AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 28th March, 2008, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Paul Wickenden**
Telephone **(01622) 694486**

Tea/Coffee will be available from 9:45 am

Membership (17)

Conservative (12): Lord Bruce-Lockhart (Chairman), Mr A R Chell, Mr B R Cope, Mr A D Crowther, Mr J Curwood, Mrs S V Hohler, Mr G A Horne MBE, Mr R A Marsh, Mr R J Parry, Dr T R Robinson, Mr R Tolputt and Mrs E M Tweed

Labour (4): Mr M J Fittock (Vice-Chairman), Mrs C Angell, Ms A Harrison and Mrs E D Rowbotham

Liberal Democrat (1): Mr D S Daley

UNRESTRICTED ITEMS

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

Item No		Timings
1.	Substitutes	
2.	Declarations of Interests by Members in items on the Agenda for this meeting.	
3.	Minutes - 8 February 2008 (Pages 1 - 20)	
4.	Health services in Dover	10:10-10:20 am

Healthcare Commission Annual Health Check

5.	Dartford & Gravesham NHS Trust Mark Devlin, Chief Executive and Susan Acott, Director of Performance & Service Development and Director Lead for Governance will be in attendance for this item.	10:20-11:00 am

Break 11:00-11:10 am

6.	Maidstone & Tunbridge Wells NHS Trust	11:10-11:50 am
	Glenn Douglas, Chief Executive and Christina Edwards, Acting Chief Nurse will be in attendance for this item.	
7.	Eastern & Coastal Kent Primary Care Trust	11:50 am-12:30 pm
	Lynne Selman, Director of Citizen Engagement & Communications, Karen Benbow, Assistant Director Assurance and Debra Vidler, Head of Standards for Better Health will be in attendance for this item.	

Break 12:30-12:40 pm

8.	Conclusions & Recommendations	12:40-1:00 pm
9.	Update on Local Involvement Network (LINk)	1:00-1:10 pm
10.	Date of next programmed meeting – Friday 9 May 2008	
	Council Chamber, Sessions House, County Hall, Maidstone commencing at 10:00 am	

EXEMPT ITEMS

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

Peter Sass
Head of Democratic Services and Local Leadership
(01622) 694002

18 March 2008

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

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at Sessions House, County Hall, Maidstone on Friday 8 February 2008.

PRESENT: Lord Bruce-Lockhart (Chairman), Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr A R Chell, Mr B R Cope, Mr A D Crowther, Mr D S Daley, Ms A Harrison, Mr C Hibberd (substituting for Mr J A Davies), Mrs S V Hohler, Mr G A Horne, MBE, Mr R A Marsh, Mr W V Newman (substituting for Mrs E D Rowbotham), Dr T R Robinson, Mr R Tolputt and Mrs E M Tweed.

OTHER MEMBERS PRESENT: Mr G K Gibbens (Cabinet Member for Public Health), Mr C J Law and Mr J F London

OBSERVERS: Mr J Cunningham, Mr R Kenworthy, Mr J Larcombe, Ms A Loveday, Ms C Swann, Mrs F Witherden from the Patient and Public Involvement Forums.

IN ATTENDANCE: Mr P D Wickenden, Overview, Scrutiny and Localism Manager, Dr D Turner, Research Officer to the Health Overview and Scrutiny Committee, and Miss T A Grayell, Democratic Services Officer.

UNRESTRICTED ITEMS

5. Chairman's Announcements

The Chairman thanked the Vice Chairman, Mr M J Fittock, for chairing the Committee's meetings while he had been away undergoing medical treatment. He also thanked Members of the Committee for their support and best wishes during his treatment.

6. Membership

Members noted that Mr R A Marsh had joined the Committee in place of Mr D A Hirst.

7. Minutes

(1) RESOLVED that the Minutes of the meeting held on 11 January 2008 were correctly recorded and that they be signed by the Chairman. The Overview, Scrutiny and Localism Manager pointed out that a scoping document for the proposed Select Committee on Transport and Access to Healthcare, referred to in Minute 3, paragraph (c), had been tabled.

(2) The Chairman proposed, and it was agreed, that the Committee should have a regular agenda item, under the Minutes of the previous meeting, to look at what progress had been made on recommendations it had previously made.

8. Local Involvement Network (LINk) Update

(Item 4 – report by Mr G K Gibbens, Cabinet Member for Public Health)
(Mrs M Blanche, LINk Lead and Senior Policy Manager, and Ms R Gardner, Management Trainee, Kent Graduate Programme, were in attendance for this item.)

(1) Mr Gibbens thanked the Committee for inviting him to update them on progress on the LINk. He explained that the LINk project had now reached the stage of launching the tendering process to find the host organisation. Briefings had taken place with County and District Council Members and meetings with the voluntary sector. Mr Gibbens outlined KCC's role in relation to the LINk as being to manage the tendering process, stimulate public interest in the LINk and to

performance-manage the host organisation. He thanked Mrs Blanche and Ms Gardner for their work in developing the LINks project.

(2) In response to questions put to them by Members and Patient and Public Involvement Forum (PPIF) representatives, Mr Gibbens and Mrs Blanche explained the following:-

(a) A key role of LINks was to ensure a better information flow to HOSCs. A challenge to be addressed was how to ensure representation for hard-to-reach groups, such as gypsies and travellers, refugees, black and minority ethnic groups, etc.

(b) The LINk, if it worked well, would draw in a good range of service users and organisations. As the body responsible for commissioning the host organisation, KCC would have more influence over the LINk than it did over PPIFs. A successful meeting, hosted by the PPIFs and aimed at voluntary organisations, and carer and user groups, as well as PPIF members, had been held at Lenham on 30 January.

(c) Regarding arrangements for the transition to the LINk, 28 volunteers had so far come forward to join a Steering Group. The Group would be meeting in March, chaired by the current Chairman of the Medway Steering Group (who could share

lessons from Medway's experience of having been a LINk "early adopter").

(d) Every local authority in England, regardless of size, had been allocated the same sum – £10,000 – to cover the cost of setting up LINks; in a large county, such as Kent, this would not go far. Ten per cent of the overall annual funding allocation for the LINk – £492,000 – would be kept back by KCC to cover the cost of its ongoing performance-management role in respect of the host organisation.

(e) A Member asked about the possible workload arising from the right of LINks to refer matters to HOSCs. Concerns were also raised by a PPIF representative about whether provision had been made for transitional arrangements from 1 April, in case the LINk was not operational from that date, as planned. He also questioned the planned top-slicing of the LINk funding allocation; some local authorities were not going to top-slice – and a few had actually contributed additional funding to their LINk budgets. Mr Gibbens and Mrs Blanche replied that the HOSC hoped to start the LINk as close to 1 April 2008 as possible. Top-slicing was occurring so that Kent had enough funding to cover its performance-management role in respect of the host organisation, and to support any referrals to the HOSC (the volume of which could not be predicted).

(f) Mr Gibbens would be happy to meet with anyone across the county who wished to discuss the plans for setting up the LINk. Information was available on Kent TV and the KCC website, and there was an extensive mailing list for the LINks newsletter, which included local MPs.

(g) KCC's planned Healthwatch body could assist the operation of the LINk by gathering information and signposting queries to the right place. KCC could not stipulate what the LINk did with this information, but the LINk ought to consider it. The county council had allocated £300,000 in the Medium Term Plan to fund Healthwatch.

(h) The draft tender specification for the host organisation was now ready. The specification could not be published, due to commercial sensitivity – but it was no secret that it was based on Department of Health (DoH) guidance. There would be 40 days during which tenders could be submitted.

(3) RESOLVED that the information given on the set up of the LINks scheme be noted, with thanks.

9. Budget and Financial Plan – Eastern and Coastal Kent Primary Care Trust

(Item 5 – Mr D Meikle, Director of Finance and Investment of the PCT, was in attendance for this item at the invitation of the Committee)

(1) The Chairman introduced Mr Meikle and thanked him for attending. He said that, although the HOSC had not yet been able to have any information on the PCT's budgets, he felt it was still very helpful for the Committee to have a discussion with each PCT about the budget-setting process.

(2) Mr Meikle gave a brief introduction to the PCT's Operating Plan for 2008/09. He explained that the 2008/09 financial year was a one of transition, with the PCT's system for budget-setting and monitoring being different from that in previous years. He explained that, as Director of Finance and Investment, he was in charge of both commissioning and finance within the PCT. He hoped to develop a system for the future based on need, building client intelligence from commissioners, and adding national and local priorities. Funding decisions would be based on need, with better discussion and public involvement than in the past.

(3) His aim was to bring the whole process forward in the year, hence the process of putting together the PCT's Operating Plan for 2009/10 would effectively start on 1 April 2008. The PCT would work with partners to identify needs and constraints. On this occasion budget-setting had been delayed by PCTs' not knowing their financial allocations and National Priorities (set out in the NHS Operating Framework) for 2008/09 until December 2007.

(4) The Chairman thanked Mr Meikle for his summary of the situation and said it was good that the HOSC would be able to be involved at an early stage in planning for 2009/10.

(5) In answering questions from Members, Mr Meikle explained the following:-

(a) PCTs had been given a one-off annual funding allocation for 2008/09, instead of the three-year allocation that was intended to be the normal pattern. This was because the funding formula was under review and would be changing soon. In future, PCTs would receive three-year allocations (which would consist of a definite figure for the year to come and indicative figures for the following two years).

(b) In East Kent there were now 11 'clusters' of GPs for the purposes of practice-based commissioning (PbC). It was variable how much commissioning decisions were being delegated to PbC clusters. Regarding audiology, for instance, most clusters were happy for the PCT to commission services, but three (at Whitstable, Deal and Ramsgate) had their own locally commissioned arrangements.

(c) Tariff splitting was an interesting challenge. As more care was shifted closer to home, more elements of patient pathways (such as diagnostics and rehabilitation) were being undertaken outside the acute hospital setting. If tariffs were not split, the PCT would end up paying for these elements twice. Acute providers, however, were reluctant to split tariffs, as they feared that financial risk would be transferred to them. It was necessary to create sustainable provision of alternative services in primary care, so that acute providers could

be reassured that they would not end up providing elements of care for which they would not be paid.

(d) The strategic context was vital to achieving the DoH's goal of world-class commissioning. Areas of deprivation and need would be highlighted as part of this. Where priorities were driven by the demands of those who already had better services, namely the articulate middle classes, investment actually compounded inequalities in access to healthcare. PCTs now had to draw up Strategic Commissioning Plans, which took account of such issues and gave a five-to-ten-year view. On the basis of this, a one-year Operating Plan (equivalent to the old Local Delivery Plan) was produced, stating how the PCT would progress towards its strategic objectives. In addition, the PCT worked with acute providers (whether NHS Trusts or the private sector) to produce a Capacity Plan (Organisational Development Plan), showing how providers would deliver services.

(e) 'Fit for the Future' was at the core of the Strategic Commissioning Plan and the Operating Plan, although it was not what was driving them.

(f) Asked to comment on whether the existing weighted capitation formula was fair, Mr Meikle said that, as it currently stood, the formula

reflected the challenges that the PCT faced; and it was up to the PCT to invest the money in the right place.

(g) Mr Meikle was asked whether the 5.5% increase in PCT allocations for 2008/09 would be enough to cover the rising cost of drugs and fuel. He replied that the greater part of the PCT's funding allocation was spent on purchasing services from the acute sector, which were paid for under the national tariff. In so far as increases in costs were not fully reflected in the annual uplift of the tariff, they were a pressure on providers rather than commissioners.

(h) The PCT had a responsibility to ensure that it balanced its finances. In relation to PbR, it built its budget by working out the number of operations expected and the cost of each under the tariff. Financial managers would meet monthly to monitor the level of activity and sign off the budget month by month. Any disparity between the level of services contracted and the level actually undertaken was then addressed. The PCT's budget allowed for flexibility in the range of +/- 5% over the year; if this was exceeded, the budget had to be reworked to allow for the changed level of activity.

(i) Funds that had previously been top-sliced from the PCT's growth funding were being returned; some had come back at the start of 2007/08 and the rest would be received in 2008/09. Discussions on possible further top-slicing in 2008/09 were ongoing; the NHS

Operating Framework did include provision for the creation of a Strategic Change Fund to pump prime change at Strategic Health Authority level.

(j) PbC represented a challenge to the existing culture of the NHS. Commissioners would need to be certain of the availability of sustainable local services. PCTs "held the ring" as regards both commissioning and providing, monitoring clinical governance, quality, etc.

(k) The withdrawal of acute Trusts from the Resource Accounting and Budgeting mechanism at the beginning of 2007/08 had been helpful, as previously a technical accounting issue had been impacting adversely on the planning of future services.

(l) Accurate forecasting was a challenge. PCTs worked with providers on an annual basis, looking at sources of demand, referral patterns, etc.; and five-year public projections were used to try and map future demand.

(m) The PCT faced two key challenges: firstly, to address health inequalities and help the whole population to access health services; and secondly, as the population aged, to take account of consequent changes in need and ensure suitable pathways.

(n) The PCT's remit was increasingly to develop the provider market in the NHS and to promote maximum choice, with the aim of driving up quality. This was a challenge in an area such as East Kent, whose geographical location made it less likely that alternative providers would want to challenge the local monopoly NHS providers. However, there had been some success, for example in audiology over the past eighteen months, where a private-sector procurement had achieved a reduction in waiting times. There were risks, but the PCT could cope if it had good quality data to allow it to commission services effectively.

(o) Responding to a question about the possibility of using patient charges to damp down demand, Mr Meikle said that the DoH's policy on charging was and always had been very clear – that health services should be free at the point of delivery. The NHS sought to reduce demand through means such as health education – for instance using "health trainers" in the community to raise awareness of the need for everyone to take care of their own health.

(p) Mr Meikle clarified some terms used in the internal PCT report which had been shared with the HOSC:-

(i) SIGs were Service Improvement Groups, composed of clinicians from primary and secondary care, charged with looking at care pathways and work relating to 'Fit for the Future'; and

(ii) The CET was the PCT's Clinical Executive Team, twelve clinicians charged with providing an objective clinical view on budget proposals.

(q) Mr Meikle was asked about the possibility of patients choosing to be treated in mainland Europe, where costs were lower than in the UK. Mr Meikle said he was unable to comment on a comparison of prices for treatments in the UK and mainland Europe. He explained that patients had increasing choice about where they could be treated in England. If options for treatment in Kent, the South East and London were exhausted and the 18-week maximum referral-to-treatment target could not be met, the PCT might consider commissioning treatment further afield.

(r) There had been an absolute increase in the number of clinical staff employed by the PCT's provider arm and by East Kent Hospitals Trust. A workforce strategy group, consisting of all interested parties, met monthly to look at the Strategic Commissioning Plan and identify issues relating to staffing, skills balance, etc. Detailed figures would be sent in a written response.

(6) The Chairman then asked Mr Meikle for his views on the process of budget-setting and performance management, and the timetable for sharing this with the HOSC and allowing the HOSC a constructive role. Mr Meikle emphasised that his aim was for the 2009/10 budget process to begin much earlier than that for

2008/09. Broad outline proposals for the 2009/10 budget would be available as early as April 2008.

(7) RESOLVED that the information given in Mr Meikle's presentation, and in his responses to questions from Members, be noted, with thanks.

10. Budget and Financial Plan – West Kent Primary Care Trust

(Item 6 – Mr S Phoenix, Chief Executive of the PCT, was in attendance for this item at the invitation of the Committee.)

(1) The Chairman introduced Mr Phoenix and thanked him for attending. He said that, although the HOSC had not yet been able to have any information on the PCT's budget for 2008/09, he felt it was still very helpful for the Committee to have a discussion with each PCT about the budget-setting process.

(2) Mr Phoenix gave a brief introduction on the PCT's current financial position. The four PCTs that had preceded West Kent PCT had had widely differing financial performances and overall the outcome had not been good. In October 2006, when he had taken up his current post, the PCT had had a £30 million financial recovery plan and by March 2007 it had moved to a £15 million overspend. This and previous debts meant that the PCT had had to pay back £20 million in the 2007/08 financial year, leaving its budget very tight. In addition, the PCT had experienced unexpected expenditure in several areas, including specialist tertiary treatment outside the area and high drugs charges. However, the PCT expected to end the year in balance.

(3) Last year, the Local Delivery Plan had set out financial priorities for the three years ahead – but the PCT had not received its funding allocation until mid- to late-December 2007, preventing it from doing any effective financial planning before then. The allocation given had been for one year only, not the expected three years. The next two years' allocations from the DoH were expected in spring 2008. The allocation formula was to change and the PCT was nervous that it would be disadvantaged by the new formula. The PCT was required to meet the national targets and priorities for the NHS, set out in the 2008/09 Operating Framework and the "Vital Signs" indicators, which were a suite of national requirements and local priorities (identified through discussions with PPIFs, the 'Fit for the Future' process and work with PbC clusters).

(4) Three priority strands had been identified, which resonated with discussions that the PCT had had with the HOSC:

(a) to reduce levels of Healthcare-associated Infections;

(b) to improve access to healthcare;

(c) to improve the health of the population and reduce health inequalities.

(5) In answering questions from Members and PPIF representatives, Mr Phoenix explained the following:-

(a) The PCT was able to forecast its future demand reasonably well by looking at past patterns and emerging trends. Patient choices were

difficult to predict, however. Choose and Book offered patients choice at referral and, under PbR, the money followed the patient. Movement here so far was slow, but the exercise of choice was expected to become more prevalent in the years ahead.

(b) PbC was already shaping this year's one year plan and all PbC clusters had produced business plans for the coming year. PbC had been slow to get going but it had speeded up in the last six months to a level comparable to that achieved in other PCT areas.

(c) Mr Phoenix thought that the issue of tariff splitting (or unbundling) was something of a "red herring" as regards making more use of community hospital services. Not a lot of work had been done on tariff unbundling but it was not a magic formula for community hospitals; there were other issues too. The starting point should be what the best place to treat people was, not financial processes. Tariff unbundling was a means to an end not an end in itself.

(d) There was nothing the PCT could do to influence private dentists who chose not to accept NHS patients. A tendering process to increase capacity in the Tonbridge area and address the gap in provision would be underway by late spring 2008.

(e) The PCT's financial turnaround plan to address its past overspends and go from a £20 million debt to break-even meant that, inevitably, it

had had £20 million less to spend on healthcare than otherwise would have been the case. Repayment of the £20 million had been helped by: making efficiency savings; reducing posts; paying only for work undertaken; delaying investment in IT; holding vacancies for longer than usual; making more efficient use of the drugs budget; and cutting training courses. Since the PCT's budget had grown overall, the £20 million recovery had been achieved by containing spending rather than by making actual cuts.

(f) Replying to a question about the impact of Private Finance Initiative (PFI) contracts on the local health economy, Mr Phoenix said that the Darent Valley Hospital PFI contract accounted for some 21% of Dartford and Gravesham Trust's annual budget. The Trust was doing well financially, but the cost of the PFI contract was a factor in its finances. The planned Pembury Hospital PFI contract would account for 15% of Maidstone and Tunbridge Wells Trust's annual budget. However, the cost of PFI projects for the Trusts was a financial issue for them rather than for the PCT.

(g) Waiting times for some procedures had been reduced, but West Kent had not performed as well as East Kent, the latter having been a "pathfinder" for achieving the 18-week maximum referral-to-treatment target. The 2007/08 financial year had not seen as much progress as had been achieved in 2006/07, so there was a lot of catching up to do in 2008/09. Darent Valley Hospital was "on a knife-edge" to achieve

the milestone target of 85% of referrals being treated with 18 weeks by March 2008. Maidstone and Tunbridge Wells Trust's hospitals had no realistic chance of meeting this target but would still try to achieve a decrease in waiting times.

(h) Money saved on the PCT drugs budget, as reported in the media, would return to the PCT. Savings had been achieved by the use of more generic drugs and had been helped by management teams working with GPs' practices. However, the most expensive area of drugs expenditure was in secondary care.

(i) Addressing health inequalities and unequal access to services would require investing in new schemes to 'add years to life and life to years'. West Kent was fortunate in having less variance than East Kent in the health levels of its population. Two particular priorities were campaigns on sexual health and smoking cessation. These campaigns needed to be targeted, as otherwise they tended to have most effect among those sections of the population that least needed them – thereby actually widening health inequalities.

(j) The operation of Free Choice and the entry of new providers into the NHS market did have the potential to make the job of PCTs as commissioners much more difficult.

(k) The PCT had negotiated to vary its contract with the Independent Sector Treatment Centre in Maidstone to ensure that referrals to the service were maximised (given that the PCT was obliged to pay for the full value of the contract regardless of the amount of work actually undertaken).

(l) Funding for Diabeta 3 software and specialist dieticians, for diabetes patients, was not currently on the priority list – but discussions on this had not yet been concluded.

(m) There was no real alternative to opting for PFI arrangements when building large-scale capital projects, as this was government policy. Mr Phoenix said that the Treasury metric showed PFI to be more cost-effective than traditional public-sector procurement. Annual PFI contract charges were more a pressure on the Trusts operating from the PFI buildings than on the PCTs commissioning services from them. The planned Pembury PFI scheme was predicated on the assumption that it would be cost-neutral to the local health economy overall (although transition costs would be borne locally). PCTs paid for most services on a tariff that was uniform across the country and so could not be affected by local PFI costs. If the PFI at Pembury did go ahead, West Kent would have among the best hospital stock in the country.

(n) Making more cost-effective use of the drugs budget (as part of the measures to recoup the £20 million debt) had not prevented patients from having access to high cost drugs where these were genuinely needed. Changes to drugs used had not been made purely for financial reasons, but only if the efficacy of the drug was in doubt. However, newer, higher-cost drugs would present PCTs with a challenge in the future, as prescribing them for one patient would raise the expectations of others.

(o) Involving clinicians in the management of the NHS was a challenge. PbC was partly about this, making GPs financial, as well as clinical, 'gatekeepers'. This had been attempted before, with GP fundholding; it remained to be seen whether PbC could do it. Clinicians tended to find finance and management boring compared to medicine. But an increasing number of managers came from a clinical background.

(6) The Chairman then asked Mr Phoenix for his views on the process of budget-setting and performance-management and the timetable for sharing this with the HOSC and allowing the HOSC Members a constructive role. Mr Phoenix said that the 2008/09 budget process had come too late to allow the HOSC any influence, but the process would start earlier for 2009/10. It was easy to have an abstract dialogue earlier in the year; the difficult bit was aligning this to hard financial numbers. He was confident that the PCT would be able to have a discussion with the HOSC in the autumn around the broad shape of the budget, even if no detail was available at that time. Mr Phoenix suggested a workshop

format to help Members understand issues and express views. The Chairman welcomed the opportunity for the HOSC to have earlier involvement and a more constructive role in the PCT's budget setting process as the statutory role of the HOSC included the receipt of good information in good time.

(7) RESOLVED that the information given by Mr Phoenix in his presentation, and in his responses to questions from Members and PPIF representatives, be noted, with thanks.

Background Briefing on the

Healthcare Commission Annual Health Check

NHS performance assessment up to 2004–5 (star ratings)

The NHS Plan (2000) proposed that NHS organisations should be performance-assessed against government targets and priorities (set out in the Plan) and given ratings.

These ratings were published by the Department of Health for the first time in September 2001, in respect of acute hospital Trusts only (based on their performance in 2000–1).

All acute Trusts in England were rated on their performance against Key targets (using the rating options for each target of Achieved, Underachieved and Significantly underachieved). They were also rated (using a five-point scale) on the following focus areas:

- Clinical focus;
- Patient focus;
- Capacity and capability.

Trusts were assessed using a "Balanced Scorecard" method (intended to allow for the relative strengths and weaknesses of each individual organisation) to produce an overall composite assessment from zero to three stars.

In July 2002 acute Trusts received their second annual ratings (relating to performance in 2001–2), alongside the first performance ratings for specialist hospital Trusts and ambulance Trusts (using the same system as for acute Trusts). Indicative "shadow" ratings were also published for mental health Trusts (again using the same rating system as for acute Trusts). The performance of Primary Care Organisations was assessed for the first time against a range of suitable indicators, but they were not given an overall star rating.

The NHS Reform Act 2002 expanded the powers of the Commission for Health Improvement (CHI – set up in 2000 to improve standards in the NHS, following several high-profile scandals about the quality of care in parts of the NHS) to include performance assessment of the NHS. This meant that CHI would publish NHS star ratings in future.

The performance ratings published by CHI in July 2003 (relating to 2002–3) covered all acute, specialist, ambulance and mental health Trusts – and all Primary Care Trusts (PCTs).

PCTs were rated on the following areas (using the same five-point scale as for other Trusts):

- Access to quality services;
- Improving Health;

- Service provision.

Subsequently, CHI was merged with the Mental Health Act Commission, the National Care Standards Commission and parts of the Audit Commission to form the Commission for Healthcare Audit and Inspection (CHAI), which was operational from April 2004. (A new Commission for Social Care Inspection for England was also created at the same time.) It was subsequently decided that CHAI would be known as the Healthcare Commission (HCC).

The HCC published the ratings for 2003–4 in July 2004; and those for 2004–5 in July 2005 – the last to use the star system. Since then, a different rating system has been used, with Annual Performance Ratings for each Trust being generated through the Annual Health Check, carried out by the HCC.

The Annual Health Check

The first Annual Performance Ratings (covering 2005–6) were issued in October 2006 and the second (covering 2006–7) in October 2007. The third set (covering 2007–8) is due to be published in October 2008.

Under the Annual Health Check, all NHS Trusts in England are given an Annual Performance Rating on two counts, Quality of Services and Use of Resources, using the following scale:

- Excellent;
- Good;
- Fair;
- Weak.

The Use of Resources score is derived from work done by: each Trust's auditors; and the Audit Commission (which compiles an Auditors' Local Evaluation score for each Trust) – or Monitor, in the case of Foundation Trusts.

The Quality of Services score is an aggregation of each Trust's scores when assessed against the following benchmarks, set by the government:

- Core Standards (using the rating options Fully Met, Almost Met, Partly Met or Not Met – in respect of each individual Core Standard, Trusts are rated using the options Compliant, Insufficient assurance or Not met);
- Existing National Targets (using the rating options Fully Met, Almost Met, Partly Met or Not Met);
- New National Targets (using the rating options Excellent, Good, Fair or Weak).

An organisation must demonstrate consistently strong performance across the board to gain the two highest Quality of Services scores (Excellent and Good). In order to score Good for Quality of Services, an organisation must score at least Almost Met for Core Standards and Existing National Targets, as well as scoring at least Good

for New National Targets. To score Excellent for Quality of Services, an organisation must receive the highest available score for each of the three components.

If an organisation scores Not Met for either Core Standards or Existing National Targets, it is automatically given a score of Weak for Quality of Services. This is the only way that an organisation can receive a score of Weak for Quality of Services. (Different rules apply to mental health Trusts.)

Overall Quality of Services scores are not directly comparable across different organisation types (PCTs, acute Trusts, Ambulance Trusts, etc.), due mainly to the differing number of Existing Targets and New National Targets that apply to each type. Direct comparisons of overall Quality of Services scores are thus only valid within an individual organisation type (i.e. when comparing PCTs with PCTs, acute Trusts with acute Trusts, etc.).

Core Standards

Core Standards (24 in total, under seven Domain headings – see attached table) were laid down by the Department of Health in *Standards for Better Health*. This was published in July 2004 as an integral part of *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/2006–2007/2008*, which set out the framework of standards and targets for all NHS organisations and Social Services authorities to use in planning over the next three financial years.

Core Standards are intended to "bring together and rationalise existing requirements for the health service, setting out the minimum level of service patients and service users have a right to expect".

In each Annual Health Check, Trusts are required to assess themselves and submit declarations on how far they have achieved each Core Standard, using sets of criteria issued by the HCC. Declarations for 2007–8 must be submitted no later than Midday on 30 April 2008, and no earlier than 21 April 2008.

Third-party commentaries and HCC inspections

As part of the declaration process, Trusts are responsible for seeking commentaries on their performance against Core Standards from "third parties":

- Strategic Health Authorities;
- Patient and Public Involvement Forums (Local Involvement Networks from 2008–9);
- local authority Health Overview and Scrutiny Committees;
- elected Governors (in the case of Foundation Trusts).

Third parties are not expected to sign off, or comment directly on, Trusts' declarations. Trusts must include third-party commentaries, word-for-word, with their declarations to the HCC.

Third-party commentaries are cross-checked by the HCC against Trusts' declarations. Depending on the information received from third parties, the HCC may

investigate a Trust further, by means of a risk-based inspection (to which around 10 per cent of Trusts are subjected each year).

The Commission also carries out random inspections for the purpose of quality assurance (involving a further 10 per cent of Trusts each year). According to its findings, the Commission can deduct penalty points, and adjust Trusts' declarations, where appropriate.

Information and guidance on third-party commentaries in the 2007–8 Annual Health Check are contained in the HCC guide *Your part in the annual health check 2007/2008* (appended to this background briefing).

The Hygiene Code

Government standards on infection control were raised in October 2006 with the introduction (under the Health Act 2006) of the Code of Practice on Healthcare Associated Infections (known as the Hygiene Code). Three of the current Core Standards are directly relevant to the Hygiene Code:

- C04a (infection control systems);
- C04c (decontamination of instruments);
- C21 (healthcare environment and hygiene).

In addition to meeting these Standards, each Trust has also been required since 2006–7 to provide a statement on the measures it is taking to observe the provisions of the Hygiene Code. For 2006–7 a statement was required in respect of the situation as at 31 March 2007; for 2007–8, the statement applies to the entire year.

This statement does not directly contribute to Trusts' Annual Performance Ratings, but the information it contains is used as part of the HCC's process to assess risk, and target local visits and inspections to provide assurance on standards.

Existing national targets

Existing National Targets assess whether levels of service set through the 2003–6 government planning round are being maintained. These targets are considered to be the basics of what Trusts should be doing.

New National Targets

New National Targets are targets for the years 2005–6 to 2007–8. They were published by the Department of Health in 2004 in *National Standards, Local Action*. These targets are considered to cover what trusts are required to do to demonstrate they are developing and sustaining improvement, and are framed in terms of ultimate public health outcomes.

New National Targets carry less weight than Existing National Targets in compiling each Trust's overall Quality of Services score.

Service Reviews, Targeted Reviews and National Studies

The HCC also conducts Service Reviews, Targeted Reviews and National Studies (Improvement Reviews and the Acute Hospital Portfolio in 2005–6) as part of the

Annual Health Check. These can be applied to a variety of healthcare settings, including patient treatment pathways, different disease groups, and services for patient groups.

Service Reviews have two stages. Firstly, the performance of all the Trusts taking part is assessed. Then the HCC works with around 10 per cent of these (chosen because they have the weakest scores in the Commission's assessment) to help them develop action plans for improving their performance.

Targeted Reviews are based solely on an analysis of national data relating to a topic or service, followed by risk-based visits to selected Trusts.

National Studies are more general assessments of commissioning and service provision, focusing on quality of services and value for money. These may cover all NHS organisations or only certain organisations.

In the 2005–6 Annual Health Check, Trusts' scores in Improvement Reviews counted towards their Quality of Services rating. In subsequent years, Review scores have not directly affected Trusts' Annual Performance Ratings. However, where Service Reviews, Targeted Reviews and National Studies give rise to concerns that Core Standards are not being met, the HCC will use that information as part of its process to assess risk, and target local visits and inspections to provide assurance on standards.

Developmental Standards

Seven Developmental Standards were set by the Department of Health, alongside Core Standards (and under the same seven Domain headings), in *Standards for Better Health* in 2004. (One of the Developmental Standards was updated in April 2006.)

Developmental Standards were intended to "signal the direction of travel and provide a framework for NHS bodies to plan the delivery of services which continue to improve in line with increasing patient expectations".

Ratings against Developmental Standards were first given in the 2006–7 Annual Health Check, as a result of "shadow assessments". Certain types of Trust were given ratings against three Developmental Standards: Safety of patients (in acute Trusts); Clinical effectiveness and cost effectiveness (in acute Trusts and mental health services); and Public health (in PCTs). As these ratings derived from "shadow assessments", they were not taken into account in awarding Trusts' Annual Performance Ratings.

There will be no separate declarations by Trusts for 2007–8 on progress against the Developmental Standards. Instead, the HCC has said that it will use the learning from the shadow assessment in 2006–7 to develop a small set of comparative, or "benchmark", indicators for Trust Boards, to show their position relative to similar Trusts within the three Domains that were looked at in 2006–7.

Ratings for Trusts in Kent and Medway

Annual Performance Ratings for Trusts in Kent and Medway in 2005–6 and 2006–7, along with star ratings for the period from 2000–1 to 2004–5, are shown in attached tables.

No Trust in Kent and Medway was rated Excellent in 2005–6. Only two local Trusts received a Good rating – Ashford PCT and South West Kent PCT, both in respect of Quality of Services. Swale PCT received a double Weak rating.

In 2006–7 too, no Trust in Kent and Medway was rated Excellent. Only one local Trust received a Good rating – Dartford and Gravesham NHS Trust, in respect of Quality of Services. Maidstone and Tunbridge Wells NHS Trust received a double Weak rating, one of only 20 Trusts in the country (10 of which were acute Trusts) to be rated so poorly.

KCC's NHS Overview and Scrutiny Committee did not submit any third-party commentaries for the Annual Health Checks in respect of either 2005–6 or 2006–7.

The future of the Annual Health Check

The government intends to create a single regulatory body for health and social care by merging the HCC with the Commission for Social Care Inspection and the Mental Health Act Commission, to form the Care Quality Commission (CQC – it has also been referred to as "Ofcare"). The legislation to enact this measure, the Health and Social Care Bill, is currently before Parliament.

It is intended that the new Commission will be established in October 2008, taking responsibility for the regulation of health and adult social care in April 2009 and working towards the full implementation of a new registration system from April 2010. The existing Commissions will continue to fulfil their functions until the end of March 2009 to allow for an adequate transition period to the new arrangements.

This means that responsibility for finalising and publishing the results of the Annual Health Check for 2008–9 will rest with the CQC.

There will be significant changes to the Annual Health Check for 2008–9, including the following:

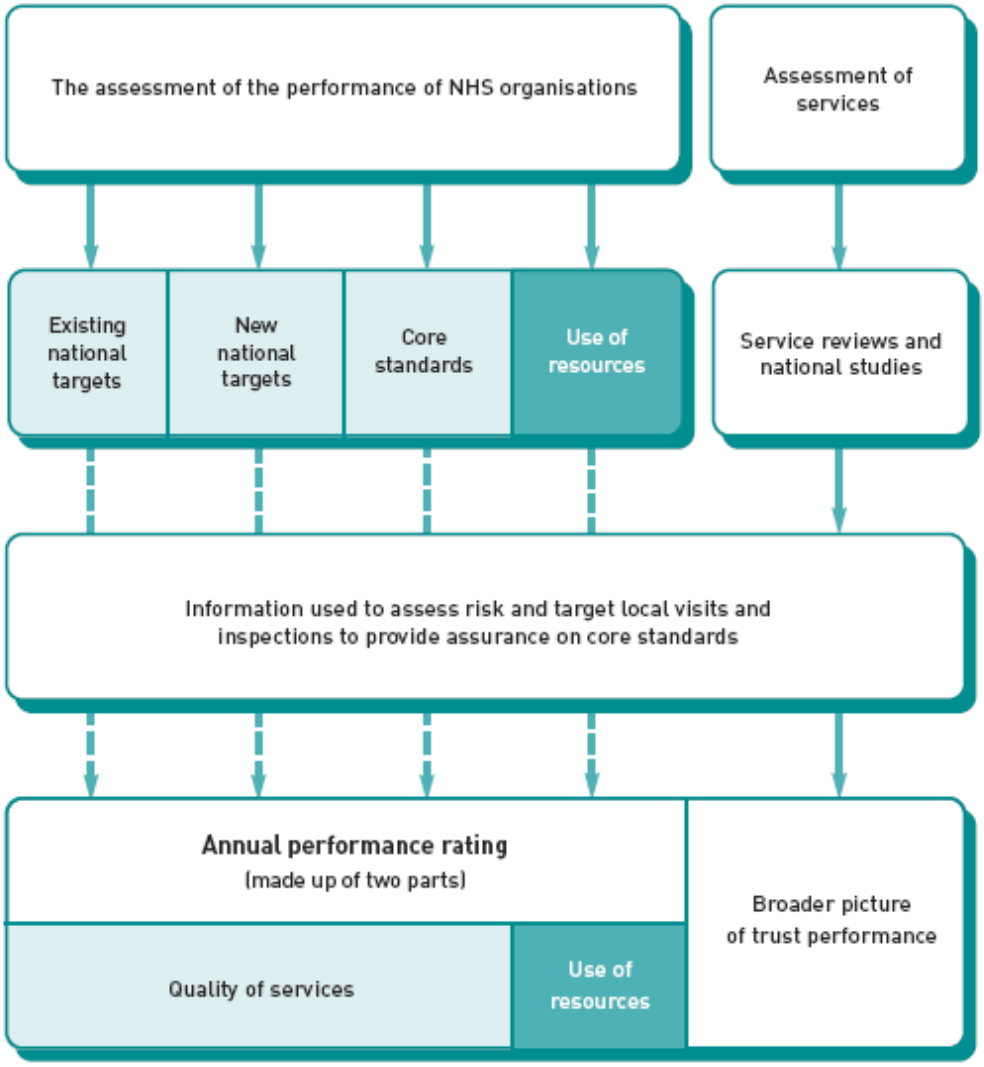
- While the "light touch" inspection regime (with risk-based and random inspections of a minority of Trusts) will continue, all acute Trusts will be inspected to check on compliance with the Hygiene Code;

- PCTs will be assessed on their performance as commissioners of services, separately from their performance as service providers;

- Assessment against National Priorities will replace the measurement of performance against Existing National Targets and New National Targets (reflecting changes in the government's targets regime from 2008–9).

From 2009–10, compliance with National Priorities will be part of the Comprehensive Area Assessment (CAA), with the CQC being one of seven inspection bodies contributing to the CAA.

Annual Health Check 2007–8: framework of assessment



Source: Healthcare Commission

David Turner
Research Officer, Health Overview and Scrutiny Committee
March 2008

This page is intentionally left blank

Annual Health Check Core Standards

Domain	Domain Outcome	Core Standard	Developmental Standard
Safety	Patient safety is enhanced by the use of health care processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.	**C1.** Health care organisations protect patients through systems that **a)** identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents; and **b)** ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required time-scales.	**D1.** Health care organisations continuously and systematically review and improve all aspects of their activities that directly affect patient safety and apply best practice in assessing and managing risks to patients, staff and others, particularly when patients move from the care of one organisation to another.
		C2. Health care organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations.	
		C3. Health care organisations protect patients by following NICE Interventional Procedures guidance.	

Domain	Domain Outcome	Core Standard	Developmental Standard
		C4. Health care organisations keep patients, staff and visitors safe by having systems to ensure that **a)** the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA; **b)** all risks associated with the acquisition and use of medical devices are minimised; **c)** all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed; **d)** medicines are handled safely and securely; and **e)** the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.	

Domain	Domain Outcome	Core Standard	Developmental Standard
Clinical and Cost Effectiveness	Patients achieve health care benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes	**C5.** Health care organisations ensure that **a)** they conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care; **b)** clinical care and treatment are carried out under supervision and leadership; **c)** clinicians continuously update skills and techniques relevant to their clinical work; and **d)** clinicians participate in regular clinical audit and reviews of clinical services.	**D2.** Patients receive effective treatment and care that: **a)** conform to nationally agreed best practice, particularly as defined in National Service Frameworks, NICE guidance, national plans and agreed national guidance on service delivery; **b)** take into account their individual requirements and meet their physical, cultural, spiritual and psychological needs and preferences; **c)** are well co-ordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations; and **d)** is delivered by health care professionals who make clinical decisions based on evidence-based practice.
		C6. Health care organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.	

Domain	Domain Outcome	Core Standard	Developmental Standard
Governance	Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of the health care organisation.	**C7.** Health care organisations **a)** apply the principles of sound clinical and corporate governance; **b)** actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources; **c)** undertake systematic risk assessment and risk management; **d)** ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources; **e)** challenge discrimination, promote equality and respect human rights; and **f)** meet the existing performance requirements set out in the annex.	**D3.** Integrated governance arrangements representing best practice are in place in all health care organisations and across all health communities and clinical networks.

Domain	Domain Outcome	Core Standard	Developmental Standard
		C8. Health care organisations support their staff through **a)** having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services; and **b)** organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.	
		C9. Health care organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.	**D4.** Health care organisations work together to **a)** ensure that the principles of clinical governance are underpinning the work of every clinical team and every clinical service; **b)** implement a cycle of continuous quality improvement; and **c)** ensure effective clinical and managerial leadership and accountability.

Domain	Domain Outcome	Core Standard	Developmental Standard
		C10. Health care organisations **a)** undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies; and **b)** require that all employed professionals abide by relevant published codes of professional practice.	**D5.** Health care organisations work together and with social care organisations to meet the changing health needs of their population by **a)** having an appropriately constituted workforce with appropriate skill mix across the community; and **b)** ensuring the continuous improvement of services through better ways of working.
		C11. Health care organisations ensure that staff concerned with all aspects of the provision of health care **a)** are appropriately recruited, trained and qualified for the work they undertake; **b)** participate in mandatory training programmes; and **c)** participate in further professional and occupational development commensurate with their work throughout their working lives.	**D6.** Health care organisations use effective and integrated information technology and information systems which support and enhance the quality and safety of patient care, choice and service planning.
		C12. Health care organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.	**D7.** Health care organisations work to enhance patient care by adopting best practice in human resources management and continuously improving staff satisfaction.

Domain	Domain Outcome	Core Standard	Developmental Standard
Patient Focus	Health care is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being.	**C13.** Health care organisations have systems in place to ensure that **a)** staff treat patients, their relatives and carers with dignity and respect; **b)** appropriate consent is obtained when required for all contacts with patients and for the use of any patient confidential information; and **c)** staff treat patient information confidentially, except where authorised by legislation to the contrary.	**D8.** Health care organisations continuously improve the patient experience, based on the feedback of patients, carers and relatives.
		C14. Health care organisations have systems in place to ensure that patients, their relatives and carers **a)** have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services; **b)** are not discriminated against when complaints are made; and **c)** are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.	**D9.** Patients, service users and, where appropriate, carers receive timely and suitable information, when they need and want it, on treatment, care, services, prevention and health promotion and are **a)** encouraged to express their preferences; and **b)** supported to make choices and shared decisions about their own health care.

Domain	Domain Outcome	Core Standard	Developmental Standard
		C15. Where food is provided, health care organisations have systems in place to ensure that **a)** patients are provided with a choice and that it is prepared safely and provides a balanced diet; and **b)** patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.	**D10.** Patients and service users, particularly those with long-term conditions, are helped to contribute to planning of their care and are provided with opportunities and resources to develop competence in self-care.
		C16. Health care organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care.	
Accessible and Responsive Care	Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or	**C17.** The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services.	**D11.** Health care organisations plan and deliver health care which **a)** reflects the views and health needs of the population served and which is based on nationally agreed evidence or best practice; **b)** maximises patient choice; **c)** ensures access (including equality of access) to
		C18. Health care organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.	

Domain	Domain Outcome	Core Standard	Developmental Standard
	of the care pathway.	**C19.** Health care organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.	services through a range of providers and routes of access; and **d)** uses locally agreed guidance, guidelines or protocols for admission, referral and discharge that accord with the latest national expectations on access to services.
Care Environment and Amenities	Care is provided in environments that promote patient and staff well-being and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.	**C20.** Health care services are provided in environments which promote effective care and optimise health outcomes by being **a)** a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation; and **b)** supportive of patient privacy and confidentiality.	**D12.** Health care is provided in well-designed environments that **a)** promote patient and staff well-being, and meet patients' needs and preferences, and staff concerns; and **b)** are appropriate for the effective and safe delivery of treatment, care or a specific function, including the effective control of health care associated infections.
		C21. Health care services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.	

Domain	Domain Outcome	Core Standard	Developmental Standard
Public Health	Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.	**C22.** Health care organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by **a)** co-operating with each other and with local authorities and other organisations; **b)** ensuring that the local Director of Public Health's Annual Report informs their policies and practices; and **c)** making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.	**D13.** Health care organisations **a)** identify and act upon significant public health problems and health inequality issues, with primary care trusts taking the leading role; **b)** implement effective programmes to improve health and reduce health inequalities, conforming to nationally agreed best practice, particularly as defined in NICE guidance and agreed national guidance on public health; **c)** protect their populations from identified current and new hazards to health; and **d)** take fully into account current and emerging policies and knowledge on public health issues in the development of their public health programmes, health
		C23. Health care organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.	

Domain	Domain Outcome	Core Standard	Developmental Standard
		C24. Health care organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.	promotion and prevention services for the public, and the commissioning and provision of services.

This page is intentionally left blank

Healthcare Commission Annual Health Check ratings for NHS trusts in Kent and Medway

Trust	2005-6					2006-7				
			Quality of Services components*					Quality of Services components		
	Quality of Services	Use of Resources	Core Standards	Existing National Targets	New National Targets	Quality of Services	Use of Resources	Core Standards	Existing National Targets	New National Targets
Dartford and Gravesham NHS Trust	Fair	Weak	Fully met	Fully met	Fair	Good	Fair	Almost met	Fully met	Good
East Kent Hospitals NHS Trust	Fair	Weak	Almost met	Partly met	Fair	Fair	Weak	Fully met	Fully met	Weak
Maidstone and Tunbridge Wells NHS Trust	Fair	Weak	Almost met	Almost met	Fair	Weak	Weak	Not met	Partly met	Weak
Medway NHS Trust	Fair	Fair	Partly met	Fully met	Good	Fair	Fair	Fully met	Fully met	Weak
South East Coast Ambulance Service NHS Trust	-	-	-	-	-	Fair	Fair	Almost met	Partly met	Good
Kent and Medway NHS and Social Care Partnership Trust	-	-	-	-	-	Fair	Fair	Partly met	Fully met	Fair
Eastern and Coastal Kent Primary Care Trust	-	-	-	-	-	Weak	Fair	Not met	Almost met	Weak
Medway Primary Care Trust	Fair	Weak	Fully met	Almost met	Weak	Fair	Fair	Partly met	Almost met	Weak
West Kent Primary Care Trust	-	-	-	-	-	Fair	Weak	Almost met	Almost met	Weak
Predecessor Trusts:										
South East Coast Ambulance Service NHS Trust										
Kent Ambulance NHS Trust	Fair	Fair	Fully met	Almost met	Fair	-	-	-	-	-
Kent and Medway NHS and Social Care Partnership Trust										
East Kent NHS and Social Care Partnership Trust	Fair	Fair	Almost met	Fully met	Weak	-	-	-	-	-
West Kent NHS and Social Care Trust	Fair	Weak	Almost met	Fully met	Weak	-	-	-	-	-
Eastern and Coastal Kent Primary Care Trust										
Ashford Primary Care Trust	Good	Fair	Almost met	Almost met	Good	-	-	-	-	-
Canterbury and Coastal Primary Care Trust	Fair	Weak	Almost met	Partly met	Fair	-	-	-	-	-
East Kent Coastal Primary Care Trust	Fair	Fair	Fully met	Partly met	Good	-	-	-	-	-
Shepway Primary Care Trust	Fair	Fair	Almost met	Partly met	Excellent	-	-	-	-	-
Swale Primary Care Trust	Weak	Weak	Not met	Partly met	Weak	-	-	-	-	-
West Kent Primary Care Trust										
Dartford, Gravesham and Swanley Primary Care Trust	Fair	Weak	Almost met	Almost met	Weak	-	-	-	-	-
Maidstone Weald Primary Care Trust	Fair	Fair	Almost met	Almost met	Weak	-	-	-	-	-
South West Kent Primary Care Trust	Good	Weak	Almost met	Fully met	Good	-	-	-	-	-

Source: Healthcare Commission

Note

* The Quality of Services score for 2005-6 was also based on the results of a number of Reviews.

This page is intentionally left blank

Annual Performance Ratings for NHS Trusts in Kent and Medway

Trust	Star rating (out of three)				
	2000-1	2001-2	2002-3	2003-4	2004-5
Dartford and Gravesham NHS Trust	Zero	*	***	***	***
East Kent Hospitals NHS Trust	**	*	*	**	**
Maidstone and Tunbridge Wells NHS Trust	*	**	Zero	Zero	*
Medway NHS Trust	Zero	**	*	**	*
Kent Ambulance NHS Trust	-	***	*	*	***
East Kent Community NHS Trust	-	**	*	-	-
Invicta Community Care NHS Trust	-	**	-	-	-
Thames Gateway NHS Trust	-	**	-	-	-
East Kent NHS and Social Care Partnership Trust	-	-	-	**	**
West Kent NHS and Social Care Trust	-	-	**	*	*
Ashford Primary Care Trust	-	-	**	**	**
Canterbury and Coastal Primary Care Trust	-	-	*	**	*
Dartford, Gravesham and Swanley Primary Care Trust	-	-	Zero	*	**
East Kent Coastal Primary Care Trust	-	-	**	***	**
Maidstone Weald Primary Care Trust	-	-	*	Zero	*
Medway Primary Care Trust	-	-	*	*	*
Shepway Primary Care Trust	-	-	**	**	**
South West Kent Primary Care Trust	-	-	*	*	**
Swale Primary Care Trust	-	-	*	*	*

Sources: Department of Health / Commission for Health Improvement / Healthcare Commission

This page is intentionally left blank

Patient
Public
Involvement
Forum Working with Darent Valley Hospital

Shaping Health
Better decisions
Better health

The annual health check: Forum commentary on Trust's compliance with the Department of Health's core standards

General

Attached is the Forum's annual report which provides information on the discharge of its responsibilities to monitor the quality of health services from the patient's perspective.

Core standard C14 : Patient Focus – Complaints

a) **Healthcare Organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect:**

Forum Comment:

Patient Advice & Liaison Service (PALS)

The Forum has had regular contact with the Darent Valley Hospital PALS Officer and Lead for Patient & Public Involvement in Health. All Forum members are able to direct specific patient queries to PALS. The Forum continues, with the Trust, to monitor the Suggestion Boxes located throughout the hospital whereby suggestions left by patients and the public are logged and acted upon.

Core Standard C15 – Food

a) **Where food is provided, health care organisations have systems in place to ensure that patients are provided with a choice and that it is prepared safely and provides a balanced diet**

Forum Comment:

Meal Provision.

Meals at Darent Valley Hospital are now prepared by Tillery Valley Foods, a new supplier who was appointed in April 2007 replacing Medirest. Members of the Forum have continually worked with the hospital on food and nutrition and have had an in depth presentation from the Head of Nutrition and Dietetics on the new menus etc.

Patient choice continues to be well provided for by Tillery Valley Foods. A three weekly menu is now in place therefore long stay patients are catered for with a varied choice of diet.

All correspondence should be addressed via:
Kent & Medway Networks Ltd
Unit 24, Folkestone Enterprise Centre, Shearway Road, Folkestone, Kent, CT19 4RH
Tel. No: 01303 297050 Fax No: 01303 297069 Email: janine@kmn-ltd.co.uk

about the consequences of underfunding and the service not being able to reach national standards. At the Forum meeting on the 10 December 2007 members were told that in the Dartford, Gravesham and Swanley area the Diabetes Team has been unable to afford a repair to one of their three special digital cameras, causing the service to be cut by 33% and putting patients at risk. The Forum also learnt that there are no plans to develop the promised Diabetes Centre at the new build PFI hospital at Pembury.

✱*Please see attached report and minutes:*

- *Report from Graham Steele on Diabetes Services dated 21 November 2007*
- *West Kent PPI Forum minutes of the meeting on 10 December 2007, Item 4 d)*

ii. Growing concerns continued to be raised by patients and the League of Friends regarding the closing of 15 beds in the Tonbridge Community Hospital. Over the year the Forum representative sitting on the PCT Consultation Advisory Group, for Tonbridge Hospital, has reported that the hospital's League of Friends pressed for closed beds to be reopened. The Forum took the view that no definitive stand should be taken over the opening of closed beds until the Advisory Group's conclusions had been made public. At its meeting of the 31 January 2008, the PCT Board received a report based on the findings of the Advisory Group and agreed to 6 beds being re-opened at the hospital, to a review being continued over other service options and to consult the public over these proposals. The Forum went along with these conclusions

iii. The Forum has also followed the consultation process for Edenbridge Community Hospital. Concerns were raised by local residents at proposed changes to the Minor Injuries Unit and the South West Kent Locality Group of the Forum followed closely these concerns and had Forum representation on the Consultation Advisory Group. Members are gratified that the PCT listened to the views of the people and that the PCT Board, at their meeting in January, agreed to improve the service at the Minor Injuries Unit securing its future.

iv. Before reconfiguration of the PCTs local residents in Hextable had been promised development of the Manzooie Clinic. At a meeting of the Forum in April 2007 members asked the Director of Civic Engagement for PCT commitment to this project. The Director explained that the PCT had inherited a £30m debt and could not entertain any capital building this financial year. The Forum is pleased to note that during this year the PCT has seen its way clear to refurbish this centre and feel that with PPI intervention this much needed centre has been kept open for patients.

Fifth domain: Accessible and responsive care

Core standard C17 *- The views of patients, their carers and others are sought and taken into account in designing, planning, delivery and improving healthcare services*

Forum comment

The Forum has been represented on several service review groups and Consultation Advisory Groups, within the PCT as evidenced by the minutes below. In some instances members have reported concerns in the way the groups have been managed eg:

- Not giving sufficient notice of meetings
- Not advertising widely enough public meetings
- Not using fully accessible and convenient venues
- Not circulating information to all members of the advisory group
- Agreeing of action without the prior knowledge of all members of the advisory group

✱ *Please see attached reports and minutes:*

- *South West Kent Locality Group minutes of meeting 4 June 2007, Item 4 ii).*
- *South West Kent Locality Group minutes of meeting 3 September 2007, Item 11 b).*
- *West Kent minutes of meeting 17 September 2007, Item 9 f) i).*
- *South West Kent Locality Group minutes of meeting 26 November 2007, Item 11.*
- *Edenbridge Consultation Advisory Group - Report by Mo Reece dated 10 January 2008*

Core standard C18 *- Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably*

Forum comment

i. As in previous years the Forum is still concerned with regard to access to NHS dental care and took part in the Commission for Patient and Public Involvement in Health national 'Dentistry Watch' campaign. Not only is the care inadequate across the whole of the West Kent area, but there is also inequality across the patch. There are five NHS dentists in each of the Dartford, Gravesham and Swanley areas, but only one dentist from Maidstone to Hawkhurst (Maidstone Weald area) and one in Tunbridge Wells and Sevenoaks (South West Kent area). The Forum understands there is only one dentist making domiciliary visits and patients have to travel out of the area to a dentist with disabled facilities. Members were told of extra funding available for dental care, but that dentists are not signing up to the NHS contract. The Forum recommends that the PCT put more emphasis on encouraging dentists to take NHS patients.

✱*Please see attached reports and minutes:*

Dartford, Gravesham and Swanley Locality Group minutes 22 October 2007 Item 6a).

ii. Members of the Dartford, Gravesham and Swanley PPI Locality Group made a visit to the Livingstone Community Hospital. Whilst on the whole pleased with the way patients were treated they did not find evidence that patients were offered information in a variety of formats especially those from the multi – cultural areas of the community. Members also did not find evidence that any translation services were offered for patients who did not have a good understanding of the English Language.

✱*Please see attached report:*
Dartford, Gravesham and Swanley Locality Group - Review of Livingstone Community Hospital, conclusions and recommendation.

Patient
Public
Involvement
Forum Working with Darent Valley Hospital

Shaping Health
Better decisions
Better health

The annual health check: Forum commentary on Trust's compliance with the Department of Health's core standards

General

Attached is the Forum's annual report which provides information on the discharge of its responsibilities to monitor the quality of health services from the patient's perspective.

Core standard C14 : Patient Focus – Complaints

a) Healthcare Organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect:

Forum Comment:

Patient Advice & Liaison Service (PALS)

The Forum has had regular contact with the Darent Valley Hospital PALS Officer and Lead for Patient & Public Involvement in Health. All Forum members are able to direct specific patient queries to PALS. The Forum continues, with the Trust, to monitor the Suggestion Boxes located throughout the hospital whereby suggestions left by patients and the public are logged and acted upon.

Core Standard C15 – Food

a) Where food is provided, health care organisations have systems in place to ensure that patients are provided with a choice and that it is prepared safely and provides a balanced diet

Forum Comment:

Meal Provision.

Meals at Darent Valley Hospital are now prepared by Tillery Valley Foods, a new supplier who was appointed in April 2007 replacing Medirest. Members of the Forum have continually worked with the hospital on food and nutrition and have had an in depth presentation from the Head of Nutrition and Dietetics on the new menus etc.

Patient choice continues to be well provided for by Tillery Valley Foods. A three weekly menu is now in place therefore long stay patients are catered for with a varied choice of diet.

All correspondence should be addressed via:
Kent & Medway Networks Ltd
Unit 24, Folkestone Enterprise Centre, Shearway Road, Folkestone, Kent, CT19 4RH
Tel. No: 01303 297050 Fax No: 01303 297069 Email: janine@kmn-ltd.co.uk

Core Standard 17 : Accessible & Responsive Care – Patient & Care Views
Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably

Forum Comment:
Generally the access to services and treatment for all communities irrespective of their age, gender, ethnic group, religion, sex orientation and disability was found that the patients were quite satisfied. The Forum has been made aware at its meetings in public of the Trusts Equality and Diversity Policy. The Forum has also had input into the Trust's new Visitors Charter together with a general information leaflet for patients.

Throughout the year the Forum has received comments through its suggestion box scheme over arrangements for the supply of patient's medication on discharge. We believe that the delays may not be at the pharmacy end of the process but emanates from arrangements at ward level.

Patient & Public Involvement
The Forum has built up a very good working relationship with the Trust, especially the members of staff involved in Patient & Public Involvement. Whenever the Forum has approached the Trust the response has been almost always been immediate and in the main the PPIF Forum and Trust are working well for the good of the patient.

Diane Steltner
Chair – PPIF Working with Darent Valley Hospital
25 February 2008

Maidstone and Tunbridge Wells Hospitals

Patient
Public
Involvement
Forum

Shaping Health
Better decisions
Better health

The Maidstone and Tunbridge Wells Hospitals Patient and Public Involvement (PPI) Forum Annual Report 2007/2008

Introduction

PPI Forums which have been in existence for four years are to be abolished at the end of March 2008. Consequently, this is the Forum's last Annual Report.

Since it was established the Forum has brought issues of concern to the public and patients to the attention of the Trust and has endeavoured to focus Trust management on addressing these issues and making improvements in the services provided. The Forum has adopted a non-confrontational and balanced approach toward the Trust, with mixed results.

The work of the Forum has covered a wide range of issues, including hygiene and cleanliness, nursing standards and clinical care, service provision, infection control, communication with patients and between doctors and nurses, waiting times, car parking and input into planning for the new PFI Hospital at Pembury. This list is by no means exhaustive.

During the period it has operated, the Forum has carried out numerous inspections, had many meetings with Trust personnel and management, attended Trust board and committee meetings, met with local MP's, attended meetings of the KCC Overview and Scrutiny Committee (OSC), met and made representations to the Healthcare Commission and issued press releases, to inform and publicise its views and recommendations on many of these issues. Generally speaking, Trust management has cooperated in enabling the Forum to carry out its programme of work. However, over the past year the Trust has been disappointingly reactive in its dealings with the Forum, responsive when approached but not (as had previously been our experience) seeking active engagement.

All correspondence should be addressed via our Forum Support Organisation:

Kent & Medway Networks Ltd
Office Hours: Monday - Friday 8.30am - 4.30pm
Unit 24, Folkestone Enterprise Centre, Shearway Road, Folkestone, Kent, CT19 4RH
Tel. No: 01303 297050 Fax No: 01303 297069 Email: janine@kmn-ltd.co.uk

Achievements

It has to be said that the Forum has had limited success in achieving its aims, despite the commitment and hard work of its Members. Throughout the period of its existence, the achievement of higher standards of hygiene and cleanliness in the Trust's hospitals has been a principal aim of the Forum. Undoubtedly progress has been made in this direction , particularly under the impetus of the recent Healthcare Commission report , but recommendations made by the Forum following its initial inspections in 2004 were only implemented in part and when the Trust has adopted the Forum's recommendations following subsequent inspections its response has often been slow .

The Forum for some time has pressed for an increase in nursing establishment. The need for which was recognised belatedly by the Trust but the Trust's recruitment programme envisages that recommended levels will not be achieved before March 2009. It is important that everything that can be done to accelerate this programme is done and that there is no slippage.

The Forum has also urged a more collaborative approach between the Trust and the PCT. Although there are indications that this may now be beginning to happen, there has been little evidence of it previously, on issues such as financing, demand management and strategic planning. We would hope to see clear evidence of closer collaboration.

Forum's work in 2007-2008

The current year has been traumatic for the Trust following publication of the Healthcare Commission's report into the outbreaks of clostridium.difficile and the subsequent resignation of most of the Trust's board. In our opinion media coverage of the report was not balanced - while criticism of management failings is justified, the problems faced by the Trust are complex and unlikely to be capable of resolution by changes in management alone. These problems are well documented in the Healthcare Commission's report and many have previously been highlighted by the Forum.

Priorities in 2007-2008

The identified priorities of the Forum at the start of this year were: (1) to continue to monitor and seek improvements in standards of hygiene and cleanliness; (2) to review and monitor the Trust's adherence to the SLA (Service Level Agreement) ; and, (3) to monitor progress and implementation of the Trust's strategy for stroke care. Outcomes are as follows:

Hygiene and Cleanliness

We have met with the hospital matrons at the three sites and with the lead infection control nurse to receive updates on progress against previously recommended actions. In November and December we conducted inspections of toilet, bathroom and related facilities and equipment on various wards at the Trust's 3 hospitals. The findings of

these reports were published in a press release in mid January 2008. Copies of the report were sent to the Trust, in mid December 2007, and subsequently to the PCT, the Strategic Health Authority, KCC OSC and the Healthcare Commission. Although we found standards had improved in some areas, we also found conditions on two wards which we did not consider acceptable. This suggests that more needs to be done to achieve uniform and consistently high standards across the Trust.

Service Level Agreement

This agreement between the PCT's and the Trust sets out the level of activity commissioned by the PCT's. It has been a source of dispute between the Trust and the PCT's in previous years, arising from differences over the level of payments due from the PCT. The agreement affects the Trust's financial performance and is of interest because financial pressures can feed through (and, in the past certainly have) to decisions affecting patient care. Our concern is that the level of activity commissioned by the PCT should be a realistic reflection of the levels of demand experienced by the Trust and that the Trust's procedures are effective to keep performance against the SLA under close review - and thereby minimise the need for unanticipated emergency measures to address a prospective financial deficit (with potentially negative implications for patient care). Regrettably, our review of the SLA, in the absence of historic and more detailed information, did not enable us to reach any conclusion on the adequacy or otherwise of commissioned activity and we remain unclear as to the Trust's procedures for monitoring performance against the SLA. We understand that changes have been made to the SLA following the Healthcare Commission's report which has ensured the availability of further funds in the current year.

Stroke Strategy

We are extremely concerned at the absence of appropriate and necessary facilities for care of stroke patients in the Trust's hospitals. The Trust rated very poorly in the National Stroke Audit and has no acute stroke unit at any of its hospitals. We have focused this year on pressing Trust management to set out and progress its strategy for provision of stroke care. We have now been assured by the CEO that an acute stroke unit will be established at both Kent and Sussex and Maidstone hospitals. We are informed that the unit at K&S is proceeding but that the unit at Maidstone, while approved in principle awaits a decision on its precise location and sign -off of the final business case. We would like to see detailed plans for the development of both units and a specific commitment on timing. We believe there is a pressing need for additional rehabilitation and physiotherapy services at both hospitals.

Members of the Forum have taken an active part in the Kent Wide Stroke Forum as a means of championing the Forum's concerns.

Other Forum work

Patient survey

The Forum undertook a survey of patients discharged from the Trust's 3 hospitals, to ascertain their views on aspects of their care. The survey indicated fewer concerns over hygiene and cleanliness than might have been expected and general satisfaction

with care and treatment. The findings show appreciation of care provided by nursing staff but highlight the shortage of nurses.

Car Parking

The Forum made strong representations to the Trust over what we consider to be inadequate parking provision at the new Pembury hospital. Members of the Forum addressed our concerns to the Planning Committee and our written objections were supported in writing by several local bodies and by some councillors. Notwithstanding a well reasoned argument the committee rejected our request for an increase in the number of spaces.

Reconfiguration of services

The Forum (with 2 Members dissenting) supported proposals for the reconfiguration of general and emergency orthopaedic surgery between Maidstone and Tunbridge Wells Hospitals. After the OSC objected to the proposals and referred them to the Secretary of State, the Forum wrote to the Secretary of State indicating its support. Subsequently the Chair and Vice - Chair of the Forum appeared before the Independent Review Panel to put the Forum's views. We are pleased that the proposals have now been approved but regret the delay occasioned by the referral which has caused delays in the implementation of planned consequential changes that would have led to service improvements, including a reduction in mixed sex wards.

KCC Overview and Scrutiny Committee

Following the Healthcare Commission report, the OSC took evidence over two days in November from providers of local health services in Kent (PCT's, Acute Hospital Trusts, the StHA) with a view to determining the adequacy of infection control measures across the local health economy and lessons to be learnt from the findings of the Commission's report. Members of the Forum along with Members of other Forums addressed the committee. The OSC has published its conclusions and recommendations in the minutes of the meeting held on the 27 November. The conclusions reflect a number of issues raised by the Forum and proposed future actions as noted in the conclusions need to be monitored.

Sexual Health

The Forum has sought to encourage the promotion and development of sexual health services and closer coordination between the PCT and the Hospital Trust.

LINks and Legacy Work

It is uncertain how LINks will evolve and whether services provided by MTW Hospitals Trust will feature within its scope. We hope that they will since the Trust's hospitals are a critical part of the local health economy and standards at the hospitals are a vitally important concern of patients and the public. We believe the legacy work for LINks includes:

1. Continuing to monitor standards of hygiene and cleanliness with specific attention being directed to arrangements for the provision, training, management and supervision of domestic cleaners.

1. Continuing to monitor standards of hygiene and cleanliness with specific attention being directed to arrangements for the provision, training, management and supervision of domestic cleaners.

2. Monitoring progress of the Trust's stroke strategy. In particular, pressing for a detailed plan and timetable for the establishment of acute stroke units at Kent and Sussex and Maidstone Hospitals.

3. Monitoring progress on waiting times in A&E and steps being taken to resolve current problems. We are very concerned that issues around A&E are not being addressed with the urgency required given the detrimental impact on patient care. Essentially the problem appears to arise from a shortage of beds at the Trust's hospitals and requires coordinated action by Social Services, the PCT and the Trust. We have been assured that the PCT and the Trust are working more collaboratively in which case we would like to see clear evidence with regard to this particular issue which, purportedly, has been a top priority for many months.

4. Monitoring progress of the recruitment programme for nurses, encouraging the Trust to make every effort to accelerate recruitment without compromising on quality of new intake.

5. Ensuring that the Trust is monitoring and performing in line with its Action Plan to address the findings of the Healthcare Commission's Report.

6. Monitoring progress of the actions points set out in the OSC's conclusions and recommendations contained in the committee's minutes of 27 November.

7. Promoting the development of sexual health services across the local health economy, ensuring that local health agencies are working together in a coordinated way to a coherent plan and that steps are taken to raise public awareness of the nature and location of the services available.

Signed: .....
Chairman

Print: D. HERBERT

Date: 6/03/08.

Commission for Patient and Public Involvement in Health

Appendix C

Annual Accounts 2007 / 2008 Financial Year

Forum Name Maidstone & Tunbridge Wells Hospitals

Forum Support Organisation Kent & Medway Networks

CPPIH Regional Centre South East - Guildford

Details	Notes	Total Actual £
Income		
Forum Income	1	0
Expenditure		
Forum Venue Costs		0
Forum Printing Costs		0
Forum Stationery Costs		0
Forum Venue Expenses		0
Forum Training Costs		0
Other Expenses		0
Total Expenditure		0
Variance Suplus / (Deficit)		0

Notes to the Accounts

1. Income and Expenditure

Forum Support Organisations are responsible for the management of funding provided by the Commission covering routine operational expenditure incurred on behalf of the Forum, including venue costs, meeting and material costs and the reimbursement of Forum Member expenses.
In addition, the CPPIH has been responsible for the management of Development funding awarded to the forum. As the Forum has not been directly responsible for the management of funds in the 2006-2007 Financial Year, we consider a Nil return to represent an accurate view of it's financial activities.

Declaration

As Forum Chair and as the representative of PPIF Maidstone & Tunbridge Wells Hospitals I confirm that the financial statement as set out above is a true and fair record of our financial activities.

Signed _____

Name D. HERBERT

Date 6/03/08.

Maidstone and Tunbridge Wells Hospitals Patient Public Involvement Forum

Shaping Health
Better decisions
Better health

11 March 2008

Press Release

Maidstone and Tunbridge Wells Acute Hospital Trust Public and Patient Involvement Forum issues its final Annual Report and Commentary on the Annual Health Check (copies attached).

The Annual Report summarises the Forum's work during 2007-2008 and the Commentary considers aspects of the Trust's compliance or otherwise with Core Standards prescribed by the Healthcare Commission.

Key points:
The Forum notes:

1. Patients comment favourably on care provided by nursing staff;
2. Improvements in hygiene and cleanliness and infection control; BUT
3. Too few nurses. Pace of recruitment of additional nurses too slow. Concern that recruitment constrained by insufficient funding;
4. Shortage of beds (reduced by 25% in just over 2 years) compounded by difficulties in discharging patients to nursing homes or community hospitals;
5. Little evidence of effective collaboration between healthcare agencies;
6. Looming financial problems.

David Herbert, Forum Chair comments:
"The Healthcare Commission report has forced the Trust and other responsible agencies to focus on hygiene and cleanliness and infection control but these issues had in any case begun to be addressed by previous management. The Trust faces many other problems that have not been highlighted.

The Trust has too few nurses on the wards; too few beds; serious concerns in the operation of its A&E department; inadequate facilities for the care of stroke patients, and is facing a financial deficit next year. All these issues impact adversely on patient care and require urgent attention. Worryingly, we have seen little evidence that the Trust, the PCT, the Strategic Health Authority, Kent County Council, are working together, collaboratively to address the issues with any conception of the meaning of urgency. "

Continued ...

All correspondence should be addressed via our Forum Support Organisation:
Kent & Medway Networks Ltd
Office Hours: Monday - Friday 8.30am - 4.30pm
Unit 24, Folkestone Enterprise Centre, Shearway Road, Folkestone, Kent, CT19 4RH
Tel. No: 01303 297050 Fax No: 01303 297069 Email: janine@kmn-ltd.co.uk

Commenting on the closure of Forums, Mr Herbert added:

"The Forum has been in existence for 4 years. During that time it has monitored standards at the Trust's hospitals, drawn attention to issues of concern and sought to hold Trust management to account .This is a valuable role. In the final analysis, however, our experience is that until something goes drastically wrong, the influence of patients and the public is limited, particularly where decisions are financially driven. "

Notes for Editors:

For further information on this press release David Herbert can be contacted on 01732 810693

For general information about Patient and Public Involvement Forums in Kent contact Graham Hills on 01303 297050 or 07817 536877

What is a Patient and Public Involvement (PPI) Forum?

The purpose of PPI Forums is to ensure an independent voice for patients and the public, not just in healthcare but in all decisions that could affect their health. Forums are made up of volunteers who represent and reflect the communities they serve. There is a PPI Forum for every NHS trust in England. Around 4,000 volunteers are now involved in helping to achieve health improvements across England. The Commission for Patient and Public Involvement in Health (CPPIH), which established the Forums, is responsible for advising the Government on how the PPI system is functioning. The CPPIH liaises with national bodies such as the Healthcare Commission and makes recommendations to these bodies and the Department of Health as appropriate. It also gathers information and opinion from PPI Forums, channelled through its shared information system, in order to ensure that these bodies are acting on the views of patients and the public.

In April, PPI Forums and CPPIH will be replaced by Local Involvement Networks (LINks). LINks will be established within each area that is served by a local authority with responsibility for social services. This means there will be 150 LINks nationwide. They will be statutory bodies with the aim of enabling local people and groups to influence local care services, from planning and commissioning to delivery.

END

Maidstone & Tunbridge Wells NHS Trust PPI Forum
Comments for Annual Health Check
March 2008

We must first comment on the publication in October 2007 of the Healthcare Commission report on Maidstone & Tunbridge Wells NHS Trust.

The Healthcare Commission report on the outbreaks of C.Diff. at the Trust between October 2005 and September 2006 was published over a year later in October 2007. The Forum feel that the report was comprehensive in its coverage and balanced in its assessment of the factors which caused these outbreaks to be so serious.

However, we also feel that the report should have been published with an up-to-date inspection (such as the one in December 2007) detailing changes since the outbreak since, predictably, the media assumed there had been no change. Our concern is that patients were frightened by the implications and many cancelled their operations. When we surveyed patients ("Discharge Patient Survey at the Maidstone and Tunbridge Wells Hospitals Trust November 2007 to January 2008", published 17 January 2008), nearly 80% said they "*felt safe, no concern over infection*"; but the other 20% had clearly been affected by the publicity ("*not entirely safe due to adverse publicity*"). Moreover, the survey showed that patients overwhelmingly felt that the nursing and medical care they had received was either good or excellent.

The HCC report has of course led to major disruption at the Trust, with the loss of all non executive directors and several directors on the Trust Board along with key senior managers. Such purges may be politically expedient but they adversely affect the management of the hospital and hence the patients' care. It will take time for the replacements (many of whom are not yet appointed permanently) to have a positive effect.

There has been a shocked realisation by staff at all levels that everyone (doctors, nurses, managers, services) contributed to the severity of the C.Diff. outbreak and its consequences. In our most recent inspections of wards at all three hospitals (February 2008), we see welcome signs that the middle management, in particular ward managers and senior nurse managers, are at last taking responsibility for changing things within their control, in particular the cleaning and repair of the wards.

The following paragraphs cover areas which cannot be related directly to the Annual Health Check categories, but are of concern to the Forum.

The Trust remains under severe financial pressure (presentation at 14 February 2008 PPI Forum meeting by temporary Financial Director). In 2007/8, the financial plan demanded savings of £17.5m. If the Trust ends the year in financial balance, it will only be due to extra assistance (amounting to

over £10m) from the PCT and the SHA. Next year's plan demands an even greater saving of £20m, approaching 10% of the planned income. Savings of this order can only be met without adversely affecting patient care through excellent operations management. Unfortunately, the Trust has had four Operations Directors in the last 18 months and still has no permanent appointee. The Trust needs to determine, in conjunction with West Kent PCT and South East Coast SHA, whether financial results or patient care are their highest priority.

We are still extremely concerned at the shortage of nurses on the wards (we commented on this in last year's Annual Healthcheck). Our most recent patient survey ("Discharge Patient Survey at the Maidstone and Tunbridge Wells Hospitals Trust November 2007 to January 2008", published 17 January 2008) asked specifically if patients felt there were enough nurses. Over half said "no". When asked what single change they would like to see made in the hospitals, nearly half the patients said "more nurses". The Trust plans to bring the number of nurses up to HCC standards by March 2009. In our view, this increase in nursing staff is taking far too long and is constrained by financial considerations rather than difficulties in recruiting. The Trust's target is to recruit 13.5 nurses per month, a far lower rate than the 20 per month which was achieved between January and December 2007 (Board papers 30 Jan 2008, Appendix B). A JobFair for nurses, held by the Trust in February 2008, had an enormous response with over 40 well-qualified nurses offered interviews, suggesting that a higher rate of recruitment could be met if it were not for the financial pressures.

We are also concerned with the lack of cover when directors and senior staff are absent, particularly if they are on extended sick leave. The HCC report on the C.Diff. outbreak noted that the lead infection control nurse was on sick leave for several months before finally retiring, and that her responsibility for surveillance was not assumed by anyone else (p.20-21). This failure to reallocate the responsibility of absent senior staff is a common occurrence in the Trust – and possibly in the NHS. Currently, we know of two senior executives who have been on sick leave for months; without formal reassignment of their responsibilities, important work is neglected and key decisions are not made. The responsibilities of anyone absent for more than 2-3 weeks should be formally reassigned, with this reported to the Board.

Comments on specific core standards are given below.

C21 Care is provided in clean environments in accordance with the *National specification for cleanliness in the NHS*

Throughout the four years of the Forum's existence, our major focus has been on reviewing standards of cleanliness and hygiene within the three hospitals. We stated in the Annual Health Check for 2007 that we did not believe that the Trust satisfied the National specification, but relied on the PEAT inspections for monitoring cleanliness. Since the publication of the HCC report, the Trust has set up a Patient Environment Action Group (PEAG),

consisting of directors and senior managers in nursing, facilities management and estates and including a Forum member. This group, together with location groups (one per hospital) which began meeting in January 2008, will be responsible for ensuring that the Trust does meet the National specification on cleanliness. Ward managers and senior nurse managers will take more responsibility for their own areas and not have to refer any changes to senior management. The improvement in cleanliness between our inspections in November 2007 and February 2008 suggest that these changes are having a positive impact.

We also (February 2008 inspection) saw far more notices requesting everyone (visitors and staff) to use gel to clean their hands, and observed that this has become more of a habit with staff. However, preventing the spread of C.Diff. requires hand-washing and this is still not publicised in the hospitals.

C13a The healthcare organisation ensures that staff treat patients, carers and relatives with dignity and respect at every stage of their care and treatment and where relevant takes action where dignity and respect have been compromised.

Our patient survey ("Discharge Patient Survey at the Maidstone and Tunbridge Wells Hospitals Trust November 2007 to January 2008", published 17 January 2008) clearly demonstrated that both doctors and nurses in the Trust treated patients with respect (only one patient felt that a doctor treated them with less than respect).

The Trust's estate makes it very difficult to provide single-sex wards or bays although our patient survey showed that, after more nurses (requested by 50%), this was the change patients wanted most (requested by 33%).

C6 Staff work in partnership with colleagues in other health and social care organisations to meet the individual needs of patients.

In just over 2 years (from Oct 2005 to February 2008), bed numbers across the Trust have reduced from 911 to 679, a reduction of 25% (figures obtained at both dates from MTW Service Transformation). This has led to a very high utilisation of beds, made worse by the difficulty in obtaining beds in social care homes run by Kent County Council or in community hospitals run by West Kent PCT. The result has been that, during the winter months, some patients have been held in ambulances in A&E at Kent & Sussex Hospital (as reported to the Board at their meeting on 30 January 2008 Appendix G of Board papers). In a meeting (8 Feb 2008) with Glenn Douglas, CEO of MTW, we asked what the current position was, and we also asked Candy Morris, CEO of South East Coast SHA, in a letter dated 21 Feb 2008 what steps the SHA were taking. The current situation in Kent & Sussex A&E is unacceptable and we still do not know if a satisfactory solution to the problem has been found.

Stroke care in the Trust's hospitals was in the bottom quartile in the last Sentinel Audit (2006) and worsened between the audits in 2004 and 2006. The provision of stroke services is now being given priority in the Kent & Medway Fit for the Future programme. The Kent Stroke Forum, with clinical, nursing and patient representatives from all trusts in Kent, has helped to define the stroke service which should be available within the next three years. Meanwhile, stroke patients discharged in the West Kent area are still met with three different systems for providing home support from the three PCTs which were amalgamated to form West Kent PCT (Kent Stroke Forum minutes 26 Feb 2008). We are concerned that, as above, this is taking a long time to resolve (West Kent PCT was formed 18 months ago) with stroke services in the area amongst the poorest in Kent.

Sexual health medicine is the responsibility of the PCT. In West Kent, GUM (genito-urinary medicine) clinics at Kent & Sussex Hospital and Preston Hall (Maidstone), which are consultant-led, are staffed by the acute Trust and are struggling to handle the rising numbers of patients within the budget assigned. The Forum has been pressing for more than two years for decisions to be made as to how and where this service will be supplied in future. The West Kent PCT Local Delivery Plan 2007-8 states that "only 51% of people were able to access GUM services within 48 hours, falling below the target of 94%. Plans to develop GUM services during 2007/08 have been established." So far, we have seen no sign of these plans being put into action.

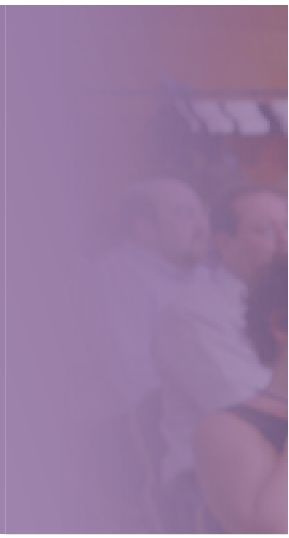
Concluding remarks

Since it was established four years ago, the Forum has sought to bring issues of concern to the public and patients to the attention of the Trust. In doing so, it has endeavoured to focus Trust management on addressing these issues and making improvements in the services provided. The Forum has adopted a non-confrontational and balanced approach toward the Trust with mixed results. There have of course been improvements, but only by small increments when we hoped to see rapid, fundamental change. In the end, the influence of the public and patients is very limited, particularly where finance drives decisions, and this seems unlikely to change whatever the form of patient and public involvement.

Healthcare Commission

Your part in the annual health check 2007/2008

A step-by-step guide for patient and public involvement forums, overview and scrutiny committees and foundation trusts' boards of governors



From April 2008, trusts will again be gearing up for the declaration part of the annual health check. We need your comments to make sure that we get the full picture about their performance in 2007/2008.

The Healthcare Commmission keeps a check on local healthcare organisations and provides information that is of interest to patients and the public about their local health services – safety and cleanliness, dignity and respect, standards of care, keeping people healthy, waiting to be seen, and good management.

By checking trusts' performance and providing information, we aim to help trusts to improve their services.

We want you to tell us how you think your local trust is performing against the standards set by Government, and to give us the views and experiences of people in your community. We are determined to put the interests of patients and the public at the heart of our work, so your feedback is very important to us. Trusts must include your comments – word for word – in the declarations they submit to us. But if you are invited to comment and say no, neither you nor the trust will be penalised.

We invited patient and public involvement forums, overview and scrutiny committees and foundation trusts' boards of governors to comment last year and they responded well. We really appreciate the hard work that went into providing commentaries that produced so much useful intelligence.

1. Getting ready

Every trust must submit a declaration to us by midday on 30 April 2008. As part of this process, trusts are responsible for inviting 'third parties' to comment on their performance. Third parties include patient and public involvement forums, overview and scrutiny committees and foundation trusts' board of governors.

Your local trust should contact you in early 2008 to agree a timetable for including your comments in their declaration. You may also want to start discussing what you might say, so you are prepared.

If you agree to comment, you may want to set up regular meetings with your members as soon as possible, so that you have enough time to seek the views of others in your community. You may also want to contact the other third parties in your area, so that you can discuss your respective roles, exchange views about local trusts and coordinate your efforts.

You may find it useful to share your draft comments with your trust or with a regional assessment manager from the Healthcare Commission. You don't have to take their feedback into account, but working together may benefit everyone involved.

2. What's new in 2007/2008

The Government published *Standards for Better Health* in July 2004, which set out 24 core standards. These core standards describe a minimum level of service, which patients have the right to expect. We are again asking trusts to tell us how they have performed against the core standards this year. You can comment on your trust's performance in relation to any of these standards. You do not have to comment on all of them.

If you provided comments to your trust for the annual health check in 2006/2007, you may remember that we also asked some of you to comment on their performance in relation to developmental standards. This was a pilot assessment for trusts and we are not asking them to report their progress in relation to these standards again this year. You therefore will not be asked to submit comments in relation to the developmental standards this year.

You are not expected to sign off or comment directly on the declaration by your local trust. Your comments should relate to the period from 1 April 2007 to 31 March 2008.

Given that patient and public involvement forums are in a period of transition, they may wish to submit their comments to trusts at an earlier stage this year. In the key dates section below, we have set out some suggestions to enable this.

3. How will your comments make a difference?

Your comments, once submitted to the Healthcare Commission, will be made publicly available. You could make a difference to your local health services just by putting your views on record.

Your comments will be taken into account when we make our final assessments of how trusts have performed in 2007/2008.

They are more likely to influence our assessments if they are supported by facts.

4. Submitting your comments

There is no standard template for giving your comments to trusts – use a format that works best for you. Consider allowing the chair of your group to 'sign off' your comments. This could help you to finalise them more quickly.

It is important that trusts have enough time to include your comments in their declarations before the deadline. They must send us their declaration no later than midday on 30 April 2008 and we will check that they have included your comments.

They should also send you a copy of their declaration once they have submitted it to us so that you can check your comments.

They do not have to share the content of their declaration with you before it is submitted.

Tips to help ensure your comments make a difference

- Think about what matters most to you and the people in your community – what are the most important points you want to get across?
- Think about examples of good practice as well as problems and areas for improvement
- Familiarise yourself with the 24 core standards and guidance relating to them. Aim to match the standards with the points you want to make
- Try to find facts and examples to back up your comments. These may include notes of a meeting or visit to a trust, the results of a local survey, or personal stories from individuals with supporting dates and documents
- Do not submit the supporting information with your comments, but be prepared in case we need to clarify some aspect of your comment

5. Cross checking and follow up

Your comments will be one of the many sources of information that will be used to check the trust's declaration. This helps to ensure our assessments are as fair and accurate as possible. We will also carry out follow up inspections with approximately 20% of trusts – some of these trusts will be chosen at random and some will have been identified as being most at risk of not meeting the core standards.

If your local trust gets a follow up inspection, you may be contacted by one of our regional assessment managers to discuss your comments. We will want to see your supporting information at this point.

Key dates

- **Early 2008**
  Establish the deadlines for submitting comments to your trust

  Because we recognise that patient and public involvement forums are in a state of transition during this period, we accept they may need to submit their commentaries early, and therefore that their commentaries may cover less than twelve months. Forums may negotiate with their trusts to submit their commentaries any time, which we suggest may be from 1 January 2008. They will need to make clear in their commentary the period of time it covers

  If you do not wish to submit any comments for the 2007/2008 annual health check, it would be helpful if you could write formally to your trust advising them of this
- **21 April 2008**
  Trusts can begin to submit their declaration to us
- **Midday 30 April 2008**
  Deadline for trusts to submit their declaration to us
- **16 May 2008**
  Trust declarations made public
- **October 2008**
  Results of the annual health check published

Learning from last year's annual health check

When writing your commentaries for this year's annual health check, try to plan and word your comments so that they include 'items of intelligence' (by that we mean pieces of information) that can be extracted from the commentary and 'coded' against one or more standard, for a particular trust.

In 2007, we received 1,469 comments from third parties. From these comments, 8,196 items of intelligence were extracted and coded because they related to one or more of the standards. Each coded item was weighted 'high', 'medium' or 'low':

- 'high' meant the item had strong association with a particular standard, was closely aligned to the criteria in our inspection guides and provided clear information to support the opinions expressed
- 'low' meant the item related to a small aspect of a standard, or was about one department rather than a whole trust, or had little back-up information
- in total, 492 (6%) of the items were weighted as 'high', 4,180 (51%) as 'low' and 3,524 (43%) as 'medium' weighting.

Find out more

The following publication offers further information about the annual health check:

The annual health check in 2007/2008: assessing and rating the NHS

This can be downloaded directly from the Healthcare Commission website at **www.healthcarecommission.org.uk**

We will shortly be publishing sets of criteria for NHS trusts to give them more information about the assessment of core standards for this year's annual health check. These will also be available to download from the Commission website once they are published.

Healthcare Commission

Telephone 020 7448 9200

Facsimile 020 7448 9222

Helpline 0845 601 3012 (for the cost of a local call)

E-mail feedback@healthcarecommission.org.uk

Website www.healthcarecommission.org.uk

This information is available in other formats and languages on request. Please telephone 0845 601 3012

Finsbury Tower
103-105 Bunhill Row
London
EC1Y 8TG

Maid Marian House
56 Hounds Gate
Nottingham
NG1 6BE

Dominions House
Lime Kiln Close
Stoke Gifford
Bristol
BS34 8SR

Kernel House
Killingbeck Drive
Killingbeck
Leeds
LS14 6UF

5th Floor
Peter House
Oxford Street
Manchester
M1 5AX

1st Floor
1 Friarsgate
1011 Stratford Road
Solihull
B90 4AG