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
- Maidstone and Tunbridge Wells NHS Trust
- East Kent Hospitals NHS Foundation Trust
- Dartford & Gravesham NHS Trust
- Medway 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.

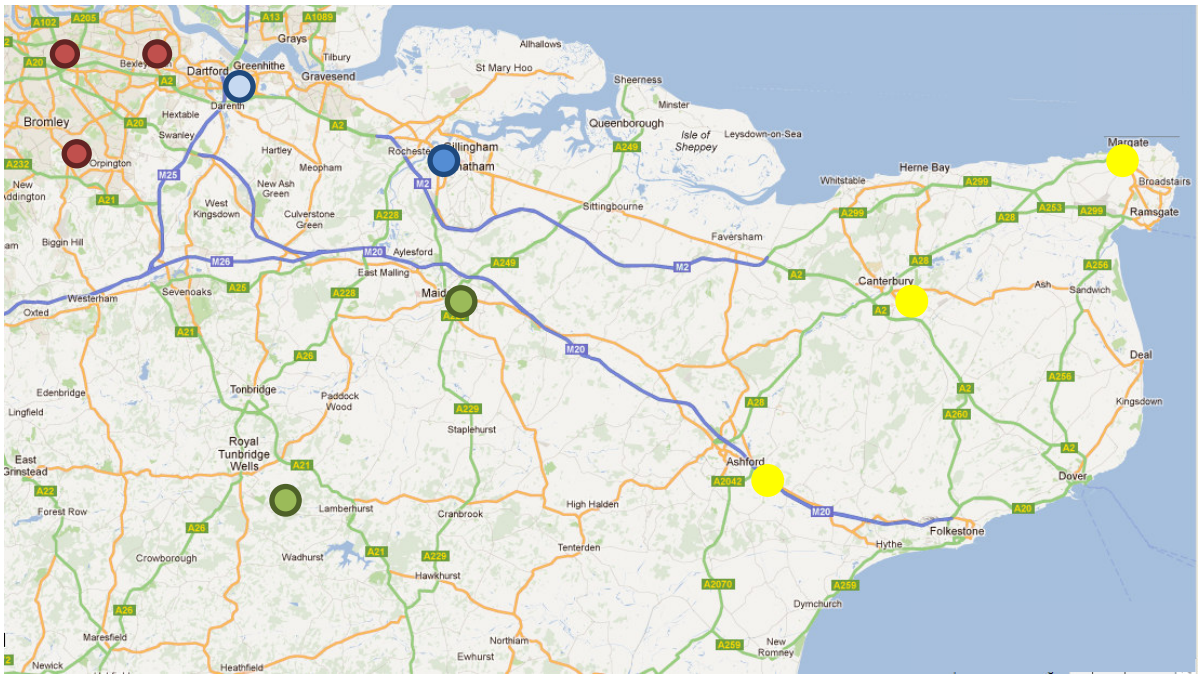
3 Current Service Profile of both Trusts

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

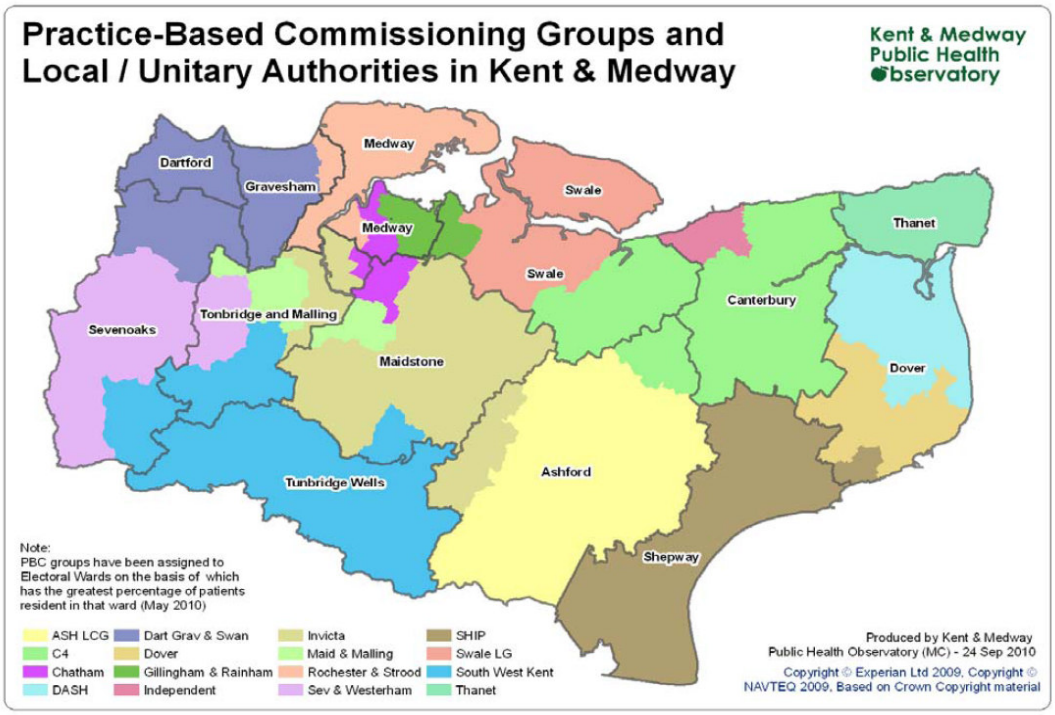
The future integrated clinical strategy recognises the impact of these commissioning changes on the outlook for the two trusts and responds to it. Current plans indicate that approximately £21m of clinical income is reduced as a consequence of the management of demand by commissioners, of which

£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

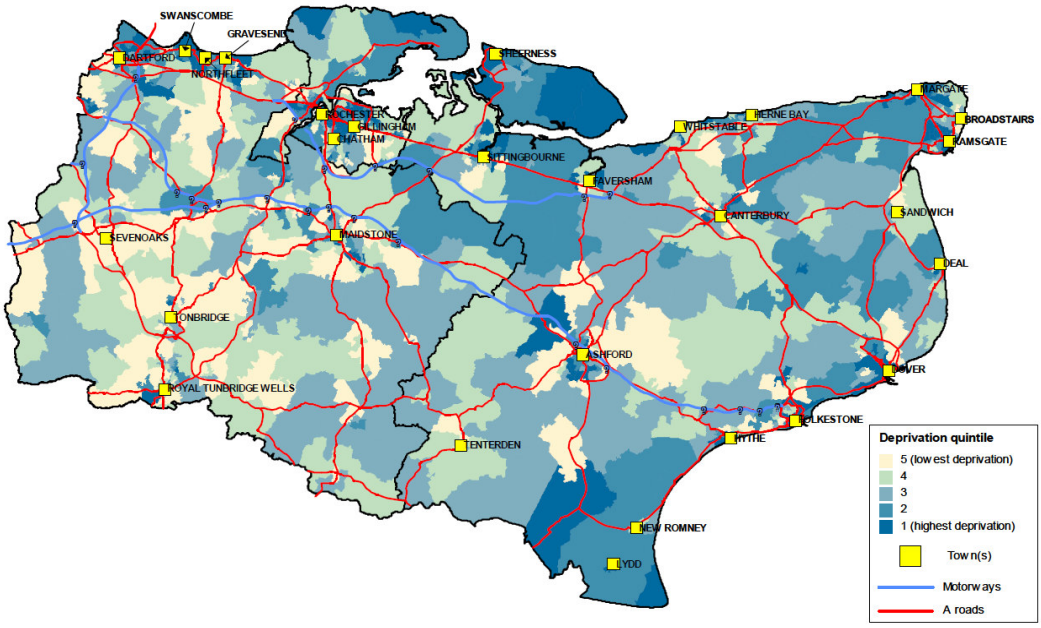
Indicator	Dartford	Medway	Gravesham	Swale	Bexley	Kent	England Average
Physically active children[13]	62.0	48.7	47.1	38.9	41.9	54.1	55.1
Obese children (Year 6)[14]	22.7	20.4	19.9	18.1	20.6	18.2	18.7
Teenage pregnancy (under 18)[15]	36.1	45.2	38.1	46.7	40.0	36.3	40.2
Adults smoking[16]	24.4	22.2	18.8	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

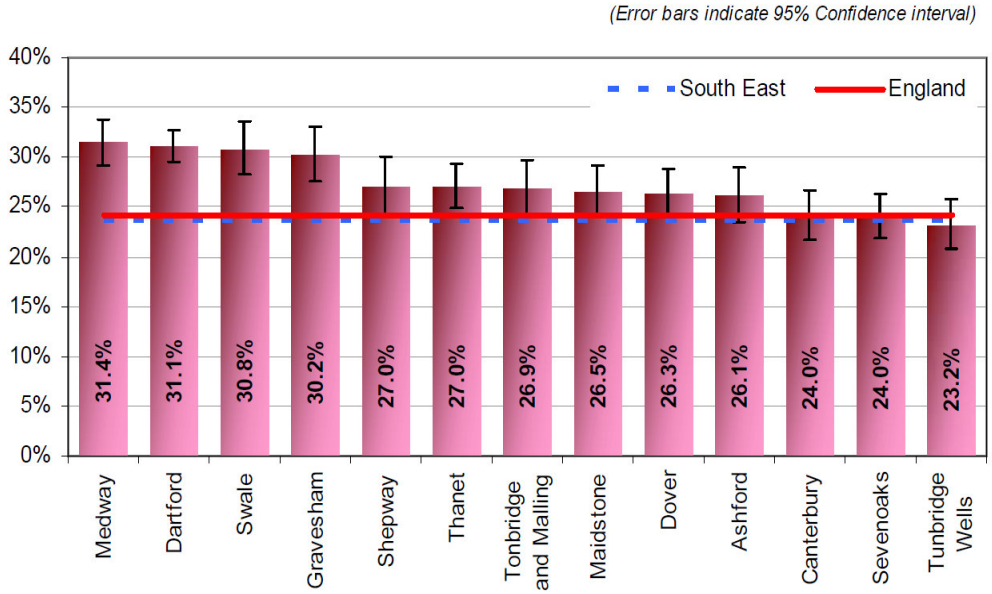
Figure 9: Map of Deprivation in Kent and Medway (2007)



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.

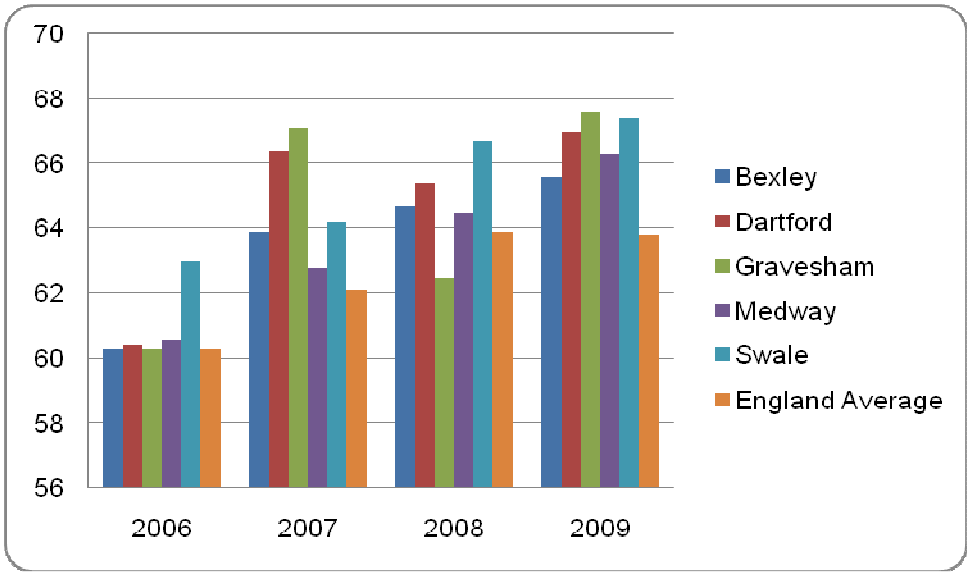
There are no in-house nephrologists in local hospitals presentably apart from at DGT, which too provide only limited renal services mainly for the patients in its locality with the majority of the patients and their relatives have to travel either to central or to East Kent Hospitals for more advanced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

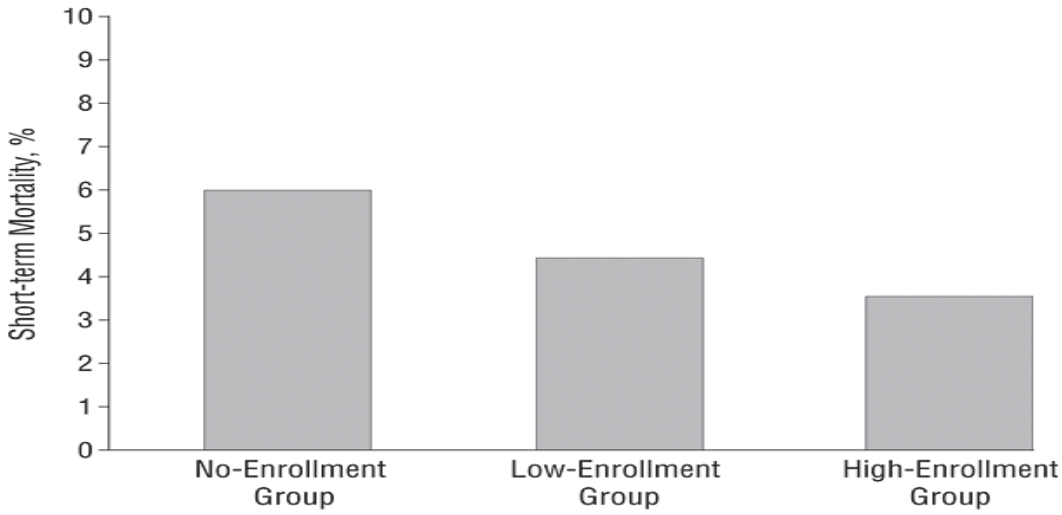


- **Research and Development**

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.

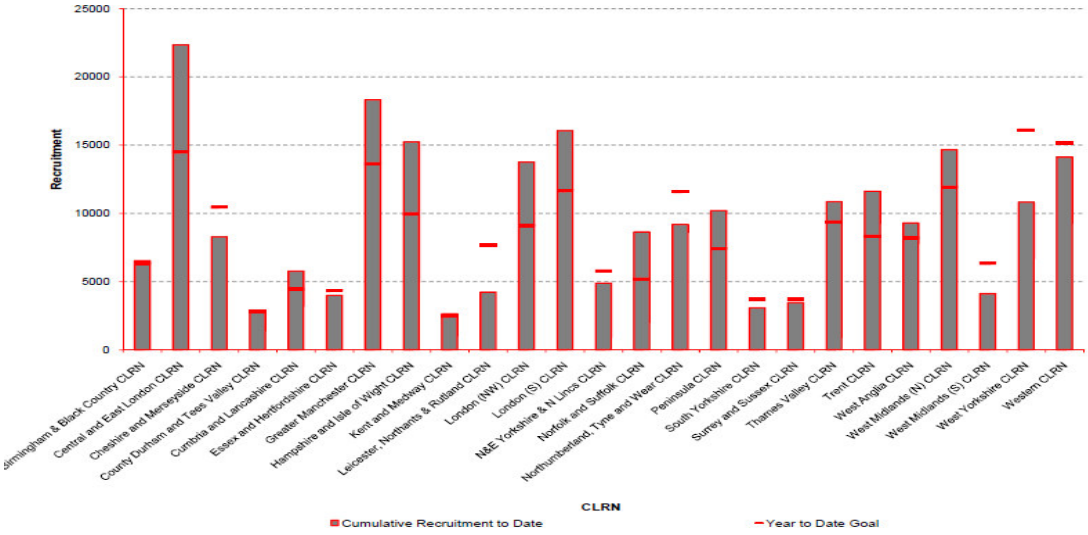
Figure 20: Cardiovascular Mortality

(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

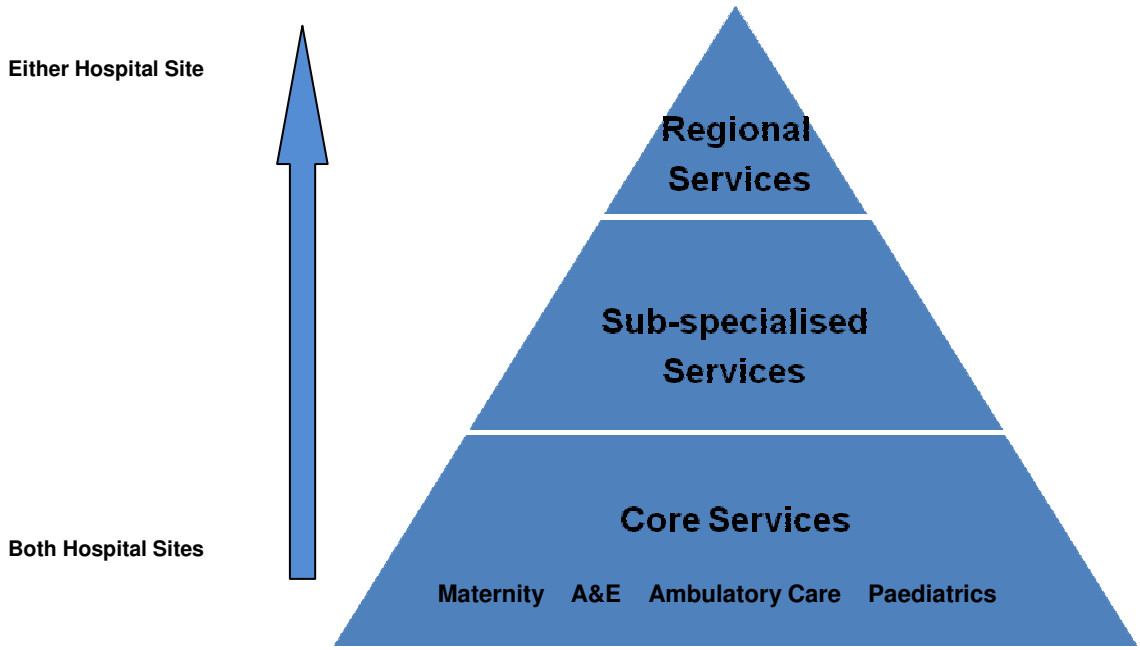
The trusts Lead Clinicians worked together with their clinical teams over a period of 18 months to develop the clinical integration strategy for the integrated trust. This work also involved the development of clinical service visions for their respective specialities and directorates. The development 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.

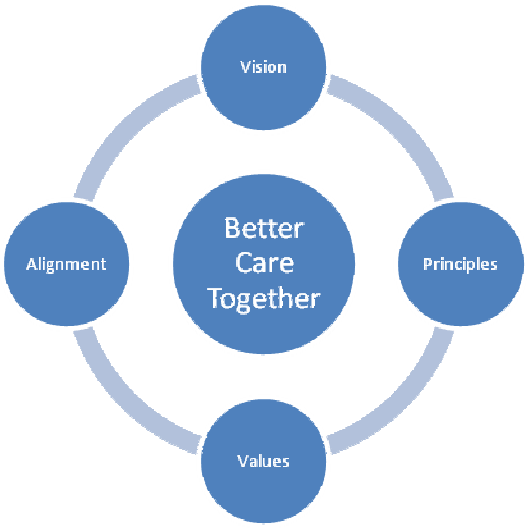
A small group of representatives, including staff, governors and trade union representatives from both MFT and DGT will come together to review the values of each Trust and to develop an integrated approach for the new organisation. The group will be invited to build on what has worked to date whilst 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
7. Incompatible cultures	Amber	• An effective Organisational Development Strategy and Plan is implemented
1. Loss of corporate memory and leadership		• Implementation of Organisational Strategy • An effective Post Transaction Implementation Plan • 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 • Regular tracking of benefits realisation through PMO approach • Identification of a Senior Responsible Officer for the Integration and designate Chair, Chief Executive and Finance Director in place pre transaction
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 • Regular tracking of benefits realisation through PMO approach
3. Inadequate investment in the transaction		
9. Quality standards reduce due to failure to integrate systems that leads to governance concerns	Green	• Early identification of governance systems required by Day One. Clinically led and organisationally owned governance systems and clinical integrated strategy. • Strong leadership and accountability • Trust Board overview and sign off of Monitor certifications • Monthly meeting with PCT cluster and Clinical Commissioning Groups • Regular meetings with NHS South of England • NHS South of England representative at the IPB
4. Changes to the local health economy render strategy flawed		
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.

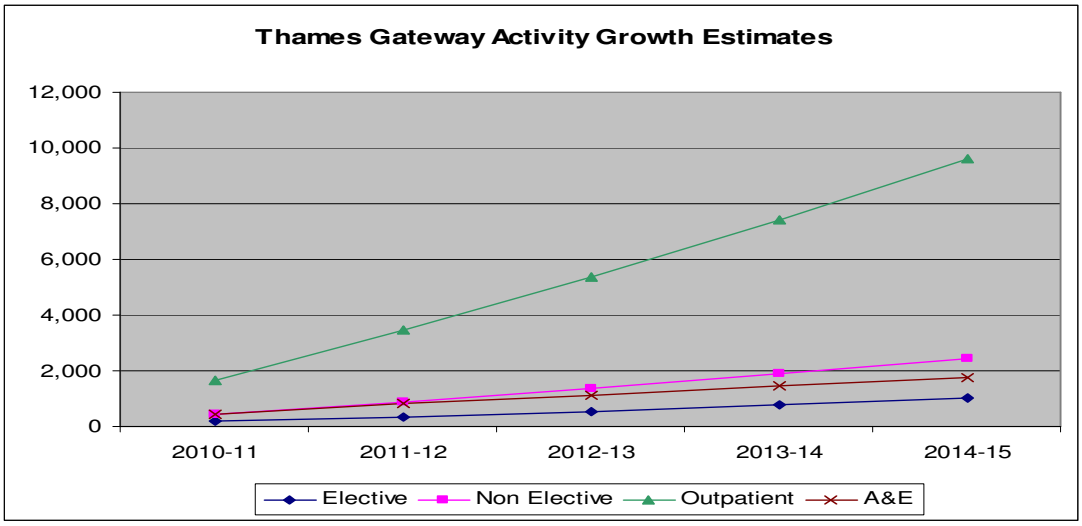
‘Kent Thameside’ covers the planned developments in and around Dartford and Gravesham where 25,000 new homes will be built by 2016. The South East Plan makes an assumption of 25,000 extra people in Dartford and Gravesham between 2006 and 2016, and 50,000 by 2026. The motorway

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.

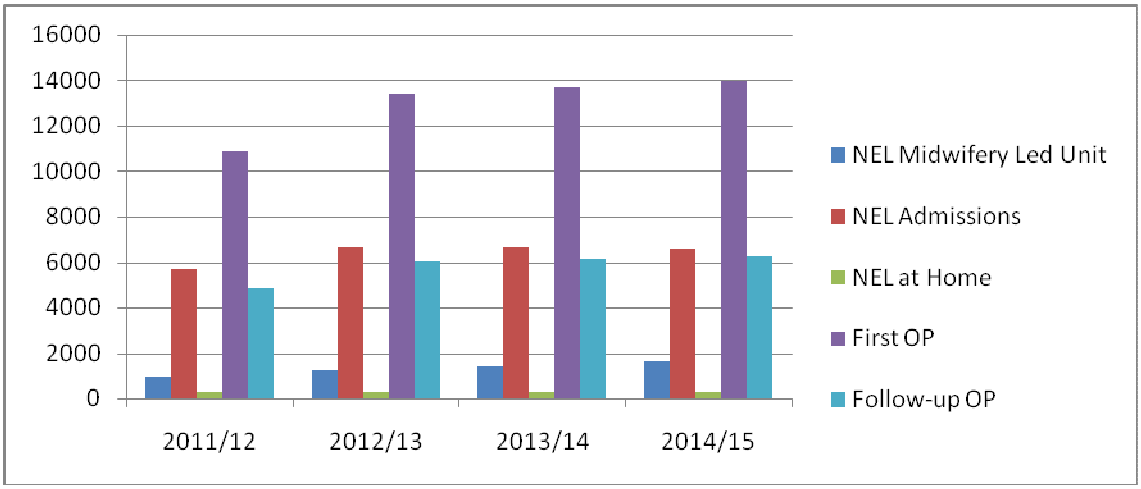
Thames Gateway Activity Growth Estimates



- **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.

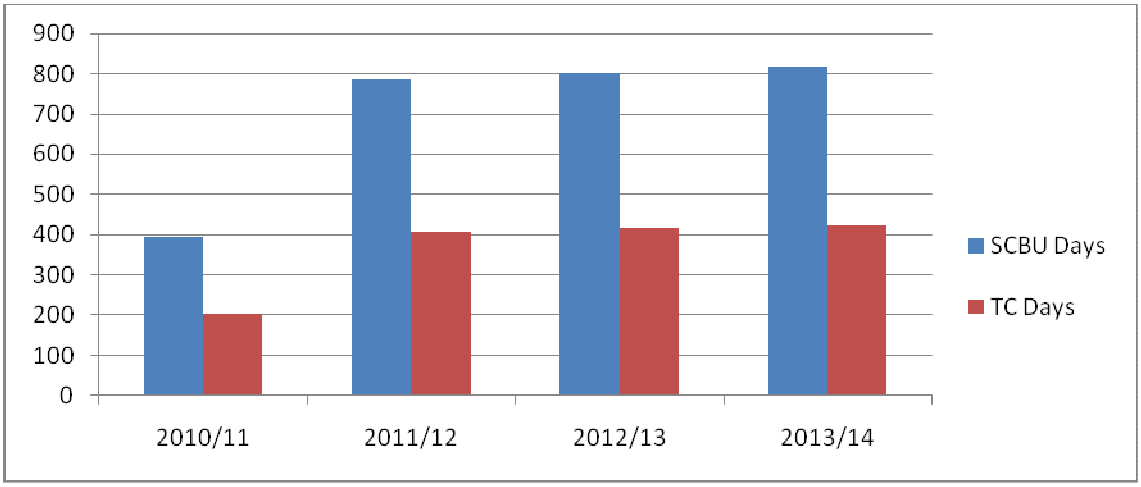
Obstetric Activity at Medway Maritime



- **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