



July 2010

Kent Local Involvement Network (LINK)
**Summary Report on Kent and Medway NHS and Social Care
Partnership Trust Quality Account 2009 / 2010**

1. Overview

This report will offer a more detailed review of the Kent and Medway NHS and Social Care Partnership Trust's (KMPT) Quality Account 2009 / 2010 to accompany the 500 word statement (Appendix 1) which was submitted to the Trust for inclusion when the Quality Account was published on the NHS Choices website and Trust website on 30 June 2010. It will also provide further evidence of the work which was undertaken with Canterbury Christ Church University to inform the LINK's statement.

The document will be made available to the Trust, NHS Eastern and Coastal Kent and NHS West Kent (the Primary Care Trusts), Care Quality Commission, Department of Health and LINK participants via the Kent LINK website and on request in hard copy from the central administration office.

The LINK will be reviewing the work which took place this year and hopes to work closely with the Trust at an early stage to establish an effective process for informing and assuring next year's Quality Account.

2. Background

'High Quality Care for All' (2008) set the vision for quality to be the key organising principle of the NHS using a new quality framework. The new framework is expected to bring clarity to the definition and measurement of quality in healthcare, by ensuring that priorities are identified correctly, that appropriate standards are set, that correct tools for measuring quality are available and that information on quality performance is published.

Quality care has been defined as having three dimensions: safety, effectiveness of processes and outcomes and a positive patient experience. It is proposed that all healthcare providers working for or on behalf of the NHS should produce Quality Accounts which aim to provide the public with information on the quality of care from their local healthcare providers. Quality Accounts are expected to drive improvements in care and most healthcare providers will be required to publish Quality Accounts from April 2010 (to cover the financial year 2009 / 2010) and onwards.

The objectives of Quality Accounts are to allow the public to hold providers to account for the quality of NHS healthcare services, for Commissioners and providers to agree priorities for improvement and for NHS Trust Boards and their non-NHS equivalents to ensure that they place quality at the heart of their planning and delivery.

Part of the Quality Account has been specified by the Department of Health, however, there must be locally determined elements contained in the Quality Account. There will also be a core of nationally determined information which is likely to include information on quality that providers supply to the Care Quality Commission for performance, assessment and registration purposes; information on quality indicators that may be needed by PCTs (for CQUIN) and information from clinical audits etc. In preparation for Quality Accounts, all Foundation Trusts in England were asked to produce 'Quality Reports' (forerunner to Quality Accounts) during 2009.

To ensure that Quality Accounts can achieve these purposes, they need to cover the provision of NHS Healthcare services and contain information that is:

- A truthful and fair picture of the quality of services provided
- Meaningful and relevant to users of quality accounts
- Designed to allow for comparisons to be made
- Produced in a timely fashion
- Published in a way that promotes easy access for users.

3. Role of LINKs in the production of Quality Accounts

LINK organisations should be given the opportunity to provide a comment of no more than 500 words on the Quality Accounts in advance of them being published. In order for their commentaries to be effective they need to possess a number of features. These include the need for the commentary to represent the consensus views of LINK participants, use of robust evidence / information to back up their statements, contain examples of users experience to illustrate the points being made. In addition the limitations of the commentary will need to be reported and the commentary will need to be clearly structured.

Kent LINK sought the support of the Canterbury Christ Church University Centre for Health and Social Care Research in accessing participants and seldom heard groups to inform the commentary for 2009 / 2010 in order to establish a pilot methodology which could be evaluated for future years.

4. Methods employed by Kent LINK to produce commentary for 2009 / 2010

- i. Each Trust's quality related plans for 2009 / 2010 were initially identified from their 2008 / 2009 Annual Report. Plans for 2009 / 2010 were specified under the three quality domains of: patient safety, clinical quality and patient experience.

- ii. Qualitative and quantitative data (related to two key areas identified above) were collected from published research, policy documents etc. and summarised to provide a context for understanding the quality targets.
- iii. Patients (seven) were recruited from existing LINK participants, voluntary sector organisations and other relevant sources to provide balance in terms of specific characteristics such as gender, age, ethnicity etc. They were asked to comment on the three quality dimensions: safety, effectiveness / outcomes and patient experience for the Trust, whether these were important areas to focus on and what they would focus on if they were managing the Trust. Data was collected via telephone communication and face to face interviews.
- iv. The demography for the Trust's catchment area was examined and 'hard to reach' groups located within the catchment were identified. In order to elicit the views of people from these minority groups, contact was made with local voluntary or third sector providers who work with specific individuals and groups, as well as, with local faith based organisations. In order to engage sensitively and appropriately (for example taking account of gender sensitive issues) with 'hard to reach/seldom heard' groups data was collected via focus groups (two groups). The focus group respondents were asked the same questions as those undertaking individual interviews but were also asked to specifically comment on the Trust's draft Quality Account Document.
- v. The data from all sources was collated and analysed and key messages, including patients' stories, identified. This data was then used by a 'consensus panel' consisting of LINK staff, LINK Governors, volunteers and members of the Centre for Health and Social Care Research at Canterbury Christ Church. The 'consensus panel' discussed the draft Quality Account and compared the contents with the evidence from the literature, patients and focus groups. The content of the draft Quality Account in terms of its language, presentation, accuracy of data etc was examined by the 'consensus panel' which then drafted and agreed the final response.

5. Results

The content and layout of the Quality Account

Overall, the account was reasonably well written although the use of acronyms (eg PCC / PCCI.) were not explained or used consistently throughout the document. The account requires an explanation of unusual terms such as 'never event'. Generally, the account appeared to focus on national rather than local targets or areas of concern and could have been balanced with more local priorities.

The review of performance – patient safety

The section on the review of quality performance (patient safety) for 2009 / 2010 focuses on infection control and the incidence of patient falls. Given the very low numbers of hospital acquired infections reported it is not clear whether this needs to be a priority area. Nevertheless, it is of concern that only 51% of non-clinical staff have

been trained in hand hygiene. The claims of achievement of targets for patient safety are not fully evidenced as the baseline data on which to judge the percentages is missing. The document also identifies the eradication of 'never events' in-patient suicide using non collapsible rails as an area for quality improvement but does not provide any quantification or targets for these.

Respondents' comments:

Generally speaking respondents did not consider that hospital acquired infections were a priority for the service or themselves as service users. Nor were hospital related falls regarded as a priority. The potential for risk of death from collapsible rails was recognised by one respondent only.

Overall, most respondents felt that they were in 'safe hands' when using the Trust's services. However, they did describe a number of potential patient safety issues. These included lack of staffing and security in areas where there were potentially dangerous patients. This was thought to place both the patient and visitors at risk. Some respondents felt they were at risk from staff in the way they were treated and they talked about a culture of abuse by dismissive staff.

Patient safety was articulated by respondents in terms of:

- Having sufficient staff and sound security measures in place to keep an eye on patients so that they did not wander off.
- Good quality communication between health professionals and patients – the reports were variable on this issue with many saying their dedicated health professionals were excellent to others saying that they were poor – particularly the psychologists.
- Not having to wait too long to access services following referral because during the 'waiting' stage they felt vulnerable and alone with their problems.
- Not having the service quality reduce by cost cutting measures.

Overall, it appeared that respondents identified more fundamental problems as key for patient safety and these were not reflected in the account.

The review of performance – patient experience

The account reported that the Trust felt that listening to patients, carers and relatives and acting on their feedback was a crucial cornerstone of improving the quality of services for patients. The account describes quality initiatives which the Trust instigated during 2009 / 2010 including a patient survey and a number of public engagement events and projects. In describing the Trust's scores from the patient survey the account does not provide sufficient information for anyone to judge what, if any improvement has occurred. For example, the statement that the 'scores about the ward were about the same or less positive' tells the reader nothing. What were the original scores and what are the current scores? The account reports that following the patient

survey, out of a choice of thirteen possible quality standards, three were selected as the most popular. These included reducing the proportion of detained acute patients who have absconded in the last three months, analysing and reporting complaints and monitoring use of mixed sex accommodation.

Respondents' comments:

Respondents reported a very variable experience in using the Trust's services. Some inpatients described their stays as like being in prison. They described being refused access to their personal items such as glasses, clothe and they talked of a 'them and us' attitude prevailing etc.

Others considered that their experience was favourable. The location of the service and whether it was an out-patient or in-patient service affected respondents' views of their experience. Respondents were asked to score their experience on a scale of one to 10 (with 10 being the highest). Half of the respondents awarded the Trust a score below four and half scored it at eight out of 10.

Those respondents who were carers or relatives tended to be unhappy with the service provided due to a lack of communication between themselves and the health professionals (as a result of patient confidentiality). They felt that the Trust did not listen to them or take note of their complaints.

Most respondents who were accessing out patient services felt that they were involved in decisions about their care and that their health professionals provided them with the information they needed. However, some respondents reported that their complaints were not taken seriously and that they were treated in a dismissive manner by staff. They suggested that staff do not understand what it is like to feel mentally ill and were, therefore, not particularly empathic.

The mismatch between the priorities selected following the Trust's patient survey and the views expressed by patients interviewed as part of the process of commenting on the Quality Account may reflect the way in which the patient survey was designed (ie pre-determined areas for people to tick as opposed to them suggesting their own priorities).

The review of performance – clinical outcomes / effectiveness

Clinical outcomes and effectiveness are covered in two parts of the account. The account describes the use of the Health of the Nation Outcome scale to measure clinical effectiveness and future plans to include patients in the planning of their care. Improving the implementation of the National Institute of Health and Clinical Excellence (NICE) guidance has also been identified as a priority. There is also a plan to enable GPs to access advice about client management from a mental health professional within 24 hours. It is not clear to what extent these have been achieved or what the targets are.

Respondents' comments:

Respondents reported that they could only judge clinical outcomes in relation to their own or a relative's experience of using the Trusts hospitals / services. Most did not understand or had not heard of the Health of the Nation Outcomes scale or NICE guidance.

However, they raised a number of issues of importance. Firstly, most respondents indicated that there seems to be a movement towards doctors / psychiatrists describing patients as being better or having been cured of their illness. As a consequence patients felt to be discharged as soon as they begin to recover and this is seen as too early. This results in patients having to be re-admitted. They felt that the focus on the recovery model meant that support is withdrawn 'at the first signs of improvement' which is too soon.

Respondents also reported being concerned that the plans to shift services to general practice / primary care are likely to be detrimental to their wellbeing because GPs are not seen as experts. Additionally, a number of respondents reported that where GPs referred a patient to mental health services there was often a long wait during which time patients felt at risk. They also described being told they were not eligible for the service after having waited a long time. Overall, they felt that the move for more primary care involvement was a cost cutting exercise.

6. Setting of future objectives

The account includes routine and national audit data which does not effectively describe quality for the lay reader. The quality priorities for 2010 / 2011 appear on page 15 and 16 and do not include any measurable targets or sufficient detail to gauge whether they might be successful. A number of them are about recording information rather than improving quality of care.

Kent and Medway NHS and Social Care Partnership Trust
Quality Account 2009 – 2010
Kent LINK Response

The Kent LINK would like to thank Kent and Medway NHS and Social Care Partnership Trust for the opportunity to comment on its Quality Account for 2009 / 2010. Our assessment is based on the extent to which the account achieves the following intentions:

1. Aiding the public's understanding of what the organisation is doing well
2. Where improvements in service quality have been made and what the priorities for improvement are for the coming year
3. How the organisation has involved service users, staff and others with an interest in the organisation in determining those priorities for improvement.

The LINK has assembled information from a range of sources to inform its commentary using qualitative and quantitative data and academic input from a local University.¹

1. Aiding public understanding

The document is generally well written but there are examples of unexplained abbreviations and jargon (such as 'PCC' and 'PCCI'). The acronym 'KMPT' is used inconsistently, and terms such as 'Never Event' are not universally understood.

The visual presentation of the document could have been improved, for example including individual stories in the section on social inclusion projects established by the Trust to demonstrate good quality patient experience.

2. Improvements made

Indicators such as reducing infections and reducing injury through falls seem to reflect national rather than local priorities. The inclusion of baseline information would demonstrate improvement more clearly. The target for conducting a falls risk assessment on 70% of new admissions to older people's wards within a week is quoted as having been achieved, but is not supported by figures. The presentation of the Trust's scores for the National Survey of Mental Health Inpatient Units is unhelpful, without additional data.

Most participants in the LINK's focus groups and interviews were unfamiliar with the Health of the Nation outcome scales. The account outlines the Trust's intentions to allow service users access to these but how this will be done is unclear.

¹ Canterbury Christ Church University Centre for Health and Social Care Research

The focus groups and interviews undertaken by the LINK strongly indicated that service users and carers do not feel that they are being listened to. Although it is commendable that the Trust has begun the process of real time surveys, it is disappointing that the response rate was so low. Alternative methods of gaining input may be required to extend the range of service users and carers responding.

3. Priorities for improvement for 2010 / 2011

Priorities for improvement have been identified, but are missing targets to enable future progress to be monitored.

4. Who has been involved in preparation of the Quality Account

The Trust has used input from service users and carers (amongst others) to establish its future priorities. However, the questionnaire appears to have been devised by health professionals and as such would not be easily accessible to most respondents.

The priorities may have looked very different if service users and carers had been able to report in their own words, as reflected by our focus groups and interviews. Further information from the survey would demonstrate the number of service users and carers involved.

The LINK recognises that limited time has been available to put the accounts together for this year and hopes to support the Trust with the process in the future.