Merger of Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford Hospitals NHS Foundation Trust

Appendices to the Full Business Case

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Appendix 1 – Clinical Senate Review

Clinical Senate Review

Integration of Clinical Services

at Peterborough and Stamford Hospitals Foundation Trust (PSHFT)

and Hinchingbrooke Health Care Trust (HHCT)

Purpose of the clinical review

The purpose of the review is to seek an external clinical opinion on the proposed way forward for the integration of clinical services at Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT) and Hinchingbrooke Health Care Trust (HHCT).

Scope of the review

The integration of the two trust's clinical services is based on the premise that there will be no adverse change to the model of care offered to patients on any of the three sites. If there were future service changes, these would be part of a wider STP process and would involve appropriate clinical senate review and consultation.

Within the case for integration into one trust, the two boards have agreed that the merged organisations should address the issues of current or potential unsustainability of services. Six clinical services have been identified for priority focus, and 21 further services for high level planning.

Out of Scope

The following are outside the scope of this exercise:

A detailed review of all services

The wider STP program for Cambridgeshire and Peterborough, which is the subject of a separate Clinical Senate review.

Questions for the Clinical Senate

In order to support and provide external scrutiny and opinion to the merger and the approach being undertaken to clinical service integration, the clinical senate is asked to consider the following questions:

1) For the six services highlighted (haematology, respiratory, cardiology, stroke, diagnostic imaging and emergency department); are there any high level opportunities or unintended / adverse clinical consequences of the merger of PSHFT and HHCT that are not already identified?

2) Do the high level implementation plans demonstrate that the direction of travel would be clinically safe and have the potential to improve the safety and quality of care compared to the current model?

3) Do the risks identified for merger demonstrate there is adequate mitigation and management in place to ensure the continuation of a clinically robust service to local and surrounding areas?

The clinical senate is asked to review the above questions with particular reference to the six priority clinical specialities.

As agreed with the clinical senate the review proposed is a table top exercise which recognises that no major reconfigurations are proposed.

Information Provided

The following information will be provided as supporting documentation to enable the clinical senate to undertake their review

The full business case, in particular the chapter on clinical vision and integration

Integration plans for six identified priority services

- Clinical haematology
- Respiratory
- Cardiology
- Stroke
- Diagnostic imaging and
- Emergency department

The planned approach to clinical integration of the 27 clinical services.

A conference call with the two Trust's Medical Directors to present and answer specific questions arising from the desktop review.

Appendix 2 – Detailed Description of Option Appraisal

Option appraisal – Notes from the session

3 March 2016

Introduction

This report briefly describes the option appraisal process on the HHCT/PSHFT collaboration conducted on 3 March 2016 at Hinchingbrooke Hospital. The main focus is on the areas where scores differed significantly. Where this occurred, this report captures the main points of the discussion which explains why there was variation.

Process

The session followed the process in the option appraisal process v1.5. The facilitator asked each person to individually score each of the section, one at a time, with scores shared with the whole group at the end of each section. The workbook checked that individual scores added up to 100 and there were no more than two tied scores per description.

Variation

Significant variation between scorers was discussed. The criteria numbers and the associated description in the table relate to those used on the scoring sheet.

Criteria	Description	Outlier	Option	Variation in score	Discussion
1	Compatible with the clinical work streams currently underway	C Hubbard and K Rege	1	35	C Hubbard – Scored option 1 at 35 as there is an opportunity for us to work together collaboratively without other back office changes. Back office change would facilitate it, but it is not a requirement that we do it. K Rege scored option 1 at 0 because of alignment with the STP. Addenbrookes joining in future provides an alternative route to achieving improvement in clinical services.
1	Compatible with the clinical work streams currently	K Rege	4	70	K Rege scored option 4 as 70 as this is the only option that truly allows free movement of staff across the two trusts. Single governance, policies, employer, stakeholders, single environment better able to facilitate the required changes and move towards the FYFV aims.

Criteria	Description	Outlier	Option	Variation in score	Discussion
	underway				
9	Maintain safe staffing levels	K Rege	3	95	Option 3 would not deliver from a medical perspective because it is still fundamentally a service level agreement type of collaboration which could unravel. Haematology and some of the other services meeting this week have spoken about the need to move staff across a single organisation with joint standards and policies. There are no SLA's under option 4, and a single organisation won't unravel under strain. C Hubbard agreed that some SLA's have had to end in the past. C CBarks – operating under a single governance structure with separate organisations would pose challenges, for example recruitment if the post was employed by one organisation but required to work across two organisations under option 3.
12	Minimise the extent to which patient choice is reduced	All	2	25	C Hubbard - Back office is invisible to patients, it won't impact materially on patient choice. S Graves – we need to agree what patient access means, are we to score this as being from the current place, or whether the collaboration will maintain service across either site. K Rege – Gerry Hackett at CUHT has commented that we need one set of documentation across the whole health economy to facilitate the changes in clinical collaboration to maintain and improve patient access. This criteria is scored on the basis of the CMA view of competition, but we need to describe this holistically
13	Acceptable to the public and key stakeholders including staff	All			There was a discussion over whether this criterion could be scored. L McCarthy said that generally stakeholders would view 'do nothing' as good, but not if they were informed of the consequences of doing nothing. C CBarks said it was most important that we maintain viable services. The status quo is not sustainable, but that is not understood by the stakeholders at this time. S Holden summarised that they need to understand the views of individual stakeholders and K Rennoldson asked if we have communicated the reasons for the change to stakeholders, and whether they understood that services could be lost in a 'do nothing' option. D Fowler said that 'do nothing' equates to reconfiguration of back office services, and then there are opportunities to change clinical services. S Holden summarised that there is a financial imperative behind the business case but there are also opportunities for clinical collaboration. C Walker – there has been an early focus on finance, but now this is extending to clinical opportunities.

Criteria	Description	Outlier	Option	Variation in score	Discussion
					S Graves – stakeholder views is an area we may not be able to overtly answer. L McCarthy said that public opinion has been heavily weighted against change, but we need to inform the public to help them understand the need for change. C Walker – this will be developed in a FBC. S Graves – the public are not of one single view. The Peterborough public are not in the same position as the Huntingdon public. We need to consider how we communicate the reasons for change with the public. S Graves –Overview and Scrutiny Committees are key stakeholders. Lance has been to his local committee who were calling for a public consultation as they assume Hinchingbrooke will close. This is absolutely not the case; one or two services may change as a result of currently unsustainable services and external reviews. S Holden - this collaboration is an enabler to maintain services, both trusts are at financial risk and have some clinically unsustainable services. L McCarthy – the local MP for Huntingdon is a key stakeholder we need to work with to help him understand what 'do nothing' means and what is being proposed. **Based on the points above, it was agreed that it was impossible to give a single answer to this question as there was no agreed position on who the stakeholders are, or which patients need to be engaged with. If we progress to FBC, there was a commitment to engage with key stakeholders. At the OBC stage, it is not appropriate to share anything, until there is a clear view of the future direction and the pace of the proposed change.** S Graves – We need to consider how we phrase the engagement in the OBC implementation plan section. We recognise that we don't have a legal duty to consult, but we need to work to inform stakeholders. There are at least four stakeholders, staff, patients, public and commissioners. There are at least two views of the options, views before an explanation and views after they understand what a 'do nothing' option means. S Holden summarised that there is a clear commitment to explain and involve stakeholders at the right time. C Walker – we want to do it properly, all the individual leaders care about getting it right.
14	The cost of investment must not be excessive relative to the	C CBarks C Hubbard	1		C CBarks – scored option 3 high because it is cheaper than option 4. C Hubbard scored option 4 as much higher than option 3 because the benefits from option 4 were so much greater than option 3, in comparison to the increase in cost. L McCarthy - It appears that this option 1 is an investment of £0, but agency etc. will be a

Criteria	Description	Outlier	Option	Variation in score	Discussion
	financial benefits				further additional investment. Both trusts are already investing beyond the available funds as they are both in a deficit position. Continuing as they are, both trusts are in deficit, and the actual baseline position is more difficult to assess as the current situation could deteriorate, costs are hidden, may need to work up what these hidden costs are.

Closing discussion

Once the group had reviewed the combined total scores for each option, discussion followed:

The group agreed that there has been an open and robust discussion around the different scores. This was demonstrated by the differing scores, which led to good discussion about how each option met the criteria.

S Holden summarised that this project is required to move at pace, but there also needs to be engagement with the public and stakeholders. Is the current timetable prescribed in the MoU right?

S Graves – We are going to do engagement if we go to FBC. Pace needs to allow enough time to do this, but be fast enough to keep people on board. In the OBC, we need a range of views on different levels of engagement with a description of the risks of both and different timescales for each.

S Holden summarised that the group agreed that trusts will need to work together during the engagement period.

S Graves – consider what sort of 'coming together' this will be, we need transformation work alongside the transaction work.

C Hubbard – this will be a journey that we are on, and it is important to implement changes which will benefit patients early on. We also need clinical engagement to help the bottom line.

S Holden summarised that there is a shared intent, and the panel needs a structure to take this forward, we also need early clinical wins.

S Graves – we need to write down what the combined intent means, this will give greater confidence that it will deliver.

L McCarthy – we have a joint view of where we are heading, and a good basis to move forward. We still need clarity on how we communicate with stakeholders what the 'do nothing' option means. There is some variability in the scores which is encouraging as it demonstrated that there has not been a 'group think'.

Option 4 a clear preferred option as long as it is delivered in a reasonable timescale to allow engagement with the relevant stakeholders, transformation of some clinical changes and transaction of back office. This will be worked up through the PMB, and discussion between the executives.

Some work up is also required on the financials.

An assurance report on the session will be provided shortly.

Comms will be limited to Executive team and Chairs. Chairs will decide if they share with NED's.

Appendix 3 – Proposed Merger CCG Letter

Our ref: GH/SKS/0916/047
Your ref:

14 September 2016

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Stephen Graves
Chief Executive
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NHS Foundation trust
Peterborough City Hospital
Bretton Gate
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Dear Stephen

Proposed Merger (formally acquisition) of Hinchingbrooke Healthcare NHS Trust by Peterborough and Stamford Hospitals NHS Foundation Trust

We are writing further to your letter dated 1 September 2016 to Jessica Bawden seeking support from the CCG to the proposed acquisition of Hinchingbrooke Healthcare NHS Trust (HHCT) by Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT).

On behalf of the Cambridgeshire and Peterborough CCG, the Governing Body considered the proposal at our meeting in public on 13 September 2016. On the recommendation of our Clinical and Management Executive Team, the Governing Body agreed to support the proposed merger (formally acquisition) of PSHFT and HHCT. The Governing Body acknowledges that whilst the final decision rests with each individual Trust Board following review of the Full Business Case, we believe that the principles of the merger support the clinical, workforce and financial sustainability of both Trusts.

The Governing Body would like to acknowledge the collaborative approach of both Boards and Executive teams throughout the process. We look forward to continued partnership working to ensure that local people receive good quality, affordable and sustainable services for the communities served by both Trusts.

We look forward to hearing the outcome of the proposals.

Yours sincerely

Dr Gary Howsam
Clinical Chair & Chief Clinical Officer

Tracy Dowling
Chief Officer

Appendix 4 – FBC Review PA Consulting Limited

PLEASE NOTE THE PA REPORT IS ATTACHED SEPARATELY TO THIS DOCUMENT PLEASE REFER TO:

"(1) PA Consulting Limited – Final Report"

Changes made to FBC v3 FINAL in response to the PA consulting report

Full business case assurance

PA recommendations were based on an earlier version of the FBC and were categorised as either 'must-do' or 'should-do' actions. The recommendations and actions taken to address them are described below. PA reports that nothing in their recommendations should prevent an FBC decision being made.

Risk register

Recommendation: All risks should be quantified and all encompassing, with explanations as to why they are risks.

Action taken: Risk section in chapter 10 updated with all due diligence risks added, scored and with an explanation of the reason for the scoring and any mitigating actions.

Options appraisal

Recommendation: Include within the OBC the full list of options initially considered and ensure that any changes in financial, risks and benefits of collaboration that have arisen as part of the FBC does not require a second analysis of all the options again.

Action taken: 4.3 of the FBC now includes the long list and short listed options and the reasons for decision making. The NPV values for the three options are included in 4.4.2.

Benefits

Recommendation: Ensure all benefits are identified and described as being quality or financial. Develop a benefits register to feed the benefits realisation strategy and plan.

Action taken: Benefits of merging are described in relevant chapters e.g. clinical benefits are within the clinical chapter. These will inform a benefits realisation strategy and plan in the implementation and integration plan to be considered by both Boards in November.

Costs and Benefits

Recommendation: Ensure all costs and benefits include VAT and inflation and confirm how assets and liabilities may or may not impact with merger.

Action taken: All costs and benefits have been checked and VAT and inflation included where relevant. Assets and liabilities for merger are included in legal due diligence work.

Summary plan

Recommendation: Include a summary plan covering the actions to be taken from transaction and covering implementation to provide assurance that the organisation will be ready from day 1.

Action taken: Both boards have agreed to a full and detailed implementation plan covering all actions and including benefits realisation, to be submitted in November.

Contingency arrangements

Recommendation: Consider and include information detailing contingency arrangements should a transaction be unable to be delivered by 1st April 2017, and contingency for loss of personnel and other risks.

Action taken: A section on contingencies has been added at section 10.6

Due diligence process

PA Consulting were also asked to provide an external review of due diligence processes and progress to date. The scope of the review included the full range of due diligence and assurance requirements set out in Monitor transaction guidance.

This includes all areas of review to be undertaken before a transaction can take place; with the items for completion at the FBC approval stage, being a sub-set of these.

Appendix 5 – Clinical Service Integration Plans

Speciality	Status
Cardiology	Signed off
Haematology	Signed off
Emergency Dept	Draft
Diagnostic Imaging	Signed off
Respiratory	Signed off
Stroke	Draft
Oral and MF	Draft
Critical Care	Draft
Gastroenterology	Draft
Dermatology	Draft
General Surgery	Signed off
Oncology	Signed off
Pain	Draft
Urology	Draft
Diabetes	Draft
Neurology	Draft
Ophthalmology	Draft
Plastic	Draft
Theatres	Draft
Breast	Draft
Therapy Services	Draft
Obstetrics	Draft
Orthopaedics	Draft

NOTE: The plan is for the initial 1-page overviews to be agreed & signed off with clinical teams by the end of September. Next steps will then be planned to keep momentum with priority services depending on the outcome of the September FBC board approvals.

Cardiology integration vision and plan

Integration vision

Inpatients: Two potential models are being explored:

a. Distinct teams for inpatient cover. Different teams based at predominantly at each site
b. Drs rotate for fixed periods across sites (one integrated team)

(pros & cons of each)

Decision is dependent upon: clinical team support/buy-in, STP preferred options, Deanery support for training roles and likely impact on ability to recruit.

Elective care: development of an elective PCI service at PCH*

Outpatients: increased range of services at HHCT

- Specialist clinics to be introduced for HHCT patients: (RACP*, HF*, valves*, pacing follow-ups*, PCI follow-up*)

Diagnostics: Inpatients require good diagnostics at both sites. Both are well placed currently.

Potential opportunity to develop cardiac CT at HHCT*

Strategic drivers for merged service

Strengths	Weaknesses
• Estate Infrastructure PCH • Strong echo service + accreditation @ HHCT • Strong angiography, pacing and echo services at PSHFT (accreditation in progress) • Clinical physiologists • Research at both sites • Education (PSHFT) • Nurse Consultant (PSHFT)	**Medical Staffing at HHCT** • Training / development at HHCT - leading to loss of Cardiology Trainees (Jnr Drs) • HHCT Consultant Recruitment - despite repeated attempts. Three new posts at PSHFT not yet recruited to. • One substantive full time HHCT consultant (+one vacancy / long-term locum) + two consultant posts shared with Papworth (outpatient clinics only)
Opportunities	**Threats**
• Increased catchment population will support greater range of services (e.g. Elective PCI) • ***>range of services offered** – particularly outpatients at HHCT • >Research and clinical trials	• Recruitment 'pull' of specialist Centres • Primary care pressures → secondary care demand • Infrastructure to support 7-day services • Potential long timescale for integrated IM&T.

Key benefits of integration

- Increase in the size of the clinical team enables a greater range of outpatient services to be offered at HHCT.
- Trainees (Jnr Drs) rotation across sites → greater opportunity for exposure / learning to support re instatement of trainees at HHCT.
- Improved consultant recruitment. Appointment to vacancies across both sites.
- Greater catchment area supports the development of some more specialist services (e.g. elective PCI)
- Potential to establish nurse consultant posts across both sites

High level integration plan	Date
Pre-transaction:	
• **Activity management**: Share activity, demand information and use to inform future service model	Nov 16
• **Clinical protocols & guidelines**: share / align clinical policy renewals. Agree timeframe for completion once scoped.	Dec 16
• **Workforce**: Agree staffing model (particularly IP), establish expectations re cross-site working and Commence recruitment	Mar 17
Post transaction:	
• **Develop service models** (starting with outpatient clinics) as new consultants come into post - From	Jun 17

Haematology integration vision and plan

Integration vision

- A fully integrated consultant-led haematology service in place before time of merger, with excellent site-based nursing, pharmacy and support services. All consultants will work at PCH and HHCT, with existing service remaining at Stamford
- On-site Mon-Fri Middle Grade presence on both sites by time of merger, meaning greater continuity of care, and support for consultant and nursing team at HHCT, as well as for clinics
- Clinical teams have single approach to all guidelines and protocols with single leadership ensuring consistency of service across the whole patient catchment
- Patients have full access to all haematology services of merged Trust (eg Teenage and Young Adult, CLIC Sargent, sub-specialties), meaning expanded access locally for HHCT
- More cost-effective service as full, flexible, service provided by substantive staff

Strategic drivers for merged service

Strengths	Weaknesses
• Patient satisfaction • Local services in good environment • Nurse specialist support • Admin and secretarial	• Recruitment and retention of senior medical staff • No HH Middle Grade cover • Not cost effective
Opportunities	**Threats**
• Strengthen/broaden services • Standardised guidelines etc • Better leadership and continuity of service • Better pathology links • Broader sub-specialty access • Better value for money	• Continuity of Care • Flexibilities to respond to need of all 3 sites • Staff retention • IT / pathology links

Key benefits of integration

- Quality of, and access to, service improved due to a fully staffed single team of consultants, middle grades and specialist nurses.
- More opportunity to have services closer to home, with wider range of subspecialty services locally
- Stronger inpatient support on both sites with common approach

High level integration plan	Date
• Joint consultant appointment panel	Sep 16
• Agree and advertise Staff Grade role at Hinchingbrooke	Sep 16
• Revise consultant job plans to reflect 11 session on site presence by all consultants at Hinchingbrooke and on-call	Oct 16
• Review locum consultant appointments assuming successful appointment in September	Dec 16
• Agree revised approach to inpatient ward rounds on both sites	Mar 17
• Identify service harmonisation opportunities for patients (ie better local access) and agree clinic templates	Mar 17

Emergency Department / Accident & Emergency Integration Vision and Plan

Integration vision

- The merger integration plan is for Hinchingbrooke and Peterborough to retain 24 hour emergency services and Stamford to retain its Minor Injuries Unit. Staff will be predominantly site-based, but with ever closer working.
- The vision for future services will be influenced by the models of care commissioned through the System Transformation Plan
- The reality of national as well as local challenges for senior medical and nurse staffing in emergency care may affect the pace at which integration can take place, but the new organisation will offer different opportunities based on patient case mix
- More rapid quality benefits can/will be achieved from increased standardisation of services and training and development, increasing the attraction of the service to prospective staff

Strategic drivers for merged service

Strengths	Weaknesses
• Access for patients • Consultant strength at PSHFT • Loyalty and teamwork • HHCT Middle Grade recruits • Facilities at PSHFT • Good networks (eg trauma)	• Consultants at HHCT and Middle Grades for both • Resilience of system • OOH Paeds ED and diagnostic reporting • Nurse vacancies
Opportunities	**Threats**
• Joint development of ENPs • System capacity planning • Improved Keogh standards • Training excellence • Better community support • Value for money • Shared recruitment	• Current staffing shortfalls and national position • Bed/GP/community capacity. Demand growth • Uncertainties re UCCs and merger discussions • Dilution of services

Key benefits of integration

- Improved opportunities to recruit skilled medical and nursing staff, with greater certainty of prospects in a sustainable service
- Greater access, over time, to a larger number of experienced and skilled staff leading to a better and safer service
- Better access to teaching and training across the sites and shared standards of clinical governance and major incident planning

High level integration plan	Date
• Joint meeting(s) of teams with clear shared agreement of commissioned services and involvement within STP process	Oct 16
• Agree opportunities and approach for shared recruitment (and retention) strategy for hard to fill posts	Dec 16
• Agree opportunities and approach for training across medical and nursing teams, with early focus on junior/middle grade	Dec 16
• Specific project looking at ENP and equivalent posts and models and opportunities for recruitment, support and training	Dec 16
• Agree joint approach to policies, guidelines and quality standards to meet internal and CQC requirements	Mar 17
• Specific work looking at community/integrated admission avoidance services and models	Mar 17

Diagnostic imaging integration vision and plan

Integration vision

Centralised storage of diagnostic images and associated reports that can be accessed easily and quickly at the point of need across our combined organisation and externally where appropriate.

- This is underpinned by:
  - Integrated IT infrastructure
  - Integrated IT systems across all three sites and remote access*
  - Standardised policies, procedures and training across all hospital sites
- Delivered by a workforce that builds further upon the strength of training and developing extended scope radiographers, and offers opportunities for consultant radiologist sub-specialisation - securing the future of services that are currently at risk*
- Separate teams and on-call rotas will remain **at least** until fully merged IT infrastructure is in place and working practices aligned, and likely beyond.
- *Productivity maximised through IT and remote working to minimise the need for cross-site travel.

Strategic drivers for merged service

Strengths	Weaknesses
• Well established outsourcing arrangements for reporting in place that work well OOH • **HHCT** small & dedicated team • **HHCT** AP Radiographers • **PSHFT** ISAS accreditation • **PSHFT** extended scope radiographer staffing model	• **Consultant Radiologist recruitment** • **Separate/different IT systems** • Regional PACS (Picture Archiving & Communication System) – cross-site image sharing. Services at risk • **HHCT:** Nuclear medicine (being decommissioned now), vascular, CT colonography, MDT cover, Neruo, MSK and ultrasound. **PSHFT:** Thoracic (PSHFT) **Both:** Paediatrics, Interventional
Opportunities	**Threats**
• Opportunities for sub-specialisation • Greater opportunity to work remotely • Better / more flexible access to sub-specialist expertise • Cardiac MR Imaging • Community e.g. Doddington / Ely	• Demand increasing faster than activity • 7-day working and funding for tech developments • Infrastructure = pre-requisite • Tech management expertise (PACS / CRIS manager – HHCT gap • Staff likely to leave if cross-site working enforced due to lack of IT infrastructure.

Key benefits of integration

- Imaging = core diagnostic service that is essential to support the effective functioning and pre-requisite for the integration of other clinical services.
- Securing the future of specialist imaging modalities that are currently at risk, and providing timely imaging and reporting.
- Strength and breadth of expertise to ensure Imaging support is provided all Cancer MDT (multi-disciplinary team) meetings to assist with the review complex cases where required.

High level integration plan

	Date
• Workforce: Clinical leads – spend time to understand services to develop a future service model outline (particularly w.r.t. recruitment risk areas)	Oct 16
• Staffing PACS/RIS manger HHCT – Priority appointment (?interim alongside PACS integration)	tbc
• Initial IT infrastructure: 1GB (expandable) fibre link – key enabler for image sharing IT systems development and testing.	Dec 16
• High level mapping of referral reporting policies. To commence post FBC decision.	Dec 16
• Joint governance meetings established (to be run as for an MDT)	Dec 16
• Hon contracts for consultants on both sites where appropriate	Dec 16

Respiratory Medicine integration vision and plan

Integration vision

Inpatients: Two potential models are being explored:

a. Distinct teams for inpatient cover. Different teams based at predominantly at each site
b. Drs rotate for fixed periods across sites (one team)

(pros & cons of each)

Key factors are: clinical team support/buy-in/impact on the acute take rota & likely impact on ability to recruit.

Elective care: development of services & repatriation of patients

- Endobronchial ultrasound (EBUS) & thoracoscopies (both sites)
- Bronchoscopy at HHCT

Outpatients: increased range of services at HHCT

- Specialist clinics to be introduced for HHCT patients: (*ILD, *TB, *COPD, *Cancer, *Pleural, *Asthma and *Oxygen therapy
- +walk-in clinics (both sites) to reduce urgent care demand

Diagnostics: Respiratory physiologists service good

- *Potential to develop specialist imaging & interventional support
- *Potential to develop sleep studies at HHCT

Strategic drivers for merged service

Strengths	Weaknesses
• Respiratory function services good on both sites • Established ambulatory care pathways on both sites • Jnr Drs at PSHFT – established links with Leicester • HHCT good links with Papworth both consultants shared posts. • HHCT – active in clinical trials • Lung cancer and TB services PSHFT	• Shortage of consultants at HHCT (1.3 wte) - both are part-time with Papworth. + 1 Specialist Nurse. • IP Capacity/demand mismatch and Respiratory outliers on other wards • No TB nurse at HHCT for contact tracing • No bronchoscopy list at HHCT (patients go to Papworth) • No dedicated oxygen therapy and follow-up OP service at HHCT
Opportunities	**Threats**
New* services: • *Endobronchial ultrasound, thoracoscopies (both sites) • *Bronchoscopy at HHCT • *Oxygen therapy at HHCT • *Sleep service at HHCT • > team → Improved recruitment	• Papworth move to Cambridge – impact on patient pathways & MDTs (HHCT) + cross-site working/travel • Different referral pathways for specialist (PSHFT with Leicester; HHCT use Papworth and CUH) • Trainees from different rotations

Key benefits of integration

- Increase in the size of the clinical team enables a greater range of elective, diagnostic and outpatient services at both sites, esp HHCT.
- Improved consultant recruitment. Appointment to vacancies.
- Greater catchment area supports the development of specialist services to be provided locally (rather than travel to Leicester or CUH)
- Community pathway redesign across a larger catchment

High level integration plan	Date
Pre-transaction:	
• **Workforce**: Agree staffing model (IP), establish expectations re cross-site working, business case + commence recruitment	Mar 17
• **Activity management**: Share activity and demand information and use to inform future service model	Nov 16
• **Clinical protocols and guidelines**: share audit results and action plans, and align clinical policy renewals. → combined meetings	Dec 16
Post transaction:	
• **Develop service models** (starting with outpatient clinics) as new consultants come into post	from Jun17

Stroke - Integration vision and plan

Integration vision

- Combine skills and expertise and provide specialist stroke physician oversight for rehabilitation services
- Provision of a stroke specialist consultant led high quality, fully integrated and sustainable 7-day Stroke service across both sites.
- Specialist nursing and therapy staffed dedicated stroke rehabilitation ward at HHCT.
- *Commissioner support required to develop an early supported discharge (ESD) care model*

Strategic drivers for merged service

Strengths	Weaknesses
• TIA service 7-days at both sites • Research strong at HHCT • Low mortality • Short LOS (PSHFT) • Dedicated stroke rehab ward/beds at HHCT • Links to community neuro-rehab HHCT • Adult psych links	• Rehabilitation service at HHCT not supported by specialist stroke physicians • Locum / agency costs • Variable quality from locum / non-specialist teams • Difficult to recruit/retain medical staff • Payment mechanisms do not cover costs of rehabilitation
Opportunities	**Threats**
• Further develop links with primary and community care • SEP co-location with community rehab teams • Specialist rehab nursing and therapy ward	• DTOCs threat to capacity • Rehab tariff to cover costs • No early supported discharge (ESD) care model

Key benefits of integration

- Combined approach to improve value for money through more efficient pathways, reduced length of stay and reduced locum costs
- Improved ability to recruit and improved governance and quality improves with permanent staff
- Improved training and development opportunities

Integration Plan – Next Steps	Date
• Staff visits to each site (HHCT Apple Ward & B11 at PSHFT)	Dec 16
• Combined Stroke Team meeting to commence following FBC approval	Dec 16
• HHCT lead (locum) consultant to participate in eastern region stroke video conference – Oct MDT	Oct 16
• Map SSNAP data return completion processes at each site	Jan 17
• Develop SLA for therapy support at HHCT and scope potential for ESD development with commissioners	Jan 17

Oral and Maxillofacial Surgery - integration vision and plan

Integration vision

- Peterborough currently has a full OMFS service for L2 (minor) and L3 (complex) surgery.
- Hinchingbrooke does not provide OMFS services. However, it has a Dental Access Centre run by community providers which also undertakes some minor (L2) oral surgery.
- Providing a more integrated service across Huntingdon and Peterborough for out-patients, day surgery and paediatric surgery.

Key factors -linking with current dental access centre at Hinchingbrooke to understand services provided and likely gaps in service provision

Strategic drivers for merged service

Strengths	Weaknesses
• Dedicated unit at PSHFT with dual qualified staff and trainees. • Additional middle grades • Orthodontics and laboratory on-site. • Provides children's general anaesthetic lists for most of the region. • Good working relationships with ENT and ophthalmology and provides support to respiratory, haematology and surgical dermatology	• Difficulties in recruiting dual qualified consultants (PSHFT fully established)
Opportunities	**Threats**
• Repatriation of elective and emergency work currently going to CUH • Have capacity to expand, particularly minor oral surgery and lab work	• Commissioning and potential tender of minor oral surgery. • Singly qualified consultants cannot undertake on-call work

Key benefits of integration

- Movement of some elective work to Hinchingbrooke.
- Potential to provide some clinics and day surgery lists to provide care closer to home
- Expansion of laboratory service to undertake ear and nose work

High level integration plan	Date
• Map the existing referral pathway and undertake a demand and capacity review for activity at HHCT Dental Access Centre	Dec 16
• Develop the vision and purpose of the service (clinics and elective lists) to be delivered at Hinchingbrooke	Apr 17
• Explore future commissioning intentions with regards to Minor Oral Surgery	2018

Critical Care integration vision and plan

Integration vision

- The future vision of an integrated service is unclear at present, but will include the provision of two intensive care units as other service configurations currently require this. Any amendments to this would be dependent on wider STP decisions on service reconfiguration including ED, obstetrics, acute medicine and emergency surgery.
- There are two models which could be explored;
  - Two separate services operating on each site
  - One department which ensures clinical cover at both sites.

The model adopted would seek to address the current sustainability issues of residential on-call at the Hinchingbrooke site and current locum cover.

Strategic drivers for merged service

Strengths	Weaknesses
• Patient satisfaction and performance • Both have new units with excellent facilities • Fully established consultant base at PSHFT	• Locum dependence and no training grade at HHCT • Unsustainable on-call arrangements (HHCT) • Different preferred IT systems between sites
Opportunities	**Threats**
• Better ability to recruit intensivists at HHCT • Trainee rotation between sites • Could develop model where consultants are not resident on-call	• Uncertainty! Future role of ICU dependent on other services / STP decisions • Different IT systems • Deanery decisions on trainees at HHCT

Key benefits of integration

- There are some benefits in sharing best practice, guidelines, widening research parameters and exploring options for junior doctor training
- Key issue is the dependency on service development decisions (e.g. possible increase in HDU at HHCT by increasing elective throughput)

High level integration plan	Date
• Develop mutual understanding of each site's service, patient demand and models of care	Mar 17
• Meetings to be held with clinical teams, sharing of protocols and guidelines	Jul 17
• Exploration of models, vision and purpose and wider benefits	Sep 17

Gastroenterology integration vision and plan

Integration vision

The merged Trust will have 10 consultant posts with excellent nurse specialists and two modern endoscopy facilities. A key part of the vision is for the service to form together into one strong and coherent team with excellent close working with surgery and diagnostic services

The vision is only partly formed at present, because it has strong interdependencies with parallel work on acute medical and surgical services and rotas at the two sites.

The underlying vision is that patients will benefit locally from access to wider specialist opinion and treatment, and will benefit from the additional resilience in both services afforded by strength in depth.

The services will also provide a strong out of hours service as part of the clinical strategy of the new organisation to deliver strong emergency and 7 day services (Keogh standards)

Strategic drivers for merged service

Strengths	Weaknesses
• Endoscopy JAG both sites • Generally good RTT • Modern facilities • Full medical team at HHCT • Nurse specialists esp HHCT	• Consultant vacancies PSH • O/P Capacity challenges • OOH endoscopy PSH • Scopes at PCH
Opportunities	**Threats**
• Bowel screening • Consultant appointments • Uniform 7 day OOH service • Joint hepatology • Further system join up on GI • Enhanced training • Resilient booking	• Diluting current strengths • Different systems, scopes, pathways • PSH consultant shortfall • Interventional radiology and histopathology gaps in service

Key benefits of integration

- Building on clinical strengths and expertise, the two services will be able to offer a wider range of resilient services across all sites
- The new service will make itself more attractive to consultants and trainees to support the combined service and the Peterborough site
- The service will be more efficient, for example in the management and use of estate and equipment

High level integration plan	Date
• Joint meeting of gastroenterologists / nurse leads etc with view to agreeing joint vision and plan	Oct 16
• Specific working looking at a joint endoscopy service, resources and facilities to build on bowel screening joint work	Mar 17
• Specific work to look at common issues on radiology and pathology to assist with merger of / prioritisation	Dec 16
• Early work between department clinical / managerial leads to identify opportunities to improve consultant recruitment at Peterborough, eg identifying specialty skills, team working with partners at Hinchingbrooke	Dec 16

Dermatology integration vision and plan

Integration vision

At time of writing (September 2016) CUHFT are withdrawing commissioned service from Hinchingbrooke and CCS are giving notice on community service. The commissioned service picture for Dermatology for the catchment seems uncertain.

- If the intention is to commission local services at the Hinchingbrooke site as well as Stamford and Peterborough, the service would become a single service on three sites, with no on-call. Inpatient opinion and advice Monday to Friday.
- The pace of this would depend largely on the pace of recruitment to an underprovided service in the HHCT catchment.

Strategic drivers for merged service

Strengths	Weaknesses
• PSHFT 4 consultant service • Full range of services • Staff grade 3 specialty nurses • Stamford clinic • HHCT 1 stop lesions (plastics)	• HHCT no on-site dermatology • PCH physical capacity • Whole system governance • Commissioning / demand
Opportunities	**Threats**
• Single service on 3 sites • Better one stop services • Overall links with plastics • Commissioned site-based service for HHCT catchment • Joined up service with 1ry care and community	• PSHFT consultant retirement and national shortages • Demand growth • Community uncertainty • Lead time to train up specialist drs /nurses

Key benefits of integration

- Better access for patients across the catchment (both at hospital sites and in the community)
- Adopting best practice from the overall organisation to make service more efficient

High level integration plan	Date
• Understand, and inform, the commissioner plans for the catchment, particularly Huntingdonshire	Oct 16
• Undertake demand and patient flows analysis across the catchment	Dec 16
• Recruit to substantive PSHFT consultant post	Mar 17
• Short term action to look at restarting UVB service at Hinchingbrooke	Dec 16
• Review HHCT model for plastics / skin lesions to identify opportunities for more streamlined service (PCH/catchment)	Mar 17

General Surgery integration vision and plan

Integration vision

- Continued presence for in-patient elective and emergency work on two sites, and out-patient provision on all three hospital sites.
- Further work is required to determine the best models for service delivery. On-call rotas will need to be maintained at both the Hinchingbrooke and Peterborough sites to support ED and obstetrics. This is not likely to change first 1-2 years post-merger as it will be influenced by the wider STP decisions.
- Opportunities do exist for elective care and outpatient service developments. E.g. developing centres of excellence in colorectal and upper GI surgery and potentially developing bariatric services and paediatric elective services.

Strategic drivers for merged service

Strengths	Weaknesses
• Fully established, strong upper GI service (HHCT) • Strong colorectal service (PSHFT) • Nurse specialist support at both sites • Good cancer performance	• Upper GI surgeon recruitment (PSHFT) • Meeting 7 Day Service requirements • Demand for colorectal cancer work increasing • Outsourcing some elective work (PSHFT)
Opportunities	**Threats**
• Increase research activity • Repatriate outsourced work • Training opportunities • Wider service developments	• Limited ability to integrate teams if needing to maintain separate on-call rotas on both sites.

Key benefits of integration

- Ability to better utilise elective and outpatient capacity and skills on both sites, thereby repatriating outsourced work and providing enhanced training opportunities.
- Improved consultant recruitment, and ability to develop a wider range of elective and outpatient services for the enhanced catchment population
- Building on existing good performance and outcome measures – sharing best practice and developing a wider research portfolio

High level integration plan	Date
• Sharing of protocols, guidelines, best practice and outcomes	Jul 17
• Develop sub-specialty meetings to identify and address key areas where collaborative working would benefit patients	Jul 17
• Develop plans to help manage demand in peak periods	Sep 17
• Recruitment to vacant consultant posts, review of capacity and demand at both sites	Apr 17

Clinical integration vision and plan - Oncology

Integration vision

- The merger integration plan is to provide oncology services for local patients at all 3 hospital sites
- Early integration can be achieved using the additional capacity from the new Woodlands building at Hinchingbrooke, and the radiotherapy expansion at Peterborough, reducing current capacity pressures and providing services more locally for patients.
- Other benefits include the development of more local support services, such as lymphoedema, joint protocols, guidelines and training opportunities and the potential to attract, and recruit to more research trials.
- The overall future direction and vision of the service needs to be agreed with all partners in the region in order to maintain the strong connections with CUH and the future vision of the newly forming Cancer Alliance networks

Strategic drivers for merged service

Strengths	Weaknesses
• Good units on both sites with strong leadership and links to palliative care and the community • Recent expansion of Woodlands unit (HHCT) and radiotherapy services at PSHFT • Good peer reviews and achievement of cancer targets at both sites. Strong links to CUH (HHCT) • modern RT department which is expanding to meet needs of the surrounding community	• Difficulty recruiting to medical posts at PSHFT • Radiology – both sites have issues with reporting and support to MDTs • No dedicated in-patient beds at HHCT • Chemotherapy capacity limited at PSHFT
Opportunities	**Threats**
• Full utilisation of chemotherapy capacity in new Woodlands Centre (HHCT) • Potential for patients to have radiotherapy at PSHFT • Development of more local services, eg.lymphedema	• Different IT systems • HHCT Consultants have job plans with CUH • Possibility of de-stabilising strong relationships with CUH (HHCT)

Key benefits of integration

- Better utilisation of capacity on both sites – radiotherapy at PSHFT and Chemotherapy at HHCT.
- Potential to develop more sustainable and local services for patients, such as lymphedema and providing care closer to home
- Opportunity to consider different network models of providing services between the three key providers – CUH, HHCT and PSHFT.

High level integration plan	Date
• Tri-partite agreement of the overall vision for cancer services in the region with CUH, Hinchingbrooke and Peterborough	Oct 16
• Explore the capacity and demand for the Hinchingbrooke and Peterborough areas , and current pathways for patients	Apr 17
• Process map the potential patient pathways, roles and responsibilities for chemotherapy and radiotherapy patients across Hinchingbrooke and Peterborough boundaries	Oct 16
• Explore the impact on workforce requirements for utilising full capacity on both sites with a view to developing split site posts	Oct 16

Chronic Pain Integration vision and plan

Integration vision

- A chronic pain service is not currently provided on the Hinchingbrooke Site
- The future vision would entail the provision of chronic pain services from both sites, enabling care closer to home and the ability to support other services at Hinchingbrooke, such as rheumatology and spinal services.

Strategic drivers for merged service

Strengths	Weaknesses
• Established multi-professional team at PSHFT, including pain consultants, specialist nurses, psychology and therapy input	• Increasing demand • Travel times for patients • Finite clinic capacity
Opportunities	**Threats**
• Provision of some services to patients from the Hinchingbrooke site • Ability to secure sustainable pain services for the combined catchment population	• Restrictions on available treatment options from the CCG • Changes in commissioning policy which may impact provision of services

Key benefits of integration

- Provision of care closer to home for patients in Huntingdon and the south of Peterborough, and the ability to work more collaboratively between primary, secondary and community care. Chronic pain services currently provided mainly from Stamford
- Ability to support more acute, in-patient pain provision in Hinchingbrooke with shared policies, protocols and guidelines. Additional support to anaesthetists at Hinchingbrooke with an interest in pain management

High level integration plan	Date
• Early discussions with Hinchingbrooke team re: service provision, gaps and requirements and potential input from existing services	Mar 17
• Review of capacity, demand and resource required to support service on all three sites	Jul 17
• Business case for additional resource requirements to meet capacity and demand requirements for service provision	Jul 17
• STP decisions on wider pain management service provision across the Cambridge and Peterborough CCG footprint	Jul 17

Urology integration vision and plan

Integration vision

The vision is for a single, combined, Urology service, but with a continued strong presence at all three hospital sites, and to bring more services locally from out of catchment due to the benefits of greater catchment population.

There is further work required to determine the best model of emergency and inpatient care which maximises use of available skills and resources, but more integration of teams and rotas is expected.

Strategic drivers for merged service

Strengths	Weaknesses
• Nine consultants with range of specialty services and good teams and governance • Nurse specialist services • One stop services • Equipment across the patch	• Some single-handed areas • 62 day target, MDT timing • Capacity issues • HHCT depth of support eg no spec middle grade rota • Path and Rad Capacity
Opportunities	**Threats**
• Medical and Nurse training and rotas / cover • Emergency/7 day service • Use of capacity/equipment • Bring services to catchment • Common pathways • Clinical trials	• 7 day service pressures • Growth in demand inc. cancer • Ensuring no loss of best practice and energy • IT systems and links and Rad/Path Capacity

Key benefits of integration

- Opportunity to combine strengths of 9 consultants and nurse specialists to provide a stronger service, eg for emergencies, training etc
- Catchment and skill set will allow for development/repatriation of services more locally
- More effective use of capacity and equipment, better opportunities for R&D/clinical trials

High level integration plan	Date
• Joint meeting to better understand services and prioritise opportunities	Oct 17
• Sharing information on capacity and demand	Dec 17
• Evaluate emergency service / take / rota options and opportunities	Mar 17
• Understand common requirements for Radiology and Pathology from merged services	Mar 17
• Identify benefits from greater use of existing equipment (eg laser)	Mar 17

Diabetes integration vision and plan

Integration vision

Integration goals for the merged specialty for the next two years including:

- No immediate change to overall service offering
- Strengthening of inpatient services to meet Keogh standards
- Strengthened single handed service areas
- Work towards integration / standardisation of service standards, IT, access to support services (eg pathology)
- More integrated service across the whole catchment with primary and community services

Strategic drivers for merged service

Strengths	Weaknesses
• Core services on both sites with good consultant and nurse team support • Meeting RTT standards • Good links with maternity • Community links improving	• IT HHCT • TPP / Pathology HHCT • Capacity / single handed support for some services • Inpatient cover at weekends HHCT
Opportunities	**Threats**
• Plenty of areas where one or other site has a good service which can be expanded for all sites • More joined up overall service with community across whole catchment	• Senior nurse posts vacant • Medical middle grade posts • Demand for services increasing compared to capacity

Key benefits of integration

- The integrated service will adopt best practice from both services to improve the overall quality and breadth of the service
- We will build on integrated IT systems to make a more responsive and efficient service with strong community links
- We will focus on levelling up inpatient services

High level integration plan	Date
• Establish regular joint meetings	Sep 16
• Ensure recruitment to vacant nursing posts at HHCT is addressed	Oct 16
• Work together on plan for weekend diabetes support at HHCT	Dec 16
• Meet together with community providers to understand current pathways and services across catchment	Mar 17
• Joint capacity and demand work and understanding of service pressures / constraints / opportunities	Mar 17
• Assess IT opportunities to improve quality of IT , especially at HH, and input into TPP / Pathology service issues	Mar 17

Neurology integration vision and plan

Integration vision

- A single neurology service across the three sites, but with consultants and nurses predominantly site-based in the first two years
- Over time, a more integrated whole community service, starting with close working towards common pathways and protocols between the new Trust, CPFT and commissioners
- Maintained close working links with CUHFT (Addenbrooke's), but with services locally where possible and viable

Strategic drivers for merged service

Strengths	Weaknesses
• Four consultant service at PSHFT • Specialist nursing eg epilepsy • Research nurse at PSHFT • Close links with CUHFT	• Capacity at HHCT to meet demand • Consultant on site support at HHCT three days per week • No clinics at Stamford
Opportunities	**Threats**
• Stronger overall service, including community • Better HHCT capacity / support • Neurophysiology access • Best practice sharing • Medical students / juniors	• Resilience at HHCT • IT pace of integration • Neurophysiology waits • Ability to recruit consultant post at HHCT if created

Key benefits of integration

- Early benefits will be around best practice sharing such as virtual clinics
- Depending on total capacity across the two Trusts there will be the opportunity for better continuity of patient services (better cover)
- Working with services in the community we can provide more integrated pathways and support for patients

High level integration plan	Date
• Build total picture of commissioned services and community services across catchment	Nov 16
• Support development of virtual clinics at Hinchingbrooke	Nov 16
• Assess options for neurophysiology across catchment for potential local enhancement	Mar 17
• Identify requirements for, and pace of, IT/information integration	Mar 17

Ophthalmology integration vision and plan

Integration vision

- A high quality single service but with staff predominantly site-based
- Joint and/or cross-site appointments for sub-specialty areas to improve patients' access and improve staff skills/knowledge and increase the attraction of the service to clinical teams
- Growing standardisation of streamlined commissioned pathways across 1ry / 2ry care
- A service which has the scale of population to become a viable high quality self-supporting service, but with continuing strong links to tertiary centres and expertise

Strategic drivers for merged service

Strengths	Weaknesses
• High quality facilities • HHCT long established specialty service • Nurse specialists at HHCT • Good relationships and joint work eg on STP • Research nurse / trials	• Physical capacity for demand • Depth of skills in parts of PSHFT nurse team • Different triage system • Private sector contracts
Opportunities	**Threats**
• Theatre capacity • Joint recruitment, eg paeds • Trials • Joint approach to Medisoft • work with commissioners to improve viability	• Private sector - viability • Staying stand-alone • Workforce / succession planning • Growth in demand • Optometrist/GP links

Key benefits of integration

- Greater depth and breadth of services including high quality sub-specialty areas with good links to tertiary centres and trials/research
- Similar best practice pathways for patients across the catchment
- Opportunities to develop skills and expertise of staff to strengthen total service

High level integration plan	Date
• Work in line with current STP to create a single view and plan for Ophthalmology across the PSHFT/HHCT catchment	Mar 17
• Joint work to identify full scope of nurse skill development	Mar 17
• Agree common Medisoft contract approach and align usage	Mar 17
• Consider / evaluate opportunities for joint appointments / services, eg Oculoplastics/Paediatrics/VR	Mar 17
• Understand commissioned pathways and similarities / differences in contracts (eg triage service)	Mar 17

Plastic Surgery integration vision and plan

Integration vision

- High quality, consultant-delivered, service across three sites, with excellent cross-specialty links, building on existing skills and interests. No perceived current need for on-call/out of hours
- Specialists will be predominantly site-based to provide services locally for patients, but with consideration for joint / cross site working for subspecialty areas depending on what provides the most effective and efficient model
- Growth opportunities are likely to come from catchment size, allowing expansion in specialty interests and development of nursing and clinical support services

Strategic drivers for merged service

Strengths	Weaknesses
• HHCT one stop service model • Facilities • Existing links eg hands • 5.5 consultants at present	• No nurse practitioners • Join up with other specialties is varied • 1 wrist surgeon at HHCT • Some Diagnostics
Opportunities	**Threats**
• Nurse practitioner • Clear combined service offering range of specialties • Stronger hand therapy • Better commissioned dermatology / plastics • Work with 1ry Care	• Tariffs for O/P service • Change to best practice pathways • Dermatology demand • Speed of decision making / amount of autonomy in larger organisation

Key benefits of integration

- The combined service should be able to better match consultant specialties to demand and support a wider population
- Plastic surgery services for patients can be expanded / provided on local sites
- Best practice can be more uniformly shared and a more consistent service offered alongside 1ry Care / GPSIs

High level integration plan	Date
• Early meeting of Plastic Surgeons to understand interests and opportunities	Oct 16
• PSHFT recruit substantively to approved third consultant post	Dec 16
• Understand volumes, case mix, capacity and links to other specialties so the full service is understood	Mar 17
• HHCT build case for additional consultant post	Mar 17
• Work through joint approach to MDT / CUHFT links	Mar 17
• Improve local service for hand therapy patients at HHCT	Mar 17

Theatres integration vision and plan

Integration vision

- As a key support function, the vision is to provide theatres on all sites (procedure rooms only at Stamford) to undertake emergency and elective surgery.
- Two clinical models are being explored;
  - Having two separate teams which are site specific for HHCT and PSHFT
  - Having two sites but one integrated team of anaesthetists who would provide a service across both sites depending on clinical need and skill levels
- The decision and future vision will be determined by the models of the services supported by theatres and will also be influenced by the Sustainable Transformation Plan.
- Other benefits include joint training and education for all theatre staff, better business continuity for HSDU, better procurement opportunities and potential to retain skills, such as spinal surgery

Strategic drivers for merged service

Strengths	Weaknesses
• Good training programmes for staff at both sites. • Theatre capacity on both sites • Fully established theatre staffing (HHCT) • Modern facilities with gold standard equipment (PSHFT) • Treatment Centre with ring-fenced elective beds (HHCT)	• Theatre staff vacancies (PSHFT) • 7 locum consultants (HHCT) • Shortage of kit (HHCT) • Need additional obstetric cover (PSHFT – covered by locum) • No rolling replacement programme for equipment (HHCT)
Opportunities	**Threats**
• Shared training, education and best practice • Ability to rationalise kit/equipment • Better purchasing opportunities • Development of further procedure room work	• Different IT/scheduling systems • Refurbishment of ventilation units in main theatres (HHCT) • HHCT Capital requirement for equipment replacement.

Key benefits of integration

- Shared training, education and best practice. Junior doctor training could be enhanced on both sites (depending on configuration of other services)
- HSDU at both sites – provides better business continuity and reduced costs
- Reduction of loan kit costs and improved purchasing power as a bigger unit

High level integration plan	Date
• Develop joint training and education plan for theatre staff	Sep 17
• Review of current IT systems and equipment	Mar18
• Agree business continuity plans, planned maintenance and pathways for HSDU	Sep 17
• Further exploration of proposed models, but would be IT dependent if required to work across both sites	Sep 17

Breast Surgery integration vision and plan

Integration vision

- Provision of breast surgery services on both sites, offering a full range of symptomatic and screening services through an integrated service working more closely together to manage patient demand and make full use of available capacity.
- Wider development of family history clinics and other diagnostic/treatment services, such as Tomosynthesis and MRI guided biopsy (patients currently have to travel to Northwick Park)

Strategic drivers for merged service

Strengths	Weaknesses
• Integrated breast screening and symptomatic service (PSHFT) • PSHFT has limited dedicated consultant radiologist and consultant radiographer • Specialist nurses • Stable and sustainable services	• Clinic capacity tight at PCH site • Increasing demand and MDT requirements at PSHFT • Radiology support to MDTs at HHCT
Opportunities	**Threats**
• Surgical capacity available @ HHCT • Increase R&D activity • Surgical and screening growth potential	• Breast screening boundaries are nationally determined. HHCT with CUH • Differences in IT, PACS and mammography equipment

Key benefits of integration

- Both services are stable and sustainable but have opportunities to increase joint working to use available capacity on the two sites.
- Shared governance arrangements and developing opportunities for increased surgical/treatment work, screening growth and diagnostics, eg mastalgia clinics, family history clinics, MRI guided biopsy and Tomosynthesis, plus opportunity to make MDTs more robust

High level integration plan	Date
• Work together to understand the overall capacity and demand of services across both sites	Mar17
• Develop plans to enable the collaborative management of patient activity at peak periods to maintain good performance in cancer targets	Sept 17
• Understand NHSE intentions for breast screening service for activity move from South Lincolnshire and national screening boundaries	Sept 17

Therapies and Rehabilitation integration vision and plan

Integration vision

- A singe therapies and rehabilitation service across all three sites, but with the majority of staff being site/locality-based
- Expertise in stroke / neurorehabilitation across all sites
- Comprehensive in-house services which provide the opportunity for outreach
- Centre of excellence for practice and therapies career development

Strategic drivers for merged service

Strengths	Weaknesses
• Strong teams, well recruited to and well led • Good skill levels – both sites • Depth of services at PSHFT • Practice development PSHFT • Community expertise HHCT	• Gaps in whole system service (incl. CPFT/CCS) • Paper-base at HHCT • Unviable/small subspecialty areas • Maternity leave / gaps
Opportunities	**Threats**
• Build on good joint working • Rotational/shared posts • Build stronger shared teams eg for stroke, SALT, dietician, hand therapy • Join education/development	• Gradual loss of small services at HHCT site • Another change for HHCT staff – more instability • Resourcing for gaps in service

Key benefits of integration

- Combining multiple strengths to provide stronger services and local access for patients
- Build attractiveness of overall service to staff through excellent combined leadership and practice development opportunities
- Reduced reliance on fragmented service from other services / providers

High level integration plan	Date
• Work on common plan to improve stroke and neuro-rehabilitation on all three sites	Mar 17
• Work on joint and improved dietetic services	Mar 17
• Work on joint and improved hand therapy services	Mar 17
• Paediatric MSK therapies service (as withdrawn at HHCT)	Mar 17
• Practice Education development across both Trust sites	Mar 17
• Agree structure of therapies going forward	Mar 17

Obstetrics integration vision and plan

Integration vision

- At the current time, there is no clear vision of how a merged service would benefit either site, and is subject to STP discussions and agreements.
- Further development of integrated community midwifery across the full catchment area
- More integrated working to meet increasing demand for sub-specialty clinics, such as diabetes and neurology clinics (HHCT)
- Further development and promotion of the normality pathway through the midwifery led birth units
- Improve and develop peri-natal mental health as part of a larger unit

Strategic drivers for merged service

Strengths	Weaknesses
• sustainable and well-governed units with high levels of patient satisfaction • Baby friendly accreditation • Enhanced recovery pathways • Capacity at both sites	• Poor IT system at HHCT • 1:32 birth ratio at PSHFT (business case approved to increase) • Gaps in middle grade rota • Deanery recruitment to training posts
Opportunities	**Threats**
• Single IT system across both sites • Utilisation of a single team in a different way • Increase research profile and activity • Enhanced governance by sharing roles	• Birth rate increases to meet available capacity • Impact of STP work • Other organisation involvement in the pathways, eg CCS for neonates and paediatrics at HHCT • Middle grade gaps in rota • Costs of maintaining 2 fully staffed obstetric units with excess capacity.

Key benefits of integration

- Early implementation of a single IT maternity system (K2)
- Shared governance roles across both sites
- Repatriation of foetal testing from CUH (HHCT)

High level integration plan	Date
- Work collaboratively with the STP plans	April 17
- Sharing of current clinical protocols and guidelines	April 17
- Agreement of common quality dashboard with the Local Commissioning Groups	July 17
- Full understanding of capacity, demand and resources in each area to start developing models for an integrated service	July 17
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Orthopaedics integration vision and plan

Integration vision

- The merger vision links to the STP work seeking a Cambridgeshire wide solution to the management of elective and emergency orthopaedic work
- The merger would provide a fully integrated service with consultant presence on all three sites and strengthening support to proposed plastic surgery and rheumatology services.
- Increased use of the Hinchingbrooke site for elective surgery to improve RTT positions and reduce outsourcing of elective work.
- Joint rotas to strengthen the middle grade tier at Hinchingbrooke and increase registrar training to provide succession planning for future consultant posts.
- Opportunity to retain and develop spinal surgery services for the local catchment population.

Strategic drivers for merged service

Strengths	Weaknesses
• Wide range of sub specialties and effective teamwork • Extended role nurses & practitioners • Good junior doctor training programme with Leicester and Cambridge	• No spinal surgery at PSHFT • Spinal svc closed at HHCT Aug-16 • Hip fracture service fragile • Inability to ring fence beds at PSHFT site • Recruitment to FY2/CT1 difficult
Opportunities	**Threats**
• Develop more robust hip fracture model • Retain and grow spinal services • Single ring-fenced beds approach • Dexa scanning for osteoporosis	• Uncertainty over #NOF model – links to STP • Intensity of current on-call system • Lack of junior doctors at HHCT

Key benefits of integration

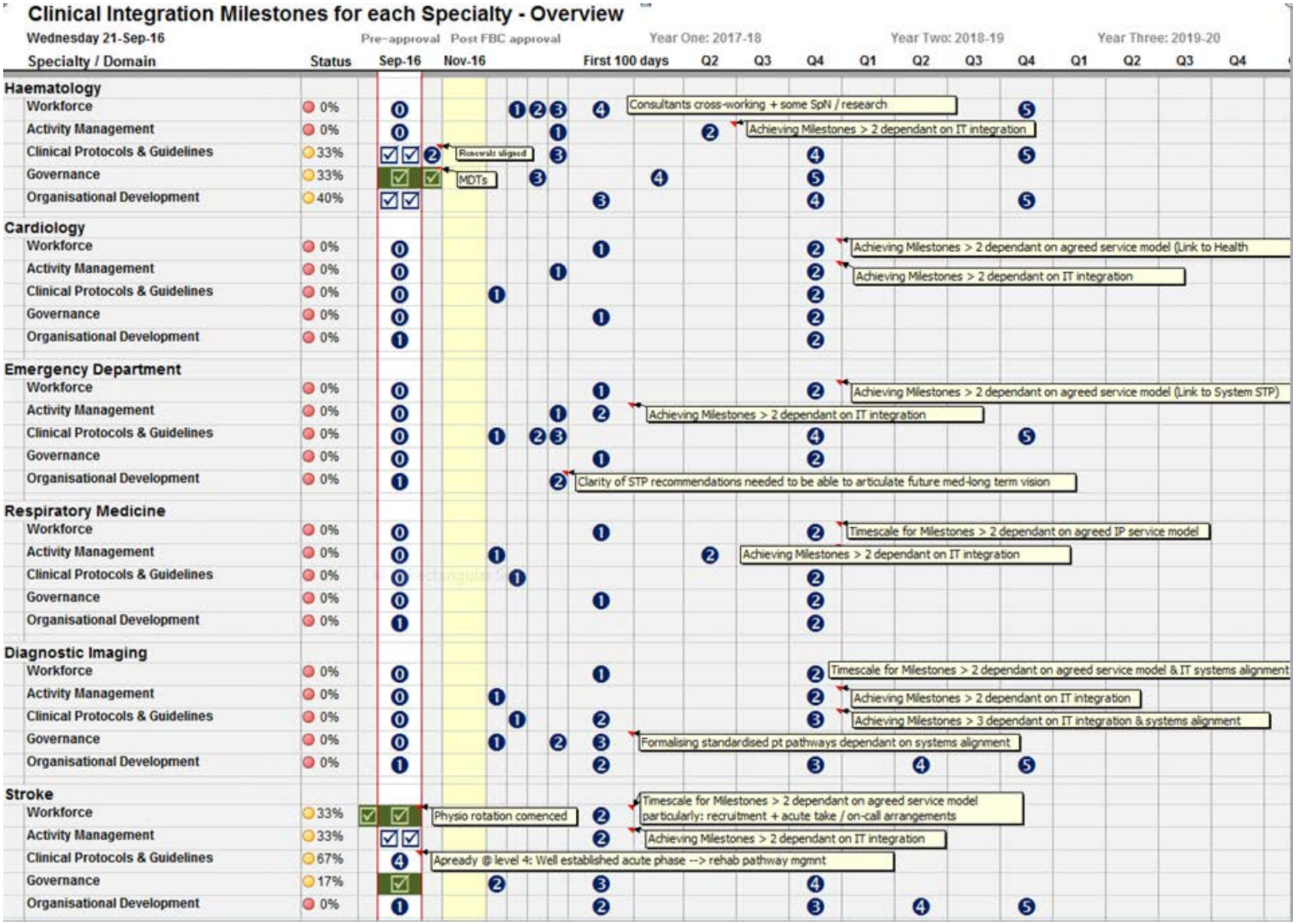
- Strengthen ortho-geriatric services to develop a more resilient hip fracture service, with integrated rehabilitation
- Reduced outsourcing of simple elective work and improved RTT position by utilising full capacity on both sites
- Effective use of available staffing, particularly out of hours

High level integration plan	Date
• Informal meetings with both teams to start to develop vision and potential models	Apr 17
• Agree to approach business case for spinal surgery and understand commissioner views	Apr 17
• Explore opportunities for Middle Grades across both sites and potential for rotation and enhanced training	Jul 17
• Explore and develop nurse specialist/practitioner posts and development on both sites	Jul 17
• Develop joint approach to therapies related to MSK	Sep 17

Appendix 6 – Clinical Integration Model/Milestones

Gateway	Workforce	Activity management	Clinical protocols guidelines	Governance	OD
5	Formalised cross-working arrangements for consultants, junior doctors and nursing staff, driven by anticipated activity management.	Centralised activity management system and process	Formalised and standardised patient pathway procedures and policies. Joint-staff training of policies and protocols.	Formalised integrated governance arrangements with integrated reporting.	**Mission & Strategy :** A shared, clear vision and purpose. Goals and priorities agreed for the next 2 years. **Leadership :** Ownership of messages from leaders is strong. Clear direction. Role modelling positive leadership behaviours in line with values. Inspiring confidence for the future. **Culture :** Change programme underway, measure to monitor culture during change agreed**.** OD approach adopted by the whole service/dept. Engagement, change and continuous improvement tools are co-ordinated and integrated into everyday practice.
4	Formalised cross-working arrangements for consultants, junior doctors and nursing staff.	Centralised activity management system and processes for specific cohorts of patients between providers.	Formalise and standardise patient pathway procedures and policies.	Formalised, regular performance meetings. Jointly led by Consultant and Exec sponsor. Ops / div attendance	**Mission & Strategy :** Vision and purpose formally communicated to staff. Formal discussions commenced to finalise future goals and priorities. Immediate goals and priorities linked to individual roles, responsibilities agreed and understood. **Leadership :** Positive leadership behaviours, in line with value, consistently communicating honest messages. Actively ensuring long-term goals are desirable and achievable to the team. **Culture :** Existing culture understood and clear programme for change agreed. All appropriate staff within service/dept applying OD approach to support engagement, change and continuous improvement.
3	Formalised staff- sharing arrangements for junior doctors and on-call senior doctors.	Access to each providers live patient lists and capacity.	Informal standardisation of patient pathways and protocols. Some formal collaboration in amending policies and procedures.	Formalised, regular performance meetings / discussions. Jointly led by Consultant and Exec sponsor. Ops / div attendance.	**Mission & Strategy :** Vision and purpose understood by leaders and managers, work underway to involve and inform staff. Immediate goals and priorities agreed. **Leadership :** Beginning to create clear direction. Recognition of implications and links beyond own area. Leadership decisions in line with our values. **Culture :** Detailed analysis of culture complete. Recommendations for change developed. Leaders and managers starting to apply an OD approach themselves to support engagement, change and continuous improvement.
2	Access to consultant advice to meet service requirements. Some shared staffing arrangements to meet patient demand for particular staffing groups in high-demand.	On-going formal collaboration in patient management and capacity planning.	On-going informal provider to provider feedback and sharing of best practice.	Formalised, regular performance meetings / discussions. Consultant-led, with ops / div management attendance and co-ordination.	**Mission & Strategy :** Leaders can describe the vision and the purpose, how things will be different in the future, but not yet shared with their wider team. **Leadership :** Involved, notice unsettling emotions in the team and acting to put things right. Leadership styles adapting to context. Communicating changes positively, behaviours in line with values. **Culture :** Some recognition of culture within the service/dept and analysis underway. Reliance on OD professionals working in the organisations for support. Some use of informal application of tools to support engagement, change and continuous improvement.
1	Informal and voluntary staff sharing arrangements to meet patient management requirements. Agreements on minimum staffing requirement	Sharing of capacity information. Informal collaboration of patient management at peak periods.	Awareness and sharing of policies and protocols Agreed outcome measures/PROMS	Informal ad-hoc performance meetings / discussions. Ops. / div. management-led, with consultant attendance on a rota basis.	**Mission & Strategy :** Vision and purpose yet to be agreed. Immediate goals and priorities unclear. **Leadership :** Leaders unable to see beyond their own area. Structure and roles unclear. Limited communication. Fixed leadership and management styles and behaviours. Difficult messages and discussions avoided. **Culture :** No analysis of culture undertaken, unaware of how this may impact change and behaviours . No application of OD practice, or tools to support engagement, change and continuous improvement in place.

Appendix 7 – Clinical Services Integration Project Plan (six priority specialties)



Appendix 8 – Dependencies of Acute Services on other Clinical Specialities and Functions

	ROW TITLES: The 11 major acute services whose dependencies on the specialties and functions in the columns is being described.	A&E /Emergency Medicine	Acute and General Medicine	Elderly Medicine	Respiratory Medicine (including bronchoscopy)	Medical Gastroenterology	Urgent GI Endoscopy (upper & lower)	Diabetes and Endocrinology	Rheumatology	Ophthalmology	Dermatology	Gynaecology	General Surgery (upper GI and lower GI)	Trauma	Orthopaedics	Urology	ENT	Maxillo-facial Surgery	Hub Vascular Surgery	Spoke Vascular Surgery	Neurosurgery	Plastic Surgery	Burns	Critical Care (adult)	Critical Care (paediatric)	General Anaesthetics	Acute Cardiology
1	A&E (Emergency Medicine). Acute unselected take (including acute surgical patients)	X					2									2	2										
2	Acute Medical Take		X				2	24	24		24		4			12											
3	Acute (Adult) Surgical Take												X														4
4	Adult Critical Care (Intensive Care)											24	2	2		24	2						X				

	ROW TITLES: The 11 major acute services whose dependencies on the specialties and functions in the columns is being described.	Thoracic Surgery	Cardiac Surgery	Hyper-acute Stroke Unit	Acute Stroke Unit	Nephrology (not including dialysis)	Inpatient Dialysis	Acute Oncology	Palliative Care	Neurology	Acute Paediatrics (non-specialised paediatrics and paediatric surgery)	Neonatology	X-ray and Diagnostic Ultrasound	CT Scan	MRI Scan	Cardiac MRI	Nuclear Medicine	Interventional Radiology (including neuro-IR)	Clinical Microbiology/ Infection Service	Laboratory microbiology	Urgent Diagnostic Haematology and Biochemistry	Acute Inpatient Rehabilitation	Occupational Therapy	Physiotherapy	Speech and Language	Dietetics	Acute Mental Health Services
1	A&E (Emergency Medicine). Acute unselected take (including acute surgical patients)																										
2	Acute Medical Take							24		24																	
3	Acute (Adult) Surgical Take								24									4	4								4
4	Adult Critical Care (Intensive Care)								4									2	2								

CO-DEPENDENCIES DEFINITIONS: COLOUR KEY	
The colour describes the dependency of the service in the row, on the support service in the column. Note that both the Purple and Red dependencies describe column services that should not require the patient to move hospitals	
PURPLE	
Service should be co-located (based) in same hospital	
RED	
Service should come to patient (patient transfer not appropriate), but could be provided by visiting/inreach from another site (either physically, or via telemedicine links) if not based in the same hospital	
2	Within 2 hours
4	Within 4 hours
24	Within 24 hours
	Not specified
AMBER	
Ideally on same site but could alternatively be networked via robust emergency and elective referral and transfer protocols	
GREEN	
Does not need to be on same site. Appropriate arrangements are in place to obtain specialist opinion or care	

Appendix 9 – Organisational Development – Culture Diagnostics Phase 1

OD Workstream - Culture

Cultural Diagnostics – Phase 1

Joint Board 14th September 2016

Hinchingbrooke Health Care NHS NHS Trust

Peterborough and Stamford Hospitals NHS NHS Foundation Trust

Appendix 10 – KPMG LLP LTFM Assessment and Transaction LTFM Assessment

PLEASE NOTE THIS IS ATTACHED SEPARATELY TO THIS DOCUMENT
PLEASE REFER TO:

"(2) KPMG LTFM Assessment"
"(3) KPMG Transaction LTFM Assessment"

Appendix 11 – Engagement Activity – July to December 2016

Date	Event	Details
6 July	Staff forum at HHCT	Regular open forum
13 July	Breakfast with Lance McCarthy	Opportunity for Hinchingbrooke staff to raise questions, face-to-face with CEO
14 July, 2pm	Cambs County Council Health Scrutiny committee meeting	To be attended by Lance McCarthy, Stephen Graves and Caroline Walker
19 July	Peterborough City Council Scrutiny Commission for Health Issues	Stephen Graves attending to update on FBC progress and engagement phase
20 July	Lincolnshire County Council Health Scrutiny Committee	Stephen Graves and Caroline Walker attending to present a paper on FBC progress and engagement phase
26 July	Council of Governors meeting in public at PSHFT	Opportunity for members of the public to raise questions to board members.
27 July	Breakfast with Lance McCarthy	Opportunity for Hinchingbrooke staff to raise questions, face-to-face with CEO
28 July	Team Brief at PSHFT	Regular briefing to staff. Update on FBC progress plus reminder of how staff can raise questions etc
28 July	HHCT board meeting in public – Including 1 hour public session on proposed merger	CEO paper will share an update on FBC progress followed by a 1-hour session at 11.30am with members of the public to discuss the proposed merger
28 July	Annual Public Meeting at PSHFT – including 1 hour public session on proposed merger	Section of formal meeting will provide an update on FBC progress and a discussion with members of the public in attendance. Starts 5.15pm
3 Aug	Staff forum at HHCT	Regular open forum – Update on FBC progress plus reminder of how staff can raise questions etc
4 Aug	Public Engagement event at Stamford Hospital – 10am	Attendees – 50 BBC Look East coverage
9 Aug	Healthwatch-hosted engagement event The Fleet, Fletton, Peterborough – 6pm	Attendees - 15
10 Aug	Two engagement events at Hinchingbrooke House – 2pm and 5.30pm	Attendees - 13 in total
31 Aug	PSHFT board meeting in public	CEO paper will share an update on FBC progress
31 Aug	Lance McCarthy – staff engagement session - 11am	Opportunity for Hinchingbrooke staff to raise questions, face-to-face with CEO
2 Sept	Engagement event Peterborough Town Hall - 4pm	To be attended by Stephen Graves, Caroline Walker and Lance McCarthy
2 Sept	Team Brief at PSHFT	Regular briefing to staff. Update on FBC progress plus reminder of how staff

		can raise questions etc
5 Sept	Two engagement events at Huntingdon Town Hall, 4pm and 5.30pm – The Chamber room	To be attended by Stephen Graves, Caroline Walker, Lance McCarthy and Cara Charles-Barks
6 Sept	CEO Chat session at PSHFT – Stephen Graves - 8.30am	Informal staff discussion session
6 Sept	Hunts District Council Overview and Scrutiny Panel (Communities and Environment) – 7pm	To be attended by Lance McCarthy and Cara Charles-Barks
7 Sept	Staff forum at HHCT	Regular open forum – Update on FBC progress
8 Sept	Annual Public Meeting, Hinchingbrooke Hospital. Merger proposal likely to be discussed.	
13 Sept	Hunts Patient Congress meeting Pathfinder House, Huntingdon.	Lance McCarthy, Cara Charles-Barks and Deirdre Fowler attending
13 Sept	BMA Peterborough Division	Stephen Graves attending
14 Sept	Lance McCarthy – staff engagement - 11am	Opportunity for Hinchingbrooke staff to raise questions, face-to-face with CEO
19 Sept	Public Engagement Event – 7pm St Neots – booked	To be attended by Stephen Graves, Caroline Walker, Lance McCarthy, Cara Charles-Barks and Deirdre Fowler
20 Sept	Full Business Case due to be published All key stakeholders to be briefed according to a separate plan	
23 Sept	CEO Chat session at PSHFT – Stephen Graves and Caroline Walker – 2pm	Informal staff discussion session
27 Sept	PSHFT board meeting in public – 1.30pm	Board due to review/approve the Full Business Case
28 Sept	Lance McCarthy – staff engagement - 8am	Opportunity for Hinchingbrooke staff to raise questions, face-to-face with CEO
29 Sept	Team Brief at PSHFT	Regular briefing to staff. Plus update from board meeting re decision on FBC
29 Sept	HHCT board meeting in public – 11.30am	Board due to review/approve Full Business Case
4 Oct	CEO Chat session at PSHFT – Stephen Graves and Caroline Walker - 8.30am	Informal staff discussion session
4 Oct	Hunts District Council Overview and Scrutiny Panel (Communities and Environment) – 7pm	To be attended by Lance McCarthy and Cara Charles-Barks
6 Oct	PSHFT Members' Meeting at Stamford Hospital	Chance to further discuss merger plan and examine Full Business Case
10 Oct	Engagement event at Deepings Leisure Centre – 7pm	To be attended by Stephen Graves, Caroline Walker, Lance McCarthy and Cara Charles-Barks
12 Oct	Lance McCarthy – staff engagement 11.30am	Opportunity for Hinchingbrooke staff to raise questions, face-to-face with CEO

17 Oct	Joint meeting of the scrutiny panels for Cambs County Council and Peterborough City Council **Confirmed – 5.30pm Peterborough Town Hall.**	To be attended by Stephen Graves, Caroline Walker and Lance McCarthy
20 Oct	Engagement event at Bourne Corn Exchange – 2pm	To be attended by Stephen Graves, Caroline Walker and Cara Charles-Barks
21 Oct	CEO Chat session at PSHFT (Stamford Hospital) – Stephen Graves and Caroline Walker – 3pm	Informal staff discussion session
26 Oct	Lance McCarthy – staff engagement 8am	Opportunity for Hinchingbrooke staff to raise questions, face-to-face with CEO
27 Oct	Team Brief at PSHFT	Regular briefing to staff. Update on FBC progress plus reminder of how staff can raise questions etc
1 Nov	CEO Chat session at PSHFT – Stephen Graves and Caroline Walker – 8.30am	Informal staff discussion session
1 Nov	Hunts District Council Overview and Scrutiny Panel (Communities and Environment) – 7pm	To be attended by Lance McCarthy and Cara Charles-Barks
9 Nov	Lance McCarthy – staff engagement 11am	Opportunity for Hinchingbrooke staff to raise questions, face-to-face with CEO
10 Nov	Cambridgeshire County Council Scrutiny Meeting. **2pm** Civic Suite 0.1A, Pathfinder House, St Mary's Street, Huntingdon, PE29 3TN	To be attended by Lance McCarthy
15 Nov	Peterborough City Council Scrutiny Commission for Health Issues – **7pm**	To be attended by Stephen Graves, Caroline Walker, Lance McCarthy and Cara Charles-Barks
23 Nov	Lance McCarthy – staff engagement 8am	Opportunity for Hinchingbrooke staff to raise questions, face-to-face with CEO
24 Nov	HHCT board meeting in public – 11.30am	Board due to finalise approval for Full Business Case
25 Nov	CEO Chat session at PSHFT – Stephen Graves and Caroline Walker – 2pm	Informal staff discussion session
29 Nov	PSHFT board meeting in public – 1.30pm	Board due to finalise approval for the Full Business Case
30 Nov	Full Business Case due to be given final approval All key stakeholders to be briefed according to a separate plan	
1 Dec	Team Brief at PSHFT	Regular briefing to staff – including update on next steps in merger process.
6 Dec	CEO Chat session at PSHFT (Stamford Hospital) – Stephen Graves and Caroline Walker – 8.30am	Informal staff discussion session
6 Dec	Hunts District Council Overview and Scrutiny Panel (Communities and Environment) – **7pm**	To be attended by Caroline Walker, Lance McCarthy and Cara Charles-Barks
21 Dec	Lance McCarthy – staff engagement 11am	Opportunity for Hinchingbrooke staff to raise questions, face-to-face with CEO
21 Dec	Lincs County Council Health Scrutiny Committee – 10am	Caroline available to attend Stephen not available
22 Dec	CEO Chat session at PSHFT – Stephen Graves	Informal staff discussion session

	and Caroline Walker – 2pm	

Additional Events - arrangements in progress:

- October – public engagement event at Hinchingbrooke Hospital
- October – public engagement event at PCH
- October – public engagement event in St Ives
- October - Briefings for health scrutiny panels in Rutland and Lincs to be organised

Appendix 12 – Trust Policy Alignment

PSHFT Policy	HHCT Policy	Date of Assimilation
Finance		
Access Policy	N/A	By 31 Dec 17
Charitable Fund Policy & Procudures	N/A	By 31 Dec 17
Clinical Coding Policy	N/A	By 31 Dec 17
Commercial Contract Policy	N/A	By 31 Dec 17
Computing Equipment and Electronic Media Dipsosal Policy	N/A	By 31 Dec 17
Counter Fraud and Corruption	Fraud and Corruption Policy	By 31 Dec 17
Information Security Policy	N/A	By 31 Dec 17
Private Patient Policy and Procedures	N/A	By 31 Dec 17
Registration Authority Policy	N/A	By 31 Dec 17
Sanction and Redress Policy in Respect of Fraud and Corruption	N/A	By 31 Dec 17
	Travel and Expenses Policy	
Corporate Governance		
Business Conduct and Bribery Avoidance Policy	Business Conduct Policy	By 31 Mar 17
Data Protection and Confidentiality Policy	Confidentiality Policy	By 31 Mar 17
Data Quality Policy	Data Quality Policy	
Freedom of Information Act Policy	Freedom of Information Act Policy	By 31 Dec 17
PSHFT no equivalent: in SOs	Governance Manual - Appointment of Committees	By 31 Mar 17
Same as business conduct above	Governance Manual - Code of Conduct	By 31 Mar 17
PSHFT in different workstream	Governance Manual - Scheme of Delegation	By 31 Mar 17
PSHFT in different workstream	Governance Manual - SFIs	By 31 Mar 17
Standing Orders for Directors	Governance Manual - SOs	By 31 Mar 17
Information Governance Management Framework Policy	IG Policy	By 31 Mar 17
PSHFT no equivalent	Media Handling Policy	
Corporate Records Management Policy	Records Management Policy	By 31 Mar 17
PSHFT in different workstream	Risk Management and Assurance Strategy	
PSHFT in different workstream	Risk Management Policies and Procedures	
Information Risk Management Policy	Safe Haven Policy and New Safe Haven Policy	By 31 Mar 17
Social Networking and Social Media Policy	Social Media Policy	By 31 Mar 17
PSHFT in different workstream	Subject Access Request Policy	
Policy for Developing Policies and Other Procedural Documents	Trust Documentation Policy	By 31 Mar 17

PSHFT Policy	HHCT Policy	Date of Assimilation
Governor and Non-Executive Director Expenses		By 31 Dec 17
Responding to External Agency Visits - Policy and Procedure		
Information Lifecycle Management Policy	Same as records management policy above	By 31 Mar 17
Back Office Estates		
	Asbestos Policy	By 31 Mar 17
	Control of Noise and Vibration Policy	By 31 Dec 17
	CoSHH Policy	By 31 Dec 17
	Electrical Safety Policy	By 31 Mar 17
	Fire Policy Part 1	By 31 Dec 17
	Fire Policy Part 2 - Operational Procedures	By 31 Dec 17
	First Aid at Work policy	By 31 Dec 17
	Health and Safety Employment of Young Persons Policy	By 31 Dec 17
	Health and Safety Policy	By 31 Dec 17
	Legionella Policy	By 31 Mar 17
	Lone Working Policy	By 31 Dec 17
	Management of Medical Gases Policy	By 31 Mar 17
	Management of Mobile Telephones and other Communication Devices Policy	By 31 Dec 17
	Medical devices policy	By 31 Mar 17
	PPE Policy	By 31 Dec 17
	Purchase of Work Equipment (Health and Safety) Policy	By 31 Dec 17
	Safe Management of Contractors Policy	By 31 Dec 17
	Security policy	By 31 Mar 17
	Slips Trips and Falls Policy	By 31 Dec 17
	Violence and Aggression policy	By 31 Dec 17
	Waste Management Policy V2.04 Feb 16	By 31 Dec 17
	Working at Height Policy	
Quality and Performance		
Patient's Own Drugs' and 'Dispensing for Discharge' (One Stop Dispensing) Policy.pdf		By 31 Mar 17
Management of Diabetic Ketoacidosis in Adults.pdf		By 31 Mar 17
Blood Transfusion Policy.pdf		By 31 Mar 17
Critical Care Out of Hours Parenteral Nutrition (PN) Policy.pdf		By 31 Mar 17
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy (EofE) Adult.pdf		By 31 Mar 17

PSHFT Policy	HHCT Policy	Date of Assimilation
Duty of Candour Policy	Duty of Candour	By 31 Mar 17
Communicating with patients and their carers about patient safety incidents.pdf		
Management of Patients with Known or Suspected Natural Rubber Latex Allergy.pdf	Latex allergy, prevention and management	By 31 Mar 17
Medical Gas Cylinder Policy.pdf		By 31 Mar 17
Medical Gas Pipeline Policy.pdf		By 31 Mar 17
Medication Error Policy for Registered Nurses, Midwives and Operating Department Practitioners.pdf		By 31 Mar 17
Medicines Management Policy.pdf		By 31 Mar 17
Medicines Reconciliation Policy.pdf		By 31 Mar 17
Meticillin Resistant Staphylococcus aureus (MRSA) Management Policy.pdf	MRSA Dec 2015 and MRSA Policy ?duplication - which to retain	By 31 Mar 17
Non-Medical Prescribing Policy.pdf		By31 Mar 17
Operational Policy for the Isolation Unit.pdf		By 31 Mar 17
Patient Group Directions Policy.pdf		By 31 Mar 17
Policy for Administration of General Sales List Medications Without Prescription to Adult Patients.pdf		By 31 Mar 17
Policy for Adult Self Administration of Medicines.pdf		By 31 Mar 17
Policy for decontamination (cleaning, disinfection and sterilisation) of re-usable medical devices and equipment.pdf	Decontamination	By 31 Mar 17
Policy for Indwelling Urethral Catheterisation of the Acute Adult Patient.pdf	Indwelling urethral catheter insertion and management & suprapubic catheter management policy	By 31 Mar 17
Policy for Management of Venous Thrombo-embolism.pdf		By 31 Mar 17
Policy for management treatment and care of TSE including vCJD.pdf		By 31 Mar 17
Policy for nurse led DVT.pdf		By 31 Mar 17
Policy for Patient Identification.pdf		By 31 Mar 17
Policy for Physiological Observations and Calculation of NEWS in Adult Patients.pdf		By 31 Mar 17
Policy for Screening Adults for Malnutrition MUST.pdf		By 31 Mar 17
Policy for Staff Hand Hygiene.pdf	Hand hygiene policy	By 31 Mar 17
Policy for Standard Infection Control Precautions.pdf	Standard precautions	By 31 Mar 17
Policy for the Infection Control and Management of Chickenpox and Shingles.pdf	Chicken pox	By 31 Mar 17
Policy for the Infection Control Management of patients with known or suspected Tuberculosis.pdf		By 31 Mar 17

PSHFT Policy	HHCT Policy	Date of Assimilation
Policy for the Infection Control mgt of Vancomycin Resistant Enterococci (VRE) Glycopeptide Resistant Enterococci (GRE).pdf	Multi-resistant gram negative IC policy	By 31 Mar 17
Policy for the Insertion and Removal of Intraosseous Access in Adults in CardiacPeri Arrest.pdf		By 31 Mar 17
Policy for the Isolation of Patients.pdf	Isolation policy	By 31 Mar 17
Policy for the Management of Adverse Events and Near Misses, including the Management of Serious Incidents.pdf	Management of SI pol & proc and Management of incidents and near misses pol and proc	By 31 Mar 17
Policy for the Management of Central Venous Catheters (CVC) in Adults.pdf		By 31 Mar 17
Policy for the Management of Parenteral Nutrition in Adults.pdf	Nutrition policy	By 31 Mar 17
Policy for the Management of Patients with Carbapenemase Producing Enterobacteriaceae.pdf		By 31 Mar 17
Policy for the Management of Patients with Extended Spectrum Beta-Lactamase (ESBL) Producing Organisms.pdf		By 31 Mar 17
Policy for the Management of Patients with Middle East Respiratory Syndrome Coronavirus.pdf		By 31 Mar 17
Policy for the Management of Patients with Scabies.pdf		By 31 Mar 17
Policy for the management of patients with suspected or confrimed influenza.pdf	Pandemic influenza Plan	By 31 Mar 17
Policy for the management of patients with suspectedconfirmed viral haemorrhagic fevers.pdf		By 31 Mar 17
Policy for the Management of Thrombosis Associated with Central Venous Access Devices (eg Hickman line).pdf		By 31 Mar 17
Policy for the Managment of Outbreaks.pdf	Management of in-pats with GI infection including norovirus	By 31 Mar 17
Policy for the Organisation and Implementation of Infection Control.pdf	Management arrangements for IP&C Feb 2015	By 31 Mar 17
Policy for the Practice of Aseptic Technique.pdf	Aseptic technique policy	By 31 Mar 17
Policy for the Prevention and Management of Venous Thromboembolism.pdf		By 31 Mar 17
Policy for the Prevention and Mgt of Slips, Trips, Falls, (including from height) and use of Bedrails Adult Patients.pdf	Slips trips and falls	By 31 Mar 17
Policy for the Prevention, Control and Management of Clostridium difficile Infection (CDI).pdf	C diff	By 31 Mar 17
Policy for the Safe and Secure Handling of Medicines.pdf		By 31 Mar 17
Policy for the Urinary Continence Care of Adult Patients.pdf		By 31 Mar 17
Policy on Surgical Hand		By 31 Mar 17

PSHFT Policy	HHCT Policy	Date of Assimilation
Decontamination and Infection Control in Operating Theatres.pdf		
Policy on the Control of Infections during Construction Renovation and Demolition.pdf		By 31 Mar 17
Prevention and Management of Pressure Ulcers in Adults and Children.pdf		By 31 Mar 17
Resuscitation Policy.pdf		By 31 Mar 17
Swabs For MRSA Screening Prior To Elective Caesarian Section - 0468.pdf		By 31 Mar 17
Transfer of Adult patients (internal and external).pdf	Safety of transfer ?new/merged document CCOT	By 31 Mar 17
Waste Management Policy.doc		By 31 Mar 17
Water Management Policy.pdf	Legionella	By 31 Mar 17
Adult Close Observation Policy (Specialling).pdf		By 31 Mar 17
Policy and assessment for clinicians in the administering of intravenous (IV) drugs.pdf		By 31 Mar 17
Appropriate Nurse Staffing levels.pdf		By 31 Mar 17
Best Practice Policy.pdf		By 31 Mar 17
Capture and Recording of Alert Notations Policy.pdf		By 31 Mar 17
Care of Casenotes Patient Identification, Order of Filing and Record Entry Policy.pdf		By 31 Mar 17
Clinical Audit Policy.pdf	Clinical audit policy March 2016	By 31 Mar 17
Clinical Handover of Adult Patients Policy (Internal and External).pdf		By 31 Mar 17
Clinical Record Keeping Policy.pdf		By 31 Mar 17
Dress Code Policy.pdf	Control of staff dress	By 31 Mar 17
eRostering Policy.pdf	Uniform and dress code policy ?duplication (HoC)	By 31 Mar 17
Health Records Management Policy.pdf		By 31 Mar 17
Intellectual Property Policy.pdf		By 31 Mar 17
Mentorship Policy for Nurses, Midwives and Operating Department Practitioners.pdf		By 31 Mar 17
Mortality Review Policy.pdf	Mortality review policy	By 31 Mar 17
Nursing and Midwifery revalidation policy.pdf		By 31 Mar 17
Policy for Preceptorship for Nurses, Midwives and Allied Health Professionals (AHPs) CS.pdf		By 31 Mar 17
Policy for Taking Patient Identifiable Documentation Offsite.pdf		By 31 Mar 17
Policy for the Management of Safety Alerts.pdf		By 31 Mar 17
Reflective Practice Policy for Nurses Midwives ODPs and AHPs.pdf		By 31 Mar 17
Research Governance Policy.pdf	Research Policy and procedure	By 31 Mar 17
Response to Call Bells in PCH Policy.pdf		By 31 Mar 17
Adult Bereavement Policy including Last Offices.pdf	End of life care bereavement policy	By 31 Mar 17

PSHFT Policy	HHCT Policy	Date of Assimilation
Adult Protection Joint Working Protocol for Statutory Agencies in Peterborough POVA.pdf		By 31 Mar 17
Chaperone Policy for Intimate Examination.pdf		By 31 Mar 17
Claims Management and Investigation Policy.pdf		By 31 Mar 17
Complaints Policy.pdf	Responding to feedback policy	By 31 Mar 17
Delivering Same Sex Accommodation Policy.pdf	Mixed sex accommodation	By 31 Mar 17
Eating and Drinking Policy.pdf		By 31 Mar 17
Equality and Diversity Policy.pdf		By 31 Mar 17
Informing Patients of their Responsible Consultant Clinician and Named Nurse.pdf		By 31 Mar 17
Interpreting and Translation Policy.pdf		By 31 Mar 17
MCA and DOLS Policy.pdf		By 31 Mar 17
Operational Policy for Management of Outliers and Opening of Non-Inpatient Escalation Areas.pdf	Outlying policy (?sits with Medicine - Phil Holland)	By 31 Mar 17
Patient Advice and Liaison Service Policy.pdf		By 31 Mar 17
Patient Visiting Policy.pdf		By 31 Mar 17
Peterborough and Stamford Hospitals Site Smoking Policy.pdf		By 31 Mar 17
Policy for Management of Patients Property including Lost Property.pdf		By 31 Mar 17
Policy for Safeguarding Children.pdf	Safeguarding children	By 31 Mar 17
Policy for the Verification of Expected Death.pdf		By 31 Mar 17
Policy for Treatment of Jehovah's Witnesses.pdf		By 31 Mar 17
Policy on Advance Decisions.pdf		By 31 Mar 17
Policy on Consent to Treatment.pdf	Consent to examoniation or treatment	By 31 Mar 17
Raising Concerns in a Safe Environment.pdf		By 31 Mar 17
Subject Access Request Policy.pdf	Subject access request policy	By 31 Mar 17
Transgender Policy.pdf		By 31 Mar 17
Trust Policy on Protection of Vulnerable Adults (Based on Adult Protection Joint Working Protocol for Statutory Agencies in.pdf	Adult safeguarding policy	By 31 Mar 17
Access Policy.pdf	Access	By 31 Mar 17
Data Quality Policy.pdf		By 31 Mar 17
Policy for the Discharge of Adult Patients (Incorporating Predicted Date of Discharge Calculation).pdf	Discharge policy	By 31 Mar 17
Safeguarding Quality of Patient Care during Transformation Quality Impact Assessment.pdf	Quality Impact Assessment Framework	By 31 Mar 17
Supporting doctors to provide safer healthcare responding to doctor's practice - K Rege author		By 31 Mar 17
	Animals in hospital policy	By 31 Mar 17
	Risk management and assurance	By 31 Mar 17

PSHFT Policy	HHCT Policy	Date of Assimilation
	strategy	
	Risk management policies and procedures	By 31 Mar 17
Business Continuity Framework and all ward/departmental BCPs (framework currently being merged with PSHFT and to incorporate all EPRR functions)	Business continuity planning and disaster recovery policy	By 31 Mar 17
	Management of linen policy	By 31 Mar 17
	Clinical audit strategy April 2016	By 31 Mar 17
	Urethral suprapubic catheters policy V1 June 2015 (?archive)	By 31 Mar 17
	Group A infection in acute care and maternity	By 31 Mar 17
	Prevention of IV related infections October 2015	By 31 Mar 17
	Policy for adult peripheral IV cannulation	By 31 Mar 17
	Prevention of intravascular related infection policy	By 31 Mar 17
	Inquest guidelines	By 31 Mar 17
	Research governance framework	By 31 Mar 17
	Post mortem consent policy	By 31 Mar 17
	Patient experience strategy	By 31 Mar 17
	PPE policy	By 31 Mar 17
	Volunteer policy	By 31 Mar 17
Major Incident Plan (currently being completely revised) Chemical Decontamination Plan (will be incorporated into MIP with radiation section added) Pandemic Influenza Plan Critical Internal Incident Plan (draft version produced but not yet endorsed and published) Evacuation Plan (currently being completely revised) Bomb Threat & Suspect Package Policy (currently being completely revised) Heatwave Plan		
	Display Screen Equipment Policy	By 31 Dec 17
	Employee infection and immunisation policy 18.1.2016 (4)	By 31 Dec 17
	Equality and Inclusion Policy 2015	By 31 Dec 17
	Freedom to Speak UP Whilstleblowing Policy	By 31 Dec 17
	Induction Policy	By 31 Dec 17
	Internal Professional Standards(5)	By 31 Dec 17
	Latex Allergy, Prevention and Management Policy	By 31 Dec 17
	Learning & Development Policy	By 31 Mar 17
	Management of Occupational Exposure to Blood Borne Viruses Policy	By 31 Mar 17
	Management of work related contact dermatitis policy	By 31 Dec 17

PSHFT Policy	HHCT Policy	Date of Assimilation
	Managing Work related Stress and Psychological Wellbeing in the Workplace Policy	By 31 Dec 17
	People Management Policy 2015	By 31 Dec 17
	People Strategy 2015-2020	By 31 Dec 17
	Smokefree Hinchingbrooke Policy May 2016	By 31 Dec 17
IT		
	Mobile Devices and Mobile Media Procedure	By 31 Dec 17
	Network Security Policy	By 31 Mar 17
	Registration Authority Policy 2.05	By 31 Dec 17
	Remote Access Policy	By 31 Mar 17
	Systems Management Policy	By 31 Dec 17

Appendix 13 – Well Led Governance Review Findings

PLEASE NOTE THIS IS ATTACHED SEPARATELY TO THIS DOCUMENT
PLEASE REFER TO:

"(4) Deloittes - Well Led Governance Review"

****CURRENTLY IN DRAFT FORM AND WILL BE CIRCULATED AT A LATER DATE****

Appendix 14 – Key Sources of Quality and Performance Intelligence – Local, Regional and National

Safe	Effective	Caring	Responsive	Well-led
Trust wide compliance monitoring, including: pressure ulcers, falls, VTE, catheter associated urinary tract infections, healthcare acquired infections.	Trust wide compliance monitoring, including; stroke care, HSMR, nutritional risk assessments	Trust wide compliance monitoring, including: Patient environment, patient experience, same sex accommodation,	Complaints data (PHSO)	Internal and external audit reports
Adverse event monitoring e.g. serious incidents resulting in harm, medication errors, prescribing errors.	Trust risk management framework	Adverse events & near misses, complaints and claims investigation and analysis (CLAEP)	Integrated performance Report	CQC Intelligent Monitoring Tool (IMT) & CQC regulatory visits, action plans and follow-up visits.
National Safety Thermometer data	NHSLA claims and lessons learning	PROMS	Urgent care, RTT, Cancer and Diagnostics performance reports	Peer reviews e.g. CCG quality assurance visits
Links to Health and Safety and any HSE feedback.	Clinical benchmarking from Dr Foster data	National and Local Patient Surveys	Stroke metrics (SSNAP)	Reviews commissioned by the Trust e.g. Royal College Reviews
Cleaning audit data – Trust and PFI reports PLACE Report	Compliance with Quality Standards, NICE & NCEPOD	Health Scrutiny Committees, Healthwatch	Single Oversight framework (NHSI)	Other regulatory visits and reports e.g. the NMC, Cancer Peer Review, CPA, HTA
National Nursing and Midwifery Dashboard (TBC for April 2017)	National and Local clinical audits	Friends and Family Test benchmarking		Information Governance data
	Educational reviews such as HEE visits	Patient Opinion website		NHS Constitution

Appendix 15 – IT Review Reports

PLEASE NOTE THIS IS ATTACHED SEPARATELY TO THIS DOCUMENT
PLEASE REFER TO:

"(5) ICT Infrastructure Report – Methods"
"(6) ICT Systems and Licensing Report"

Appendix 16 – Risk Matrix Scoring Tool

RISK ASSESSMENT MATRICES

CONSEQUENCES/ SEVERITY	LIKELIHOOD					
	Impossible 0	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
No adverse outcome - 0						
Insignificant - 1		1	2	3	4	5
Minor - 2		2	4	6	8	10
Moderate - 3		3	6	9	12	15
Major- 4		4	8	12	16	20
Catastrophic - 5		5	10	15	20	25

KEY: No risk | Low risk | Moderate risk | Significant risk | High risk

RATE	LIKELIHOOD	DESCRIPTION
0	Impossible	The event cannot happen under any circumstances.
1	Rare	The event may occur only in exceptional circumstances.
2	Unlikely	The event could occur at some time.
3	Possible	The event might occur or re-occur at some time.
4	Likely	The event is likely to occur or re-occur in most circumstances.
5	Almost Certain	The event is expected to occur or re-occur in most circumstances.

RATE	CONSEQUENCE	DESCRIPTION
0	No adverse outcome	No injuries. No loss.
1	Insignificant	First-aid treatment (e.g. cuts, bruises, abrasions). Moderate financial loss.
2	Minor	Short-term medical treatment required (sprains, strains, small burns, stitches etc.) Moderate environmental implications. High financial loss/ compensation claim. Moderate loss of reputation. Moderate service interruption.
3	Moderate	Semi-permanent injury/damage (lasting up to 1 year), Over 3 Day staff injuries under RIDDOR, MDA reportable, short term sickness <4 weeks. Litigation possible but not certain
4	Major	Excessive or permanent injuries (loss of body parts, mis-diagnosis – poor progress etc.). (Major injuries under RIDDOR). Short term negative impact on recruitment and retention. High environmental implications. Serious financial loss. Serious loss of reputation. Serious service interruption. Litigation/Prosecution expected.
5	Catastrophic	Death, Toxic off site release with detrimental effect, National adverse publicity, affects large numbers of people (i.e. cervical screening disaster) Litigation/Prosecution expected/certain. Medium to long term negative impact on recruitment and retention. Major financial loss. Major loss of reputation. Major service interruption.