

Annual Plan 2011/12

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1 Introduction

This Annual Plan outlines the key developments and priorities for Dartford & Gravesham NHS Trust for the year 2011/12. Our aim is to get things right for the patient, first time. We don't always do this but this will be a key priority in the year ahead. To do this we have important initiatives and investments in Emergency Care, Infection control, pressure care, falls and care of the elderly amongst others.

2 Contextual factors to be considered for 2011/12 and beyond

In the current NHS economic environment, the Trust is aware of the need to respond to a range of contextual factors, as outlined below.

2.1 Operating Framework 2011/12

The Operating Framework for the NHS in England contains the following key aspects:

- Patients' rights to access services within maximum waiting times under the NHS Constitution will continue. Providers should be expected to offer maximum waiting times to patients and there will be monitoring of compliance with this and the 95th percentile of waiting time. The median wait will also continue to be monitored with a view to improvement;
- The existing cancer waiting times standards will continue to apply;
- The A&E 4-hour indicator will be replaced by a suite of indicators;
- Elimination of mixed-sex accommodation;
- Extension of best practice tariffs (see further details under section 1.3);
- Tariff reduced overall by 1.5%, and non-tariff services also reduced by 1.5% (see below for further details);
- Hospitals will not be reimbursed for emergency readmissions within 30 days of discharge following an elective admission, and all other readmissions within 30 days of discharge will be subject to locally agreed thresholds, set to deliver a 25% reduction, where possible;
- Continuation of the 30% marginal tariff rate for emergency admissions above the 2008/09 baseline year;
- The amount that providers can earn via the Commissioning for Quality and Innovation (CQUIN) framework will be 1.5% on top of Actual Outturn Value. The existing national CQUIN goals on venous thromboembolism (VTE) risk assessment and on responsiveness to personal needs of patients must again be included in CQUIN schemes, and they must again be linked to around one fifth of the value of schemes.
- The national requirement for efficiency in 2011/12 is 4% (2% of which is embedded in tariff prices – see section 1.3)
- Introduction of a flexibility which will create the opportunity for providers to offer services to commissioners at less than the published mandatory tariff price (use of this flexibility must be agreed by commissioners and providers)

2.2 Local commissioning intentions

2.2.1 NHS West Kent

NHS West Kent ¹ have indicated the following commissioning intentions:

- To reduce A&E attendances by 2-7%;
- To reduce non-elective admissions and length of stay;
- To achieve the national average for attendance-to-admission conversion rate;
- To reduce Consultant to Consultant referrals at specialty level to the top quartile Kent performance;
- To reduce follow-up ratios to the top quartile Kent performance;
- To reduce readmission rates and establish a baseline rate for same-condition readmission;
- To introduce community ambulatory blood pressure testing;
- To introduce Carpel Tunnel Surgery in the community;
- To introduce a community Pulmonary Rehabilitation service;
- To introduce a new pathway for Parkinson's Disease

2.2.2 Bexley Care Trust

Bexley Care Trust ² have not yet finalised their commissioning intentions.

2.2.3 The 2011/12 Payment by Results (PbR) national NHS Tariff

The 2011/12 Tariff contains the following key points:

- Expansion of best practice tariffs to Adult Renal Dialysis; Daycases (for 12 procedures ³ within Breast surgery; General surgery; Gynaecology/urology; Orthopaedic surgery; and Urology); Interventional Radiology ⁴, Primary Total Hip and Knee Replacements; Transient Ischaemic Attacks (Mini Strokes); and paediatric diabetes;
- Continuation of existing best practice tariffs (Cholecystectomy; Acute Stroke and Fragility Hip Fracture);
- Targeting long stay payments so that relatively short stays do not attract a payment;
- Incentivising the provision of care in less acute settings where clinically appropriate;
- Updating the market forces factor (MFF) payment index. For the Trust, MFF has been reduced from 14.98% to 14.56%

2.2.4 Structural changes resulting from 'Liberating the NHS' / Health and Social Care Bill 2011

The Government's proposals include:

- Increased focus on outcomes;

¹ NHS West Kent became part of a Kent and Medway-wide PCT cluster in April 2011

² Bexley Care Trust became part of a South East London PCT cluster in April 2011

³ Sentinel node mapping and resection; Simple mastectomy; Repair of umbilical hernia; Primary repair of inguinal hernia; Repair of recurrent inguinal hernia; Primary repair of femoral hernia; Operations to manage female incontinence; Therapeutic arthroscopy of shoulder - subacromial decompression; Bunion operations with or without internal fixation and soft tissue correction; Dupuytren's fasciectomy; Endoscopic resection of prostate (TUR); and Resection of prostate by laser.

⁴ Endovascular aortic repair; and Uterine fibroid embolisation (neither procedure is currently undertaken at the Trust)

- Establishment of GP consortia (emerging GP Consortia for Dartford, Gravesham and Swanley and Bexley have been assigned GP Consortia 'Pathfinder' status by the Department of Health);
- Abolition of Primary Care Trusts (PCTs) / Clustering of existing PCTs;
- Foundation Trusts being the only organisational form allowed after April 2014;
- Introduction of a new NHS Outcomes Framework;
- Increased accountability via local authorities and local Health Watch;
- Increased transparency / use of information;
- Affirmation of NHS Constitution, and patients' rights therein

2.2.5 Proposed integration with Medway NHS Foundation Trust

The Trust is exploring formal integration with Medway NHS Foundation Trust. Please refer to Appendix 3 for further information

2.2.6 Cost-pressures

A range of cost-pressures have been identified via budget setting meetings with each Directorate between January and March 2011. Some of these cost pressures are unavoidable and need to be funded, including Agenda for Change incremental increases, PFI inflation and other unavoidable inflation.

3 Trust objectives

3.1 Long-term strategic objectives

The 9 previous long-term objectives (see Appendix 1) will be replaced with 1 overall 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"

This high-level objective has a number of specific sub-objectives, to enable the objective to be managed via the Board Assurance Framework process. These sub-objectives are reproduced in Appendix 2.

3.2 Annual objectives, 2011/12

The annual objectives should support the achievement of the overall strategic objective. The Annual objectives for 2011/12 (in order of relative importance) are:

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

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

Each of these high-level objectives has a number of specific sub-objectives, which are reproduced in Appendix 3.

The Trust's previous (2010/11) annual objectives are reproduced in Appendix 4.

4 Likely significant service developments for 2011/12

'Significant' service developments are defined as those that will result in an expansion to the existing number of Consultants employed within a service (i.e. new Consultant posts, not replacements), and also includes significant financial investments.

Unless stated otherwise, the developments listed below are subject to consideration of a full business case, in accordance with the appropriate Trust procedures. These developments will therefore direct any business case requests for 2011/12 (i.e. it should be only be under exceptional circumstances that business cases are submitted that refer to developments not listed below).

4.1 Corporate

- A business case has been agreed to increase the Trust's nursing numbers via an investment of £500k (this is the final stage of a previous review of ward staffing);

4.2 Accident & Emergency directorate

- Previously agreed investment in A&E infrastructure/re-design⁵ and staffing will be fully implemented, to support a new model of care (i.e. expansion to 6 Consultants, 9 'middle grade' doctors (with potential to increase to 13), and further nursing staff;
- Implementation of the recommendations from the Emergency Care Intensive Support Team (ECIST)

4.3 Adult Medicine directorate

- Development of Elderly care via expansion of the Consultant workforce and a review of the structure and approach to acute elderly care;
- Expansion of the Nephrology (Renal) service (to 2.5 Consultants);
- A business case for the establishment of a 'hot area' for the care of Level 1 patients is likely to be submitted during 2011/12
- Implementation of the recommendations from the Emergency Care Intensive Support Team (ECIST), primarily in relation to the Clinical Decisions Unit (CDU)

⁵ Phase 1 of the project (relating to paediatric A&E) was completed in April 2011. Phase 2 (relating to resuscitation, majors, and trolleys) will require some temporary accommodation outside of the existing A&E department, in order to create space for the building works to take place. The construction period will last until Autumn 2011.

4.4 Surgical directorate

- Expansion of the Orthopaedic service to 6 Consultants (from the current 5);
- Transfer of the current Endoscopy Suite to a dedicated area, to increase its capacity to 5 rooms;
- Expansion of Day care theatre, to increase capacity from 3 theatres to 5;
- Development of Step-down High Dependency Unit (HDU) facilities, to release the pressure for ITU/HDU beds. This will require the identification of appropriate clinical space, in addition to increase staffing;
- Recent increased clinical activity within the Breast service is likely to lead to a request for increased Consultant staff, and a 'one-stop-shop' approach for patients;
- Development of the anaesthetic on-call rota, to enable the rota to be split between general anaesthetics and ITU (at present, one rota is expected to cover both ITU and general anaesthetic care);

4.5 Women and Children's directorate

- Due to the increasing birth rate it is likely that both paediatrics and Obstetrics/Gynaecology will need to increase Consultant numbers by the end of the 2011/12 financial year to meet activity demand;

4.6 Radiology directorate

- A previously agreed business case for a new MRI scanner will be applied during 2011/12. This will lead to repatriation of patients to the Trust (i.e. the Trust currently outsources some MRI scans to an independent sector provider);
- The department of Radiology is currently being reviewed and recommendations regarding growth of the service are likely to be considered during 2011/12;
- A business case for replacement CT scanner facilities is likely to be submitted during 2011/12 (though this will be for implementation from 2012/13 onwards)

4.7 Pathology directorate

- The Pathology services of Dartford & Gravesham NHS Trust and Medway NHS Foundation Trust will be developing a strategic and operational partnership (see Appendix 5)

5 Other intended service developments for 2011/12

The following services are intended to be developed in 2011/12. These developments will not involve an increase in numbers of Consultant medical staff, but will likely require consideration of business cases (unless otherwise stated):

- A business case for additional emergency survey and trauma sessions in main theatres has been approved (this is to avoid the need to operate at night by providing an extra session during the day);
- Following the appointment of a Consultant, the Chronic pain service will expand with the aim of repatriating patients who had previously had to attend other Trusts for care and treatment;
- An Enhancement programme for Colorectal, Urology and Orthopaedic patients will be introduced. This will require changes to current clinical pathways, and an additional Nurse Specialist;

- Repatriation of sickle cell services from London (this is likely to require payment of sessions to non-Trust staff);
- The development of paediatric surgery links with Medway NHS Foundation Trust (see Appendix 5);
- Due to the increasing birth rate it is likely that midwife numbers will need to increase to meet activity demand;
- Nephrology (Renal) services will continue to repatriate patients from King's College Hospital NHS Foundation Trust, via the establishment of low clearance clinics, increasing the management of complex cases, & increasing the inpatient bed base;
- Neurology service developments from previous years will continue, including increasing the inpatient bed base;
- An ambulatory care model (for urgent care) is being developed, involving the establishment of 'one-stop' clinics, and the strengthening of the current ward round arrangements;
- The Trust will manage an acute stroke and stroke rehabilitation service for Bexley patients;
- The Hospital at Home Team will be expanded, in response to the drive to provide care in non-acute hospital settings;
- Repatriation of Cardiology patients from London hospitals will continue;
- A business case has been agreed in relation to surgical site antisepsis (i.e. change of skin preparation from the current iodine-based products to a product of 2% Chlorhexidine / 70% alcohol);
- A business case has been agreed to establish a joint outpatient sickle cell clinic consisting of a specialist team from King's College Hospital NHS Foundation Trust and the local paediatric consultant with interest in sickle cell disease;
- A business case for additional investment in the Infection Control Team has been approved (an additional nurse and administrative support);
- A business case has been agreed to establish a Trust Bed Management contract with an external provider to supply a complete maintenance service for all bed frames in use, a supply and decontamination service for all dynamic mattress requirements and foam/mattress cushion requirements, and to provide usage audit support to the Tissue Viability Nurse;
- The Trust will also aim to cease its reliance on window escalation beds during 2011/12

6 Likely significant service changes / disinvestments for 2011/12

6.1 Clinical service changes

- Any reductions and/or disinvestments in 2011/12 will only take place in response to local commissioning intentions, or as part of service reviews undertaken as part of the Trust's Quality, Innovation, Productivity and Performance (QIPP) programme.

6.2 Potential workforce changes

- There are likely to be workforce reductions within management and administrative posts, as part of the Trust's efforts to improve efficiency and Productivity
- Any reductions in the clinical workforce in 2011/12 will only take place in response to local commissioning intentions.

7 Quality Plan for 2011/12

This is in development⁶, but the key aspects so far are outlined below.

7.1 Patient safety

7.1.1 Priority 1: To develop and improve care pathways for patients attending the Emergency Department, giving faster access to diagnostic investigations in the management of emergency admissions

- This will include streamlining the admission pathway to the Clinical Decision Unit (CDU) and the wards
- The Trust is working with the Department of Health Intensive Support Team to ensure that patients are seen more quickly and that their needs are assessed by a senior doctor in a timely manner.
- The Trust has recruited a new Clinical director for the Department to develop more efficient and organised care for patients.
- The Trust will measure the improvement in our performance against the new A&E clinical outcome framework

7.1.2 Priority 2: To fully engage in 'Safety Express' which is part of the Quality, Innovation, Productivity & Prevention (QIPP) Safe Care Workstream

- 'Safety Express' is an initiative launched in 2011 which aims to see pressure ulcers reduced by 50, catheter acquired urinary tract infections reduced by 30%, and achieve zero (0) avoidable fractures related to falls in hospital.
- The outcomes will be an improvement in reported patient experiences, a reduction in length of in-patient stay and fewer patients readmitted.

7.1.3 Priority 3: To reduce hospital infection rates for all hospital acquired bacteraemias and clostridium difficile

- In 2011/12 the Trust aims to achieve a level below three MRSA bacteraemia infections, less than 20 cases of clostridium difficile, less than 10 cases of MSSA bacteraemia infections and (0) avoidable cases of other bacteraemia infections.
- The Trust has a robust, proactive Infection Control action plan in place which supports best practice in the prevention and control of infection.

7.2 Patient experience

7.2.1 Priority 1: To introduce a training programme for staff focussing on caring for vulnerable, elderly patients

- The Health Ombudsman's 'Care and Compassion' report (February 2011) highlighted a national picture of deficits in the standard of care provided to older people by the NHS. The new training programme is a response to this report and to recommendations made by the Care Quality Commission following their inspection visit to the Trust in

⁶ The Quality Plan is part of the Trust's annual Quality Account, which will be published by 30th June 2011

March 2011 (in relation to the Commission's national programme of inspection of dignity and nutrition for older people).

7.2.2 Priority 2: To improve the care received by patients and their families in their interactions with Trust staff and systems and reflect the Trust's commitment to provide services that demonstrate respect, dignity and efficiency

- To measure our achievement we will demonstrate improvement which is reflected in the ratings in privacy and dignity parts of the Care Quality Commission (CQC) inpatient surveys

7.3 Clinical effectiveness

7.3.1 Priority 1: To achieve a year on year reduction in hospital mortality

- Quality Laboratories (Q Labs) are Directorate clinical meetings in each at which Consultant teams, Nurses and Managers review the detailed comparative clinical quality indicators and patient care data. The information is collated and produced by CHKS, the Trust's external partner for data analysis.
- The Trust will work to strengthen Q Labs at Directorate level, and strengthen links with clinical governance system. The Q Lab setting allows peer review to take place in a structured environment which in turn supports clinical effectiveness and evidence based practice.

7.3.2 Priority 2: To achieve less than 5% delayed calls (or absence of a call) to the Medical Emergency Team (MET) in 2011/12

- The Trust has worked to reorganise the care and management of patients whose condition is deteriorating to ensure that the care given to patients is timely and effective.
- The establishment of a Medical Emergency Team (MET), which can be called at any time, provides a rapid response to these patients before they enter a crisis stage. Early recognition of these patients gives a better opportunity for effective management.

7.3.3 Priority 3: To aim to have 100% of hospital inpatients assessed for their risk of developing a blood clot by January 2012

- Each patient, over the age of 16, admitted for care in our hospital will have an assessment to determine their risk of developing venous thrombosis (clot in a vein) or pulmonary embolism (clot in the lung) and if necessary will be given preventative treatment to minimise this risk.
- This will be monitored externally by the Department of Health and the Primary Care Trust.

8 Financial projections and analysis

The financial outlook for the NHS continues to be challenging one. At the time of writing this report, the Trust had agreed a break-even budget for 2011/12 though the budget included income risk of £3m where the value of Service Agreements did not match with the Trust's budget.

The Trust has set a Quality, Innovation, Performance and Productivity (QIPP) target of £6.4m for 2011/12 which is 4% of the Trust's income plan. The NHS Operating Framework has clarified that the tariff prices to acute hospitals receive 1.5% cost of living reduction and that the assumed rate of inflation was 2.5%. This means that there is an inherent 4% cost saving requirement for all NHS hospitals.

In respect of Dartford & Gravesham, the inflation increase is likely to more than 2.5% and with PFI payments linked with the Retail Price Index and ring-fenced, the actual QIPP requirement on Clinical services are likely to be 5-6%. Discussions with local commissioners indicate further demand management plans may reduce income by £1.6m and the non payment of re-admissions within 20 days, the Trust has a major financial challenge in 2011/12.

With these circumstances in mind, at the time of writing this report, the Trust Board has agreed financial plan which achieves a break-even position in 2011/12 but an IFRS deficit of £1.6m. The Board is continuing to collaborate with local acute Trusts in respect of clinical and non clinical services as a way of mitigating the impact of the economic downturn.

8.1 Income plans 2011/12

8.1.1 Contract income

	Gross proposals 2011/12		Revised
	Outturn 2010-11	SLA value	Net PCT Proposal (incl. CQUIN & other adjustments)
	£m	£m	£m
Income			
West Kent PCT	114.8	113.3	110.6
Bexley PCT	16.3	20.7	21.0
Medway PCT	3.5	3.5	2.5
Greenwich PCT	1.0	1.0	1.0
South West Essex PCT	2.3	2.3	2.3
PCT Commissioner adjs	0.0	0.0	(1.6)
Start Point	137.9	140.7	135.7

8.1.2 Non-contract income

	Gross proposals 2011/12		Revised
	Outturn 2010-11	SLA value	Net PCT Proposal (incl. CQUIN & other adjustments)
	£m	£m	£m
Income			
Non Contractual Agreements	2.4	2.4	2.4
Private patients and RTA	1.2	1.2	1.2
Other income (incl. provider to provider)	12.4	12.7	12.7
SHA - PFI Support	0.0	0.0	3.0
Start Point	16.0	16.3	19.3

8.2 Income and expenditure plan 2011/12

	£000s
Income	155,000
Expenditure	
Pay	(87,116)
Non-Pay	(22,331)
Drugs	(6,262)
PFI Services	(10,597)
Reserves - Quality	(900)
Reserves	(9,019)
Total Expenditure	(136,225)
Operating Surplus (EBITDA)	18,775
PFI Financing Costs	(13,536)
Depreciation - PFI	(2,601)
Depreciation - Non-PFI	(2,241)
Dividend	(1,497)
Surplus/(deficit) including IFRS impact	(1,100)
IFRS impact	1,100
Surplus/(deficit) excluding IFRS impact	0

8.3 Directorate level budgets

	Total
Emergency Medicine	27,801
Surgery	26,686
Women & Children	16,794
Radiology	4,803
Operations	14,316
Pathology	7,038
CEO	1,096
HR	1,830
Nursing	498
Private Patients	246
Governance	1,522
Service Development	5,006
Finance	20,301
Unallocated 11-12 QIPP	(1,632)
Reserves 10-11	0
Reserves - Quality	900
Reserves 11-12	9,019
Total	136,225

8.4 Quality, Innovation, Productivity & Prevention (QIPP) programme 2011/12

The focus for the QIPP programme for 2011/12 is to balance the necessary efficiency savings required to meet the economic challenges that face the NHS with an improvement in quality of care for our patients. To this end the Trust will be investing £1m in quality schemes and initiatives, some of which are identified in the table in Appendix 6. This investment and commitment to quality will ensure that necessary savings which need to be made will not impact adversely on patient care.

8.5 Outline Capital Programme 2011/12

Capital expenditure

Category	Description	Allocation £000
Buildings	Emergency Department Project - Phase 2	1055
	Mortuary Expansion	160
	Privacy and Dignity - Radiology (scoping exercise)	20
	MRI Enabling Work for 2nd MRI	40
	Total Buildings	1275
IM&T	PC replacement	200
	SAN	45
	Core Network Switches	120
	Maternity (E3)	5
	GP Order Comms (Pathology)	250
	Community working	30
	Total IM&T	650
Medical Equipment	Scope Washer	30
	4 Hysteroscopes	34
	To be decided (including Rolling Replacement Programme)	465
	Total Equipment	529
Other	Energy Project	246
	Total Other	246
	Contingency	300
	Grand Total	3000

8.6 Statement of financial position (balance sheet) 2011/12

	Balance at 01/04/11 £000	Planned Balance at 31/03/12 £000
Non-current assets	113,355	111,544
Current assets	15,338	15,338
Liabilities	-85,758	-85,497
Total assets employed	<u>42,935</u>	<u>41,385</u>
Taxpayers equity	<u>42,935</u>	<u>41,385</u>

9 Declarations and self-certification

The Trust Board agreed to withdraw the Trust's application for Foundation Trust (FT) status in January 2010. However, the Board agreed that many of the structures and processes put in place as part of the FT application, should remain in place, as these processes had helped to strengthen governance at the Trust. One such process was the forward-looking self-certification against a series of Board statements. The February 2010 Trust Board agreed to continue with self-certification on a regular basis, and in particular that self-certification against the non-target-related statements should be undertaken by the Board on an annual basis, as part of the Trust's Annual Plan.

9.1 Statements with confirmed compliance

The Board certified compliance with the following statements⁷ in April 2011:

Quality

1. The board is satisfied that, to the best of its knowledge and using its own processes and having had regard to Monitor's Quality Governance Framework (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients;
2. The board will certify annually that, to the best of its knowledge and using its own processes, it is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements;
3. The board will certify that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant revalidation requirements.

Other risk management processes

5. Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner;
6. All recommendations to the board from the Audit Committee are implemented in a timely and robust manner and to the satisfaction of the body concerned;
7. The necessary planning, performance management and risk management processes are in place to deliver the annual plan;
8. A Statement on Internal Control ("SIC") is in place, and the NHS trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

NHS Constitution

10. The Board will ensure that the trust will, at all times, have regard to the NHS Constitution;

Board roles, structures and capacity

11. The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board;
12. The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability;
13. The selection process and training programmes in place ensure that the nonexecutive directors have appropriate experience and skills;

⁷ Based on the self-certification requirements of the Monitor's Compliance Framework 2011/12 (but amended to take account of the fact that the Trust is not an FT (and does not, for example, have 'terms of authorisation').

14. The management team has the capability and experience necessary to deliver the annual plan;
15. The management structure in place is adequate to deliver the annual plan objectives for the next year

The evidence considered by the Trust Board in relation to these statements is outlined in Appendix 7.

9.2 Statements without confirmed compliance

However, the Board was unable to self-certify against the following statements in April 2011. The reasons for this are outlined below:

Service performance

4. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds), and a commitment to comply with all known targets going forwards.
 - There is no evidence to suggest that the equivalent target of those that the Trust met in 2010/11 will not be met for 2011/12.
 - Only 2 'headline measures' are conformed as not being met in 2010/11: the targets for MRSA bacteraemia and for A&E 4-hour waits.
 - For a further 'headline measure', 62-day waits for Cancer treatment, the year-end target position is not yet confirmed, but this target was challenging during 2010/11, and is expected to be so for 2011/12. However, additional measures to strengthen the Trust's position in relation to this include the strengthening of the Trust's information and waiting list systems, and strengthening the accountability to the Trust's Cancer Services Committee.
 - The Trust is confident that the A&E 4-hour wait times target ⁸ will be achieved in 2011/12, based on the implementation of the recommendations from the Department of Health's Emergency Care Intensive Support Team (ECIST), the internal management changes made (i.e. making A&E a separate Directorate, and appointing a separate Clinical Director), and the investment in A&E infrastructure and staffing.
 - However, the Trust recognises that the objective in relation to MRSA bacteraemia (a maximum of 3 hospital-acquired cases) will be very challenging, and at the present time is unable to self-certify that this target will be met. However, an action plan in relation to infection prevention and control has been agreed with NHS West Kent, and once implemented should enable the Trust to self-certify against this target, and therefore this statement.

This statement is included in the quarterly self-certification process undertaken by the Board, so there will be an opportunity to review this decision within year.

Other risk management processes

9. The Trust has achieved a minimum of Level 2 performance against the requirements of its Information Governance Statement of Compliance (IGSoC) in the Department of Health's Information Governance Toolkit;

⁸ Waiting time within A&E is included within the suite of A&E quality indicators applicable from April 2011

- Requirement 110 relates to contract clauses detailing information governance requirements have been included and formally agreed to in the contracts and/or agreements of all (existing and new) contractors or support organisations with access to the organisation's information assets. The Trust was unable to confirm level 2 compliance, until review of the existing agreements relating to all local IT systems has been undertaken, to confirm inclusion of required clauses;
- Requirement 112 states that all staff, including new starters, locum, temporary, student and contract staff members have completed (or are in the process of completing) mandated information governance training, and that additional training is provided to staff in key roles. The Trust was unable to confirm level 2 compliance, until the agreed revised approach for training for medical staff is delivered⁹, and until the planned programme of additional training to staff in key roles is established and delivery commenced.

The action plan relating to the above actions will be monitored via the Trust's Information Governance Committee.

⁹ it was agreed in March 2011 that medical staff should be required to undertake their training via the national online training tool, rather than via the current method of face-to-face training delivery, as there was insufficient time available to enable a competency assessment

Appendix 1: The Trust's previous long term strategic objectives

1. To improve the patient experience, patient safety and health outcomes of the diverse community
2. To ensure a thriving and sustainable provision of a range of core services with sufficient critical mass to ensure service quality
3. To foster continuous improvement of performance and a positive culture of service innovation and flexibility
4. To maintain the environment and infrastructure to a high standard, and meet the national expectations for sustainability and energy reduction
5. To recruit, develop, manage, lead and support excellent staff to ensure high levels of staff satisfaction and quality of service
6. To maximise utilisation of digital, information and communications technology to provide clinicians with the means of rapid assessment and decision making to improve patient care
7. To ensure productive and valuable relationships with commissioning Primary Care Trusts, Kent and London hospitals Trusts, local authorities and the voluntary sector, to provide comprehensive and high quality care packages for patients with complex needs, as close to home as possible
8. To maintain high standards of governance across the Trust
9. To ensure that the principles and values within the NHS Constitution are at the heart of the Trust's decision making

For 2011/12, the Trust's sole strategic objective will be:

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.

Appendix 2: The Trust's long-term sub-objectives

A number of specific sub-objectives have been developed, to enable the Trust's sole long-term objective ¹⁰ to be managed via the Board Assurance Framework process. These sub-objectives are as follows.

- 6.1 To improve the patient experience, patient safety and health outcomes of the diverse community
- 6.2 To ensure a thriving and sustainable provision of a range of core services with sufficient critical mass to ensure service quality
- 6.3 To foster continuous improvement of performance and a positive culture of service innovation and flexibility
- 6.4 To recruit, develop, manage, lead and support excellent staff to ensure high levels of staff satisfaction and quality of service
- 6.5 Implement the required actions (under the 6 headings) within the Sustainable Development Management Plan (SDMP)
- 6.6 To maximise utilisation of digital, information and communications technology to provide clinicians with the means of rapid assessment and decision making to improve patient care
- 6.7 To ensure that the principles and values within the NHS Constitution are at the heart of the Trust's decision making
- 6.8 Meet the required Care Quality Commission outcomes, legislative requirements and local targets in relation to health inequalities, and equality and diversity policy and practice
- 6.9 Maintain a clean, modern environment supporting a 21st century hospital

¹⁰ 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

Appendix 3: The Trust's sub-objectives for 2011/12

Objective 1: To improve patient experience and patient safety, and achieve the best health outcome for patients, through implementation of the Quality Plan for 2011/12;

Sub-objectives (N.B. these are taken from the Quality Plan for 2011/12 – see earlier):

- 1.1 Patient safety - To develop and improve care pathways for patients attending the Emergency Department, giving faster access to diagnostic investigations in the management of emergency admissions (as determined by achieving the national requirements regarding the 8 A&E clinical quality indicators)
- 1.2 Patient safety - To fully engage in the 'Safety Express' initiative, and:
 - 1.2a Reduce pressure ulcers by 50%
 - 1.2b Reduce catheter acquired urinary tract infections reduced by 30%
 - 1.2c Achieve zero (0) avoidable fractures related to falls in hospital
- 1.3 Patient safety - To reduce hospital infection rates – See objective 2
- 1.4 Patient experience - To introduce a training programme for staff focussing on caring for vulnerable, elderly patients (85% of relevant staff, once the programme is established)
- 1.5 Patient experience - To improve the care received by patients and their families in their interactions with Trust staff and systems and reflect the Trust's commitment to provide services that demonstrate respect, dignity and efficiency (as demonstrated by improvement in ratings in the 4 privacy and dignity questions in the national inpatient survey)
- 1.6 Clinical effectiveness - To achieve a year on year reduction in hospital mortality
- 1.7 Clinical effectiveness - To achieve less than 5% delayed calls (or absence of a call) to the Medical Emergency Team (MET) in 2011/12
- 1.8 Clinical effectiveness - To have 100% of our hospital inpatients assessed for their risk of developing a blood clot by January 2012

Objective 2: To maintain the highest standards of cleanliness and reduce healthcare associated infections, maintaining a zero tolerance approach to infections acquired within Darent Valley Hospital;

- 2.1 Ensure no more than 3 cases of hospital-acquired MRSA bacteraemia occur in 2011/12
- 2.2 Ensure no more than 20 cases of hospital-acquired clostridium difficile occur in 2011/12
- 2.3 Ensure no more than 10 cases of hospital-acquired MSSA bacteraemia occur in 2011/12
- 2.4 Ensure zero (0) avoidable cases of other bacteraemia infections

Objective 3: To develop productive relationships with emerging GP Consortia, local authorities, and other new partners, in order to provide sustainable services for the community, and achieve a sustainable local health economy;

- 3.1 Ensure there are new pathways to improve patient care and meet commissioning intentions
- 3.2 Maximise benefit of local health economy re-ablement funds that are held by partner agencies
- 3.3 Achieve a 15% reduction in length of stay through enhanced joint working with partner organisations

- 3.4 Increase access to local services for patients currently treated in London (from 2010/11 levels), through the repatriation of services
- 3.5 Reduce the number of patients with a length of stay over 30 days, and delayed discharges, from 2010/11 levels
- 3.6 To work with partner organisations to maximise the benefits for patients with mental health needs
- 3.7 To agree an inclusive intermediate care solution with partner organisations

Objective 4: To recruit excellent staff, and develop, manage, lead and support our staff fairly, to ensure they are motivated to deliver high quality and excellent services;

- 4.1 Improve the Trust's score on at least 50% of its 'below average' scores on the national staff survey (including the scores on harassment, bullying and physical violence)
- 4.2 To ensure appropriate processes are in place to support staff through organisational change
- 4.3 Ensure at least 85% of staff receive an annual appraisal
- 4.4 Ensure a vacancy rate of between 5% and 7% for nursing and midwifery staff, and below 7% for all other staff groups
- 4.5 Ensure a turnover rate of between 5% and 7% for nursing and midwifery staff, and between 5% and 12% for all other staff groups
- 4.6 Ensure a sickness absence rate of less than 3.75% for all staff groups
- 4.7 Ensure 85% of staff attend mandatory training over a rolling 2-year period
- 4.8 Ensure the Trust delivers its Health and Safety Commitment by comprehensive completion of risk assessment, using them to ensure safe working practices, training staff to work safely, and promoting health and safety

Objective 5: To deliver the objectives set out in the Financial Plan for 2011/12, including the delivery of a Quality, Innovation, Productivity and Prevention (QIPP) programme that develops patient pathways which provides care closer to patients' homes, and improves the efficiency of the services the Trust provides, thereby saving resources and releasing capacity

- 5.1 To achieve the planned income and expenditure break-even position (£1.6m deficit including IFRS) and 12% EBITDA
- 5.2 To meet the Trust's Capital Resource Limit of £3m
- 5.3 To deliver the Trusts Quality Innovation, Productivity and Performance (QIPP) plan for 2011/12 of £6.4m
- 5.4 Achieve a rating of "performing" against the NHS Performance Framework, in relation to national access targets
- 5.5 Demonstrate a reduction in emergency readmissions from 2010/11 levels
- 5.6 Ensure capacity across the Trust meets the requirements of commissioning intentions, balanced with quality and patient experience, as demonstrated by a reduction in the number of escalation beds from 2010/11 levels

Appendix 4: The Trust's previous (2010/11) annual objectives

1. To improve the Trust's patient experience, patient safety and health outcomes as described in the Quality Plan
2. To maintain the highest standards of cleanliness and reduce healthcare associated infections, maintaining a zero tolerance approach to infections acquired within Darent Valley Hospital
3. To sustain improvements in patients' access to Trust services, in accordance with the NHS Constitution
4. To deliver the Trust's objectives as set out in the Financial Plan
5. To improve the efficiency of the services the Trust provides, saving resources and releasing capacity
6. To continue to be the Hospital of Choice for the people of North Kent, whilst preparing to meet the needs of those communities that may be affected by the reconfiguration of NHS services in South East London
7. To develop productive and valuable relationships with commissioning Primary Care Trusts, Kent and London hospitals Trusts, local authorities and the voluntary sector, to provide comprehensive and high quality care packages for patients with complex needs, as close to home as possible
8. To recruit, develop, manage, lead and support excellent staff to ensure high levels of staff satisfaction and quality of service

Appendix 5: Proposed integration with Medway NHS Foundation Trust

The Trust is exploring formal integration with a Foundation Trust partner (Medway NHS Foundation Trust).

Both Trusts have been undertaking collaboration on a range of clinical and non-clinical services over the past year, and both Trust Boards have approved a Memorandum of Understanding, which commits each Trust to explore the feasibility of formal integration via acquisition of Dartford & Gravesham NHS Trust by Medway NHS FT, leading to a single FT managing two acute hospital sites.

Both Trusts have agreed to make their best endeavours to complete the feasibility work that would allow any subsequent integration by April 2012.

The programme of work to establish the feasibility of integration will be overseen by the two Trust Chief Executives, who will establish an Integration Feasibility Project Board (IFPB) with membership drawn from the Boards and Senior Management Teams of both Trusts (including both Chairmen).

A Project Director will report and be accountable to the two Chief Executives, and be a member of the IFPB.

The IFPB will meet monthly and be alternately chaired by the two Chairmen. It will also oversee plans for stakeholder engagement with the public, local authorities and other NHS partner organisations, and will report to both Trust Boards on a monthly basis.

Much of the feasibility work has commenced, or has been completed, including:

- A 'Partnership Working Options Appraisal' (by Tribal Consulting Ltd), which explored the Operational, Tactical, and Strategic measures that could be employed via a partnership
- A joint steering group established and has met monthly (involving the Chief Executives, Medical Directors and Director of Operations at both Trusts)
- A Quarterly Steering Board of Chief Executives and Chairs, including PCTs (NHS West Kent and NHS Medway)
- Joint Board meetings of the two Trusts, in September 2010 and February 2011
- Initial work on a Long Term Financial Model for an integrated organisation
- Two successful Clinical Leaders Events (July 2010 and January 2011)
- Joint working on clinical services, including Renal services, Pathology, Rheumatology and Urology
- A joint Estates review (by Capita Ltd)
- Joint working on non-clinical services, including a review of integration opportunities in Information Management and Technology; the development of a joint staff bank service; and the commissioning of a Strategic Education Review.

Appendix 6: Quality, Innovation, Productivity & Prevention (QIPP) programme 2011/12

Directorate	QIPP	Details of Potential Cost reduction/Savings	Saving / Income / Non Cash Releasing	Plan
Facilities	Quality	Bed making policy	Saving	1,125
Facilities	Quality	Breakfast service	Saving	114,019
Facilities	Quality	Dignity gown roll out	Saving	5,000
Cancer Services	Quality	Acute oncology service (admission avoidance)	Non Cash Releasing	
Corporate Held	Quality	VTE Assessments	Non Cash Releasing	
Corporate Held	Quality	Thermometer replacement	Saving	25,000
Adult Medicine	Quality	Closure of window beds	Non Cash Releasing	
Adult Medicine	Quality	Dementia Pathway Work	Non Cash Releasing	
Adult Medicine	Quality	Admission avoidance from Care homes	Non Cash Releasing	
Adult Medicine	Quality	Cellulitis Pathway	Non Cash Releasing	
Adult Medicine	Quality	Pneumonia Pathway	Non Cash Releasing	
Adult Medicine	Quality	Heart Failure Pathway	Non Cash Releasing	
Surg Specialties	Quality	Lap Chole Best Practice Pathway	Income	40,000
Surg Specialties	Quality	Fractured neck of femur best practice pathway	Income	38,000
Surg Specialties	Quality	Enhanced Recovery Project	Non Cash Releasing	
Surg Specialties	Quality	Development of Pain Service	Income	TBC
Surg Specialties	Quality	Expansion of Bridging Team	Non Cash Releasing	
Surg Specialties	Quality	90% same day POA	Non Cash Releasing	
Surg Specialties	Quality	Theatres Improvement Project	Saving	42,588
Wom & Children	Quality	Increase Breast Feeding Rate	Saving	10,000
Wom & Children	Quality	Early Pregnancy Unit Development	Income	TBC
Wom & Children	Quality	Reduce C Section Rate	Non Cash Releasing	
Wom & Children	Quality	1-2-1 Care in Labour	Non Cash Releasing	
Wom & Children	Quality	CNST Midwife	Non Cash Releasing	
Wom & Children	Quality	SCBU Transitional Care Beds	Income	TBC
Wom & Children	Quality	Gynae nurses trained for U/S scanning	Non Cash Releasing	
Wom & Children	Quality	Safeguarding Liaison Role	Non Cash Releasing	
Wom & Children	Quality	Nurse Led Infertility Clinic	Income	TBC
Wom & Children	Quality	Sickle Cell Development	Income	9,000
Facilities	Innovation	Switchboard Reconfiguration	Saving	TBC
IM&T	Innovation	Medway Strategic IT	Income	400,000
IM&T	Innovation	IT Staff Restructure	Saving	70,000
Corporate Held	Innovation	Staff Lottery	Income	TBC
Pathology	Innovation	Pathology Review	Income	81,000
Adult Medicine	Innovation	GUM review	Saving	305,000
Operations	Innovation	Auto Check-in Project	Saving	4,200
Operations	Innovation	Nursing Led Clinics	Income	12,000
Operations	Innovation	Patient Transport Review	Saving	30,000
Radiology	Innovation	Clinical Trials	Income	12,000
Radiology	Innovation	Thermal paper	Saving	4,000
Wom & Children	Innovation	Maternity Activity	Income	700,000
Procurement	Productivity	EBME contracts review/rationalisation	Saving	56,000
Procurement	Productivity	Materials Management Review	Saving	44,789
Procurement	Productivity	Administration review	Saving	9,520
Finance	Productivity	Payroll Review	Saving	15,000
Finance	Productivity	Audit fees reduction	Saving	10,000
Finance	Productivity	Staff Restructure	Saving	152,635
Finance	Productivity	Provider to Provider Contracts	Income	134,000

Directorate	QIPP	Details of Potential Cost reduction/Savings	Saving / Income / Non Cash Releasing	Plan
Facilities	Productivity	Actimel Review	Saving	5,166
Facilities	Productivity	Cleaning Review	Saving	15,000
Facilities	Productivity	Waste reduction	Saving	7,000
Facilities	Productivity	Pest Control Specification Review	Saving	3,000
Facilities	Productivity	Insurance premiums review	Saving	15,000
Facilities	Productivity	Radiology Provisions Review	Saving	1,320
Facilities	Productivity	Call Charges Review	Saving	2,000
Facilities	Productivity	Hornbeam Staffing Review	Saving	2,000
Facilities	Productivity	Reduce food wastage	Saving	2,000
Cancer Services	Productivity	Haematology Review	Saving	TBC
Cancer Services	Productivity	Staff retirement	Saving	TBC
Cancer Services	Productivity	Urology Chemo Repatriation	Income	TBC
Corporate Held	Productivity	Procurement Contract Negotiations	Saving	338,000
Corporate Held	Productivity	Benefit from PFI Contract	Saving	TBC
Corporate Held	Productivity	Commissioning Challenges Reduction	Saving	155,000
Pathology	Productivity	Histology Review	Saving	44,789
Pathology	Productivity	Staffing Review	Saving	52,227
Pathology	Productivity	Procurement Contract Negotiations	Saving	20,000
HR	Productivity	Occupational Health Income	Income	10,000
HR	Productivity	Training Budget Review	Saving	20,000
HR	Productivity	Advertising Budget Review	Saving	10,000
HR	Productivity	Accommodation Income	Income	38,000
HR	Productivity	Removal Expenses	Saving	15,000
HR	Productivity	Legal Budget	Saving	39,000
HR	Productivity	Staff Review	Saving	TBC
HR	Productivity	Staff Awards Review	Saving	15,000
Governance	Productivity	CNST Level 2 Achievement	Saving	77,000
Adult Medicine	Productivity	Cardiology Service Development	Income	300,000
Adult Medicine	Productivity	Rheumatology Service Review	Saving	122,500
Adult Medicine	Productivity	Admin re-design	Saving	66,753
Surg Specialties	Productivity	Sterile Services Unit staffing review	Saving	20,390
Surg Specialties	Productivity	Equipment Repairs	Saving	15,000
Surg Specialties	Productivity	Main Theatre - Staff Review	Saving	4,440
Surg Specialties	Productivity	Procurement Contract Negotiations & Consumable Usage	Saving	331,150
Surg Specialties	Productivity	Ward Closure	Saving	450,000
Surg Specialties	Productivity	Staffing Review	Saving	351,432
Surg Specialties	Productivity	Computer Expenses	Saving	7,400
Surg Specialties	Productivity	Travel	Saving	2,100
Surg Specialties	Productivity	Office Equipment	Saving	1,500
Surg Specialties	Productivity	Office Sundries	Saving	1,000
Surg Specialties	Productivity	Emergency trauma operating list review	Non Cash Releasing	
Nursing	Productivity	Staffing Review	Saving	9,756
Operations	Productivity	Staffing Review	Saving	63,000
Operations	Productivity	Patient Transport Staffing Review	Saving	30,000
Operations	Productivity	Drugs Costs	Saving	294,000
Operations	Productivity	Managed Archives	Saving	12,000
Operations	Productivity	Staffing Review	Saving	151,800
CEO	Productivity	Staffing cross-charge - Medway Alliance	Saving	70,800
CEO	Productivity	Annual report fees	Saving	3,000
Radiology	Productivity	Staffing review & recruitment slippage	Saving	293,322
Radiology	Productivity	Agency Costs	Saving	41,000
Radiology	Productivity	Bank Staff costs	Saving	15,000
Radiology	Productivity	Consumables	Saving	42,000
Radiology	Productivity	Direct Access	Income	35,000

Directorate	QIPP	Details of Potential Cost reduction/Savings	Saving / Income / Non Cash Releasing	Plan
Radiology	Productivity	Reduction in outsourcing	Saving	6,000
Radiology	Productivity	Drugs Savings	Saving	6,000
Radiology	Productivity	Baby Scans	Income	4,000
Wom & Children	Productivity	Consumables	Saving	40,581
Wom & Children	Productivity	Staffing Review	Saving	35,000
Wom & Children	Productivity	Locum costs	Saving	72,000
A&E	Productivity	Staffing Review	Saving	135,000
A&E	Productivity	Ward Review	Saving	182,600

Appendix 7: Evidence of compliance with self-certification statements

The evidence presented below is intended to support the Board's existing knowledge and in-year assurances, and therefore be indicative, not exhaustive.

Quality

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

Evidence (please note this is intended to support the Board's existing knowledge and in-year assurances, and therefore be indicative, not exhaustive):

- The quality of healthcare is assured primarily through the Clinical Governance & Risk Committee, which is the delegated committee of the Trust Board for monitoring the quality of healthcare.
- All Directorates have a clinical and managerial representative on the Clinical Governance & Risk Committee.
- Directorates report to the committee on a range of clinical governance and risk management indicators twice per year.
- The Clinical Governance & Risk Committee receives a quarterly integrated safety report covering incidents, complaints and claims and highlights significant risks issues and expectations. The committee also receives a quarterly report on the implementation of Medical Device Alerts & patient safety notices.
- The Clinical Governance & Risk Committee has a range of sub-committees coordinating the management of specific aspects of clinical quality. These sub-committees include:
 - Trust Risk Register Review Committee (which oversees the assessment of risks on the Corporate Risk Register, and the implementation of controls relating to such risks)
 - Patient Safety Committee (which oversees investigation of incidents/complaints)
 - Medical Devices Committee
 - Infection Control Committee (which is responsible for supervising the delivery of the annual infection control programme and for maintaining full compliance with the requirements of the Health & Social Care Act 2008)
 - Clinical Audit and Effectiveness Committee (which oversees the Trust's arrangements for auditing of clinical care processes and outcomes)
 - Medicines Management Committee (which oversees the Trust's arrangements for the provision and administration for medicines)
 - Resuscitation Committee (which oversees the Trust's arrangements for the provision and management of resuscitation services, including staff training)
 - Hospital Transfusion Committee
 - Safeguarding Committee
 - Health at Work Committee

- Complaints Committee
- Thrombosis Committee
- Nutrition Steering Committee
- At Directorate level, there are local clinical governance meetings to support the corporate committee structure.
- Quality Laboratories (Q-Lab) are established. These engages clinicians in monitoring the wide range of conditions they treat and look at patient safety factors including mortality and morbidity, patient experience factors such as length of stay and readmissions and clinical efficiency factors including bed losses from day case overstay and procedures not being carried out.
- Mortality rates are considered at the Clinical Governance & Risk Committee. The Trust Board also receives information on mortality monthly.
- A number of clinical quality indicators are monitored and reported to each Board as part of the Performance Report. These include HCAI rates, patient falls, emergency readmissions, mortality (including peer comparison), pressure sores, and complaints.
- The Trust Board receives the Annual Governance Report, which accounts for clinical quality in the previous financial year.
- Matrons have reported to the Trust Board on a quarterly basis relating to aspects of clinical quality. Such reporting will continue in 2011/12.
- A range of policies and procedures are in place relating to the monitoring of and improvement in, the quality of healthcare, such as incident reporting, patient falls, blood transfusion and early warning systems (for preventing in-patient deterioration).
- A monthly Risk Register Review Committee meeting is chaired by the Medical Director, and attended by Executives, to review Corporate risk register entries.
- The Trust has strong clinical audit and research programmes, which are overseen by relevant specialist committees and clinical leads.
- The Trust Board schedules a clinical presentation at each meeting, to ensure the Board are informed of front-line issues at first hand, and also to provide the opportunity for front-line staff to raise any issues or concerns directly to the Board.
- The Council of Governors is actively encouraged to explore clinical quality issues, and its sub-committee, the 'Patient Experience Committee' continues to develop its role in scrutinising the quality of Trust services.
- In 2010, the Trust was again named as one of the 40 best performing Trusts in the United Kingdom in the CHKS (Comparative Healthcare Knowledge Systems) Top Hospital Awards.

2. The board will certify annually that, to the best of its knowledge and using its own processes, it is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

- Evidence** (please note this is intended to support the Board's existing knowledge and in-year assurances, and therefore be indicative, not exhaustive):
- The Trust was registered without conditions by the Care Quality Commission throughout 2010/11.
 - To provide internal assurance that these standards were being met, a series of peer review challenge sessions were undertaken, which involved challenge of the evidence.
 - An Internal Audit review of the Trust's process for Care Quality Commission registration requirements concluded that 'significant assurance' could be obtained.

- On 1st March, the Trust Board approved strengthened arrangements for Board assurance for the Care Quality Commission registration requirements, including the establishment of mock inspections

3. The board will certify that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant revalidation requirements.

Evidence (please note this is intended to support the Board's existing knowledge and in-year assurances, and therefore be indicative, not exhaustive):

- The Medical Director has been appointed as Responsible Officer, in accordance with The Medical Profession (Responsible Officers) Regulations 2010, which came into force on 1st January 2011.
- Medical revalidation in the UK is expected to start from late 2012 (subject to test of readiness by the General Medical Council in the summer of 2012).
- Work will be undertaken during 2011/12 to ensure that the Trust is able to comply with its obligations under the Medical Revalidation scheme

Service performance

4. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds), and a commitment to comply with all known targets going forwards.

Please refer to comments within the Annual Plan document

Other risk management processes

5. Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner.

Evidence (please note this is intended to support the Board's existing knowledge and in-year assurances, and therefore be indicative, not exhaustive):

- The Trust was successful in retaining Level 1 compliance with the NHSLA risk management standards for acute Trusts, which were assessed on 10th & 11th August 2009. The Trust achieved the maximum score of 50 (a total of 40 was required to pass, with a score of 7 required in each of the 5 standards). The assessors commended the Trust on the level of preparation and presentation of the evidence, as well as the level of Executive Director involvement throughout the two days of the assessment.
- The Trust's maternity service was successful in achieving Level 1 compliance with the CNST maternity clinical risk management standards, which were assessed on 14th & 15th December 2009. The service achieved the maximum score of 50 (40 was required in order to pass). A score of 7 was required in each of the 5 standards
- The Trust's 'Policy for the management of external assessments' ensures that a register of external assessments is maintained. A report on the outcome of any external assessments is submitted to each meeting of the Trust's Audit Committee. Assurance is also provided on any forthcoming assessments. The register provides details of the following assessments:
 - 'Enter and View' visit by Local Involvement Network (LINK)

- Bowel screening QA
- Cancer peer review
- Cervical screening QA
- CNST Clinical Risk Management Standards (Maternity)
- CPA Cellular Pathology (including the Mortuary)
- CPA Chemical Pathology (Clinical Biochemistry)
- CPA Haematology (& Blood Transfusion)
- CPA Microbiology (& Immunology)
- Environmental Health Officer Visit
- Fire Safety Audits / Inspections
- Infection Control relating to MRSA bacteraemia objective – external review by NHS West Kent
- Inspection of hygiene code compliance (Care Quality Commission)
- Investors in People
- Joint Advisory Group (JAG) on GI endoscopy
- Local Education Provider (LEP) (Post-graduate medical education and training) – Speciality reviews
- Local Education Provider (LEP) (Post-graduate medical education and training) – Education Centre review
- Local Supervisory Authority (LSA) assessment
- Medical Device Certification (Sterile Services)
- NHSLA Risk Management Standards (acute)
- Patient Environmental Action Team (PEAT)
- Pharmacy – Approval for pre-registration pharmacist training
- Pharmacy - Aseptic production unit (operating under section 10 of the Medicines Act exemption)
- Pharmacy - Medicines Information (MI) unit (external peer review)
- Pharmacy – RPSGB premises inspection
- Undergraduate medical education reviews
- Waste audit (Environment Agency)
- There have been some non-conformities across the range of external assessments, but these were generally minor, and are being addressed by the relevant clinical and/or managerial lead, with the required level of Executive Director oversight as required. Where more serious non-conformities have emerged, these have been escalated to the appropriate level of authority for action and oversight.

6. All recommendations to the board from the Audit Committee are implemented in a timely and robust manner and to the satisfaction of the body concerned.

- Evidence** (please note this is intended to support the Board's existing knowledge and in-year assurances, and therefore be indicative, not exhaustive):
- The Audit Committee reports to the Board following each committee meeting. This always consists of the minutes (unapproved) with a verbal update from the Audit Committee Chair or Deputy Chair. The Audit Committee chair is invited to highlight the key points, and raise any issues of concern.
 - At present, there are no outstanding recommendations requiring the consideration &/or action of the Trust Board.
 - The Audit Committee also produces an Annual Report, in line with the Audit Committee handbook (2005). The 2009/10 Annual Report was considered at the May 2010 meeting of the Audit Committee, and duly approved for submission to the Board. The report was subsequently received by the Trust Board in May 2010. There were no recommendations to be taken forward by

the Board from that report.

- The May Trust Board is scheduled to receive the 2010/11 Audit Committee Annual Report

7. The necessary planning, performance management and risk management processes are in place to deliver the annual plan.

Evidence (please note this is intended to support the Board's existing knowledge and in-year assurances, and therefore be indicative, not exhaustive):

- Existing Trust processes that support delivery of the plan include:
 - Reporting against financial metrics within the monthly finance reports to the Board and Finance Committee
 - Monthly performance scorecards are published to directorates which includes relative performance on a range of operational and clinical key performance indicators (KPIs).
- The Trust holds a Corporate risk register, which is a live document, and is updated regularly. The top corporate risks are discussed as part of the Trust Risk Register Review Committee chaired by the Medical Director
- The top risks from the Corporate Risk Register are also reported to the Audit Committee at each meeting.
- Risks to the Trust's objectives (annual and long-term) are documented in the Board Assurance Framework (BAF), which is scrutinised at each meeting of the Audit Committee, and every 6 months at the Trust Board.
- The Audit Committee undertakes in-depth scrutiny of selected items of the BAF at each meeting. This entails the lead Executive Director presenting the details of the key controls in place to manage the risks, and progress of any actions to identify any gaps in control or gaps in assurance.

8. A Statement on Internal Control ("SIC") is in place, and the NHS trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

Evidence (please note this is intended to support the Board's existing knowledge and in-year assurances, and therefore be indicative, not exhaustive):

- The Annual Statement of Internal Control (SIC) is presented to the Audit Committee and is the responsibility of the Chief Executive as Accountable Officer.
- The 2009/10 SIC was prepared in line with HM Treasury Guidance and the latest guidance from the Department of Health (issued in February 2010)
- The 2010/11 SIC has been drafted and submitted to NHS South Coast and the Trust's External Auditors (PriceWaterhouseCoopers), for review as part of the core external audit work. The 2010/11 has been prepared in accordance with the latest guidance from the Department of Health (which, in turn, is based on guidance issued by HM Treasury)

9. The Trust has achieved a minimum of Level 2 performance against the requirements of its Information Governance Statement of Compliance (IGSoC) in the Department of Health's Information Governance Toolkit.

Please refer to comments within the Annual Plan document

NHS Constitution

10. The Board will ensure that the trust will, at all times, have regard to the NHS Constitution.

Evidence (please note this is intended to support the Board's existing knowledge and in-year assurances, and therefore be indicative, not exhaustive):

- The Board has been apprised of developments relating to the NHS Constitution, including the insertion of additional patient rights regarding access to treatment, via the Chief Executive's report
- The Trust fully supports the values, principles, rights and pledges within the NHS Constitution and has made efforts in year to promote awareness of the Constitution among patients and staff. The Trust's website contains information on the Constitution, and information posters have been erected in the Boardroom, to ensure that the Trust is best placed to meet, and exceed, its legal duties.
- Proper reference to the NHS Constitution has been made within the Trust's objectives, which will ensure that both the achievement, and control of risks to that achievement, will be reported via the Trust's governance processes (including the Board Assurance Framework)

Board roles, structures and capacity

11. The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board.

Evidence (please note this is intended to support the Board's existing knowledge and in-year assurances, and therefore be indicative, not exhaustive):

- The Trust's Standing Orders require that details of board members' interests be kept up to date by means of an annual review. The most recent review of the declarations of interest was received by the Board in September 2010.
- Since September 2010, three new Board members have been appointed, and all three have completed a declaration of interest and the Trust's register has been updated accordingly.
- None of the declared interests are considered to represent material conflicts.
- In addition, at all Board meetings (and Audit Committee meetings) members are requested to declare any interests with the matters to be discussed at the meeting.

12. The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability.

Evidence (please note this is intended to support the Board's existing knowledge and in-year assurances, and therefore be indicative, not exhaustive):

- The Medical Director, Director of Nursing and Director of Finance are all appropriately professionally qualified and accountable to their professional body (in addition to the Trust).
- All Executive Directors performance and competencies are reviewed via annual performance reviews, as part of the Personal Development Review (PDR) process. The performance of the Chief Executive is appraised by the Chair. The performance of Trust Executive Directors is appraised by the Chief Executive.
- Non Executive Directors receive an annual performance appraisal from the Chairman.

13. The selection process and training programmes in place ensure that the non executive directors have appropriate experience and skills.

Evidence (please note this is intended to support the Board's existing knowledge and in-year assurances, and therefore be indicative, not exhaustive):

- Non Executive Directors have been appointed via the process administered by the Appointments Commission.
- Each Non Executive Director successfully fulfils requirements across the range of generic competencies underpinning the Appointments Commission's selection procedures.
- In addition, the NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity including finance, commerce, and property/estates, so that collectively the Non Executive Director component of the Board is suitably qualified to discharge its functions.
- Once in post each Non Executive Director undergoes an internal induction to facilitate the development of an understanding about the Trust, its operations and strategic direction. This induction programme has been refreshed and revised in the light of recent NED appointments, and accords with the best practice guidance on NED induction from the Appointments Commission.
- Thereafter, ongoing training to develop existing and new skills relevant to the Non Executive Director role is undertaken by attendance at external conferences and workshops as required.
- Non Executive Director's progress is monitored by the Chair via one to one meetings including a formal annual appraisal session at which achievements against objectives for the preceding year are evaluated and new goals for the forthcoming year and a personal development plan are established.
- This is supplemented by a number of Board away days throughout the year to discuss strategy and policy as well as developing the knowledge and skills of the Board on specific issues.
- The Trust's Audit Committee has also approved a training programme for new members (all Audit Committee members are NEDs), which has been applied to new appointment to the Audit Committee in 2010/11.

14. The management team has the capability and experience necessary to deliver the annual plan.

Evidence (please note this is intended to support the Board's existing knowledge and in-year assurances, and therefore be indicative, not exhaustive):

- All managers undertake a selection process that includes an analysis of a CV, an interview and a presentation. Directorate level managers were also provided with a development centre opportunity to identify areas for improvement of their skills.
- Capability procedures to manage performance shortfalls are available if required. Each individual also has a personal development plan.

15. The management structure in place is adequate to deliver the annual plan objectives for the next year.

Board roles, structures and capacity

- There has been a conscious decision to maintain a Directorate, rather than a Divisional, structure;
- The Directorate structure has been strengthened, to the effect of creating A&E as a separate Directorate, with a separate Clinical Director appointed;

- The Trust had decided to appoint a Director of Estates, to obtain improved efficiencies from the management of the Trust's PFI contract;
- The Deputy Chief Executive has been appointed to manage the Trust's transition work in relation to the proposed integration with Medway NHS Foundation Trust, and the post of Director of Operations has been back-filled with an experienced Director from NHS West Kent;
- The Clinical Governance & Risk Committee will be subject to changes in 2011/12, including the change in chair from the Medical Director to a Non Executive Director. Further changes to the committee's function and operation will be considered in the early part of 2011/12