HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 9th March, 2012

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 9th March, 2012, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Peter Sass**
Telephone: **01622 694002**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (10):	Mr N J D Chard (Chairman), Mr B R Cope (Vice-Chairman), Mr R E Brookbank, Mr N J Collor, Mr A D Crowther, Mr K A Ferrin, MBE, Mr C P Smith, Mr K Smith, Mr R Tolputt and Mr A T Willicombe
Labour (1):	Mrs E Green
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor J Burden, Councillor R Davison, Councillor G Lymer and Councillor Mr M Lyons
LINk Representatives (2)	Dr M Eddy and Mr M J Fittock

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UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item	Timings
1. Introduction/Webcasting	
2. Substitutes	

3. Declarations of Interests by Members in items on the Agenda for this meeting.

4. Minutes (Pages 1 - 8)

5.	Public Health Update (Pages 9 - 42)	10:00 – 10:30
6.	Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust: Developing Partnership (Pages 43 - 192)	10:30 – 11:25
7.	Older People's Mental Health Services in East Kent (Pages 193 - 288)	11:25 – 12:00
8.	Mental Health Services Review (Pages 289 - 300)	12:00 – 12:10
9.	Patient Transport Services (Pages 301 - 306)	12:10 – 12:20
10.	HOSC Report into Reducing A&E Attendances (Pages 307 - 320)	12:20 – 12:30

11. Date of next programmed meeting – Friday 13 April 2012 @ 10:00 am

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services
(01622) 694002

1 March 2012

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 3 February 2012.

PRESENT: Mr N J D Chard (Chairman), Mr B R Cope (Vice-Chairman), Mr R E Brookbank, Mr N J Collor, Mr A D Crowther, Mr D S Daley, Mrs E Green, Mr K Smith, Mr R Tolputt, Mr A T Willicombe, Cllr J Burden, Cllr M Lyons, Cllr G Lymer, Cllr J Cunningham (Substitute for Cllr R Davison) and Mr M J Fittock

ALSO PRESENT:

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee) and Mr P Sass (Head of Democratic Services)

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Declarations of Interest.

Michael Lyons declared a personal interest in the Agenda as a Governor of East Kent Hospitals University NHS Foundation Trust.

3. Minutes
(Item 4)

RESOLVED that the Minutes of the meeting of 6 January 2012 are correctly recorded and that they be signed by the Chairman. There were no matters arising.

4. Overview of Health Scrutiny Regulations
(Item 5)

(1) The Chairman introduced the item by saying that the report in the Agenda was produced in response to a request made at the previous meeting and thanked the Officers for preparing what was a useful and timely summary of the position relating to health scrutiny regulations as it currently stands and which will continue until at least April 2013.

(2) In response to a query about membership, it was clarified that the Committee was able to co-opt experts and others on to the Committee on a non-voting basis. The situation regards locality boards was still being developed. The Chairman reminded the Committee of the discussion paper brought to the Committee in October which indicated the room for a more localist view to feed into the discussions of the Committee, particularly as there was more to health than the NHS and the impact of housing, for example, needed to be recognised.

(3) A representative from LINk raised the issue of social care referrals as something to be aware of. While LINk had the ability to refer health and social care matters, HOSC only dealt with health.

(4) AGREED that the Committee note the report.

5. Reducing Accident and Emergency Admissions: Part 3: Mental Health Services
(Item 6)

Lauretta Kavanagh (Kent and Medway Director of Commissioning for Mental Health and Substance Misuse, NHS Kent and Medway), Bob Deans (Chief Executive, Kent and Medway NHS and Social Care Partnership Trust), David Tamsitt (Director Acute Services, Kent and Medway NHS and Social Care Partnership Trust), Justine Leonard (Director Older Adults and Specialist Services, Kent and Medway NHS and Social Care Partnership Trust), and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(1) In introducing the item, the Chairman reminded Members that this was the third meeting looking into the topic of reducing accident and emergency attendances. He explained that his intention was to circulate a draft report drawing on the findings of all three meetings and the discussion around the preliminary findings presented at the 6 January meeting for Members' comments as soon as was practical.

(2) One Member referred to recent media reports around national findings of differing levels of accident and emergency at the weekend compared to weekdays meaning the subject was an important and topical one.

(3) The broader context of mental health was set out by representatives of the NHS. One in four people will suffer from a mental health problem at some stage in their lives, and on any given day the number was one in six. There was a need to raise the profile of the issue and reduce the stigma attached to it. The continuing interest of the HOSC and other Committees at Kent County Council was commented on positively by health colleagues. Similarly, the recent report on mental health produced by the Kent LINk was referenced as a useful contribution to the subject of mental health.

(4) This broader context translated into a major challenge for the health services, particularly as physical and mental health problems were often experienced by people simultaneously, sometimes complicated by alcohol misuse. The preventive health and wellbeing agenda involved a whole range of sectors, including employers. The valuable role Borough/City/District Councils played in providing such services as housing and leisure could not be underestimated. There were good examples of partnership working, including the Live it Well strategy produced by local NHS commissioners, Kent County Council and Medway Council and the work between KCC and the NHS on dementia prevention. Third sector providers also had a key role to play. In responding to a specific request from a Member of the Committee, representatives of NHS Kent and Medway and Kent and Medway NHS and Social Care Partnership Trust present at the meeting undertook to produce a

series of bullet points about how each sector could contribute to improving mental health across the community and make the report available to Members of the Committee.

(5) In terms of mental health services along the urgent and emergency care pathway, there were two services in particular which NHS representatives brought to the attention of the Committee: Crisis Resolution Home Treatment Teams and Liaison Psychiatry.

(6) Crisis Resolution Home Treatment Teams were the first port of call and took referrals from a number of sources, including the ambulance service, GPs, and community hospitals. These teams were able to provide care in people's homes and so prevent unnecessary admission to an acute hospital.

(7) A general principle applied to mental health staff called on to provide out of hours cover was that they should have transferable skills. This would enable referrals to be handled more effectively. Concerning GP out of hours services, a representative of the Kent Local Committee explained that most of Kent was covered by the service provided by South East Health, but that the GPs were not necessarily local to the County. This might mean that not knowing the patients histories, and where they were risk averse, sending a patient to A&E might be seen as the safer option.

(8) It was also explained that there was a double pressure of GPs to reduce A&E attendances. As part of emerging Clinical Commissioning Groups, they took part in producing plans to this end. As providers of primary care, part of the Quality Outcomes Framework (QOF), which were a set of indicators that determined part of a GP practices income, looked at the reduction made in A&E attendances. There was also a financial drive for Commissioner and Provider NHS Trusts to improve urgent and emergency care. The QIPP Programme (Quality, Innovation, Productivity and Prevention) included such measures as improving the diagnosis of dementia in general hospitals and reducing the use of antipsychotic medicine.

(9) The point was made that A&E can be the right place for people with mental health problems and can enable the right physical and mental health diagnosis to be made.

(10) Liaison Psychiatry services looked to make secondary care mental health services available in A&E departments. The service is fully implemented in East Kent Hospitals NHS University Foundation Trust and has led to a reduction in admission through A&E as well as reduced length of stay of those patients who are admitted and have mental health needs. NHS representatives indicated the reference to the well regarded Rapid Assessment Interface and Discharge (RAID) service in Birmingham mentioned in the background Note by the Committee Researcher. It was explained that the service in East Kent had been visited by the people establishing the service in Birmingham and was a chance to share good practice. The NHS locally was looking to expand the service 24/7 across the whole County. In response to a specific question, a representative from KMPT explained that there had been no recruitment or retention problems relating to the Liaison Psychiatry service in East Kent and they were positive the same would apply

in both Dartford and Gravesham NHS Trust and Maidstone and Tunbridge Wells NHS Trust.

(11) In response to a specific question about whether elderly people were assessed for dementia as a matter of course when they arrived in A&E, Dr Allingham explained that this did depend to an extent on where a patient was being sent from and who received them and more generally related to the quality of the paperwork. The requirement for a second assessment of dementia was getting less, and the paperwork relating to the Liaison Psychiatry service in East Kent was very good. In addition, more forward planning of care plans and Do Not Resuscitate (DNR) requests meant there were decisions made ahead of time not to send a person to hospital.

(12) One Member raised the forthcoming changes in policing arrangements. Representatives of the NHS explained that no analysis of the impact of the changes had been made, but highlighted the good joint working between the NHS and police in the area of mental health which had been developed. Much effort had been put into providing education and training of people in the police service. There was also more co-location of mental health staff where people with mental health needs were likely to be. Liaison and diversion services were present at all custody suites with the aim of keeping people out of the criminal justice system.

(13) In response to a query, the Committee Researcher provided clarification that the additional information requested by Members on Minor Injuries Units provided for them by Kent Community Health NHS Trust related to those services provided by that Trust only. The Researcher undertook to provide information about the other services.

(14) The Chairman explained that for this, as for other items, the recommendation to simply note the report was a useful procedural device but proposed a fuller recommendation.

(15) AGREED that the Committee note the report and thank KMPT and NHS officers for their comprehensive and constructive input.

6. East Kent Hospitals NHS University Foundation Trust Clinical Strategy
(Item 7)

Liz Shutler (Director of Strategic Development and Capital Planning, East Kent Hospitals NHS University Foundation Trust), Noel Wilson (Divisional Medical Director for Surgical Services, East Kent Hospitals NHS University Foundation Trust), Robert Rose (Divisional Director for Urgent Care and Long Term Conditions, East Kent Hospitals NHS University Foundation Trust), Carmen Dawe (Assistant Director of Marketing and Fundraising, East Kent Hospitals NHS University Foundation Trust), and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(1) The Chairman introduced the item and explained that the Chief Executive of East Kent Hospitals NHS University Foundation Trust had requested the opportunity for the Trust to bring the work being done on developing a clinical strategy to the Committee. The subject had also generated some media

interest in the East of the County and so the Chairman hoped there would be clarification around it as a result of the day's meeting.

(2) Trust representatives outlined the main features and drivers of the review. It had begun in October 2010 to look at various clinical issues and those raised by the need to continue to provide core services as well as enable healthcare closer to home. No decisions around service configuration had been made but the Committee would be continually involved in the Trust's developing strategy.

(3) The whole development of the strategy needed to be seen in the context of a shift of emphasis nationally from the work which had been done to improve planned care, such as the 18-week pathway, and towards improving emergency care. Emergency care was a high risk area, and one of the drivers for change was the Royal College of Surgeons report, *Standards for Emergency Care.* Members had a summary of this document in their Agenda pack and several Members highlighted the finding in the report that 80% of surgical mortality arises from unplanned/emergency surgical intervention and it was clarified that this referred to 80% of deaths which occurred as a result of surgery. The emergency surgery mortality rate for the Trust was below the national average, but this was not seen as a reason for complacency.

(4) The same principles around clinical care applied in East Kent as they did elsewhere, such as in West Kent, and would continue to do so and there were areas where work was being done with West Kent, such as vascular surgery.

(5) Consultants were rightly involved in planned care, but emergency care could be improved by involving them more at the 'front door' of hospitals to establish a quality care plan for emergency patients with a one stop assessment. Consultant acute physicians had already been brought into front door services and EKHUFT achieved 97% against the 4-hour A&E target in January, which is a very challenging month.

(6) Consultants needed to be supported by appropriately skilled teams and so achieving this raised workforce issues. There was a need to maintain locally accessible services, but there was also a requirement for specialisation of services in some areas. This had happened with cardiac care being centralised at the William Harvey Hospital in Ashford. There had also been centralisation of vascular surgery. Breast surgery was an area of increasing specialisation and there was also the requirement to develop a Level 2 Trauma Unit at William Harvey. In addition, some specialist centres were not in Kent at all. Trust representatives explained that the 'hub and spoke' model was applicable in many areas.

(7) In relation to transfers to the Trauma Unit, the Trust representatives explained that this would only be necessary in a minority of cases, and in many instances, the necessary skills were present at the Queen Elizabeth the Queen Mother Hospital (QEQM) in Margate meaning treatment would continue to be provided locally in Thanet.

(8) The specific issue of travel times was raised by Members with the response given was that travel times were based on clinical evidence, which supported

the idea of taking patients further to access specialist services. More broadly, Trust representatives explained that they were concerned about transportation issues where the transport network was geared more towards going into London than travelling across East Kent. A transport group was being established and this would work with the emerging Clinical Commissioning Groups and the Ambulance Trust to look at such issues as travelling between sites.

(9) There was a potential knock on effect to elective surgery and Trust representatives explained that a clear separation between emergency and elective teams was being made. Currently a 24 hour emergency theatre (known as a CEPOD theatre, referring to *The Confidential Enquiry for Peri-operative Deaths*) was kept specifically for emergency surgery and one discussion was around whether to invest in a second. The development of trauma rotas was geared to an aspiration towards having dedicated teams. This was a whole workforce issue and the review needed to look at the currently available workforce as well as what sorts of skills would be required in the future. Consultants were costly, but there were ways of working smarter.

(10) This was demonstrated by the Trust in response to specific concerns raised by Members about the future of services at the QEQM. Dealing with heart attacks and strokes, for example, was seen as a core service to deliver locally in Thanet. Bringing consultants to the front door of the hospital meant that many patients would be able to be dealt with as ambulatory cases, rather than having to be admitted as inpatients. Where there may need to be some specialisation is in using such medical advances as treatments to directly dissolve clots in the brain. Similarly with gastroenterology, there had been no discussions about moving services from QEQM as this is a core medical component of the services provided by the hospital, and in terms of surgery, it would only involve the very specialist kinds of care.

(11) Further examples of services being developed at the QEQM were provided. More investment was being made in CT scanners. The Trust was looking to introduce a pathway model of care, already introduced in Peterborough, for fractures of the neck of the femur which would see patients under the care of medical consultants, and benefitting from surgery available at QEQM.

(12) As with travel times, Trust representatives provided information on the evidence base. There were a wide range of different measures and more were being developed specifically around the patient experience. This was collected and published. The example of vascular care was given, where there were national peer reviews and data available down to the level of individual surgeons. This connected with a point raised by a Member about the tension between a focus on process and a focus on care, to which NHS representatives felt that as the processes did impact on the patient outcomes, the two things went together.

(13) The Trust felt this could further be seen in the priority it gave to dealing with healthcare associated infection. East Kent Hospitals had very low MRSA and C. diff. rates but were not complacent and the separation of elective and emergency care was a core element in keeping rates low. The achievements

the Trust has made in reducing length of stay also made an important contribution.

(14) As with the previous item, the Chairman looked to the Committee to make a specific resolution on this issue rather than simply noting the report and asked Mrs Green to suggest one which would be appropriate.

(15) AGREED that the Committee notes the high level of concern of residents in East Kent to any proposed changes and that the HOSC will continue to monitor the situation very closely and scrutinise any further developments as and when they emerge to ensure we look after the best interests of Kent residents.

7. East Kent Maternity Services Review: Written Update
(Item 8)

(1) The Chairman introduced the item and explained that the consultation had recently closed and the NHS had provided a written update and looked to bring the decision to HOSC at its meeting of 13 April

(2) He also took the opportunity to once again thank the Members of the informal HOSC Liaison Group for the work they had done with the Trusts in between formal HOSC Meetings. Several Members felt this was a good example of the valuable work a small group of Members could do and more broadly the Committee felt this was one area where HOSC had added real value.

(3) One Member reported that he had been able to attend two of the public meetings held as part of the consultation. Attendance at the first one had been hampered by weather and timing, but the second had been well attended with a good cross section of the population present. At this meeting, the high levels of affection they had for the Dover facility had been made clear.

(4) Making a broader point about consultations, one Member asked whether the different health consultations could not be pulled together to prevent consultation weariness and the Chairman undertook to consider this notion after the meeting.

(5) As Mr Daley had been a Member of the informal HOSC Liaison Group, the Chairman asked him to put forward a recommendation for the Committee.

(6) AGREED that the Committee note the report and also notes that its recommendations made during the proceedings of the public consultation were largely followed and that we are therefore pleased to note that the consultations appear to have been successfully concluded, and now look forward to the presentation of the final report and the results of the collated opinions to the Boards of EKHUFT and the PCT for their decisions in April.

8. Mental Health Services Review
(Item 9)

(1) The Chairman introduced the item and explained that the paper provided further information about the upcoming mental health services review. A more

detailed paper would be available for the 9 March meeting and that this topic might involve the establishment of a Joint HOSC with Medway Council's Health and Adult Social Care Overview and Scrutiny Committee.

(2) AGREED that the Committee note the report.

9. Date of next programmed meeting – Friday 9 March 2012 @ 10:00 am
(Item 10)

THE REPORT

Item 5

By: Meradin Peachey – Director of Public Health

To: Health Overview and Scrutiny Committee – 9th March 2012

Subject: Briefing on recent developments relating to NHS reform and public health transition

Classification: Unrestricted

Recommendations

1. This briefing is for the KCC Health Overview and Scrutiny Committee and comments or observations are welcome.

Introduction

2. Since December a large number of documents have been issued by the Department of Health and LGA regarding reforms to the NHS and the transition of Public Health to local authorities.

3. This briefing summarises some of the most pertinent:

The Factsheets issued on:

1. Public Health in Local Government
2. Public Health England's Operating Model

The other documents are:

- Public Health Workforce Issues – Local Government Transition Guidance
- Public health transition planning support for primary care trusts and local authorities
- Towards establishment: Creating responsive and accountable clinical commissioning groups
- The NHS Outcomes Framework 2012/13
- LGA/DH Healthwatch Implementation Programme: Offer of support to Local Authorities
- The Public Health Outcomes Framework – Improving outcomes and supporting transparency
- Baseline spending estimates for the new NHS and Public Health Commissioning Architecture
- The draft guidance to support the provision of healthcare public health advice to CCG's has been issued for consultation

4. We still await important documents that will give final detail of the public health budget allocations and the main workforce transition guidance.

Key Issues for Kent

5. The Outline Transition Plan for Public Health has been submitted to the DH. The draft summary plan is attached for HO&SC to consider.

6 The baseline spending estimates for local authorities that are calculated from the reported spend of the relevant PCTs in the last financial year give Kent a budget equivalent to £24 per head p.a. This compares very unfavourably with other local authorities where the highest per capita figure is £117 (Tower Hamlets). Of the 152 authorities concerned only 15 have lower levels of funding.

7. The budget identification process that has been undertaken nationally revealed that the average figure for staffing costs was 10% of overall budgets. In Kent this figure was less than 4% because of the relatively fewer numbers of Public Health Consultants

8. The CCGs should be operating in shadow form by April 2012. KCC needs to consider whether or how it engages with the Commissioning Support Organisations that are being established.

9. CCG budgets will be delegated from April and this holds potential implications for any integrated commissioning and the discussion at the last Shadow Health and Wellbeing Board refers.

10. Issues remain concerning CCGs operation at locality level and how they will relate to district councils and Locality Boards.

11. KCC needs to develop and agree a vision for the public health function for which it will be responsible.

12 The transfer of public health service contracts requires careful consideration under Due Diligence to ensure they are fit for purpose in the new arrangements.

Mark Lemon

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Appendix 1 - CCG Establishment

Towards establishment:
Creating responsive and accountable clinical commissioning groups - Draft Dec 12

This guidance essentially outlines good practice in establishing public sector organisations including the principles of "Good Governance Standards for Public Services" and the Nolan Principles. Following the report of the Future Forum some changes have been made around membership of the governing body (most likely to be a Board). The document also addresses issues such as the sharing of functions across CCGs and sub-CCG level locality arrangements

Earlier guidance (Towards Authorisation) set out the configuration issues and authorisation process. Authorisation remains with the NHS Commissioning Board. All GP practices must belong to a CCG.

Although officially in draft there will be no further guidance issued on establishment or governance beyond any necessary amendments to this document subject to the passage of the Health and Social Care Bill.

Towards establishment deals with the CCG establishment process and governance arrangements sets out the expectations of how CCGs will be set up and poses a list of questions for CCGS to answer as they progress.

This includes:

- setting out the CCGs responsibilities
- developing a constitution
- establishing good governance arrangements
- identifying leadership roles
- demonstrating public accountability and probity
- identifying key leadership roles

CCGs are designed to bring far greater clinical leadership to commissioning of services and improve public influence and CCG clinical leaders will be expected to have a visible role in their communities.

CCGs will draw on existing NHS expertise to help establish themselves and their role.

Constitution

Minimum requirements for the constitution and partner organisations to be involved, including local authorities and other members of the shadow Health and Wellbeing Board, are set out. The constitution will include:

- the defined geographic area for which the CCG is responsible including unregistered patients in the area
- a vision for commissioning local health care services
- governance arrangements for any subcommittees
- arrangements to involve partners including the public, local authorities and health care professionals in commissioning decisions

The requirements for good governance are laid out to include:

- Corporate governance
- Clinical governance
- Financial governance
- Information governance and
- Research governance

Accountability and probity

The accountabilities to the Health and Wellbeing Board to deliver the Joint Health and Wellbeing Strategy based on the Joint Strategic Needs Assessment and to Local Authority's overview and scrutiny function are stressed.

Key meetings are to be held in public

A written communications strategy for public and partners is recommended.

Arrangements and safeguards to manage conflicts of interest need to be in place including guidance concerning community based services provided by GPs.

Governance

The CCG will require a governing body to oversee the good governance and legal probity of the organisation and to determine re-numeration issues for its officers. Regulations will be issued to clarify who may, or may not, be a member of the governing body.

The membership will include:

- at least one registered nurse
- one secondary care specialist doctor
- at least two lay people = one to champion patient and public empowerment and one to oversee audit, re-numeration and managing conflicts of interest
- GP member practices will decide how they are to be represented.

An Accountable Officer and a Senior Finance Officer must be appointed and an Audit and Re-numeration Committee established. A Quality Committee should be considered.

Other committees or sub-committees can be established according to the CCGs constitution.

Localities

CCGs may choose to operate at a lower population, or locality, level. This will require clear governance and accountability arrangements including schemes of delegation where necessary. Issues that will need to be considered include relationships with the CCG Governing Body, risk sharing, sharing and devolution of resources, consistency and compatibility with local arrangements of partner organisations.

Leadership roles

CCGs need to identify their leaders to ensure clinical leadership and discharge their functions to best effect. Leadership roles will include:

An Accountable Officer - to ensure the organisation functions effectively, efficiently and economically; fulfils all its obligations and requirements and the necessary managerial and leadership arrangements are in place. The role is explicitly differentiated from that of a Chief Executive and the se of the title Chief Executive is discouraged

The AO will be a GP who is a member of the CCG, and employee or any member of, the CCG, or where there is a joint appointment, an employee or member of any of hose groups. Further guidance on appointment of AO's will be issued including their expected skills and competencies.

Where the AO is not the Clinical Leader, the Chair of the governing Body should be, to ensure clinical leadership of the organisation is clearly demonstrated. The AO and the Chair of the governing body should not be the same person and the AO could fulfil the role on behalf of more than one CCG.

Chair of Governing Body – should be the Clinical Leader where this is not the AO. The role of the Chair was set out in the government's response to the Future Forum and further guidance will be issued in due course. If the chair is a GP, the Deputy Chair should be a lay member.

Chief Financial Officer – should hold a recognised professional accounting qualification and could exercise the role on behalf of more than one CCG.

The two lay members have separate roles as outlined above and one will be the deputy chair of the governing body.

Further consideration is being given to the issue of the two other clinician members not being employed in local provider organisations

Governance for collaborative arrangements across CCGs

A series of benefits from collaboration and sharing of functions between CCGs are suggested including clinical improvements, efficiency, resilience and risk management. Increased leverage with provider organisations is explicitly referred to. It is clearly stated that strong collaborative arrangements will lead to tangible benefits for patients.

Robust collaborative arrangements across and between CCGs will be required especially regarding joint commissioning arrangements with local authorities.

The Governance and accountability issues are described but the general tenor is that collaboration across CCG functions could being significant benefits.

Appendix 2 - NHS Outcome Framework

NHS Outcomes Framework

The NHS Outcomes Framework for 2012/13 was issued in December 2011 and identifies the indicators that will be used to assess the performance of the NHS against the priorities contained in the previously issued Operating Framework for the NHS.

The framework is structured across 5 Domains

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment; and protecting them fro avoidable harm

The NHS Outcomes Frameworks one part of a trinity that also includes the Public Health Outcomes Framework and the Adult Social Care Outcomes Framework.

All three should be aligned and complimentary with shared indicators such as Under 75 mortality rate from cancer which is intended to be shred with the Public Health outcomes framework (still awaited).

There are therefore important overlaps with local authority responsibilities for social care and public health and the integration of the frameworks is welcome.

The NHS Outcomes Framework will be used to hold the NHS Commissioning Board to account with the setting of expected improvements or level of ambition against indicators being set. Work to integrate health inequalities into the indicators is continuing.

The identification of international comparators is also progressing.

A summary table of the domains and indicators is attached.

1 Preventing people from dying prematurely

Overarching indicators

1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
1b Life expectancy at 75 i males ii females

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease*
1.2 Under 75 mortality rate from respiratory disease*
1.3 Under 75 mortality rate from liver disease*
Cancer
1.4 i One-and ii five-year survival from colorectal cancer
iii One-and iv five-year survival from breast cancer
v One-and vi five-year survival from lung cancer
vii under 75 mortality rate from cancer*

Reducing premature death in people with serious mental illness
1.5 *Excess under 75 mortality rate in adults with serious mental illness**

Reducing deaths in babies and young children
1.6.i Infant mortality* ii Neonatal mortality and stillbirths

Reducing premature death in people with learning disabilities
1.7 *An indicator needs to be developed*

2 Enhancing quality of life for people with long-term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions**

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition**

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions*

Reducing time spent in hospital by people with long-term conditions
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers**

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness **

Enhancing quality of life for people with dementia
2.6 *An indicator needs to be developed*

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital

Improvement areas

Improving outcomes from planned procedures
3.1 **Patient Reported Outcomes Measures** (PROMs) for elective procedures
i Hip replacement ii Knee replacement iii Groin hernia
iv Varicose veins

Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma
3.3 *An indicator needs to be developed.*

Improving recovery from stroke
3.4 *An indicator to be derived based on the proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months*

Improving recovery from fragility fractures
3.5 The proportion of patients recovering to their previous levels of mobility / walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury
3.6 Proportion of older people (65 and over) who were i still at home 91 days after discharge into rehabilitation*** ii offered rehabilitation following discharge from acute or community hospital ***

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
i GP services ii GP Out of Hours services iii NHS Dental Services
4b Patient experience of hospital care

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii NHS dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 *An indicator to be derived from the survey of bereaved carers*

Improving experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare
4.8 *An indicator to be derived from a Children's Patient Experience Questionnaire*

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicators

5a Patient safety incidents reported
5b safety incidents involving severe harm or death

Improvement areas

Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare associated infection (HCAI) i MRSA ii C. difficile
5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

One framework
defining how the NHS will be accountable for outcomes
Five domains
articulating the responsibilities of the NHS
Twelve overarching indicators
covering the broad aims of each domain
Twenty-seven improvement areas
looking in more detail at key areas within each domain
Sixty indicators in total
measuring overarching and improvement area outcomes

The NHS Outcomes Framework 2012/13
at a glance

**Shared responsibility with the public health system and Public Health England and local authorities - subject to final publication of the Public Health Outcomes Framework.*

*** A complementary indicator is included in the Adult Social Care Outcomes Framework*

****Indicator replicated in the Adult Social Care Outcomes Framework*

Indicators in italics are placeholders, pending development or identification of a suitable indicator.

Appendix 3 – Updates to Public Health System

Public Health System Factsheets

A series of factsheets setting out the roles and responsibilities of local authorities including specific local authority public health functions, the role of the Director of Public Health and commissioning responsibilities have been issued by the Department of Health.

The factsheets give more information on the roles of local government and Public Health England and further details of which responsibilities will be mandatory for local government. Expectations of the accountability of Directors of Public Health are included.

Local government leading for public health

The factsheets emphasise the role of local authorities as a shaper of place and their expertise in building strong relationships with local populations and service users and in tackling health inequalities. Directors of Public Health (DPH) will be well placed to bring health inequalities into the mainstream of local authority's business as well as more widely, for example through relationships with the police for issues such as crime reduction, violence prevention and reducing reoffending, which also affect health inequalities.

To be effective local authorities should:

- Include health in all policies
- Invest the new ring-fenced grant in high-quality public health services
- Encourage health promoting environments
- Support local communities
- Tailor services to individual need
- Make effective and sustainable use of all resources, using evidence to direct to areas and groups of greatest need.

The importance of involving district councils in two-tier areas is emphasised.

Commissioning

The local authority commissioning responsibilities are set out. The Government expects that local authorities will commission, rather than directly provide, the majority of services to engage local communities and the third sector in the provision of public health. The desirability of a range of providers and of commissioning from staff-led enterprises is emphasised. Local authorities should decide which services to prioritise for choice on a diverse provider model based on local needs and priorities and informed by the joint strategic needs assessment. Local authorities are in an excellent position to test out new and joint approaches to payment by outcomes, such as reducing drug dependency.

The role of the Director of Public Health

The Health and Social Care Bill makes clear that each authority must, acting jointly with the Secretary of State for Health, appoint a Director of Public Health. The DPH can be shared with another local authority, where that makes sense. DPHs may come from "a wide range of disciplines including, but not limited to, medicine".

Directors of Public Health will be added to the list of statutory chief officers. Statutory guidance on the responsibilities of the Directors of Public Health will be issued. Further guidance has been issued to relating to the appointment of a DPH through a letter from the Chief Medical Officer and the Chief Executive of the LGA.

The Government expects direct accountability between the DPH and the local authority Chief Executive for the exercise of the local authority's public health responsibilities but it is unclear how this will operate in authorities that do not have a Chief Executive post.

Responsibilities of the DPH

- the public health functions of local authorities
- the DPH annual report on the health of the local population
- statutory membership of health and wellbeing boards
- promoting opportunities for action across the "life course" working with the Directors of Children's Services and Adult Social Services
- working with local criminal justice partners and the proposed new Police and Crime Commissioners.
- Day-to-day responsibility for the ring-fenced grant.

A Public Health Workforce Strategy is to be published, accompanied by formal public consultation.

Public Health responsibilities of Local Authorities

It is intended that local authorities have key responsibilities across the three domains of public health.

Some responsibilities are mandatory:

- Appropriate access to sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
- Steps to be taken to protect the health of the population, in particular giving the local authority a duty to ensure there are plans in place to protect the health of the population
- Ensuring NHS commissioners receive the public health advice they need
- NHS Health Check assessments
- The National Child Measurement Programme

Further consideration is being given to responsibility for the Healthy Child Programme (Ages 5-19).

Other responsibilities include:

- tobacco control and smoking cessation services
- alcohol and drug misuse services
- public health services for children and young people aged 5-19 (and in the - longer term all public health services for children and young people)
- interventions to tackle obesity
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- public mental health services
- dental public health services
- accidental injury prevention
- population level interventions to reduce and prevent birth defects
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- local initiatives on workplace health
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- local initiatives to reduce excess deaths as a result of seasonal mortality the local authority role in dealing with health protection incidents, outbreaks and emergencies
- public health aspects of promotion of community safety, violence prevention and response
- public health aspects of local initiatives to tackle social exclusion
- local initiatives that reduce public health impacts of environmental risks
- Local authorities may also choose to commission additional services under their health improvement duty.

The Government has revised its previous view that abortion services would rest with local authorities. They will remain provisionally with the NHS and be commissioned by clinical commissioning groups, subject to further consultation. Sexual assault services will rest with the NHS Commissioning Board and responsibility for early diagnosis of cancer etc will be shared between Public Health England and the NHS Commissioning Board.

In relation to commissioning services for children under 5, the Government aims to bring responsibility for these services within local government by 2015.

Public health advice to NHS commissioners

This factsheet gives considerable detail on the type of advice that local authorities will be expected to give NHS commissioners. This includes population data of the kind that local authorities are familiar with, but also more medical advice, such as advice on medicines management and prescribing policies.

Professional appraisal and support, and capacity building

Public health specialists working in local authorities will continue to be expected to undergo the revalidation process. The Department of Health will also expect non-medical public health specialists to undergo a professional appraisal. Options are currently being considered on how this will work.

Much of the information given in these factsheets is not new. What is new is the amount of detail on matters such as the advice service that DsPH and their teams will be required to provide to the NHS and to Clinical Commissioning Groups in particular.

Appendix 4 – Public Health England Operating Model

Public Health England Operating Model

The operating model for Public Health England (PHE) has been issued detailing how Public Health England (PHE) will be expected to work with local government and their respective roles. Detail is also given of the proposed national, regional and local structures for PHE, including local units spanning a number of local authority areas and based on the existing Health Protection Units. PHE will be expected to take a major role in emergency planning and further detail will be issued on its role and the respective roles of Directors of Public Health.

Subject to the passing of the Health and Social Care Bill, in April 2013 Public Health England will be established as an executive agency of the Department of Health, and its Chief Executive will be accountable, to the Permanent Secretary and the Secretary of State for Health, for performance and strategic development. It will have an advisory Board with at least three non-executive members.

Local authorities will lead local public health and PHE will not duplicate the work they do. PHE will be expected to develop "a culture of subsidiarity", focused on support for local accountability and action. PHE will be "the expert body with the specialist skills to support the system as a whole". It will support local authorities by providing services, expertise, information and advice "in a way that is responsive to local needs" and is based on evidence of what works.

PHE will work with the NHS Commissioning Board to provide public health and population healthcare advice "to ensure the prevention of ill health and promotion of good physical and mental health and wellbeing are addressed systematically across services and care pathways". PHE will work with the devolved administrations to tackle nationwide threats to health from infectious disease, radiation, chemicals and other health hazards and to respond to UK-wide emergencies.

The three main functions of PHE are:

1. **Delivering services to national and local government, the NHS and the public**

    - specialist public health services as described above
    - information and intelligence to support effective action locally and nationally
    - support for NHS and local authority health and care services and public health programmes

2. **Leading for public health**

    - publish information on local and national health and wellbeing outcomes and supporting improvement action
    - support public health policy development

- support effective and integrated public health delivery across the system
- work with partners to build the evidence base

3. Supporting the development of the specialist and wider public health workforce.

Organisational structure

PHE will have three structural components:

- a national office with four hubs that oversee its "locally facing services" – these will be co-terminous with the four sectors of the NHS Commissioning Board and Department for communities and Local Government resilience hubs, covering London, the South of England, Midlands and East of England and North of England

- units that deliver these locally facing services and act in support of local authorities, organisations and the public in their area will be developed from the 25 current health protection units of the Health Protection Agency to provide co-ordination across several local authorities in managing incidents and outbreaks. Consultation about how Public Health England can best provide its responsiveness and expert contribution to localities will occur with local authorities, health and wellbeing board early implementers and local partners in early 2012

- a distributed network for some functions including information and intelligence, and quality assurance, located alongside the NHS and academic partners.

Timetable

The Chief Executive will be appointed in April 2012.

Approximately 5,000 existing staff will transfer to PHE from the Health Protection Agency, the National Treatment Agency for Substance Misuse, the NHS, the public health observatories and the Department of Health from April 2013. Full details of this transfer will be published in June 2012.

While the operating model gives more definition to the proposed functions of Public Health England, further clarification about the roles of PHE and local DPH's in providing expert advice to the NHS, particularly in the area of emergency planning and resilience will be needed.

Appendix 5 – Local Healthwatch

Local HealthWatch

The government has announced some significant changes to the timescales for establishing Local HealthWatch and further details around funding:

- Local HealthWatch will now start in April 2013, rather than October 2012. Synchronising the start date with other NHS reforms will help us ensure that we set up Local HealthWatch to support the new health landscape in Kent.

- £5k funding for each of the Local HealthWatch pathfinders has now been agreed (KCC, the Kent Link and Kent and Medway Networks put in a joint bid and have been accepted onto the pathfinder programme)

- The exact sum that Local Authorities will receive to fund Local HealthWatch has not yet been announced although we have been informed that it will be based on the Relative Needs Formula rather than working age population

- In recognition of the critical leadership role Local Authorities have in setting up Local HealthWatch, The Local Government Association has established a new HealthWatch Implementation programme sponsored by the Department of Health. Lorraine Denoris who led Kent's LHW Readiness Programme, is to be the Strategic Co-ordinator for this programme.

Kent County Council

NHS
Kent and Medway

Kent Public Health Outline Transition Plan

v.1.1

January 2012 to March 2013

Version Control

Version	Date	Amendments
v.1	18 January 2012	Creation of original and draft outline plan following publication of DoH guidance and the requirement to submit this plan to SHAs by the end of January 2012
v.1.1	20 January 2012	Updated document, added lead names where identified and cross checked with Medway's PH Outline Transition plan.

Introduction

This Kent Public Health Transition Plan supports NHS Kent and Medway and Kent County Council in the transformation of the local public health system including the transfer of accountability from the NHS to local government through the transition year.

The plan is build upon Department of Health and Local Government Association guidance published in January 2012:

1. Public health transition planning support for primary care trusts and local authorities[1]
2. Public Health workforce issues. Local government Transition guidance[2]

Whilst this plan pertains to NHS Kent and Medway and Kent County Council, there will also be an analogous plan for NHS Kent and Medway and Medway Council and where the plans relate to NHS Kent and Medway, the plans will be aligned to ensure a consistent and collective approach.

The plan builds upon further guidance published previously in December by the Department of Health including:

- The New Public Health System: Summary
- Public Health in Local Government:
    - Local government leading for public health
    - Local government's new public health functions
    - The role of the Director of Public Health
    - Commissioning responsibilities
    - Public health advice to NHS Commissioners
- Professional appraisal and support, and capacity building
- Public Health England's Operating Model

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132178

[2] http://www.dh.gov.uk/health/files/2012/01/public-health-workforce-issues.pdf

1. **Ensuring a robust transfer of systems, services and staff**

Define Elements of Transfer	Current status	Actions	Identified Lead
Understood and agreed set of arrangement as to how the local public health will operate during 2012/2013 system	○ Memorandum of Understanding between the NHS Kent and Medway PCT Cluster and Kent County Council	○ MOU require updating to reflect the County abolishing the post of Chief Executive ○ MOU needs updating to reflect how the public health system will operate during 2012/13 ○ Agree working arrangements for joint working between Kent County Council and Medway Council ○	
Plan that sets out the main elements of transfer including functions staff TUPE and commissioning Contracts for 2012/12 and beyond	○ Mapping exercise completed for current establishment – 1/4ly returns submitted to DH; ○ Establishment matched against ESR/public health budgets ○ Employment T&C and PCT HR policies – eg Office locations – estates review in hand	○ Cluster PCT organisational change policy yet to be agreed ○ Liaise with new Cluster HR lead ○ Impact on staff of potential proposed relocation of base	Susan Nwanze….PCT HR lead for PH Transition Amanda Beer KCC Karen Hudson KCC

Agreed transition milestones	○ Part of wider PCT Cluster programme ○ Undertaking work to ensure there is an agreed set of milestones for transition ○ Meeting 8th February to gain agreement on key HR milestones	○ Need to agree PH transition milestones as part of overall transition	○
Plan to develop the Joint Strategic Needs Assessment	Kent Health and Wellbeing Board in shadow status as one of the national pathfinders Public Health currently producing and consulting upon a new JSNA for Kent.	JSNA summary to Performance Overview and Scrutiny Committee; mid Jan 2012 JSNA to H&WB Board 18th Jan 2012 JSNA to All Party member briefing 31st Jan 2012 JSNA to Be consulted upon and completed by March 18th 2012	Meradin Peachey Abraham George Natasha Roberts
Plan for ensuring the smooth transfer of and commissioning arrangements to Kent County Council	○ Contract Mapping exercise completed as part of Cluster review (lead by Daryl Robertson) ○ Novation lead identified ○ Performance management process in place 2012/13 ○ providers and CCGs to receive letter of intent re services to be contracted until 31.3.13 ○	○ Governance pathways and accountabilities to be defined ○ Need to engage with LA process ○ Performance of PH programmes currently reported to POSC and PAT (both in KCC governance system) ○ Need to further check we	Matt Capper (PCT) Tricia Bailey

		have complete set of contracts covered ○ Ensure we have agreements with KCC on: ○ Transition risk registers agreements ○ Assurance Framework	
Plan for ensuring the smooth transfer of public health functions and commissioning arrangements migrating to the NHS Commissioning Board and Public Health England	○ Totality of movement yet to be determined: ○ Screening ○ Imms and Vacc ○ PH support to Specialist Commissioning ○ Ensure PH Consultant input into the Kent HP On-call rota is maintained	○ Need to develop and test ongoing understanding of how PH functions will move to Public Health England and NHS Commissioning Board ○ Ongoing communication with Kent HPU as transition proceeds	○
Plan on delivering the core offer of Kent County Council public health support (advice) to Clinical Commissioning groups	○ specification written; discussions being held with CCGs on PH leads for each CCG in Kent ○ PH leads for each CCG currently identified and are working with each CCG	Revisit as and when CCGs combine/merge/change	Declan O'Neill

2. Meeting Public Health Delivery Plan and Target during Transition year

Define Elements of Transfer	Current status	Actions	Identified Lead
Delivery of mandated services during and after transition • Appropriate access to sexual health services • Plans to protect the health of the population • Public health advise to commissioners • National Child Measurement Programme NHS Health check measurement	○ Delegated leads identified– review in light of staff changes ○ JSNA and Needs Assessments ○ Health checks ○ Emergency planning in place ○ MOU with local Kent HPU ○ PH advice to commissioners ○ PH advice to Clinical Networks eg Cardiovascular etc	○ Retirement of WK DoHI; authorised signatory/budget lead ○ Identify gaps ○ Ensure business continuity (2012 to 2013 ○ Olympic year – impact of external events) ○	○
Clarity around the delivery of critical PH services/programmes locally: • Screening programmes • Immunisation programmes • Drugs and alcohol services • Infection control and prevention	○ Current programmes in place and are robust. ○ Screening Programmes currently co-ordinated for Kent and Medway via Kent PH department with specialist team ○ Imms and Vacc co-ordinated by Kent PH department ○ Drugs & Alcohol services commissioned via Kent DAAT hosted by KCC ○ Infection Prevention and Control currently provided by the Director of Nursing	○ There is a need to undertake further work locally as to how these are delivered through transition and beyond and testing of those arrangements carried out	

3. Workforce

Define Elements of Transfer	Current status	Actions	Identified Lead
Have the workforce elements of the plan been developed in accordance with the principles encapsulated within the Public Health Human Resources Concordat	○ Mapping staff destinations ○ 1-2-1 meetings for all staff ○ 1/4ly returns completed ○ Letters to all staff 31st January ○ Future Structure ○ Appointment of DPH guidance issued ○ Skill mix ○ Identify future functions to inform appropriate skill mix ○ Identify job descriptions/persons spec ○ Intelligence support to CCGs ○ Mandatory training/revalidation ○ All staff to continue to use existing appraisal process; ○ PDPs identified; ○ training identified ○	○ HR have informed letter to be issued in January to all staff ○ HR to identify timetable for TUPE requirements etc ○ Specialist HR advice required (e.g. for contracts for medics) ○ Awaiting timetable ○ Ensure correct interview process is adhered to prevent legal challenge ○ Consultation timetable ○ Communications ○ Full and working alignment to KCC directorates ○ Workforce co-ordinator to advise? ○ Create portfolio of appropriate JDs – align with KCC HR processes? ○ Identify “back office/admin” support both within public health, and elsewhere (eg finance, comms, HR, commissioning) ○ needs to align to KCC processes	○

4. Governance

Define Elements of Transfer	Current status	Actions	Identified Lead
Does the PCT with local Authority have in place robust internal and performance monitoring arrangements to cover the whole transition year, including schemes of delegation	○ Cluster PCT Board ○ Cabinet/POSC and PAT ○ Health & Wellbeing Board ○ Strategic Oversight Board	Schemes of delegation in place; these will require agreement and transition to KCC Transition plan to go to POSC in March for member scrutiny	
Are there robust arrangements in place for key public health functions during transition and have they been tested eg new emergency planning response to include: Accountability and governance Details of how the Director of Public Health, on behalf of the local authority, assures themselves about the arrangements in place Lead Director of Public Health arrangements for emergency planning, preparedness and response, and how it works across the Local Resilience Forum area.	○ NHS Emergency planning team streamlined across Kent and Medway ○ Team fully integrated with the Kent LRF with the DPH continuing to attend key LRF meetings through transition ○ Plans outline one emergency response across Kent and Medway ○ MOU with HPA and Consultants continuing to provide on call rota support for PH emergencies	Ensure NHS emergency planning team transitions to appropriate place in the new system	Meradin Peachey Matthew Drinkwater
Are there robust plans for clinical governance arrangements during transition including for example arrangements for the reporting of serious untoward incidents/incident	○ Currently via PCT arrangements through	○ Need to work through these governance arrangements for future SUIs , PGDs etc	

reporting and Patient Group Directions			
Has the PCT with the local authority agreed a risk sharing based approach to transition	○ Discussions commenced on risk sharing		
Is there an agreed approach to sector-led improvement	○ Links to CCGs commissioning plans; CCGs have PH named lead ○ Cluster Operating Framework ○ Health Improvement programmes commissioned with LAs and KCHT ○ Links with JSNA and Needs assessments ○ PH links to Clinical Network and emerging Clinical ○ Formal arrangements through joint KCC/PCT Strategic Oversight Board	○ Continuity and succession planning continue to be key to the successful transition	
Is the local authority engaged with the planning and supportive of the PCT approach to public health transition	○ KCC and NHS Kent and Medway fully engaged at a senior level	○ Further work to engage leads to ensure all elements of the plan are covered	

5. Enabling Infrastructure

Define Elements of Transfer	Current status	Actions	Identified Lead
Has the PCT with the local authority identified sufficient Capacity and capability to deliver plan	○ Leads identified	Further leads require identification	
Has the PCT with the local authority identified and resolved significant financial issues	○ Mapping of current spend to shadow budget when published ○ Agreement on overheads ○ Estates	○ hidden costs to be fully identified (resources utilised by public health but not within ph budget e.g. commissioning support, finance support, Comms and engagement , HR support,	Finance leads to be identified from both PCT and KCC
Has the PCT with the local authority agreed novation/other arrangements for the handover of all agreed public health contracts	○ PH contracts and SLAs – Process in place to ensure contracts list is comprehensive and includes PH contracts and SLAs	○ Further work to check list is comprehensive and covers everything	Matt Capper
Clinical and non clinical risk and indemnity issues identified for contracts	○ Currently within standard NHS contracts and within the corporate PCT costs	Discussions in process with KCC	Matt Capper
Are there plans in place to ensure access to IT systems, sharing data and access to health intelligence in line with information governance and business requirements during transition and beyond transfer	○ Currently sits under PCT ○ Access to PCT held info post-transition process established within PCT (eg FOI requests/ access to old docs) ○	Info Sharing agreements to be reviewed future access to NHS data through audit of GP/hospital/KCHT data if public health staff are no longer NHS	Jamie Sheldrake Mark Gray Mark Ashby Terry Hall

		employees ? national view on this ○ Work required on access to current NHS data, information system, library systems, NHS.net for confidential information	
Have all issues in relation to facilities, estates, and assest registers been resolved.	○ Currently sits under PCT ○ Asset register to be interrogated to identify what needs to transfer	○ Estates review in hand ○ Asset review also required to understand what assets PH use and how these will be handled in the trasnfer	Terry hall, IT leads East and West Kent
Plan in place for the development of a legacy handover document during 2012/13	○ PH contributes to cluster document	Need to delineate the PH legacy to be handed over to KCC	Judy Clabby

6. Comms and Engagement

Define Elements of Transfer	Current status	Actions	Identified Lead
Is there a robust Communication plans and does it consider relationships with: • The Health and Wellbeing Board • Clinical Commissioning Groups • NHS Commissioning Board • HealthWatch • Local professional networks	○ Need one	○ ? how links to KCC comms/engagement plan	○
Is there a robust engagement plan involving stakeholders, patients, the public, providers or public health services, contractors and PH England.	○	○	○

Appendix 7 - The Public Health Outcomes Framework – Improving Outcomes and supporting transparency

The Public Health Outcomes Framework – Improving Outcomes and supporting transparency -has been published very recently. It is designed to complement the outcomes frameworks for the NHS and Adult Social Care. It contains the indicators that will be used to gauge how well each authority is addressing public health issues and in particular how they are impacting on health inequalities in their area. Performance against these indicators will inform the distribution of the Health Premium funding although we still await details of how this will be calculated.

The Public Health Outcomes Framework consists of over 60 indicators that are divided between 4 key domains:

Improving the wider determinants of health

Health Improvement

Health Protection

Healthcare public health and preventing premature mortality

The domains and indicators are designed to address public health issues across the Marmot Life Course.

The domains and indicators are attached.

Fuller briefing on the public health outcomes framework and budget can be a brought to future meeting.

Appendix A: Overview of outcomes and indicators

Vision

To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest.
Outcome measures
Outcome 1: Increased healthy life expectancy, ie taking account of the health quality as well as the length of life.
Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

1 Improving the wider determinants of health

Objective

Improvements against wider factors that affect health and wellbeing and health inequalities

Indicators

- Children in poverty
- *School readiness (Placeholder)*
- Pupil absence
- First time entrants to the youth justice system
- 16-18 year olds not in education, employment or training
- People with mental illness or disability in settled accommodation
- *People in prison who have a mental illness or significant mental illness (Placeholder)*
- Employment for those with a long-term health condition including those with a learning difficulty/ disability or mental illness
- Sickness absence rate
- Killed or seriously injured casualties on England's roads
- *Domestic abuse (Placeholder)*
- *Violent crime (including sexual violence) (Placeholder)*
- Re-offending
- *The percentage of the population affected by noise (Placeholder)*
- Statutory homelessness
- Utilisation of green space for exercise/health reasons
- Fuel poverty
- *Social connectedness (Placeholder)*
- *Older people's perception of community safety (Placeholder)*

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions
- *Child development at 2-2.5 years (Placeholder)*
- Excess weight in 4-5 and 10-11 year olds
- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- *Emotional wellbeing of looked-after children (Placeholder)*
- *Smoking prevalence – 15 year olds (Placeholder)*
- Hospital admissions as a result of self-harm
- *Diet (Placeholder)*
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol-related admissions to hospital
- *Cancer diagnosed at stage 1 and 2 (Placeholder)*
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check Programme – by those eligible
- Self-reported wellbeing
- Falls and injuries in the over 65s

3 Health protection

Objective

The population's health is protected from major incidents and other threats, while reducing health inequalities

Indicators

- Air pollution
- Chlamydia diagnoses (15-24 year olds)
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for tuberculosis
- Public sector organisations with board-approved sustainable development management plans
- *Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)*

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

Indicators

- Infant mortality
- Tooth decay in children aged five
- Mortality from causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- *Mortality from communicable diseases (Placeholder)*
- *Excess under 75 mortality in adults with serious mental illness (Placeholder)*
- Suicide
- *Emergency readmissions within 30 days of discharge from hospital (Placeholder)*
- Preventable sight loss
- *Health-related quality of life for older people (Placeholder)*
- Hip fractures in over 65s
- Excess winter deaths
- *Dementia and its impacts (Placeholder)*

Appendix 8 - Briefing on the development of Clinical Commissioning groups in Kent and Medway

In anticipation of the Health and Social Care Bill's passage through Parliament, GPs in Kent and Medway are being asked to form 'Clinical commissioning groups' (CCGs). Subject to the passage of the Bill these groups will be authorised as statutory NHS organisations and take on the responsibility for commissioning health care for their constituent populations.

The CCGs will take over the health commissioning responsibilities from the PCTs. In total, 80% of the PCTs commissioning budgets are anticipated to transfer to CCGs. Unlike PCTs the CCGs will be membership organisations with each constituent GP practice being a constitutionally recognised member of the CCG.

In preparation for the establishment of CCGs, the PCTs will be delegating commissioning responsibilities to the emergent CCGs through establishing them first as sub committees of the PCT Board for 2012/13.

In Kent and Medway it is anticipated that there will be 7 CCGs.

CCG	**Population size (based on GP list size)**	**Estimated potential budget '000**	**Clinical leaders**
Maidstone and Malling with West Kent and the Weald (A single CCG will be confirmed by the current CCG Boards during February.)	463,741	£525, 372	Dr Bob Bowes and Dr Garry Singh
Dartford, Gravesham and Swanley	248,364	£302,063	Dr David Woodhead
Medway	281,923	£340,040	Dr Peter Green
Thanet*	140,157	£213,412	Dr Tony Martin
Ashford*	121,533	£146,582	Dr Navin Kumta
Canterbury* (C4G)	210,107	£262,933	Dr Mark Jones
South Kent Coast*	199,192	£287,028	Dr Chee Mah, Dr Chaudhuri and Dr Bruce Cawdron

* denotes CCGs within the East Kent Federation of CCGs

There is no current resolution for the GP practices in Swale.
In addition to CCGs, the new health commissioning architecture will include the following bodies: Upper tier local government, Public Health England, NHS Commissioning Board, Commissioning support services.

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Item 6: Dartford and Gravesham NHS Trust and Medway Foundation Trust: Developing Partnership.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 9 March 2012

Subject: Dartford and Gravesham NHS Trust and Medway Foundation Trust: Developing Partnership.

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1. Background

(a) This topic has previously been discussed at the meetings of 22 July 2011 and 25 November 2011, at which time the Trusts undertook to return at an appropriate time in the future.

(b) The specific questions which have been asked of both Trusts in advance of this meeting are appended to this report.

2. Recommendation

That the Committee consider and comment on the report.

Appendix – Questions submitted in advance.

1. Can you provide information on what progress has been made on the proposed merger since the HOSC meeting of 25 November, and what the next steps are, along with an updated timeline?

2. On public and stakeholder engagement, what findings can you share arising from Phase 1 of your engagement plan and what Phase 2 will involve?

3. What guarantees can you give about the continuity and improvement of services currently provided at both sites?

4. What commitment can you give about public and stakeholder engagement concerning any future services changes?

5. Can you provide a summary of the benefits and drawbacks of merger?

6. What are the major challenges to a successful merger that still need to be addressed?

7. What lessons have been learnt from mergers elsewhere and from reports such as last year's King's Fund report on reconfiguring services in South East London and the recent report on mergers from the Centre for Market and Public Organisation?

8. What are the implications of the merger on providing integrated care services working with other NHS providers, social services and others?

9. What work is underway to address concerns around transportation to/between the sites and car parking?

10. Is there a 'Plan B' should the merger not proceed?

By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee, 9 March 2012

Subject: NHS Trust and NHS Foundation Trust Status

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1. Foundation Trusts (FTs)

(a) Foundation Trusts are independent public benefit organisations but remain part of the NHS. They are accountable to Parliament as well as the local community. They have a duty to engage with their local community and encourage local residents, staff and service users to become members. Members can stand for election to the board/council of governors.

(b) The council of governors is drawn from various constituencies, with members either elected or appointed by that constituency. It works with the board of directors, which has the responsibility for day-to-day running of the FT.[1]

(c) As things currently stand, there are a number of differences between NHS Trust and NHS Foundation Trust status. One of the areas of difference is around financial duties:

1. NHS Trusts have a duty to break even, meaning that their expenditure must not exceed their income, taking one financial year with another. Spending on capital and cash held must be within certain limits.

2. FTs are not statutorily required to break even, but must achieve the financial position set out in their financial plan. One main measure of an FT's financial performance is EBITDA (earnings before interest, tax, depreciation and amortisation).[2]

2. The Foundation Trust Pipeline

(a) The NHS Operating Framework for 2012/13 provides the following summary of the FT Pipeline:

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[1] Monitor, *Current practice in NHS foundation trust member recruitment and engagement,* 2011, http://www.monitor-nhsft.gov.uk/sites/default/files/Current%20practice%20in%20foundatio...ecruitment%20and%20engagement.pdf

[2] Academy of Medical Royal Colleges and Audit Commission, *A Guide to Finance for Hospital Doctors*, July 2009, p.23, http://www.audit-commission.gov.uk/health/audit/financialmgmt/hospitaldoctors/Pages/hospitaldoctors9jul2009.aspx

"Progress on the NHS Foundation Trust (FT) pipeline is not an end in itself but a critical means for creating clinically and financially sustainable organisations across the provider sector. NHS trusts are expected to achieve NHS FT status on their own, as part of an existing NHS FT or in another organisational form by April 2014, with a few concluding beyond this date by exceptional agreement. Plans for all NHS trusts have been agreed under Tripartite Formal Agreements (TFAs), which codify the locally owned issues, actions and processes and set out the journey each organisation must take going forward."[3]

(b) Since October 2010, the Department of Health has been developing new processes to assist aspirant Trusts towards authorisation. The completions of a 'tripartite formal agreement' (TFA) for each Trust has been a core element of this with the TFA summarising the main challenges faced by each organisation along with the actions to be taken by the Trust, SHA and Department of Health.[4] Any issues were put into four categories:[5]

- Financial;
- Quality and Performance;
- Governance and leadership; and
- Strategic issues.

(c) As of 30 January 2012 there are 140 FTs. Across England, this accounts for around 57% of acute, 73% of mental health and 27% of ambulance trusts.[6]

(d) Across the South East Coast region, 50% of Trusts have been authorised as Foundation Trusts.[7] In Kent and Medway, the Foundation Trusts are currently:

- East Kent Hospitals NHS University Foundation Trust;

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[3] Department of Health, *The Operating Framework for the NHS in England 2012/13*, 24 November 2011, p.29, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131428.pdf

[4] National Audit Office, *Achievement of foundation trust status by NHS hospital trusts*, Full report p.6, 13 October 2011, http://www.nao.org.uk/publications/1012/foundation_trusts.aspx

[5] Ibid., p.21. The TFA for Dartford and Gravesham NHS Trust can be viewed here, http://www.dvh.nhs.uk/news-events-and-publications/annual-reports-accounts-and-plans/?locale=en All TFAs can be accessed here: http://healthandcare.dh.gov.uk/foundation-trusts-tripartite-formal-agreements/

[6] Monitor, *140th foundation trust authorised by Monitor*, 1 November 2011, http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/latest-press-releases/140th-foundation-trust-authorised-monitor

[7] NHS South East Coast, *Provider Development Update*, Board Papers 28 September 2011, http://www.southeastcoast.nhs.uk/Downloads/Board%20Papers/28%20September%202011/71-11%201%20Provider%20Development%20update%20Sept%202011.pdf

- Medway NHS Foundation Trust; and
- South East Coast Ambulance Service NHS Foundation Trust

3. Financial Support for NHS Trusts[8]

(a) On 3 February 2012, the Department of Health announced that 7 Trusts may receive additional funding support from the DH. The Trusts are:

1. Barking, Havering and Redbridge NHS Trust;
2. Dartford and Gravesham NHS Trust;
3. Maidstone and Tunbridge Wells NHS Trust;
4. North Cumbria NHS Trust;
5. Peterborough and Stamford Hospitals NHS Foundation Trust;
6. South London Healthcare NHS Trust; and
7. St Helens and Knowsley NHS Trust.

(b) These Trusts had demonstrated they face "serious structural financial issues" and have historic PFI arrangements. Subject to 4 tests, these Trusts will be able to access financial support up to £1.5 billion over 25 years. A local plan to achieve long term, financial balance must also be in place.

(c) The 4 tests are:

1. The problems they face should be exceptional and beyond those faced by other organisations;
2. They must be able to show that the problems they face are historic and that they have a clear plan to manage their resources in the future;
3. They must show that they are delivering high levels of annual productivity savings;

[8] This section sources from: Department of Health, *NHS trusts to receive funding support*, 3 February 2012, http://mediacentre.dh.gov.uk/2012/02/03/nhs-trusts-to-receive-funding-support/

4. They must deliver clinically viable, high quality services, including delivering low waiting times and other performance measures.

4. Monitor and the NHS Trust Development Authority (NTDA)

(a) Monitor is the independent regulator of NHS Foundation Trusts and is directly accountable to Parliament.

(b) The three main strands to its work are currently:

1. Assessing the readiness of Trusts to become FTs;

2. Ensuring FTs comply with their terms of authorisation and that they are well governed and financial robust; and

3. Supporting FT development.[9]

(c) A number of changes to the role of Monitor have been proposed as a result of the NHS White Paper, *Equity and Excellence: Liberating the NHS*, and the passage of the Health and Social Care Bill through Parliament. It will become the sector regulator for health, licensing providers of NHS services and carrying out functions in the following three areas:

1. Regulating prices;

2. Enabling integration and protecting against anti-competitive behaviour; and

3. Supporting service continuity.[10]

(d) Monitor will maintain its oversight role of Foundation Trusts until 2016 (or two years following authorisation if this is later) when the role will be reviewed.[11]

(d) The establishment of the NTDA will involve bringing together a number of functions currently carried out by the DH, SHAs and Appointments Commission. Its core functions will be:

1. Performance management of NHS Trusts;

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[9] Monitor, *What we do*, http://www.monitor-nhsft.gov.uk/home/about-monitor/what-we-do
[10] Monitor, *The Health and Social Care Bill: Monitor's Evolving Role*, 10 October 2011, http://www.monitor-nhsft.gov.uk/sites/default/files/The%20Health%20and%20Social%20Care%20Bill%20-%20Monitor's%20evolving%20role%20[Information%20sheet]%2010%20October%202011.pdf.pdf
[11] Ibid., and Monitor, *Assessing and regulating NHS foundation trusts, http://www.monitor-nhsft.gov.uk/home/monitors-new-role/assessing-and-regulating-nhs-foundation-trusts*

2. Overseeing the FT pipeline;

3. Assurance of clinical quality, governance and risk at NHS Trusts; and

4. NHS Trust appointments, including Chairs and non-executives.[12]

(e) The timeline is that the NTDA will be established as a Special Health Authority in June 2012, take on the functions of the Appointments Commission in October 2012 and be fully operational April 2013.[13]

(f) A review of the continuing need for the NTDA is likely to take place in 2016.[14]

(g) Monitor and the Department of Health jointly sponsor ***The Co-operation and Competition Panel*** (CCP). The CCP was formally established on 29 January 2009.[15] It provides advice on the application of the Department of Health's *Principles and Rules of Co-operation and Competition*.[16] Cases are undertaken by the CCP in the following four categories:

- Merger cases;
- Conduct cases;
- Procurement dispute appeals; and
- Advertising and misleading information dispute appeals.[17]

5. Hospital Reconfiguration: Recent Reports

(a) In March 2011, The King's Fund published the report *Reconfiguring Hospital Services - Lessons from South East London.*[18] This was a review of the reconfiguration exercise known as *A Picture of Health*.

(b) Then six key lessons drawn from the review are as follows:

1. The likely need for reconfiguration of services across hospital sites being the only way for some Trusts to achieve financial balance

[12] Department of Health, *Building the NHS Trust Development Authority*, 5 January 2012, p.8, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132049.pdf
[13] Ibid., pp.6, 19.
[14] Ibid., p.7.
[15] Co-operation and Competition Panel, *Guide to the Co-operation and Competition Panel*, http://www.ccpanel.org.uk/content/Guide-to-the-CCP.pdf
[16] Co-operation and Competition Panel, *Principles and Rules of Co-operation and Competition*, http://www.ccpanel.org.uk/content/Principles_and_Rules_REVISED5.pdf
[17] Co-operation and Competition Panel, *About the CCP*, http://www.ccpanel.org.uk/about-the-ccp/index.html
[18] The King's Fund, *Reconfiguring Hospital Services Lessons from South East London*, 3 March 2011, http://www.kingsfund.org.uk/publications/reconfiguring.html

without deterioration in the quality of care given the current financial climate.

2. The large deficits and legacy deficits of Trusts with PFI schemes are caused in part by under-funding of fixed capital charges in Payment by Results tariffs.

3. Achieving the best patient outcomes and patient experience and narrowing the quality gap between the best and worst performers should be the focus of the reconfiguration.

4. Competition and choice in contestable services may have the unintended consequence of deterioration in essential services.

5. There needs to be strong commissioning of emergency and network services across a large catchment area.

6. The acquisition of financially challenged Trusts by high-performing Foundation Trusts may often be the best way to bring about reconfiguration along patient pathways.[19]

(c) A different approach was taken by the Centre for Market and Public Organisation at the University of Bristol in the January 2012 report, *Can governments do it better? Merger mania and hospital outcomes in the English NHS*.[20] This examined merger activity between 1997 and 2006; there were 223 acute hospitals in 1997, and 112 had merged by 2006 (the research paper used 102 mergers). The Abstract of this report is as follows:

"*The literature on mergers between private hospitals suggests that such mergers often produce little benefit. Despite this, the UK government has pursued an active policy of hospital mergers, arguing that such consolidations will bring improvements for patients. We examine whether this promise is met. We exploit the fact that between 1997 and 2006 in England around half the short term general hospitals were involved in a merger, but that politics means that selection for a merger may be random with respect to future performance. We examine the impact of mergers on a large set of outcomes including financial performance, productivity, waiting times and clinical quality and find little evidence that mergers achieved gains other than a reduction in activity. Given that mergers reduce the scope for competition between hospitals the findings suggest that further merger activity may not be the appropriate way of dealing with poorly performing hospitals.*" [21]

[19] Ibid., pp.26-29.
[20] Centre for Market and Public Organisation, January 2012, http://www.bristol.ac.uk/cmpo/publications/papers/2012/wp281.pdf
[21] Centre for Market and Public Organisation, January 2012, http://www.bristol.ac.uk/cmpo/publications/papers/2012/abstract281.html

Dartford and Gravesham NHS
NHS Trust

Medway NHS
NHS Foundation Trust

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Mr Nick Chard
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Ref: HOSCMarch2012.doc

29 February 2012

Dear Nick,

Re: Health Overview and Scrutiny Committee Meeting – 9th March 2012

Further to your invitation for us to attend the above meeting, please find the answers to your questions below.

1. **Can you provide information on what progress has been made on the proposed merger since the HOSC meeting of 25 November, and what the next steps are, along with an updated timeline?**

   Since the HOSC meeting of 25 November, an outline business case (OBC) has been produced (attached at appendix 1). The OBC contains plans for clinical specialties including their planned year of implementation. Commercially sensitive information has been removed from the document. The OBC has been through an internal approvals process with final sign off by DGT Trust Board on 23 February 2012. The OBC has been shared with GP commissioners, the primary care cluster and will be considered by NHS South of England Board in March 2012.

   The OBC forms the basis of the full business case and integrated business plan and these will be submitted to approving bodies in September 2012. It is proposed that the timeline will be revised and that the Trust's will not formally become 1 organisation until 1st April 2013 but this has not been formally agreed by the Integration Programme Board. It is due to be considered in detail on the 7th March 2012. We will provide you a full update on the timeline changes in the

meeting. A chronology of the approvals process can be found at appendix 2.

The Trusts made a submission to the cooperation and competition panel (CCP) in October 2011. This is the first formal stage in the approvals process. Their role is to consider whether the benefits of the integration will outweigh the potential costs of reducing competition between local healthcare providers. Due to the numbers of current cases in the NHS, the CCP were unable to start to look at this case until 15th February 2012 and the first stage will complete on 13th April 2012. It is possible for the CCP to make a final recommendation to the Department of Health and Monitor on this date. However, if further information is required, the Trusts will move into CCP phase 2. This process takes 80 working days and will conclude in September 2012. For more information about the CCP process, please visit their website: www.ccpanel.org.uk

There has been an announcement by the government that Trusts that are unable to demonstrate long term financial sustainability due to the structure of a PFI contract will receive funding support if they can meet 4 key tests. Dartford and Gravesham NHS Trust has been identified as a recipient of such financial support. Further information can be found at appendix 3.

2. On public and stakeholder engagement, what findings can you share arising from Phase 1 of your engagement plan and what Phase 2 will involve?

The extended timeline has allowed us to extend the public engagement exercise until 27 April 2012 and this has been welcomed by Trust Governors and community groups and it allows the Trusts time to gain further feedback from our communities.

Key themes arising from public engagement to date include:

- Transport, travel and car parking concerns
- Maintaining clinical quality during the transition
- The degree of changes to services and how they can be accessed
- The effect of integration on relationships with other health and social care providers
- The cost of potential redundancies
- The financial position of each Trust
- The PFI contract in place at Dartford and Gravesham NHS Trust
- The importance of excellent IT systems

Further information on the current position of each of these themes can be found in appendix 3. Over 800 members of the public have participated in engagement events, from large participative events to small and informal briefings, following the format that we presented to you in our submission

dated 16th November 2011. A large number of frequently asked questions have now been compiled and our responses to them can be found on both Trust websites. We keep the integration web pages, on both Trust websites, up to date and have had over 5,600 hits on them. We also keep our members, numbering over 15,000 between the two trusts, up to date via our regular members' newsletters.

Following the completion of phase 1, an engagement analysis document will be compiled, focusing on each of the themes and will be circulated to both the Medway and Kent Overview and Scrutiny Committees.

We are pleased to report a close working relationship with LINks and will continue to work closely with them in the second phase of our engagement plans. This will commence after plans have been submitted to key official bodies. This is likely to be in September 2012. Phase 2 will focus on the practicalities of implementation planning at a specialty and departmental level. It will be more specific and stakeholders, including local community groups, members but particularly governors will be invited to participate in planning and developing services.

3. **What guarantees can you give about the continuity and improvement of services currently provided at both sites?**

Core services that you would expect to see in a district general hospital will continue to be offered at both hospitals. Our densely populated local community require a 24/7 accident and emergency department led by senior doctors at both hospital sites. This automatically protects all services that underpin the effective running of an excellent emergency department, for example a 24 hour medical facilities, 24 hour trauma services, theatres, diagnostic and hot laboratory facilities. As one of the fastest growing populations, with increasing birthing numbers in the country, there is a full commitment to provide maternity and children's services on both hospital sites. Local people voiced concerns very early on in the process about having to travel further for treatment. We have committed to full outpatient facilities at both hospitals.

We are deeply committed to not only maintaining but improving the range and quality of services that will be provided. The sharing of best practice between sites and learning from national and international innovations is being built into our plans, as you would expect. This process is being led by senior doctors who are working together in a way that has set firm foundations for a successful integration.

Careful planning is crucial. There will be no large scale, 'big bang' approach. Changes and developments will be carefully phased. Many organisations experience an 'operational dip' as a consequence of integration, but by keeping clinical leaders in place at both hospitals for the year following integration we are planning a smooth, phased transition that will ensure continuing improvements.

4. **What commitment can you give about public and stakeholder engagement concerning any future service changes?**

NHS healthcare providers have a legal obligation to hold a formal consultation with stakeholders and members of the public when service reconfiguration resulting in a change of access is involved. Should service change become necessary in the future, formal consultation will be required.

5. Can you provide a summary of benefits and drawbacks of the merger?

The key benefits of the integration can be found in section 6 of the OBC attached at appendix 1, they have been summarised into clinical and non-clinical benefits:

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.
- Becoming top performing
- Improving access to patients through repatriation
- The opportunity to develop specialised services

Non Clinical Benefits:

- Workforce opportunities including the ability to remove duplication
- Estates synergy
- Financial investment for modernisation

The key challenges and risks to the integration can be found in tabulated format in chapter 9 of the OBC. They have been divided into pre and post transaction risks. We will be pleased to take further questions on the identified risk during the meeting.

6. What are the major challenges to a successful merger that still need to be addressed?

There are a series of challenges to the success of this integration and these are well documented in chapter 9 of the OBC alongside a summary of the proposed mitigations. We believe that we have made excellent progress towards significantly mitigating some of the biggest risks:

- There is significant engagement with senior doctors who are driving forward their clinical visions. Decisions are being made by those closest to patients and this reduces any risk of lack of clinical ownership or lack of collective focus on developing and delivering the vision and strategic aims for the new organisation.

- We have separated operational day to day running of the hospital from the work on integration so that we can be confident that the risk of any dip in performance will be minimised. This will be further helped by careful planning and phasing of the key changes that need to be made.

- Much academic research has focused on the impact of cultural differences of the entities to be merged. A detailed cultural audit has highlighted the key differences and strategies are being developed to overcome those differences, something which is often ignored by senior executives.

- One of the biggest criticisms of published research to date is that the described benefits of mergers rarely materialise. The Trusts are taking a meticulous approach to benefits realisation. The post transaction implementation plan is being developed in full consultation with clinicians and managers within specialties and departments to ensure that behind each and every financial benefit, there is a comprehensive plan. The transition team are making the most of the time available pre-integration to ensure that these plans are robust and deliverable.

- We are continually learning lessons from both NHS organisations and in the wider commercial sector, this includes accessing the relevant expertise through external advisors and developing relationships with other organisations who have already integrated and learning lessons from them.

7. What lessons have been learnt from mergers elsewhere and from reports such as last year's King's Fund report on reconfiguring services in South East London and the recent report on mergers from the Centre for Market and Public Organisation?

The pre and post transaction risks outlined in chapter 9 of the OBC reflect our learning from both academic research and experiences of other organisations who have merged.

It should be noted that the approvals process for mergers and acquisitions is technically very different today when compared to the M&As considered by both the Kings Fund and CMPO. Monitor and the cooperation and competition panel apply significant rigour and scrutiny to plans in a way that did not apply to South London NHS Trust or to any merger which took place between 1997 – 2006.

We believe that the approach taken to this integration will mitigate the risks identified in the academic research to date and we will be content to answer further questions during the meeting.

8. What are the implications of the merger on providing integrated care services working with other NHS providers, social services and others?

We do not envisage that the integration will place working relationships with our commissioners or providers at a disadvantage. Both trusts already work closely with a range of other organisations to provide integrated care pathways for our patients and we believe that there are opportunities to

strengthen and consolidate practice so that there is consistency across North Kent.

We are working closely with commissioners and clinical commissioning groups to develop these plans and both Trusts participate in a number of regional networks including the Comprehensive Learning and Research Network and Cancer Network. Our close working relationships with other NHS and social care providers is set to continue.

9. **What work is underway to address concerns around transportation to/between the sites and car parking?**

   We know that transport issues are a real concern for local communities. The vast majority of patients will continue to access their usual services at their local hospital and so we do not anticipate a significant increase in patients needing to move between the hospitals. Bus companies are aware of the proposed integration. Should there become a need; we will discuss this further with them. There will be a requirement for staff to travel between sites and it is anticipated that a shuttle bus service will be put into place.

   Car parking is an existing concern of patients. Regardless of our plans to integrate, both Trusts continue to deal with the on-going challenges of the demand for car-parking facilities. Dartford and Gravesham NHS Trust is in the process of creating a number of additional spaces and the changes will result in a separate car park for blue badge holders. Medway NHS Foundation Trust is currently considering options for additional car parking facilities.

10. **Is there a 'Plan B' should the merger not proceed?**

    The status quo is not a viable option for either trust on clinical or financial grounds. Neither Trust have developed a plan B at this stage but it is recognised that DGT needs a route to Foundation Trust status.

We look forward to attending the HOSC meeting on the 9th March. Should members have any questions in the meantime, do not hesitate to contact us.

Yours sincerely

Mark Devlin

Susan Acott

Appendix 1

Dartford and Gravesham NHS Trust

Medway NHS Foundation Trust

OUTLINE BUSINESS CASE FOR THE INTEGRATION OF DARTFORD AND GRAVESHAM NHS TRUST AND MEDWAY NHS FOUNDATION TRUST

Table of Contents

1 Executive Summary

The current drivers in the health care system mean that neither Dartford and Gravesham NHS Trust (DGT) nor Medway NHS Foundation Trust (MFT) in their current form is clinically or financially sustainable. A strategic solution is required to prevent a deterioration of clinical services and a diminishing quality of care and patient experience. The integration between DGT and MFT is a unique opportunity to create a new sustainable health care provider for the population of North Kent, Bexley and Swale. Together, the hospitals will provide high quality core patient services and enhanced specialist services that deliver excellent health outcomes.

The Trusts

Dartford & Gravesham NHS Trust is a modern hospital operating from a single site Private Finance Initiative (PFI) facility, serving a population of 270,000 in Dartford, Gravesham and Swanley. The hospital has developed an increasing secondary market in Bexley as a result of the significant strategic service changes in South East London. Medway NHS Foundation Trust has a rich heritage, starting life as a naval hospital. It provides general acute services to a population of 360,000 across Medway and Swale as well as a selection of regional specialist services for Kent. The two trusts have a strong history of clinical collaboration including the shared provision of clinical services.

Strategic Drivers for Integration

There are a number of key strategic drivers in the healthcare system that have all called into question the sustainability of small to medium sized general acute hospitals such as Dartford & Gravesham NHS Trust and Medway NHS Foundation Trust. They include:

- **Clinical sustainability** requirements to deliver Royal College recommendations, safe and effective clinical rotas, national guidelines and improving outcomes guidance
- **Financial viability** linked to the economic downturn and the impact of the NHS Operating Framework
- **A Strategic opportunity** to improve both the quality and range of specialist services for local people that require a critical mass of population and respond to local demographics and health profile
- **The Policy context** specifically related to the Health & Social Care Bill's aim to provide more integrated care closer to home and for Foundation Trust status to be achieved

Dartford and Gravesham NHS Trust was unable to meet the required monitor financial metrics as a result of its Private Finance Initiative (PFI) arrangements. The McKinsey & Company report commissioned by the Department of Health identified the trust as one of seven in the NHS that requires on-going structural support in relation to PFI commitments demonstrating that the issue requires national rather than Trust or local health economy changes and interventions.

Synergies of the Trusts

This combination of drivers led to Dartford & Gravesham NHS Trust undertaking an options appraisal in April 2011 to identify an appropriate integration partner. The option of integration was considered in partnership with commissioners and was designed to fit with their commissioning intentions. Medway NHS Foundation Trust was identified as the preferred option given the unique synergies and opportunities between the two trusts:

- The trusts have a similar community demographic health and deprivation profiles including some of the poorest wards in the Kent county and the wider South East region. This provides opportunities to build services specific to our local health economies

- The trusts have a common core clinical business, as busy neighbouring small to medium sized district general hospitals

- The trusts have existing and, in some cases, long standing clinical relationships at a number of levels including hosted services, shared patient pathways and junior doctor rotations

- There are differentiation opportunities at a sub specialty level which can be developed in response to the needs of similar community profiles

- The trusts will be able to consolidate both clinical support services and corporate functions

- The combined trust estate and equipment will present opportunities to enable clinical developments and scope to make the most of the DGT PFI facilities and close some unsuitable estate at MFT

- The trusts serve neighbouring communities making the local population of the new organisation an adjacent one as the map below illustrates. Their nearest acute hospital sites (South London NHS Healthcare Trust and Maidstone and Tunbridge Wells NHS Trust) have both closed or downgraded their emergency and maternity services

- The trusts have different secondary markets. This gives further growth opportunities at both ends of the local health economy in Bexley and Swale

Figure 1: Map of Local Acute Hospitals

Key:
- South London Healthcare NHS Trust
- Dartford & Gravesham NHS Trust
- Maidstone and Tunbridge Wells NHS Trust
- Medway NHS Foundation Trust
- East Kent Hospitals NHS Foundation Trust

Vision: Better Care Together

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 have 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.

Figure 2: Better Care Together

The integrated organisation aims to compare favourably with the highest performing NHS organisations in the country. It will continually assess its ability to provide high quality patient services in terms of quality outcomes and efficiency and productivity. The premise of the strategy is not entirely based on aiming sights high and developing specialist services. Without integration, it will be increasingly difficult to sustain core services. The strategy is one of

securing and safeguarding, as well as strengthening and developing, clinical services.

The integrated organisation recognises that it will best realise these benefits by working in partnership with patients, the local community and other health and social care providers. This will ensure both that services meet patient and commissioner needs and that the plans are complimentary and supportive. For example, the trust will work in partnership both with primary and social care colleagues to provide integrated care closer to home, and with world class specialist providers to allow our communities access to specialist services locally. The new organisation will act as a catalyst to accelerate collaborative working with other providers to bring benefits to local people, modernise services, as well as improve accessibility and outcomes for patients.

Integration Benefits

The benefits of integration have been considered and developed by those closest to the patient with the aim to become top performing. Clinical directors and their teams have worked together across the trusts to develop visions for future services, taking into account local healthcare needs and harnessing the synergies between the two trusts. Clinical directors have focused on developing service plans which will provide best in class clinical outcomes and that could not otherwise be delivered without integration. The benefits include:

- Ensuring clinical sustainability and the provision of clinical services that improve outcomes
- Improving quality and achieving excellent health outcomes for the local population
- Being top performing benchmarked against the best acute providers in the NHS
- Improving access for patients through repatriation and development of specialised services
- Workforce rationalisation to remove duplication
- Harnessing the estates synergy of a PFI and non PFI site
- Financial investment for modernisation

Realising the benefits

These benefits are realised through a number of key strategies including the Clinical integrated strategy. This strategy is complimented and directly supported by the Estates strategy, Corporate Services strategy and the Information Management and Technology strategy. The detailed implementation plans of these strategies are being developed to ensure the robust management of the implementation phase.

The delivery of Better Care Together and the benefits that it provides is also underpinned by an organisational development and workforce plan. This provides detail on how the principles and values of the new organisation will be further developed, cascaded and aligned across the integrated organisation. These are all essential components of developing a strong culture and brand. A keen emphasis has been placed on the approach to communication and engagement with key stakeholders, including patients and staff, during the transaction. This will be a key feature of the integrated organisation. These plans are a prelude to the organisational development strategy which will be part of the Full Business Case.

The integration provides clear benefits for patients, staff and the wider health care system of North Kent and Bexley in South East London. Should the integration not progress, a strategic response to the clinical, financial and political drivers would still be required to maintain the clinical and financial sustainability of Dartford & Gravesham NHS Trust. A solution would be required to prevent a deterioration of services which would result in the diminishing quality of care and patient experience. An alternative partnership with another viable organisation would need to be sought.

Governance and management of the integration process

To support the effective integration of DGT with MFT, a clear structure for the management of this process has been established. The Integrated Programme Board (IPB) which currently comprises Chairs, CEO's and Medical Directors from MFT and DGT and a NED from each Trust's Board will

continue to be the overarching Board with responsibility for the delivery of the integration on behalf of the Trust Boards of MFT and DGT. It directs and holds to account the Transition Team who is responsible for the delivery of the integration programme plan. The Transition Team comprises of Executive Directors, who have been seconded from each organisation's Executive Team, and a support function.

Conclusion

The OBC describes the rationale for the integration of DGT and MFT. It sets out the strategic drivers, the future vision and the benefits that the integration provides. In the absence of integration, clinical services would deteriorate resulting in a diminishing quality of care and patient experience. Should the integration not progress, an alternative partnership for DGT with another viable organisation would need to be sought. The options appraisal for a merger partner for DGT was conducted in April 2011, therefore a new options appraisal would need to be undertaken in collaboration with NHS South of England and Commissioners to reflect changes to the provider landscape.

The integration is the strategic solution to a range of complex clinical, financial and political drivers and is an exciting opportunity to create a new sustainable health care provider for the population of North Kent, Bexley and Swale.

2 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. It is designed to take the best from both organisations to drive up overall quality across all services. 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.

2.1 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.

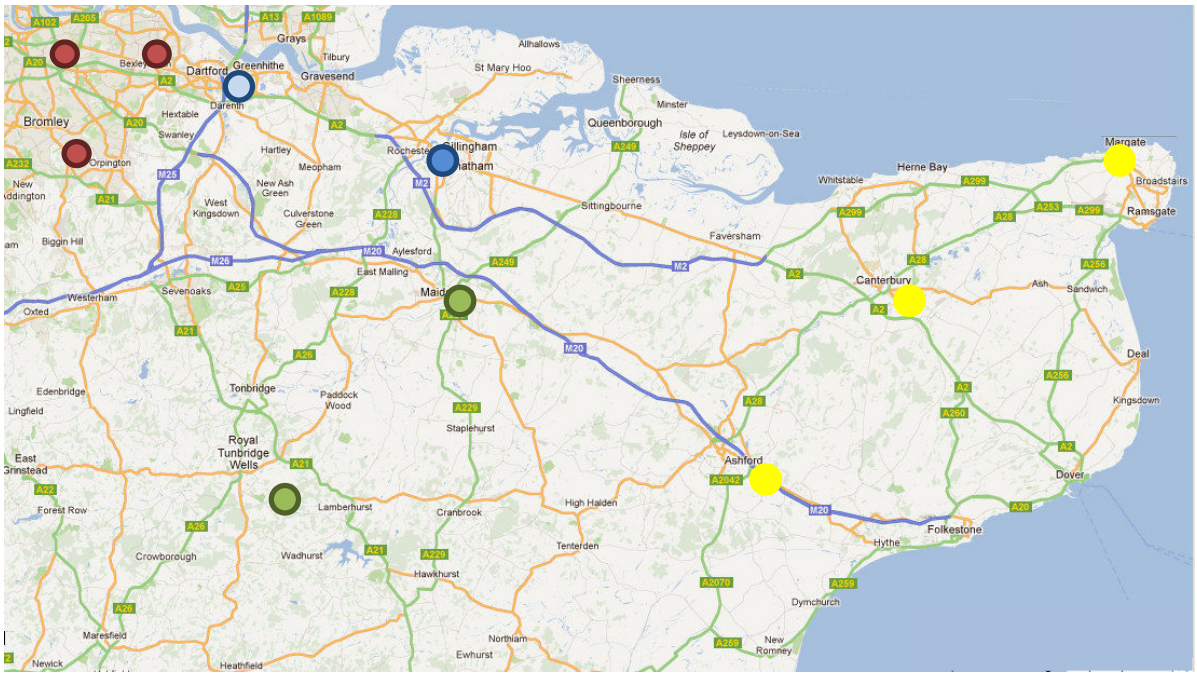
3 Current Service Profile of both Trusts

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.

3.1 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. Towards London 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. Across the Thames 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



Key: South London Healthcare NHS Trust; Medway NHS Foundation Trust; Maidstone & Tunbridge Wells NHS Trust; Dartford & Gravesham NHS Trust; East Kent Hospitals NHS Foundation Trust

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 Level 3 Neonatal Intensive Care, ENT and Audiology services at Darent Valley Hospital for over 10 years.

3.2 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 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.

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 a strategic decision by DGT Board to reduce its dependence on one commissioner and the closure of Queen Mary's Sidcup A&E and maternity services at the beginning of 2011 DGT has increased its percentage of clinical income from South East London 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.

3.3 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 is commissioned primarily from NHS Medway (now part of the West Kent and Medway commissioning cluster). Medway Council is a unitary authority.

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.

3.4 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. Figure 4 provides a visualisation of the **Better Care Together** strategy.

Figure 4: 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 provide sustainable quality 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 improvement in and development 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.

3.5 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:

- Clinical 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: Clinical 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'[1], 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,

[1] Delivering High-quality Surgical Services for the Future, The Royal College of Surgeons of England (2006)

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[2] and 'High Quality Women's Health Care: A proposal for change'[3]. 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.

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

[2] See www.nice.org.uk/Guidance/CSG/Published
[3] See www.nice.org.uk/Guidance/CSG/Published

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 5 below:

Figure 5: 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 6 below:

Figure 6: 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

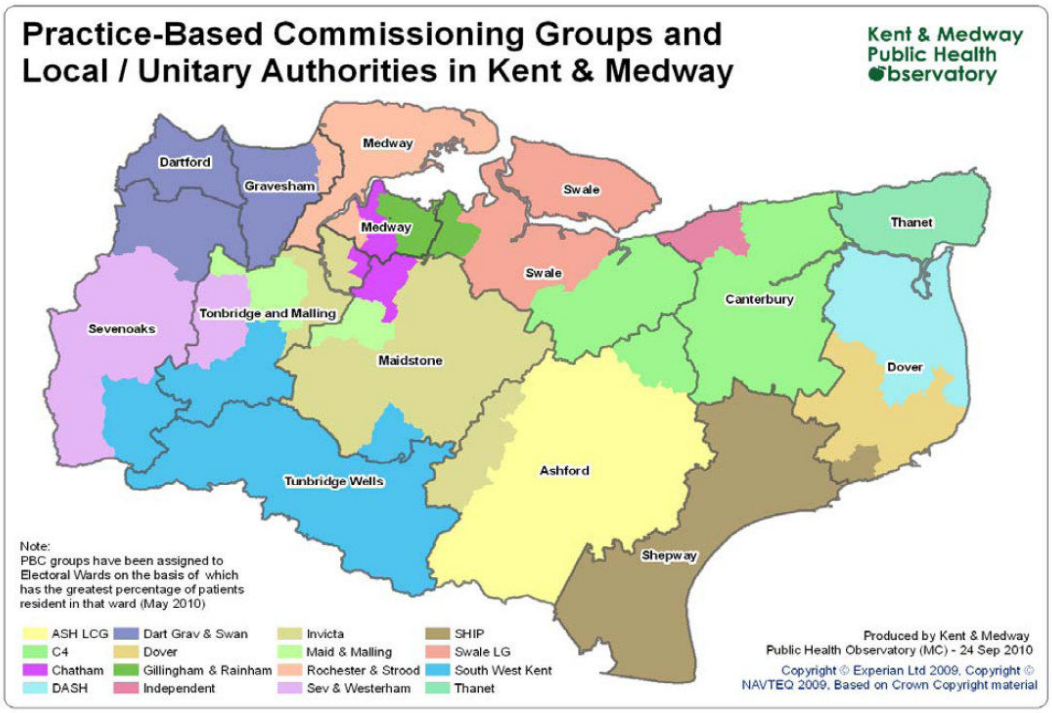
The future integrated clinical strategy recognises the impact of these commissioning changes on the outlook for the two trusts and responds to it. Current plans indicate that approximately £21m of clinical income is reduced as a consequence of the management of demand by commissioners, of which

£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. This leads to clinicians who provide this specialised care not being attracted to roles within DGT and MFT as these services will be based in other hospitals. Clinicians who provide specialised care will also not be available to partake in rotas for medicine and surgery that support core services such as A&E. 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 7: 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 8: 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[4]	78.9	77.3	78.4	77.3	79.4	78.8	78.3
Life expectancy – female[5]	81.1	81.6	82.4	81.1	83.1	82.6	82.3
Obese adults[6]	28.2	30.0	28.5	30.2	26.4	27.3	24.2
People diagnosed with diabetes[7]	5.03	6.16	5.50	6.26	5.93	5.43	5.40
Early deaths: heart disease & stroke[8]	75.0	77.8	58.4	80.1	64.7	64.4	70.5
Early deaths: cancer[9]	111.6	123.3	116.5	118.2	107.0	108.9	112.1
Smoking related deaths[10]	220.9	239.9	211.3	227.8	210.9	207.9	216.0
Infant deaths[11]	2.99	3.89	2.57	6.75	3.69	3.86	4.71
Smoking in pregnancy[12]	14.2	20.1	14.2	20.0	12.5	17.2	14.0

[4] At birth 2007-2009
[5] At birth 2007-2009
[6] Percentage of adults 2006-2008
[7] Percentage of people on GP registers with a diagnosis of diabetes 2009/10
[8] Directly age standardised rate per 100,000 population under 75, 2007-2009
[9] Directly age standardised rate per 100,000 population under 75, 2007-2009
[10] Per 100,000 population aged 35+, directly age standardised rate 2007-2009
[11] Rate per 1,000 live births 2007-2009
[12] Percentage of mothers smoking in pregnancy where status is known 2009/10

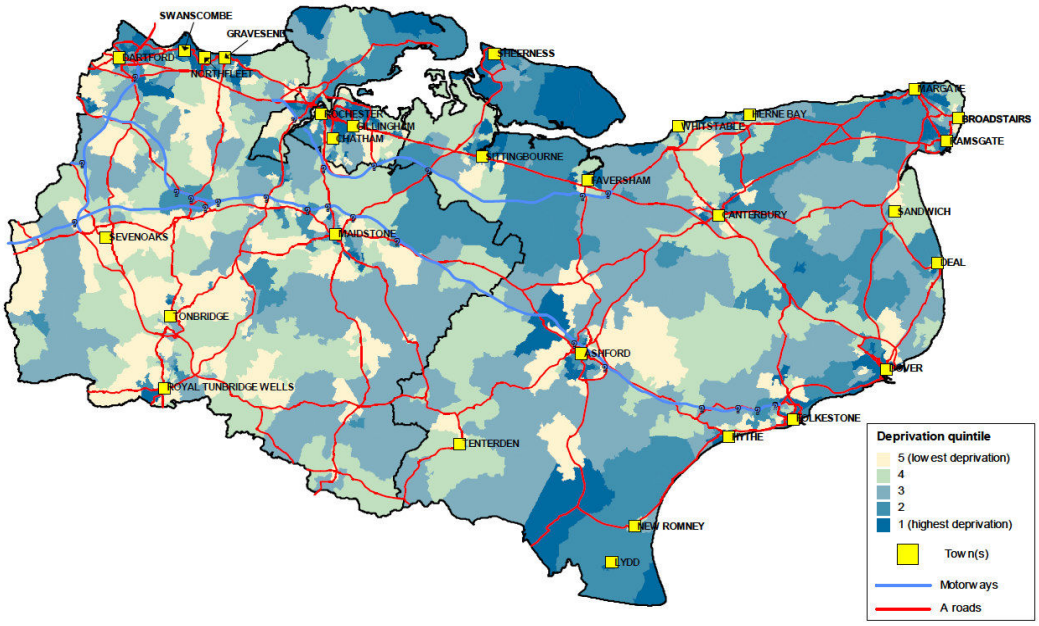
Indicator	Dartford	Medway	Gravesham	Swale	Bexley	Kent	England Average
Physically active children[13]	62.0	48.7	47.1	38.9	41.9	54.1	55.1
Obese children (Year 6)[14]	22.7	20.4	19.9	18.1	20.6	18.2	18.7
Teenage pregnancy (under 18)[15]	36.1	45.2	38.1	46.7	40.0	36.3	40.2
Adults smoking[16]	24.4	22.2	18.8	16.7	18.8	21.8	21.2
Increasing and higher risk drinking[17]	18.1	19.4	17.1	15.8	30.4	18.3	23.6
Incidence of malignant melanoma[18]	10.7	14.1	11.4	14.6	12.1	13.3	13.1
Hospital stays for self-harm[19]	213.4	246.5	194.3	259.0	118.8	239.4	198.3
Drug misuse[20]	4.8	8.0	6.7	7.6	4.8	6.3	9.4
Hip fracture in 65s and over[21]	451.3	474.0	530.0	440.3	478.0	450.0	457.6
Excess winter deaths[22]	13.0	16.1	9.7	20.9	23.5	16.6	18.1
Long term unemployment[23]	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.

[13] Percentage of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport in 2009/10
[14] Percentage of school children in Year 6, 2009/10
[15] Under 18 conception rate per 1,000 females aged 15-17 2007-2009
[16] Percentage of adults aged 18+ 2009/10
[17] Percentage of aged 16+ in the resident population, 2008
[18] Directly age standardised rate per 100,000 population under 75, 2005-2007
[19] Directly age and sex standardised rate per 100,000 population 2009/10
[20] Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09
[21] Directly age and sex standardised rate for emergency admission 65+, 2009/10
[22] Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 01.08.06-31.07.09
[23] Crude rate per 1,000 population aged 16-64, 2010

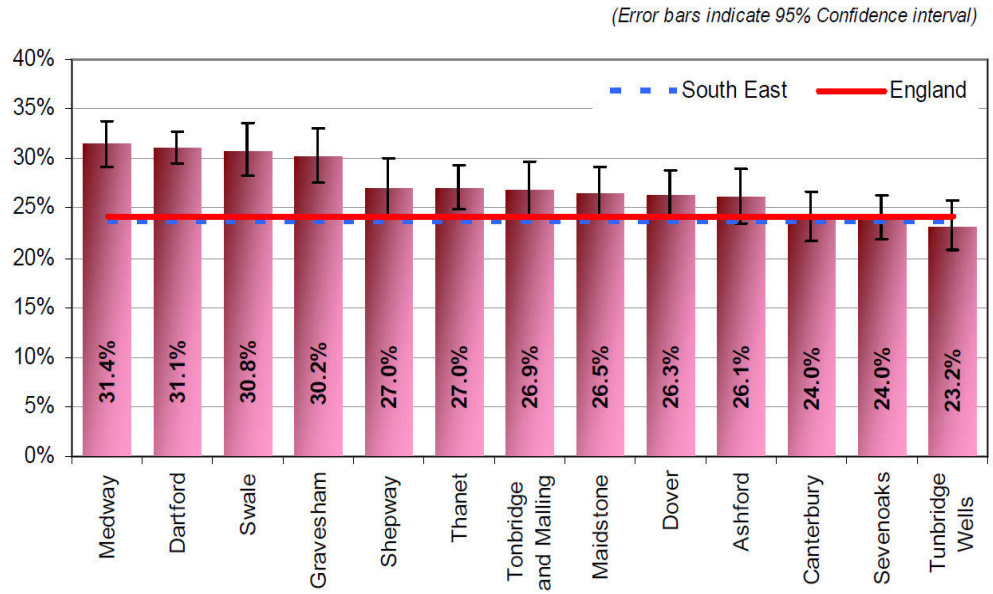
Figure 9: Map of Deprivation in Kent and Medway (2007)



Obesity

The chart below demonstrates the high levels of obesity in the main population areas that the hospitals serve.

Figure 10: 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 11: 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.

3.6 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 12: PEST Analysis

Political	Social
• White paper: Liberating the NHS centralisation/ localisation • Big Society • Stronger control of efficiency & reform • New Bill – impact on NHS Foundation Trust status and Employment status • Fixed five-year democratic cycle	• Growing and ageing population • Growth of long-term conditions • Increased health awareness • 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

3.7 Internal capability/SWOT analysis

The SWOT analysis below identifies the current strengths and weaknesses of DVH and of MMH.

Figure 13: 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;	GPs and patients continue to choose to access services	Specialist clinical service development

Key Current Strength	Supporting Evidence	Impact	Potential Initiatives
	reduced the number of hospital acquired infections; improved patient outcomes		Shared best practice
Clinical Engagement	Clinical Directors take a lead role in shaping services. Autonomous decision making bodies of clinicians	Clinically lead organisations	Build and strengthen the range and quality of services provided Increase research 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 14: 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 develop specialist services Senior surgical clinical cover and critical care access to meet Royal College guidelines for emergency surgical care	Reduction in the range of services available locally – reducing choice Loss of income from existing specialist services that are to be located elsewhere Unable to meet the best practice guidance and therefore provide appropriate level of care	Integration will ensure the Trust serves a greater population and therefore can continue to provide 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	Hospitals will fail financially without integration 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	Strategic response required

Key Current Weakness	Supporting Evidence	Impact	Potential Initiatives
		Unable to attain Foundation Trust status	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 (LA) boundaries	Medway is a unitary authority. Dartford and Gravesham have borough councils and are part of Kent County Council	The LAs may have opposing views and strategies	Continue to work closely with the two 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 15: 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.	Share best practice	Increase the quality of care provided Offer greater range

Key Opportunity for the combined Trust	Validation	Potential Initiatives	Likely Net Benefits
	Achievement of economies of scale	Share facilities and equipment Invest in research and development Invest in specialist equipment and modernising the patient areas Rationalise the MMH estate and increase clinical income at DVH	of specialist facilities and equipment available locally Provide innovative care to patients Improve patient outcomes and experience Improved estate 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 16: 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 Reproducing best practices of both hospitals at the other	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	Secure and maintain sustainable services that meet both commissioner and patient expectations Replace income loss

Key Threat for the combined Trust	Validation	Potential Initiatives	Likely Net Benefits
		Increase third party income Improve efficiency and productivity	
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. This may limit the extent to which repatriation of secondary or tertiary activity occurs.	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 the partnership offers benefits to all parties.	Increased likelihood of successful repatriation
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	Positive cultures on both hospitals that respect and work conterminously Improved staff satisfaction, autonomy and empowerment Improved patient experience

Key Threat for the combined Trust	Validation	Potential Initiatives	Likely Net Benefits
		their behaviour	
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 Flexible estate at MFT can facilitate reduction in capacity without loss to service 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 market	Recruitment is challenging for 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	Increase the number and range of 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	Increase sustainability of rotas 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.

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) [24], the options 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

[24] See www.ccpanel.org.uk

4.3 Options appraisal – consideration of options

The following options were considered (listed alphabetically) in April 2011 and a recommendation was made.

Figure 17: Options Appraisal: Consideration of Options

Option		Recommendation
1	Integration with Basildon and Thurrock University Hospitals NHS Foundation Trust	Not recommended
2	Integration with East Kent Hospitals University NHS Foundation Trust	Not recommended
3	Integration with Guy's and St Thomas' NHS Foundation Trust	Not recommended
4	Integration with Kent and Medway NHS and Social Care Partnership Trust	Not viable
5	Integration with Kent Community Health NHS Trust	Not viable
6	Integration with King's College Hospital NHS Foundation Trust	Not recommended
7	Integration with Lewisham Healthcare NHS Trust	Not recommended
8	Integration with Maidstone and Tunbridge Wells NHS Trust	Not viable
9	Integration with Medway NHS Foundation Trust	Recommended
10	Integration with Oxleas NHS Foundation Trust	Not viable
11	Integration with South London Healthcare NHS Trust	Not viable
12	Status quo i.e. with existing organisational structure	Not viable

Appendix A outlined a feasibility and quantative cost-benefit analysis of each option, but 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. Should the recommendation from this options appraisal not result in integration then the long list of partners would be revisited in collaboration with Commissioners and NHS South of England. As the options appraisal was conducted in April 2011, and therefore only valid at this point of time, a new options appraisal would therefore be required to reflect changes in the provider landscape.

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 18: 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, MFT and DGT 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 MFT.

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 MFT 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.

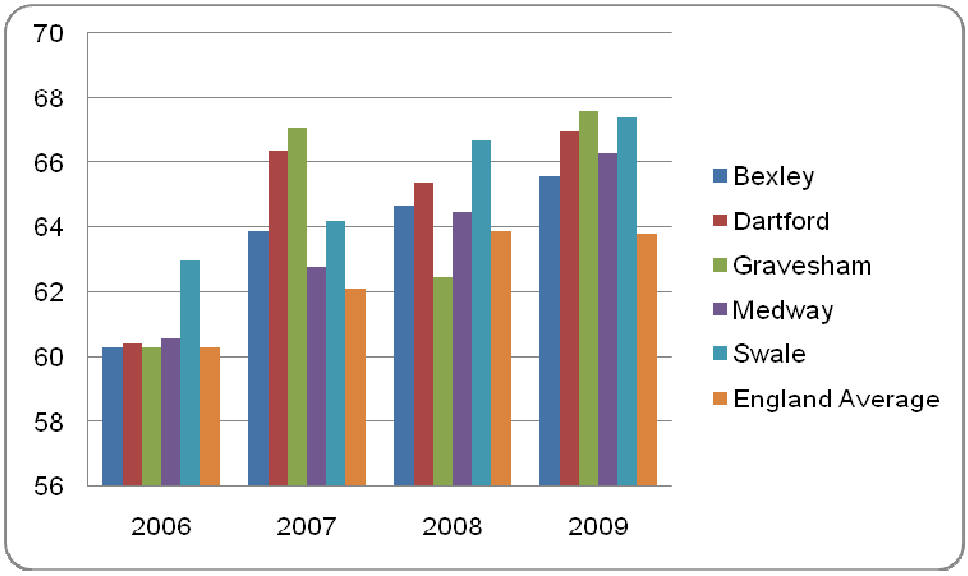
There are no in-house nephrologists in local hospitals presentably apart from at DGT, which too provide only limited renal services mainly for the patients in its locality with the majority of the patients and their relatives have to travel either to central or to East Kent Hospitals for more advanced 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 19: Local and National Fertility Rates – births per thousand of population

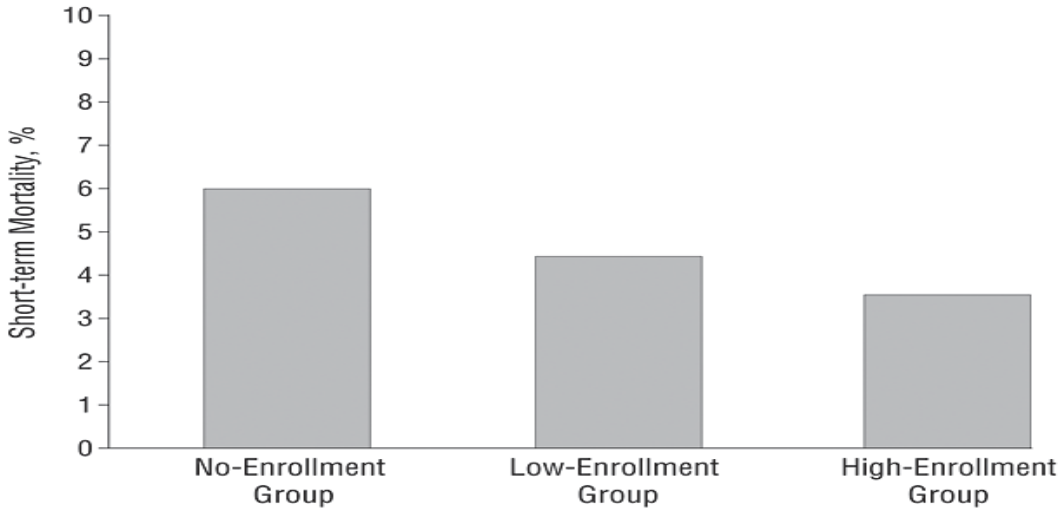


- **Research and Development**

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.

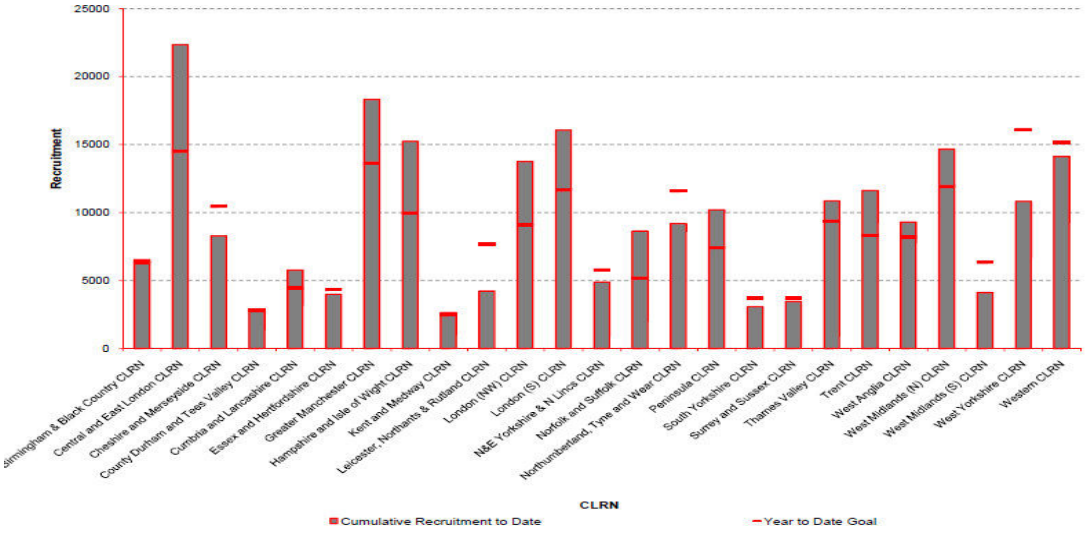
Figure 20: Cardiovascular Mortality

(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 21: 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. 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 22: 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 [25]	1,049 DNAs	2,632 DNAs
Reducing pre procedure elective bed days	164 bed days	123 bed days
Saving bed days through achieving target performance	14,523 bed days	22,300 bed days
Increased day cases (resulting in a saving in bed days)	1,764 -1,983 bed days	718 – 1,072 bed days

[25] Did Not Attend

Indicator	DVH opportunity	MMH opportunity
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 (III) Team because of affordability issues. Currently, neither DGT or MFT 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 III Team 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 III Team 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 MFT standing alone:

Figure 23: 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

Efficiency and Productivity Identified Improvement	Key Solutions Derived from the Integrated Organisation
▪ Save bed days through achieving target performance (Risk Adjusted Length of Stay and BADS [26] short stay directory) ▪ Increase day cases which has a consequence for theatres and inpatient beds	▪ Segmentation enables specialisation and expertise to be concentrated at designated elective sites 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:

[26] 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 reduces commissioner spend; improves access for patients, and leads 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 12-18 months. 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. 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 24: 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 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

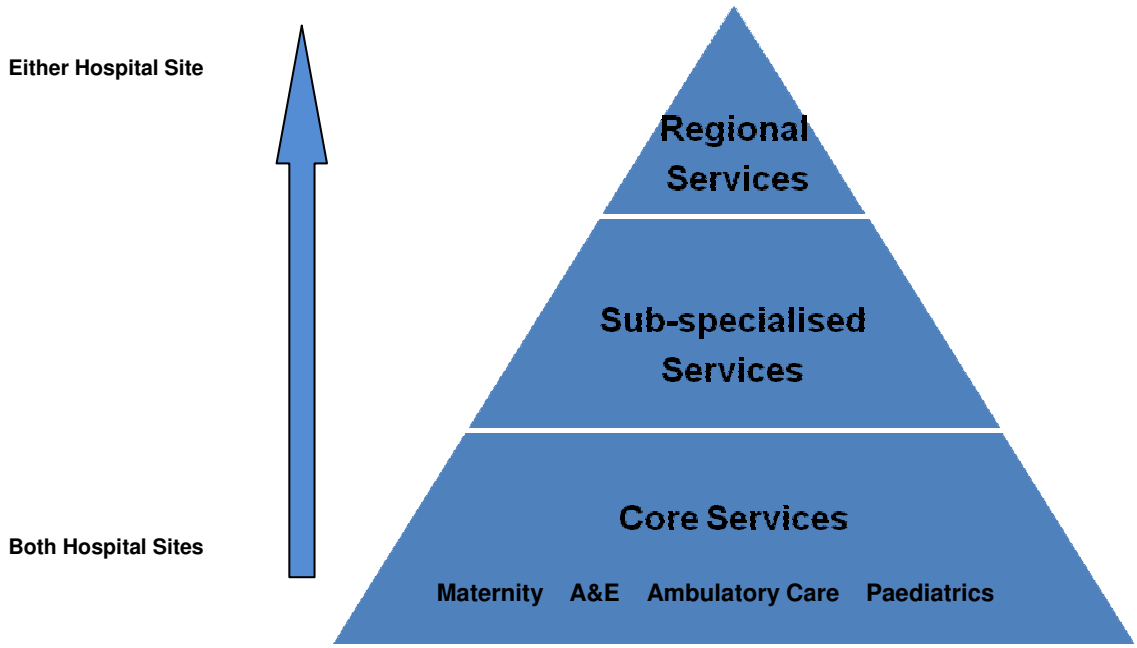
The trusts Lead Clinicians worked together with their clinical teams over a period of 18 months to develop the clinical integration strategy for the integrated trust. This work also involved the development of clinical service visions for their respective specialities and directorates. The development 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 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 25: 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 base 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 26: 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 27: 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 economically 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 28: 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 29: 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 are being addressed as a matter of urgency by both DGT and MFT as part of their current estates plans.

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 30: 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					

Action	Year				
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 31: 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
- Adoption of Telemedicine
- 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[27] 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 redesign of services 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:

[27] Department of Health, 'Equality and Excellence: Liberating the NHS', July 2010 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

Figure 32: 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.

7 Financial case – redacted due to commercial sensitivity

8 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 Full Business Case.

8.1 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 33: Better Care Together

In order to deliver the vision, a series of strategic aims have been developed and are described fully in chapter 4. 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.

8.2 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.

8.3 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 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.

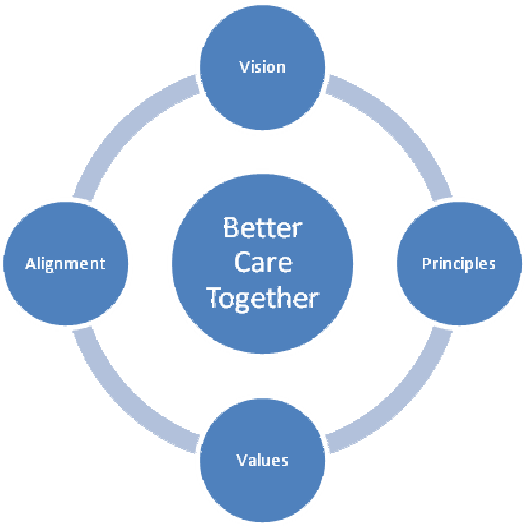
A small group of representatives, including staff, governors and trade union representatives from both MFT and DGT will come together to review the values of each Trust and to develop an integrated approach for the new organisation. The group will be invited to build on what has worked to date whilst 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.

8.4 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 34: 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**

8.5 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.

8.6 Strategy Development

The Trust Board of the integrated organisation has 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.

8.7 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.

8.8 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. 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.

8.9 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 on 27 April 2012. 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.

8.10 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.

8.11 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 35: 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.

8.12 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.

8.13 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.

8.14 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.

8.15 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.

8.16 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 will be included the corporate strategy.

8.17 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.

8.18 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.

8.19 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.

8.20 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.

8.21 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

8.22 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.

8.23 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

9 Governance, Management of the Integration Process and Risks

This chapter summarises the governance arrangements that the integration has adopted, the arrangements for the management and monitoring of the integration process and the key risks to its successful delivery.

9.1 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 Co-operation 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.

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. Due diligence will be conducted and its findings used in the Full Business case for the integration. It will be undertaken in five key areas:

<u>Clinical Due Diligence</u>

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.

9.2 Management and Monitoring of the Integration Process

Programme Management

To support the effective integration of DGT with MFT, a clear structure for the management of this process has been established. As described above in the Governance section the Integrated Programme Board currently comprises Chairs, CEO's and Medical Directors from MFT and DGT, a NED from each Trust Board and lead Directors from the Transition Team. It scrutinises and directs the work of a Transition Team and ensures programme milestones are met through receiving key issues and exception reports on a monthly basis.

This Board will have expanded representation as appointments to designate roles are made (e.g. Finance Director). The Integration Board will continue to be the overarching Board with responsibility for the delivery of the integration on behalf of the Trust Boards of MFT and DGT.

The Integrated Business Plan (IBP) and Post Transaction Integration Plan (PTIP), will show in detail the activities (including any intervention needed) for the integration. These plans continue to be fully developed and will be made available on submission of the Full Business Case (FBC). The IBP and PTIP will be the mechanism that MFT engages with Monitor to gain a risk assessment for the acquisition. This risk assessment will form a key part of the decision to proceed with the acquisition when it is formally considered by MFT Board.

As part of the integration process MFT and DGT will make a submission to the Co-operation and Competition Panel (CCP) who will assess the costs to the taxpayer and patient choice against the benefits of the integration. They will make a recommendation based on their findings that will be considered by key decision making bodies in the integration.

Transition Team

The Transition Team is led by a Programme Director (seconded from MFT Director of Finance role) who is supported by:

- Operations Director and Integration Lead (seconded from DGT Operations Director role)
- HR, Workforce and Organisational Development Director and Integration Lead (seconded from MFT HR Director role)
- Integration Programme Manager
- Finance Lead
- Communications lead
- Integration Project Manager
- M&A advisors (PricewaterhouseCoopers)

The Medical Directors of both organisations support the Integration programme by taking a lead role across their respective organisations.

Support from other corporate functions is utilised as required e.g. Governance and Information Management and Technology

The Transition team supports the development and delivery of the integration plans at an individual clinical specialty level.

Resourcing of the Programme

The programme has been funded from April 2011 to March 2012 by Kent and Medway PCT cluster. This agreement was subject to monitoring of progress through the IBP and regular collaborative working and updates that was made through the Transition Team. A further application will be made to the Cluster for programme resources for 2012/13 in order for the integration work in both organisations to continue. This is expected to form part of a 'Heads of Terms' agreement for transitional funding for the integration with principles and details to be agreed before submission of the FBC.

Performance Management

The IPB and Transition team will drive and support the process of integration and benefits delivery through the Executive, Clinical and Operational Management teams. The benefits critical to the success of the integration are summarised in Chapter 6. To facilitate effective monitoring and performance management of delivery, a benefits realisation plan and scorecard will be developed for the FBC. This will be monitored by the Executive Board of the integrated organisation. In achieving these benefits, the risks identified in the section below will also be developed and mitigated against.

9.3 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).

Pre Transaction

Figure 36: 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 restructuring and transactions costs	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 • Heads of Terms agreement before the production of the FBC
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. A loss of middle and top management due to uncertainty of job role security leads to temporary appointments	Amber	• Implementation of Communication and Engagement Plan • Regular informal updates to key

Identified Risk	RAG	Mitigation/s
having to be made		leadership groups • Continue to appoint substantively to key posts where it is deemed necessary to maintain organisational stability and minimise business risk
6. 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
7. 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
8. Risk of PFI financial support not being received by DGT	Amber	• DGT recognised as one of seven provides that would be eligible for recurring Department of Health structural support to fund PFI costs • Executive level collaboration with commissioners and NHS South of England to secure medium to long term sustainability through integration process
9. Respective organisation withdrawal from integration	Green	• Issues raised and resolved through IPB • Issues addressed through existing governance system and processes
10. 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
11. Risk of delay due to Medway NHS FT breach of terms of authorisation with Monitor	Amber	• Development and implementation of plans for financial delivery of forecast outturns • Monthly monitoring of key Monitor metrics • Delivery of the Transforming Performance programme
12. Risk of cancellation due to not meeting Monitor requirements	Green	• Following REID and best practice guidance • Appointment of merger and acquisition advisors

Identified Risk	RAG	Mitigation/s
		• Due diligence part of process
13. 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
14. 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
15. 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
16. Lack of performance to year end 2011/12 and in year 2012/13	Amber	• Executive Team from both organisations in place following backfilling in roles from Executive Team members seconded to Transition Team. • Governance processes of both organisations remain in place to manage strategic and operational business. • Integrated Programme Board has governance links to MFT and DGT Trust Boards.

Post transaction

Figure 37: Post Transaction Risks

Identified Risk		Mitigation/s
1. Loss of corporate memory and leadership	Amber	• Implementation of Organisational Strategy • Retention of Clinical Directors in roles through year one of integration • Clear leadership/accountability throughout the integration
2. Lack of clear leadership		• 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 • An effective Post Transaction Implementation Plan • Clear leadership/accountability throughout the integration • Strong leadership and accountability • Monthly meeting with PCT cluster and Clinical Commissioning Groups • Regular meetings with NHS South of England • NHS South of England representative at the IPB
8. Insufficient capability and capacity of leadership teams	Green	• Implementation of Organisational Strategy • Retention of clinical directors in roles through year one of integration • An effective Post Transaction Implementation Plan • Clear leadership/accountability throughout the integration
3. Inadequate investment in the transaction		• An effective Post Transaction Implementation Plan • Regular tracking of benefits realisation through PMO approach • Trust Board overview and sign off of Monitor certifications
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. • Regular tracking of benefits realisation through PMO approach
4. Changes to the local health economy render strategy flawed		
7. Incompatible cultures	Amber	• An effective Organisational Development Strategy and Plans implemented
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

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.

10 Conclusion and Recommendation

Conclusion

This document has set out the case that DGT cannot remain a standalone NHS Trust. It sets out the strategic drivers, the future vision and the benefits that the integration provides. In the absence of integration, clinical services would deteriorate resulting in a diminishing quality of care and patient experience. Should the integration not progress, alternative partnerships for DGT would need to be sought. The options appraisal for a merger partner for DGT was conducted in April 2011 therefore, a new options appraisal would need to be undertaken in collaboration with NHS South of England and Commissioners to reflect changes to the provider landscape.

The integration is the strategic solution to a range of complex clinical, financial and political drivers and is an exciting opportunity to create a new sustainable health care provider for the population of North Kent, Bexley and Swale.

Recommendation

The NHS South of England Board is asked to approve the preferred option of the acquisition of Dartford & Gravesham NHS Trust by Medway NHS Foundation Trust and to give permission to move to the Full Business Case stage which will include full due diligence and details of the integration.

The Full Business Case will be submitted to NHS South of England and will recommend that the statutory process for the dissolution of DGT and for assets and services to be transferred to MFT at the point of dissolution.

11 Appendices

11.1 Appendix A: Dartford & Gravesham NHS Trust Options Appraisal – redacted due to commercial sensitivity

11.2 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.

11.3 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.

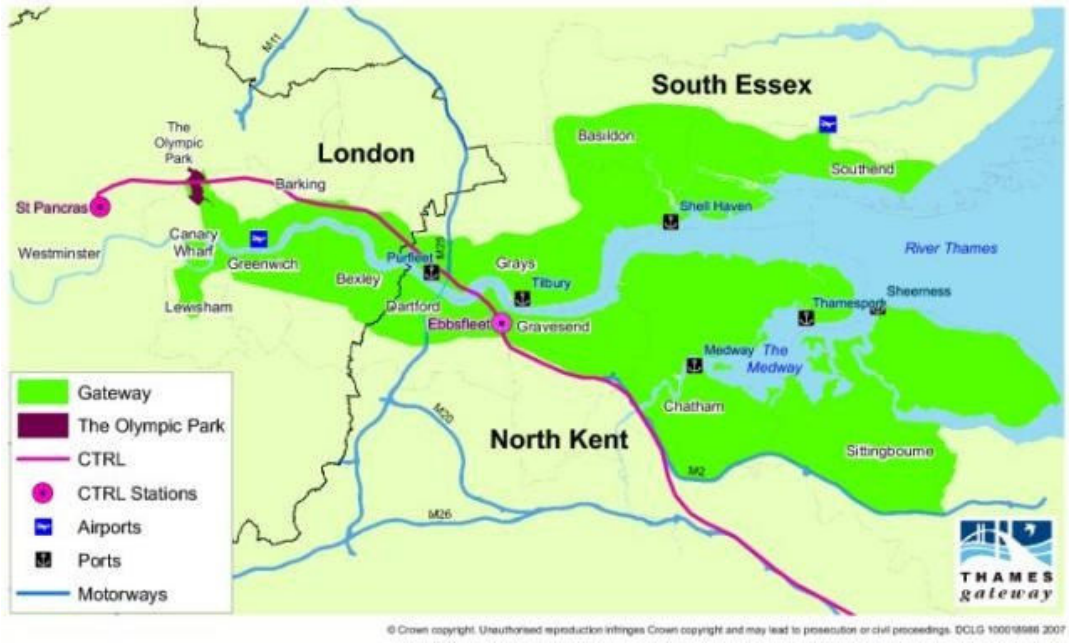
Kent Thameside encompasses the Boroughs of Dartford, Gravesham, Medway and Swale with a focus on the urban area north of the A2/M2 and south of the River Thames. It is a major new housing and commercial development within the Thames Gateway Partnership, including the creation of new high speed train 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

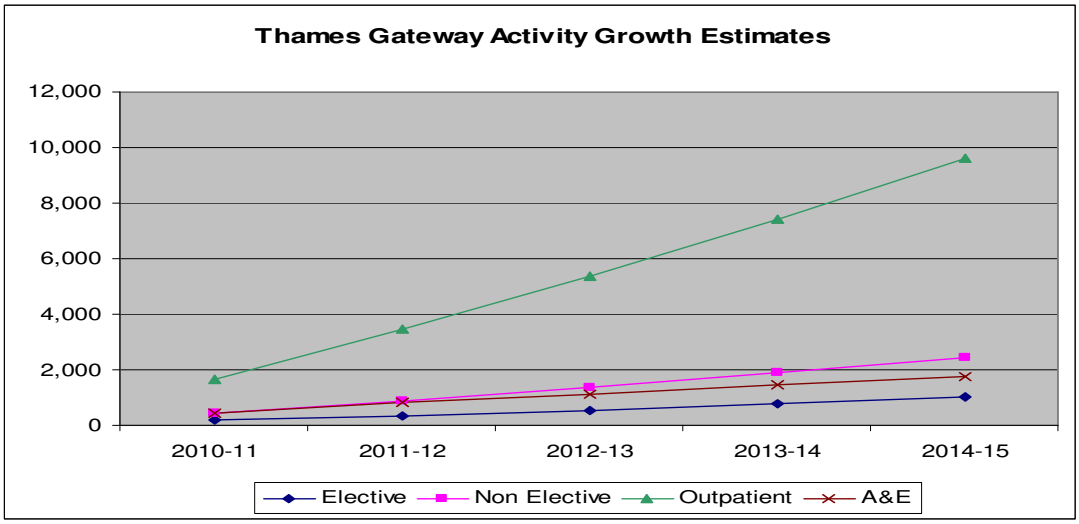
infrastructure is being upgraded as part of the enabling works for the population growth and vast tracks of quarry land have been cleared to prepare for on-going development. The Ebbsfleet high speed rail link connecting Kent to London is also in place.

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.

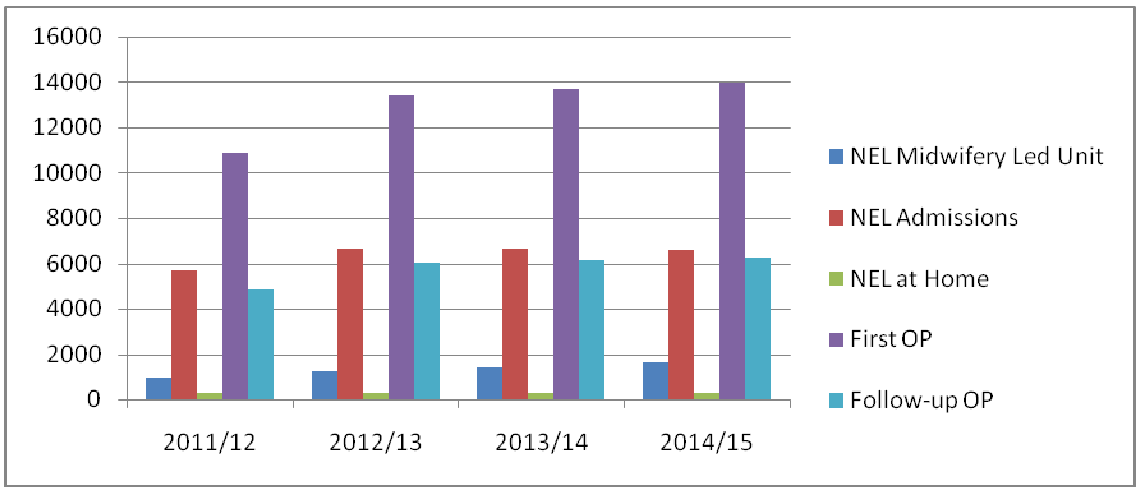
Thames Gateway Activity Growth Estimates



- **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.

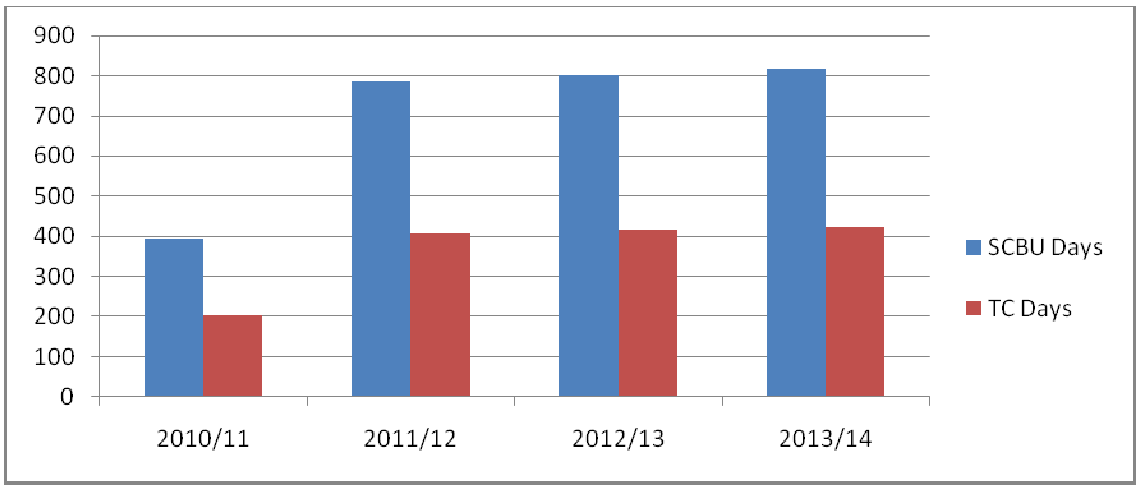
Obstetric Activity at Medway Maritime



- **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 accessed 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.

11.4 Appendix D: Removed as part of the financial case

11.5 Appendix E: Removed as part of the financial case

11.6 Appendix F: Table of Figures

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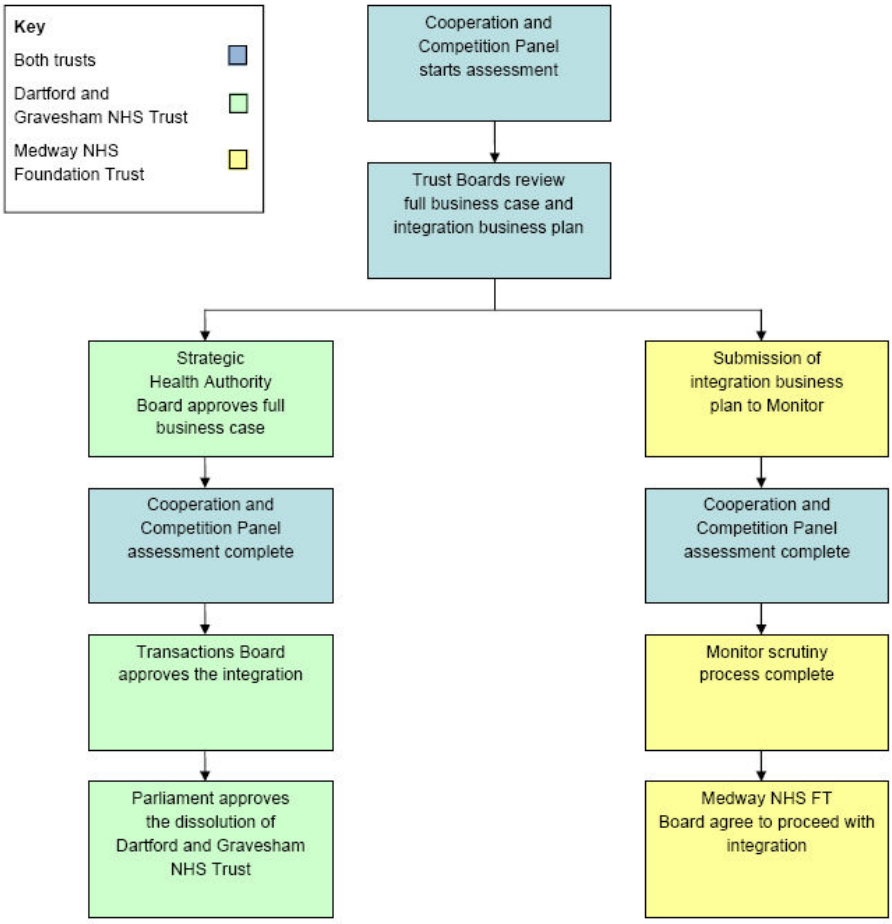
Appendix 2:

Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust Formal Approval Processes



Appendix 3: Structural Support for NHS Trusts with PFIs

Department of Health press release

NHS Trusts to receive funding support

February 3, 2012

Seven NHS hospital Trusts who have demonstrated that they face serious structural financial issues may receive additional support from the Department of Health if they can demonstrate that they can meet four key tests.

In October, Health Secretary Andrew Lansley announced that the Department of Health would provide ongoing support to a small number of NHS Trusts with historic Private Finance Initiative (PFI) arrangements that were unable to demonstrate the necessary long-term financial viability. To meet the criteria for such support, a shortlist of affected Trusts would need to demonstrate that they had met four key tests:

- The problems they face should be exceptional and beyond those faced by other organisations;

- They must be able to show that the problems they face are historic and that they have a clear plan to manage their resources in the future;

- They must show that they are delivering high levels of annual productivity savings;

- They must deliver clinically viable, high quality services, including delivering low waiting times and other performance measures.

This process was established so that patients and taxpayers could see that additional funding for NHS organisations that face financial issues would be provided in a transparent and open way, where it can clearly be demonstrated that these organisations would otherwise be financially sustainable.

Following further work, seven Trusts who may need financial support have been identified and further work on the detail of each individual case is underway including showing whether or not they can meet the four key tests:

- Barking, Havering and Redbridge NHS Trust
- Dartford and Gravesham NHS Trust
- Maidstone and Tunbridge Wells NHS Trust
- North Cumbria NHS Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust

- South London Healthcare NHS Trust
- St Helens and Knowsley NHS Trust

Any Trusts that can satisfy the rigorous tests will have access to financial support of up to £1.5 billion in total over a period of 25 years. Some of this funding will be available from 2012/13 from within the Department of Health's budget.

Alongside this, Trusts must have in place local plans to achieve long-term financial balance, which will require other factors to be addressed, while continuing to deliver the best possible services for NHS patients. The funding will be provided in a transparent way that represents the best possible value for money for taxpayers.
Health Secretary Andrew Lansley said:

"The NHS is delivering great results for patients but we know that a small number of NHS Trusts with PFI arrangements have historic problems relating to these arrangements that make it very difficult for them to manage financially."

"Today's announcement is the latest stage in a programme of work we began in 2010 to identify and tackle financial problems at local level in the NHS. In the past, local Trusts have received extra funding on the quiet in order to avoid embarrassment. We have already signalled that we are determined to end these backroom deals by bringing greater transparency and openness to the process.

"We need to balance the accountability of the NHS at local level to live within its means on one hand, with recognising that there is a legacy of debt for some Trusts with PFI schemes.

"And we need to be certain that those NHS Trusts that face historic financial problems are not taking their eye off the most important issue of all – maintaining and improving their frontline patient care."

--- ends ---

APPENDIX 4:
Summary of Key Themes Arising From Public Engagement

Transport, travel and car parking concerns
These mainly centre around existing issues that both hospitals currently face, once it is explained that core services will continue to be provided on both sites and that local public transport providers have been informed of our plans. We will be closely monitoring the situation for any transport issues that arise during the implementation phase.

Clinical quality must be maintained during integration
Members of the public are generally reassured when it is explained that clinical directors of both trusts will continue in their roles for some time even after integration, to ensure continuity of safety and service quality. Furthermore, to reduce the risk of any 'operational dip', changes will be introduced gradually, in phases and after careful planning.

Service changes
Audiences are reassured that we have no plans to move services and should it become necessary in the future, we have an obligation to consult.

The effect of integration on relationships with other NHS trusts and organisations
Both trusts are active in regional networks for specialist services, such as cancer, and have no plans to remove themselves from these arrangements. In the coming years, the trusts aim to work closely with these networks to identify opportunities to develop specialist services to serve the region at one or other hospital. 'Innovative partnerships' are part of the vision for the integrated trust and includes not only NHS partners, but also social services, community healthcare providers and third sector organisations.

The cost of redundancies
We aim to protect frontline clinical posts, but there will be removal of duplication in corporate back-office functions. The cost of redundancies has been incorporated into our financial plans. We aim to minimise redundancies through natural turnover and retraining.

Finances
This topic has been raised at every public event. We are open and transparent about both trusts' positions: Dartford and Gravesham NHS Trust has an expensive PFI arrangement, but one that offers benefits to patients, while Medway NHS Foundation Trust expects to make a small deficit at the end of this financial year with a strong efficiencies programme in place. Our financial planning shows that maintaining the

status quo is not a viable option for either trust in the long term and that coming together can result in a financially sustainable organisation.

There was a recent announcement by the Department of Health regarding emergency funding for NHS trusts with PFI contracts. Dartford and Gravesham NHS Trust was named as one trust that may be eligible for funding. Please see the press release from the Department of Health in Appendix 3. We would be pleased to provide a verbal update at the meeting.

IT systems

We are currently developing an Information Management and Technology strategy. Both trusts have systems that are coming to the end of their lifespan and so will look to purchase a single system. This will not only be more cost effective, but also ensure that information can easily be shared across sites.

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 9 March 2012

Subject: Older People's Mental Health Services in East Kent.

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1. Background

(a) NHS Kent and Medway presented a preliminary paper on this subject for inclusion in the Agenda of 25 November with a view to returning at an appropriate time in 2012.

(b) Members were also invited to an Options Appraisal Workshop on *Remodelling the Acute Care Pathway for East Kent Older Adult Services* which took place on 22 December 2011. The report on this workshop by NHS Kent and Medway and Kent and Medway NHS and Social Care Partnership Trust is included in the reports for this item.

2. Recommendation

That the Committee consider and comment on the report.

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By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee: 9 March 2012

Subject: Older People's Mental Health Services: Recent National Policy Developments.

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1. Select Committee Report on Dementia

(a) On 15 December 2011, County Council endorsed the work of the Select Committee report, *Dementia – a new stage in life.*[1] The Executive Summary to this report is appended to this Background Note.[2]

2. Recent National Policy Developments

(a) In the NHS Operating Framework for 2012/13, published on 24 November, one of the areas highlighted for particular attention during 2012/13 is dementia and care of older people, with reference being made to the recent Care Quality Commission report, *Dignity and Nutrition for Older People.*[3] A number of systemic things which need to be done were included in the Framework, including:

- "commissioners should ensure that providers are compliant with relevant NICE quality standards and ensure information is published in providers' quality accounts;
- commissioners should work with GP practices to secure ongoing improvements in the quality of general practice and community services so that patients only go into hospital if that will secure the best clinical outcome;
- ensuring participation in and publication of national clinical audits that relate to services for older people;
- initiatives to reduce inappropriate antipsychotic prescribing for people with dementia to improve quality of life with a view to achieving overall a two-thirds reduction in the use of antipsychotic medicines;
- improving diagnosis rates, particularly in the areas with the lowest current performance;
- the continued drive to eliminate mixed-sex accommodation;

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[1] County Council, 15 December 2011, http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=113&MId=3486&Ver=4

[2] Full Select Committee Report and Executive Summary available at:: http://www.kent.gov.uk/your_council/how_the_council_works/decisions/overview_and_scrutiny/select_committee_reports/dementia_select_committee.aspx

[3] Care Quality Commission, October 2011, http://www.cqc.org.uk/node/1785

- the use of inappropriate emergency admission rates as a performance measure for national reporting; and

- non-payment for emergency readmissions within 30 days of discharge following an elective admission.

- PCT clusters should ensure that all providers have a systematic approach to improving dignity in care for patients."[4]

(b) On 7 December, the NHS Outcomes Framework for 2012/13 was published. This is structured around five domains that set out the high level outcomes which the NHS should be aiming at nationally.

(c) These five domains are: [5]

1. Preventing people from dying prematurely;

2. Enhancing the quality of life for people with long-term conditions;

3. Helping people to recover from episodes of ill health or following injury;

4. Ensuring people have a positive experience of care; and

5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

(d) There are a number of indicators under each domain by which these outcomes will be measured. Under Domain 2, "A placeholder has been included for the development of a suitable indicator for dementia. (A placeholder represents a commitment to develop an indicator in this area, recognising that this may take time)."[6]

(e) On 6 February 2012, the Joint Commissioning Panel for Mental Health published *Guidance for commissioners of dementia services*.[7] This report set out six key principles underpinning dementia commissioning:

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[4] Department of Health, *The Operating Framework for the NHS in England 2012/13*, 24 November 2011, pp.12-13, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131428.pdf

[5] Department of Health, *The NHS Outcomes Framework 2012/13*, 7 December 2011, p.16, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf

[6] Ibid., p.12, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf

[7] Joint Commissioning Panel for Mental Health, *Guidance for commissioners of dementia services*, 6 February 2012, http://www.rcpsych.ac.uk/pdf/JCP-MH%20dementia%20(Feb%202012).pdf

1. Seamless services across health, social care, housing and other providers;

2. Commissioning on the basis of need, not chronological age;

3. The availability of different services at different times;

4. Dementia to be seen as 'everybody's business' and mainstream health and social care services to have a basic awareness of dementia;

5. Delivery of care by organisations and individuals in partnership; and

6. Care should be personalised.[8]

(f) To put these into practice, the report recommended the commissioning of a wide range of services, including:

1. Preventive public health interventions;

2. Dementia assessment, diagnosis and intervention services;

3. Home care and care home support;

4. Specialist mental health care;

5. Acute hospital liaison services; and

6; Support for carers.[9]

[8] Ibid., p.8.
[9] Ibid., p.8-13.

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DEMENTIA - A NEW STAGE IN LIFE

SELECT COMMITTEE REPORT

EXECUTIVE SUMMARY

September 2011

Kent County Council
County Hall
Maidstone
ME14 1XQ
08458 247247
county.hall@kent.gov
Select Committee Officer: Sue Frampton

Contents

Chairman's Foreword

In a recent national survey, people said they feared the onset of dementia more than anything else including cancer. Yet the Select Committee found that few people understood dementia and its causes and even fewer people were aware that we can all take steps to help prevent it and delay its progress.

This lack of understanding in the general population, and more surprisingly amongst professionals, is making life for both sufferers and carers more difficult, stressful, costly and emotionally and physically draining than it needs to be. Many people said to us "No one listened to me. I was left alone to cope."

We have also heard stories where knowledgeable and skilled workers, volunteers and communities have been able to have a transformational effect, helping people to live well with dementia.

During our work, dementia has become a high profile subject nationally and many other bodies have begun working on improving their dementia services. We hope this report is a workmanlike addition to their knowledge and will help focus attention on the practical improvement which will make a difference.

We have heard many moving stories of carers who have looked after a relative with dementia at quite extraordinary personal cost; they have in many cases given up their right to a private life, career and home, and done so willingly and with love. They deserve our thanks and support

The Select Committee would like to thank all those organisations and individuals who helped us by giving evidence. In particular we would like to thank those who shared their very personal memories.

Trudy Dean

Trudy Dean
Chairman, Dementia Select Committee

I EXECUTIVE SUMMARY

1.1 Committee membership

The Select Committee comprised nine Members of the County Council; seven Conservative, one Labour (co-opted Member) and one Liberal Democrat.

Kent County Council Members (County Councillors):

Ann Allen
(Cons)

David Brazier
(Cons)

Alan Chell
(Cons)

Leslie Christie
(Lab)

Trudy Dean
(Lib Dem)

John Kirby
(Cons)

Steve Manion
(Cons)

Ken Pugh
(Cons)

Avtar Sandhu
(Cons)

1.2 Establishment of the Select Committee

1.2.1 The Select Committee was established by the Adult Social Services Policy Overview and Scrutiny Committee[1] at the end of 2010 as a result of a proposal submitted originally in 2007 by Members Mrs Trudy Dean and Mr George Koowaree.

1.2.2 In the intervening period a National Dementia Strategy was established and Members wished to scrutinise local progress on its implementation, particularly in light of the impact of demographic changes in Kent, concerns expressed by constituents and increased media interest.

1.3 Definitions of Dementia

1.3.1 *"The term 'dementia' is used to describe the symptoms that occur when the brain is affected by specific diseases and conditions. Symptoms of dementia include loss of memory, confusion and problems with speech and understanding"*[2]*.*

1.3.2 The National Dementia Strategy: Living Well with Dementia defines it thus:

"Dementia is used to describe a syndrome which may be caused by a number of illnesses in which there is progressive decline in multiple areas of function, including decline in memory, reasoning, communication skills and the ability to carry out daily activities. Alongside this decline, individuals may develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering, which cause problems in themselves, which complicate care, and which can occur at any stage of the illness".

1.3.3 Defined by a former carer: "*Dementia is a change to a new stage in life. It is not the end of life*."

1.3.4 The most common causes of dementia are given on page 15.

1.3.5 Though the presentation and course of different types of dementia varies, the common characteristics noted above become more pronounced over time and the condition is degenerative.

1.3.6 Current care approaches focus on extending the period during which people can live well with dementia, supported within their communities or in residential care settings.

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[1] now succeeded by the Adult Social Care and Public Health Policy Overview and Scrutiny Committee.
[2] Alzheimer's Society Online at:
http://alzheimers.org.uk/site/scripts/documents_info.php?documentID=161

1.4 Terms of Reference

1.4.1 To examine issues around the '9 Steps' of 'Quality Outcomes' for people with dementia and their carers in Kent[3].

The 9 Steps Draft synthesis of outcomes desired by people with dementia and their carers: By 2014, all people living with dementia in England should be able to say:

- I was diagnosed early
- I understand, so I make good decisions and provide for future decision making
- I get the treatment and support which are best for my dementia, and my life
- Those around me and looking after me are well supported
- I am treated with dignity and respect
- I know what I can do to help myself and who else can help me
- I can enjoy life
- I feel part of a community and I'm inspired to give something back
- I am confident my end of life wishes will be respected. I can expect a good death.

1.4.2 To identify good practice and innovation in Kent and elsewhere, that could contribute to achievement of the '9 steps'.

1.4.3 To identify factors militating against achievement of the '9 steps' and make recommendations for improvements.

1.5 Scope of the review

1.5.1 The original draft scope included aspects noted on the next page and those considered to be of most concern to people living with dementia and carers who participated in the review were given greater focus, and hence feature more prominently in this report.

[3] Department of Health (2010)

- Stigma
- Awareness-raising among professionals
- Inclusiveness of training, care and support
- Early diagnosis
- Post-diagnosis support
- Carers
- Technology
- Information, advice and signposting
- Decision-making
- Personalisation
- Person-centred care

1.6 Exclusions

1.6.1 It was decided at the outset to exclude End of Life Care from the scope, other than from the perspective of decision-making since this aspect of care is not exclusive to dementia and could benefit from investigation by a separate, full and focused select committee review.

1.7 Evidence gathering

1.7.1 A list of the witnesses who submitted written evidence is given at Appendix 2 along with the names of professionals who attended one or in some cases two Focus Group meetings to assist the Select Committee prior to decisions about Terms of Reference and Recommendations. A list of witnesses attending hearings is at Appendix 3; details of training and visits carried out as part of the review are given at Appendix 4 and feedback summaries from consultation events on 11th and 15th April are given at Appendix 5.

1.8 Key findings

1.8.1 Early diagnosis of dementia is important for a number of reasons. Importantly, it enables the person who is affected to make sense of cognitive or other difficulties they have been experiencing; it enables them to obtain treatment if appropriate for their type of dementia and it is often the means by which they are able to link in to vital sources of local information and support. Being diagnosed early on also buys time for people to discuss and make clear their wishes about the future and to make arrangements for living their life well.

"It makes such a difference if people make their wishes known when they are able to do so and not when they are in a crisis situation."

1.8.2 Dementia is a condition which is more common in older people and relatively few people under 65 are affected. However, people with learning disabilities (and in particular Down's Syndrome) are living longer and in their 50s and 60s are more likely to develop a dementia than other people of the same age. Due to the relative rarity of younger onset dementia, suitable services and support have been slow to develop in Kent, with the exception of some voluntary sector provision, and as a result the needs of this group are not currently being met.

"If twelve months ago someone had asked me what thoughts came to mind when dementia or Alzheimer's were mentioned I would have described an elderly person who was either being cared for in their own home by a devoted family member or in a residential or nursing home. Since then I have experienced first-hand how mis-informed this view is."

1.8.3 The assessment and diagnosis of people with dementia at Memory Clinics (as directed by NICE guidelines) may not always be the most supportive option e.g. for frail elderly people. There are also gaps in support post diagnosis due to poor communication and a lack of formal shared care arrangements between GPs and specialists. People with dementia who go into hospital may have their medication discontinued because it is not on GP lists. Assessment and diagnosis closer to home could contribute to reduced stigma; improve the rates of diagnosis overall and improve outcomes for more people with dementia and their carers.

"Mum had a fall and fractured her hip. She went into the William Harvey Hospital. The staff ignored me when I tried to speak to them about her dementia medication. Her GP hadn't recorded it so the hospital thought that she wasn't on any medication. We found it hard to get information when she was in hospital."

1.8.4 The stigma associated with dementia is steadily reducing as people become more aware of the condition. It is important to keep up the momentum that has built up in awareness-raising. Reducing stigma will ensure that people with dementia are treated with dignity and respect in their communities. It will also mean they are less afraid to seek support and help. Some Black and Minority Ethnic (BME) communities need a different approach to ensure that stigma is addressed and families are not left isolated and unsupported. Ensuring that young people have a good understanding of dementia could reduce the level of stigma people will experience in the future; help to build compassion in communities and contribute to a more caring and empathetic workforce in the future.

"Image is everything. Minority Groups need to be confident that when they raise issues they will be heard."

1.8.5 Public health messages have an important role to play in persuading people to adopt healthier lifestyles that could reduce the chances of their developing a dementia in the future. The national programme of Health Checks, as it is established in Kent, could reinforce messages about healthy lifestyles and help to identify people at risk of a dementia in future. It could also help to identify people at the early stages of dementia and link them to appropriate treatment and support earlier than is currently achieved in Kent.

"We are at the tipping point of public awareness".

1.8.6 Voluntary Sector organisations provide invaluable specialised support for people with dementia and their carers and this will become increasingly important as fewer in-house (council provided services) are available. There is currently an uneven distribution of services across the county and commissioners of health and social care services for dementia will have an important role in ensuring everyone in Kent who has a dementia can access support locally.

"We are looking at the possibilities of new groups as some have become so popular that they are outgrowing their venues. At our newest group for those with Younger Onset Dementia last evening we had nine couples including three new couples . . ."

1.8.7 Home care support is not currently set up in a way that acknowledges the particular problems and challenges faced by people with dementia, whether or not they have a diagnosis. The level of dementia awareness and training of the care workforce needs to be raised overall and in order to achieve this, the Select Committee proposes that KCC assessment and enablement workers should have a higher level of dementia training. Furthermore, dementia training should be a requirement in contractual arrangements with providers. The Select Committee believes that provision of specialist as opposed to generic services is not, in itself, a solution but an increase in the availability of highly specialised voluntary sector dementia support in Kent will ensure that more people purchasing services can choose the level of support that they need. It could also enable different models of homecare provision (e.g. combining personal budgets at local level) to be tested.

"We often find carers deciding it is easier to struggle on coping alone rather than put up with different and often poorly trained workers coming into the home."

1.8.8 Residential care services, whether specialised to dementia or generic can improve the lives of people with dementia, firstly, if the living environment incorporates physical design features in line with current best practice and secondly if well-trained staff can ensure there are meaningful activities and positive interactions for people, helping to retain skills and pursue interests, faiths and important relationships.

1.8.9 Carers for people with dementia play an important role which needs to be better recognised and acknowledged. If people with dementia are expected to live well and safely at home, carers too must be well supported. Carers for people with dementia need respite appropriate to their needs; and ready access to the information they need to help them in their caring role. The important relationship between the carer and cared for person must be protected and supported. Carers must also be able to enjoy their own lives. Carer support organisations would welcome a '9 Steps for Carers' which acknowledges the crucial role that carers play in supporting people living with dementia. Carers across the county are now able to access comprehensive 'Confidently Caring' training to support them in their role.

"What happens when a carer gets ill – carers neglect themselves and miss even flu jabs as they have no-one to help."

1.8.10 The dementia care pathway in the future should be one which acknowledges the high level of social care needs that the condition demands. The particular health needs of people with dementia must be met in whichever setting they are living. The available funding should be identified and directed towards preventative (early intervention) services so that people with dementia and their carers can access a range of support to improve health and wellbeing. This should include positive and educational activities; social support, including memory cafes and peer support; advocacy services; crisis and emergency support and planned respite.

"It is only because we can see his house, coupled with the technology we now use, that he is able to remain in the home he has lived in for 55 years."

"The Dementia Advocacy team were a godsend. To have an independent person to represent D's needs and rights was a huge relief, and made me feel less of a lone (and emotionally involved) voice."

1.8.11 Professionals in health and social care fields must be made more aware of dementia, its effects on people with the condition and their carers and the support that is available. Professionals must ensure they integrate their planning and their records as well as their day to day working so that people with dementia and carers are better supported. The Health and Wellbeing Board can play an important role, ensuring that this integrated working takes place at all levels. A range of professionals from different sectors including Kent Police can also contribute to better safeguarding for people with dementia and their carers.

"None of the services are not doing their job but what they are not doing is doing it together."

1.8.12 People with dementia, their carers and former carers can play a vital role in directing the development of services and support including through Local HealthWatch and potentially through membership of any dementia advisory group set up in relation to the Health and Wellbeing Board.

'Co-production is an idea whose time has come. The idea, put simply, is that people's needs are better met when they are involved in an equal and reciprocal relationship with professionals and others, working together to get things done.'

1.8.13 There is an increasing body of research and knowledge about dementia. Dementia service commissioners and providers have the opportunity to work with academic colleagues to develop new services and test models of service provision developed with and by people with dementia and their carers. This will ensure that future services and support are better tailored to meet their needs.

1.9 RECOMMENDATIONS[4]

DEMENTIA IN KENT

R1
That a business case is developed in Kent for shared care prescribing arrangements for dementia medication and that GPs are encouraged to be more proactive in reviewing all people diagnosed with dementia, regardless of whether dementia medication is indicated. (p50)

R2
That in disposing of KCC buildings, the options for Community Asset Transfer are proactively explored to maximise the opportunity for voluntary sector dementia respite and day services. (p54)

R3
That KCC seeks to work with Dementia UK and relevant health organisations including GP practices in Kent to explore ways of widening access to the Admiral Nursing Service in Kent so that more people with dementia and their carers have access to a named, specialist contact. (p57)

SUPPORTING EARLY DIAGNOSIS BY RAISING AWARENESS AND REDUCING STIGMA

R4
That, to improve the rates of early diagnosis of dementia in Kent, KCC:

- works with colleagues in Public Health, the Voluntary Sector, community and faith groups to raise awareness (and dispel stigma) about dementia in the general population and among particular cultural groups, encouraging the use of positive and inclusive language and images in communications about dementia.
- works with the Alzheimer's Society to develop a '10 signs of dementia' poster (which distinguishes between signs of concern and normal signs of ageing).
- considers whether media/publicity could help to raise awareness about dementia, such as:

[4] Page numbers refer to main report

Memory problems that interfere with daily life?
Inability to plan and solve problems?
New problems with speaking or writing?
Difficulty completing familiar tasks?
See your doctor and discuss ways to get advice, information and support

- presses for the inclusion of an appropriate dementia screening tool in the NHS Health Checks programme in Kent (and adherence to relevant NICE guidance). (p79)

R5
That, to ensure young people have a good understanding of dementia, KCC:

- ensures libraries in Kent have books which explain dementia to children of different ages and encourages schools to do so

- seeks to fund a youth project to create a DVD, raising awareness about dementia and encouraging inter-generational support, which could be shown in Kent schools. (p82)

SUPPORTING CARERS AND CARING RELATIONSHIPS

R6
That KCC acknowledges and highlights the perspective of carers (and former carers) for people with dementia in a '9 steps for dementia carers' for inclusion in the next Kent Carers' Annual Report. (p85)

R7
That KCC encourages the commissioning of a variety of early intervention measures in order to reduce avoidable, inappropriate and expensive hospital admissions for people with dementia, to improve the quality of life and outcomes for a greater number of people with dementia and carers and that commissioning should include:

- Implementation of a pilot Shared Lives scheme for people with dementia, in co-operation with PSSRU Kent University, which develops the current Adult Placement Scheme and explores whether the management of personal budgets by voluntary sector service providers could help to provide more person-centred respite, for example, for people in rural areas, using the Shared Lives Model.

- Independent advocacy services for people with dementia in East and West Kent.

R8
That KCC seeks to promote greater awareness of Lasting Powers of Attorney (LPA) and considers whether a service could be offered by KCC Legal Services in this regard and that KCC supports the work of the British Banking Association to improve training for staff on LPA in order to minimise stress experienced by carers for people with dementia in organising finances. (p97)

R9
That KCC works with Kent Police and relevant health organisations in order to ensure that there is proactive support for and appropriate responses to carers who may be experiencing domestic violence as a result of dementia-related aggression in a loved one. (p101)

R10
That KCC extends the successful Telecare pilot work by evaluating how different types of assistive technology can support people with dementia to live safely and securely at home and in particular to assist with 'safer walking'. (p104)

INFORMATION AND SIGNPOSTING

R11
That KCC ensures that people living with dementia and their carers have access to good quality, well maintained information on local services and support in Kent and in their local area and that:

- printable, district level information is made available through links on DementiaWeb.

- KCC works with relevant health organisations and partners in the voluntary sector to ensure that this standard information 'set' is known to/made available through local authority offices, Gateways, Citizens Advice Bureaux, dementia and carer support organisations and in particular GP surgeries.

- as well as signposting to local groups offering dementia support, DementiaWeb should provide information about Adult Education opportunities and details of the Health Referral Scheme (50% discount on courses), and Library services for people with dementia.

- there is a consistent approach to the provision of information and signposting by KCC in response to enquiries regarding people with dementia who are self-funded, ensuring that all enquirers are made aware of DementiaWeb and the local information guides. (p111)

R12
That KCC and Health Commissioners should ensure that every Kent district or borough has at least one memory cafe as well as peer support for people with dementia. That KCC should promote the grass roots development of a network of memory cafes and peer support by engaging local groups such as Rotary, U3A, Older Person's forums, Carer Support Groups and Neighbourhood Watch; encouraging them to apply for funding through Members' Community Grants. (p115)

DEMENTIA CARE PATHWAY – FUTURE STRATEGY FOR KENT

R13
That in establishing and developing the 'core offer' of services and support for people with dementia and their carers, KCC and NHS Dementia Service Commissioners build on existing links with the academic sector (particularly the Dementia Services Development Centre at Canterbury Christ Church University and PSSRU at the University of Kent) to maximise research opportunities and ensure that the development of the dementia care pathway in Kent is informed by evidence and best practice. (p120)

R14
That, given the high proportion of undiagnosed dementia in Kent, '2nd level' training in dementia should be compulsory for all KCC assessment and enablement workers; basic dementia awareness training should be strongly encouraged for other KCC staff engaged in dementia support work and a requirement for an appropriate level of dementia training should be reflected in contractual arrangements with providers. (p121)

R15
That KCC (through the Health and Wellbeing Board, where appropriate):

- encourages GP practices to invite voluntary sector dementia support organisations to protected learning sessions to raise awareness among clinical and non-clinical staff about dementia and the local support available for people with memory problems.
- focuses on maximising KCC's role in the training and development of the social care workforce to ensure that safety and quality of care for people living with dementia are given the highest priority.
- encourages the commissioning of joint education and training for health and social care professionals including General Practitioners, on dementia, to support integrated working in the future.

- encourages greater awareness among hospital staff in Kent about when to engage with liaison nurses to minimise admissions, reduce lengths of stay, ensure dignified care and speed up discharges to appropriate locations for people with dementia in order minimise distress and contribute to cost savings.
- encourages relevant health organisations, including GP practices and partners in the voluntary sector to identify opportunities for pooled health and social care funding of community based care co-ordinators (see recommendation 2) and that personalised multi-agency care plans can be readily accessed by professionals providing care and support to people with dementia at home and during transitions of care.
- Identifies as a matter of urgency the approximate current spend on dementia by all agencies and models the change in spend between providers as diagnosis rates improve, the social care model is implemented and there is a change in use of acute services. This will provide a benchmark for the development of services and a context for assessing the value both in cost and quality of provision of pooled budgets and preventative services. (p128/9)

R16
That KCC considers whether a separate Kent & Medway strategy for Younger Onset Dementia is required to ensure that the needs of this group are met and that any future dementia strategy or plan:

- takes account of the particular circumstances experienced by a younger age-group and the development of appropriate services and support based on evidence and best practice
- includes an assessment of the likely impact of increased numbers of people with learning disabilities having dementia in the future
- is proactive in mapping where support and services will be needed. (p130)

R17
That people living with dementia and their carers are enabled to play a central role in encouraging integrated services and deciding how best to support people with dementia and their carers in Kent including through HealthWatch and its links to the Health and Wellbeing Board and the GP commissioning bodies. (p132)

"… by taking part in things like this to raise awareness, it gives me a purpose in life. It makes me feel like I am doing something worthwhile and helping others in my situation while I still can. Thank you for listening."

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Improving Outcomes for People with Dementia in East Kent

1. Introduction and purpose of this report

This paper provides an update on the proposals to improve outcomes for people with dementia presented to the Kent Health Overview and Scrutiny Committee (HOSC) in November 2011 and, more specifically:

a) Outlines the progress made in delivering improved outcomes for people with dementia in east Kent.

b) Provides Members with details of options for inpatient care which will be presented as part of a formal public consultation to reconfigure services. This involves reducing the overall number of acute beds for older people, improving the environment and consolidating staff skills and expertise to ensure flexible care is provided which meets the changing needs of patients' and improves their overall experience of services provided by the Kent and Medway Partnership Trust (KMPT).

The aim is to ensure high quality environments which use a therapeutic approach to help people with dementia to maintain their independence and reduce the reliance on the use of medication, such as anti psychotic drugs.

This redesign process is one element of an overall redesign of mental health services for older people and a similar process is being undertaken in Medway.

A separate redesign of mental health services for working age adults and functional mental health services is also being developed. This will be presented to Kent HOSC Members separately and will cover services commissioned across both Kent and Medway. It is this element of service redesign which will require a Joint Overview and Scrutiny Committee (JOSC).

The proposals for people with dementia cover east Kent only. A similar process was undertaken in 2009/10 in west Kent to enhance community support and to reduce and consolidate inpatient provision.

2. Update on service reconfiguration proposals outlined in November 2011 HOSC report

The aim of this redesign process is to improve the outcomes of people with dementia**.** Familiar environment, familiar carers and established daily routines are critical in supporting a person with dementia to keep their independence and to help them to be happy and free from stress or anxiety. Hospital wards in particular are busy clinical environments with lots of different people and set ward routines and procedures. Removing someone with dementia from their familiar environment, whether this is their home or a care home, very often increases their confusion and their levels of anxiety both of which have a direct effect on their wellbeing and their recovery. People with dementia are also much more likely to be discharged to a care home following a hospital admission.

Approximately two thirds of people with dementia live in the community, with or without a carer and one third live in care homes. In the survey, "Support, Stay, Save" (Alzheimer's Society, 2011), 83% of carers and people with dementia said that being able to live in their own home was very important to the person with dementia.

This was also the finding of the National Dementia Strategy,(Department of Health, 2009) which found that most family carers want to be able to provide support to help the person with dementia to remain in their own home, but sometimes need additional help and support themselves.

The proposals are intended to shift the focus of provision from acute mental health beds to community services by:

- Reducing inpatient capacity from 76 to 45 beds.
- Increasing the capacity of the Home Treatment Service for Dementia by 14%.
- Introduction of a dementia crisis service which will be available 24/7.

Inpatient redesign. The Home Treatment service has already had an impact on inpatient services. The older adults' service has maintained a number of inpatient vacancies over the last 12 months. Between July to October 2011, vacancy rates were between 9.6% to 15% of the total bed stock of 76 beds. To make more effective use of staff and enhance the staffing levels, these vacancies have been consolidated on the St Martin's site. This means one of the least suitable wards is now empty. The wards on the St Martin's site are located within a Victorian building with a temporary structure attached. The planning permission for the temporary structure expires in 2013. It is proposed to make this closure permanent.

The current number and location of beds in use is given in the table below.

Cranmer Ward, St Martin's, Canterbury	Arundel Unit, WHH, Ashford	Thanet Mental Health Unit, QEQM, Margate
15 beds	20 beds	26 beds

Table 1

Home Treatment Service (HTS). This service provides specialist mental health intensive care for people with dementia and their carers when the care situation is breaking down or to support timely discharge from acute mental health inpatient services to the most enabling care environment. Overall the services improve the quality of living for the service users, their family and paid carers. The proposal is to revise service eligibility criteria to enable urgent and emergency referrals to be responded to by a local HTS which will enable them to provide follow up support where the crisis service has been called out. The service will also provide improved and targeted support for residential and nursing care home providers.

The revised specification has been developed and performance indicators to measure the delivery of outcomes are being finalised The Kent and Medway Partnership Trust (KMPT) is in the process of recruiting to the new posts. It is anticipated that the extended service will be in place by 1 May 2012.

Crisis Service. This service will be available 24/7 for people with dementia and their carers and will support home treatment and therefore avoidance of inappropriate hospital admission. This will be modelled on the service already provided in west Kent which provides support to people with dementia and their carers. The service is provided by three domiciliary care agencies, with support from statutory services. The service provides support to service users and carers where an emergency response is needed, which could be to the service user or to the carer where the caring situation has broken down.

The first year of the west Kent service has been evaluated and has indicated that it has prevented 25 admissions to acute trusts and prevented 44 admissions to mental health beds. It also prevented a number of admissions to care homes. It has also supported a number of carers and prevented a breakdown in the caring situation.

A joint procurement process led by Kent County Council (KCC) has commenced for this service. The funding will be transferred to KCC via a section 256 agreement. The section 256 will clearly set out what outcomes are required and the performance indicators that will be used to determine if outcomes have been achieved. These will be based on best practice and evidence from the west of the county. A provider forum was held in December 2011 where potential providers of the service were invited to find out more about the proposed service and tendering process. This was well attended by a range of providers, so it is anticipated that there will be a good response to the tendering process.

Both the HTS and the crisis service will initially be funded from non-recurrent monies, The services are being established in advance of the bed closures to support the transition from inpatient to community services. Recurrent funding will be made available from the savings realised from the reduction in acute beds.

Case Studies

Home Treatment Service Case Study

Kathryn Davis believes it is thanks to the home treatment team that her mother Gwen was able to remain independent in her home for an extra year. Gwen Davis, 87, who served in the land army during the Second World War, was diagnosed with vascular dementia two years ago.

Kathryn, 48, said, “She was fiercely independent and had lived on her own since my dad died in 1997. It was at a goodbye party for my sister, who was going to live in Australia, that we first noticed she was acting differently. I remember her putting a strange combination of food on her plate, mixing chocolate and salad, and behaving oddly. At first, we dismissed it. To be honest, we just thought she’d had a bit too much to drink.”

Gwen’s mother had dementia, but she had always refused to talk about it, so alarm bells didn’t start to ring for Kathryn until things got worse. “She used to play chess and loved flower arranging, but just started to lose interest. She had my phone number in her purse. I started to get calls from people saying they had found her sitting on the pavement in the village.”

Gwen’s GP, Dr Thaker, diagnosed her with vascular dementia and prescribed her aricept to slow down the disease.

Kathryn said, “There was a small improvement at first but then she started to go down hill. Her personality started to change. She was really sharp with me, and became rude and irritable. She kept falling out with her friends.” Kathryn, who works full time, and her daughter Emily, 16, decided to draw on the support of a local care agency. “My mum would refuse to stay in when the carers came to visit, sometimes she wouldn’t even let them in. I couldn’t be there at the end of the day to make sure she was eating the food they left. She stopped looking after herself and wouldn’t change her blouse or clothes and was forgetting to wash. In the end she became very dehydrated.”

The Home Treatment team was called in to see if they could help. “They were amazing, they had such a great softly, softly approach, which worked. They quickly figured out what made situations escalate and what worked. For example, she’s of a strip wash generation which was much better, and they would lay her clothes out for her to put on. It was more about suggesting things to her. I definitely think they prevented her from going into hospital.”

In September, after a number of falls, Kathryn decided it was safer that Gwen moved to a care home, and chose Elliott House, in Reculver. “The Home Treatment team helped us with getting mum to understand and helped with the transition. It was a difficult decision but I was comforted by the fact we had been able to give her that extra year in her own home.”

West Kent Crisis Service Case Study

A referral was made to the crisis service from Social Services Duty Team on 9th February 2012 to respond to an emergency situation. Mr P who cared for his wife with dementia had been taken to hospital following a fall which resulted in a head injury. Mr P was admitted to the acute trust. Mrs P who has significant cognitive impairment and confusion was being cared for at home by a friend. The dementia crisis team responded immediately and relieved the friend. Mrs P was unable to remain safely at home without continuous support. The dementia crisis team provided round the clock support until Mr P was discharged from hospital the following day.

The dementia crisis service prevented Mrs P from being admitted to an emergency hospital bed or to a temporary care home placement. Mr P was able to be discharged from the hospital with crisis support allowing an earlier discharge.

3. Improving the overall quality of care

It has long been recognised that extended periods of inpatient care have a detrimental impact on patients’ long term capacity. Therefore timely treatment and discharge to familiar environments are vital to prevent institutionalisation. Familiar environment, familiar carers and established daily routines are critical in supporting a person with dementia to keep their independence and to help them to be happy and free from stress or anxiety.

KMPT have a target average length of stay of 49 days and a target occupancy rate of 85-90%. Occupancy rate is within target (87.8% in December 2011), but average length of stay is consistently over target. This is usually a result of a small number of patients with an excessive length of stay which impacts on the average.

In order to validate the proposed number of beds, a number of scenarios have been created. These were developed using data provided by KMPT for the older people's mental health beds for the period August 2010 – July 2011. The data was used to create various scenarios, ie

- Occupancy rates with a maximum length of stay of 42 days with 45 beds.
- Occupancy rates with a maximum length of stay of 42 days with 61 beds.
- Occupancy rates with a maximum length of stay of 49 days with 45 beds.
- Occupancy rates with a maximum length of stay of 49 days with 61 beds.

It was also assumed that anyone with a length of stay of less than seven days would be supported in the community in the future with additional community support.

The length of stay of 42 days has been utilised as it mirrors a similar piece of work which was undertaken in Medway.

The scenarios show that with a bed stock of 45 beds it would be possible to manage the current volume of admissions over 7 days of duration if the average length of stay was reduced to 42 days. It also shows that there is capacity to manage for most of the year should the length of stay be nearer to 49 days average.

The information provided by KMPT also showed a significant number of admissions came from care homes and had a longer length of stay when compared to people admitted from their own homes. This is shown in the table below.

	Care Home Residents		**Non Care Home Residents**	
Length of Stay	**Number**	**%**	**Number**	%
<7	14	4.3	15	4.6
7-12	17	5.2	33	10.2
22-42	30	9.2	39	12.0
42-60	29	8.9	27	8.3
60+	78	24.0	43	13.2

Table 2

The Home Treatment Service helps to facilitate individual discharges to care homes and also supports care homes to manage individuals who develop challenging behaviours. Part of their enhanced role will be to provide support and training to care homes in a more systematic way to enable care homes to appropriately manage these more challenging patients and reduce the need for a hospital admission. It is therefore expected that there will be a decrease in admissions from care homes and a reduced length of stay following admission.

The additional community capacity was also calculated and this has resulted in the conclusion that the reduced bed capacity will be sufficient to meet demand in east Kent, providing the additional capacity of and investment in the Home Treatment Service and the Crisis Response service is sustained.

4. Increasing prevalence of older people with dementia.

Dementia is one of the main long term conditions of later life and it has a huge impact on capacity for independent living. Dementia is estimated to cost £17 billion per year in the United Kingdom and it is predicted that there will be a doubling, possibly trebling of the number of people who have dementia in the UK.

The risk of developing dementia doubles every five years, with a 65 year old having a 1.3 % chance of having dementia and a 95 year old having 32.5% chance. In east Kent the highest levels of dementia can be seen in the 85 plus age range.

The table below provides the estimated numbers of dementia patients in Kent between 2006 and 2026 by Local Authority District in east Kent.

	2006		2026	
	Est. number	Est. prev	Est. number	Est. prev
Kent	**17,400**	**1.3%**	**30,100**	**1.9%**
Ashford	1,300	1.2%	2,500	1.6%
Canterbury	2,100	1.4%	2,900	1.9%
Dover	900	1.0%	1,700	1.3%
Shepway	1,500	1.5%	2,600	2.5%
Swale	1,400	1.1%	2,600	1.8%
Thanet	2,100	1.6%	3,000	2.2%
NHS Eastern and Coastal	**9,200**	**1.3%**	**15,300**	**1.9%**

Source: Dementia UK prevalence estimates applied to South East Plan Strategy-based forecasts (July 2010), Research & Intelligence, Kent County Council.

Due to projected changes in the age structure of the population, the local authorities expected to experience the greatest increases in the prevalence of dementia are Shepway and Swale.

This increasing demand is seen in the context of a health and social care community which is seeing its resources increasingly under pressure. It is therefore essential to identify opportunities to redesign services to improve quality outcomes for individuals by lengthening the time people maintain their independence, so delaying and reducing the need for health and social care intervention.

This will be achieved by the following developments:

- **Memory Assessment.** Currently, KMPT provide all memory assessment clinics across Kent and Medway. However, the prospect of managing increasing demand within existing resources means that new ways of working need to be identified. It is therefore proposed to work with KMPT and Clinical Commissioning Groups (CCGs) to agree how primary care may be able to diagnose and manage people with dementia in primary care.

- **Improve awareness and diagnosis of dementia in an acute hospital setting.** A significant number of older people admitted to acute hospitals have dementia or some level of cognitive impairment. This fact, plus the recent reports on the quality of care received by some older people in acute hospitals, has resulted in this area being made a priority in the Operating Framework for 2012/13. Liaison psychiatry services have a key role in helping to support acute hospital staff in the management of people with dementia. This service is already in place in east Kent and is being implemented in Medway and plans are being developed to implement this service in west Kent.

  Co-production. This is a process where communities are engaged with and asked about what the issues are for them in relation to the delivery of services for dementia. It is intended to act as a two way dialogue with people as active contributors towards the design, delivery and review of public services. This work is being led by Kent County Council's (KCC) Social Innovation Lab, Kent (SILK) and some work has already been undertaken which has identified a number of themes which will be useful in helping to design future dementia services.

- **Peer support groups and dementia cafés.** A tendering process in currently in progress to establish peer support groups and dementia cafés across Kent. Peer support groups are aimed at people who in the early stages of dementia and allows them to receive help and support. Dementia cafés are aimed at people with dementia and their carers.

These developments also need to considered alongside other workstreams, e.g.

- Proposed intermediate care review.
- Enhanced support to care homes,
- Health and social care integration programme.
- Co-ordination of care for end of life.

5. Developing the options for a reconfigured inpatient service

In order to develop the options for the public consultation a full options appraisal was undertaken. It was commissioned from an independent consultant who specialises in NHS option appraisals and it followed a tried and tested process of rigorous appraisal.

The full options appraisal is made up of three elements:

- Non financial appraisal.
- Economic and financial appraisal.
- Risk analysis.

The results of the three appraisals have been combined to determine which options should be taken forward to consultation. The full report is attached (annex 1).

Non Financial Appraisal

In order to develop the options to be included in the consultation process, a non financial appraisal workshop was organised in December 2011 which was facilitated

by an external consultant using a well recognised process. The workshop was attended by a range of stakeholders and the list of participants can be found at Appendix A of the attached report.

The objectives of the workshop were to:

- Ensure there was an understanding of the options to be evaluated.
- Rank the evaluation criteria in order of importance.
- Weight the criteria.
- Score the options against each criterion to reflect how well the option performed.
- Agree any sensitivity tests where alternative markings, weights and scorings were considered important.
- Review the overall outcome to ensure the results accurately reflected the views of the participants.

A draft list of eight options was presented to the workshop participants for discussion with the objective of deriving a short list for further assurance and evaluation. The options were based on national and local best practice and were worked up over a number of months by clinicians and mangers, with input from commissioners and service users and carers.

Benefits Criteria

The options were assessed against a list of high level criteria with sub definitions which were agreed with the workshop participants. The high level criteria are given below and the sub definitions are detailed in annex 1.

- Clinical quality and integration.
- Access.
- Sustainability and flexibility.
- Operational and environmental suitability.
- Efficiency.
- Staff recruitment, training and development.

The criteria were then ranked by the workshop participants in order of importance and weighted. The full process is described in the attached report.

The Options

The outcome of the non financial appraisal indicated that three of the seven options evaluated performed consistently better than the other options and these are summarised below.

	Canterbury	Thanet MHU	Ashford
Option 1	One ward. 15 beds	One ward. 15 beds	One ward. 15 beds
Option 5	One ward. 15 beds	Two 15 bedded wards	
Option 6		Three 15 bedded wards.	

Table 3

The Kent and Medway Partnership Trust estate in the west has been largely purpose built and the therapeutic environments have been developed to offer personal accommodation and bathrooms, shared living space such as lounge rooms, dining rooms, and activity areas, as well as quiet rooms and walking space together with safe outdoor areas. It is understood that the trust is looking at a phased capital investment programme to improve the living environments for older people's services over the next three years. Their ambition is to provide flexible, environments which can offer a high quality of care.

Economic and Financial Appraisal

The options which were subjected to the economic and financial appraisal and risk analysis were the four highest scoring options from the non financial appraisal, plus the 'do nothing' option which was used as a benchmark. These are the options outlined in table 1 above, plus the fourth scoring option (option 4) and option 8 (the 'do nothing' option) in table 4 below.

	Canterbury	Thanet MHU (Woodchurch)	Thanet MHU (Sevenscore)	Ashford (Winslow)
Option 4 Separate Functions Mixed Gender	Organic		Functional	Functional
Option 8 Do nothing	Functional	Functional	Organic	Mixed Organic and Functional

Table 4

The financial appraisal deals with both the capital and revenue cost of each of the options. The capital costs are broadly similar across all the options.

The centralisation of all services in Thanet in option 6 indicates the greatest yield of revenue savings, whereas the other three options are within a closer banding of savings. However, the actual savings to be achieved will be dependent on the final option, following public consultation.

The economic analysis shows that option 6 has the lowest equivalent annual cost and demonstrates the lowest economic cost out of all of the options. This arises from the service being provided from one site with the savings in associated running costs and more efficient staffing costs.

Risk Analysis

A qualitative risk assessment of the short listed options was undertaken and the approach adopted involved firstly identifying potential risk areas such as operational, finance and project risk. Each of the options was scored against each risk on two counts:-

- impact of risk on the service should it occur; and
- the likelihood of the risk occurring.

The risk assessment of the options indicates that option 5, has the lowest level of risk overall. This is due to a number of factors but more notably the fact that this option operates from two sites rather than three, has one site co-located with an acute hospital and would be regarded as reasonably accessible to patients, visitors and staff.

The 'do nothing options' came second which was due to the negligible risk associated with refurbishment and project management risks. If these risks were excluded from the overall score, it would be the highest level of risk overall.

Conclusion

The appraisal has assessed five options (the four highest scoring options from the non financial appraisal and the do nothing option) from which to select a minimum of three to include in the consultation process. Based on the full analysis, it is recommended that the 'do nothing' option should not be taken forward. It does not address the requirements of the new patient pathway nor does it deliver any revenue savings which is a key requirement so that the community based services can be expanded and sustained.

Of the remaining options the analysis indicates that options 1, 5 and 6 should be taken forward as the relative benefits of each varies depending on benefits delivered, costs and levels of risk. Given the relatively poor performance of option 4 compared with the other change options it is recommended that this option is not included in the consultation process. This has been accepted by the Boards of NHS Kent and Medway and Kent and Medway Social care Partnership NHS Trust so we propose to take only three options forward for wider consultation with staff, stakeholders and the public.

6. Engagement and Consultation

It is proposed to commence the formal consultation from the middle of March for a period of 13 weeks. This process will be conducted using a number of approaches which are outlined below. The communications and engagement strategy is attached (annex 2).

Clinical advocates and champions
KMPT and commissioners has a panel of both commissioners and providers including clinicians, who will listen to views and explain the improvements that are being planned at public events, in community forums, or by speaking with the media.

Public meetings and events
A small number of public meetings and events will be organised, tailored to best meet local circumstances and stakeholder expectations in terms of the number, location, format and content; supported by core materials and suitable spokespeople from the PCT and KMPT and other advocates. Recognising that this is a particularly vulnerable group of service users and that carers have pressures on their time, it is intended to visit those organisations or events in venues they know and feel comfortable using, to meet people within their local community and hear their views such as the dementia cafés, pensioner forums, carer events.

Public events will be extensively promoted through the media, targeted distribution of leaflets and posters, and through partner stakeholder channels and followed up through proactive media relations, in staff communications and in updates to stakeholders.

Media relations
Key media will be identified and briefed on the consultation before it launches. Following the consultation launch we will maintain a regular flow of proactive media stories to promote and report on consultation events. Existing media monitoring arrangements will be employed to keep abreast of any media coverage and to ensure that any inaccurate or adverse coverage is addressed immediately.

Consultation documentation
A full consultation document and a summary document will be produced. Documents and summaries will be clear, person centred and accessible following best practice in terms of plain English, font sizes and colour schemes. They will be made available in alternative formats and will offer advice in the most common community languages on how to receive more detail in other languages.

Websites
Detailed consultation materials (including reference material such as national policy frameworks, clinical evidence etc) will be hosted on KMPT and the relevant PCT's website, along with updates, latest information on events and opportunities to provide feedback and get involved. Both the PCT website and KMPT website will feature core information about the overarching plans, providing links to the other consultation materials and enabling partner organisations to flag the consultation on their website and provide enabling links.

Social media will be used to promote active engagement for those utilising different forms of virtual discussions: tweets, blogging, etc.

Response handling
A wide range of mechanisms to capture consultation responses (or the use of existing, where possible) in each PCT, including:
• Freepost address
• E-mail address
• Online response form

Informal Consultation and Approval Process

In advance of the start of the formal consultation process, the proposals have been presented to a number of groups and committees. Discussions have taken place with Clinical Commissioning Groups (CCGS) who have supported the proposals in principle.

Extensive discussions have also been undertaken with KMPT clinical staff who have been key in working up the future options. Service users and voluntary organisations were also involved in the options appraisal process.

7. Timetable

As indicated above, it is proposed to commence consultation from the middle of March 2012. An overview of the approval process is given below and a full timetable is attached (annex 3).

December 2011	Stakeholder option appraisal
January 2012	Finance and risk assessment Presentation to east Kent Commissioning Committee.
February 2012	Briefing MPs, SHA assurance meetings, report to Boards for approval
March 2012	HOSC presentation
March – June 2012	Consultation
July 2012	Analysis
September 2012	Board decision

Following the consultation all responses will be analysed and considered in conjunction with the full options appraisal. This process will result in a recommended option which will be presented to the relevant committees and Boards for approval, i.e.

- NHS Kent and Medway Board.
- KMPT Board.
- CCG Boards.

This will be undertaken before reporting back to the HOSC on the outcome.

8. Recommendation

The Committee is asked to note

a) The progress made in delivering improved outcomes for people with dementia in east Kent.

b) Note the recommendation to proceed to public consultation with options one, five and six.

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Remodelling the Acute Care Pathway for East Kent Older Adult Services

Option Appraisal

Kent & Medway NHS & Social Care Partnership Trust working in partnership with NHS Kent and Medway

Kent and Medway

Kent and Medway NHS and Social Care Partnership Trust

Document control sheet

Client	Kent & Medway NHS & Social Care Partnership Trust NHS Kent and Medway
Document Title	Remodelling the Acute Care Pathway for East Kent Older Adult Services Option Appraisal
Version	01
Status	Draft
Reference	
Author	Andrew Leeson
Date	16th February 2012

Document history			
Version	Date	Author	Comments
01	16 February 2012	Andrew Leeson	Draft version

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Glossary

Term	Explanation
Non-financial appraisal	A process where a set of options is appraised against a qualitative set of criteria. The process involves scoring the options against each criterion. The option with the highest score gives the best performance against the criteria compared with the other options considered
Benefits criteria	A set of criteria that reflect the benefits sought from options that could satisfy the service objectives of a proposed development.
Weighted criteria	A system to ensure that the more important criteria will have a greater effect on the overall scores on options. For example a criterion with a weighting of 20 will have greater effect on an option's score compared with one with a weighting of 10.
Raw score	The score allocated to an option based on how well the option performs against the relevant criterion. Raw scores are usually scored out of a maximum of ten.
Weighted scores	The raw score allocated to an option multiplied by the weight attached to the criterion. For example, a raw score of 7 against a criterion with a weighting of 20 will give weighted score of 140.
Pairwise comparisons	Pairwise comparison consists on selecting two criteria and deciding how much less important the second criterion is to the first criterion. For example, if the first criterion is assigned a weight of 100, and the second criterion is considered to be half important, then a weight of 50 is assigned to the second criterion. This process is repeated for each successive pair of criteria, until each has been weighted (i.e. the first and the second criteria, then the second and third, and so on). The weights of each criterion are then scaled so that they sum to 100.
Discounted Cash Flow (DCF)	A series of cash flows that have been subject to discounting.
Discounting	The economic technique used to reflect the time value of money. It is normally regarded that £1 in one year's time will be worth less than £1 today. This is not because of inflation, but because: people prefer to receive benefits sooner rather than later, there is uncertainty about future years, and because in later years it is assumed people will be better off, and so value an additional £1 less.
Net Present Cost (NPC)	The best recognised discounting technique, in which all future costs are discounted to their present costs. The total of the present costs is the net present cost.
Equivalent Annual Cost (EAC)	This is used to compare the costs of options with different life spans. The different life spans are accommodated by discounting the full cost and showing this as a constant annual sum over the lifespan of the investment.

Executive Summary

Introduction

1. NHS Kent and Medway in partnership with Kent and Medway NHS and Social Partnership Trust (KMPT) is looking to change the pattern of services provided to older adults with mental health issues (OPMH) in East Kent. The aim will be to provide early intervention and responsive care in a crisis which will reduce reliance on acute mental health beds in order that the OPMH in-patient facilities in East Kent can be reviewed and reconfigured. The reconfigured inpatient services will aim to provide high quality person centred care in appropriate environments which will treat individuals in a timely manner in order that people can return to their long term home setting as soon as the person is fit for discharge

2. As part of the service development exercise, the service has undertaken an option appraisal to assess the relevant merits of alternative in patient bed configurations on different sites in East Kent. The appraisal examined a set of short listed options that could deliver the objectives of older people's services and was in three parts:

   - A non-financial appraisal that assessed the benefits that could be delivered by each option against a set of weighted criteria;
   - An economic and financial appraisal that assessed the relative value for money and affordability of each option;
   - A risk assessment of the options to see which options performed better in terms of levels of risk to the health economy

3. The results of the three appraisals were then combined to determine which options should be taken forward to consultation.

Non-financial appraisal

4. A workshop was held on the 22nd December 2011, attended by key stakeholders in the service (see Appendix A) and facilitated by Hygeian Consulting. The appraisal assessed the following short listed options:

	Canterbury	TMHU (Woodchurch)	TMHU (Sevenscore)	Ashford (Winslow)
Option 1 Locality Configuration Mixed Gender Mixed Functions	Mixed Functional and Organic ward		Mixed Functional and Organic ward	Mixed Functional and Organic ward
Option 2 Separate Functions Single-sex	Organic		Functional male	Functional female
Option 3 Separate Functions Single-sex		Organic	Functional male	Functional female
Option 4				

	Canterbury	TMHU (Woodchurch)	TMHU (Sevenscore)	Ashford (Winslow)
Separate Functions Mixed Gender	Organic		Functional	Functional
Option 5 Locality Configuration Mixed Gender Mixed Functions	Mixed Functional and Organic ward	Mixed Functional and Organic ward	Mixed Functional and Organic ward	
Option 6 All wards at Thanet		mixed Functional and Organic	Sevenscore & Elmstone Mixed Functional and Organic	
Option 8 Do nothing	Cranmer – Functional	Functional	Organic	Mixed Organic and Functional

5. Option 7 was deleted from an initial long list that was discussed at the workshop as it was agreed unsuitable for taking forward for further analysis however the original option numbering was retained to maintain an audit trail.

6. The options were assessed using a ranked and weighted set of benefits criteria. The performance of each option against each criterion was assessed by allocating a score out of ten. The criteria weights then translated the raw score into a weighted score. The weighted scores for each option are summarised in the table below.

	Option						
Criterion	**1**	**2**	**3**	**4**	**5**	**6**	**8**
Clinical quality & Integration	141	66	69	79	116	112	102
Operational & Environmental Suitability	81	84	78	84	102	115	55
Staff Recruitment, training & development	107	76	63	83	93	97	68
Access	107	46	55	57	59	46	70
Efficiency	69	43	54	54	86	112	41
Sustainability & flexibility	63	44	42	49	63	69	44
TOTAL	**569**	**358**	**361**	**405**	**519**	**551**	**380**
Rank	**1**	**7**	**6**	**4**	**3**	**2**	**5**

7. The results show that the highest scoring option was option 1. Subsequent sensitivity tests confirmed that this option was relatively insensitive to changes in scoring or weightings.

8. The outcome of the non-financial appraisal indicated that three of the seven options evaluated performed consistently better than the other options – options 1, 5 and 6. It was also agreed that a non-mixed function option should also be taken forward and option 4 was selected for this purpose. It was therefore agreed that these options were taken forward to the financial/economic and risk analyses along with the Do Nothing option that would act as a baseline option.

9. For information these options are summarised below.

	Canterbury	TMHU (Woodchurch)	TMHU (Sevenscore)	Ashford (Winslow)
Option 1 Locality Configuration Mixed Gender Mixed Functions	Mixed Functional and Organic ward		Mixed Functional and Organic ward	Mixed Functional and Organic ward
Option 4 Separate Functions Mixed Gender	Organic		Functional	Functional
Option 5 Locality Configuration Mixed Gender Mixed Functions	Mixed Functional and Organic ward	Mixed Functional and Organic ward	Mixed Functional and Organic ward	
Option 6 All wards at Thanet		mixed Functional and Organic	Sevenscore & Elmstone Mixed Functional and Organic	
Option 8 Do nothing	Cranmer – Functional	Functional	Organic	Mixed Organic and Functional

Economic and financial appraisal

10. For the economic appraisal a discounted cash flow for each of the options was undertaken using a discount rate of 3.5% in line with the requirements of HM Treasury Green Book and Department of Health guidance. Both the Net Present Cost (NPC) and Equivalent Annual Cost (EAC) have been calculated. The EAC is particularly useful for comparison where the options have different life spans as it converts the NPC to an annual figure.

11. For the financial appraisal the affordability of the options were considered by examining staff and running costs of the facilities and the capital charges of any new build / refurbishment.

12. The savings that would be derived from each option are as follows:

£000	Option 1	Option 4	Option 5	Option 6	Do nothing
Pay Costs	4,507	4,507	4,424	4,237	5,880
Drugs and Pharmacy	138	138	131	126	161
Other non pay	204	204	204	231	271
Running costs (incl current depr / ROR))	3,491	3,491	3,199	1,684	3,731
Total pay and non pay	**8,340**	**8,340**	**7,958**	**6,278**	**10,043**
Capital charges new	529	529	523	560	-
Total costs before overheads	**8,869**	**8,869**	**8,481**	**6,838**	**10,043**
Directorate overheads	361	361	361	361	361
Contribution to central overheads	554	554	531	432	624
Total overheads	***915***	***915***	***892***	***793***	***985***
Total revenue costs	**9,784**	**9.784**	**9,373**	**7,631**	**11,028**
Saving from Do nothing	**1,244**	**1,244**	**1,655**	**3,398**	**-**

13. The table shows that option 6 delivers the highest level of savings by a clear margin followed by option 5 which is narrowly ahead of options 1 and 4.

14. The equivalent annual cost (EAC) of each option is shown in the table below.

£000	Option 1	Option 4	Option 5	Option 6	Do nothing
Equivalent Annual Costs	8,864	8,864	8,491	6,938	9,947
Rank	**3=**	**3=**	**2**	**1**	**5**

15. The table shows that Option 6 gives the lowest EAC with Option 5 in second place.

16. The risks assessment shows the following risk scores by risk category:

Risk Category	Option 1 – Canterbury, Thanet, Ashford – mixed function / gender	Option 4 – Canterbury, Thanet, Ashford – split function, mixed gender	Option 5 – Canterbury, Thanet (x2) – mixed function / gender	Option 6 – Thanet (x3) – mixed function / gender	Option 8 – Do nothing
Operational	51	53	48	54	69
Finance / commercial	66	70	48	42	56
Service / clinical	87	87	62	73	95
Refurb / equipment	48	46	46	50	42
Project	56	56	60	64	8
TOTAL	**308**	**312**	**264**	**283**	**270**
Rank	**4**	**5**	**1**	**3**	**2**

17. The number of red-rated risks incurred by each option is:

- Option 1: 2
- Option 4: 3
- Option 5: 1
- Option 6: 5
- Option 8: 8

18. This indicates that options 6 and 8 contains a number of risks that would be major in nature and would need careful monitoring.

Identification of the preferred option

19. A summary of the outcomes of each appraisal and ratios is shown below:

	Option 1	Option 4	Option 5	Option 6	Option 8
Benefit points	569	405	519	551	380
RANK	**1**	**4**	**3**	**2**	**5**
Capital Costs	7,903	7,903	7,815	8,354	0
RANK	**3=**	**3=**	**2**	**5**	**1**
Revenue costs	9,784	9,784	9,373	7,361	11,028
RANK	**3=**	**3=**	**2**	**1**	**5**
Economic Appraisal (NPC)	229,965	229,965	220,298	180,011	258,063
RANK	**3=**	**3=**	**2**	**1**	**5**
Capital cost per benefit point	13.89	19.51	15.06	15.16	0
RANK	**2**	**5**	**3**	**4**	**1**
Revenue cost per benefit point	17.2	24.2	18.1	13.4	29.0
RANK	**2**	**4**	**3**	**1**	**5**
Net present cost per benefit point	404.2	567.8	424.5	326.7	679.1
RANK	**2**	**4**	**3**	**1**	**5**
Risk Analysis - overall	308	312	264	283	270
Risk Analysis – number of high risks	2	3	1	5	8
RANK - score	**4**	**5**	**1**	**3**	**2**
RANK – high risks	**2**	**3**	**1**	**4**	**5**

Conclusion

20. This appraisal has assessed five options from which to select a minimum of three to put forward for consultation. Based on the analysis above it is clear that the Do nothing option should not be taken forward. In common with all option appraisals in the NHS it is used as a base line against which change options can be compared. It does not address the requirements of the new patient pathway and neither does it deliver any revenue savings which is a key requirement.

21. Of the remaining options the analysis indicates that options 1, 5 and 6 should be taken forward as the relative benefits of each varies depending on benefits delivered, costs and levels of risk. The consultation process should reveal which if these are regarded as more important and the level of any compromise that would be required in order to conclude on a preferred option. Given the relatively poor performance of option 4 compared with the other change options it may be appropriate not to take this forward unless it was believed that a split function option should be tested further within a consultation process.

1 Introduction

1.1 Background

1.1.1 NHS Kent and Medway in partnership with Kent and Medway NHS and Social Partnership Trust (KMPT) is looking to change the pattern of services provided to older adults with mental health issues (OPMH) in East Kent. The aim will be to provide early intervention and responsive care in a crisis which will reduce reliance on acute mental health beds in order that the OPMH in-patient facilities in East Kent can be reviewed and reconfigured. The reconfigured inpatient services will aim to provide high quality person centred care in appropriate environments which will treat individuals in a timely manner in order that people can return to their long term home setting as soon as the person is fit for discharge.

1.1.2 As part of the service development exercise, the service has undertaken an option appraisal to assess the relevant merits of alternative in patient bed configurations on different sites in East Kent. The objective of the option appraisal is to determine which options for older people's services most appropriately meet the required features of a modern inpatient service for older people with a mental illness and their carers.

1.1.3 This report:

- Describes the process undertaken for carrying out an option appraisal on the identified options;
- Lists the options considered;
- Sets out the results of the non-financial appraisal carried out on a set of short listed options using a set of weighted criteria;
- Describes the results of a finance and economic appraisal of an agreed set of options taken forward from the non-financial appraisal;
- Describes the process for undertaking a risk analysis on each option, indicating an overall risk score against agreed categories of risk and identifying the number if major risks applicable to each option.
- Draws initial conclusions on the options to be taken forward for consultation.

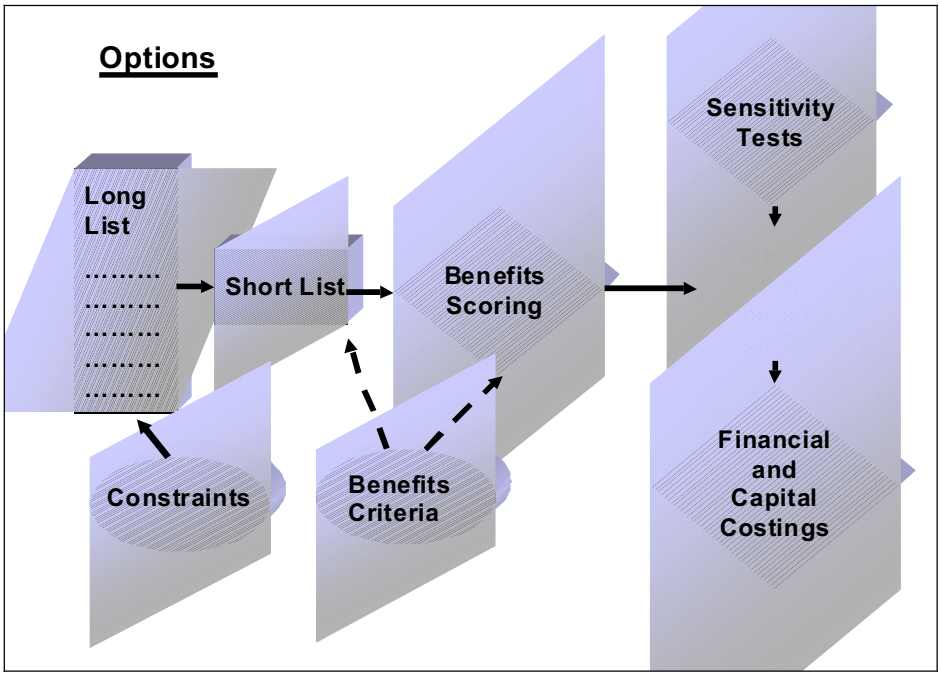
1.2 Approach – Non-financial appraisal

1.2.1 The development of the non-financial option appraisal process involved the participation of all of the stakeholders involved in the service development including representatives from:

- Service commissioners;
- Service users and carers;
- Clinicians;
- Social services;
- Local authorities;
- NHS managers from the East Kent health community.

1.2.2 The process of identifying options, developing and weighting evaluation criteria and scoring the options is illustrated below.

Figure 1 – Option Appraisal Process



1.2.3 A draft list of options was developed by clinicians and managers from the East Kent OPMH service in October 2011 and presented in a report to the Strategic Oversight Group on the 28th October 2011. This resulted from a workshop involving managers and clinicians from the OPMH to formulate options that could deliver the required objectives. In addition, a do minimum option was added and these eight options formed the basis of the option appraisal included in this report.

1.2.4 The workshop also agreed a draft set of criteria to evaluate the options. These were discussed further between representatives from KMPT and NHS Kent and Medway to discuss the criteria, supported and advised by Andrew Leeson from Hygeian Consulting. Hygeian then drafted a set of criteria for presentation to the option appraisal workshop. This was based on similar non-financial appraisals they have facilitated involving mental health services. These were circulated to the workshop participants as part of the briefing papers and then discussed at the workshop for comment and refinement. Following discussion the agreed criteria definitions were used to score the short listed options.

1.2.5 The non-financial appraisal workshop was held on 22nd December 2011 to:

- Ensure an understanding of the options to be evaluated;
- Rank the evaluation criteria in order of importance;
- Weight the criteria;
- Score the options against each criterion to reflect how well the option performed;
- Agree any sensitivity tests where alternative rankings, weights and scorings were considered important;

- Reviewing the overall outcome to ensure the results accurately reflected the views of the participants.

1.2.6 The workshop was attended by representatives from the service stakeholders as referred to in paragraph 1.2.2 above and was facilitated by Andrew Leeson of Hygeian Consulting a firm of healthcare specialists who have undertaken similar appraisals for mental health services elsewhere. A list of attendees is provided in Appendix A.

1.2.7 Participants in the workshop were initially allocated into one of 8 groups: A to H however the number of attendees on the day allowed a reduction to seven groups with Group D no longer included (participants allocated to this group were transferred to the other seven groups.

1.2.8 Each group ranked the benefits criteria according to level of importance. The average ranking was then presented and discussed. Suggestions on any variance from the average ranking were then agreed to be tested via sensitivity tests.

1.2.9 Each group then took the average ranking and weighted the criteria using the Pairwise comparison technique. As for the ranking, the average weightings were adopted and any agreed variations were included in the sensitivity tests.

1.2.10 Finally each group scored each option against each criterion with a mark out of ten and the average of the groups' scores was subjected to a weighted score.

1.2.11 The results for each group were compared for consistency and to ensure that assumptions about each option did not vary significantly between groups. The results of the scoring process were discussed to ensure that the outcome reflected the participants' views on how each option performed against the criteria used.

1.2.12 It should be noted that the options will also be subjected to financial / economic and risk analyses in order to conclude on an overall preferred option.

1.3 Structure of report

1.3.1 The remaining sections of this report cover the following:

- Section 2 describes the long and short listed options and the benefit criteria used for evaluation. It also indicates the weights attached to the criteria.
- Section 3 describes the process for scoring the options and the outcome of the scoring exercise that took place at the workshop. This section draws initial conclusions on the better performing non-financial options after carrying out sensitivity tests.
- Section 4 describes the process and results of an economic and financial appraisal of those options from the non-financial appraisal that were agreed to be carried forward to the economic / financial and risk analyses.
- Section 5 describes the process and results of a risk assessment of the options.
- Section 6 summarises the results from each analysis and draws initial conclusions on options that should be taken forward for consultation.

2 Options and Benefits Criteria

2.1 Introduction

2.1.1 This section describes:

- The options considered for older adult inpatient services in East Kent for evaluation purposes;
- The criteria used to evaluate the options;
- The results of the ranking and weighting of the criteria used to evaluate the options.

2.2 Options for Evaluation

2.2.1 A key stakeholder group, involving clinicians and managers from KMPT, NHS Kent and Medway and CCGs developed a long list of options based on a proposed service model pathway presented in a report to the Strategic Oversight Group.

2.2.2 The options for older people's inpatient services are set out below.

Figure 2 – Option long list

	Canterbury	TMHU (Woodchurch)	TMHU (Sevenscore)	Ashford (Winslow)
Option 1 Locality Configuration Mixed Gender Mixed Functions	Mixed Functional and Organic ward		Mixed Functional and Organic ward	Mixed Functional and Organic ward
Option 2 Separate Functions Single-sex	Organic		Functional male	Functional female
Option 3 Separate Functions Single-sex		Organic	Functional male	Functional female
Option 4 Separate Functions Mixed Gender	Organic		Functional	Functional
Option 5 Separate Functions Mixed Gender		Organic	Functional	Functional
Option 6 All wards at Thanet		mixed Functional and Organic	Sevenscore & Elmstone Mixed Functional and Organic	
Option 7				

	Canterbury	TMHU (Woodchurch)	TMHU (Sevenscore)	Ashford (Winslow)
Single sex mixed diagnosis & mixed gender functional	Organic female		Organic male	Functional male and female
Option 8 Do nothing	Cranmer – Functional	Functional	Organic	Mixed Organic and Functional

2.2.3 The above long list was presented to the workshop participants for discussion with an objective of deriving a short list for further evaluation. The following adjustments were agreed:

- Options 5 and 7 would not be short listed as the other options would always be selected in preference;
- An additional option would be evaluated. This would be the same as Option 1 with the one exception that the mixed functional and organic ward provided from Ashford in Option 1 would be provided from Woodchurch in Thanet. This became the new option 5.
- After the workshop had taken place, and the options subjected to the economic, financial and risk analyses, a further option was proposed by East Kent Hospitals University Foundation Trust. This was the same as for option 5 with the exception that the Canterbury ward would be located on the acute hospital site. It was agreed that this option would not be assessed as part of this report. The option may be assessed at a later stage if a suitable location was agreed by all stakeholders on the Canterbury Hospital site.

2.2.4 The short list taken forward for further evaluation is shown below. The eliminated options are highlighted.

Figure 3 – Options short list

	Canterbury	TMHU (Woodchurch)	TMHU (Sevenscore)	Ashford (Winslow)
Option 1 Locality Configuration Mixed Gender Mixed Functions	Mixed Functional and Organic ward		Mixed Functional and Organic ward	Mixed Functional and Organic ward
Option 2 Separate Functions Single-sex	Organic		Functional male	Functional female
Option 3 Separate Functions Single-sex		Organic	Functional male	Functional female
Option 4				

	Canterbury	TMHU (Woodchurch)	TMHU (Sevenscore)	Ashford (Winslow)
Separate Functions Mixed Gender	Organic		Functional	Functional
Option 5 (original) Separate Functions Mixed Gender		Organic	Functional	Functional
Option 5 (new) Locality Configuration Mixed Gender Mixed Functions	Mixed Functional and Organic ward	Mixed Functional and Organic ward	Mixed Functional and Organic ward	
Option 6 All wards at Thanet		mixed Functional and Organic	Sevenscore & Elmstone Mixed Functional and Organic	
Option 7 Single sex mixed diagnosis & mixed gender functional	Organic female		Organic male	Functional
Option 8 Do nothing	Cranmer – Functional	Functional	Organic	Mixed Organic and Functional

2.2.5 Option 8, Do Nothing, was short listed as a means of comparing potentially suitable options against the current configuration. This is normal for option appraisals carried out in the NHS.

2.3 Benefits Criteria

2.3.1 A set of high-level criteria with sub-definitions was presented to the participants of the non-financial appraisal workshop. The definitions were discussed in further detail and a number of minor modifications agreed. Participants then ranked the high level criteria in order of importance. They then weighted the criteria using the Pairwise comparisons technique. This work was carried out in groups and the overall outputs represented the average views of the groups. The criteria are listed below.

Figure 4 – Evaluation Criteria

1. Clinical Quality and Integration

- Demonstrates a good service user experience
- Facilitates multi-disciplinary and inter-agency working
- Provides a good strategic fit as part of the whole system approach
- Ensures consistent and equitable access to the patient care pathway
- Supports a needs-led approach to service delivery which takes account of

	patient choice and carer needs • Maximises service integration with mental health and social services, community services, the third sector and other health services • Enables compliance with national standards such as CQC etc
2.	**Access** • Enables timely access to district general hospital facilities, support and assessment • Service readily accessible by service users, families and carers through local transport solutions
3.	**Sustainability and Flexibility** • Feasible and achievable within a reasonable and acceptable time frame • Ability to meet current and future demand for acute services, for example through demographic growth. Services to manage demand may include dementia crisis service, greater provision of home care, shorter lengths of stay, appropriate training to address increasing complexity of patient care / treatment • Ability to adapt to meet national, regional and local requirements in the future • Ability to accommodate additional service developments
4.	**Operational and Environmental Suitability** • Supports the safe management of environmental risk through well designed and fully compliant accommodation • Considers the "green" agenda • Good physical condition, elimination of backlog maintenance and compliance with Health & Safety • Provides a welcoming and therapeutic environment (internal and external)
5.	**Efficiency** • Enables efficient and effective 24/7 service delivery through the creation of appropriately balanced critical mass to support training, rotas, ECT delivery, research, etc. • Creates flexibility in bed use and patient case mix • Facilitates progression through the care pathway
6.	**Staff Recruitment, Training and Development** • Attractiveness to staff – recruitment and retention • Provides better training and development opportunities and career pathways across the health and social care system • Provides opportunities to re-model current workforce and improve staff morale / job satisfaction across the health and social care system.

2.3.2 The results of the weighting criteria process for older adult inpatient services are shown below. Details of the ranking and weighting by each group are shown In Appendix B.

Figure 5 – Benefit Criteria Weighting

Criterion	Rank	Raw Weight	%
Clinical quality and integration	1	100	22
Operational and environmental suitability	2	83	18
Staff recruitment / training	3	77	17
Access	4=	69	15
Efficiency	4=	69	15
Sustainability and flexibility	6	56	13
			100

Note: differences in additions are due to rounding

2.3.3 Findings arising from the ranking process include:

- Five out of seven groups selected the highest ranking criterion, the two groups that didn't ranked this criterion as third;
- Operational environment was ranked marginally higher than staff recruitment and retention. With the latter, five groups out of seven ranked staffing as second highest, however two groups ranked operational environment as highest, hence its higher overall ranking;
- No groups ranked the efficiency and sustainability criteria higher than third with most groups ranking these criteria as fourth or below.

2.3.4 Overall the groups agreed to the average rankings and weights and these were used to score each of the options. This is described in the next section.

3 Scoring of Options

3.1 Introduction

3.1.1 This section shows the results of the scoring of each of the options against each of the weighted criteria. This then shows the highest scoring option for older adults inpatient services. The section then tests the strength of the results by showing the effects of sensitivity tests on the ranking, weighting and scoring.

3.2 Process

3.2.1 The scoring was undertaken by each of the seven groups for the short listed options.

3.2.2 The scores were made on the following basis:

10 - Could hardly be better
9 - Excellently
8 - Very well
7 - Well
6 - Quite well
5 - Adequately
4 - Somewhat inadequately
3 - Badly
2 - Very badly
1 - Extremely badly
0 - Could hardly be worse

3.2.3 The final results were the average scores of the groups. The outcome of the scoring process was reviewed at the plenary session and initial conclusions drawn, including agreement on sensitivity tests to be performed on the results.

3.3 Results of benefit scoring

3.3.1 The results of the scoring are shown below.

Figure 6 – Benefit scores: average unweighted

	Option						
Criterion	**1**	**2**	**3**	**4**	**5**	**6**	**8**
Clinical quality & Integration	6.4	3.0	3.1	3.6	5.3	5.1	4.7
Operational & Environmental Suitability	4.4	4.6	4.3	4.6	5.6	6.3	3.0
Staff Recruitment, training & development	6.3	4.4	3.7	4.9	5.4	5.7	4.0
Access	7.0	3.0	3.6	3.7	3.9	3.0	4.6
Efficiency	4.6	2.9	3.6	3.7	5.7	7.4	2.7
Sustainability & flexibility	5.1	3.6	3.4	4.0	5.1	5.6	3.6
TOTAL	**34**	**21**	**22**	**24**	**31**	**33**	**23**
Rank	**1**	**7**	**6**	**4**	**3**	**2**	**5**

3.3.2 Details of the scores allocated by each group are provided in Appendix C.

Figure 7 – Benefit scores: average weighted

	Option						
Criterion	**1**	**2**	**3**	**4**	**5**	**6**	**8**
Clinical quality & Integration	141	66	69	79	116	112	102
Operational & Environmental Suitability	81	84	78	84	102	115	55
Staff Recruitment, training & development	107	76	63	83	93	97	68
Access	107	46	55	57	59	46	70
Efficiency	69	43	54	54	86	112	41
Sustainability & flexibility	63	44	42	49	63	69	44
TOTAL	**569**	**358**	**361**	**405**	**519**	**551**	**380**
Rank	**1**	**7**	**6**	**4**	**3**	**2**	**5**

Note: differences in additions are due to rounding.

3.3.3 In scoring the options the groups stressed a number of assumptions behind their scores. These were:

- For all options the units will be refurbished / remodelled to ensure fit for purpose facilities -
  - Some groups specified this for the Canterbury site only;
  - Some groups specified patients have their own room with separate dedicated areas
- Staff accommodation issues (KCC) will be addressed;
- Staff training would be provided to derive the best service from the new units;
- "Lost" beds will be replaced by equivalent community services;
- For option 6 under access, a patient transport scheme is operated to transport patients and carers to Thanet;
- It was assumed that a successful recruitment campaign took place for option 6 under the staff recruitment / training criterion.

3.3.4 The results show that option 1 scored the highest weighted score. Its unweighted score was one point higher than option 6. It is also noted that the average scoring was no higher than 7 for any of the options suggesting that none of the options performed better than "well" against the criteria. It also reflects the differing views of the groups when scoring the options.

3.3.5 Further points raised from the scoring include:

- There was a notable gap between the scoring of the top three options (1, 5 and 6) compared with the rest. These options were all based on mixed gender, mixed function wards, allowing for the greatest flexibility in terms of bed capacity;
- Option 6 scored well on the efficiency and operational environment criteria, reflecting the provision of the service from one location;
- Option 1 scored above 5 for all criteria except operational environment and efficiency (interestingly the opposite to option 6), reflecting the easier access for patients across East Kent and the greater attraction for staff recruitment / retention;
- Option 5 (similar to option 1 but one ward provided from Woodchurch rather than Ashford) score marginally less than option 1 across all criteria with the exception of operational environment (option 5 score higher due to better quality facilities) and access (option 5 scored considerably lower given the concentration of beds in fewer locations).
- All groups gave competitive scores to option 6 across most criteria, however it was noted that one group scored this option poorly giving a zero score for clinical quality and integration and access criteria;
- The Do Nothing option (option 8) scored better than options 2 and 3 overall. Notable criteria where this was the case was with clinical quality and integration and access.

Switching Analysis Test

3.3.6 The switching analysis test shows by what percentage the lower scoring options must increase in order for them to become the highest scoring option. The results are shown below.

Figure 8 - Switching analysis tests

Option	1	2	3	4
Rank	**1**	**7**	**6**	**4**
Weighted Scores	569	358	361	405
% increase required	**N/A**	**37.1**	**36.5**	**28.8**

Option	5	6	8
Rank	**3**	**2**	**5**
Weighted Scores	519	551	380
% increase required	**8.7**	**3.0**	**33.2**

3.3.7 The results of the switching value test shows that the second and third highest scoring options would need to increase their weighted score by 8.7 and 3.0% respectively which

indicates that changes in assumptions could change the option ranking for these options. Conversely the fourth highest scoring option and below would need to increase their score by at least 29% to become the highest scoring option

Sensitivity Analysis

3.3.8 The following sensitivities were applied to the appraisal:

- Test 1 – switch the ranking of the operational / environment criterion with the staff recruitment criterion – although the operational / environment criterion was ranked higher on average, the staff recruitment criterion was ranked second highest by 5 out of the seven groups.
- Test 2 -.compensate for optimistic / pessimistic bias – this is a common sensitivity to test whether any moderation of group scores would change the ranking of options.

3.3.9 The results of the tests are shown below.

Figure 9 - Sensitivity tests on benefit scoring

Option	Initial Score	Rank	Test 1 Revised Score	Rank	Test 2 Revised Score	Rank
Option 1 – mixed gender, mixed functions – Canterbury, Thanet, Ashford	569	1	565	1	577	1
Option 2 – separate functions, single sex Canterbury, Thane, Ashford	358	7	354	7	351	7
Option 3 – Separate functions single sex, Thanet (2), Ashford	361	6	357	6	363	6
Option 4 – Separate function, mixed gender, Canterbury, Thanet, Ashford	405	4	401	4	408	4
Option 5 – mixed function, mixed gender, Thanet (2), and Canterbury	519	3	514	3	516	3
Option 6 – All wards at Thanet	551	2	545	2	544	2
Option 8 – Do nothing	380	5	378	5	374	5

3.3.10 The results of the sensitivity tests show that the ranking of the options does not change as a result of the sensitivity tests, indicating that the assumptions behind the scoring are robust. However given the closeness of the highest three scoring options the finance /economic and risk implications of these three options would be necessary before concluding on an overall preferred option.

3.4 Conclusions

3.4.1 The outcome of the non-financial appraisal indicated that three of the seven options evaluated performed consistently better than the other options – options 1, 5 and 6. In

terms of which options to take forward for further analysis it was agreed that, in addition to the above options a non-mixed function option should also be taken forward and option 4 was selected for this purpose. It was therefore agreed that these options were taken forward to the financial/economic and risk analyses along with the Do Nothing option that would act as a baseline option.

3.4.2 For information these options are summarised below.

Figure 10 – Summary of preferred options for finance / economic and risk assessment

	Canterbury	TMHU (Woodchurch)	TMHU (Sevenscore)	Ashford (Winslow)
Option 1 Locality Configuration Mixed Gender Mixed Functions	Mixed Functional and Organic ward		Mixed Functional and Organic ward	Mixed Functional and Organic ward
Option 4 Separate Functions Mixed Gender	Organic		Functional	Functional
Option 5 Locality Configuration Mixed Gender Mixed Functions	Mixed Functional and Organic ward	Mixed Functional and Organic ward	Mixed Functional and Organic ward	
Option 6 All wards at Thanet		Mixed functional and organic	Sevenscore & Elmstone functional and organic mixed	
Option 8 Do nothing	Cranmer – Functional	Functional	Organic	Mixed Organic and Functional

4 Economic and financial appraisal

4.1 Introduction

4.1.1 This section presents an economic and financial appraisal of each of the options that were agreed to be suitable for further analysis on the non-financial appraisal. The economic appraisal assesses the value for money generated by each option whilst the financial analysis assesses their affordability.

4.1.2 For the economic analysis a discounted cash flow for each of the options has been undertaken using a discount rate of 3.5% in line with the requirements of HM Treasury Green Book and Department of Health guidance.

4.1.3 Both the Net Present Cost (NPC) and Equivalent Annual Cost (EAC) have been calculated. The EAC is particularly useful for comparison where the options have different life spans as it converts the NPC to an annual figure.

4.2 Methodology and assumptions

4.2.1 A discounted cash flow model, following the principles of the Department of Health Generic Economic Model (GEM), was populated with the base data for each option.

4.2.2 As all options are predominately refurbishment (it is assumed that the Do nothing option would involve regular maintenance costs only). It has been assumed for comparability purposes that all the facilities become operational during the summer / autumn of 2014, depending on option.

4.2.3 No differential inflation has been applied to any costs. This is because it is anticipated that this will have a similar impact on each of the short listed options, and so will not affect the results of the economic appraisal.

4.2.4 Further details of the costs used for the economic appraisal are detailed below.

4.3 Capital Costs

4.3.1 Capital costs for the options have been prepared by the Trust. Key features of the capital costs are as follows:

- Costs have been prepared at PUBSEC FP 173. These have then been adjusted to PUBSEC FP 182 for inflation purposes.
- A planning contingency of 10% has been assumed for all options.
- An optimism bias adjustment of 10.0% has been applied to all refurbishment options.
- VAT at 20% has been applied to all costs except fees.

4.3.2 The capital cost of each option is presented below. The capital cost OB Forms, prepared by Turner & Townsend, Quantity Surveyors are presented in Appendix D.

Figure 11 - Capital costs of options

£000	Option 1	Option 4	Option 5	Option 6	Do nothing
Departmental Costs	3,664	3,664	3,664	3,859	N/A
On Costs	382	382	336	418	
Works Cost Total	4,046	4,046	4,000	4,277	
Location Adjustment	324	324	320	342	
Sub Total	4,370	4,370	4,320	4,619	
Fees	699	699	691	739	
Non-Works Costs	66	66	65	69	
Equipment Costs	131	131	130	139	
Planning Contingency	526	526	521	557	
Sub Total	***5,792***	***5,792***	***5,727***	***6,123***	
Optimism bias	579	579	573	612	
Total for approval	***6,371***	***6,371***	***6,300***	***6,735***	
Inflation adjustment	331	331	328	350	
Total before VAT	***6,702***	***6,702***	***6,628***	***7,085***	
VAT	1,201	1,201	1,187	1,269	
Grand Total	**7,903**	**7,903**	**7,815**	**8,354**	

Source: Trust / Turner & Townsend

4.3.3 It has been assumed that option 4 costs are the same as those for option 1. Option 5 has similar costs with option 6 being the highest. This is because the refurbishment of at Thanet, included in option 6, involves an element of new build.

Phasing of capital costs

4.3.4 The phasing of the capital spend is required both for capital budgeting purposes (where VAT is included), and for the discounted cash flow analysis (where VAT is excluded).

4.3.5 Details of the phasing of the capital costs (both including and excluding VAT) are shown below.

Figure 12 - Phasing of capital costs (including VAT)

£000	TOTAL	Year ending		
		31/03/2013	31/03/2014	31/03/2015
Option 1	**7,903**	541	5,760	1,602
Option 4	**7,903**	541	5,760	1,602
Option 5	**7,815**	535	5,681	1,599
Option 6	**8,354**	572	6,184	1,598
Do nothing	**N/A**	N/A	N/A	N/A

Source: Trust / Turner & Townsend

Figure 13 - Phasing of capital cost (excluding VAT)

£000	TOTAL	Year ending		
		31/03/2013	31/03/2014	31/03/2015
Option 1	**6,703**	521	4,840	1,342
Option 4	**6,703**	521	4,840	1,342
Option 5	**6,628**	515	4,773	1,340
Option 6	**7,085**	551	5,194	1,340
Do nothing	**N/A**	N/A	N/A	N/A

Source: Trust / Turner & Townsend

4.4 Lifecycle costs

4.4.1 Detailed life cycle costs have not been prepared for this analysis. As an alternative it has been assumed that the capital costs will be repeated every 35 years for the refurbishment element and every 5 years for equipment. This approach has been adopted for the Economic analysis.

4.5 Transitional costs

4.5.1 Transitional costs include:

- Moving (assumed £20k per ward);
- Assisted travel (£10k per ward for isolated sites);
- Parking (£5k);
- Double running costs (1 month SLA)

Figure 14 - Transitional costs of short-listed options

£	Year ending			
	31/03/2013	31/03/2014	31/03/2015	31/03/2016
Option 1	-	-	-	-
Option 4	-	-	-	-
Option 5	-	-	73,871	-
Option 6	-	-	225,166	-
Do nothing	-	-	-	-

Source: Trust

4.5.2 No transition costs have been assumed for options 1, 4 and 8 as the existing wards would continue to be used. For options 5 and 6 the following assumptions apply:

- Moving costs are for 1 ward (option 5) and 2 wards (option 6);
- Assisted travel costs are for 1 ward (option 5) and 2 wards (option 6);
- Additional parking costs assumed for option 6 only;
- Double running costs assumed as 1 month's SLA for options 5 and 6 plus one month's running costs for option 6 (including St Martin's depreciation)..

4.6 Revenue costs

4.6.1 The Trust has carried out a detailed analysis of the revenue consequences of each option. A detailed summary is provided in Appendix E. This is an extract from a detailed revenue analysis of each option, prepared by the Trust's finance department. The analysis can be obtained from the department by request. A summary (full year effect) is provided below.

Figure 15 – Revenue costs by option

£000	Option 1	Option 4	Option 5	Option 6	Do nothing
Pay Costs	4,507	4,507	4,424	4,237	5,880
Drugs and Pharmacy	138	138	131	126	161
Other non pay	204	204	204	231	271
Running costs (incl current depr / ROR))	3,491	3,491	3,199	1,684	3,731
Total pay and non pay	**8,340**	**8,340**	**7,958**	**6,278**	**10,043**
Capital charges new	529	529	523	560	-
Total costs before	**8,869**	**8,869**	**8,481**	**6,838**	**10,043**

£000	Option 1	Option 4	Option 5	Option 6	Do nothing
overheads					
Directorate overheads	361	361	361	361	361
Contribution to central overheads	554	554	531	432	624
Total overheads	***915***	***915***	***892***	***793***	***985***
Total revenue costs	**9,784**	**9.784**	**9,373**	**7,631**	**11,028**
Saving from Do nothing	**1,244**	**1,244**	**1,655**	**3,398**	**-**

Source: Trust

4.6.2 The table shows that there is potentially significant savings to be made compared with the Do nothing option.

Pay costs

4.6.3 Pay costs supporting the above revenue costs are as follows:

Figure 16 – Pay costs

£000	Option 1	Option 4	Option 5	Option 6	Do nothing
Ward	3,604	3,604	3,594	3,479	4,753
Psychology	106	106	106	106	137
Medical	797	797	724	652	990
Total pay costs	***4,507***	***4,507***	***4,424***	***4,237***	***5,880***
Saving from Do nothing	**1,373**	**1,373**	**1,456**	**1,643**	**-**

4.6.4 The significant reduction in pay costs reflect the reduction in bed numbers compared with the Do nothing option. This assumption is based on the implementation of the new care pathways planned in the community in line with that implemented in Medway.

Running costs

4.6.5 Running costs, excluding depreciation and return on capital are shown below.

Figure 17 – Running costs

£000	Option 1	Option 4	Option 5	Option 6	Do nothing
Internal recharges	765	765	237	237	769
Hotel costs	692	692	912	709	912
Utilities	191	191	207	77	207
Rent and rates	155	155	155	46	155

£000	Option 1	Option 4	Option 5	Option 6	Do nothing
Site administration	306	306	306	133	306
Total running costs	***2,109***	***2,109***	***1,817***	***1,202***	***2,349***
Saving from Do nothing	**240**	**240**	**532**	**1,147**	**-**

Note: The variance of the total running costs from the revenue summary above are the existing and new depreciation / RoR charges, analysed below

4.6.6 The significant reduction in running costs for options 5 and 6 reflect the smaller number of sites. For option 5 the current running costs of Arundel have been deducted (£526k internal recharge)) and for option 6, both Arundel and Canterbury have been deducted (£1,854k, internal recharge and capital charges).

Capital charges

4.6.7 The effect on capital charges for each option is shown in the table below.

Figure 18 – Effect on Capital Charges

£k	Opening capital charges	Capital charges on new facilities	Capital charge saving on existing facilities	Closing Capital charges	Net increase / (decrease)
Option 1	1,381	529	-	1,910	529
Option 4	1,381	529	-	1,910	529
Option 5	1,381	523	-	1,904	523
Option 6	1,381	560	900	1,042	339
Do nothing	1,381	-	-	1,381	0

4.6.8 It has been assumed that the refurbishment work will add to the capital value of the buildings (except Arundel which is rented), therefore the capital charges will be added to the existing charges. Note that the Arundel element would be reflected in increased rent rather than capital charge. The reduction in capital charges for option 6 reflects the vacating of the ward at St Martin's in Canterbury.

Summary of revenue cost savings over Do nothing

4.6.9 A summary of the overall savings derived from each cost heading is provided below.

Figure 19 – Summary of cost savings

£000	Option 1	Option 4	Option 5	Option 6	Do nothing
Opening cost	11,029	11,029	11,029	11,029	11,029
Pay costs	(1,373)	(1,373)	(1,456)	(1,643)	-

£000	Option 1	Option 4	Option 5	Option 6	Do nothing
Non pay	(90)	(90)	(97)	(75)	-
Running costs	(240)	(240)	(532)	(1,147)	-
Capital charges	529	529	523	(339)	-
Contribution to overheads	(70)	(70)	(93)	(192)	-
Option cost	**9,785**	**9,785**	**9,374**	**7,633**	**11,029**
Saving from Do nothing	**1,244**	**1,244**	**1,655**	**3,398**	**-**
% Saving from Do nothing	**11.2**	**11.2**	**15.0**	**30.8**	**N/A**

4.6.10 It can be seen that the larger areas of savings are in pay costs (due to the smaller number of beds) and running costs due to the smaller areas / sites from which the service will be provided.

4.7 Economic appraisal results

4.7.1 Discounted cash flow analysis using the Net Present Cost (NPC) method is used to compare the options over the relevant time period. Discounting is undertaken to reflect the fact that £1 in one year's time is worth less than £1 today.

4.7.2 The evaluation has been carried out in accordance with the Capital Investment Manual and HM Treasury's The Green Book – Appraisal and Evaluation in Central Government.

4.7.3 In accordance with guidance, the cash flows exclude:

- Depreciation, as this cost is reflected through the life cycle costs; and
- VAT, as this represents a flow of money from one part of Government to another.

4.7.4 In addition, the following assumptions apply to the appraisal:

- The start point for the economic appraisal is assumed to be 1st April 2012;
- A discount factor of 3.5% has been applied to cash flows for years covered by the analysis;
- A price base of 2011/12 has been used;
- A 60 year appraisal period has been used. This represents the standard 60 year appraisal period for new build.
- Life cycle costs have been assessed based on a full replacement cost of the upgrade costs every 35 years (5 years for equipment).

4.7.5 The costs of the proposed investment have been assessed and aggregated to reflect:

- The total expected property-related, capital and revenue costs of each option;
- The opportunity costs of each option;

- The cost implications for all public sector parties that arise as a consequence of the investment.

4.7.6 Figure 20 summarises the results of the economic appraisal over 60 years, commencing 2012/13. A year by year analysis is provided in Appendix F.

Figure 20 - Cash flows of short-listed options

£000	Option 1	Option 4	Option 5	Option 6	Do nothing
Undiscounted Cash flow	530,441	530,441	506,386	405,553	603,161
Discounted cash flow (Net Present Cost)	229,965	229,965	220,298	180,011	258,063

Source: Trust / Hygeian

4.7.7 The Equivalent Annual Costs of the options are provided below.

Figure 21 - Equivalent annual costs of short-listed options

£000	Option 1	Option 4	Option 5	Option 6	Do nothing
Equivalent Annual Costs	8,864	8,864	8,491	6,938	9,947
Rank	**3=**	**3=**	**2**	**1**	**5**

Source: Trust / Hygeian

4.7.8 The economic analysis shows that option 6 has the lowest equivalent annual cost and demonstrates the lowest economic cost out of all of the options. This arises from the service being provided from one site with the savings in associated running costs and more efficient staffing costs.

4.8 Sensitivity tests

4.8.1 In order to test the robustness of the above economic analysis the key variables have been subjected to a sensitivity analysis of the key variables. The tests look at changes to the variables that may change the ranking of the options.

- Capital costs – for the base line assessment the costs for option 8 assume that capital investment would be required after five years, using figures from options 4 and 5 on the grounds that these options involved three sites. A test was undertaken to see the effect of delaying such investment by a further 5 years.

- Savings from vacating St Martin's – option 6 assumes that the running costs for St Martin's and Arundel would cease at the same time that the new facilities were opened. In the case of Arundel, this would be feasible from a KMPT perpective as notice could be served on the landlord in good time, however with St Martin's the reduction in running costs may not be immediate. This test assumes that the reduction in running costs are phased over three years post commissioning of the new facilities (option 6).

- Savings from vacating Arundel – options 5 and 6 involve the vacation of Arundel ward at Ashford. This ward is currently rented and the base line analysis assumes that the rent would cease immediately the service moves to the new premises. Economic analyses examine costs from the perspective of the health economy as a whole and it is likely that the costs associated with running the service at Ashford could are fixed and would be difficult to avoid in the short term. This test delays the reduction in running costs at Ashford by three years.

4.8.2 The results of the sensitivity tests are shown below.

Figure 22 – Sensitivity tests

£000	Option 1	Option 4	Option 5	Option 6	Do nothing
Base line Equivalent Annual Costs	8,864	8,864	8,491	6,938	9,947
Rank	**3=**	**3=**	**2**	**1**	**5**
Sensitivity 1 – Delayed cap ex on Do Nothing EAC	8,864	8,864	8,492	6,938	9,899
Rank	**3=**	**3=**	**2**	**1**	**5**
Sensitivity 2 – delayed reduction in running costs – Option 6 EAC	8,864	8,864	8,492	6,959	9,947
Rank	**3=**	**3=**	**2**	**1**	**5**
Sensitivity 3 – delayed reduction Arundel rent – options 5 and 6 EAC	8,864	8,864	8,546	6,993	9,947
Rank	**3=**	**3=**	**2**	**1**	**5**

4.8.3 The above sensitivity analysis shows that the ranking of the options does not change for the sensitivity test which indicates that the options are relatively insensitive to changes in assumptions around costs and their timing.

Switch Values

4.8.4 The percentage change in variables sensitised in Figure 21 above at which the EAC of Option 1 equals Option 2 is shown below.

Figure 23 – Switching values

£000	Option 1	Option 4	Option 5	Option 6	Do nothing
Equivalent Annual Costs	8,864	8,864	8,491	6,938	9,947
Change required to become lowest EAC	(1,926)	(1,926)	(1,553)	-	3,548
%	-21.7	-21.7	-18.3	-	-35.7

4.8.5 The table indicates that Option 6 gives a significantly lower equivalent annual cost compared with options 1, 4 and 5 (c20%) and Do nothing (c35%). Therefore significant changes in assumptions or cost estimates would be necessary to change the highest ranking option.

4.9 Conclusions

4.9.1 The overall conclusion from the economic appraisal of the options is that Option 6 gives the lower economic cost of the options which indicates that this option would provided the best value for money overall

4.9.2 In terms of affordability all of the change options deliver savings over the status quo, ranging from between 11% and 31%. The overall conclusion will depend on the extent of savings delivered compared with the benefits and relative risks applicable to each option.

5 Risk analysis

5.1 Introduction and approach

5.1.1 Representatives from the Older Adult service, together with commissioners and staff from estates and finance carried out a qualitative risk assessment of the short listed options.

5.1.2 The approach adopted involved firstly identifying potential risk areas such as operational, finance and project risk. Each of the options was scored against each risk on two counts:-

- impact of risk on the service should it occur; and
- the likelihood of the risk occurring.

5.1.3 The basis for the assessment in terms of impact and probability are shown below.

Figure 24 – Basis of risk scoring

	Impact	Probability
1	Insignificant	Remote
2	Minor	Possible
3	Moderate	Medium
4	Major	Likely
5	Catastrophic	Almost certain

5.1.4 The overall exposure to risk is then a combination of the impact of risks and likelihood of them occurring, taking into account the likely effectiveness of a risk management strategy.

5.2 Defining the risk register

5.2.1 A risk register was developed based on the expected areas of key risk which each option would be exposed to. The risks were categorised into the headings shown in the table below.

Figure 25 - Risk Categories

Risk Category	Comment
Operational	These are risks that can impair the older adults' service ability to provide health services, for example continued compliance with national and local regulations / guidelines
Commercial / financial	These are risks associated with the revenue and costs of providing the service within current and future funding parameters.
Service / clinical	These risks relate to the ability of the Trust to recruit and retain the right calibre of staff, both clinical and support. It also identifies risks associated with retaining clinical accreditation, operating within set out clinical guidelines etc.
Refurbishment	These risks relate to the refurbishment process and result in delays to completion of the facility or increased costs. An example may include

Risk Category	Comment
equipment	unforeseen complications with refurbishment on some of the options.
Project	These risks relate to the ability to run the development project to time and budget, for example ensuring that properly qualified and experienced personnel are appointed and that other projects do not detract from the need to devote the right time and commitment to this project

5.3 Results of risk assessment of the short listed options

5.3.1 A summary of the risk scores for each short listed option is provided below. The results also summarise the number of risks occurring in each category of risk exposure based on the following criteria:

- Yellow: low risk
- Orange medium risk
- Red high risk

5.3.2 The numbers in each coloured box indicates the number of risks that have been classified as the combination of impact and likelihood.

5.3.3 The overall scores by risk category are summarised below. A detailed assessment of the options is provided in Appendix G.

Figure 26 – Scores by risk category

Risk Category	Option 1 – Canterbury, Thanet, Ashford – mixed function / gender	Option 4 – Canterbury, Thanet, Ashford – split function, mixed gender	Option 5 – Canterbury, Thanet (x2) – mixed function / gender	Option 6 – Thanet (x3) – mixed function / gender	Option 8 – Do nothing
Operational	51	53	48	54	69
Finance / commercial	66	70	48	42	56
Service / clinical	87	87	62	73	95
Refurb / equipment	48	46	46	50	42
Project	56	56	60	64	8
TOTAL	**308**	**312**	**264**	**283**	**270**
Rank	**4**	**5**	**1**	**3**	**2**

5.3.4 The table indicates that option 5 provides the lowest level of risk followed by options 8 and 6. Option 8 can be discounted as the low score is due to it not being subject to refurbishment and project risks. In the areas of operational and service / clinical risks it performed poorly. The good performance of options 5 and 6 is partly due to their being on two and one site respectively and are therefore less exposed to site-based risks.

5.3.5 The number of risks occurring under each of the headings low, medium and high for each option is shown below

Figure 27 - Outputs from risk assessment

KMPT - Older Adult Inpatient Services
1 - Canterbury, Thanet, Ashford - mixed function / gender

LIKELIHOOD							
	Almost Certain	5					
	Likely	4		1	3	2	
	Medium	3		1	2	12	
	Possible	2		2	8	1	
	Remote	1					
308			1	2	3	4	5
			Insignificant	Minor	Moderate	Major	Catastrophic
			IMPACT				

KMPT - Older Adult Inpatient Services
4 - Canterbury, Thanet, Ashford, - Split function, mixed gender

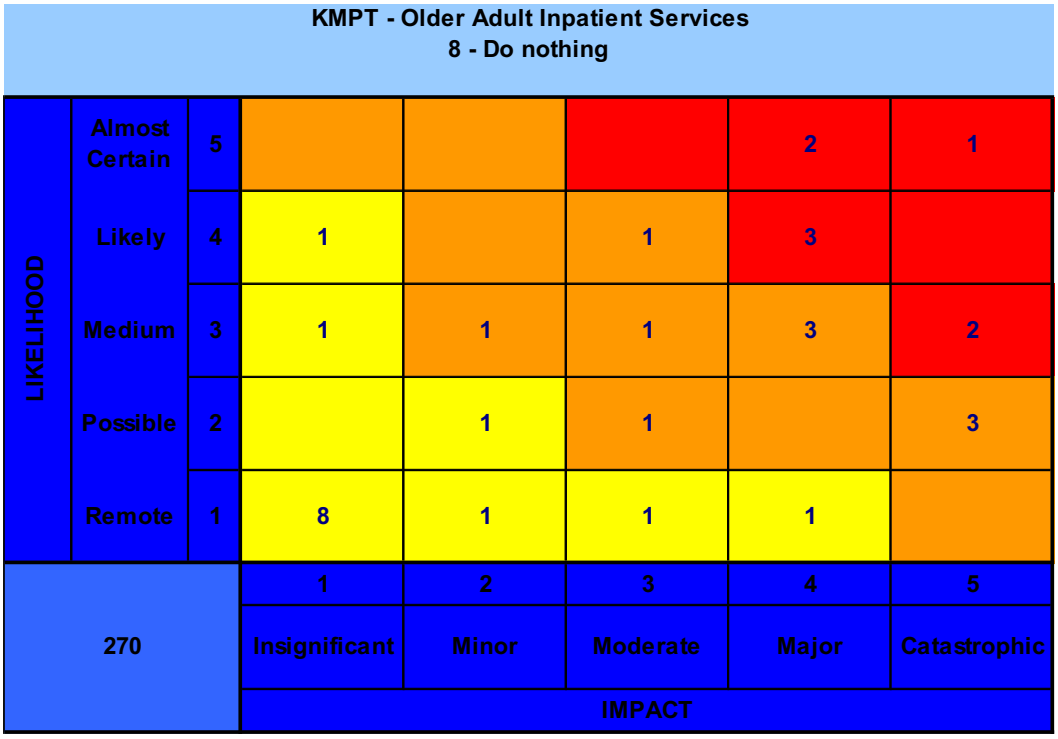
LIKELIHOOD							
	Almost Certain	5					
	Likely	4		1	3	3	
	Medium	3		1	2	10	
	Possible	2		2	6	4	
	Remote	1					
312			1	2	3	4	5
			Insignificant	Minor	Moderate	Major	Catastrophic
			IMPACT				

KMPT - Older Adult Inpatient Services
5 - Canterbury, Thanet (x2) - mixed function / gender

LIKELIHOOD							
	Almost Certain	5					
	Likely	4		1	2	1	
	Medium	3		2	4	6	
	Possible	2		3	8	4	
	Remote	1				1	
264			1	2	3	4	5
			Insignificant	Minor	Moderate	Major	Catastrophic
			IMPACT				

KMPT - Older Adult Inpatient Services
6 - Thanet (x3) - mixed function / gender

LIKELIHOOD							
	Almost Certain	5				2	
	Likely	4		1	3	3	
	Medium	3		4		5	
	Possible	2		6	1	2	1
	Remote	1	1	1		2	
283			1	2	3	4	5
			Insignificant	Minor	Moderate	Major	Catastrophic
			IMPACT				



5.3.6 The diagrams indicate the following:

- Although the Do nothing option scores favourably it has 8 risks rated as red, that is, the probability and impact of these risks occurring are significant and, potentially unacceptably high.
- Option 6 scored well however there are 5 risks rated as red which means that certain risks are likely and/or would have a high impact if they occur.
- Option 5 had the lowest risk score and has 1 risk rated as red indicating that this option's risks could be managed effectively.
- Option 1 and 4 had 2 and 3 red rated risks respectively which would be acceptable, however their overall risk score placed them at a higher overall risk than option 5 and 6.

5.4 Conclusion

5.4.1 The risk assessment of the options indicates that option 5, two sites at Canterbury and Thanet (2 wards) has the lowest level of risk overall. This is due to a number of factors but more notably the fact that this option operates from two sites rather than 3, has one site co-located with an acute hospital and would be regarded as reasonably accessible to patients, visitors and staff. The Do nothing options came second which was due to the negligible risk associated with refurbishment and project management risks. If these risks were excluded from the overall score, it would be the highest level of risk overall.

5.4.2 The results of this analysis will be included in the overall assessment described in the preferred option section.

6 Summary of option performance

6.1 Introduction

6.1.1 This section summarises the results of the non-financial, economic and risk appraisals of the short listed options to determine the better performing configurations with manageable levels of risk.

6.2 Comparison of cost and benefit points

6.2.1 The table below summarises the results of the three option appraisal analyses

Figure 28 – Summary of option appraisal

	Option 1	Option 4	Option 5	Option 6	Option 8
Benefit points	569	405	519	551	380
RANK	**1**	**4**	**3**	**2**	**5**
Capital Costs	7,903	7,903	7,815	8,354	0
RANK	**3=**	**3=**	**2**	**5**	**1**
Revenue costs	9,784	9,784	9,373	7,361	11,028
RANK	**3=**	**3=**	**2**	**1**	**5**
Economic Appraisal (NPC)	229,965	229,965	220,298	180,011	258,063
RANK	**3=**	**3=**	**2**	**1**	**5**
Capital cost per benefit point	13.89	19.51	15.06	15.16	0
RANK	**2**	**5**	**3**	**4**	**1**
Revenue cost per benefit point	17.2	24.2	18.1	13.4	29.0
RANK	**2**	**4**	**3**	**1**	**5**
Net present cost per benefit point	404.2	567.8	424.5	326.7	679.1
RANK	**2**	**4**	**3**	**1**	**5**
Risk Analysis - overall	308	312	264	283	270
Risk Analysis – number of high risks	2	3	1	5	8
RANK - score	**4**	**5**	**1**	**3**	**2**
RANK – high risks	**2**	**3**	**1**	**4**	**5**

6.2.2 The above analysis gives a mixed result. A summary of the performance of each option is provided below.

- **Option 1** – this shows average rankings for the economic, finance and risk scores, however its high benefit score has meant that it has performed favourably when comparing the benefit score with the other analyses.
- **Option 4** – this is the same as option 1 with split functions. It has performed relatively poorly across all analyses and, although costs are the same as for option

1 its lower benefit score means that it always performs less well compared with option 1

- **Option 5** – this option has one ward at Canterbury and two at Thanet. It scores well in the revenue and economic analyses, being second to option 6 due to the greater savings to be derived from providing all of the inpatient services from two sites rather than 3. However its benefit scores were lower than for options 1 and 6 which means that its benefit score compared with the other analyses places it below options 1 and 2. The exception was its risk scores where it was seen as being more acceptable to commissioners while still delivering savings.
- **Option 6** – this option involves all three wards being provided from Thanet. It was the lowest cost option in terms of revenue savings and economic costs but was the highest capital cost due to the level of refurbishment required to provide all inpatient services on one site. It was second highest in benefit scores which meant that it performs well when compared with the other analyses. Although it performed well in terms of risk score (3rd) the risks included 5 red-rated risks which was due to the likely issues perceived during the consultation stage.
- **Do nothing** – although this option score well in capital costs (1st) and risk score (2nd) these should be considered in the light of no refurbishment being undertaken with the consequences on building quality and their not being fit for purpose. The risk score relates to the lack of construction risks and the number of major risks shows this option to be high risk in terms of service and finance risks. Finally this option does not deliver savings and would not be consistent with planned changes to the care pathways and improved community service.

6.3 Conclusion

6.3.1 This appraisal has assessed five options from which to select a minimum of three to put forward for consultation. Based on the analysis above it is clear that the Do nothing option should not be taken forward. In common with all option appraisals in the NHS it is used as a base line against which change options can be compared. It does not address the requirements of the new patient pathway and neither does it deliver any revenue savings which is a key requirement.

6.3.2 Of the remaining options the analysis indicates that options 1, 5 and 6 should be taken forward as the relative benefits of each varies depending on benefits delivered, costs and levels of risk. The consultation process should reveal which of these are regarded as more important and the level of any compromise that would be required in order to be able to conclude on a preferred option. Given the relatively poor performance of option 4 compared with the other change options it may be appropriate not to take this forward unless it was believed that a split function option should be tested further in a consultation.

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Older People's Mental Health Communications and Citizen Engagement strategy

Annex 2

Background

Dementia is one of the main long term conditions of later life and it has a huge impact on capacity for independent living. Dementia is estimated to cost £17 billion per year in the United Kingdom. It is predicted that there will be a doubling, possibly trebling of the number of people who have dementia in the UK. It represents a huge challenge to health and social care at a time when resources are restricted so all services have to be as effective and productive as possible whilst providing a high quality of care.

The vision for east Kent is as follows and is consistent with the recommendations in the National Dementia Strategy (Department of Health, 2009 :

- To increase awareness of dementia, improve early detection and diagnosis and reduce the stigma attached to dementia.
- To ensure that people with dementia receive timely diagnosis and support that promotes their independence and helps them to 'live well' with dementia, and that all services and support are provided to the highest possible standards; promoting dignity, choice and respect.
- To ensure that there is sufficient capacity in community based services so that people with dementia and their carers are well supported and independence is maximised for as long as possible

People with dementia thrive best in a familiar environment, with familiar carers and established daily routines. Removing someone with dementia from their home (or their care home), very often increases their confusion and their levels of stress and anxiety, with a direct effect on their wellbeing, their recovery and their ability to do things for themselves. It is therefore better for people with dementia to be looked after in their own environment when appropriate (National Dementia Strategy, 2009, Counting the Cost, Alzheimer's Society, 2009) and important to avoid admission to hospital wherever possible. If hospital admission is necessary, the length of stay should be as short as possible to minimise disorientation and maintain independence.

This is also what people with dementia and their carers want. In a recent survey for the Alzheimer's Society (Support, Stay, Save, 2011), 83 per cent of carers of people with dementia or people with dementia themselves said that being able to stay in their own homes was very important.

Older People's Mental Health Communications and Citizen Engagement strategy

Annex 2

Business case

In east Kent, too many people with dementia are currently being admitted to general or mental health hospital beds, because of a lack of community services to support them at home when their condition deteriorates, or their carer feels unable to cope any longer.

In September and October 2011 an audit by the mental health trust, Kent and Medway NHS and Social Care Partnership Trust, estimated that up to a third of inpatients need not have been admitted if there had been better support in the community.

Admission to hospital is distressing and disruptive to both the person with dementia and their carers, detrimental to their long-term care (as people with dementia are likely to spend longer in hospital than people without dementia, and are likely to need more care after leaving hospital than before they were admitted. It is also very expensive for the NHS and social care.

NHS plans are to increase the availability of community services which will be available 24 hours a day and which can provide support to people with dementia and their carers in their own homes and reduce the need for people to go into either a general or mental health hospital bed. This will be achieved by the introduction of a dementia crisis service which will be available 24 hours a day, seven days a week, together with an enhanced home treatment service. Both services will work closely together to assist people to remain in their own homes when extra support is needed. The crisis service will be provided by trained carers. The home treatment service is already in operation and is provided by a range of professionals (nurses, occupational therapists and psychologists) and helps to identify why the behaviour of the person with dementia may have changed, e.g. they may be aggressive to their carers, and help to identify ways of managing these behaviours. The home treatment service will work with people with dementia and their carers in their own homes as well as in care homes. These changes will mirror the approach already operating successfully in the west of Kent.

The enhancement of community support will allow a review of the function, location and number of mental health beds for older people. Outcomes from this process will be to:

- Improve the flexibility of the accommodation to meet the changing needs and demographics of patients.
- Enhance the staff provision and specialism of staff on the older people's mental health wards to deal with the more complex cases who will require inpatient care.
- Reduce the spare capacity in current wards and therefore reduce overheads.

Older People's Mental Health Communications and Citizen Engagement strategy

Annex 2

Objectives
• Clear vision - communications and engagement activity based on our clear strategic vision for the future of mental health services in Kent and Medway articulated in a clear and accessible way. • Clinically led - the proposals are based on clinical evidence and judgement, and clinicians will work alongside commissioners to present and explain them to the public. • Discreet but linked consultations - there are two separate consultations the NHS will use economies of scale where possible, and ensure a coherent a joined-up story about mental health services across Kent and Medway. • Targeted, effective communications, while ensuring all members of the public have opportunity to have their say, some audiences will be more interested than others and we will target our resources accordingly, working with partners where that is the most effective way to reach our audiences. • Effective partnership in a time of great change - communications and engagement activities will support each organisation's broader strategic aims at the same time as delivering the engagement and consultation, working consistently together in partnership to improve clarity and consistency for all audiences

Older People's Mental Health Communications and Citizen Engagement strategy

Annex 2

Key message
A step-change is needed in the support offered to people with dementia. Resources at the moment are concentrated on high cost inpatient services for the few, rather than preventative, strong support close to home for the majority, to help them live well with dementia. Reversing this approach is already working in West Kent. It is important that the approach is an integrated one between health and social care. The aim is to: • Increase the emphasis on early intervention and enable people to access appropriate community services which support people in their own homes and maintain independence for as long as possible. • Increase levels of support in primary care to enable early diagnosis and the development of an personalised care plan. Ensure high quality environments which utilise a therapeutic approach to help people with dementia to maintain their independence and reduce the reliance on the use of medication, such as anti psychotic drugs. • Ensure the delivery of safe, efficient services which are flexible and reflect best practice locally and nationally • Encourage the role of voluntary organisations, particularly in enhancing support for carers.

Older People's Mental Health Communications and Citizen Engagement strategy

Target audience

- Clinical Commissioning Groups
- GPs as providers of primary care
- LMCs, royal colleges professional bodies etc
- Mental health clinicians and interrelated disciplines
- SEC Amb, police and emergency care providers
- NHS and independent community providers
- Social care providers KCC, MC, care homes
- Patients, carers and the public
- District and Borough councillors
- MPS,
- HOSCs Medway and Kent
- LINk
- VCS organisations e.g. Age concern, Alzheimer's Society, etc.
- Out of hours providers and NHS Direct
- Regional and local media

Focusing particularly on service users and carers, an audience we can be confident of a high level of interest and feedback such as pensioner's forums, carer organisations and support groups. Building upon the strong relationships and regular meetings which have already been established by KMPT, KCC and the VCS.

The community and voluntary groups will be an important audience, especially where they are able to act as a channel to reach service users, carers and people who do not traditionally engage.

Effective staff engagement is vitally important and essential if change is to be successful. As well as being a crucial audience in their own right, health and social care staff is also a vital channel to reach the wider public and service users. GPs are a particularly important group within the staff audience.

Health Overview and Scrutiny Committees (HOSCs) and Local Involvement Networks (LINks) are a critical audience having shown an interest in this topic already. The HOSC input is fundamental to shape the consultation process, the proposals consulted on and then to approve the plans that emerge from the process and they should be fully engaged at every stage.

MPs and councillors represent the interest of their constituents and as such are an important audience. They also have a significant impact on the media. Regular briefings are held by PCT CE and chair with MPs this dialogue should include regular updates on progress, but more specific briefings will be arranged in the run up to consultation.

Older People's Mental Health Communications and Citizen Engagement strategy

Methods

Clear Core narrative and communication materials
A core narrative, set of key messages, detailed Q&A and set of core presentation materials will be produced to support each consultation and the communications around it. (JR)

Stakeholder engagement
A stakeholder list should be readily agreed by commissioners and KMPT; each stakeholder should be communicated with as soon as possible to ensure that they are aware of the process and able to influence current proposals. Once the formal consultation has begun, all stakeholders will receive regular updates on progress. Spokespeople will be provided to present the proposals and receive feedback at stakeholder events and meetings.

GP engagement
Clinical mental health leads already work with commissioners but are less familiar with acute side of mental health they need to be involved in all aspects of planning and consultation able to cascade information to their peers and act on behalf of their CCG. In addition the GP clinical leads must be regularly briefed through the commissioning committees and able to influence and approve plans. One lead per review should be part of the operational working groups.

Staff and clinical communications
Maximising the use of existing staff communications channels; team briefings/workshops will lead the process and be regularly given to support consistent and timely communication with staff, newsletters or ebulletins will ensure consistent messages across the various organisations involved, staff will also use the intranet and be signposting the website for further details within organisations without creating further communications vehicles where they are not needed. These briefings and materials will be provided to all NHS and social care organisations in Kent, including acute trusts, CHT and the ambulance trust, to encourage widespread staff engagement.

Service user and carer engagement
Service users and stakeholders have a regular involvement in all aspects of planning and managing of mental health services these should be used before the formal consultation begins, to engage them as stakeholders in the development of the proposals and in planning the process. We will build on this at workshops or options appraisals, which will ensure a range of views influence the options developed for consultation and make sure that all key stakeholders are identified and engaged in advance of the formal consultation.

Case studies and evidence
A bank of case studies, real patient stories, examples, quotes, evidence, graphs, illustrations and photographs will be built to help set out improvements so far and to bring to life the vision for the future. Some of this maybe found in west Kent, or existing services which are to be

enhanced. We will also use this ongoing dialogue to identify potential advocates possibly film the service user, carer clinical stories.

Clinical advocates and champions
KMPT and commissioners will identify a panel of key spokespeople from both commissioners and providers, clinical and managerial, who will take public platforms and speak with the media. We will ensure that they are fully prepared, briefed and (where appropriate media trained) from the outset, and that they receive regular updates of key messages, Q&A etc. We will see if core service user representatives and VCS organisations will agree to champion the involvement of their service users and carers, ensuring that their representatives carry the message within their own working relationships with local communities.

Public meetings and events
A few should be arranged, tailored to best meet local circumstances and stakeholder expectations in terms of the number, location, format and content; supported by core materials and suitable spokespeople from the PCT and KMPT and other advocates. Showing that we are striking a balance between targeting audiences and demonstrating that we are giving all sections of the public a chance to have their say. Events will be extensively promoted through the media, targeted distribution of leaflets and posters, and through partner stakeholder channels and followed up through proactive media relations, in staff communications and in updates to stakeholders.

Media relations
Key media will be identified and briefed on the consultation by each PCT before it launches. Following the consultation launch we will maintain a regular flow of proactive media stories to promote and report on consultation events. We will use existing media monitoring arrangements to keep abreast of any media coverage and to ensure that any inaccurate or adverse coverage is addressed immediately.

Consultation documentation
We will produce a full consultation document and a summary document for each consultation OPMH first. There will be economies of scale in the design and drafting of the documents, with content shared between the documents where appropriate. Documents and summaries will be clear, person centred and accessible following best practice in terms of plain English, font sizes and colour schemes. They will be made available in alternative formats and will offer advice in the most common community languages on how to receive more detail in other languages.

Websites
Detailed consultation materials (including reference material such as national policy frameworks, clinical evidence etc) will be hosted on KMPT and the relevant PCT's website, along with updates, latest information on events and opportunities to provide feedback and get involved. Both the PCT websites and KMPT website will feature core information about the overarching plans, providing links to the other consultation materials and enabling partner organisations to flag the consultation on their website and provide enabling links etc

Social media will be used to promote active engagement for those utilising different forms of virtual discussions: tweets, blogging, etc

Response handling

Older People's Mental Health Communications and Citizen Engagement strategy

We will establish (or use existing, where possible) a wide range of mechanisms to capture consultation responses in each PCT, including:
- Freepost address
- E-mail address
- Online response form
- Dedicated phone line with voicemail
- Provision to transcribe comments from those unable to use other means.

Budget
£26,000

Older People's Mental Health Communications and Citizen Engagement strategy

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Timescales

- Feb financial appraisal, case consideration by SHA, preparations for consultation, brief MPs and key stakeholders
- 9 March HOSC presentation
- 14 March – Consultation documents to printer
- 19 March – 15 June (13 week consultation period)
- June Analyse results
- July 20 – report levels of engagement to Kent HOSC
- July Board decision
- September/October implement

Media coverage

Warm-up

- **Pre-launch week one:** Launch campaign to raise awareness of signs and symptoms in line with DH and Alzheimer's UK campaign (w/c 20 February)
- **Pre-launch week two:** Support provided for those just diagnosed – dementia cafes, dementia webs, admiral nurses (w/b 27 February)
- **Pre-launch week three:** Home treatment and crisis service (w/b 5 March)
- **Pre-launch week four:** Caring for dementia patients in hospital (w/b 12 March)
- **LAUNCH (week one) :** Launch east Kent consultation with press release, web link to online consultation document (19 March), promote roadshow dates

Evaluation

This communications and engagement strategy will be formally evaluated by both commissioners and trust based upon the responses, evaluation of core parts of the strategy against measureable outcomes.

Older People's Mental Health Communications and Citizen Engagement strategy

Annex 2

Risks
○ Reputation, radical plans are likely to be opposed by local communities. Mitigation: build carefully internal support and championship with local stakeholders to build acceptance for need to change and trust in plans. Have clear and consistent information and communication that builds understanding of the situation and the proposed plans. ○ Carers and service users may have differing views, be sure to provide adequate means for both to comment – difficult with dementia patients so clinical and voluntary advocates necessary. ○ Engagement and consultation process requires changes in original planning so will delay financial savings. Mitigation Strategic overview group work with PCT cluster and SHA from outset to manage process on reasonable timetable for success. ○ Legal challenge if process is not thorough and does not fulfil four tests the decision could be held up by challenge to the process. Mitigation early engagement of SHA to build in assurance from start, regular briefings and information to HOSCs to agree plans for JHOSC and constructive scrutiny of process, plans and decision, early engagement with clinicians and stakeholders leading to comprehensive consultation process delivered within local communities working with local support groups.

Improving Outcomes for People with Dementia - Project Plan

	2011			2012									
Activity	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**
Develop project proposals for approval at KMPT Strategic Oversight Group (SOG)													
Commence consolidation of beds													
Finalise paper, 'Re-modelling of East OPMHN Acute Care Pathway'													
Seek approval from KMPT Strategic Oversight Group													
Develop formal consultation plans													
Seek approval from East Kent Commissioning Committee													
Agree plans for Extended Home Treatment Services													
Briefing paper to Kent HOSC to set the scene and invite members to attend fact finding session.													
Seek approval from Cluster Board Meeting													

Improving Outcomes for People with Dementia - Project Plan

	2011			2012									
Activity	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**
Commence informal consultation and organise fact finding event for HOSC members and other stakeholders as required.													
Undertake option appraisal workshop to develop draft options for public consultation.													
Update Strategic Oversight Group on progress.				27th									
Undertake financial and estates appraisal of draft options.					By 16th								
Engage SHA in proposed plans.													
Present proposals to meeting of east Kent MPs.					23rd								
KCC procure interim Dementia Crisis Services which become operational													
Develop communications plan and consultation documents.													
Deliver Extended Home Treatment Services													

Improving Outcomes for People with Dementia - Project Plan

	2011			2012									
Activity	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**
Present options to CCG Boards. 3rd Swale, 8th C4G & SKC, Ashford 29th. Thanet TBC													
Present options to east Kent Commissioning Committee and Kent and Medway Cluster Board for approval					22nd								
Present options to KMPT Board for approval.						1st							
Present final proposal for approval at Kent HOSC						9th							
Conduct formal consultation													
Crisis service implemented following procurement via KCC processes and funding transferred by section 256.													
Analyse and evaluate outcomes of formal consultation													
Present consultation outcomes and recommendations to associated Boards for agreement												KMPT 27th	
Update Kent HOSC												7th	

Improving Outcomes for People with Dementia - Project Plan

	2011			2012									
Activity	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**
Begin implementation of outcomes of consultation													

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 9 March 2012

Subject: Mental Health Services Review: Decision on Substantial Variation of Service.

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1. Summary

(a) Under *The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (S.I. 2002/3048)*[1] local NHS bodies must consult the HOSC over any proposals "for a substantial development of the health service in the area of a local authority, or for a substantial variation in the provision of such services."

(b) The subsequent *Directions to Local Authorities (Overview and Scrutiny Committees, Health Scrutiny Functions) 2003*[2] from the Department of Health stated that when an NHS body consulted two or more local authority health scrutiny committees a joint committee "shall" be established. It is only this joint committee which may exercise the health scrutiny powers over the specific issue being consulted on, including that of referral.

(c) In effect this means that where a service change is proposed that affects an area covered by more than one statutory local authority health scrutiny committee, and where both consider the change to be a "substantial variation," then a Joint HOSC will need to be established.

(d) Where only one Committee decides it constitutes a "substantial variation" of service, then that Committee only is able to exercise the full range of scrutiny powers over that issue as the Committee which decided it was not substantial would in effect have delegated its authority to the other Committee.

(e) If neither decides it is a substantial variation, then while both Committees will be able to be kept informed by the local NHS of how the proposals were being taken forward, they could not exercise the full range of scrutiny powers over that issue, up to and including that of referral.

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[1] *The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (S.I. 2002/3048)*, http://www.legislation.gov.uk/uksi/2002/3048/contents/made

[2] *Directions to Local Authorities (Overview and Scrutiny Committees, Health Scrutiny Functions) 2003*, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4066609.pdf

2. Joint Health Scrutiny Committee with Medway Council

(a) In order to prepare in advance for a Joint HOSC being required, a Joint Committee with Medway Council was established at the meeting of the County Council of 25 March 2004. The arrangements were updated at County Council on 14 September 2006.[3]

(b) The Joint Committee consists of 12 Members: 8 from Kent County Council and 4 from Medway Council.

(c) This topic will also be presented to the Health and Adult Social Care Overview and Scrutiny Committee at Medway Council at its meeting of 27 March 2012.

(d) The requirement for a Joint HOSC will be determined by the decisions taken by this Committee today and Medway's Health and Adult Social Care Overview and Scrutiny Committee on 27 March.

3. Recommendation

That the Committee determines whether or not the NHS proposals constitute a substantial variation of service.

[3] http://democracy.kent.gov.uk/Data/County%20Council/20060914/Agenda/sep06-item7.pdf

Right care, right time, right place – inpatient mental health

1. Introduction

This paper outlines significant changes over the past eight years to the provision of inpatient mental health services, including specialist Psychiatric Intensive Care (PIC) services, for those people aged over 18 in Kent and Medway. It sets out how this has resulted in many more people being treated at home and a higher level of need among people still admitted to inpatient units, who require more focused, specialist care within centres of excellence.

Other factors taken into account are the elements required to deliver a successful, safe, recovery-focused inpatient service for people who are acutely mentally ill, and the need for the NHS to make best use of its resources.

Mental health services for children and adolescents, and for people with dementia, are commissioned separately and do not form part of this proposal, which however has been developed alongside separate plans for improving services for people with dementia in east Kent.

2. Background

Around 160,000 people in Kent and Medway[1] at any one time are affected by common mental health problems, such as anxiety, depression, phobias and obsessive compulsive disorder.

Three quarters of them will either self help or get better in time. Around one quarter will need treatment with medication and/or psychological therapies.

Around 12,000 people in Kent and Medway are estimated to have a severe complex mental illness such as schizophrenia (also known as psychotic disorder), bi-polar disorder, personality disorder or an eating disorder.[2]

The rate of mental health problems in the population is broadly stable: For 'common mental illness' (the majority of depression and anxiety problems) the estimate is 1 in 4 people[3], and for 'severe and enduring mental illness' (mostly psychosis - schizophrenia and bi-polar disorder) it is 3 per 1000 people.[4]

3. Mental health services

The main NHS mental health provision in Kent and Medway consists of:

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[1] Source: Joint Strategic Needs Assessment, Kent, 2011
[2] *Ibid*
[3] Source: National Adult Psychiatric Morbidity Survey, Meltzer 2001
[4] Source: New Oxford Textbook of Psychiatry 2000

- Primary care services, such as GP services and talking therapies. National Institute for Clinical Excellence (NICE) guidelines make it clear that primary care is the best and most appropriate care for the vast majority of people with common mental health problems
- Secondary care services, provided by Kent and Medway NHS and Social Care Partnership Trust, comprising community services and acute services for people who need more intensive or specialised support
- Tertiary care services, offering specialist help, often involving hospital or complex rehabilitation and observation. These include intensive day treatment services and some services for people with eating disorders or women with ante or postnatal mental illness (although most people will recover without such specialist care)
- Forensic services, for people who have mental health problems who are also in the criminal justice system

Latest statistics from NHS Information Centre[5] show that around one in 11 people receiving secondary or tertiary services for a severe mental illness will at some point be admitted for inpatient care. 10 in 11 will not access inpatient care at any point in their illness.

The focus of this review is acute inpatient services which, along with crisis resolution home treatment services, treat people who are in a mental health crisis.

4. What is a mental health crisis?

Crisis takes different forms in different people.

The mental health charity Mind[6] says crisis may take the form of:

- suicidal behaviour or intention
- panic attacks/ extreme anxiety
- psychotic episodes (loss of sense of reality, hallucinations, hearing voices)
- other behaviour that seems out of control or irrational and that is likely to endanger the self or others

"…the mind is at melting point and everything is frightening, even the affected person's loved ones."

"…I get very paranoid, and think of myself as a horrid burden to my family."

"People describe being in crisis as an overwhelming experience; something that is more than the person can deal with and not one's normality. It can mean having nowhere to turn or having exhausted all one's coping strategies."[7]

[5] NHS Information Centre E-bulletin, November 2011
[6] Learning from experiences, Mind 2011

5. Best for people to be treated at home

There is extensive evidence[8] that it is best for people in a mental health crisis to be supported and treated at home or in another community setting (such as intensive day support), whenever possible. Most service users and carers prefer home-based treatment and research has shown that clinical and social outcomes achieved by community-based treatment are at least as good as those achieved in hospital. For example, the National Audit Office[9] suggests that more admissions should be avoided and that improving service quality and outcomes should be the primary imperative to reduce unnecessary or overly long inpatient stays. Time spent as an inpatient can weaken people's connections to their family, community and support networks. It found that areas with Crisis Resolution and Home Treatment (CRHT) teams saw a 21% reduction in admissions over five years compared to those without (10%)

Some service users do not feel safe in hospital. This is especially true for women, and for individuals with a history of abuse, as well as for young people. New psychiatric ward building and renovation work is partially addressing these concerns, by using only single sex and/or single roomed wards, the latter helping to make inpatient care more personalised.

Treatment at home or in the community reduces the stress and anxiety of people who are acutely unwell and enables them to stay in touch more easily with friends and family, to maintain their independence and their normal routine, to continue making choices about their lives and to avoid the risk of institutionalisation. All of these improve outcomes for people.

It is also what the majority of people who use services say they want, in both national surveys, such as Listening to Experience, Mind's review of acute and crisis services[10], and local discussion, such as with people in Medway in recent years[11]. Carers in areas with similar services say that they are glad not to have their relatives going into hospital and find 24 hour on-call service availability particularly supportive, even when they don't use it that often. [12]

Changes to mental health services over recent years therefore mean that effective, and where necessary intensive, treatment at home is now much more widely available and accepted.

6. A quiet revolution

Over the last eight years, matching the national drive[13], there has been very significant local development of services to support people in an acute phase of mental illness, so their needs can be safely met in the best place possible. For most people, that will be at home while, for some, it will be in an inpatient unit.

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[7] Learning From Experiences, Mind 2011
[8] The Mental Health Policy Implementation Guide, Department of Health 2001
[9] Helping People Through Mental Health Crisis: The role of Crisis Resolution and Home Treatment services, National Audit Office 2007.
[10] Published November 2011
[11] Scrutiny of Mental Health Bed Numbers and Capacity, Mental Health Strategies 2009
[12] Locality Services in Mental Health: The Home Treatment Team, Sainsbury Centre for Mental Health 1998
[13] Idem (8)

Acute care follows one agreed “care pathway” so that people consistently get the care that is right for them, whether that is at home or in an inpatient unit. Multidisciplinary teams work together and always aim to ensure that people receive a seamless and joined-up service.

Among other mental health and social care services, people in Kent and Medway can now access:

- CRHT teams that provide treatment and support in a mental health crisis for people in their own homes rather than in hospital and which work very closely with inpatient teams for the particular locality.
- Early intervention in psychosis services for people having a first episode of psychosis, which improves the long-term course of their illness
- Specialist psychiatric nurses in emergency departments across the county who offer swift assessment and access to other support for people attending with mental health needs (such as people who have self-harmed)
- Recovery teams, which provide therapeutic input and social care support to people with severe and longer lasting mental illness
- Assertive outreach services, which work with people with severe mental illness who find services hard to engage with, and might be at risk of losing contact
- Supported accommodation services, including some which offer intensive support
- Specialist county-wide services for people with eating disorders, personality disorder and mother and infant mental health services
- Improved referrals by other agencies, such as the ambulance service, the police, and probation, supported by agreed protocols

These changes amount to a transformation of mental health services in Kent and Medway.

Treatment at home is now the norm for people in an acute phase of mental illness who, in the past, would have been admitted to an inpatient unit. In 2010/11 2646 people who are acutely unwell were treated at home by a CRHT service compared to 1615 people admitted to hospital. Payment by Results, which is being fully introduced in NHS mental health services from 2013, will place most of those people who use inpatient wards and CRHT services in the same ‘care cluster’ with the same ‘tariff’ for payment from NHS service commissioners to providers, so there will be an even greater imperative for these services to be managed and delivered very closely together for each and every locality, wherever the wards’ physical location.

At any given time, 100 people who are acutely unwell will be being treated at home in Kent and Medway – the equivalent of almost six hospital wards.

There have already been some reductions in inpatient demand over the last few years, whether in terms of admissions or average lengths of stay, thanks to

higher levels of therapeutic intervention during the person's stay through schemes such as the Productive Ward, advances in the medication now available, and early discharge planning facilitated as required by follow-on 'intensive home treatment'. There is scope for reducing overall demand further ('occupied bed days'), particularly through early discharge work with our partners to ensure that services such as supported housing are available when people are ready to leave hospital.

Choice of psychological treatments available for service users is usually wider in community than inpatient care, while most medication can be administered and monitored just as effectively at home as in hospital. Shorter, focused stays in inpatient units also make it easier for people to pick up the threads of their everyday life, get back to work and see their family and friends.

As a result of plans to improve care pathways and the management of demand, it is expected that over the next few years even fewer people will be admitted for inpatient care and their stays will be for shorter periods: hence in Kent and Medway fewer beds will be needed per head of population and in Medway fewer beds will be needed in absolute terms. This is currently subject to modelling of historical and predicted 'occupied bed days' demand by the specialist provider of this service, the Kent and Medway NHS Partnership Trust (KMPT), and this will inform the detailed options for consultation - for the future allocation of Kent and Medway localities and CRHTs to inpatient units.

7. Inpatient care

This quiet revolution in mental health services for people who are acutely unwell means that people are now only treated in an inpatient mental health unit if clinical assessment shows it would be unsafe for them, or others[14], for them to stay at home.

In turn, this improvement in community based care means those few people needing acute inpatient units have a higher level of need than in the past.

The priorities of mental health inpatient units are:

- to care for people safely
- to promote their recovery
- to ensure the safety of staff

These are also the priorities of the Psychiatric Intensive Care Outreach service which offers specialist support to acute inpatient Psychiatric Intensive Care Units When staff in an acute inpatient unit are not sure if they can safely manage the care of a particular person, they can call on their colleagues from psychiatric intensive care.

Staff from the Psychiatric Intensive Care Outreach service will assess the person, and either suggest strategies for working with him/her to the staff on the ward, or admit him/her to the Psychiatric Intensive Care Unit.

[14] They may be admitted, for instance, if their family carer can no longer cope, or if they are intent on suicide.

Most admissions are now more a matter of days rather than weeks – like intensive care units for physical illness, in the majority of cases a Psychiatric Intensive Care Unit provides short-term support (the median stay is now 20.5 days with over 80% of patients discharged from the units within six weeks). When a person's condition is stabilised, they will move to a regular inpatient unit or back home, under the care of a CRHT.

To deliver safe care which promotes recovery as effectively as possible, it is essential that that there are **sufficient highly trained, expert staff** available round the clock to provide a robust and resilient service and that people are treated in **modern fit-for-purpose accommodation**.

8. Staff

Given that people who are acutely unwell in inpatient units now present a higher level of risk and more complex needs than in the past, ward staff need to be more highly trained and highly skilled than ever before. The NHS nationally is promoting the development, as a separate mental health specialism, of a highly skilled inpatient and crisis resolution workforce, who can manage these risks and meet these needs in a way that best promotes recovery.[15]

Teams start to work with people from admission, offering multi-disciplinary therapeutic interventions tailored to match the wishes and interests of the individual. Increasing post-qualification training is underway to ensure that for the few people who do need to be admitted, highly purposeful admission, intervention and review systems are in place for them.

It is important to have enough staff to carry out this complex work; hence the recent KMPT announcement of a funded increase of 40 mental health ward nurses from February 2012. It is equally important to have stability in this staff group: continuity of care promotes trust and so wellbeing, enhancing recovery. Hence, it is best to use permanent staff rather than agency nurses wherever possible.

It is still the case nationally that the majority of assaults on NHS staff are by people who are mentally unwell. To ensure the safety of both service users and staff, it is essential that there are enough highly trained and expert staff on duty in each inpatient unit; this requirement lends support to the designation in Kent and Medway of fewer, better 'centres of excellence'.

9. Environment

Thanks to extensive research, much more is known about the physical elements of inpatient mental health care which promote recovery.[16] [17] We know, for instance, that the physical environment is very important. People who

[15] The Pathway to Recovery, Healthcare Commission Review of Mental Health Services 2008
[16] Star Wards, Marion Jenner 2006
[17] The Productive Ward: Releasing Time to Care, Institute for Innovation and Improvement 2010

are acutely mentally unwell need access to outdoor space and to have their own room where they feel safe and can be alone if they wish.

The DH Mental Health Policy Implementation Guide[18] highlighted that the impact of a poor environment on patients and staff alike cannot be under-estimated and that the environment must be comfortable, relaxed, safe and secure, with particular attention to the needs of women. It also emphasised that new services should be designed to be socially inclusive and connected to the community. The extra demands placed on staff when providing care in a poor environment inevitably leads to a level of containment and custodial care that impacts on patients' experience and recovery.

The NHS Constitution states that every service user has the right to high-quality care that is safe, effective and respects their privacy and dignity. Since 2000, all new-build units have been required to incorporate single bedrooms, ideally with en-suite facilities.

The physical environment is also a very important element of providing safe care. It is, for instance, essential that there are clear lines of sight, so that staff can monitor those patients who may be suicidal or aggressive.

The Healthcare Commission's *National Audit of Violence*[19] reported that the design of many wards failed to meet basic safety standards. There were particular problems with poor visibility associated with obstructed sight-lines.

This finding was consistent with NIMHE's survey where over one-third of ward managers described significant reported, but unresolved, environmental risks. In relation to the impact of environmental risk: in the Healthcare Commission's audit, 36 per cent of service users and 78 per cent of nursing staff said that they had experienced violence on the ward that was being studied. There is a strong link between this level of violence and the environment within which patients are being cared for.

However, not all the accommodation currently available in Kent and Medway meets these important standards.

10. The existing situation including what the problems are and why

People who are acutely unwell are currently treated at five inpatient units across Kent and Medway – in Dartford, Maidstone, Medway, Ashford, and Canterbury. The closure of outdated accommodation in Ashford is already planned as part of the development of the new £10million unit at St Martin's Hospital, Canterbury, which is due to open in autumn 2012. People in East Kent will then be cared in state-of-the art accommodation.

Dartford and Maidstone are also modern, purpose-built units which offer the best possible environment for care.

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[18] Adult Acute Inpatient Care Provision, Department of Health, 2002

[19] Healthcare Commission, 2005).

However, people from Medway and Swale are looked after in A Block, a KMPT unit in former orthopaedic wards at Medway Maritime Hospital. There are poor sightlines for observation and several beds are in bays with only curtains to provide privacy.

People using services have restricted access to the outside, because wards are on the first floor and if, for instance, they want a cigarette, they have to wait to be accompanied downstairs, rather than being able to move in and out of doors at will. This inevitably builds up frustration, which can have a major impact on inpatients' needs and experiences of care as well as on staff time and resources.

The Care Quality Commission (CQC) compliance inspection of Medway in November 2010 identified that "people were generally protected from harm although there was risk where the layout of the ward made de-escalation *(of violence),* difficult and there was no seclusion room on the ward. People would have also been at risk from self harm where there are no ligature free rooms".

Although the staff working at A Block do the best possible job of providing care, given the restrictions they face, this is not an environment that promotes either safety or recovery, despite measures that have been taken to improve the fabric of the building. The NHS in Medway has since 2000 made many attempts to look for alternative more suitable buildings nearby, without success. Hence some new service foundations need to be made to provide inpatient and CRHT services for Medway users and to match the development of more integrated and individualised care pathways.[20]

Similarly, the PIC Unit is currently provided at two bases, Willow Suite at Dartford and Dudley Venables House in Canterbury. Willow Suite is housed in purpose built accommodation which offers the best possible environment for intensive care. Dudley Venables House is a converted 1994 ward and is therefore limited in what can be achieved for PIC Unit purpose.

In West Kent, there is a PIC outreach team which can be called upon by KMPT staff in acute inpatient units in Dartford, Medway and Maidstone. However this service does not extend to East Kent.

11. The options for change

Kent and Medway NHS and Social Care Partnership Trust, supported by commissioners, would like to explore the development of **centres of excellence** (CoE) for people needing inpatient care in Kent and Medway, each based in modern accommodation that promotes safety and recovery, which are compatible with their latest acute care pathway (see Appendix).

A CoE can be described as a service that is delivered to a recognised high (national or world class) standard, in terms of measurable results and innovation, so that, in addition to performing its own core work very effectively, it has an additional role in improving its practice expertise and knowledge resources. The centre can then, in turn, assist other parts of its service system

[20] Laying the Foundations, Department of Health (CSIP) 2008

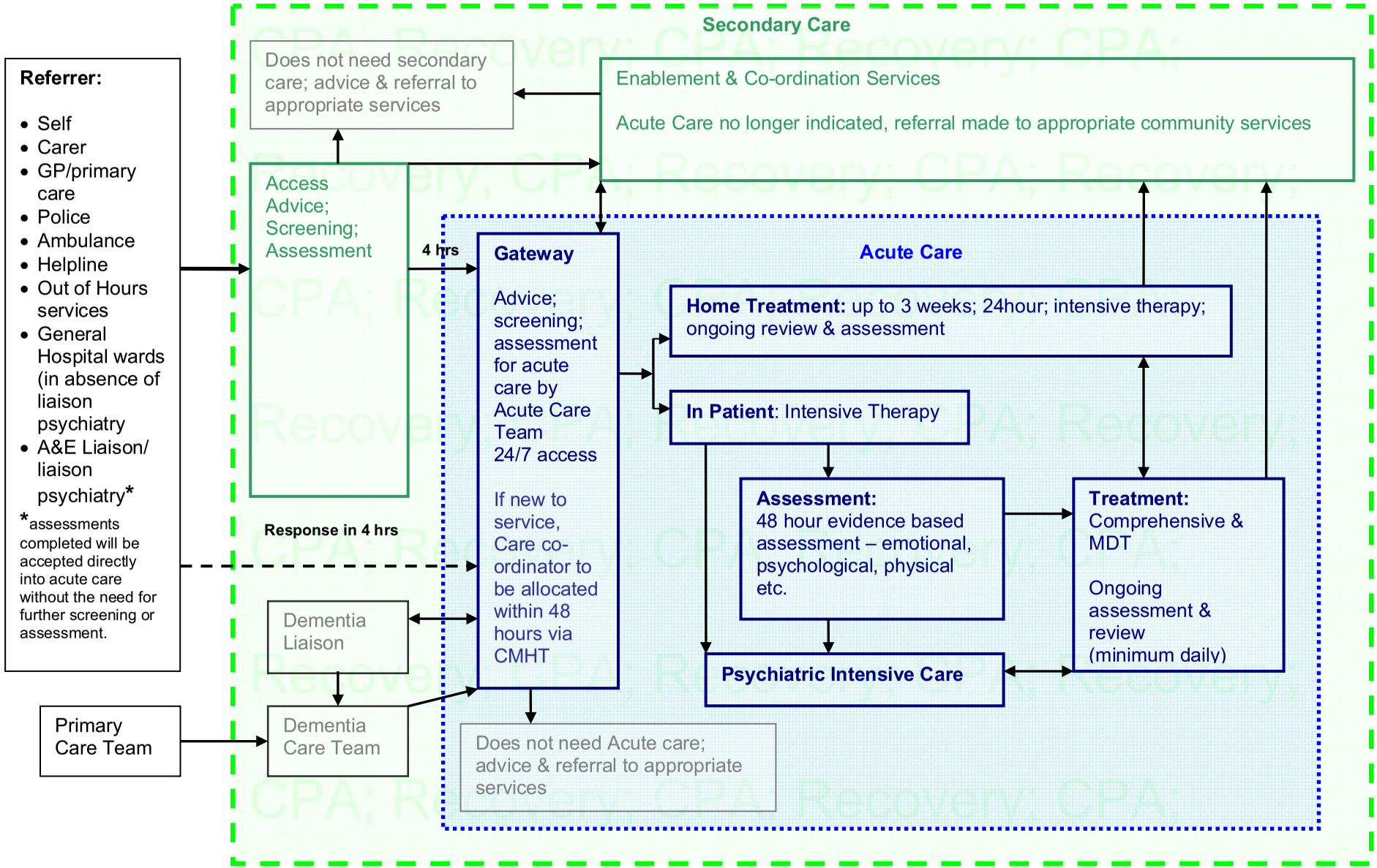
to improve continuously and work collaboratively. The defining features of a CoE are therefore: A critical mass of specialist staff organised around one locus; an ability to integrate complementary multidisciplinary skills; evidence-based research and knowledge management capabilities; and the capacity and stability to attract, retain and exchange a skilled workforce.

Options for the locations of inpatient care will now be examined to create units that are more robust, with a critical mass of staff working at each, consolidating and exchanging staff expertise and improving safety for everyone. This should also allow for the optimal deployment of specialist resources such as mental health occupational therapy teams in accordance with NICE guidelines about making therapies available at the evening/weekend, yet not spreading these resources too thinly. Another example is having sufficient nurses and nursing management cover on hand for the safe provision of 'Section 136' rooms, to receive those people taken to hospital for assessment by police under this section of the Mental Health Act.

It would also enable the numbers of inpatient beds in Kent and Medway to be reduced over time to match the reduced demand for these beds, ensuring that the NHS is making best possible use of its resources. For those that still need inpatient care, for their own and other people's safety, all options for the inpatient environment would need to be suited to more individualised care and treatment and facilitate demand management.

We have had discussions with a range of stakeholders including clinicians, service users, carers and MPs about potential changes. These conversations will continue as we develop our plans.

Appendix: Acute Mental Health Care Pathway – Kent and Medway NHS and Social Care Partnership Trust



Key Principles for Acute Care:

- Clear Criteria for Acute Care required (Home treatment, Admission & Intensive Care) to aid appropriate referrals to this service
- Involvement of carers; advocacy; community team; social network/employer as requested by service user.
- Interventions should be client centred and recovery focused.
- Discharge planning commences at admission.
- Dedicated Acute Care Medical input – integrated with CRHT to enable timely discharge and 7 day follow up

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 9 March 2012

Subject: Patient Transport Services: Decision on Substantial Variation of Service.

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1. Summary

(a) Under *The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (S.I. 2002/3048)*[1] local NHS bodies must consult the HOSC over any proposals "for a substantial development of the health service in the area of a local authority, or for a substantial variation in the provision of such services."

(b) The subsequent *Directions to Local Authorities (Overview and Scrutiny Committees, Health Scrutiny Functions) 2003*[2] from the Department of Health stated that when an NHS body consulted two or more local authority health scrutiny committees a joint committee "shall" be established. It is only this joint committee which may exercise the health scrutiny powers over the specific issue being consulted on, including that of referral.

(c) In effect this means that where a service change is proposed that affects an area covered by more than one statutory local authority health scrutiny committee, and where both consider the change to be a "substantial variation," then a Joint HOSC will need to be established.

(d) Where only one Committee decides it constitutes a "substantial variation" of service, then that Committee only is able to exercise the full range of scrutiny powers over that issue as the Committee which decided it was not substantial would in effect have delegated its authority to the other Committee.

(e) If neither decides it is a substantial variation, then while both Committees will be able to be kept informed by the local NHS of how the proposals were being taken forward, they could not exercise the full range of scrutiny powers over that issue, up to and including that of referral.

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[1] *The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (S.I. 2002/3048)*, http://www.legislation.gov.uk/uksi/2002/3048/contents/made

[2] *Directions to Local Authorities (Overview and Scrutiny Committees, Health Scrutiny Functions) 2003*, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4066609.pdf

2. Joint Health Scrutiny Committee with Medway Council

(a) In order to prepare in advance for a Joint HOSC being required, a Joint Committee with Medway Council was established at the meeting of the County Council of 25 March 2004. The arrangements were updated at County Council on 14 September 2006.[3]

(b) The Joint Committee consists of 12 Members: 8 from Kent County Council and 4 from Medway Council.

(c) This topic will also be presented to the Health and Adult Social Care Overview and Scrutiny Committee at Medway Council at its meeting of 27 March 2012.

(d) The requirement for a Joint HOSC will be determined by the decisions taken by this Committee today and Medway's Health and Adult Social Care Overview and Scrutiny Committee on 27 March.

3. Recommendation

That the Committee determines whether the NHS proposals constitute a substantial variation of service.

[3] http://democracy.kent.gov.uk/Data/County%20Council/20060914/Agenda/sep06-item7.pdf

Kent and Medway

Procurement for non-emergency patient transport service (PTS)

Introduction

Following the comprehensive report on transport undertaken by the Kent and Medway LINKS in 2010, NHS Kent & Medway agreed to undertake a procurement project to deliver an improved service. This paper reports on the current status of the procurement for the Non-Emergency Patient Transport Service (also known as "PTS"). The process will address several of the recommendations of the report, includes the consistency of eligibility criteria, booking arrangements and travel for all residents of Kent and Medway who are eligible for patient transport journeys. This would encompass both standard and renal dialysis PTS, going to/from a patient's place of care and residence and to/from all hospitals, clinics and providers of NHS healthcare.

Background

PTS transport is provided for patients with an assessed medical need for transport to/from their place of care or residence and a premise providing NHS healthcare, and between premises providing NHS healthcare. This can and should encompass a wide range of vehicle types and levels of care consistent with the patients' medical needs. This is defined in the 'Eligibility Criteria for Patient Transport Services (PTS)' by the Department of Health in 2007. (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_078372.pdf.

PTS for patients receiving NHS renal dialysis treatment varies from other non-emergency PTS, in that patients receiving hospital dialysis treatment attend their dialysis unit three times a week, every week of the year. A session of dialysis lasts for approximately 4 hours and often has a significant physical impact on patients, with their eligibility for transport changing between arriving at hospital and departing.

Patients who are receiving NHS healthcare are ordinarily expected to make their own way to and from a provider of NHS healthcare. However, PCTs are required to provide PTS to patients who qualify for NHS-funded transport based on an assessed medical need for the duration of the journey, in accordance to the national eligibility criteria for PTS mentioned above for standard PTS. Renal dialysis PTS eligibility criteria had historically varied depending on the provider of the service. However, extensive audits and a national Learning Set have identified the need for a consistent and fair approach to renal dialysis PTS.

Summary of current situation

PTS is currently provided across Kent and Medway, either directly or through subcontracts, by several providers, including:

- Healthcare Transport of East Kent Hospitals University Foundation Trust (EKHUFT);
- South East Coast Ambulance (SECAmb);
- Maidstone and Tunbridge Wells NHS Trust (MTW);
- Dartford and Gravesham NHS Trust (DGT);
- Kent Community Health NHS Trust (KCHT);
- Guy's and St Thomas' NHS Foundation Trust (GSFT); and
- King's College Hospital NHS Foundation Trust (KCFT).

The current legacy contracts are managed separately and lack the key features needed for cost-effective operation which are principally a clear service specification based on outcomes, visibility of levels of activity and associated costs, performance measures and incentive schemes. This new service will improve the current needs through better integration, hours of operation and same day access, etc. and will initially use the previously agreed South East Coast Eligibility Criteria (see attached). We will also work with the future provider to consolidate and clarify any other eligibility criteria, as well as institute an ongoing process to work with the new provider after implementation to streamline and clarify the different interpretations of said eligibility criteria.

The PCT Cluster Board identified a need to review and re-procure the services to improve patient care and efficiencies in a variety of ways. It is envisioned that some of these efficiencies will be achieved through choosing a cost effective provider and others through decreasing aborted and cancelled journeys.

The project team is currently undertaking a review of all activity, finance and provider vehicle and staffing data to help identify the total PTS project scope, which will include renal transport. It is not expected that cardiac or paediatric transport will be included as this service has recently been re-tendered and will not be part of this procurement. It is proposed to continue to commission mental health PTS via the Kent and Medway Partnership Trust as this requires a different type of service which is currently being delivered/contracted for effectively by the provider.

Eligibility to access volunteer transport is based on social need and therefore, does not align with the national criteria for standard and renal dialysis PTS which is based on an assessed medical need. There will be a requirement for the Provider of the new service to work in partnership with volunteer organisations who provide volunteer car schemes for people receiving NHS healthcare and who do not qualify for PTS.

Timeline

The target date for the new service to be operational is 1 April 2013, to tie in with giving existing providers the required period of notice, while achieving the expected benefits from the new procurement at the earliest practicable opportunity. The official procurement process will commence in mid April. Prior to that time, engagement events with the public and patient representatives will be held, to build on and confirm any further issues subsequent to the LINk report. A bidder event will also be held. Subsequently, we expect to select the final bidder by the end of October 2012.

An engagement subgroup has been created to allow service users and patient representatives to feed into the Project, help inform the service specification, procurement documentation and other issues that may arise during the process.

It is believed that based on comparable procurement projects undertaken in east Kent, the project would need approximately five_months from initiation to having selected the preferred provider(s). The time required to complete implementation will be influenced in part by the number of providers who are selected, but is expected to be between four and five months.

Procurement objectives

A procurement across Kent and Medway would achieve the following:

a. Better Value for Money
   - Reduced costs as a result of (i) a competitive process and (ii) more effective service provision.

b. High Quality
   - Managed, booked and transportation services that meet the identified need.
   - Service specification based on outcomes.

c. Simplified Processes
   - Clear eligibility criteria in line with Department of Health guidelines for access to PTS, applied across Kent and Medway.
   - Clear process providing a single point of access to PTS.

d. Robust Contract Management
   - Stringent contract management and agreed Key Performance Indicators.
   - Regular reporting on performance and financial spend of the contract.
   - A robust contract is in place to support handover to the Clinical Commissioning Groups.

Public, patient and stakeholder engagement

Although engagement was previously undertaken through PTS steering groups around identifying areas for improvement and the development of local service specifications, engagement will continue throughout the entire procurement, mobilisation and continuing through the term of the contract. This will start with several engagement events and will continue by using the engagement workstream that feeds into the Project directly. This will include various forums including Kent LINk, Medway LINk, patients and the public, local health and non-health transport groups, Kent County Council events, two patient groups covering Kent and Medway, providers of transport, commissioners, clinical leads and all other key stakeholders. This is to ensure that engagement will be adequate and effective both in supporting the proposal for a PTS procurement and in the development of not only the service specification but also documents such as the procurement documents. It is envisaged that engagement will continue through to the selection of successful bidders, during the mobilisation period and into the implementation stage of the contract.

Conclusion

It is not the project team's intention to change the service currently provided under the various PTS contracts but rather, to improve it. The aim of this procurement is to streamline the booking service and making easier access available to the eligible residents of Kent and Medway. Additionally, alongside the procurement, it is expected that we will work to improve the booking systems with trusts to reduce the number of aborted and cancelled journeys.

It is intended that the new PTS service provide a more equitable service for all residents, a reduction in costs and the ability to provide a greener, more effective service overall.

The project team will provide regular updates to HOSC during the procurement and mobilisation stages of this project and request that HOSC support this project.

Item 10: Reducing Accident and Emergency Attendances: Draft HOSC Report.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 9 March 2012

Subject: Reducing Accident and Emergency Attendances: Draft HOSC Report.

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1. Background

(a) The Committee held three meetings on this subject: 14 October 2011, 25 November 2011, and 3 February 2012. In addition, preliminary findings were noted at the meeting of 6 January 2012.

(b) Following the final hearing on this subject, a provisional draft report was circulated to Members of the Committee and Trusts who had contributed to the review for comment.

(c) Following the agreement of the Committee as to the final shape of the report, it will be sent to local NHS Trusts and their formal response to the recommendations will be presented to the Committee at the appropriate time.

2. Recommendation

That the Committee discuss and approve the report.

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"Not the Default Option."

Health Overview and Scrutiny Committee,
Kent County Council
March 2012

A Review into Levels of Attendance at Accident and Emergency Departments.

Accident and Emergency: Not the Default Option

1. Key Issues

(a) As many as 1 in 5 people who attend accident and emergency departments in Kent and Medway could be treated more effectively elsewhere.[1] This runs counter to the health service's aim of making sure everyone is seen in the right place at the right time by the right person.

(b) The impact goes beyond that of the individual turning up at A&E. The forecast spend for 2011/12 on accident and emergency attendances by Kent and Medway residents is just under £45 million. An additional £342 million is likely to be spent on emergency hospital admissions.[2] In the current financial climate, with the NHS as a whole asked to find £20 billion in efficiency savings by the end of 2014/15 as part of QIPP (Quality, Innovation, Productivity and Prevention), it was not surprising to find that all the NHS organisations we spoke to agreed that reducing accident and emergency attendances and admissions was a local priority. Nationally, the QIPP workstream looks to achieve a 10% reduction in A&E attendances.[3]

(c) With limited resources, each A&E attendance costs £52 to £183 and where this is spent on people who could be treated elsewhere, it is unable to be spent on other services.[4] There is also a negative impact on the organisations providing the services. Those available outside acute hospitals may be under utilised, and there is a knock on effect to the whole range of services provided by the Hospital Trusts and the Ambulance Service as staff and resources are diverted to deal with emergency attendances and subsequent admissions.[5]

(d) Yet for all the discussion about the cost of A&E, the alternatives are not without cost. The Committee was provided with information on the overall costs of different elements of urgent and emergency care[6] and we will be following this issue up to see what the costs are of individual episodes of care at Minor Injuries Units and elsewhere.

(e) However, if we concentrate too much on the details of the costs of care we risk being diverted from the bigger picture. Most important is the impact on the patient concerned. The care provided by the skilled professionals in accident and emergency departments is generally very

[1] HOSC Minutes, 25 November 2011.
[2] Evidence from NHS Kent and Medway, HOSC Agenda 14 October 2011, p.14.
[3] Department of health, October 2011, http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPPworkstreams/DH_115468
[4] Evidence from NHS Kent and Medway, HOSC Agenda 14 October 2011, p.30.
[5] Evidence from South East Coast Ambulance Service NHS Foundation Trust, HOSC Agenda 14 October 2011, p.45. Evidence from Maidstone and Tunbridge Wells NHS Trust, HOSC Agenda 25 November 2011, p.4.
[6] Evidence from NHS Kent and Medway, HOSC Agenda 14 October 2011, p.35.

good, and a necessary service for thousands of people each week across Kent and Medway. For many people though, they may be missing the convenience of care closer to home as well as avoiding an unnecessary visit to hospital.

(f) The majority of people attending A&E go there directly, without having being referred or conveyed by an ambulance.[7] The Committee was made aware of research which had been conducted around the reasons why people choose to go to accident and emergency departments over the alternatives. The reasons are no doubt very complex and depend on the individuals concerned and the situation, but, tellingly, research in Maidstone in 2008 showed **that 42% chose A&E because they did not know where else to go.**[8]

(g) More generally, the Committee senses that both where there is a lack of knowledge or confusion about the alternatives, and where accessing the alternatives has been a negative experience, attending A&E has in effect become the default option for too many people. A 24/7 accident and emergency department is a great asset to a community and there will always be a need for the life saving skills delivered by the health professionals working in them, particularly where there is a good chance of being seen within 4 hours. However, there is an urgent need to address this idea of default.

(h) The Committee has identified four interconnected factors it believes have contributed to this idea of default which will set the context for the recommendations it is making.

(i) These factors are:

- the changing nature of urgent and emergency care;
- lack of consistency;
- lack of joined up services; and
- lack of effective communication.

2. The Changing Nature of Urgent and Emergency Care

(a) The Department of Health defines urgent and emergency care as "the range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly."[9] This is a helpful definition, but it is very broad and covers everything from advice received online or on the phone from NHS Direct to being transferred to a Major Trauma Centre in a London Hospital.

[7] Evidence from Acute Trusts, HOSC Agenda 25 November 2011.
[8] Evidence from NHS Kent and Medway, HOSC Agenda 14 October 2011, p.25.
[9] Department of Health, October 2011, http://www.dh.gov.uk/en/healthcare/urgentandemergencycare/index.htm

(b) The Committee heard about a wide range of services available across the whole care pathway, with more in development. Accident and emergency departments themselves are also changing and this is mirrored by changes in each part of the pathway. Many of these changes are positive and contribute to delivering improved healthcare and saving lives. However, where they are not communicated successfully to the public or coordinated well with each other, there is a danger that they are having the **unintended consequence of increasing public confusion.** This could exacerbate the tendency to regard the nearest A&E department as an element of certainty and continuity and hence the default option.

(c) Primary care, and GPs in particular, are key to ensuring people receive the right care at the right time. They provide continuity of care and are in a better position to treat the whole person than staff in an A&E. While concerns were raised during our evidence gathering around the difficulties sometimes experienced by people wishing to make an appointment with a GP, this was balanced by the acknowledged need to ensure that GPs could access the appropriate services provided by others efficiently and directly for their patients.

(d) There are six Type 1 accident and emergency departments within Kent and Medway providing a full range of services for minor and major emergencies. Work is already underway to address accident and emergency attendances. All the Acute Trusts we spoke to were looking at ways to allow patients to bypass A&E, such as being directly admitted to an assessment unit by a GP, or signposting people who turned up but could be seen elsewhere to a more appropriate place. Many sites had pharmacies, GP services and other non-emergency care co-located with the A&E department. We heard that such work had enabled East Kent Hospitals NHS University Foundation Trust to reduce A&E attendances by 2%. Good work in other areas had been impacted by changes outside of Kent, such as the closure of A&E at Queen Mary's in Sidcup.

(e) A&E itself is also changing, with the establishment of certain specialist centres. Patients requiring primary angioplasty, for example, will often be taken direct to William Harvey hospital at Ashford. Three hospitals are aiming to be Level 2 Trauma Units, and this will also impact where people are taken in certain clinical circumstances. The intention is for these units to be at the William Harvey in Ashford, Medway and Pembury.

(f) Parallel to these changes, the ambulance service itself is also changing, with the training and introduction of Paramedic Practitioners able to treat people at home or closer to home, and Critical Care Paramedics able to care for patients over longer distances to enable them to access specialist treatment.

(g) There are mental health services provided along the entire urgent and emergency care pathway. This includes the Crisis Resolution and Home Treatment Teams who take referrals from a range of sources, and provide treatment at home as well as facilitating admissions to acute inpatient beds. It was admitted that finite resources may mean the Teams are unable to prioritise someone in A&E.[10] However, the good work in developing liaison psychiatry services embedded in A&E departments across the County was recognised.[11] The well regarded RAID (Rapid Assessment Interface and Discharge) 24/7 service in Birmingham had looked to the service in East Kent for inspiration.[12] The liaison psychiatry services in Medway and West Kent are also great successes, but are not currently provided 24/7.[13]

(h) On 1 April 2011, Kent Community Health NHS Trust was formed as a new organisation, bringing together the two community service provider arms of the Primary Care Trusts in West Kent and Eastern and Coastal Kent. One of the major health policy drivers in recent years has been towards a broader shift of activity out of the acute sector and into the community and there is a lot of interesting activity in this sector, including telehealth and the use of community hospitals to provide step up beds from the community to avoid acute hospital admission. The Trust made the point that the levels of people attending A&E do not directly impact community health services; however, there was the potential for more effective use of the sector to avoid admission to hospital.[14]

(i) One area of community services activity which is directly geared to providing an alternative to A&E attendance are the **10 minor injuries units and 3 walk in centres across Kent and Medway.**[15] The levels of use vary across the sites, with the Folkestone walk in centre seeing 1000 patients each month, and the minor injuries unit in Faversham seeing 100.[16] The evidence tends to suggest that while people living near one of these sites will often turn to them before A&E, increasing their use is restricted by at least two things. Firstly, the geographical spread means that access to them is unequal; **Maidstone, for example, does not have a minor injuries unit**, meaning the A&E at the acute hospital is the more accessible option. Secondly, there is variation across minor injuries units and walk in centres with regards the services offered and the opening hours. At the six minor injury units and one walk in centre run by Kent Community Health NHS Trust, for example, the opening hours vary. Where people are unclear about

[10] Evidence from Kent and Medway NHS and Social Care Partnership Trust and NHS Kent and Medway, HOSC Agenda 3 February 2012, p.20.
[11] Ibid, p.21
[12] Minutes, HOSC, 3 February 2012.
[13] Evidence from Kent and Medway NHS and Social Care Partnership Trust and NHS Kent and Medway, HOSC Agenda 3 February 2012, p.21.
[14] Information from Kent Community Health NHS Trust, HOSC Agenda 14 October 2011, p.52.
[15] Evidence from NHS Kent and Medway, HOSC Agenda 14 October 2011, p.23.
[16] Ibid.

what services are available and when, the easier choice is to go straight to A&E. **The very phrase 'minor injury' means different things to medical professionals and the public.**

(j) All of these developments taken together mean an increase in the complexity of the problems presented by those patients who do attend A&E departments.

(k) It would be highly misleading to suggest that the different healthcare providers never acted in an integrated way or worked together to improve the quality of services. For example, Dartford and Gravesham NHS Trust had worked with local nursing homes and GPs on the assessment of elderly patients before being sent to hospital. This had resulted in a 30% reduction in admissions from nursing homes.

(l) The Committee feel strongly that any patient requiring urgent care shouldn't notice any difference when moving from one organisation to another, such as from a minor injuries unit to an A&E department, and different providers need to share information efficiently and effectively. Anecdotal evidence suggests that this is not always the case.[17] If the patient experience is disjointed, such as being referred to A&E from a minor injuries unit with tests being carried out twice in the same day, then this will impact future decisions negatively. However, we also acknowledge that there is sharing of information across Trusts and as not all minor injuries units are able to carry out all tests, the tests may be different, but the perception of the patient remain. We feel this is an area where further work needs to be undertaken to fully assess the extent of this problem.

(m) The situation is analogous with regards GP out-of-hours services, where the first experience (or the reported experience of others) is likely to determine future choices, even where the provider may have changed, or the service improved. This is one area where we hope the development of Clinical Commissioning Groups and thus the increased involvement of GPs in commissioning decisions will be able to make a positive impact.

(n) One message that came out from all the meetings the Committee held on this topic was the belief within the NHS that the coming together of three changes across Kent and Medway would address a lot of these issues. These are:

- NHS 111.
- NHS Pathways.
- Directory of Services.

(o) NHS 111 is to be a single point of access for patients unable to contact their GP, but who do not need to call 999 or attend A&E. It has been

[17] Minutes, HOSC, 6 January 2012.

trialled in the North East of England and results suggest it has led to a decrease in A&E attendances.[18] The intention is that it becomes an England-wide non-emergency healthcare service on a three-digit telephone number.[19] When rolled out nationally by April 2013, it will replace the NHS Direct number, though NHS Direct is expected to continue, alongside other providers.[20] It will be commissioned locally.[21] The procurement for the whole south east coast region is currently underway with a view to it becoming operational by 1 April 2013. NHS Pathways is triage software currently used for 999 calls and some GP out of hours calls. The Directory of Services refers to the development of a live database of what services are available when and where. The intention is that the three of them in conjunction will ensure that anyone using the service will be directed to the right service in the right place to suit each individual person.

(p) If successful, this could be the biggest means to changing the default to A&E which we currently have. **The importance of getting the communication of the change right cannot be underestimated. A person's first experience of 111 may determine whether there is a second.**

3. Conclusion

(a) This short report has focused on the challenges faced by the local health economy in finding another way of responding to the needs of people who attend A&E in a more effective and efficient manner. However, there is the much bigger issue of why people need to access urgent and emergency care services in the first place. While accidents will always happen, there are large numbers of A&E attendances which could be prevented in the first place, and not simply be dealt with elsewhere.

(b) Overall, it has been estimated that around 35% of A&E attendances are alcohol related (including violent assaults, road traffic accidents, mental health emergencies and deliberate self-harm).[22] Locally, self-

[18] Evidence from South East Coast Ambulance Service NHS Foundation Trust, HOSC Agenda 14 October 2011, p.47.
[19] Ofcom, *New 111 non-emergency healthcare phone number confirmed*, December 2009, http://media.ofcom.org.uk/2009/12/18/new-111-non-emergency-healthcare-phone-number-confirmed/
[20] Department of Health, *NHS 111*, November 2010, http://www.dh.gov.uk/en/Healthcare/Urgentandemergencycare/DH_115054
[21] Department of Health, *Dear Colleague Letter. Rolling out the NHS 111 Service,* August 2011, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129104.pdf
[22] Department of Health, *Checklist Improving the management of patients with mental ill health in emergency care* settings, September 2004, p.3 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4089197.pdf

harm is the third highest reason for attending A&E in West Kent and Medway, and sixth highest reason in East Kent.[23]

(c) The evidence for saying that a higher priority needs to be given to public health and preventive work speaks for itself. The establishment of the Health and Wellbeing Board in Kent and the transfer of public health responsibilities to local government give grounds for optimism. While we can admit that problems exist and that all sectors of the health service agree that reducing A&E attendances is a priority, we believe that not only can those one in five people referred to at the beginning of this report be treated more appropriately and at a lower cost to the whole health economy, but that more can and will be done to reduce the need for any kind of urgent and emergency care.

4. Recommendations

1. **The patient journey should be seamless, with no duplication of diagnostic tests, or better communication with patients of why tests are being carried out. We ask the commissioners and providers to report back to the Committee with details of what work is being undertaken to assess the scale of the problem and achieve this.**

2. **Lack of awareness or confusion around the alternatives to accident and emergency mean turning to A&E is often the simplest and most rational choice, even where it is not the most appropriate one. Commissioners and providers should produce a joint communication plan to simplify the choice of GP out-of-hours services, minor injuries units, walk-in-centres and other alternatives and improve public understanding.**

3. Following from the above recommendation, the Committee asks that commissioners and providers explore the appropriateness and viability of introducing **standardised opening hours** around a clearly understood set of services across all the minor injury units in Kent.

4. We ask the commissioners to provide further information on the costs per case for those patients seen at a walk in centre or minor injuries unit compared to those seen at A&E departments.

5. The Committee congratulates the work done so far in developing Liaison Psychiatry services and asks that commissioners and providers work together to ensure the successes are consolidated and the service fully rolled out across the county.

[23] Evidence from Kent and Medway NHS and Social Care Partnership Trust and NHS kent and Medway, HOSC Agenda 3 February 2012, p.20-21

6. The role of GPs in ensuring the goal of each person receiving the most appropriate treatment at the right time is achieved cannot be underestimated. We ask NHS Kent and Medway to provide assurances that all of the emerging Clinical Commissioning Groups are leading on the work to develop the urgent and emergency care pathway.

7. The rollout of 111 is a great opportunity accompanied by great risks. There is only one chance to introduce it properly. The Committee requests that the commissioners of the service and relevant providers involve the HOSC and other key stakeholders early on in the development of the communication and implementation strategies.

8. The creation of the Health and Wellbeing Board and transfer of substantial public health responsibilities to local government provides a golden opportunity to develop integrated preventive health plans and we ask the Health and Wellbeing to prioritise work which will reduce the number of people entering the urgent and emergency care pathway in the first place.

9. The HOSC requests that NHS Kent and Medway produce a written report for the Committee by the end of the year detailing what success has been achieved in reducing attendance at A&E and what plans have been agreed with the NHS provider Trusts in order to further meet the challenge.

Appendix – Committee Meeting Information

(a) In the first part of 2011, the Health Overview and Scrutiny Committee of Kent County Council held a series of meetings into *NHS Financial Sustainability.* In the resulting report, the Committee undertook to carry out a series of further whole systems reviews focussing on some of the key areas impacting financial sustainability across the Kent health economy.

(b) To provide a focus to the discussions, the Committee looked to answering the following two strategic questions:

- What is the impact of the current levels of attendance at accident and emergency departments on the sustainability of health services across Kent and Medway?
- How can levels of attendance best be reduced?

(c) The HOSC held three meeting on the first of these reviews, *Reducing Accident and Emergency Admissions.* The dates of these meetings, along with names of organisations attending are below along with links to the Agendas. The evidence provided to the Committee from NHS organisations in Kent and Medway can be found in the respective Agendas.

- 14 October 2011
    - NHS Kent and Medway
    - South East Coast Ambulance Service NHS Foundation Trust
    - Kent Community Health NHS Trust
    - Kent Local Medical Committee
        - Link: http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3502&Ver=4
- 25 November 2011
    - East Kent Hospitals NHS University Foundation Trust
    - Medway NHS Foundation Trust
    - Dartford and Gravesham NHS Trust
    - Maidstone and Tunbridge Wells NHS Trust
        - Link: http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3503&Ver=4
- 3 February 2012
    - NHS Kent and Medway

- Kent and Medway NHS and Social Care Partnership Trust
- Kent Local Medical Committee

  - Link: http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3977&Ver=4

(d) Preliminary findings were published and discussed at the meeting of 6 January 2012.

  - Link: http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3976&Ver=4

(e) The Committee would like to thank everyone involved in the inquiry for their openness and informative engagement with the process. The HOSC has always aimed at a constructive engagement with the local NHS and believes that scrutiny should lead to positive outcomes. The following findings and recommendations are offered in this spirit.

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