster and the South East Coast Strategic Health Authority in September 2011. The agreement confirms that the preferred route to FT status for DGT is by integration with MFT.

- **Key Strategic Driver: Commissioning intentions**

The national commissioning intention is to provide care closer to home – reducing activity such as the management of long term conditions that were traditionally conducted in the secondary acute care setting and transferring it into a more appropriate primary care setting. Both former commissioning

bodies in the shape of NHS Medway and NHS West Kent developed their strategies for 2010-2015 which identified their commissioning intentions. The focus is on managing those with long term conditions such as dementia, diabetes and cardiovascular disease (CVD) as well as acute conditions including stroke.

NHS Medway set out six key health goals to focus on between 2010-15 in their strategy 'Growing Healthier'. The goals are shown in Figure 7 below:

Figure 7: NHS Medway Strategic Health Goals between 2010-15

	Goals
1	Improving health and wellbeing
2	Target killer disease
3	Care pathways – closer to home
4	Supporting future generations
5	Promoting independence and improved quality of life
6	Improving mental health

The commissioning intentions for NHS west Kent were similar to NHS Medway in that the focus is on provision for the over 65s and particularly in managing long term conditions. NHS West Kent set out their strategic aims in their 2010-15 strategy 'Best Possible Health', these are shown in Figure 8 below:

Figure 8: NHS West Kent Strategic Health Goals between 2010-15

	Goals
1	Eliminate waste to maximise reinvestment and build a sustainable future
2	Improve health, quality of life, and patient experience
3	Eradicate the gap in life expectancy
4	Deliver national, regional and county commitments and targets

- **Key Strategic Driver: Future Commissioning Intentions**

All local commissioners have published or are developing commissioning plans that aim to reduce acute hospital activity and therefore, income. From April 2011, the three Primary Care Trusts in Kent came together to form the Kent & Medway PCT Cluster, ahead of the development of Clinical Commissioning Groups. Commissioning plans are likely to impact in the following areas:

- A reduction in A&E attendances;
- A reduction in non-elective admissions and length of stay;
- A reduction in consultant-to-consultant referrals;
- A reduction in new to follow-up ratios for outpatient attendances;
- A reduction in readmission rates;
- The transfer of activity from hospital into the community through the introduction of new community pathways for designated conditions

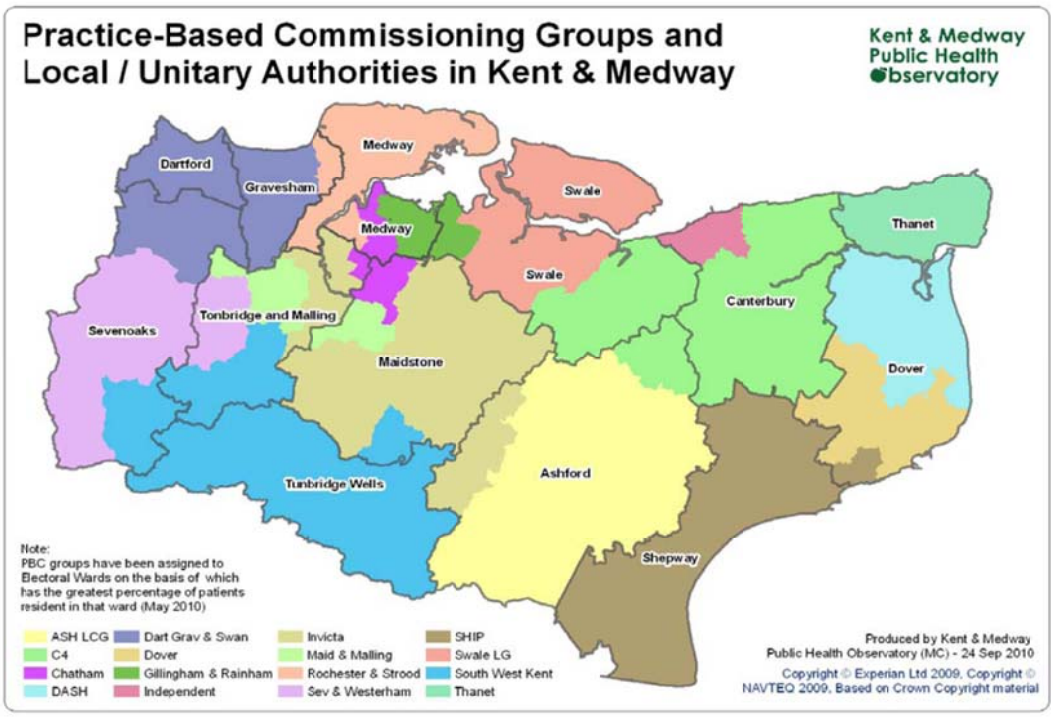
The future integrated clinical strategy recognises the impact of these commissioning changes on the outlook for the two trusts and responds to it. Current plans indicate that approximately £21m of clinical income is reduced as a consequence of the management of demand by commissioners, of which £11.7m is assumed relating to Dartford and Gravesham NHS Trust and £9.3m relating to Medway NHS Foundation Trust.

More specifically, a number of county wide and local health economy initiatives will emerge that seek to deliver clinical services on a more networked or centralised basis. Arguably, the clustering that has occurred across Kent will accelerate that and the clinical strategy will need to adapt to accommodate these schemes. Currently a number do exist and are underway. For example, the centralisation of histopathology services across Kent and a review of the haematological and sexual health clinical model of care.

Clinical Commissioning Groups (CCGs) are currently being established. The map below shows the existing Practice-based Commissioning (PbC) groups in Kent and Medway which will form the CCGs. Both MFT and DGT have long

standing relationships with the local General Practitioners (GPs) and have worked closely to improve the standard of care patients receive. For example, redesigning pathways of care for diabetes, heart failure, urology and haematology, cancer and stroke. The successful management of low priority procedures has been achieved by working collaboratively with GPs. Similar collaborative working will be a key point of emphasis for the new organisation to support the emerging Clinical Commissioning Group development plans.

Figure 9: Practice-Based Commissioning Groups and Local/Unitary Authorities in Kent and Medway



- **Key Strategic Driver: Local Demographic and Health Profile**

The clinical preparatory work for the integrated clinical strategy took into account healthcare profiles of the local population and also recognised a number of synergies that are highlighted below such as a shared community health profile (as illustrated in deprivation ranking below) which is of an urban and densely populated nature. Other notable shared demographic and health profiles that the two populations share include a relatively younger age grouping and a significant prevalence of obesity. The synergy of the North

Kent and Bexley population gives the integrated organisation greater prominence to deliver services to meet local health care priorities.

The recent report to the Department of Health and the Future Forum by the Kings Fund and Nuffield Trust, emphasised how improved outcomes are achieved by integrating care for patients and populations. The aging population and increased prevalence of chronic diseases requires a move towards prevention, self-care and care that is well coordinated and integrated. The integrated trust will work collaboratively with partner organisations, acting as a catalyst to integrate services for specific local patient groups e.g. diabetes and respiratory.

The table below highlights a number of key issues that are points of emphasis for the Clinical integrated strategy and require a unified model to be developed with primary care, notably in the management of diabetes and respiratory disease.

Both hospitals are also based inside the Thames Gateway development area which is the largest regeneration programme in Europe and means that MFT and DGT are both required to manage an underlying growth in population.

Figure 10: Health Profile of the Local Population to DVH and MMH (2007)

(Department of Health, 2011)

(Red indicates worse than England Average; Green indicates better than England Average. N.B. figures in this table are the value not the number per year)

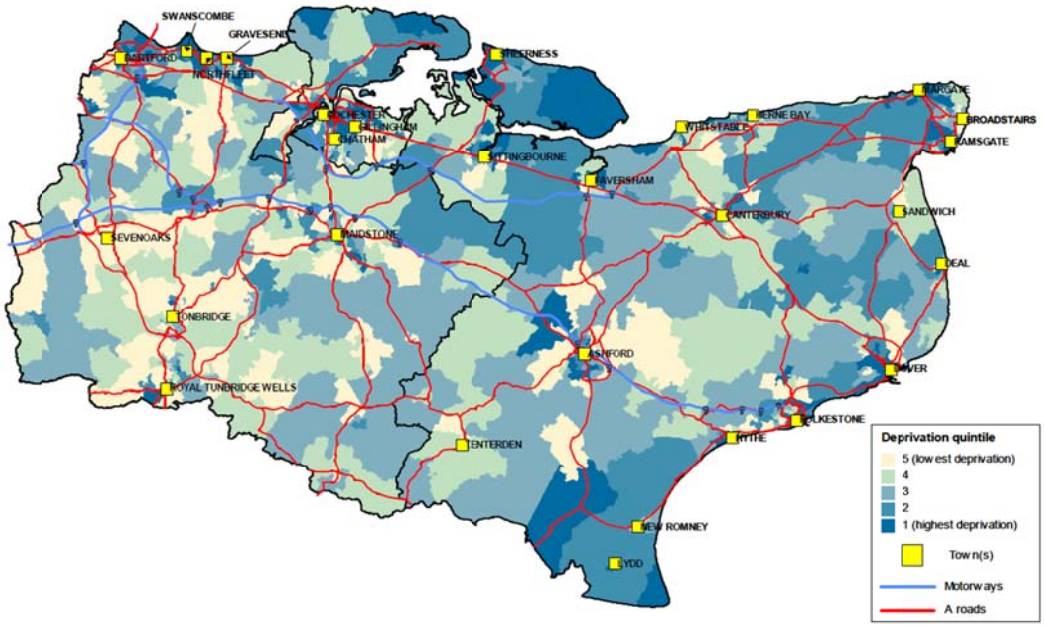
Indicator	Dartford	Medway	Gravesham	Swale	Bexley	Kent	England Average
Life expectancy – male	78.9	77.3	78.4	77.3	79.4	78.8	78.3
Life expectancy – female	81.1	81.6	82.4	81.1	83.1	82.6	82.3
Obese adults	28.2	30.0	28.5	30.2	26.4	27.3	24.2
People diagnosed with diabetes	5.03	6.16	5.50	6.26	5.93	5.43	5.40
Early deaths: heart disease & stroke	75.0	77.8	58.4	80.1	64.7	64.4	70.5
Early deaths: cancer	111.6	123.3	116.5	118.2	107.0	108.9	112.1
Smoking related deaths	220.9	239.9	211.3	227.8	210.9	207.9	216.0

Infant deaths	2.99	3.89	2.57	6.75	3.69	3.86	4.71
Smoking in pregnancy	14.2	20.1	14.2	20.0	12.5	17.2	14.0
Physically active children	62.0	48.7	47.1	38.9	41.9	54.1	55.1
Obese children (Year 6)	22.7	20.4	19.9	18.1	20.6	18.2	18.7
Teenage pregnancy (under 18)	36.1	45.2	38.1	46.7	40.0	36.3	40.2
Adults smoking	24.4	22.2	18.8	16.7	18.8	21.8	21.2
Increasing and higher risk drinking	18.1	19.4	17.1	15.8	30.4	18.3	23.6
Incidence of malignant melanoma	10.7	14.1	11.4	14.6	12.1	13.3	13.1
Hospital stays for self-harm	213.4	246.5	194.3	259.0	118.8	239.4	198.3
Drug misuse	4.8	8.0	6.7	7.6	4.8	6.3	9.4
Hip fracture in 65s and over	451.3	474.0	530.0	440.3	478.0	450.0	457.6
Excess winter deaths	13.0	16.1	9.7	20.9	23.5	16.6	18.1
Long term unemployment	6.3	8.3	7.0	6.0	4.3	4.9	6.2

Deprivation

The map below shows the levels of deprivation in Kent. The population of Dartford, Gravesham and Swanley and Medway have similar characteristics and are urban in nature and are some of the most densely populated area in the county. The Medway Towns, Dartford, Gravesham and Swale have several pockets of the highest level of deprivation in Kent. Whilst levels of deprivation vary across the County the more rural areas to the south of the two indigenous populations that the two hospitals serve are more affluent in nature.

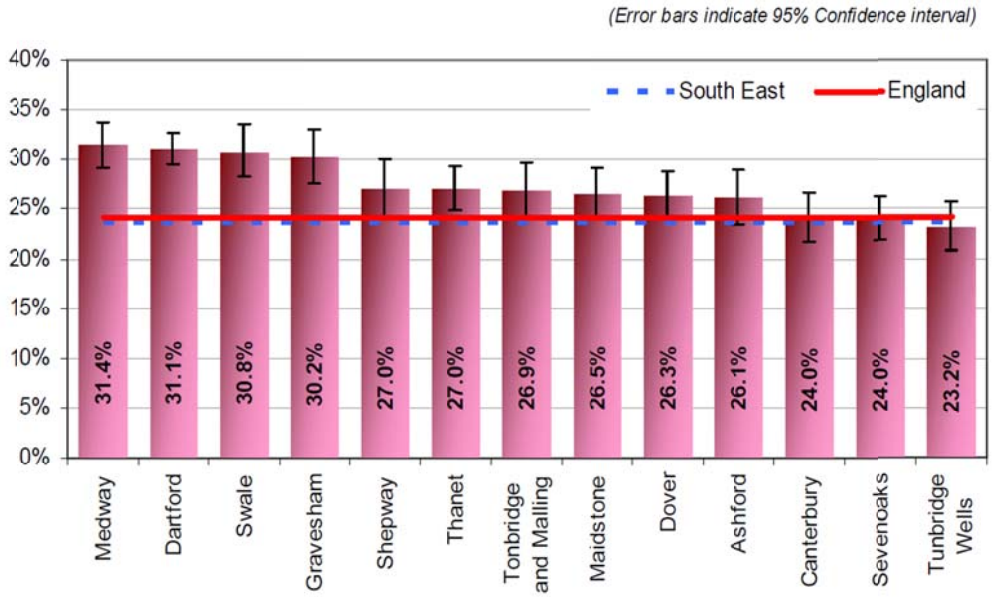
Figure 11: Map of Deprivation in Kent and Medway (2007)



Obesity

The chart below demonstrates the high levels of obesity in the main population areas that the hospitals serve.

Figure 12: Estimate of Obesity Prevalence in general population aged 16+ by Local Authority area, 2006-08



Medway, Dartford, Swale and Gravesham have significantly higher levels of obesity than the average in England and the South East Coast region.

Age Profile

The table below shows the percentage of the population served per age range.

Figure 13: Age profile of the local population (2010)

	0-15 Years	16-64 Years	65+ Years
Dartford, Gravesham & Swanley	18.1%	66.1%	15.8%
Medway	20.4%	64.1%	15.5%
Swale	18.8%	64.7%	16.5%
England	*17.6%*	*66.3%*	*16.1%*

The distribution of ages in the population shows that the age profile of the population that the integrated organisation will serve is younger than the England national average.

However, the growth in population size planned in Medway is projected to be particularly in people aged 65 years and over (increase of 29%) and those over 85 years (increase of 32%). The number of people aged 65 years and over with a long term condition is expected to rise by 34% by 2020. The population growth in West Kent is similar to that of Medway in that it is the over 65s population that is anticipated to grow most significantly. By 2017 it is anticipated that 20% of the West Kent population will be over 65s.

3.3 High Level Political Economic Social and Technology Analysis

The Political Economic Social and Technology (PEST) analysis of the health care environment in England is outlined below.

Figure 14: PEST Analysis

Political	Social
• White paper: Liberating the NHS centralisation/ localisation • Big Society	• Growing and ageing population • Growth of long-term conditions • Increased health awareness

• Stronger control of efficiency & reform • New Bill – impact on NHS Foundation Trust status and Employment status • Fixed five-year democratic cycle	• Patients want to be informed and given choices: access to health records and where to be treated • Olympic games being held in London during 2012 • Health and Social Care Bill
Economic	**Technology**
• Balance of payments deficit • Comprehensive Spending Review 2010 driving economic policy options • More private sector delivery • £15-20bn Department of Health 2009/10 Annual Report	• Increasing e-literacy • Greater use of remote consultation and home monitoring for patients • Continual technological advances • Green agenda and carbon trading

3.4 Internal capability/SWOT analysis

The SWOT analysis below identifies the current strengths and weaknesses of DVH and of MMH.

Figure 15: Summary of Existing Strengths

Key Current Strength	Supporting Evidence	Impact	Potential Initiatives
Demographics and Population Growth	Similar demographics (high proportion of young people in the population, growing elderly population, and areas of deprivation) and continual population growth due to housing developments	Demand for services likely to remain high Knowledge of expected growth in elderly care as well as maternity and paediatric services	Ability to plan for growth in targeted services and to tackle health inequalities
Access to Services	Both trusts have: consistently achieved access targets; reduced the number of hospital acquired infections; improved patient outcomes	GPs and patients continue to choose to access services	Specialist clinical service development Shared best practice
Clinical Engagement	Clinical Directors take a lead role in shaping services. Autonomous decision	Clinically lead organisations	Build and strengthen the range and quality of services provided Increase research

	making bodies of clinicians		initiatives Increased clinical network involvement
Loyal Workforce	Both trusts have lower turnover and vacancy rates Both trusts have a long serving workforce	Ability to attract and retain staff Wide range of specialist skills	Further develop staff through a wider range of training and development opportunities Increase skills of staff through sharing best practice
Engaged Stakeholders and Communities	Both trusts have a large number of members and Governors as well as committed volunteers Well attended stakeholder engagement events Positive relationships with stakeholders including the press	Local public have high expectations for the quality and range of services provided Substantial volunteer community and fundraising capacity	Further strengthen relationships with community groups such as LINks Increase in patient flows as population grows
Flexible Estate	DVH is a modern PFI hospital opened in 2000 MMH has a large estate with a range of buildings built over the past 100 years	Synergy between PFI and non PFI estate	Convert non clinical areas at DVH into clinical areas to maximise income per meter squared Convert old clinical areas at MMH into non clinical areas to host corporate functions
Transport Links	Set in urban areas with access to motorways both hospitals have good transport links. Supported by a direct linked A road car travel time between the two hospitals is 31 minutes	Patients can access hospitals	Work with councils to improve the public transport links between the hospitals and from the more remote villages

Figure 16: Summary of the Existing Weaknesses

Key Current Weakness	Supporting Evidence	Impact	Potential Initiatives
Unable to meet the recommendations of Royal Colleges' or Networks'	Unable to meet population size requirements to continue to provide some services (such as cancers) or	Reduction in the range of services available locally – reducing choice Loss of income from	Integration will ensure the Trust serves a greater population and therefore can continue to provide

	develop specialist services Senior surgical clinical cover and critical care access to meet Royal College guidelines for emergency surgical care	existing specialist services that are to be located elsewhere Unable to meet the best practice guidance and therefore provide appropriate level of care	specialist services as well as provide new specialist services Greater workforce will enable greater flexibility for rota maintenance and, therefore, compliance and improved care
Inability to compete with neighbouring Trusts	DVH and MMH are both surrounded by larger multi sited Trusts. To the west is South London Healthcare Trust (3 sites); to the south is Maidstone & Tunbridge Wells NHS Trust (2 sites); and to the east is East Kent Hospitals University NHS Foundation Trust (3 sites)	The surrounding hospitals are likely to be able to develop more specialist services given their population base There is a risk that services will be lost to the larger neighbouring acute hospitals	Integration will ensure there is competition and ensure patient choice for the local population
Financial Position	Poor cash position and limited financial reserves	Reduction in financial sustainability Unable to invest in service developments or capital projects	Integration will enable efficiencies for the new organisation that aren't obtainable as standalone entities
Medway Maritime Estate	Buildings constructed between 1900 – 2000 One main building surrounded by several standalone buildings	Parts of the hospital are not fit for acute patient care High maintenance costs Significant backlog maintenance	Integration will enable the: centralisation of corporate functions at MMH Rationalisation of the MMH estate Reduction of the number of wards at MMH
PFI Contract	PFI contract restricts the financial flexibility of DGT.	Large annual QIPP savings required Unable to attain Foundation Trust status	Strategic response required Increase the income per metre squared of the asset by increasing the space used for clinical services – integration will enable this as more space can be used at DVH for clinical activity
Spans Two Distinct Local Authority	Medway is a unitary authority. Dartford	The LAs may have opposing views and	Continue to work closely with the two

(LA) boundaries	and Gravesham have borough councils and is part of Kent County Council	strategies	LAs to ensure the hospitals provide appropriate care for the local population

The SWOT analysis continues below to identify the opportunities that combining the two organisations presents and the threats that the combined organisation may face.

Figure 17: Summary of Opportunities for the Combined Trust

Key Opportunity for the combined Trust	Validation	Potential Initiatives	Likely Net Benefits
Attain critical mass to provide specialist services through a population size of 630,000	DVH serves a population of 270,000 MMH serves a population of 360,000 Currently can only offer limited specialist services due to critical mass guidance	Increase the range of specialist services available locally Repatriate services from tertiary centres	Attract and retain specialist staff Continue to provide the range of core and specialist services currently provided Provide specialist services for the wider population in Kent and South East London
Rationalise non clinical services	Reduction in duplication Reduction of space utilised on both sites for non-clinical activity	Eliminate corporate function duplication of roles	Reduce hierarchy within management functions Reduce costs of management overheads Increase investment to improve the number of patient facing personnel
Investment in patient care – quality, equipment, and environment	Increase in cash will enable greater investment into patient care. Achievement of economies of scale	Share best practice Share facilities and equipment Invest in research and development Invest in specialist equipment and modernising the patient areas	Increase the quality of care provided Offer greater range of specialist facilities and equipment available locally Provide innovative care to patients Improve patient outcomes and experience Improved estate

		Rationalise the MMH estate and increase clinical income at DVH	utilisation
Improved efficiency and productivity by 'levelling up' and striving for top decile performance	Each trust has services that perform better in terms of efficiency and productivity than others.	Share best practice and adopt innovative practice early Increase throughput by extending working days, adopting more 7 day working	Improved quality Improved patient experience Improved estate utilisation

Figure 18: Summary of Threats for the Combined Trust

Key Threat for the combined Trust	Validation	Potential Initiatives	Likely Net Benefits
National and Local Economy	The financial challenge that the current economic downturn presents means that the financial savings required will remain challenging The local health economy is financially challenged	Improve the efficiency and productivity of services through improving quality and reducing duplication	Improved patient care Improved value for money of assets Improved efficiency of pathways and services Sustainable services Release of resource for investment into patient care
Planned commissioning changes and clinical centralisation	The planned commissioning changes will result in a reduction of income Clinical centralisation is occurring in many specialist services. Current size of the trusts is limiting bids for hosting services	Work collaboratively with commissioners to plan and design services Increase market share in secondary markets Increase the range of services provided Increase third party income Improve efficiency and productivity	Secure and maintain sustainable services that meet both commissioner and patient expectations Replace income loss
Other providers compete for activity	The loss of income in the health economy impacts on all providers. It is inevitable that other providers will be marketing their services and be aiming to increase market share in secondary markets.	Implement and invest in the robust marketing strategy. Establish partnerships with expert providers to set up high quality specialist services with an excellent reputation. Ensure	Increased likelihood of successful repatriation

	This may limit the extent to which repatriation of secondary or tertiary activity occurs.	the partnership offers benefits to all parties.	
Risk to Current Reputation	Neither trust has high performing patient and staff survey results Both trusts are striving to improve reported safety performance metrics e.g. mortality indicators	Invest in training and development opportunities for staff particularly focusing on holistic care Improve the management of performance Investigations into Serious Untoward Incidents to continue to report to the Board Investment into the coding of patients to eliminate coding concerns	Improved patient and staff experience Improved outcomes Invest in patient care to continue Shared best practice
Cultures	Each trust has a unique culture that has both positive and negative aspects	Invest in the development of a values driven culture and organisational development Ensure buy in to the vision and values Align the culture, values, vision, leadership behaviours and strategy Agree behaviours and manage staff on their behaviour	Positive cultures on both hospitals that respect and work conterminously Improved staff satisfaction, autonomy and empowerment Improved patient experience
Commissioning Intentions	Commissioning intentions over the next 5 years indicate a significant reduction in activity and income, which is likely to reduce the sustainability of local services	Increase the range of specialist services provided Form innovative partnerships with community providers	Replace loss in activity and income and increase the range of services provided locally Ensure appropriate care is provided in the appropriate setting
IT systems	Each trust has different patient administration systems, both nearing the end of their life	Invest in a single patient administration system	Ability to access patient data on both sites, making it easier to transfer care between the hospital sites
Challenging medical labour	Recruitment is challenging for	Increase the number and range of	Increase sustainability of rotas

market	medical staff, exacerbated by the changes in immigration laws Deanery may place junior doctors in larger Trusts that have more specialist services to provide greater learning opportunities	specialist services to ensure the trust provides challenging, flexible and varied training posts to all level of medical staff Build and strengthen relationship with the deanery and local medical universities	and services Improved career development opportunities for staff Improved vacancy rates Improved relationship with the deanery and local universities

4 Options Appraisal

Taking into account the strategic drivers described above, this chapter outlines the options and feasibility appraisal that Dartford & Gravesham NHS Trust conducted on the potential for integration with other providers. It also explains the process adopted to examine the feasibility of integration between DGT and MFT.

4.1 Background

A number of factors led the Trust Board of DGT to explore the feasibility of integration with another NHS organisation. These factors are outlined in section 3 above. In April 2011, the Board of DGT considered a Strategic Outline Case (SOC) to consider the options to ensure that it achieved its long-term strategic objective “to achieve the best health outcome for patients, through the provision of safe and effective care; and to provide an excellent patient experience, guided by the values and principles of the NHS constitution, all at a sustainable cost”.

The content of the SOC was developed from documents and discussions that have previously been considered by the Board, but were presented together in a single document for the first time. The SOC included an options appraisal, representing the first formal step (from the perspective of DGT) in the feasibility testing for the proposed integration with MFT.

It was made clear to the Board that the options appraisal was reliant on readily available information, and not on the type of information that would be, for example, available via detailed due diligence work with each of the organisations considered.

4.2 Options appraisal - Principles and methodology

In developing the options appraisal, the following principles were applied:

- All potential options were included (i.e. there was no pre-determined 'short-list');

- Potential benefits and costs were divided into patient-related and tax-payer-related;

- Effort was made to list all potential benefits and costs that are relevant to the option in question, but it was recognised that certain benefits and costs can be expected to be similar for different options;

- Effort was been made to categorise benefits and costs into short-term and long-term, though no time-based definitions were offered to these categories, as they involve an element of subjectivity

- Potential integrations were categorised into horizontal integrations (between providers of the same services, i.e. two acute hospital trusts) and vertical integrations (between organisations providing services as different points along the care pathway, i.e. an acute hospital trust and a community trust).

- Principle 10 of The Department of Health's 'Principles and Rules for Cooperation and Competition' states that "Mergers, including vertical integration, between providers are permissible when there remains sufficient choice and competition or where they are otherwise in patients and taxpayers' interests, for example because they will deliver significant improvements in the quality of care". Although any integration will require formal consideration by the Cooperation and Competition Panel for NHS-funded services (CCP) [5], the options

[5] See www.ccpanel.org.uk

appraisal attempted to include comments on choice and competition, based on review of guidance from the CCP and on review of their previous judgements.

- Based on the appraisal, options were allocated to one of three concluding categories:

    - Not viable;
    - Not recommended;
    - Recommended

4.3 Options appraisal – consideration of options

The following options were considered (listed alphabetically):

Figure 19: Options Appraisal: Consideration of Options

Option	
1	Integration with Basildon and Thurrock University Hospitals NHS Foundation Trust
2	Integration with East Kent Hospitals University NHS Foundation Trust
3	Integration with Guy's and St Thomas' NHS Foundation Trust
4	Integration with Kent and Medway NHS and Social Care Partnership Trust
5	Integration with Kent Community Health NHS Trust
6	Integration with King's College Hospital NHS Foundation Trust
7	Integration with Lewisham Healthcare NHS Trust
8	Integration with Maidstone and Tunbridge Wells NHS Trust
9	Integration with Medway NHS Foundation Trust
10	Integration with Oxleas NHS Foundation Trust
11	Integration with South London Healthcare NHS Trust
12	Status quo i.e. with existing organisational structure

A feasibility and qualitative cost-benefit analysis of each option is outlined in Appendix A. N.B. Appendix A has been redacted due to commercial sensitivity

4.4 Conclusion and recommendation from the options appraisal

Based on the above analysis, option 9 (integration with MFT) was the recommended option, and it was therefore recommended that more detailed testing of the feasibility of integrating with MFT should continue to be pursued. The Board of DGT accepted the recommendation.

4.5 Feasibility study for the integration

In early 2011, both MFT and DGT decided to formally explore the feasibility of integrating the two Trusts to form one organisation. In the case of DGT, the Board carefully considered its options to achieve Foundation Trust status. Given the Trust's obligations under the Private Finance Initiative (PFI), it could not meet the financial criteria required to achieve Foundation Trust status as a standalone entity. It therefore concluded that partnering with another organisation would be the best route to achieve Foundation Trust status. A detailed options appraisal was undertaken and MFT was identified as its preferred integration partner.

MFT Trust Board considered its future strategy in the light of the current financial climate and changes to the NHS proposed in the Health and Social Care Bill and concluded that there is potential to improve clinical and financial sustainability in the medium to long term through integration with DGT. Whilst the Trust could continue as a standalone entity in the short term, clinical and financial sustainability will become increasingly difficult to sustain in the medium to long term.

It was therefore agreed that a detailed examination of both Trusts should be undertaken and to this end, a small team of executive directors were brought

together to assess whether integration would be feasible. Both Trust Boards signed a memorandum of understanding (MOU) in February 2011. The purpose of the MOU was to establish how the feasibility work should be carried out, the governance arrangements, and importantly the ethos behind any potential integration. It was explicit that any subsequent integration would be experienced as a merger of equals, stating that:

"Notwithstanding the technical transaction the Trusts agree that the integration will be managed as a merger of two organisations of equal standing and that, as far as allowed by the required approval processes, will be pursued collaboratively. The intention is that staff and patients will experience this as a merger of equals with neither Trust acting as the dominant partner"

4.6 Feasibility Process

Following the signing of the MOU, both Boards agreed the criteria to be used in assessing feasibility. These were:

Figure 20: Feasibility Criteria

	Feasibility Criteria
1	Do both Boards agree that the integration shows sufficient tangible benefits to patients and the public
2	Is the agreed clinical strategy for the integrated organisation acceptable to both Trust Boards and formally supported by the commissioners
3	Does the long term financial model (LTFM) of the integrated organisation achieve the risk ratings for Foundation Trusts?
4	Do both Boards agree that the outline post integration plan shows how to achieve the required financial benefits, the clinical strategy and the benefits to the patients and the public?

In order to assess criterion 1,2 and 4, Trust Boards received extensive documentation and evidence on which to base their decision making, including a clinical, estates and back office strategy alongside a long term financial model and an outline post transaction implementation plan. For criterion 3, formal presentations to the West Kent and NHS Medway Commissioning committees were provided and formal letters of support in principle for the clinical strategy and integration were received.

The decision to proceed towards integration was made with unanimous support from both Trust Boards in September 2011.

5 Benefits

The options appraisal and feasibility study determined sufficient benefits to justify proceeding with integration. This chapter describes these benefits and how they will be delivered.

5.1 Key Benefits

There are a number of both clinical and non clinical benefits that the integration will deliver that are outlined below:

Clinical Benefits:

- Ensuring clinical sustainability and the provision of clinical services that improve outcomes
- Improving quality and achieving excellent health outcomes for the local population
- Top performing
- Improving access to patients through repatriation and development of specialised services

Non clinical Benefits:

- Workforce rationalisation
- Estates synergy
- Financial investment for modernisation

5.1.1 Key clinical benefit - ensuring clinical sustainability and the provision of clinical services that improve outcomes

The Royal Colleges, Improving Outcomes Guidance, Clinical Networks and NHS national guidelines are increasingly relating patient outcomes to population size and a need for a critical mass of operations/patients to be treated per annum. For many specialist services a population of over 500,000 is required. MFT and DGT in their current form face obstacles to compete with

their larger neighbouring trusts in the attraction and retention of specialist services given their local health economy population size of 360,000 and 270,000 respectively. This will lead in the medium term to a loss of services from both hospitals given they do not serve a large enough population. It is likely, that without integration, MMH and DVH will not be able to compete and over time will lose services to larger neighbouring trusts. The clinical workforce that provide these more specialised services will also be lost and as they are integral to providing core services to the local population this threatens the clinical sustainability of both DGT and MMH.

Integrating the two trusts will result in a combined current population of 630,000 being served by the two hospitals that can enable plans for clinical centres of excellence to be established within the new organisation. Moreover, integration will enable a pooling of workforce and therefore will ensure that both rotas are more robust and recommendations are met. For instance, ensuring rota sustainability to meet guidelines and quality requirements such as the Royal College of Surgeons recommendation for the provision of Emergency Care requiring access to senior clinical decision making and optimal access to critical care facilities. The flexibility and depth of combining the surgical clinical workforce and facilities flexibility directly leads to these recommendations being harnessed and high quality services being sustained.

The new organisation will develop these services with a range of partners to ensure that joint models of care are established (including: GPs, patient groups, charities, and London specialist trusts) whilst ensuring that they are of an excellent standard and meet both patient and commissioner needs.

It is recognised that working collaboratively as part of clinical networks improve the quality of care and outcomes for patients. Clinical networks facilitate the implementation of national policy, NICE guidance and recommendations from the Royal Colleges. The trust will proactively continue to work collaboratively with clinical networks as they have for cancer, cardiology, stroke, clinical haematology and pathology services. For instance,

Clinical networks such as the Kent and Medway Cancer Network are central to the design of service models, monitoring quality particularly in terms of health outcomes, and sharing learning from both clinicians and research. The KMCN helped MFT to establish a centre of excellence which is the West Kent Urology Cancer Centre and have worked closely since then to ensure that the quality of care received by patients meets Improving Outcomes Guidance. The case example below for clinical haemato – oncology describes another example of where collaborative working will ensure sustainability and improve clinical outcomes.

Case Example

National and regional guidelines and practices are aimed at providing specialised ***clinical haemato-oncology*** *at designated units, reducing inpatient stay by expanding ambulatory care and enabling sub-specialisation. A hub and spoke model which entails centralised level 2 care admissions and extended ambulatory care at the hub, and providing outpatient, level 1 chemotherapy and haematology consultation and laboratory supervision on the spoke is being appraised by a joint clinical team. There is a national shortage of nursing able to administer chemotherapy agents. The centralisation of inpatient services will release a group of highly skilled staff to develop a chemotherapy ambulatory service either on a day case basis or in the patient's own home. This will prevent unnecessary duplication and ensure that there is a concentration of this highly skilled staff group in the area that is required. The development of a 3 service rotation (inpatient, day case, and home care) will also improve recruitment, training and retention of staff.*

A number of other examples of how clinical sustainability and quality is improved through the greater ability to respond to clinical recommendations by developing integrated and networked models of care with partner organisations are contained in the service vision and developments in Appendix B.

5.1.2 Key Clinical Benefit - Improving quality and achieving excellent health outcomes for the local population

Improving quality and achieving excellent health outcomes for the local population is achieved by the integration through:

- **Integrating models of care with partner organisations**

The trust will continue to work closely with key partners such as primary and social care providers and commissioners to develop unified models of care, redesigning care pathways and working more closely with communities to ensure care meets the needs of our patients. Delivering services in a joined up fashion offers the greatest potential to improving quality and safety as referenced earlier in the Kings Fund and Nuffield report to the Department of Health ‘Integrating care for patients and populations: improving outcomes by working together’. It is also anticipated in the 2012 social care white paper that emphasis will be given to the further development of integrating services to improve the quality of patient care. The new organisation will be at the forefront of forging these partnerships and act as a catalyst with others to achieve these improvements in quality.

For instance as described above, Medway, Dartford, Swale and Gravesham have significantly higher levels of obesity than the average in England and the South East Coast region. This puts increasing pressure on the health economy both in primary and secondary care. The new organisation will implement a DESMOND and DAPHNE teaching programme for patients to better manage their Type 1 and Type 2 diabetes using the model developed jointly with primary care in the Dartford and Gravesham locality. Whilst it can be expected that health conditions impacted by obesity continue to rise in Kent and Medway it is anticipated that further speciality specific services joint models of care will be developed in collaboration with partners to treat the diseases associated with obese patients such as the insulin pump service described in the case study below.

Case Example

*There is growing demand in **Diabetes**, particularly for insulin pump services. The service is nurse led and requires patients to attend a course run by nurses, teaching patients to use the pump and manage their health in the community. The service is currently provided at Darent Valley but many of Medway's patients are treated in London.*

- **Sharing best practice**

Sharing and learning from each other will result in improved quality of care. For example, MMH reported zero cases of hospital acquired MRSA in 2010/11 – by sharing their knowledge and experience of achieving this, the number of hospital acquired MRSA cases at DVH has been reduced and meant that in the year to date in 2011/12 it has met and sustained its performance trajectory has subsequently fallen. Improving the training and development opportunities to staff is vital to achieving better health outcomes, improving the patient experience and enabling more specialist services to be provided locally.

- **Developing specialised clinical services**

Both DGT and MMH have staff with unique expertise, skills and experiences that on a combined basis will contribute to the provision of excellent quality. As the previous clinical sustainability section demonstrates the provision of a combined clinical workforce that provides a specialist clinical service has a direct link to an improvement in quality and outcomes.

Case Example

***Fetal Medicine** is a service that has the potential to expand as a result of sub specialisation. The service recently developed at MFT can be grown rapidly as a result of work that is currently being transferred to Kings College Hospital by DGT and can now be effectively conducted 'in-house' as part of a continuum of patient care. This initiative demonstrates a significant opportunity to improve quality, achieve repatriation of specialist activity via the development of sub-specialisation and to share best practice.*

The need for kidney care is increasing and ability to provide specialised and quality care closer to patient's home is currently being developed at DGT through the recent appointment of two Consultant Nephrologists. The integration makes it feasible to plan and develop a more advanced renal service locally given the population size the new organisation will serve, with DVH as the main hub which would have close link to tertiary centres both at King's College/Guy's Hospitals and Kent and East Kent Hospitals.

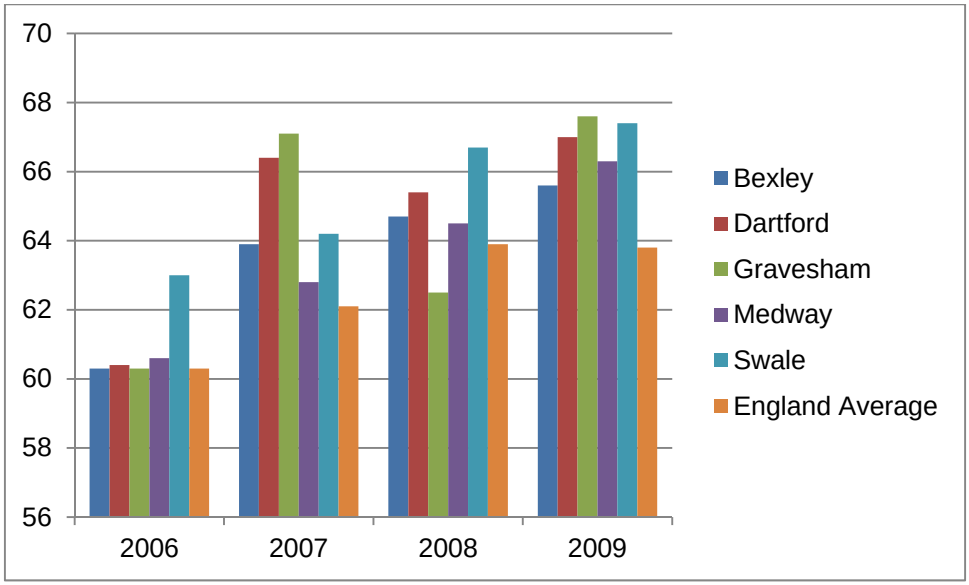
There are no in-house nephrologists in local hospitals presentably apart from at DGT, which too provide only limited renal services mainly for the patients in its locality with the majority of the patients and their relatives have to travel either to central or to East Kent Hospitals for more advanced and complex renal care. In addition, DVH is also getting increasing number of renal referrals from the Bexley area. Future plans involve developing a renal service providing a wide range of out-patient and in-patient service to the population of Dartford, Gravesham, Medway and Bexley locally, but will expand to include the Medway catchment area. This involves development of Low Clearance Clinics, a renal anaemia service, inpatient and acute kidney injury service.

- **Meeting local healthcare needs**

With a continually high demand for maternity services in Kent and Medway as the chart below shows, midwives and obstetricians have identified a number of service developments see Appendix B that will ensure that the trust provides high quality services that best meet the needs of prospective parents. Alone, neither hospital could offer the complete range of services but together, the trust can provide a full range of specialist clinical services on a local basis including: diabetes, HIV, substance misuse, public health, safeguarding, screening, midwife led ultrasound, parent education, obesity, normal birth, VBAC services, bereavement support and infant feeding. This will improve access for mothers, improve the knowledge and skills of our clinicians and improve outcomes for local mothers and their babies. Many of these services are particularly relavent given the local demographics such as diabetes, smoking during pregnancy and obesity. Inevitably, as a result of the

high maternity activity, significant service developments are also planned for paediatric services.

Figure 21: Local and National Fertility Rates – births per thousand of population

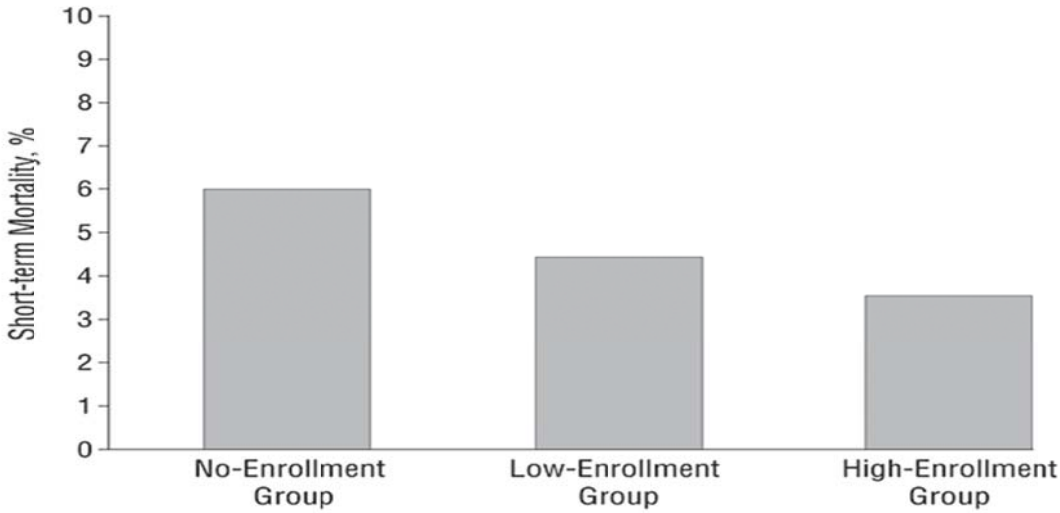


- **Research and Development**

Involvement in research is one of the key ways to improve the quality of our services. Two small sized research units are constrained when attracting grants to invest in research projects. The integration will result in one larger unit which will result in an increase in the number and range of projects that our patients can be a part of. Increasing the number of research trials and studies that take place at the hospitals will significantly improve the quality of care provided to patients. The chart below demonstrates the impact of research on the mortality of cardio-vascular patients.

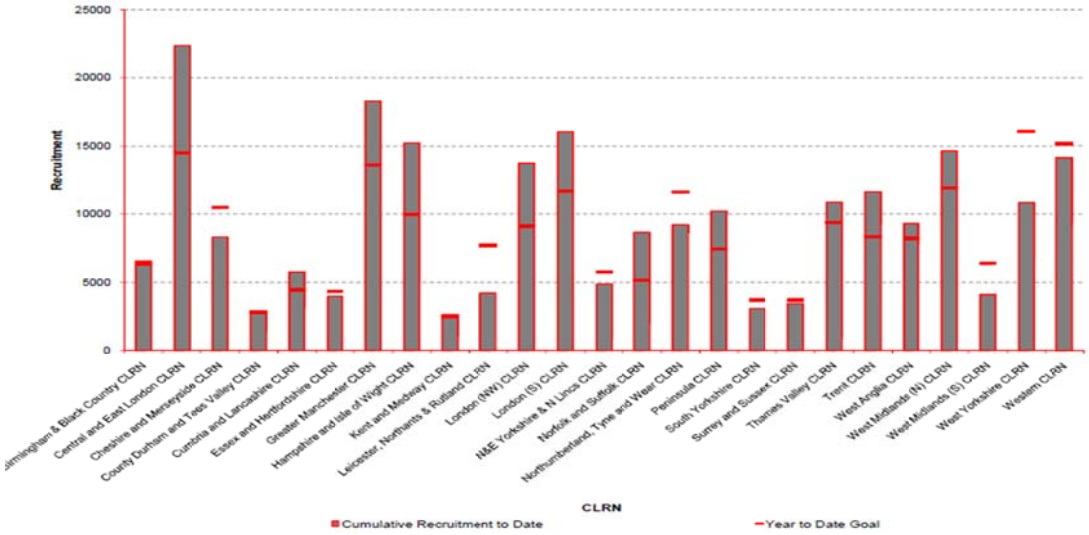
Figure 22: Cardiovascular Mortality

(Source: Majumdar 2008)



Although Kent and Medway CLRN met its target for patients involved in clinical research, there is significant opportunity to expand this in Kent and Medway as the chart below demonstrates.

Figure 23: Cumulative Recruitment to Date Compared to Year to Date Goals by CLRN



Research and development also requires working in partnership with other leading healthcare institutes such as universities and Royal Colleges from across the world. These innovative partnerships will provide excellent

development opportunities to our staff and will result in excellent health outcomes for local patients. The aim of the clinical strategy is to double the size of the research income in the new organisation and whilst it links to an improvement in quality it will also derive a cumulative financial benefit over three years of £200k.

- **High performing and values driven workforce**

The workforce at both hospitals is of a high calibre, long-serving and committed to providing excellent patient care. In the CHKS report 'What makes a top hospital?: Quality and Change' one of the key themes is a workforce who are passionate about getting things right for patients. It also describes the importance of having a strong set of values that are used in the hospital to improve the quality of care that is provided.

Across the combined organisation there is a large workforce of approximately 6000 staff with a range of specialist skills. Both organisations' staff surveys indicate that effective team working is prominent. However the proximity to London and the limited range of specialist activity currently performed at either trust has historically minimised the attraction of clinical specialists. Integration will enable both the expansion of existing services and increase in the range of specialist services. This will enhance the appeal of the new organisation as an employer of choice, and improve the recruitment and retention of clinical specialists and junior doctors.

Key to the success of ensuring quality is embedded into the new organisation is setting expectations around a set of common standards, values and behaviours that should be, in the first instance, developed and implemented by its leaders. These expectations should include the importance of collaboration and teamwork, personal commitment and involvement and, the importance of reflection and learning when things go wrong.

These values and behaviours will need to be clearly communicated and articulated to all levels of the organisation. Any training and education required to meet these expectations should be provided and a measurement

system introduced. An important feature as outlined above should be the ability to use patient experience to learn from and design systems and processes. Clinical services and individual practitioners should then be called to account for consistent bad practice or failure to meet organisational expectations. The approach is described as part of the Organisation Development section.

5.1.3 Key clinical benefit - Top performing

The integration provides an opportunity for the efficiency and productivity of all services to improve and be best in class. CHKS compared the performance of the hospitals against a high performing peer group based on their own database. They have identified the potential for improved clinical efficiency and productivity on both sites based on 2010/11 data. Achieving these efficiency opportunities will also improve the financial sustainability of the integrated trust making a cumulative three year financial saving of £3.6m. The vacated space from efficiencies could be used for alternative to house repatriated specialised clinical activity or the facilities could be closed or disposed of on an optimal basis.

The table below demonstrates the productivity & efficiency opportunities (as identified by CHKS) and which have been set as the standards that will be achieved by the new organisation.

Figure 24: Productivity and Efficiency Opportunities

Indicator	DVH opportunity	MMH opportunity
Reducing lengths of stay	5,739 bed days	7,473 bed days
Reducing outpatient follow-up attendances	10,240 attendances	9,010 attendances
Reducing emergency readmissions	297 admissions	562 admissions
Reducing pre-procedure non elective bed days	1,508 bed days	1,850 bed days
Reducing outpatient DNAs [6]	1,049 DNAs	2,632 DNAs
Reducing pre procedure elective bed days	164 bed days	123 bed days
Saving bed days through achieving	14,523 bed days	22,300 bed days

[6] Did Not Attend

target performance		
Increased day cases (resulting in a saving in bed days)	1,764 -1,983 bed days	718 – 1,072 bed days
Reduced emergency admissions / discharge on the same day as admission	0 bed days	185 bed days
Reduced outpatient attendances through reduced follow ups and DNA rate	21,276 – 23,001 attendances	80,682 – 93,119 attendances

The NHS Institute for Innovation and Improvement report ‘What the NHS needs to do to implement high quality care for all’ cites organisational skills to support performance improvement as a key feature of organisations that are high performing.

Delivery of improvements will therefore be overseen at Executive level with a named Executive Lead who will establish an Innovation, Improvement and Integration Team. Currently, neither DGT or MMH has a service improvement unit. A Programme Management Office (PMO) approach to making changes will be adopted. The team will be designed and be equipped with the skills and authority to introduce the stretch, inspiration and catalyst where required to ensure services in the first instance ‘level up’ to the higher performing of the two hospital services. A Plan, Do, Study, Act (PDSA) methodology will be introduced that is underpinned with a strong analytical function that is capable of measuring improvement against required standards.

In parallel, services will be required to achieve performance indicators at the standard of the services’ high performing peer through modernisation, adopting the very best clinical practice, harnessing new technologies and exploiting innovation. A key feature of the SPIT will be working not just with internal teams but also collaborating and influencing the partner organisations that often are critical to the success of achieving top performance.

For instance, commissioning intentions involve reducing the volume of less complex clinical care being undertaken in the acute sector and transfer it to the community. In many cases this will only be through the integrated models

of care that will be developed with primary care and the SPIT will provide a focal point through its PMO approach to deliver this. Sharing of best practice between organisations externally will be formalised and more rapidly implemented through this approach and applied to areas that require integrated working such as in the case example below.

Case Example

A community ventilated (NIV) service *is to be developed at Medway and will initially be commissioned by NHS Medway later this year. This service could then be offered to patients from the surrounding areas, offering a local service for the local population. Currently, patients are treated in acute centres and transferred back to the community, however, it is believed that a community based, nurse led service would allow a significantly better introduction to, and ongoing monitoring of, the patients' condition. It will also promote self management reducing the need for frequent attendances to hospital and reduce emergency admissions.*

The table below reflects the benefits derived from the integration in realising the efficiency and productivity opportunities that cannot be achieved by DGT and MMH standing alone:

Figure 25: Benefits derived from integration that realises the efficiency and productivity improvements

Efficiency and Productivity Identified Improvement	Key Solutions Derived from the Integrated Organisation
▪ Save bed days through a reduction in length of stay driven by peer performance	▪ Improving weekend discharges: - 7 day a week clinical discharge teams created as a result of economies of scale - Extended weekend access to diagnostics - Hospital at Home teams integration facilitates extended access to service ▪ Integrated clinical teams facilitate more flexible approach to daily senior decision making ▪ Clinical team resilience improved to cover sickness absence, leave and vacancies. ▪ Unified models of care to improve admission avoidance and development of ambulatory care pathways
▪ Save bed days through achieving	▪ Segmentation enables specialisation and expertise to be concentrated at designated elective sites

target performance (Risk Adjusted Length of Stay and BADS [7] short stay directory) ▪ Increase day cases which has a consequence for theatres and inpatient beds	where appropriate e.g. Paediatric Surgery (See Appendix B) ▪ Development of cross site training and service lists to improve throughput
▪ Reduce emergency admissions discharged on the same day as admission which has a consequence for ambulatory management and income	▪ Improvement in attraction and retention of A&E clinical workforce through shared rotation schemes both internally and with key specialties such as critical care ▪ Introduction of outpatient and rapid assessment clinics and emergency pathways that are both clinically and nurse led e.g. Early Pregnancy Assessment Unit ▪ Nurse led teams dedicated to facilitation of same day discharges ▪
▪ Reduce outpatient appointments through a reduction in follow-ups and DNAs	▪ Integrated organisation provides opportunity to realise best practice standards and approach to improving performance in appropriate centralisation of expertise and resource. ▪ Flexibility of clinical workforce enables nurse led services, therapy practitioner roles and extensions of telephone liaison services. ▪ Common pathways and approaches developed to promote correct discharge pathways to primary care.

Improving the efficiency and productivity of services has the added benefit of improving access to patients by reducing the time taken to be seen and receive results. The trust aims to ensure that patients receive the appropriate care at the appropriate time by the most appropriate clinician. This will improve health outcomes and the patient experience as demonstrated by the case example below:

[7] British Association of Day Surgery

Case Example

The driver for the ***Nurse-led Fertility Clinics / Infertility service*** *is to share skills and expertise locally, increase gynaecology market share and contribute to clinical workforce strategy. A further benefit is to increase the skills of nurses to enable them to perform diagnostic ultrasounds, which will reduce new to followup ratios in line with commissioning intentions, releasing consultant time for specialist clinics. The realignment of this outpatient capacity will also provide the benefit of services on both sites at convenient times for women to attend.*

Using the same principles clinical support services will take advantage of consolidation opportunities notably in Pathology and Pharmacy. In Pathology, for instance a centralised laboratory will be located on one site, and a smaller "hot" laboratory on the other. Front line Pharmacy services will be required to support the function of core services that exist on both hospital sites. However, integration benefits will be derived from the ability to centralise back office and storage services on one site therefore driving efficiencies from workforce and process re design. This will lead to a greater degree of sustainability for rotas and generate workforce efficiencies and as a result of the integration a 3 year cumulative financial benefit of £1.4m will be achieved.

5.1.4 Key clinical benefit - improving Access to Patients through Repatriation and Development of Specialised Services

In a response to the national commissioning intention to provide care closer to home and therefore increasing the range of less complex clinical care available in the community, there is an opportunity through a more flexible integrated clinical workforce to develop sub specialisation and therefore provide a greater range of more complex services. The reduction in less complex activity releases capacity at a clinical speciality level that can be used for more specialised repatriated clinical treatments.

The integration work that has been conducted to date identifies two strands of repatriation based on data from both the commissioners and from CHKS. Firstly, a significant proportion of existing activity is being undertaken at other

hospitals. Local patients are therefore travelling further, and the commissioners paying more, for services that both hospitals currently offer. Secondly, the trust can identify the volume of patients receiving treatment for tertiary care in tertiary centres. The integration will result in a critical mass being achieved in the majority of specialties, increasing the viability to undertake more of the tertiary activity. A recent example of how this has worked successfully is in Urology as outlined in the case example below.

Case Example

*Following on from the recent segmentation of **Urology**, kidney stone work was centred on the DVH site and cancer work at MMH. Currently, CHKS data shows that the combined Trust has a market share for stone work in West Kent; Bexley; Medway and East Kent localities of approximately 47%. Segmentation has enabled the speciality to make plans to grow that market share of elective procedures and repatriate income of up to an additional £309k.*

However, in order to maintain existing market share the quality of the services offered must be better than that of our competitors. It is therefore important that patients want to receive care from the hospitals again and that the commissioners want to commission services from the trust. As described previously in this chapter the integration also improves the quality of care that underpins repatriation. Repatriating activity to the local health economy also reduces commissioner spend; improve access for patients, and lead to the integrated organisation remaining clinically and financially sustainable in the future.

The CHKS market assessment tool has enabled the trust to analyse the spread of activity across providers per specialty and per commissioning area. This demonstrates that approximately £57m of local activity could be repatriated; £23m of this activity is general acute level activity and £34m is tertiary activity. It has been assumed that 40% of the general acute activity and 10% of the tertiary activity could be repatriated within 3 years of integration. This amounts to £12.6m additional activity and a 3 year cumulative financial benefit of £3.8m. This is not new activity to the health

economy and would save the commissioners money on the level of MFF that is paid. The MFF values compared to London tertiary providers shows that DGT and MFT are in a very competitive position financially when proposing to increase their market share and repatriate activity from North Kent, Medway, Bexley, Swale and the surrounding areas.

Case Example

Dermatology *and* ***ENT*** *clinics for DVH are currently managed by Medway with clinics provided at DVH on an outreach basis. There is therefore a natural platform to repatriate Bexley activity to this service to increase and consolidate market share.*

Whilst there is the opportunity to consolidate and increase market share for clinical activity from the catchment areas of both Medway and West Kent PCTs, there is also the opportunity to grow market share in neighbouring health economies due to changes over the past 12-18months. The closest hospital to DVH is Queen Mary's in Bexley, now part of the South London Healthcare Trust. In November 2010 Queen Mary's closed the A&E and maternity services and as a result DVH has treated a greater number of patients from the Bexley area in A&E and maternity. The closest hospital to MMH, Maidstone Hospital (part of Maidstone and Tonbridge Wells NHS Trust) has more recently moved the maternity services to Pembury and downsized the A&E service at Maidstone. MMH has since experienced an increase in the number of births and A&E attendances from the Maidstone area. This supports DVH and MMH maintaining A&E and maternity services. Moreover, it is anticipated that the market share in these two secondary markets can increase as the profile of both DVH and MMH is raised in these areas. Increasing the market share in these areas will result in increased income for the integrated trust.

CHKS undertook a market analysis to identify the activity and income repatriation opportunities for each hospital based on the 2010/11 activity case mix. The tables below demonstrate the repatriation opportunities. It has been assumed that the activity from Bexley and Dartford, Gravesham and Swanley

would flow to DVH whilst the activity from Maidstone and East Kent would flow to MMH.

Figure 26: Market Share 2010/11 Elective Activity

Commissioner	DGT	MFT	Combined
Bexley Care Trust	5%	0%	5%
Dartford Gravesham & Swanley GPs	58%	4%	62%
NHS Medway	3%	57%	60%
NHS Eastern & Coastal Kent	0%	6%	6%

A large proportion of work commissioned from Bexley PCT is delivered in London. DGT, and subsequently the integrated organisation, would be in a position to provide this care more cost effectively, due to MFF savings for commissioners. Repatriating work from London to the integrated trust would therefore be beneficial for the local health economy and reduce travelling time for patients. Secondly, it is generally accepted that there is a potential for a drift northwards of clinical referrals following the movement of services to Pembury from the Maidstone hospital site. Given the proximity of MFT to Swale and Maidstone, there is the opportunity to increase the trust's market share from these localities, as the trust would be able to provide more local care for a number of these patients.

Repatriation will be supported by the implementation of an integrated marketing strategy that will have a nominated Executive lead. The marketing strategy will establish a commercial team including a GP liaison Manager that will have a co-ordination role in ensuring that the targets for repatriation set out above are delivered. In the longer term, it is envisaged that this team will also lead the development of dedicated private patient facilities that will be established at one of the hospital sites and will be supported by the introduction of more specialised services into the new organisation. As such, by Year 3 the income generated by private patient activity is forecast to have doubled and derive a cumulative benefit of £200k per annum.

The Executive lead for this commercial development team will also take a lead role in new service developments. For example, NHS West Kent have identified that over 65s are 20 times more likely to suffer with eye conditions. In response, one of the significant service developments that the integrated trust is planning for in the medium term is the establishment of an ophthalmology service – this will increase capacity, access and choice for patients in North and West Kent and aims to specifically meet the need for the growth in over 65s. Commissioners in Dartford, Gravesham, Swanley and Medway currently spend approximately £6m with other acute providers to provide eye services and there is an option to take this service development forward in partnership with a world class provider of ophthalmology.

5.1.5 Non clinical benefit - Workforce rationalisation

Rationalising the non-patient facing workforce is one of the opportunities that integration brings. Eliminating unnecessary activities and duplication currently within corporate functions and redesigning processes so that they are more automated and efficient will release funds to be reinvested into frontline clinical services. The integrated trust will be committed to people rather than roles and will strive to redeploy staff wherever possible. The main focus of corporate activities will be to add value and support quality, with flexibility about how this can be achieved.

5.1.6 Non clinical benefit – Estates synergy

Both MFT and DGT are single site hospitals. The estates are very different. DVH is a PFI hospital opened in 2000; it is maintained at Condition B (which is the highest quality of condition an estate can be categorised unless newly built) or above throughout the 30 year contract. The building is flexible in that much of the space currently used for non-clinical activity could be used to provide clinical care. MMH was a naval hospital built c.1900 it comprises of one main hospital and several smaller buildings on the periphery of the site. The condition of the buildings vary from nearly new (10 years old) to unfit for

acute service clinical use. Collaboration enables an estate footprint reduction at the MMH site and a conversion of non-clinical space into clinical areas if required at the DVH site enabling top performance against national estates benchmarking.

5.1.7 Non clinical benefit – Financial investment for modernisation

The local health economy in Kent is financially challenged and the current financial position of the two trusts has resulted in diminishing finance for investment. The integration will release savings for investment which would otherwise not be available. The integration will provide the capital to invest in new technologies, modernise services and provide for the development of the estates infrastructure. For instance:

- Ambulatory Care in the form of Day care and endoscopy demand has significantly increased over the past 3-5 years due to the introduction of new models of clinical care. For this reason, the current capacity is struggling to meet current demand and will need to change to meet future demand to ensure that access is maintained.

- The information technology systems at both hospitals consistently require updating and in several key areas investment will be required to enable clinical modernisation and control costs. The introduction of a patient administration system and electronic patient record system that supports pathology and radiology information systems (such as PACs and RIS) will require investment to be fit for purpose for the future that can be purchased jointly.

The integration also allows the trust to become more efficient through economies of scale through opportunities such as increased buying leverage in procurement to support QIPP schemes.

5.2 Delivering the benefits

The benefits described earlier in this chapter will be delivered through the implementation of key strategies, namely the Clinical Integration Strategy, the Estates Strategy, the Information Management and Technology Strategy and the Corporate Services Strategy that are described below.

5.2.1 Delivering the benefits: Clinical Integration Strategy

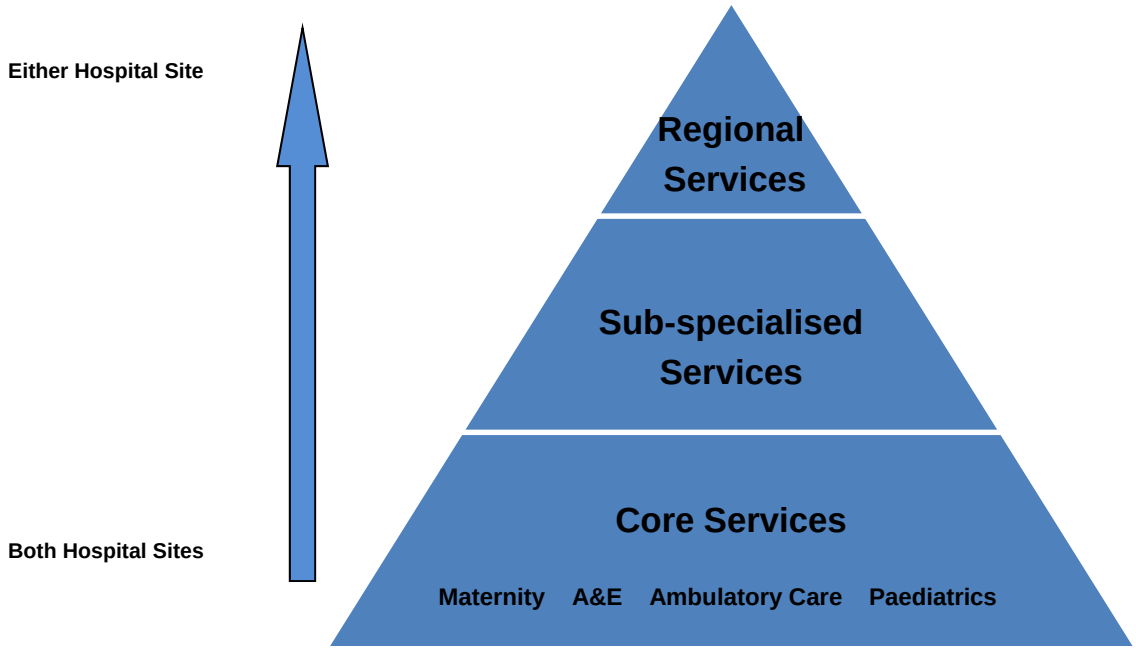
The trusts Lead Clinicians worked together with their clinical teams over a period of 18 months to develop the clinical integration strategy for the integrated trust. This work also involved the development clinical service visions for their respective specialities and directorates. The development of the strategy took into account the strategic drivers in the healthcare system that have already been described, notably optimal population size, subspecialisation and, the imperative to maintain medical rotas and educational needs. It also harnessed the vision and strategic objectives of ‘Better Care Together’ and incorporated the knowledge of the current strengths and weaknesses of the two organisations alongside the opportunities that the integration offers.

A number of fixed points were established as part of the development of the clinical model. Both hospitals will continue to offer full accident and emergency, maternity, children’s and ambulatory services. However, for some clinical specialties, it may be possible to offer more specialised treatments for local patients if they were centralised at one hospital. Although, local access to patients would be maintained through the continuing provision of general outpatient services at both sites.

A clinical model can therefore be shown in the diagram below as a ‘pyramid of services’ with core services provided at both sites but with the possibility that services that are of a more specialized or regional nature, provided at one

hospital site. Clinical services on both sites will be supported by a comprehensive range of clinical and non-clinical support services.

Figure 27: The Pyramid of Services



Clinical Integration Strategy Key Objectives

The ten specific objectives described below have been identified to deliver the integrated clinical strategy. They are arranged in two parts: the first set of five objectives is aimed at securing clinical services locally for patients, and enabling change. The second set is designed to develop and build clinical services. Improving patient experience, patient safety and value for money are key components of the strategy and are reflected in the appropriate objectives below.

These first five objectives are intended to secure and safeguard clinical services, ensuring that both hospitals continue to maintain a stable basis which will be particularly important during the early period of integration. These objectives provide the foundations for proposed development and growth and will act as enablers to proposed changes and developments.

Figure 28: Objectives: Securing and Safeguarding Clinical Services

No	Objective
1	Ensuring quality, the best possible patient experience and the highest patient safety standards meet top performing benchmarks
2	Improving the efficiency, productivity and value for money of clinical services to meet top performing benchmarks
3	Sharing education and best practice
4	Integration of clinical support services
5	Driving improvements in patient care and quality through clinical networks and partnerships

The second five objectives identify the changes required to strengthen and develop clinical services in the integrated organisation.

Figure 29: Objectives: Strengthening and Developing Clinical Services

No	Objective
6	Repatriation of general acute activity in North Kent and Medway localities through the development of a marketing plan and collaboration with local commissioning groups
7	Attraction of general acute activity from neighbouring localities, notably Bexley and Swale, through the development of a marketing plan and in collaboration with local commissioning groups
8	Repatriation of appropriate specialist clinical activity through the development of sub specialisation
9	Developing clinical research in relation to quality
10	Generating increased beneficial third party clinical income in Private Patients

The clinical integration objectives support the achievement of the Better Care Together vision fully taking advantage of the strategic opportunities that the integration provides and frames the delivery of the key clinical benefits that are described earlier in this chapter.

Service Visions

The Clinical Directors and their clinical teams have developed detailed plans to support their five year services visions. They have built upon their existing service developments and have based their visions on the objectives of the

clinical integration strategy. Some of these key developments are attached in Appendix B.

5.2.2 Delivering the benefits: Estates strategy

In the current NHS context, a key estate performance indicator is the income earned per m^2, as this shows how well the estates are working for the trusts.

Based on the performance of peer trusts in 2009/10, an upper quartile target of £2750 per m^2 has been set, and significant improvement is required to reach this level. This could be achieved in two ways:

- *Reducing the size of the estate*: this is not possible at DVH because of the PFI agreement, but is considered as the key driver for MMH. The MMH estate would need to reduce to 78,516m^2 to achieve an income of £2750 per m^2 at 2011/12 income levels. This represents a reduction in the total estate of 14,911m^2
- *Increasing income levels*: this will be required at DVH. Income for this estate would need to be £162.9m to achieve the target: and represents an increase of 10% clinical income per annum.

This approach has been used as one of the key drivers to shape the Estates Strategy alongside the need to enable the clinical integrated strategy.

The vision for the estate of the integrated trust is:

- To have a fit for purpose, high quality environment for patients and staff in a safe and well-maintained facility.
- To achieve top quartile performance, compared to other NHS peers.

The strategic objectives for estates integration are as follows:

Figure 30: Estates Strategic Objectives

No	Objective	Areas to be addressed
1	To maximize the productivity of the estate	• Extending the working week to 7 days • 24/7 use of equipment e.g. pathology • Smoothing activity flows across the working week, avoiding peaks and troughs for example on Friday afternoons
2	To reduce the operating costs of the estate	• Disposal of surplus/unoccupied properties • Disposal of surplus, or poorly used land at MMH • Disposal of leased or rented properties • Continue to improve and tighten the PFI contract management at DVH • Continue to make energy cost reductions on both sites, but particularly at DVH • Increased income from third parties • Consolidation of services into main hospital buildings on MMH site • Rationalising FM services across the sites
3	To rationalize the estate across the two main sites, avoiding unnecessary duplication	• Back office functions • Improved efficiency in the provision of office accommodation • Clinical support services • Clinical services
4	To increase the return on the assets/maximize income potential	• Achieving £2750 income per m^2 across the combined estate • Increase the % of space used for clinical services at DVH
5	To improve the quality of the patient environment	• Elimination of nightingale wards • Increasing the % of single rooms • Improving clinical adjacencies and streamlining patient pathways • Patient privacy and dignity
6	To reduce backlog maintenance	• Disposal of older, poor condition facilities • Investment to address infrastructure issues at MMH
7	Sustainability	• Work with the Carbon Trust to reduce the carbon footprint across the combined estate • Promote energy efficiency • Increase recycling

Options to deliver the Strategic Vision and Objectives have been considered as follows:

Figure 31: Strategic Vision and Options for Estates

No	Option
1	Concentrating all services on the 2 main hospital sites and disposing of all other properties
2	Improving utilisation of both hospital sites
3	Rationalising clinical support services
4	Rationalising office accommodation/back office functions
5	Rationalising educational facilities
6	Rationalising clinical services
7	Increasing the use of premium facilities for clinical services
8	Reducing the operating costs of the estate
9	Reducing the carbon footprint of the estate
10	Increasing third party income
11	Increasing third party utilisation of the estate

Options 8, 9 and 10 should be and are being addressed as a matter of urgency.

The two options with a high potential for delivery, shortest timescales and a low risk profile are options 1 (concentrating services on the two main hospital sites and disposing of all other properties) and 4 (rationalizing office accommodation/back office functions). Proposals have also been developed to rationalise pathology services (option 3).

The outline plan is as follows: -

Figure 32: Estates Action Plan

Action	Year				
	1	2	3	4	5
Develop Residential Accommodation Strategy to inform options 1 and 2					
Dispose of Off-site properties (Option 1)					
Clear site periphery: (Option 2) Identify all current occupants Give notice/relocate					
Rent vacant space on periphery					
Change MMH (Option 2) Consider land/building disposal					

Centralise pathology services (option 3)					
Centralise back office functions (Option 4)					
Expand theatre/day case capacity at DVH (Option 7)					
Implement Options 8 + 9					
Implement option 10					
Assess feasibility of option 11					

The trusts are developing an integrated capacity plan to show the impact on activity over time of improved efficiency, productivity, repatriation and service developments identifying shortfalls and excess of capacity. To date, the integrated capacity plan demonstrates the need to expand day and elective theatre capacity at DVH. Plans to create this capacity need to be developed with the aim of increasing the clinical utilisation of the DVH site (Option 7) and facilitating the rationalization of clinical services (Option 6).

The three year cumulative financial benefit of implementing the estates strategy is £2.3m through disposal of estate and achieving the £2750 per m^2 metric.

In addition to these options the estate must be capable of supporting the planned service developments and the following approach has been taken to assess and plan for the estate implications:-

Figure 33: High Level Plan for Estates Implication

Stage	Plan
Stage 1	Assess baseline clinical capacity of the two estates
Stage 2	Clinical Directorates confirm the details of planned service developments and the estate required
Stage 3	Assess the estates impact of the integrated capacity plan and planned service developments on the estate
Stage 4	Confirm any shortfall/gaps
Stage 5	Development of business cases for capital investment

5.2.3 Delivering the benefits: Information Management and Technology (IM&T) strategy

In order to provide modern services, to do business more efficiently and to ensure IM&T is an enabler to enhancing quality, changes to the existing IM&T infrastructure at DVH and MMH are required. There are some business critical systems that will need to be replaced including a single Patient Administration System (PAS), the Picture Archiving and Communications System (PACS) and the Radiology Information System (RIS). The replacement of these systems will be both time and resource intensive. Therefore, there are a number of investments in IM&T that need to be made prior to the integration to enable the sharing of data across sites from Day 1 to enable the clinical strategy developments such as in radiology services.

An objective review of the existing systems was undertaken which advised on the most appropriate course of action. This information has been used as the basis for the IM&T strategy which outlines the direction of travel for IM&T in the new organisation and highlights the decisions required prior to integration. Having received feedback from both GPs, patients and staff a number of improvements to IM&T have been identified to better improve the patient, GP and staff experience of accessing information.

A formal IM&T workstream has been established and is being led at Executive level and includes two consultant level clinicians. This workstream reports to the Integration Programme Board on a monthly basis. The workstream is focusing on developing the detailed plans as to how to achieve the strategic intent and aims are outlined below:

Strategic intent and aims of IM&T Strategy:

The key strategic intent of the IM&T strategy is to develop an electronic patient record (EPR) capability that will improve clinical safety and timeliness and optimise the allocation of resources.

- Single PAS and supporting clinical systems (or integrated EPR system)
- Single future strategy and approach
- Single server, desktop and network
- Single system management team
- Joint robust governance structures
- Single approach to information management
- Clinically led developments
- Single local helpdesk for IT support
- Single sign on with context management

Prior to integration the aims are to:

- Align teams
- Align CAG and governance
- Start PAS Tender
- Data warehousing for reporting
- Develop detailed short and medium term plans including costs and capacity

The IM&T workstream has been required to work closely with the clinical strategy, estates, workforce and organisational development workstreams in order to ensure that all of the IM&T implications of developments have been identified and planned for. For example, IM&T experts have worked closely with the clinical leads in radiology as their strategy includes single PACS and RIS systems, a joint reporting system and central booking service for patients. Each of these developments is recognised to enable cross-site working for

other specialties, improve efficiency and improve the quality of the current systems and patient, staff and GP access to information including test results.

5.2.4 Delivering the Benefits: Corporate Services strategy

Equity and Excellence: Liberating the NHS[8] reiterated the continued drive for efficiency savings within the NHS, specifically regarding management costs, to be achieved via the Quality, Innovation, Productivity and Prevention (QIPP) programme. There is a specific back office efficiency and management optimisation work stream, said to be able to save £700m from a budget of £2.8 billion across the NHS in England. This has been a key consideration when developing plans for integration.

Current analysis of MFT and DGT as separate and combined organisations using 2010/11 has placed both in the 3rd quartile for management costs. This demonstrates the opportunity for improvement inherent within each trust.

In order to work towards improving performance in the integrated organisation, several key themes have been identified. There will be a removal of unnecessary processes, roles and activities; services will be redesigned to increase automation and create direct management access wherever possible; and functions will be fully integrated and co-located wherever it makes sense to do so. This will ensure that services will be fit for purpose for a new, larger integrated organisation.

The strategic aims of the corporate services strategy are as follows:

[8] Department of Health, 'Equality and Excellence: Liberating the NHS', July 2010 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

Figure 34: Supporting Mechanism for Corporate Services Strategy

Strategic Aim	Corporate Services Strategy Supporting Mechanism
High quality core services and enhanced local specialist services	Release funding through efficiencies and reduced duplication to be reinvested into frontline services. Enable staff and managers to concentrate on the day job, helped, not hindered by transactional functions. Interaction with corporate functions to be streamlined. Ensure value for money support services which are sustainable and contribute to the delivery of an excellent patient experience.
Top Performing	Match top quartile performance in terms of efficiency and cost against the top fifteen nhs acute providers in England
Modern, sustainable services	Use technology to support the automation of transactional services so that clinicians can spend a larger proportion of their time delivering clinical services
Innovative Partnerships	Commit to review the feasibility of providing services differently and with other markets, particularly if there is a commercial market and the proposed outcome is a more cost-effective and higher quality service.

A review of current staffing levels has been undertaken by executives at both trusts, which has informed the corporate services strategy. Directors were asked to consider more than simply bringing together and consolidating similar departments and to instead explore new ways of working and opportunities for the integrated organisation. From these discussions, five main work streams have been developed.

- **Corporate**

  A review of Trust Board roles and the supporting administration required will continue over the coming months as a designate chair and chief executive are appointed. This is expected to generate cumulative savings of £0.8m in the first three years.

- **Back Office**

Back office requirements for a larger, two site organisation have been considered and drafted, subject to review once designate executive leads have been appointed. Plans focus on increasing automation and utilising technology more effectively, as well as redesigning processes to improve efficiency. Services include finance, procurement, HR, IM&T and coding functions and will contribute cumulative savings of £3m in the first three years of integration.

- **Hard and Soft Facilities Management**

MFT carries out the majority of its facilities management in-house and has made cumulative savings of £2m over the past two years by removing inefficiencies from its processes, whilst DGT has the majority of its services provided by Carillion at a fixed cost. When considering facilities management, it has therefore been essential to consider each site's requirements separately.

Detailed work is being undertaken to review the benchmarked position at MFT and develop a negotiating position and target for savings. A negotiations team has been established and procurement advice sought. The savings target of £0.7m in the first three years represents 8% of the MFT budget alone, so it is possible that additional savings could be achieved if efficiencies at DGT could be identified, following discussions with Carillion.

- **Support services**

A paper-based review of support services has been undertaken and consideration given to which services could be integrated, outsourced or would need to remain hospital specific. A number of posts have been identified for removal in year 2, representing 13% of the combined budget. Detailed work with general managers and service managers will continue pre-integration to firm up plans and processes.

- **Clinical directorate management**

  To limit disruption during integration, directorate structures will remain stable for the first financial year. This will ensure that the process of integration is achieved successfully with minimal impact on patient services. During this, it will be important to review which aspects of directorate management should remain site specific, and to consider opportunities for collaboration between teams. This has the potential to realise benefits of £1.2m in the first three years.

At the time of writing, MFT is undertaking significant workforce analysis which will have an impact on the corporate baseline figures. The transition team has been working closely with the organisation and PwC, the external support, during this process and will factor in any changes prior to submission of the Full Business Case.

5.2.5 Delivering the benefits: Existing Service Changes

There are a number of developments that are a continuation of existing strategic objectives or service development plans. DGT is continuing to plan for a general growth in the population due to the Thames Gateway housing developments and repatriation from Bexley as a result of the closure of Emergency and Maternity services at Queen Marys Hospital. MFT will continue to develop capacity in maternity and emergency care due to the recent relocation and downsizing of these services at the Maidstone site of Maidstone and Tunbridge Wells NHS Trust. See Appendix C for further detail.

Details of the 'Financial Case' have been redacted due to commercial sensitivity.

7 Organisational Development

Organisational Development (OD) will be a key enabler in achieving the ambition of creating a new integrated acute healthcare provider and delivering the benefits presented above. The implementation of the OD strategy is crucial to the success of the integrated organisation. It is designed to achieve the vision and strategic objectives of Better Care Together through the effective engagement of our employees. It recognises that there are significant challenges in bringing about a safe, effective, clinically led organisation and builds on lessons learnt from mergers / acquisitions of other NHS organisations. A full OD strategy will be available as an appendix to the FBC.

7.1 Setting the Vision of the Integrated Organisation

The vision “Better Care Together” was born from a desire that the integrated organisation must be better than the sum of the parts and it is this vision with which we are engaging with our stakeholders and developing plans with them to achieve this. The overarching vision of the organisation is to provide high quality patient services and enhanced specialist services.

Figure 60: Better Care Together

In order to deliver the vision, a series of strategic aims have been developed and are described fully in chapter 5. Key to the success of the OD strategy will be the ability to ensure that senior leaders have all the critical skills necessary to deliver the strategic objectives.

7.2 The Principles of the Integrated Organisation

The principles of the organisation describe how the integrated Trust will go about its business. They are intended to be a commitment to our key stakeholders and will drive the underlying behaviours required to achieve the strategic objectives:

> **We will exceed your expectations:** We will care for you, not just treat you.
>
> **We will always innovate and improve:** We will be a top performing hospital and we will strive to make sure that our care and treatment compares with the very best.
>
> **We will be an organisation to be proud of:** Our staff will want to recommend the services that we provide to you. We will attract the best and the brightest to join us so that we can continually provide great care.

The principles were developed with Trust Board members from both MFT and DGT and the programme board and further consultation on the principles will take place before submission to the full business case. They are currently being shared across MFT and DGT through the programme board and clinical directorates and departments will further develop the vision and principles so that they apply to their own local areas. This will ensure alignment of objectives and local ownership.

7.3 The Values of the Integrated Organisation

Both organisations cite their commitment to the NHS constitution and the NHS values and have recently sought to strengthen their values based culture. MFT have committed to the patient pledge which is a public representation of their commitments to patients whereas DGT has embarked upon a patient service standards programme known as “professional care, exceptional quality”. The success or otherwise of these initiatives will be ultimately be judged through the experiences of our patients and quantitatively, they should be reflected in the national inpatient survey results, the most recent of which, are not yet available.

Many organisations in the NHS have developed personalised values and branding with very similar themes. The importance of the values, is not the words, but how they are translated into action and how they are experienced by the patient. The executive team of the integrated organisation will have a key responsibility in leading the development of a values based culture and aligning training, development, communication and reward will be crucial.

A small group of representatives, including staff, governors and trade union representatives from both MFT and DGT will come together to review the values of each Trust and to develop an integrated approach for the new organisation. The group will be invited to build on what has worked to date whilst ensuring that the values of the integrated organisation will enable the achievement of what is an ambitious vision and drive through the benefits of the integration, as described in chapter 6.

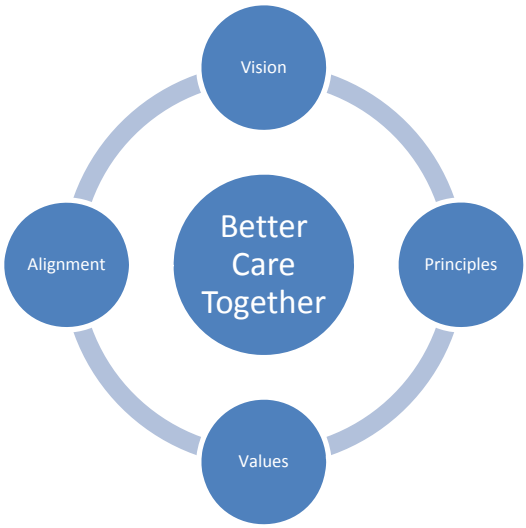
7.4 Aligning the vision, principles and values

The organisational development strategy will ensure that the vision and strategic objectives details are not aspirational but become a reality through the development of a strong culture and brand. Aligning and implementing the strategy will be supported by a highly performing workforce and organisational

development function who base their activity on international best practice and top performing organisations.

The diagram below describes how the vision for better care together is constructed and will be implemented. At this point in the programme, the better care together vision is widely known and is being used to brand the integration agenda, both internally and externally. The vision has been fully developed and the strategic aims have been widely shared, consulted upon and there is a dialogue on how they are going to be achieved. The principles of the organisation have been established, further consultation on them is required before the submission of the full business case. Finally, the post transaction implementation plan will be crucial in the alignment of policies, systems and processes, right across the organisation. Again, this will be available at the point of FBC submission.

Figure 61: Development of Vision



At its simplest, the vision, principles and strategic aims will not be delivered without focused attention being paid to:

- The way we do things here **Culture**
- The nature of leadership **Leadership Behaviour**
- Setting and providing direction **Strategy Development**

- The value placed on the involvement of staff, patients and other key stakeholders **Stakeholder Engagement**
- The structures and processes needed to support efficient and effective working and development of the workforce **Systems and Processes**

7.5 Culture

Too often, cultural considerations are not given enough emphasis during integrations, and this is cited as the most common reason why mergers / acquisitions fail to ascertain their projected benefits. Although both organisations are fundamentally aligned to the values of the NHS, a cultural audit found key differences in the way that each trust is organised and works in practice.

The audit was undertaken with a view to harnessing the cultural similarities of the organisations, but more importantly to understand where the key differences are and what action could be taken to mitigating the risks that may result from the differences.

In addition to a comparative analysis of the staff and patient survey results, a series of focus groups and individual interviews were undertaken using a semi-structured format. Over 100 employees across both trusts participated and the core components of culture were reviewed. These are:

- Rules and Policies
- Rewards and Recognition
- Training and Development
- Leadership Behaviour
- The Physical Environment
- Goals and Measures
- Staffing and Selection
- Ceremonies and Events
- Communications
- Organisational Structures

The audit was not sophisticated enough to consider sub-cultures which inevitably exist in such large, complex organisations and particular consideration will need to be given to medical culture. However it found 3 key components that will need specific consideration as each organisation is vastly different in its approach. These were:

- Rules and Policies
- Leadership Behaviour
- Organisational Structures

Recommendations for the future of each of the core components were made and sense checked with executive teams, with careful consideration given to the 3 key differentials. The outcomes have been built into the full OD strategy and into the post transaction implementation plan.

The audit was the first in a 3 stage process, which will lead to the development of a strong culture and brand:

Stage 1: Understanding the Current Organisational Cultures

Undertake an analysis of the two organisational cultures to identify and understand the strengths, weaknesses, similarities and differences.

Stage 2: Developing the New Organisational Culture

Executives and staff work together to identify a set of core values that are meaningful that staff are committed to and a plan is developed, to align the different elements of the organisational culture.

Stage 3: Embedding the New Organisational Culture

Embed and align the values so that practices drive the new organisational culture, through training and development, communications, policies and practices.

Given that a significant proportion of staff will continue to provide services in the same work location, in the same team, it is important to convey a sense of change; renewed energy and expectation, as it is our staff, on the ground, who will deliver the change that is required if the combined trust is to obtain patient and staff satisfaction levels that they can be truly proud of.

7.6 Strategy Development

The Trust Board of the integrated organisation have responsibility for setting the direction of the organisation. To this end, both the MFT and DGT Trust Boards are driving the strategy of the integrated organisation, with the detailed activity being undertaken by a joint programme board. At an appropriate point in the process, there will be a formal handover of the strategy and post transaction implementation plan to the Trust Board of the integrated organisation.

The designate Chair and Chief Executive, working alongside the nominations and remuneration committee will put in place a robust, externally facilitated board development programme. This will ensure that board members can effectively fulfil their role on an individual and collective basis. In addition to the expectation that the Trust Board will formulate strategy and ensure accountability, they will have an extremely important role in shaping the culture, behaviours and values of the integrated organisation and challenging actions and activities which do not support the desired culture of the integrated organisation.

The executive team will take responsibility for ensuring that the strategic aims of the organisation are translated into measurable and achievable in year objectives and that these are aligned with the objectives of the clinical and corporate directorates. It will be important to foster a strong link between the organisational objectives and individual objectives and this will be delivered

through a comprehensive appraisal and performance management process, which rewards excellence.

7.7 Leadership

The executive team of the newly integrated organisation have a great responsibility for setting the tone and culture of the integrated organisation and inspirational leadership will be required if the vision and strategic aims of the organisation are to be achieved. The behaviour of the most senior leaders will set standards in a way that a written document could never achieve.

The visibility of senior leaders in an integrated organisation, across more than one hospital site, is a concern that has been raised in both public engagement meetings and in the cultural audit and consideration will need to be given to overcoming this concern. All executives will take responsibility for coaching and developing leadership potential in others, as a core requirement of their role.

A strong culture and brand provides good reasons for growing, promoting and developing talent internally. Some of the most successful commercial organisations set talent targets, to internally appoint to a certain percentage of senior roles. MFT has recently established a talent management programme “Being your Best”. This will be rolled out across the integrated organisation and will be used to develop and integrate the most promising leaders. Executives and the integration team will directly work with individuals on the programme who will be tasked with implementing certain aspects of the integration programme, to support their development.

Work has been undertaken to develop and grow leadership behaviour in the same way at MFT and DGT. These are important foundations and will go some way towards cultural integration. The leadership behaviours will need to be reviewed to ensure that they remain fit for purpose and have the right

emphasis during a period of significant organisational change and appointments to the leadership roles will specifically assess leadership behaviours in the appointments process.

It is recognised that for some leaders, there will be significant expectation. For example, the general manager role will change and become more complex, working across both hospital sites and there will be an increasing emphasis on clinical leadership. With autonomous directorate leadership roles, and a real focus on quality and safety in leadership, leaders will need to be able to access appropriate leadership development and coaching support pre and post integration.

7.8 Developing Organisational Structures

The structure of the organisation can support the development of a strong brand and culture and symbolise the expectations required of the leadership team. The cultural audit found key differences in the composition of current organisational structures at MFT and DGT and to this end, some key principles have been established and will be used when developing structures which are fit to deliver the vision and strategic objectives of the integrated organisation, these are:

- Structures should be designed to support the ethos of clinical leadership and enhance clinical engagement
- Structures should support the strong team working ethos that already exists across both Trusts, and should be built on in the transition to the new organisation
- Structures should not be hierarchical. The structures will be flat and there should be a clear line of sight from Board to Ward. There should be no more than 6 layers, from Chief Executive Officer to Health Care Assistant.
- The span of control for line managers will be maximised, and set within limits of best practice.

- There is a careful balance to be struck between driving through change, realising synergies of the integration, and destabilising the operational and financial performance of the newly integrated Trust. A phased approach to the organisational changes required has been established and can be seen below:

Phase 1: Trust Board

Appointment of the designate Chair, designate Chief Executive and designate Finance Director will be made by MFT by January 2012. The designate Chair will review the current Trust Board composition and consider changes which may need to be made to deliver the vision, strategic objectives and discharge the statutory duties of the new organisation. These will be shared with the Nominations and Remuneration committee and any impact on the role and composition of Non-Executive Directors will be shared and consulted upon with Trust Governors. The Chief Executive will consider the impact of the integrated organisation on executive roles and portfolios and any proposed changes to the executive structure will be recommended to the Nominations and Remuneration committee.

Phase 2: Trust board supporting roles and corporate functions

This phase will develop confirmed structures in place for roles that support the Trust Board, sub-committees of the Trust Board and all corporate functions, such as Finance, HR, IT and Governance. There is a commitment to drive through the necessary changes in this area as quickly and effectively as possible, whilst ensuring that the changes are carefully planned and communicated, so as not to have a detrimental impact upon the service provided. Roles included in this phase are subject to collective consultation, which according to legal advice cannot take place until the integrated organisation exists. However, consideration is being given to integrating back office functions early, independently of integration. Any decision to proceed will be confirmed in the full integrated business plan.

Phase 3: Clinical support functions

This tier includes pathology, pharmacy and radiology. There is a commitment to fully integrate these support functions as soon as practically possible. A separate work stream for each function has been established.

Phase 4: Clinical directorate leadership positions and wider clinical structures

In order to maintain clinical engagement and minimise the risk of a dip in operational and financial performance at the point of the integration, a fixed period of dual running has been agreed in the first instance. In practice, this means that all Clinical Directors will remain in post for this period. During this period, the new structure will be developed, consulted upon and implemented.

7.9 Stakeholder Engagement

Fundamental to the success of the integration, will be the ability to create engagement and support for the integration both with internal and external stakeholders. The development of the clinical strategy particularly, has been led by the Clinical Directors. Chief Executives and executive teams have taken responsibility for personally engaging staff across all sections of both Trusts with a series of briefings and a commitment to continued dialogue.

It is essential that the trusts bring all their stakeholders, both internal and external, with them on the journey towards integration, to achieve the vision. The programme's vision, 'Better care together', reflects their holistic approach and aspirations. To this end, they have had a communications and engagement strategy in place since the start of feasibility testing.
The trusts recognise that this change must be clinically led by their doctors and nurses, and so have endeavoured to involve them every step of the way, including through:

- Away days for our clinical directors
- Nursing events
- Presentation and Q&A sessions at team meetings
- Open sessions with Chief Executives
- Liaison with staff side committees (union representatives)
- Regular email and intranet updates
- A dedicated email address for questions from staff

There has been strong support from a number of leading doctors and nurses at both trusts, as they see opportunities to develop and strengthen their services as a result of the integration.

The public engagement plan supports the overarching communications strategy and ensures that patients and the public are not only kept informed, but also have the opportunity to get involved and influence integration plans. Both the strategy and plan focus on on-going engagement and partnership working.

The trusts are working closely and in partnership with key stakeholders to engage with patients and the public over at least a six month period, in two phases. Phase 1 has been focusing on hearing the views of the general public and patients of both hospitals, ensuring that views, concerns and suggestions are fairly considered and built into the integrated business plan wherever possible. It concludes at the end of February 2012, in order to build in time for views to influence the business case. Phase 2 will take place after the business plan has been submitted to the relevant approval bodies, and it will focus on ensuring that implementation plans address the issues that are raised.

A number of mechanisms have been used to engage with external stakeholders, including attending community events, publishing information online, working with the local media, sending regular updates to community

groups and having a dedicated email address and telephone number for questions and comments. A number of influential key stakeholders have been kept up to date by the Chairs and Chief Executives of the trusts personally, such as MPs.

Throughout the on-going engagement process, the trusts have focused on explaining the reasons behind pursuing integration and reassuring stakeholders that there are no plans for service change. Major themes that have emerged from meetings with the public and patients include concerns over when and whether services may change, financial viability of the integrated trust and travel and transport difficulties. Although these are major themes, the trusts are able to offer both explanation and reassurance on all three counts, which have been positively received by audiences.

The trusts are working closely with LINks in Kent and Medway, who have been very supportive during the engagement process. Kent and Medway LINks held well-attended public events in winter 2011, marking the start of Phase 1 of the public engagement period.
The trusts also have an active dialogue with the health overview and scrutiny committees in Kent and Medway. They visited both committees in summer and winter 2011, where integration plans were well received. The trusts have been invited to return in spring 2012.

Commissioners are another group of stakeholders that have been involved from the beginning. The transition team meets regularly with both CCGs and PCT cluster representatives to ensure that commissioner and provider strategies are aligned, and any concerns are addressed as they arise. Furthermore, these relationships are used to ensure GPs and other colleagues in primary care are kept informed.
Following the conclusion of Phase 1 of the engagement period, an analysis of public feedback and an outline of how it has informed integration plans will be published.

7.10 Systems and Processes

A key outcome of the OD strategy will be to ensure that each individual within the organisation understands how their role contributes to the success of the organisation through their line manager, through the behaviour of others, through appraisal and objective setting and good communication, as well as ensuring that policies and procedures support the vision and strategic objectives of the organisation, and do not hinder it. The transition team will be responsible for actively managing the alignment of systems and processes through the development of the post transaction implementation plan, to ensure consistency within priorities. At the point of integration, this will be passed to the executive team to ensure delivery.

In order to satisfy the Foundation Trust regime, it is proposed that the MFT sub-board committee structure is incorporated into the combined organisation. The integrated organisation will therefore contain the following sub-board committee structures:

- Performance and Investment Committee
- Quality Committee
- Nominations and Remuneration Committee
- Integrated Audit Committee

Chairs of current Board Level sub committees at MFT and DGT will meet to share best practice and to understand the current agendas within each sub-board committee. The infrastructure and committee members, as well as full terms of reference for each committee will be available at the point of submission of the Full Business Case.

7.11 The outputs that can be expected from the Organisational Development Strategy

In summary, the table below describes what can be expected from the delivery of the OD strategy.

Figure 62: Outcome of OD Strategy

	Outcome
1	Shared vision and purpose of the organisation, embedded and understood by all
2	Strong Board level leadership, visible and closely connected to the rest of the organisation
3	Strong clinical leadership and organisational structures that deliver the vision and principles of the organisation
4	Highly engaged and supportive stakeholders, including staff, patients, the public and members.
5	A highly performing workforce who understand and buy in to their personal role in delivering the vision and achieving the strategic aims of the organisation.
6	Systems, processes, policies and behaviours which are aligned and support the delivery of the vision and strategic aims of the organisation

The OD strategy will direct the creation of a single organisation, where staff will deliver the vision and strategic objectives by providing “Better Care Together”. All staff will see the value of bringing together the two trusts and will be able to articulate that the sum of the parts will be greater than the individual trusts. Staff will be understand their personal contribution to the vision and strategic objectives and live the values, developed through the implementation of this strategy. They will feel the outputs of the leadership behaviours in their everyday interactions with their line manager and will deliver the benefits of the integrated organisation to our patients and wider community of North and West Kent.

7.12 Establishing the Integrated Organisation

The integrated organisation will see an overall reduction in full time equivalent (FTE) when compared to the baseline establishments currently employed by MFT and DGT due to the opportunities to remove duplicated roles and realise

economies of scale. The full business case will document the proposed changes to the workforce numbers and will be based upon:

- Baseline FTE predictions, following workforce changes, pre-integration at MFT
- Removal of duplicated roles and economies of scale, particularly in corporate and clinical support functions
- Planned commissioning intentions and subsequent predicted impact on activity levels
- The development of specialist services and the repatriation of activity

The remainder of this section outlines the legal obligations both under the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) and section 188 of the Trade Union and Labour Relations Act 1992 (TULRCA). It also indicates how the workforce elements of the organisation will be organised and integrated.

7.13 TUPE

Due to the technical nature of the transaction, there will be a TUPE transfer. Current employers will take responsibility for informing employees of the impending transfer and there have been a series of staff briefings and dialogue with trade unions to date. There will be formal consultation period of 60 days. During this period employees will be formally invited to give comment, ideas and suggestions on the proposals to integrate.

7.14 Collective consultation

Workforce analysis is incomplete at this point due to MFT currently undertaking significant workforce structural changes and it is for this reason that the exact number of proposed redundancy dismissals is, at this point unclear, but will be confirmed at the point of submission of the full business case.

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Current legal advice indicates that collective consultation cannot commence prior to the transfer of staff into the integrated organisation. In practical terms, this means that tiers 2-4 management structures will be collectively consulted upon following the integration. Consideration is being given as to whether corporate functions such as HR and Finance could be integrated early and if this is the case, there will be a separate programme of collective consultation. Further information will be available at the point of submission of the full business case. Tier 1 appointments at executive level will be dealt with separately.

7.15 Minimising redundancy and maximising support for affected staff

At risk staff will be given priority treatment within recruitment processes and new posts advertised will be filled where possible by restricting recruitment to internal applicants only in the first instance. For those staff under notice, support will be provided.

7.16 Human Resources Function

There will be a Board Level Director with responsibility for Human Resources, Organisational Development and Training and Education and the model for delivering HR functions will be based on current best practice, the Ulrich model, with 3 key pillars:

> **HR Business Partners –** The business partner role is central to devolving earned autonomy to directorates**.** HR business partners will form a key part of the directorate management structure and be responsible for delivering the clinical workforce agenda, ensuring the effective delivery of high quality patient care. Professional accountability will be retained within HR.

Corporate Centre - The business partner model will be supported by a corporate centre responsible for employee relations, policy development, learning and development, diversity and other activities best suited to a centralised approach, required to avoid duplication.

Transactional Services Centre – All transactional services, including recruitment, workforce information, medical staffing and flexi bank will be centrally located on 1 site and extensive work is planned to simplify and streamline processes, removing duplication, utilising IT systems and self-service wherever possible. All transactional services will be tested against the market for assurance in quality and value for money in year 2.

More information on the structure and priorities for the HR function in the corporate strategy.

7.17 Working in partnership with Trade Unions

Both organisations have good relationships with Trade Union colleagues. Working in partnership during a period of significant change and uncertainty will be extremely important, if employees are going to remain engaged and be supportive of the integration. A recognition agreement for the newly integrated organisation will be re-drafted with DGT and MFT trade union representatives. A shadow joint staff committee will be established at the point of the submission of the full business case.

7.18 Terms and Conditions

Both organisations employ all staff, with the exception of doctors and the most senior managers on agenda for change terms and conditions. An audit will be undertaken, to assess where there is any deviation from national terms and conditions and steps taken to standardise terms and conditions for new starters across all staff groups where this is the case. There will be a review of

on-call practices in all specialties and rotas will be amalgamated wherever possible.

7.19 Agenda for Change Pay Bandings

After the organisational structure has been agreed, job descriptions will be developed. They will be banded in line with the principles of the national job evaluation scheme. Job evaluation teams will jointly receive refresher training. Banding panels will have DGT and MFT representatives, as well as staff and management representatives.

The cultural audit found that there was some concern about the application of agenda for change pay bandings across MFT and DGT. There will be a staged review of agenda for change bandings with a commitment to ensuring parity of pay bandings across the organisation. There will be a consistency checking process, completed in partnership with staff side and in cases where inconsistencies cannot be objectively justified, posts will be subject to re-matching and re-evaluation through the national job evaluation scheme.

7.20 Policies and Procedures

HR staff and trade union representatives will work together to ensure that there is a suite of HR policies in place at the point of integration for new starters. An audit has already taken place.

7.21 Workforce Information and Performance Indicators

Workforce information systems will be integrated as early as possible and a workforce information workstream will be established to prioritise and deliver integrated performance systems in a timely fashion. Discussions are taking place with McKesson, to integrate the Electronic Staff Record, the most important of the workforce information systems, currently used by both Trusts.

The integrated organisation will report key workforce performance indicators to the integrated Trust Board on a monthly basis including:

- Vacancy Levels
- Temporary Staff Usage (bank and agency)
- Turnover levels, including lost talent and leavers in the first year
- Statutory & Mandatory Training compliance levels
- Total workforce, including clinical / non clinical ratio
- Absence levels

7.22 Learning and Development

MFT and DGT bring different learning strengths to the integrated organisation. Whilst MFT provides a comprehensive programme of leadership development through the Front Line Leadership Programme, consultant development programme and a plethora of nursing leadership programmes, DGT's learning and development function concentrates on providing a comprehensive provision of statutory and mandatory training. The learning and development functions will come to together at the point of integration, but the teams are already working closely together and aligning IT infrastructure, such as the Oracle Learning Management system, and aligning ways of working, such as the implementation of the same appraisal system and leadership behaviours across both Trusts. The fact that both trusts have the same processes, will contribute to the development of a strong culture and brand and allow a much quicker realisation of benefits.

7.23 Statutory and Mandatory Training

Ensuring safety and quality of the organisation is key to delivering successful outcomes and statutory and mandatory training must support the aim to be a top performing hospital, with outcomes that compare with the very best. A full and objective review of statutory and mandatory training will be undertaken in

consultation with subject specialists, those who receive training and senior managers who have to plan services and release staff for training. The review will consider what training is required to deliver the vision and strategic aims of the organisation. At the point of the establishment of the new organisation:

- Approaches to statutory / mandatory training will maximise the use of online learning wherever possible
- All staff will be aware of the statutory and mandatory training requirements of their role
- There will be reliable data on compliance, available on a real time basis for Trust Boards and line managers
- There will be a modern and sophisticated administrative infrastructure, which makes the most of the available IT systems and self service

8 Governance and Risks

This chapter summarises the governance arrangements that the integration has adopted and the key risks to its successful delivery.

8.1 Governance

Process adopted for considering integration with Medway

The process for considering the integration between DGT and MFT has been open, inclusive and based upon the principles of partnership working. This approach consists of 4 main components and each will be considered in turn:

1. Memorandum of Understanding (MoU)
2. Establishment of an Integration Feasibility Project Board which was followed by the creation of an Integration Project Board
3. Establishment of a Transition Team
4. Scheme of delegation

Memorandum of Understanding (MoU)

A Memorandum of Understanding (MoU) was agreed and signed between DGT and MFT in early 2011. This MoU was subsequently updated and agreed by both Boards (DGT, 24 November 2011 and MFT, 29 November 2011). It provides an important governance framework for the process.

The previous MoU between the trusts was primarily concerned with exploring the feasibility of bringing the two trusts together as one organisation. In September 2011, the Boards of both trusts agreed the proposed integration as feasible and that integration plans should proceed.

The current MoU sets out the principles to achieve integration as the acquisition of DGT by MFT in accordance with Monitor's Compliance Framework. It also takes full account of Monitor's Risk Evaluation of Investment Decisions (REID) guidance. In addition to an acquisition, a divestment, resulting in dissolution will be required in relation to DGT as determined by the NHS Transactions Manual.

The trusts agreed that the integration will be managed as an integration of two organisations of equal standing, and that as far as allowed by the required approval processes will be pursued collaboratively. Staff and patients would experience this process as an integration of equals with neither trust acting as the dominant partner.

The MOU agreed that following the Integration Feasibility Test Report, business cases would be developed seeking the dissolution of DGT and an Integrated Business Plan (IBP) would be prepared for the integrated organisation. Details would be submitted to the Cooperation and Competition Panel for NHS-funded services (CCP) and the IBP for the integrated organisation would be submitted to Monitor as part of the process for assigning individual risk ratings to the integration.

The MoU details the governance arrangements for the work programme to progress the integration which would be overseen by the two trust Chief Executives. It was agreed that a Project Board would be established and a Programme Director and transition team appointed. Agreement was made on the costs of the programme and the sharing of these between the two trusts. Communication processes and the management of the confidentiality of data and information were agreed.

Both parties to the MoU agreed that no work under the provisions of the MoU commits either trust to a transaction to integrate. Furthermore, no assumption was made that actual integration would be the outcome of this work.

Establishment of an Integration Feasibility Project Board which was followed by the creation of an Integration Project Board

Initially an Integration Feasibility Project Board (IFPB) was established under the terms of the MoU, which was subsequently replaced by an Integration Project Board (IPB) following the approval of the Integration Feasibility Test Report which demonstrated that integration was viable.

The purpose of the IPB is to oversee and ensure the delivery of the Integration Programme on behalf of the Boards of DGT and MFT. The IPB facilitate the necessary steps to enable the integration of the two trusts.

The IPB oversees the work of the transition team, which is outlined below, and provides this Team with the required reporting, governance and guidance to deliver the requirements of the updated MoU. Furthermore, the IPB oversees and scrutinises the development of the Integration Case.

The IPB ensures that the Programme undertakes all the appropriate steps to achieve integration through the acquisition of DGT by MFT in accordance with Monitor's Compliance Framework, the NHS Transactions Manual and taking into account Monitor's Risk Evaluation of Investment Decisions (REID). The IPB also ensures the development of a post-transaction integration plan (PTIP) which meets the external standards required and which will deliver the benefits of the integration.

Stakeholder engagement is a key component of integration planning, and the IPB oversees the plans for engaging with the public, staff, commissioners, local authorities and other NHS partner organisations.

The IPB reports to both Trust Boards on a monthly basis and is authorised to make decisions regarding the management of the integration programme.

The IPB is chaired alternately by the Chair of DGT and MFT each month. The IPB consists of the two Trust Chief Executives, one non-executive director

from each trust and both Medical Directors. The Programme Director and Core Members of the Transition Team are also included in this project board. Representation is also included from NHS South of England who has observer status.

Transition Team

A Transition Team was established in April 2011 which consists of Directors from both trusts. It consists of Programme Director, and two Integration Directors. The Transition Team has a small support function. Work is commissioned by the Transition Team to support the integration and M&A advice is provided by PriceWaterhouseCoopers. The Team have been working with key stakeholders and staff across both hospitals developing the strategies that will secure the proposed integration in order to deliver benefits.

Scheme of Delegation

Upon the achievement of feasibility, a scheme of delegation was developed. The purpose of the scheme is to provide a clear decision making structure and lines of accountability held by individuals, meetings and committees in relation to the proposed integration.

Due Diligence

As part of the process of the integration, the organisations are required to undertake due diligence reviews to enable the Boards of each organisation to understand the risks and opportunities and in particular any issues that might preclude a decision to integrate. The integration therefore requires appropriate independent advice to inform this process. This will be undertaken in five key areas:

Clinical Due Diligence

The purpose of this exercise is to provide the Boards of each organisation with the appropriate assurance that they have considered all the relevant issues surrounding the clinical governance arrangements and outcomes of clinical practice at their partner organisation, and have identified and understood the areas of risk and/or concern. Recommendations for future quality governance arrangements and plans to mitigate risks and issues will also be produced. This review will be carried out in accordance with the addendum to the NHS Transactions Manual (October 2010).

Financial Due Diligence

Financial Due Diligence will be undertaken in two key phases. The first phase in will be conducted to accompany the IBP and FBC in the areas of Profit and loss and the Long Term Financial Model review to cover the two years ended 31 March 2011 and the forecast period to 31 March 2016, reviewing areas such as balance sheets, cash flow and capital expenditure. Comment will also be sought on a combined summary of historical and forecast profit and loss accounts, balance sheets and cash flow statements and on a summary showing how the results of the trusts may be combined (together with collective synergies for forecast results) to arrive at the recent historic and forecast results for turnover, EBITDA and net assets;. In regard to the LTFM model generated for the combined entity a comment will be made upon Financial Risk Rating; and sensitivities. The second phase will be undertaken during the Monitor assessment to provide opinions in areas such as post transaction, quality governance and working capital.

Estates Due Diligence

The purpose of this exercise will be to ensure the risks and opportunities associated with the management of the PFI asset at Dartford & Gravesham NHS Trust are fully understood and recommendations made to ensure that these issues are appropriately managed.

Legal Due Diligence

The key aim of the legal due diligence exercise is the assessment of risks associated with pending or likely statutory enforcement action and civil or criminal litigation. The report will also ensure that all relevant stakeholders are apprised of the extent and nature of other legal liabilities associated with both Trusts' position as landowners, contracting bodies and as employers.

Workforce Due Diligence

Workforce due diligence will be undertaken internally and forms part of the TUPE transfer process. The key aim of the due diligence is to establish a complete picture of the workforce as well as highlight any potential liabilities and risks so that plans can be put in place to mitigate them.

It will review shared services, bank staff, agency workers, secondees from other organisations, self-employed persons, inappropriate and unusual employment arrangements, employees of third parties and honorary contract arrangements, policies and procedures.

8.2 Risk

The tables below summarise at a high level key risks to achieving a successful integration pre and post transaction and an assessment of the degree of risk posed (using Red Amber Green ratings) and how such risks will be addressed.

The risks relate specifically to the delivery of the integration and not to specific corporate risks for each trust involved in the process. Risks and mitigations have been identified by the Transition Team. Risks rated as high are escalated automatically to the Integration Programme Board (IPB).

8.3 Pre Transaction

Figure 63: Pre Transaction Risks

Identified Risk	RAG	Mitigation/s
1. Stakeholder opposition	Green	• Visible and affirmative leadership within both Trusts • Close collaboration with key stakeholders notably commissioning Clusters CCG's and patient groups • Implement of Communications and Engagement Strategy
2. Capacity to focus on the integration within the organisation	Green	• Transition Team fully seconded from substantive posts • Integrated Programme Board established with Trust Chair and CEO's of respective organisations in lead roles • Non-Executive Directors as members of the IPB and Trusts' Boards
3. Lack of external funding for transactions process	Amber	• Monthly meeting with commissioning cluster as part of funding agreement • Regular update given to commissioning cluster through IPB papers • Regular Chair and CEO engagement with Cluster
4. Inability to recruit to key posts due to the integration	Green	• Implementation of Communication and Engagement Plan • Regular informal updates to key leadership groups
5. Lack of, or insufficient, leadership or ownership from clinical leaders	Green	• Clinical Strategy development continues with close involvement of Clinical Directors • Retention of CD's in roles through year one of integration • Implementation of Communications Plan • Tailored meetings with clinical groups with concerns
6. Inability to meet Monitor's risk ratings – financial and quality	Green	• Joint LTFM at feasibility as basis for integration remains • Individual organisations deliver existing plans • Appropriate mitigations in place for each individual organisation
7. Respective organisation withdrawal from integration	Green	• Issues raised and resolved through IPB • Issues addressed through existing governance system and processes

8. Respective Trust Board do not approve integration	Green	• Feasibility passed in September agreeing key benefits • Integrated approach to planning business case / integrated business case • Regular monthly updates at Trusts' Board meetings
9. Risk of cancellation due to not meeting Monitor requirements	Green	• Following REID and best practice guidance • Appointment of merger and acquisition advisors • Due diligence part of process
10. Risk of cancellation due to not meeting requirements of SHA/Transactions Panel/PCT	Green	• Regular monthly meetings with NHS South of England • NHS South of England represented at IPB • Appointment of merger and acquisition advisors • Due diligence part of process
11. Risk of delay due to delay in CCP pipeline	Red	• Appointment of external support in Frontier Economics • Use of experience from previous organisations submissions put into practice • Regular contact with CCP through Transition Team liaison
12. Risk of cancellation due to not meeting CCP requirements	Green	• Appointment of external support in Frontier Economics • Use of experience from previous organisations submissions put into practice

8.4 Post transaction

Figure 64: Post Transaction Risks

Identified Risk	RAG	Mitigation/s
1. Loss of corporate memory and leadership	Green	• Implementation of Organisational Strategy • Retention of Clinical Directors in roles through year one of integration
2. Lack of clear leadership	Green	• Implementation of Organisational Strategy • Retention of Clinical Directors in roles through year one of integration • Identification of a Senior Responsible Officer for the Integration and designate Chair, Chief Executive and Finance Director in place pre transaction
3. Inadequate investment in the transaction	Green	• An effective Post Transaction Implementation Plan • Clear leadership/accountability throughout the integration • Regular tracking of benefits realisation through PMO approach
4. Changes to the local health economy render strategy flawed	Amber	• Monthly meeting with PCT cluster and Clinical Commissioning Groups • Regular meetings with NHS South of England • NHS South of England representative at the IPB
5. Loss of financial control in the short term immediately post transaction leading to failure to achieve benefits	Green	• Strong financial leadership from the outset (DoF downwards) • Robust planning for the first 100 days in the Post Transaction Implementation Plan • Clear governance system and accountability in place at outset
6. Inability to deliver key performance and financial measures due to integration	Green	• An effective Post Transaction Implementation Plan • Robust plans for individual organisations • Clear leadership/accountability throughout the integration
7. Incompatible cultures	Amber	• An effective Organisational Development Strategy and Plan is implemented • An effective Post Transaction Implementation Plan • Clear leadership/accountability throughout the integration • Regular tracking of benefits realisation through PMO approach

8. Insufficient capability and capacity of leadership teams	Green	• Implementation of Organisational Strategy • Retention of clinical directors in roles through year one of integration
9. Quality standards reduce due to failure to integrate systems that leads to governance concerns	Green	• Early identification of governance systems required by Day One. Clinically led and organisationally owned governance systems and clinical integrated strategy. • Strong leadership and accountability • Trust Board overview and sign off of Monitor certifications

8.5 Risks if integration does not proceed

A strategic response to the clinical, financial and political drivers for the integration (outlined above) would still be required.

The key risks to DGT and MFT if integration does not proceed include:

- **Clinical sustainability**: compliance with guidelines; maintaining rotas; limited research and development opportunities leading to a reduction in range and quality of services provided locally
- **Financial sustainability**: limited resource flexibility and capital for investment, unachievable cost improvement plans with detrimental effects on the quality of patient care and staff welfare
- **Foundation Trust status**: DGT's inability to attain Foundation Trust status as required by the Department of Health.

The clinical and financial sustainability in the short term for DGT and in the medium to long term for MFT would result in a diminishing quality of care and patient experience. Solutions would need to be found that would involve partnering with other viable organisations.

Appendix A has been redacted due to commercial sensitivity.

9 Appendices

9.1 Appendix B: Service Visions: Short and Medium Term

Short Term

Womens' Health

The overall aim by year 2 is to have established or be developing combined services to ensure that patients that access the hospitals have equal access to the full range of services provided. One of the key areas in which skills and expertise will be shared between the team is in fetal medicine. This will ensure that the patients at DVH are no longer referred to London. The service will be expanded at DVH to ensure 98 hour labour ward consultant presence. A private clinic for fetal scanning will also be established.

Improving the acumen and skills of junior doctors and midwives is a key aim in women's services. A joint training programme will result in more diverse training opportunities and will be led by a greater range of specialists.

Given the local changes in maternity services with the closure of the unit at Queen Mary's Sidcup and the relocation of services from Maidstone to Pembury, significant repatriation of births and midwifery services is planned for year one, some of which is already being seen.

The major obstetric on-call rota will be joined in the first year. This will make the 98 hour labour ward cover rota more robust, will reduce duplication and enable additional expertise to support the rota.

Paediatrics

Paediatric surgery is currently provided at MMH in a dedicated children's day case setting. Both hospitals provide inpatient and non-elective care to

paediatrics. The aim is to expand the paediatric surgery department at MMH by ensuring the recently established outpatient clinics at DVH refer patients eligible for surgery to MMH rather than to London. The surgical procedures can be safely and appropriately conducted by clinicians and activity increased immediately as facilities already exist. There are currently 300 patients per annum receiving these services from London from the local health economy. Repatriating this activity from London will provide a new source of income and will enable the surgeons to build their expertise and expand the range of surgical procedures provided. Most importantly, this development will improve the accessibility of services to parents and their children.

Paediatric endoscopy is not yet provided locally. Children with gastro-intestinal problems are currently referred to London for endoscopy investigations from secondary care. Developing this service links with the aim to increase paediatric surgery and the overall principle of providing care closer to home. The aim is to develop a paediatric endoscopy service locally in conjunction with a paediatric gastroenterologist based in a tertiary centre. With excellent endocsopy facilities on both sites, each Trust is well equipped to deliver local services. Between DVH and MMH approximately 40 children per year are referred to London for an endoscopy procedure.

Medicine

There are many developments in Adult and Emergency medicine that will involve the sharing of skills and expertise, developing new outpatient outreach clinics and providing more specilaist services. Each of these developments therefore will improve access for local patients to more specialist services; improve the acumen of our staff; and have been developed in response to local healthcare needs.

As nationally recognised, long term condition management is to become a primary focus of healthcare, particularly for medical specialties. Therefore, many of the medicine developments involve increasing the range of services

provided in the community. For example, rheumatology are planning more clinics in the community including infusion therapy provision, working with primary care to better manage patients in the community.

Given the prevalence of diabetes in the local population, educating diabetic patients to use insulin pumps is one initiative to improve patients' ability to better manage their condition. There are also plans to develop a specialist diabetes foot clinic which will support the GPs in the community and improve health outcomes for local patients.

There are a range of respiratory services which will be developed to provide a far more comprehensive respiratory service to local patients. The local population have high respiratory needs due to the high level of smoking, the dockyard at Medway at which many of the older generation worked with high exposure to asbestos, and the proximity of several power stations in Dartford resulting in poor air quality.

MFT currently provide sleep apnoea and allergy services which have capacity to extend the services to patients of West and North Kent. The aim is to provide outreach clinics at the DVH site for ease of access to patients. These are services that the Dartford, Gravesham and Swanley GPs are keen to see developed as they are continuing to see a rise in the number of patients that would benefit from the services.

In collaboration with the Medway commissioners, MMH are establishing NIV services which can be expanded to the West Kent patient population. The increase in patients will support the further development of a community outreach service reducing the need for patients to attend the acute sites for monitoring or trials of equipment.

The integrated trust plans to bid for the provision of an EBUS service which will be directed from the Kent Cancer Network. The service is closely linked to gastroenterology and would then enable the development of a specialist gastroenterology service as the main equipment required is the same.

In line with the national intitiative to consolidate level 2 clinical haematology inpatient beds, plans are being developed to establish a hub and spoke model to provide specialised clinical haematology-oncology. This will reduce inpatient stay by expanding ambulatory care and allow for sub-specialisation. The national guidance recommends a hub and spoke model which entails centralised level 2 care admissions and extended ambulatory care at the hub, and providing outpatient, level 1 chemotherapy and haematology consultation and laboratory supervision on the spoke. This will require investment in nurses trained to administer chemotherapy. Both hospitals have chemotherapy services and have specialist nurses who will provide training.

DVH currently hosts a nephrology service which is jointly run with Kings College London. Having recently employed an additional two nephrology consultants it is expected that in the medium to long term there will be an increased range of nephrology services available to local patients. This will include some acute inpatient activity and renal dialysis.

Surgical Services

One of the benefits of the integration to the specialties, particularly in surgery, is the maintance of rotas to: comply with the latest recommendations; offer greater training and development opportunities; and to provide the service in a more robust way to meet the European Working Time Directive. Another significant benefit, particularly in surgery, is the ability to prevent duplication of specialist equipment resulting in improved access for patients and improved value for money for tax payers.

The overall aims are: firstly, to invest in laparoscopic theatre equipment to increase the volume and range of minimally invasive surgery that can be undertaken. Secondly, increase the endoscopy theatre capacity by beginning an evening session and build additional endoscopy theatres. Thirdly, to centralise specialist surgical services (particularly cancer surgery) on one site

to maximise equipment utilisation and improve the care provided to patients with specialist needs.

The additional endoscopy capacity will be used to provide a Bowel Screening Centre. The development of both pelvic floor and rectal ultrasound / biofeedback services will offer new local services for patients within two years of the integration.

DVH has begun to develop the West Kent Urology Stone Centre, a regional stone service. The aim is to develop a stone centre at DVH to provide a one stop clinic, outpatient service and treatment facilities to include Lithotripsy, endoscopy, Truss and template biopsy services. Patients from Medway are already being treated at DVH for the ablation of kidney and bladder stones. The expansion of this service will ensure that commissioners and urology consultants in acute providers in Kent and South East London will refer patients to DVH for surgery.

A West Kent wide spinal service is to be established at MMH with the view to expand spinal services, centralising day surgery and inpatient activity on the MMH site.

Pathology

In line with national initiatives the centralisation of pathology is underway; this is anticipated to have significant efficiency gains. The pathology service will take place on both sites in the form of a hot and cold laboratory. A comprehensive pathology laboratory located on one of the existing two acute hospitals providing a 24/7 service for blood sciences and 7 day working microbiology service with on-call from home for out-of-hours urgent cases.

The laboratory will receive pathology specimens from both Trusts and direct access requests from GPs as well as referred work from other hospitals / laboratories. The laboratory will include a central specimen reception (CSR)

for all specimen types and will act as a hub for distribution internally and externally as required.

- In addition to the above there will be a satellite laboratory sited at the other acute hospital for both Blood Transfusion and Blood Sciences. There would be no on-site provision for microbiology testing at the satellite laboratory and all specimens would be transferred to the main lab.

Radiology

Interventional radiology is currently only provided at MMH, expanding the service to provide care for both sites will reduce outsourcing costs and allow for the expansion of interventional radiology services such as embolisation.

A central booking system will allow patients to attend either hospital site for their imaging tests, improving their access and choice of location. This will be enabled by cross site access to PACS and RIS systems, allowing images and reports to be accessed on both sites. This will improve the productivity of the equipment, utilisation of staff time and skills and enhance patient choice.

There continues to be an increase in the number of MRI and CT imaging tests in both hospitals. This is likely to continue as the hospital imaging facilities support the community providers of care as well as the hospital activity. Both hospitals require an additional MRI scanner, the integration will enable the trust to invest in only one additional MRI scanner. This will provide the required capacity improving access for patients whilst reducing unneccessary duplication, improving the productivity of the new scanner and providing greater value for money.

Medium Term

All services will continually plan to develop new services and expand existing services to better meet the specific needs of the local population. Repatriating tertiary activity is anticipated to be a medium to long term developmentand will depend on the speciality. This is due to the need to build the more specialist services in house over the next few years, demonstrate the quality of the service through excellent health outcomes and achieve commissioner support.

Womens' Health

The service aims to have attained urogynaecological accreditation within three years. This will require more robust rotas (which a larger workforce will provide) and attract specialist clinicians and lead to the development of more specialist services.

Within the service there are opportunities for development of sub-spcialisations which would strengthen the services provided locally and increase the market share. These services could be developed on one site with some investment, releasing some capacity on the other or making use of the clinical skills in different directorates within the organsiation. These include pelvic pain clinics, oncology services and minimal access endometriosis surgery.

Paediatrics

The integrated trust will have over 10,000 deliveries and hence would be eligible to act as a hub for the proposed managed clinical network model for future services in paediatric cardiology. DVH has a well-established paediatric cardiology service with Evelina Children's Hospital and also hosts an adult

congenital cardiology clinic. There are established cardiac intervention and investigation facilities to augment the plan, which are supported by the Heart Centre at DVH. The aim is to become the hub for paediatric cardiac care by Year 5.

Arrangements for continuing care for babies born prematurely and/or with on going ventilatory support are not well coordinated and babies often have extended length of stay in the London units whilst clinicians, service managers and commissioners work through each case on an individual basis. Individual packages are costly with high use of agency staff and charges associated with extended hospital stay.

MFT has a well developed team of Community Outreach Nurses and Carers providing care in the home to children following premature birth and to those with long term medical conditions, oncology and other complex life threatening and life limiting conditions and is actively recruiting more staff.

A National Framework for Continuing Care has been developed which suggests that given the population size of the integrated trust, there will be opportunity to expand the service. There is also opportunity to develop some dedicated inpatient capacity to service the transition period between hospital and home for these children and reduce length of stay in London hospitals and Neonatal Units. This will improve the quality of care for both parents and children as well as being more cost effective for commissioners. This will also result in greater working relationships with the community paediatric teams.

Surgery

The Trust aims to establish an ophthalmology service in partnership with a leading specialist from a world class provider to provide a growing service locally. Neither hospital currently provides this service, although MMH hosts this service for Maidstone & Tunbridge Wells and has a theatre for this activity.

9.2 Appendix C: Existing Service Changes

- **Existing Service Changes: Thames Gateway Regeneration and Development**

The Thames Gateway development area is the largest regeneration programme in Europe. The Gateway stretches 40 miles along the estuary from Canary Wharf in London to Southend in Essex and Sittingbourne in Kent. 160,000 homes are projected to be built as part of this initiative.

Kent Thameside encompasses the Boroughs of Dartford, Gravesham, Medway and Swale with a focus on the urban area north of the A2/M2 and south of the River Thames. It is a major new housing and commercial development within the Thames Gateway Partnership, including the creation of new high speed train links to central London. The international and domestic passenger interchange for the Channel Tunnel Rail Link at Ebbsfleet has created an international transport hub, connecting Kent to mainland Europe and to London (17 minutes). The aim of the Partnership is to deliver the economic, physical and social regeneration of the Thames Gateway into London.

The population of the Medway Towns is expected to grow by at least 4.6% by 2018 from 2006 population figures. This is partly due to the housing developments planned as part of the Thames Gateway project. The population of West Kent is expected to grow by 7.6% by 2022 from 2007 population figures.

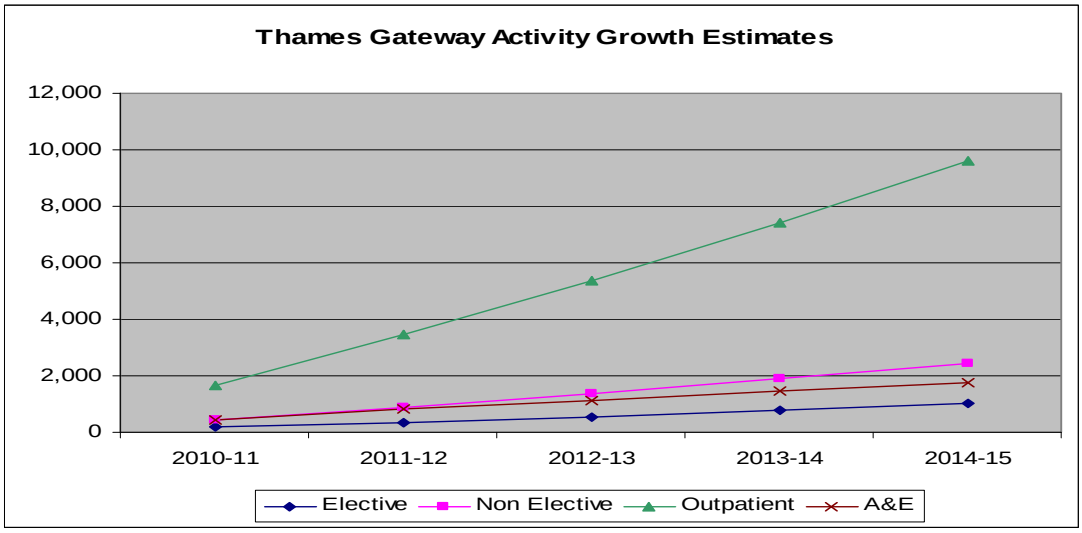
‘Kent Thameside’ covers the planned developments in and around Dartford and Gravesham where 25,000 new homes will be built by 2016. The South East Plan makes an assumption of 25,000 extra people in Dartford and Gravesham between 2006 and 2016, and 50,000 by 2026. The motorway infrastructure is being upgraded as part of the enabling works for the population growth and vast tracks of quarry land have been cleared to

prepare for on-going development. The Ebbsfleet high speed rail link connecting Kent to London is also in place.

Thames Gateway Development Map

DVH will be the local acute hospital for this population. DVH has therefore been engaged in the planning and development process. To date the services most significantly affected by the population growth have been Maternity services, Paediatrics, Sexual Health and A&E. This is due to the majority of the new residents being younger people and new families. The population growth associated with the Thames Gateway is reflected in the LTFM and resource implications. The graph below shows the current activity growth realised in 2010-11 and the estimated growth per annum until 2014-15.

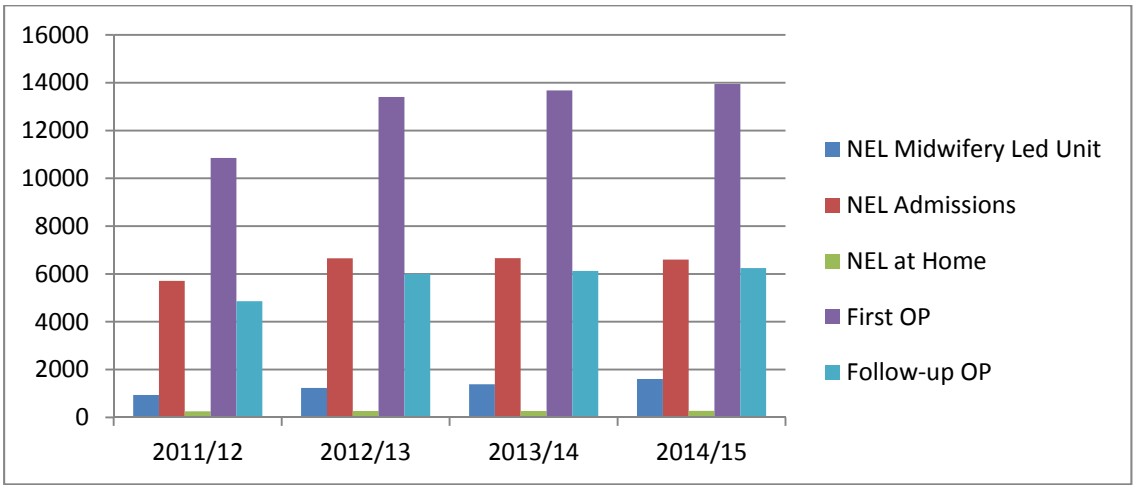
Thames Gateway Activity Growth Estimates



- **Existing Service Changes: Obstetrics at Medway Maritime Hospital**

There is planned growth until 2014/15 in maternity services as a result of demographic drivers; the relocation of maternity services from Maidstone to Pembury, and the establishment of a Midwifery Led Unit (MLU) at MMH. The Midwifery Led Unit at MMH was opened in 2011 in line with the Department of Health's framework for maternity services, Maternity Matters (2007). This stated that women should be able to choose to have a birth at home, in an obstetric unit or a midwifery led unit, increasing the choice for women resulted in an increase in the number of births at MMH. The aim is for 25% of births to take place in the Midwifery Led Unit by 2014/15. The graph below demonstrates the activity increase anticipated until 2014/15.

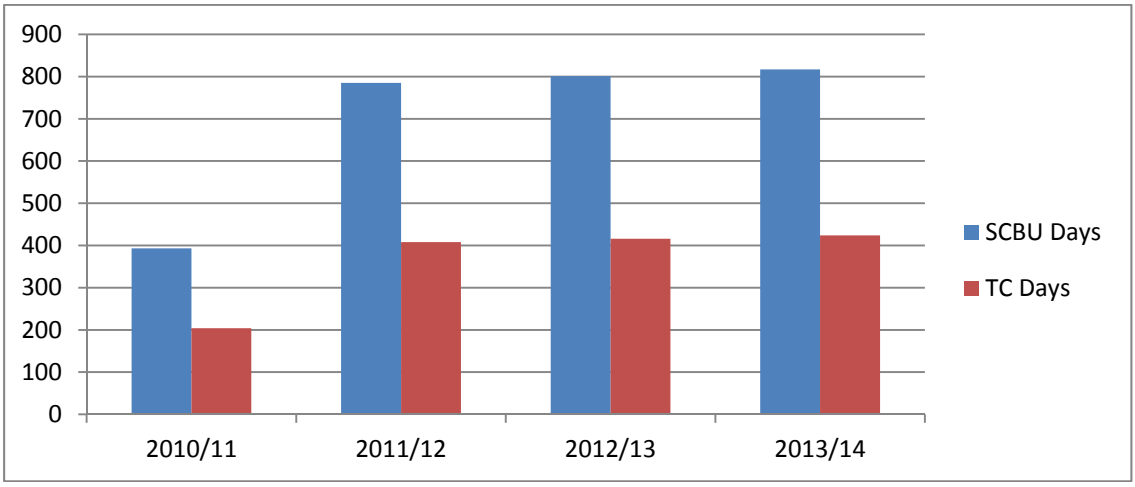
Obstetric Activity at Medway Maritime



- **Existing Service Changes: Neonatal Intensive Care Unit**

The NICU service at MMH is being expanded to accommodate the increasing demand for level 3 services in Kent. This has been a Kent wide commissioning decision as the NICU service provides the only level 3 care baby unit in Kent. Given the increase in births anticipated in Kent the demand for NICU beds will continue to increase. In order to prevent local babies being transported to London for care that could be provided locally the decision to expand the unit has been made. The activity graph below demonstrates the recent and anticipated demand for NICU.

NICU Activity at Medway Maritime Years 2010/11 – 2014/15



- **Existing Service Changes: Impact of “A Picture of Health” and Bexley Repatriation**

”A Picture of Health” was the name given to the plan to centralise specialist acute services between fewer acute sites in South East London. The “A Picture of Health” plan resulted in considerable downsizing of the Queen Mary’s site in Sidcup, including closure of the Level 1 A&E facility, consultant led obstetrics and some complex surgery. DVH, as one of the closest hospitals to Sidcup, has seen an increase in the number of patients from the Bexley area – patients that would otherwise have access services from Queen Mary’s Sidcup. Although the closures of A&E and maternity occurred in December 2010 increases in activity are anticipated to continue until 2015.

DVH continues to plan to accommodate obstetrics and has incorporated 2,200 spells of emergency activity and additional elective and day case activity (1,700 spells) into its baseline clinical activity.

There has been specific efforts to repatriate urology and trauma and orthopaedic activity from Bexley with the appointment of an additional consultant in each specialty.

9.3 Appendix D: Benchmarking of Metrics from Foundation Trusts with PFIs

BENCHMARKING OF METRICS of FT's WITH PFI's

		Actual	Outturn	Forecast	Forecast
		Mar - 11	Mar - 12	Mar - 13	Mar - 14
Manchester	Income	665.2	719.7	729.8	736.4
	EBITDA	49.2	56.6	59.8	62.5
	Surplus	0.1	7.3	7.4	7.5
	EBITDA %	7.4%	7.9%	8.2%	8.5%
	Surplus %	0.0%	1.0%	1.0%	1.0%
	CIP% OP Exp less PFI Exp	4.0%	4.8%	2.3%	3.5%
	Liquidity days	17.7	13.5	13.4	12.4
Derby	Income	422.8	421.8	410.7	409.7
	EBITDA	26.5	23.9	26.9	27.5
	Surplus	1.1	2.4	0.8	0.9
	EBITDA %	6.3%	5.7%	6.5%	6.7%
	Surplus %	0.3%	0.6%	0.2%	0.2%
	CIP% OP Exp less PFI Exp	2.2%	3.1%	5.3%	4.3%
	Liquidity days	12.4	15.7	19.0	19.7
Sheffield	Income	800.8	850.4	828.6	814.4
	EBITDA	47.0	42.8	45.6	46.2
	Surplus	2.4	3.0	3.0	3.0
	EBITDA %	5.9%	5.0%	5.5%	5.7%
	Surplus %	0.3%	0.4%	0.4%	0.4%
	CIP% OP Exp less PFI Exp	4.7%	3.0%	3.6%	3.9%
	Liquidity days	34.1	23.2	23.8	26.4
Newcastle	Income	778.7	833.6	822.9	819.3
	EBITDA	55.8	57.5	62.0	67.0
	Surplus	-3.3	-8.8	-7.4	0.0
	EBITDA %	7.2%	6.9%	7.5%	8.2%
	Surplus %	-0.4%	-1.1%	-0.9%	0.0%
	CIP% OP Exp less PFI Exp	4.5%	4.0%	4.1%	4.1%
	Liquidity days	22.6	26.8	3.8	-0.1
Darlington	Income	341.2	458.8	447.5	446.2
	EBITDA	29.3	29.6	30.7	32.1
	Surplus	6.0	2.0	2.8	2.0
	EBITDA %	8.6%	6.5%	6.9%	7.2%
	Surplus %	1.8%	0.4%	0.6%	0.4%
	CIP% OP Exp less PFI Exp	2.8%	4.6%	5.6%	4.6%
	Liquidity days	37.0	16.9	22.1	23.2
Bristol	Income	506.6	491.6	464.9	457.1
	EBITDA	41.8	33.4	35.6	36.3
	Surplus	12.0	6.0	5.1	4.8
	EBITDA %	8.3%	6.8%	7.7%	7.9%
	Surplus %	2.4%	1.2%	1.1%	1.1%
	CIP% OP Exp less PFI Exp	2.4%	3.5%	4.1%	4.2%
	Liquidity days	39.5	25.6	35.6	36.1

		Low	High	Median
Ranges	EBITDA %	5.0%	8.5%	7.7%
	Surplus %	0.2%	1.2%	0.6%
	Liquidity days	12.4	36.1	22.1

9.4 Appendix E: Assumptions for Financial Modelling

		2012/13	2013/14	2014/15	2015/16	2016/17
National tariff	Integrated model	-1.5%	-1.5%	-1.5%	-1.0%	-0.5%
	Downside model	-2.0%	-2.0%	-2.0%	-1.5%	-1.0%
CQUIN	Integrated model	1.88%	1.88%	1.88%	1.88%	1.88%
	Downside model	0.63%	0.63%	0.63%	0.63%	0.63%
Pay inflation	Integrated model	0.3%	1.0%	1.0%	1.9%	1.9%
	Downside model	-	-	-	2.5%	2.5%
Non pay Inflation - general	Integrated model	2.5%	2.5%	2.5%	2.5%	2.5%
	Downside model	3.75%	3.75%	3.75%	3.75%	3.75%
Non pay Inflation - drugs	Integrated model	5.0%	5.0%	5.0%	5.0%	5.0%
	Downside model	7.5%	7.5%	7.5%	7.5%	7.5%
PFI costs	Integrated model	3.0%	3.0%	3.0%	3.0%	3.0%
	Downside model	4.5%	4.5%	4.5%	4.5%	4.5%
Demand Management NHS Medway	Integrated model	£3.9m	£3.3m	£2.0m		
	Downside model	£7.8m	£6.6m	£4.0m		
Demand Management NHS West Kent	Integrated model	£4.1m	£3.6m	£3.0m		
	Downside model	£8.2m	£7.2m	£6.0m		
CIP Achievement	Integrated model	90%	90%	90%	90%	90%
	Downside model	81%	81%	81%	81%	81%

9.5 Appendix F: Table of Figures

Dartford and Gravesham NHS
NHS Trust

TRUST BOARD MEETING - JANUARY 2012

Item 1-11.1. Attachment 25 - Forward programme of agenda items

1-11.1 FORWARD PROGRAMME OF AGENDA ITEMS CHAIRMAN

The forward programme of Board agenda items is enclosed.

Board members' attention is drawn to the items provisionally scheduled for the February 2012 Board meeting (in addition to the reports received routinely at each meeting), i.e.:

- Discussion of outline Annual Plan 2012/13;
- Security Annual Report 2011;
- Annual Fire Report (to include findings from annual Fire safety audit & Annual Statement of Fire Safety 2011);
- Matrons – Quarterly report (clinical presentation): Conclusions from the nutrition workshop;
- Annual audit of consultants' appraisal;
- Ward staffing benchmarking;
- Quarterly update of the implementation of the Sustainable Development Management Plan (to include agreement of Carbon Management Plan);

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

Equality Impact Assessment initial screening applicable to this report? No

This report provides information on the following annual objectives (delete as required)**:**

- To improve patient experience and patient safety, and achieve the best health outcome for patients, through implementation of the Quality Plan for 2011/12;
- To maintain the highest standards of cleanliness and reduce healthcare associated infections, maintaining a zero tolerance approach to infections acquired within Darent Valley Hospital;
- To develop productive relationships with emerging GP Consortia, local authorities, and other new partners, in order to provide sustainable services for the community, and achieve a sustainable local health economy;
- To recruit excellent staff, and develop, manage, lead and support our staff fairly, to ensure they are motivated to deliver high quality and excellent services;
- To deliver the objectives set out in the Financial Plan for 2011/12, including the delivery of a Quality, Innovation, Productivity and Prevention (QIPP) programme that develops patient pathways which provides care closer to patients' homes, and improves the efficiency of the services the Trust provides, thereby saving resources and releasing capacity

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors understanding of the Trust & its performance

Trust Board meetings – Forward programme of agenda items

Heading	26th Jan 2012	23rd Feb 2012	29th Mar 2012	26th Apr 2012	31st May 2012	6th or 8th June 2012 (TBC)	28th June 2012	26th July 2012	30th Aug 2012	27th Sep 2012	25th Oct 2012	29th Nov 2012
CORPORATE REQUIREMENTS, **CONSENT / APPROVALS,** **MISCELLANEOUS**	▪ Register of Sealings, notification of covert surveillance & other matters (by exception) ▪ Declarations of interest ▪ Self-assessment against areas to be covered in the recommendations from the Mid Staffordshire NHS Foundation Trust Public Inquiry ▪ To approve the Partnership Board's revised ToR ▪ Chief Executive Report	▪ Register of Sealings, notification of covert surveillance & other matters (by exception) ▪ Declarations of interest ▪ Chief Executive Report ▪ Discussion of outline Annual Plan 2012/13	▪ Register of Sealings, notification of covert surveillance & other matters (by exception) ▪ Declarations of interest ▪ Chief Executive Report ▪ Agreement of draft Financial budgets 2012/13 ▪ To approve the Remuneration Committee's revised ToR ▪ To receive generic details of the matters discussed at the Remuneration Committee, Mar 2012	▪ Register of Sealings, notification of covert surveillance & other matters (by exception) ▪ Declarations of interest ▪ Chief Executive Report ▪ Agree Annual Plan 2012/13 (including annual Self-certification against all Board statements, and revised Financial budgets 2012/13) ▪ To approve SLAs with commissioners (if ready)	▪ Register of Sealings, notification of covert surveillance & other matters (by exception) ▪ Declarations of interest ▪ Chief Executive Report ▪ Approval of draft Annual Report 2011/12 ▪ Discussion of Quality Account 2011/12	▪ Register of Sealings, notification of covert surveillance & other matters (by exception) ▪ Declarations of interest ▪ To approve the final accounts for 2011/12 (incl. Statement on Internal Control and Remuneration report) ▪ To approve the Management representation letter	▪ Register of Sealings, notification of covert surveillance & other matters (by exception) ▪ Declarations of interest ▪ Chief Executive Report ▪ Review of Board Terms of Reference ▪ Discussion of Board evaluation process for 2012	▪ Register of Sealings, notification of covert surveillance & other matters (by exception) ▪ Declarations of interest ▪ Chief Executive Report	▪ Register of Sealings, notification of covert surveillance & other matters (by exception) ▪ Declarations of interest ▪ Chief Executive Report	▪ Register of Sealings, notification of covert surveillance & other matters (by exception) ▪ To receive updated declaration of Directors' interests ▪ Chief Executive Report ▪ Ratification of reviewed Standing Financial Instructions ▪ Ratification of reviewed Powers of Reservation / Scheme of Delegation ▪ Ratification of reviewed Standing Orders	▪ Register of Sealings, notification of covert surveillance & other matters (by exception) ▪ Declarations of interest ▪ Chief Executive Report	▪ Register of Sealings, notification of covert surveillance & other matters (by exception) ▪ Declarations of interest ▪ Chief Executive Report
QUALITY												
Safety		▪ Security Annual Report 11 ▪ Annual Fire Report (to include findings from annual Fire safety audit & Annual Statement of Fire Safety 2011)	▪ Health & Safety Ann Report 11	▪	▪		▪	▪	▪	▪ Safeguarding Children report (annual report to Board) ▪ Safeguarding adults report (annual report to Board)	▪	▪
Patient experience	▪ To receive a draft Dementia strategy ▪ *Findings from CQC mock inspections (by exception)*	▪ Matrons – Quarterly report (clinical presentation): Conclusions from the nutrition workshop ▪ Review of the Trust's response to the 'Francis enquiry' ▪ *Findings from CQC mock inspections (by exception)*	▪ Latest findings from Patient Experience survey (ward-based survey from Jan/Feb) ▪ Chaplaincy Annual report 2011 ▪ Update on progress on actions taken to address issues raised by the CQC ▪ *Findings from CQC mock inspections (by exception)*	▪ *Findings from CQC mock inspections (by exception)*	▪ Latest findings National NHS inpatient survey 2011 ▪ Matrons – Quarterly report (clinical presentation): TBC ▪ *Findings from CQC mock inspections (by exception)*		▪ PEAT assessment 2012 – findings and planned actions ▪ *Findings from CQC mock inspections (by exception)*	▪ *Findings from CQC mock inspections (by exception)*	▪ Matrons – Quarterly report (clinical presentation): TBC ▪ *Findings from CQC mock inspections (by exception)*	▪ Latest findings from Patient Experience survey (ward-based survey from July/Aug) ▪ Safeguarding Children report (annual report to Board) ▪ Safeguarding adults report (annual report to Board) ▪ *Findings from CQC mock inspections (by exception)*	▪ *Findings from CQC mock inspections (by exception)*	▪ Matrons – Quarterly report (clinical presentation): TBC ▪ *Findings from CQC mock inspections (by exception)*
Clinical effectiveness			▪ Clinical presentation: Renal services (confirmed)	▪ Clinical presentation: Orthogeriatric services (TBC)			▪ Clinical presentation: TBC	▪ Clinical presentation: TBC		▪ Clinical presentation: TBC	▪ Clinical presentation: TBC	
Quality & Safety Committee	▪ Minutes of Nov. meeting (& actions log) ▪ Minutes of Dec. meeting ▪ Summary from Jan. meeting (to include complaints update)	▪ Minutes of Jan. meeting (& actions log) ▪ Summary from Feb. meeting (to include complaints update) ▪ Quality reporting to the Board	▪ Minutes of Feb. meeting (& actions log) ▪ Summary from March meeting (to include complaints update)	▪ Minutes of March meeting (& actions log) ▪ Summary from April meeting (to include complaints update)	▪ Minutes of April meeting (& actions log) ▪ Summary from May meeting (to include complaints update)		▪ Minutes of May meeting (& actions log) ▪ Summary from June meeting (to include complaints update)	▪ Minutes of June meeting (& actions log) ▪ Summary from July meeting (to include complaints update)	▪ To approve revised ToR Minutes of July meeting (& actions log) ▪ Summary from Aug. meeting (to include complaints update)	▪ Minutes of August meeting (& actions log) ▪ Summary from Sept. meeting (to include complaints update)	▪ Minutes of Sept. meeting (& actions log) ▪ Summary from Oct. meeting (to include complaints update)	▪ Minutes of Oct. meeting (& actions log) ▪ Summary from Nov. meeting (to include complaints update)

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Infection Prevention & Control (to be a sub-heading of the Quality & Safety Committee agenda item)	▪ Monthly report	▪ Monthly report DIPC to attend	▪ Monthly report	▪ Monthly report	▪ To approve the Infection Control Annual Programme, 2012/13 ▪ To approve Infection Prevention & Control Annual report 2011/12 – DIPC to attend ▪ Monthly report		▪ Monthly report	▪	▪ Monthly report DIPC to attend	▪ Monthly report	▪ Monthly report	▪ Monthly report DIPC to attend
Organisational culture	▪ Update on developments	▪ Update on developments	▪ Update on developments	▪ Update on developments	▪ Update on developments		▪ Update on developments	▪ Update on developments	▪ Update on developments	▪ Update on developments	▪ Update on developments	▪ Update on developments
INNOVATION												
Information Management & Technology				▪ IM&T Strategy update							▪ IM&T Strategy update	
Miscellaneous	▪ Emergency Department & ECIST – closure report ▪ Cancer Intensive Support Team visit update	▪ Facing the Future Programme – Quarterly report ▪ Cancer Intensive Support Team visit update (progress against action plan)	▪ Facing the Future Programme – presentation: closure of programme ▪ Cancer Intensive Support Team visit update (progress against action plan)	▪ Cancer Intensive Support Team visit update (progress against action plan)	▪ Facing the Future Programme – Quarterly report				▪ Facing the Future Programme – Quarterly report		▪ To receive a report on the outcome and response to the Cancer Intensive Support Team visit	▪ Facing the Future Programme – Quarterly report
PRODUCTIVITY												
Key Performance Indicators (KPIs): ▪ Targets; ▪ Productivity; ▪ Contract activity; ▪ Workforce; ▪ Quality & safety	Performance report – M9 (to include Q3 self-certification against targets)	Performance report – M10	Performance report – M11	Performance report – M12	Performance report – M1		▪ Performance report – M2 2011/12) ▪ Details of the changes to the performance measures for 2012/13	Performance report – M3 (to include Q1 self-certification against targets)	Performance report – M4	▪ Review of Winter Pressure Plan ▪ Performance report – M5	▪ Further review of Winter Pressure Plan ▪ Performance report – M6 (to include Q2 self-certification against targets)	Performance report – M7
Financial performance (including HR-related financials)	▪ Finance report – M9 (extended discussion) ▪ QIPP programme report – M9	▪ Finance report– M10 ▪ QIPP programme report – M10	▪ Finance report– M11 ▪ QIPP programme report – M11	▪ Finance report– M12 (extended discussion) ▪ QIPP programme report – M12	▪ Finance report– M1 ▪ QIPP programme report – M1		▪ Finance report– M2 ▪ QIPP programme report - M2	▪ Finance report– M3 (extended discussion) ▪ QIPP programme report – M3	▪ Finance report– M4 ▪ QIPP programme report – M4	▪ Finance report– M5 ▪ QIPP programme report – M5	▪ Finance report– M6 (extended discussion) ▪ QIPP programme report – M6	▪ Finance Report– M7 ▪ QIPP programme report – M7
Finance Committee	▪ Minutes of Nov. meeting ▪ Minutes of Dec. meeting ▪ Summary from Jan. meeting	▪ Minutes of January meeting ▪ Summary from Feb. meeting ▪ To approve revised ToR	▪ Minutes of Feb. meeting ▪ Summary from March meeting	▪ Minutes of March meeting ▪ Summary from April meeting	▪ Minutes of April meeting ▪ Summary from May meeting		▪ Minutes of May meeting ▪ Summary from June meeting	▪ Minutes of June meeting ▪ Summary from July meeting	▪ Minutes of July meeting ▪ Summary from August meeting	▪ Minutes of Aug. meeting ▪ Summary from Sept. meeting	▪ Minutes of Sept. meeting ▪ Summary from Oct. meeting	▪ Minutes of Oct. meeting ▪ Summary from Nov. meeting
Staff focus		▪ Notification of recent Consultant medical appointments ▪ Annual audit of consultants' appraisal ▪ Ward staffing benchmarking	▪ Receipt of workforce report (6-monthly)	▪ Annual Review of Workforce Development Strategy & delivery of strategic objectives ▪ National NHS Staff Survey 2011 – Report on findings and consideration of action plan	▪ Notification of recent Consultant medical appointments				▪ Notification of recent Consultant medical appointments	▪ Receipt of workforce diversity report (annual report to Board) ▪ Receipt of workforce report (6-monthly)		▪ Notification of recent Consultant medical appointments
ASSURANCE												
Audit Committee	▪ Minutes of January meeting		▪ Minutes of March meeting		▪ Minutes of May meeting ▪ Audit Committee Annual report 2010/11		▪ Minutes of June meeting (annual accounts)	▪ Minutes of July meeting ▪ To approve revised ToR		▪ Minutes of Sept meeting ▪ Receipt of Annual Audit Letter 2011/12		▪ Minutes of Nov. meeting ▪ Audit Committee self-assessment (for information)
Board Assurance Framework (BAF)			▪ Review of BAF		▪ Review of BAF							▪ Review of BAF

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Council of Governors	▪ Minutes of Nov. meeting		▪ Minutes of Feb meeting					▪ Minutes of June meeting		▪	▪ Minutes of 13th Sept. meeting	
Corporate Trustee responsibilities [2]		▪ Minutes of Dec Charitable Funds Committee			▪ Minutes of May Charitable Funds Committee		▪				▪ Minutes of Charitable Funds Committee, 7th October ▪ To approve revised Terms of Reference for the Charitable Funds Committee ▪ To approve 2010/11 Annual Report & Accounts of Charitable Fund	
Miscellaneous	▪ Receipt of The Hospital Company's statement of compliance re legal responsibilities	▪ Quarterly update of SDMP implementation (to include agreement of Carbon Management Plan)	▪ Approval of revised Single Equality Scheme ▪ Mid-year progress report on Equality & Diversity		▪ Quarterly update of SDMP implementation (to include refresh of SDMP)		▪		▪ Quarterly update of SDMP implementation ▪ Receipt of Equality & Diversity Annual Report 2011/12	▪	▪ Emergency resilience – annual report to the Board	▪ Quarterly update of SDMP implementation
STRATEGIC												
Proposed integration with Medway NHS Foundation Trust	▪ Update ▪ Approval of Outline Business Case	▪ Update ▪ To agree proposals for the Governor arrangements of the integrated Trust ▪ Consideration of draft Constitution for integrated organisation ▪ Consideration of draft Board structure and sub-committee structure	▪ Update ▪ To receive the draft Business Case (FBC / IBP), to be submitted to NHS South of England / Monitor ▪ To receive outcomes from due diligence (estates, legal, finance, clinical)	▪ Update ▪ To receive the final Business Case (FBC / IBP), to be submitted to NHS South of England / Monitor ▪ To approve the post-transaction implementation plan (PTIP)	▪ Update		▪ Update ▪ Final decision on dissolution ▪ Views from Council of Governors	▪ Update	▪ Update	▪ Update	▪ Update	▪ Update
Miscellaneous	▪ Consideration of Outline Business Case for location of pathology laboratories at Dartford and Gravesham NHS Trust & Medway NHS Foundation Trust (presentation)	▪	▪	▪	▪		▪	▪	▪	▪	▪	▪ Ratification of reviewed Risk Management strategy
ITEMS FOR INFORMATION												
Information items	▪ Forward planner	▪ Forward planner	▪ Forward planner	▪ Forward planner	▪ Forward planner	▪ Forward planner	▪ Forward planner	▪ Forward planner	▪ Forward planner	▪ Forward planner	▪ Forward planner	▪ Forward planner

[2] Dartford & Gravesham NHS Trust is the sole corporate Trustee of Dartford and Gravesham NHS Trust Charitable Fund