NHS OVERVIEW AND SCRUTINY COMMITTEE
SELECT COMMITTEE – FINANCING OF THE HEALTH ECONOMY

Autumn 2003

FINANCING OF THE HEALTH ECONOMY - CONTENTS

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1. OVERVIEW AND SCRUTINY OF THE NHS

The Health and Social Care Act 2001 makes statutory provision for local authorities with social services responsibilities to extend their scrutiny and overview functions to cover Health.

Kent County Council established a Pilot NHS Overview and Scrutiny Committee in November 2001, and this committee became a legal entity when the local authority Overview and Scrutiny Committee's Health Scrutiny Functions Regulations 2003 were implemented on 1 January 2003.

The Department of Health in July 2003 issued guidance for the Scrutiny of the National Health Service, and this guidance has been followed when undertaking this review.

2. SELECT COMMITTEE

The Select Committee is made up of seven Members of the County Council. 4 Conservative, 2 Labour, 1 Liberal Democrat, and 1 CHC representative:-

Dr Tony Robinson (Chairman)
Mr Alan Chell
Mr John Davies
Mr Robin Kenworthy (Community Health Council representative)
Mr Ray Parker
Mr Geoff Rowe
Mr Mike Snelling
Mrs Margaret Stevens

The Terms of Reference for this topic review are outlined below:-

"To investigate and identify any improvements to the financing of the Health Economy in Kent and its impact on Health, Social Care and Community including clarifying the following: -

(a) the current position with regard to financing the Health Economy in Kent;

(b) the demographic and cost issues for the South East of England; and

(c) the financial flows and the transactional costs".

The Select Committee agreed that this review would be undertaken in two phases. The first phase concentrated on the funding mechanisms and current financial position of the health economy in Kent. The second phase of the review builds upon the foundations of this stage and addresses the Terms of Reference in full.

The first stage of the review focused on gaining an overview of the current financial position of the health economy in Kent.

The second stage of the review sought written evidence from the following organisations:-

The Strategic Health Authority, Acute Trusts, Mental Health Trusts, Kent Ambulance Trust, Primary Care Trusts and Kent County Council Social Services, Non executive Directors of the Health bodies, Kent MPs and District Councils.

In addition 5 hearings were held, to which all these organisations were invited.

The Committee also attended three sessions of visits and a meeting with the Chief Executive and three Directors of the Strategic Health Authority.

Further details of the review are summarised in Appendix 2 and copies of the written and oral evidence collated are available upon request.

As so much has changed within one year, this report reflects the re-ordered priorities that the Committee found when they gathered evidence in autumn 2003.

3. STRATEGIC CONTEXT

3.1. Achieving the NHS Plan

3.1.1. In April 2002 the NHS underwent significant organisational change. The previous Health Authorities were dissolved and many of their functions, including their commissioning role have been transferred to the Primary Care Trusts (PCTs). These changes place PCTs at the cornerstone of the NHS with the authority and power to develop the modern style of health service outlined in the NHS Plan. They commission services from acute trusts and provide primary health services in their communities.

Health Authorities have been replaced by 28 Strategic Health Authorities (StHA), who are responsible for developing strategy and for the performance management of PCTs and NHS Trusts.

In Kent and Medway, the changes in the Health organisations have been:-

Organisation to 31.3.2002	From 1.4. 2002
East Kent Health Authority[1] West Kent Health Authority Directorate of Health and Social Care (DHSC) – (Regional offices of Department of Health)	Kent and Medway Strategic Health Authority
Canterbury and Coastal Primary Care Group (PCG) Thanet PCG Channel PCG	From 1.4. 2002 Canterbury and Coastal PCT (With some boundary changes) East Kent Coastal PCT
Shepway PCG	Shepway PCT
Ashford PCG	Ashford PCT
South West Kent PCT(Early pilot)	South West Kent PCT
Maidstone and Malling Primary Care Trust, Kent Weald Primary Care Group	Maidstone Weald PCT
Swale PCG	Swale PCT
Medway PCG	Medway PCT
Dartford Gravesham and Swanley PCT(Pilot From Oct, '01)	Dartford Gravesham and Swanley PCT
Invicta Community Trust Thames Gateway Community Trust	West Kent NHS and Social Care and Trust[2]
East Kent Community Trust	East Kent NHS and Social Care Partnership Trust[3]

[1]Most functions of the old Health Authorities are now vested in PCTs; SHA takes on a number of functions previously performed by DHSC

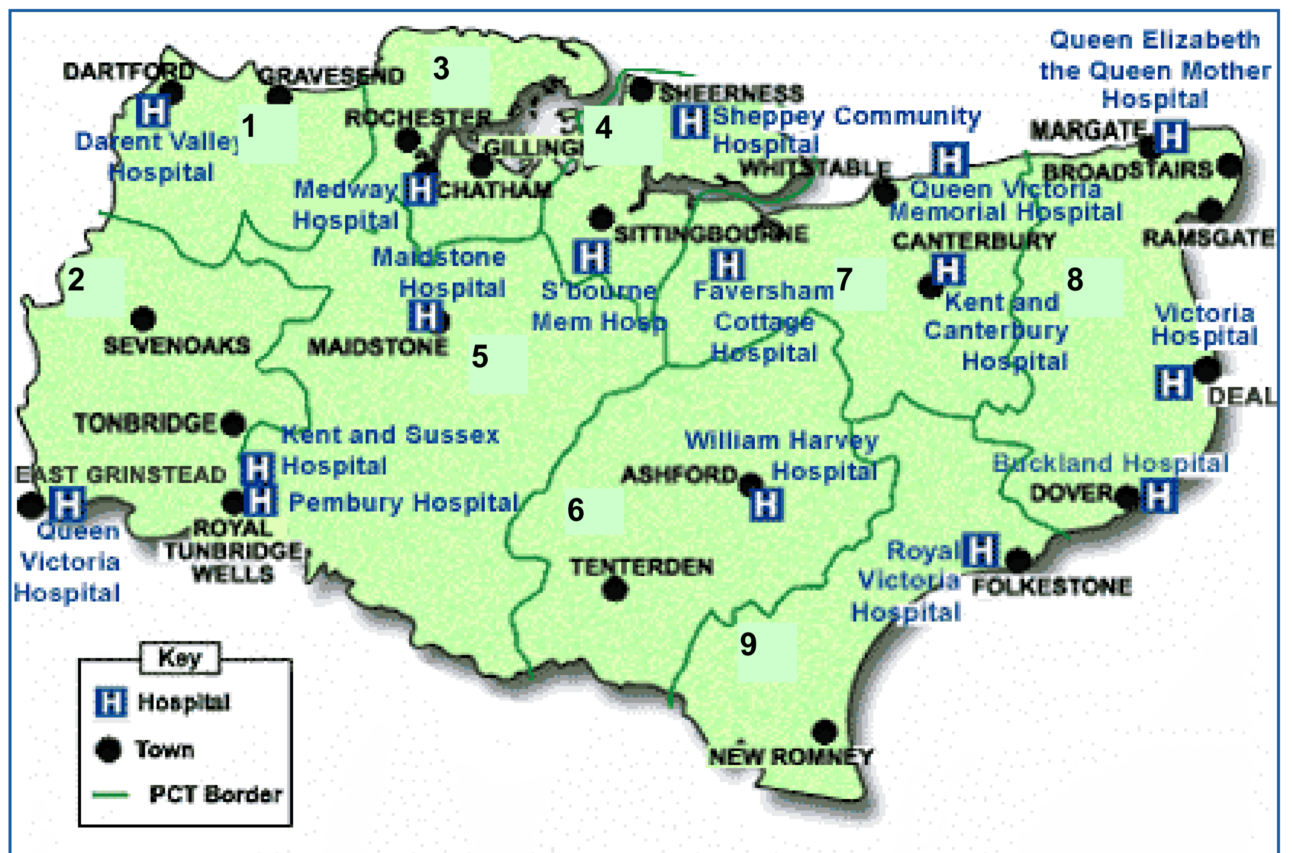
[2] Community Services moved to PCTs when mental health trusts were formed.

[3] Community Services moved to PCTs when mental health trusts were formed.

The Kent & Medway Health Economy

The distribution of the nine Primary Care Trusts across Kent and Medway.

1 Dartford, Gravesham & Swanley
2 South West Kent
3 Medway
4 Swale
5 Maidstone Weald
6 Ashford
7 Canterbury Coastal
8 East Kent Coastal
9 Shepway



3.1.2. As part of the NHS Plan implementation, the Department of Health (DoH) has produced the document 'Shifting the Balance of Power', which explained plans to devolve local decisions to local bodies and the functions of the new health organisations.

To improve standards the DoH has produced National Service Frameworks (NSF) for several specialities, such as Diabetes and Cancer.

The National Service Framework for cancer has led to the National Cancer Plan, which is being implemented as a separate management initiative to ensure national equity.

The National Institute for Clinical Excellence has been constituted to lay down standards, including those in prescribing. These are just some of the key components which are driving the modernisation of the health service.

The priorities for health and social care are set out in 'Improvement, Expansion and Reform: The Next 3 Years'[4]. Extra money coming into Health and Social Services is to be used to develop new services and create new facilities. The emphasis is on making measurable progress over the three years 2003-6, and these are outlined in the Department of Health's Public Service Agreement[5]. This sets out the aims and objectives of the health and social care and underpins the priorities with specific quantifiable targets. The priorities are:-

- Improved access to all services through:-
  - better emergency care
  - reduced waiting, increased pre-booking for appointments and admission at convenient times and more choice of provider for patients
- Focusing on improving services and outcomes in:-
  - cancer
  - coronary heart disease
  - mental health
  - older people
- Improving life chances for children
- Improving the overall experience of patients
- Reducing health inequalities
- Contributing to the cross-government drive to reduce drug misuse

3.1.3. The government set access targets in the NHS Plan and all health organisations have been ranked by means of a star rating system on their ability to meet these targets (see Appendix 3 for Kent and Medway results). The Commission for Health

[4] Improvement, Expansion and Reform: The next 3 years – Priorities and Planning Framework 2003-2006. – Department of Health.
[5] See Glossary for definition of Public Service Agreement.

Improvement (CHI) is the agency developing a process to rate the achievements of those targets using a particular methodology and threshold. Star ratings for all Trusts began in 2001 and CHI took over responsibility in 2003, publishing the results on 15 July 2003. CHI also has the responsibility for clinical audit of health organisations, and where these inspections have been done, they have informed the star rating process.

The reform of the Health Service is a key strand in the current strategy for social reform, and the Department of Health has produced a series of documents to implement this.

For the first time, the Department of Health published three year resource allocations (budgets) for Primary Care Trusts, to enable them to engage in medium term planning.

3.2. Preparing for Payment by Results and Patient Choice

3.2.1. Payment by Results

At the same time, preparations for the full introduction of 'Payment by Results' in 2007/8 continued. In July the Department issued guidance on the working of patient choice which is being phased in from 1 April 2004

'Reforming Financial Flows, Introducing Payment by Results' sets out fundamental changes to commissioning in the NHS. The introduction of this is to be phased in between 2003/4 and 2007/8. Initially the focus is on acute care but it will eventually cover all financial transactions within the NHS. Currently most services are commissioned by Primary Care Trusts with NHS Trusts who run hospitals in block contracts. This means that the Primary Care Trust pays an agreed fee to be able to refer any patients requiring treatment who fall within the scope of the contract. There is thus no restriction on activity. In future there will be a greater emphasis on 'cost and volume' and 'cost per case contracting'. The vision is that it will be possible to purchase services from a diversity of providers who will be paid for the activity that they undertake.

Thus the risk of paying for extra demand – an increase in volume – will lie with the commissioners, the PCTs. The providers of services will still retain the risks of overspending on their operating costs.

When the payment by results system is fully in place, the price charged for each clinical episode (Healthcare Resource Group) will be based on the national average price – known as the national tariff.

3.2.2. National Tariffs

Each year the Department of Health publishes the national tariffs for each Hospital Resource Group and shows the average tariff for each organisation.

The annual issue of Reference costs by the Department of Health in August has taken on a greater importance with the imminent phasing in of Payment by Results. These show how Acute Trusts' costs compared with a National average. Trusts who are above the national average - ranked 100 will have to make cost cutting adjustments to meet targets on tariffs in 2005/6. When Payments by results is fully in place they will

be paid the national tariff for their work, regardless of whether their costs are higher or not.

The usefulness of the national tariffs is tempered by the delay in producing them in that the latest figures available refer to 2001/2 financial year.

National Health Bodies are being consulted on the technical aspects of the movement to National Tariffs, the tariff structure, scope, commissioning and safety nets for those PCTs commissioning from NHS Trusts which are high cost.

3.2.3. Patient Choice

By the end of 2005 patients are to be routinely offered a choice of at least four hospitals when referred by a General Practitioner (GP) for treatment. These may be hospitals within the same NHS trust or a neighbouring trust, Treatment centres, private hospitals or even overseas hospitals. The variety of providers offered will be decided by the Primary Care Trust, but the patient will be able to choose at the time of their referral if they wish, using an electronic booking system which is to be rolled out nationally.[6] The intention, announced by the Secretary of State for Health in July 2003, is to:-

> *"Empower patients by giving them individual choices about where, when and by whom they are treated".*

A consultation exercise on how the principle of choice might be extended across the health service, into areas such as primary care, long term conditions and mental health care, is currently under way.

In August 2003, the Department of Health published details of how Foundation Hospital Trusts will work. Many issues are still unresolved, and also in August a consultation paper ‘Preparing for 2005’ was issued. The consultation document identified the key decisions needed for implementing the next stage of Payment by results and consulted on the details of the tariff structure, commissioning, transitional arrangements and standardising costing across the whole health economy. The consultation document sets out how all NHS services can be made more responsive to patients, by offering more choice across the complete spectrum of healthcare. The consultation period ended on 31 October.

3.3. The Kent and Medway Health Economy

3.3.1. There was also strategic change locally, with the Independent Reconfiguration Panel (IRP)[7] publishing advice on service change in East Kent. There were 14 recommendations, including abandonment of the long awaited Private Finance Initiative (PFI). The three most important recommendations were:-

- That the three main acute hospitals, at Ashford, Margate and Canterbury, should work interdependently, each contributing to the provision of

[6] Electronic Booking System – described in Glossary.

[7] Independent Reconfiguration Panel -was set up to advise the Secretary of State for Health on contested proposals for major NHS reconfigurations and service changes. The review of the proposals for East Kent was the first that the panel carried out.

specialist services where it is feasible to provide such services only on one or two of those hospital sites.

- The health community of East Kent must continue to follow an inclusive process of involvement. The Overview and Scrutiny Committee, Community Health Councils (CHCs) until 1 December 2003 and all stakeholders, including patients and the public, must be fully involved in the development of services for the whole of East Kent.

- The interim proposals represent the speediest and most efficient means of proceeding in the interest of the people of East Kent.

3.3.2. The 'interim proposals' have now been adopted as the Reconfiguration Plan for East Kent Hospitals NHS Trust. This directly led to the September document which consulted on the remaining aspects of the East Kent Hospitals Reconfiguration Plan.[8] This is to be accomplished simultaneously with the Financial Recovery Plan. The Four East Kent PCTs made a decision on which option they wished to see adopted which was subsequently endorsed by the Strategic Health Authority and agreed by the Secretary of State for Health.

The options were:-

Option 1: Centralisation of in-patient orthopaedic surgery and in-patient breast surgery at Canterbury

Option 2: Two site working of in-patient orthopaedics but centralised in-patient breast surgery.

Option 3: Two site working of both in-patient orthopaedics and in-patient breast surgery. This option proposed orthopaedic surgery and breast surgery at both Ashford and Margate and was the favoured option.

3.3.3. The Strategic Health Authority has grouped the health organisations into four 'health economies'. These comprise:-

Health Economy	Primary Care Trust	Secondary 'Acute' Trusts	Mental Health Trust
East Kent	Ashford Canterbury Coastal East Kent Coastal Shepway	East Kent NHS Hospitals Trust	East Kent NHS and Social Care Partnership Trust.
Medway	Medway Swale	Medway NHS Hospitals Trust.	West Kent NHS and Social Care Trust
Dartford	Dartford Gravesham and Swanley	Dartford and Gravesham NHS Hospitals Trust	West Kent NHS and Social Care Trust
South of West Kent	Maidstone Weald South-West Kent	Maidstone and Tunbridge Wells NHS Hospitals Trust	West Kent NHS and Social Care Trust

Kent Ambulance Trust covers the whole of Kent and Medway.

[8] East Kent Hospitals Reconfiguration Plan – Public Consultation Document – EK PCTs. Consultation period was from 1 September to 13 October 2003

4. FINANCING THE NHS

NHS funding is agreed by Parliament after the Budget process.

On the 11 December 2002, Alan Milburn, then Secretary of State for Health, announced in Parliament an increase in funding to PCTs of at least 28% over financial years 2003-6 and revealed the actual figures for each Primary Care Trust. This will ensure that by 2007/08 the level of Gross Domestic Product allocated to healthcare will match that of other similar European countries.

In December 2002, the Department of Health published the budgets for Primary Care Trusts for 2003/4-2005/6.

Kent and Medway StHA: PCT Allocations: 2003/04, 2004/05 and 2005/06						
	2003/04 Baseline Allocation	2003/04 Actual Allocation[9]	2004/05 Allocation	2005/06 Allocation	Total Three Year Increase	
	£000s	£000s	£000s	£000s	£000s	%
Ashford	78,097	85,546	93,528	102,199	24,102	30.86
Canterbury and Coastal	137,636	150,208	163,549	177,927	40,291	29.27
Dartford, Gravesham and Swanley	179,977	196,417	214,153	233,267	53,290	29.61
East Kent Coastal	213,242	234,126	256,544	280,660	67,418	31.62
Maidstone Weald	166,017	182,029	199,462	218,377	52,360	31.54
Medway	189,363	208,169	228,675	250,623	61,260	32.35
Shepway	87,073	95,502	104,546	114,328	27,255	31.30
South West Kent	130,095	141,986	154,808	168,529	38,434	29.54
Swale	71,234	78,399	86,218	94,536	23,302	32.71
Totals	**1,252,734**	**1,372,381**	**1,501,484**	**1,640,446**	**387,712**	**30.94**

4. 1. Revenue Funding

Since April 2003, Primary Care Trusts control 75% of NHS funding and revenue funding flows directly to them from the Department of Health. These allocations cover the commissioning and provision of services managed in the secondary[10] and tertiary sectors or by the PCT itself, as well as PCT administration costs. This allocation also covers expenditure relating to issues such as general practice infrastructure and prescribing.

NHS funding is designed to be flexible to enable resources to be managed to meet local needs, and PCTs are given a single allocation without any amounts being earmarked for specific expenditure. Earmarked allocations such as funding for key

[9] These allocations have been uplifted to reflect growth and increase in capacity.
[10] See Glossary for definitions of primary, secondary and tertiary sectors

initiatives like Cancer Care are allocated within the financial year from Department of Health central budgets.

An examination of how these budgets are committed shows that over 90% are spent on commissioning[11] and less than 10% on providing their own services directly.

A single resource allocation formula underpins all NHS expenditure and unified allocations are made on the following basis: -

(i) Weighted capitation targets – set according to the national weighted capitation formula, which calculates PCTs fair share of available resources based on the age distribution of the population and additional needs. One of the factors in the formula is designed to reflect the unavoidable variations in the cost of providing services and is called the Market Forces Factor or MFF

(ii) Baselines – represent the actual current allocation which PCTs receive. For each allocation year the recurrent baseline is the previous year's actual allocation, plus any adjustments made within the financial year.

(iii) Distance from target – this is the difference between (i) and (ii) above. If (i) is greater than (ii), a PCT is said to be under target. If (i) is smaller than (ii), a PCT is said to be over target.

(iv) Pace of change policy – this is the speed at which PCTs are moved closer to their weighted capitation targets This has already been agreed for the financial years 2003-6 and the allocations agreed; Kent and Medway health organisations will move slowly towards their targets, following Department of Health policy. The overall distance from target in Kent and Medway is, in any case, not more than 0.6% of total budget.

The weighted capitation formula is adjusted for local conditions.

4.2 Capital Funding

There are two areas of Capital funding in the NHS; block and discretionary funding. Block funding is allocated directly to NHS organisations and its use is under the control of that organisation, within overall delegated limits set by the Department of Health. Discretionary funding is held by the StHA, who will approve capital schemes on the basis of local strategic planning priorities and the merits of the outline and full business cases submitted. These transitional arrangements were put fully in place from 1 April 2003. The Department of Health also reserves some capital funding to cover national projects or initiatives, for example to fund schemes which improve access to services. In certain circumstances it has been possible to use capital money for revenue purposes, for instance to pay back deficits, and this can only be done with agreement of the Strategic Health Authority. This ability exists for 2003/4 financial year only.

A major development, over £25m, must be tested against Private Finance Initiative (PFI)criteria.

[11] Operating Cost Statements, Annual report and accounts 2002-3 - PCTs

5. THE KENT HEALTH ECONOMY

5.1. Resource Allocation Budgeting

5.1.1. Resource Allocation Budgeting[12] was introduced formally from 1 April 2003, although health organisations have been coming into line with the principles since its inception in 1999. PCTs have generally followed the principles since their formation in 2001 or 2002.

Before resource accounting, it was possible to overspend, and deficits could be 'written off' by underspends elsewhere in the vast national health economy. Conversely, there was no reward for prudence and no ability to carry forward underspends towards investment in local health services. With resource accounting there are carry forward arrangements by which Trusts will be able to retain surpluses.[13] The Strategic Health Authority will administer this procedure each financial year.

As part of resource allocation budgeting, the Health Organisations have Statutory and financial duties to achieve as part of their overall performance assessment. Their financial duties are:-

Health Authorities and Primary Care Trusts	NHS Trusts
Required by Statute	
Remain within cash limits	Break even taking one financial year with another (*see table overleaf)
Contain expenditure, measured on an accruals basis, within approved revenue resource limits	
Contain expenditure measured on an accruals basis, within approved capital resource limits	
Required by the Department of Health	
Achieve financial balance without the need for unplanned financial support	Absorb the cost of capital at 6% pa (This is to be reduced to 3.5% from 2004/5)
Apply the better payment practice code (Payment of trade creditors within 30 days)	Not to exceed the external financing limit set by the Department of Health[14]
	Contain expenditure measured on an accruals basis, within approved capital resource limits
	Apply the Better Payment Practice code. (NHS trusts should pay external suppliers within 30 days of receipt of goods, or a valid invoice, whichever is the later, unless covered by other agreed payment terms.)

[12] Resource allocation budgeting, July 1999 revised and rewritten 31 March 2003

[13] Frequently Asked Questions – Department of Health

[14] A guide to Resource Accounting and Budgeting for the NHS & Glossary

The National Audit Office found that no NHS Hospital Trust failed its statutory duty to break-even taking one year with another in 2001-2. The definition of this measure is:-

***The Department of Health's Method for Measuring Break Even**

- Where a NHS Trust reports a cumulative deficit, the duty is met if this deficit is recovered within the following two financial years.
- Exceptionally, extensions of up to a total of four years can be given to NHS Trusts, for example where recovery over two years would have unacceptable service consequences and a recovery plan has been agreed with the Department
- The Department determines break-even to be achieved if a NHS Trust has a cumulative deficit no greater than 0.5 per cent of turnover.

5.1.3. It is clear that these financial duties have been achieved only with extreme effort by a proportion of Health organisations. In National Audit Office 'NHS summarised accounts 2001-2'. The Department assessed 46 out of the 318 NHS Trusts (14.5 per cent) as managing significant financial difficulties by the end of 2001-2002. The Strategic Health Authorities involved were by March 2003 working closely with these NHS Trusts, and where necessary other NHS organisations within the health economy, to ensure that action plans are implemented that address the causes of the difficulties.

At the same time, as part of the Department's analysis of financial performance, it identifies those Health authorities managing significant financial difficulties. The number has varied over time, but there were 30 (31.6% of the 95 health authorities) at the end of 2001-2002.

	Health Authorities Assessed as Managing Significant Difficulties – Financial Years 1997/2002				
	01-02	**00-01**	**99-00**	**98-99**	**97-98**
Proportion assessed as managing significant financial difficulties	32	11.1	28.3	18	29

5.1.4. Financial Situation in Kent and Medway

The evidence collected during the Interim report of this Select Committee showed that by 2002/2003, the financial situation in Kent and Medway had worsened.

All the Kent and Medway health organisations have had to deal with financial problems and in many ways there are common themes. However, there are particular problems in some organisations, which have been revealed dramatically by:-

- The size of their year end deficit.
- Problems they have had in drawing up a balanced budget.
- Problems they are having in remaining within that budget.

Primary Care Trusts - financial position at 31 March 2003

	Organisation	Debt carried over 2001/02	Base budget 2002/03	Forecast deficit at year end	Budget per final accounts	Actual Expenditure	Less non discretionary expenditure	Operating costs less non discretionary	**Surplus/ deficit 2002/3**	Star Rating
		£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	**£'000s**	
1	Ashford PCT	128	78,120	-	84,839	88,349	3,561	84,788	**51**	**
2	Canterbury & Coastal	228	142,880	-	148,554	152,407	3,871	148,536	**18**	*
3	Dartford, Gravesham and Swanley PCT	2,036	186,351	1,617	193,537	201,291	6,565	194,726	**-1,189**	0 stars
4	East Kent Coastal PCT	356	213,332	-	222,101	229,277	7,195	222,082	**19**	**
5	Maidstone Weald PCT	2,960	169,223	-	177,836	184,838	7,493	177,345	**491**	*
6	Medway PCT	N/A	N/A	-	199,485	208,369	8,893	199,476	**9**	*
7	Shepway PCT	145	86,656	300	89,518	92,815	3,315	89,500	**18**	**
8	South West Kent PCT	458	134,000	-	133,725	140,173	6,579	133,594	**131**	*
9	Swale PCT	200	75,860	1,700	77,327	79,980	2,716	77,264	**63**	*
	Total		1,086,422	3,617	1,326,922	1,377,499	50,188	1,327,311	**-389**	

NHS Trusts - financial position at 31 March 2003

	Organisation	Debt carried over 2001/02	Base budget 2002/03	Forecast deficit at year end	Budget per final accounts	Actual Expenditure	**Surplus/ deficit 2002/3**	Reference costs revised (2002)*	Star rating	
		£'000s	£'000s	£'000s	£'000s	£'000s	**£'000s**			
1	Dartford & Gravesham NHS Trust	1,798	80,800	1,490,000	83,750	86,431	**-2,681**	105	***	

2	Maidstone & Tunbridge Wells NHS Trust	4,100	157,448	2,500-5,500	177,006	181,046	**-4,040**	105	0 stars	
3	Medway NHS Trust	Surplus - 766,000	Not known	0	115,831	116,798	**-967**	93	*	
4	East Kent NHS Trust	2,000	273,000	14,500	277,358	288,729	**-11,371**	107	*	
5	East Kent NHS & Social Care Partnership Trust	N/A	55,950	800	58,824	59,134	**-310**	101	*	
6	West Kent NHS & Social Care Trust	N/A	100,000	-	99,680	99,651	**29**	100	**	
7	Kent Ambulance Trust	0	26,000	-	26,675	26,618	**57**	N/A	*	
			693,198		839,124	858,407				
						Total deficit	**-19,283**			
	Reference costs are shown not adjusted for Market Forces Factor which is 2% less than national average in all areas									

The deficit problems in East Kent NHS Trust, Maidstone and Tunbridge Wells NHS Trust, and Dartford and Gravesham PCT require individual analysis.

5.2. Kent and Medway Financial Year Results 2002/3

The final result for the whole of the Kent Health Economy was a total overspend of £19.67m. The detailed results are shown in the table: 'Financial position at 31 March 2003' (see previous page). Cumulative allocations to the Kent and Medway health economy for 2002/03 amounted to £1.3 billion, and at the time of the interim report a deficit of £27.1 million (as of Month 6) was being predicted unless further action was taken. Budget Managers and Directors of Finance achieved the final improved results after considerable effort.

5.2.1. Acute Trusts

As noted in the Interim report, the highest overspends are by the NHS Acute Trusts. This pattern of expenditure is repeated across England. The majority of healthcare is delivered by the primary sector.[15]

Kent has four Acute Trusts:-

- Dartford and Gravesham NHS Trust
- East Kent Hospitals NHS Trust
- Maidstone and Tunbridge Wells NHS Trust
- The Medway NHS Trust

All ended the financial year with an overspend on their total budgets. A loan from the NHS Bank[16] was approved on behalf of East Kent Hospitals Trust, as part of the Independent Review Reconfiguration Panel's process. It would enable them to balance their budget and attack the underlying shortfall in their budget whilst continuing their reconfiguration process. They are faced with a recovery plan, which expects a total of 5.5% savings in 2003/04. Maidstone and Tunbridge Wells NHS Trust overspent by just over £4m and also gained no stars in the CHI rankings. These two deficits have affected the whole of the two health economies where they provide services. Dartford and Gravesham NHS Trust's deficit was smaller (£2m), and still enabled them to gain three stars. This deficit was a planned and agreed position within their franchise plan with the Department of Health. They have largely solved their finance problems by re-financing their PFI arrangements to take advantage of lower interest rates.

The Audit Commission print their document 'NHS Summarised Accounts' each March, and the most up to date figures available refer to 2001/02. At that time, using the Audit Commission's definitions, no NHS Trust[17] failed in its breakeven duty at 31 March 2002. This was their analysis of the results:-

- 50 out of the 318 running at that time incurred an in-year deficit (2000-2001: 39 NHS Trusts), ranging from £1 to £11.5 million.

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[15] Primary sector – see Glossary
[16] NHS Bank – described in glossary
[17] This includes hospitals and mental health trusts.

- Nineteen deficits were not classed as significant by the Department of Health, being less than 0.5% of turnover.

As the summarised accounts are not made public until a whole year after the end of the financial year to which the accounts refer; the summarised 2002/3 accounts are not due until March 2004. Comparing 2001/2, and what we know of 2003/4, the trend is clearly upwards.

In the current transitional phase, the performance targets set by the Department of Health, the commissioning process itself and even the separate definitions for breakeven, cause the risk of overspend to fall on to the Acute Trusts, rather than Primary Care Trusts. This will gradually alter by 2007-8 with the introduction of Payment by Results, when risks will be shared with the commissioners.

5.2.2. Primary Care Trusts

Primary Care Trusts see as their mission:-

- Understanding local issues and needs.

- Working to improve the health of our residents.

- Making choices about how the NHS budget is spent for our residents.

- Making sure that local hospitals and services are providing high quality care and value for money to the health and social care of our population.[18]

Primary Care Trusts both commission health services and also provide health care services. Their commissioning (or purchasing) is on a 'block contract' basis where the price is worked out by negotiation at the beginning of the financial year. This will change when national tariffs are more widely introduced for individual clinical procedures (Healthcare Resource Groups, or HRGs)

This will mean that when more procedures are carried out, PCTs will pay more and the risk of overspend will move over from the acute trusts more on to the PCTs.

The Audit Office report judged that 14.5% of NHS trusts were managing significant financial difficulties at the end of 2001/2.[19] These debts were then allocated amongst the new Primary Care Trusts who took over the Health Authorities' commissioning duty from 1 April 2002.

At this time, it is noteworthy that there were only four Primary Care Trusts in England that did not achieve departmental financial balance, as defined by the Department of Health in 5.1, and required unplanned support:-

[18] South West Kent PCT Annual Report and Accounts 2002/3

[19] NHS (England) Summarised Accounts 2001-2002

Trust	Deficit
Bexley Primary Care Trust	£ 691,000
Dartford Gravesham and Swanley Primary Care Trust	£1,363,000
Greenwich Primary Care Trust	£1, 330,000
Maidstone and Malling Primary Care Trust	£ 983,000

(Note there has been reorganisation and renaming of the Maidstone PCT since this report, and on 31.3.2002 only about 100 of the 304 Primary Care Trusts were established.)

Although only formed in April 2002, Canterbury and Coastal PCT was able to report in their Annual Report for 2002/3:-

> *'In September 2002 the PCT's finance recovery plan brought its own challenges for staff. A general recruitment freeze was introduced and an appeal process established to ensure that essential posts could be filled.*
>
> *A financial recovery plan was introduced part way through the year, as an overspend of £1.3m was forecast. This was a key challenge for the Board. Our staff took immediate grip of the issue and were prepared to make some very difficult decisions. Due mainly to their efforts the PCT was able to end the year with a very small underspend of £18,000.'*

PCTs have a legal requirement to keep within their allocated budget. Before the reorganisation of the NHS, deficits in the health economy were managed through brokerage arrangements (loans from other parts of the health economy which have under spent). Since the reorganisation of the Health Service completed on 1 April 2002, cash brokerage continued to be allowed to enable accounts to be paid and the business to flow, but without affecting budgets. Brokerage of budgets should no longer be possible because budget is now linked to performance and so there are no available underspends between organisations, and the Department of Health believes that the use of brokerage blurs the true financial position of a health organisation.

5.3. Budget Pressures 2003/4

At the time of the interim report, health organisations set out some common reasons for overspends. These were:-

- Historical Debt
- Increased Activity
- Prescribing
- Staffing
- Referral Patterns
- Placements
- Delayed Discharges

The current level of predicted overspend for all the organisations that submitted evidence was at October 2003:-

Primary Care Trusts	Predicted out turn at 31/03/04 £s
Ashford	Will break even after management action
Canterbury Coastal	Will break even
East Kent Coastal	Will break even
Shepway	Will break even
Swale	Will break even
Dartford Gravesham and Swanley	Up to £4m deficit, but continuing to seek solutions
Maidstone Weald	Undergoing management action to break even
South West Kent	Will break even using slippage on developments
Acute and Mental Health Trusts	
East Kent NHS Hospitals Trust	Should break even for year, with £14m underlying deficit carried forward to be on target with recovery plan
Maidstone and Tunbridge Wells NHS Trust	A complex situation, including deficits brought forward and a wide range of recurrent funding challenges. Approximately £4m deficit
Dartford and Gravesham NHS Trust	Will break even
East Kent NHS and Social Care Partnership Trust	£1.8m deficit – pursuing management action strenuously.
West Kent NHS and Social Care Trust	Will break even, but with reduced service.
Kent Ambulance Trust	Will break even

Exactly a year ago at the time of the Interim Report, a total figure of £27m deficit was being reported. As the actual deficit of £19m at end of financial year 2002/3 was achieved through the use of some recurrent and some non-recurrent savings, it is possible that health organisations will be able to do this again in 2003/4. A 4% Cash Releasing Efficiency Savings (CRES) Target was identified by commissioning PCTs as necessary to achieve a balanced local delivery plan and meet all priorities, and this has been set as a target for all the health organisations in Kent and Medway apart from Kent Ambulance Trust. The Strategic Health Authority monitors this as part of their performance management role.

The evidence collated by the committee points to several common reasons that have resulted in overspends in all the Kent health organisations. These are:-

- The impact of managing historic deficits
- Increased activity
- Problems that are exacerbated in the South East due to the high cost of living such as the high cost of placements, agency staff and recruitment and retention difficulties.
- Other significant budget pressures such as prescribing are a national problem.

The main reasons for overspends are identified below.

5.3.1. Historical Debt

Following the cessation of the health authorities on the 31st March 2002 their deficits were shared amongst their successors, most PCTs coming into being in April 2002. The deficits carried over from 2001/02 ranged from £850,000 to £4.1million. As a consequence of this a number of Acute Trusts and Primary Care trusts operated within their 2002/03 budgets but have failed to repay their debts.

5.3.2. Increased Activity

Activity is now clearly linked to the targets (see below) to deliver the NHS Plan. Health Trusts are charged with monitoring their performance and managing access and other NHS targets to ensure that access targets are met whilst a financial balance is maintained.

The activity targets for 2005 are:-

- Generally, no one should wait more than four hours for treatment in Accident and Emergency (A&E) – and the average wait should be no longer than 75 minutes.
- Outpatients will wait no more than 3 months for an appointment.
- Inpatients will wait no more than six months for treatment.
- Local people and patients will be involved in service planning and decisions as well as in their own care.
- Nurses, therapists and other frontline staff will continue to develop their roles.
- There will be electronic booked appointments and patient records.
- There will be an extension of choice for patients, about how and where they receive treatment.[20]

It is clear that the enhanced budget levels that have been announced for Kent PCTs have the expectation that growth in activity will follow. However, when a Health organisation has inherited debts this makes reaching targeted activity levels more difficult. Kent and Medway is not the only Health Area in this position:

Surrey and Sussex Strategic Health Authority (July 2003)
The NHS Bank had approved £40 million support for 2003/04 with a requirement that all Surrey and West Sussex organisations deliver financial break-even and deliver key Local Delivery Plan targets; if this were not achieved, the Bank support would be repayable over the next few years. The out turn position was that organisations had ended the year £21.5 million adrift from plan and this would be carried forward into the current year. There were significant risks in that about 30% of the financial recovery plans were not fully developed. The Chairman and Chief Executive had written to Surrey Sussex Chairmen and Chief Executives drawing attention to a number of important issues around financial performance.[21]

[20] Strategic Health Authority – Annual report and accounts 2002-3
[21] Surrey and Sussex strategic health authority, Minutes of the board meeting, Held on 23 July 2003

Bedfordshire and Hertfordshire SHA (June 2003)
The proximity of London and the high cost of living have long had a significant negative impact on the local health economy. Recruitment continues to be a major issue with large numbers of vacancies remaining unfilled for long periods. Coupled with high levels of demand, this has meant that local providers have found it a challenge to deliver health care of the required standard within the resources available, and this has been reflected in the star ratings awarded.[22]

Bedfordshire and Hertfordshire Strategic Health Authority received £25m loan and a further £25m grant in 2002/3 to clear outstanding deficits, but now further support in 2003/4 has been refused.

For Kent and Medway, the Strategic Health Authority felt that at roughly the mid year point, projections were consistent with Local Delivery Plans. 2003/4 is viewed as a 'tough year' – although the budgets have been increased generously, so has the expectation for planned activity[23]. Much will depend on the quality and accuracy of the budget and activity monitoring. An extreme example of where a Health organisation was not able to do this can be shown by the case history of the North Bristol NHS Trust. They were unable to control their budgets after striving to meet activity and access targets and ended 2002/3 with an overspend of £44m. A report on this case concluded that the Trust should (among other recommendations) ensure quality in performance and financial reporting.[24]

5.3.3. Prescribing

The Prescribing budget is one of the largest elements of a Primary Care Trust's Budget. Prescribing costs are also an issue for hospital trusts and mental health trusts, although the size of the budget in these cases is much less.

The Diagram shows an extract from East Kent Coastal PCT[25] – showing that from a total budget of £242,233m, £36,826m, or 15.2% was for General Practitioner prescribing.

[22] Bedfordshire & Hertfordshire Local Delivery Plan 2003/04-2005/6 – Executive Summary – June 2003
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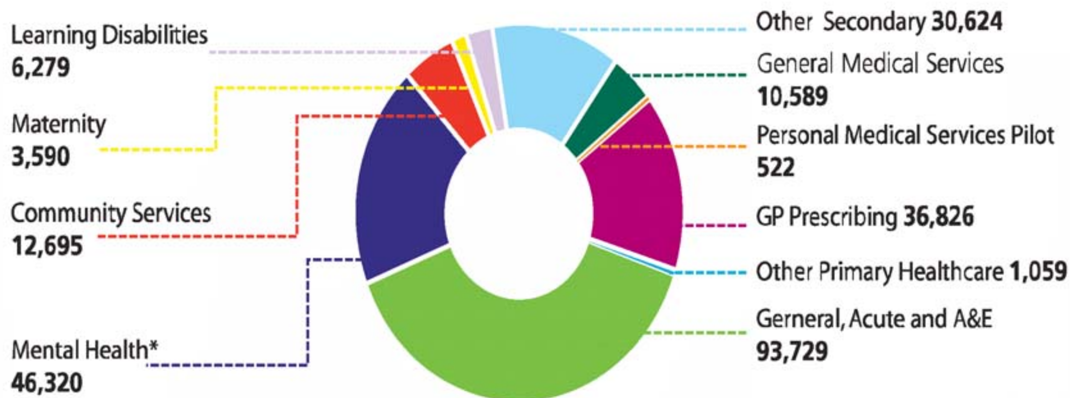
[23] Director of Finance, Strategic Health Authority – 26 September.

[24] Report to Avon, Gloucestershire and Wiltshire NHS SHA
[25] East Kent Coastal, Annual report and Accounts 2002/3



All of the PCTs interviewed by the Select Committee mentioned the rising cost of prescribing (commonly referred to as the "drugs bill"). In hospital – drugs are prescribed, provided and paid for by the hospital. In primary care, prescriptions are written by GPs and supplied directly by the pharmacist to the patient. The pharmacist sends numbered prescription forms to the Prescription Pricing Authority (PPA). The PPA identifies the Primary Care Trust and charges them with the costs, less the income from prescription charges.

As found in the Interim report, the development and increasing costs of new drugs are continuing to create budget pressures, both nationally and locally.

Despite the 4% CRES, the Local Delivery Plan for 2003/04 identified growth of 12% in the prescribing budget, and all the organisations interviewed measured their performance against this figure.

The Derek Wanless[26] report recommended that the United Kingdom must expect to devote a significantly larger share of its national income to health care over the next 20 years.

To reverse the significant cumulative under investment over the past decades, catch up with the standards of other countries and to deliver a high quality service, will need 10% growth, net of inflation, each year.

The Department of Health has issued guidance to Primary Care Trusts to help them to earmark realistic amounts to underpin primary care prescribing by GPs and nurses. PCTs are advised to factor into their planning the best forecast prescribing costs associated with meeting priorities over the next three years, taking into account any scope to target prescribing more effectively and potential efficiency savings. PCTs are provided with monthly national in-year forecast updates on the Prescribing Support Unit's Web site, which they can compare with their own monthly forecasts. The Prescribing budget is affected by these factors:-

[26] Securing our future health; Taking a long term view – Derek Wanless April 2002

- **The National Institute for Clinical Excellence (NICE):** PCTs are under a statutory obligation to provide funding for clinical decisions within recommendations from NICE contained in Technology Appraisal Guidance

- **National Service Frameworks (NSFs):** Are clearly leading to additional expenditure as more patients are treated. For instance, national expenditure on Statins[27] continues to increase by around 30% year on year. PCTs are advised to consider monitoring patients' compliance with their treatment and their benefit from their treatment.

- **Newly Licensed Drugs:** Most significant new drugs will be referred to NICE for appraisal, but plans should recognise the scope for prescribing during the interim period between the reference and NICE providing their guidance. Underlying trends of new drugs are picked up in the drugs bill forecast but any large spends may need to be factored in. To help with these assessments, the National Prescribing Centre helps by providing information about significant developments to aid capacity planning.

- **Primary Care/Secondary Care Collaboration:** The Department of Health recommends a common understanding between primary and secondary care about a consistent approach to clinical responsibilities and funding. Such arrangements could only be facilitated by a re-alignment of funding between primary and secondary care.

- **Audit Commission Bulletin "Primary Care Prescribing":** Provides information on the management of prescribing.

5.3.4. Prescribing Budgets for Practices

Primary Care Trusts have been given the responsibility of agreeing strategies for setting practice prescribing budgets that meet the need of patients and represent the most efficient use of resources. They are also responsible for the cost of nurse and out of hours prescribing. From 2003/4 they also gained extra responsibility, and budget, for Practice prescribing which had previously been held centrally, and were advised to set aside sufficient provision to meet their costs.

They are still faced with the same problems however – how to encourage GPs to spend effectively on a drugs budget that they are ultimately not responsible for; this is the PCT's budget which the GP spends. Without the co-operation of Doctors, Primary Care Trusts cannot control this large and growing budget.

All of the Primary Care Trusts who provided information demonstrated that they are being pro-active in targeting this problem area: for instance, through the use of prescribing advisors, reviewing repeat prescribing or increasing the percentage of generic products.

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[27] Statins - Powerful drugs which are used to lower cholesterol to reduce the risks of heart attacks.

Dartford Gravesham and Swanley PCT have aimed for savings in expenditure on drugs of 'limited clinical value' (those which have no proven clinical efficacy) Links to finance to build medicines management into planning and budget-setting processes

In addition to their 4% CRES savings, the four East Kent PCTs have contributed £3m towards the East Kent Hospitals Trust deficit. This has meant a £1m cut in the prescribing budget in East Kent. However, they have put strategies in place to achieve this target:-

- **East Kent Coastal PCT** has a team, led by a pharmacist, line managed by the Trusts' medical director to ensure clinical effectiveness. They have 2.5 pharmacists and three prescribing technicians who advise GPs
- They are part of the Primary Care Clinical Effectiveness Project (PRICCE) programme for prescribing drugs. PRICCE covers 14 disease areas to improve financial practice.[28]
- Their use of STATINS as a preventative for heart attacks is the second highest in the country.
- They have influenced GPs to prescribe generic drugs and they have reached the 80% mark with this strategy. The national target is 72%.
- They have made progress in reducing repeat prescriptions. They have 43 GP practices, and all of them will have a protocol for repeat prescriptions
- They aim to give GPs a neutral view of new drugs available and thus save them some time.
- Their prescribing bill is holding at 11% growth. East Kent Coastal PCT is in a good position for the future as they have already brought in many of the new expensive drugs.

Shepway PCT have initiated a prescribing incentive scheme, which 75% of GPs have signed. This rewards GPs for meeting targets and to put money into prescribing advisors. They have introduced a 'Script switch' system, which lets GPs know when prescribing whether there is a cheaper alternative drug.

Ashford PCT have made it clear to GP's that if they overspend on prescribing then money will not be available for other services.

It is clear that, particularly in East Kent, Primary Care Trusts have been innovative to ensure that they are getting value for money from the Prescribing Budget.

There are new issues to be addressed shortly, which the prescribing teams will face in 2004/5:-

[28] Disease areas outlined in Glossary

- On the medicines management agenda are the potential implications of Personal Medical Services (PMS), the new General Medical Services contract and the future pharmacy contract.

- With these initiatives, monitoring and maintaining the operation of the prescribing budget is never complete; technology is always advancing, changes in reception and prescribing staff happen constantly.

- There is still the overwhelming difficulty of **managing a budget without direct control,** which will always remain unless GPs are given responsibility for their own drugs budgets. GPs have no direct accountability for the prescribing budget.

Recommendation for the Primary Care Trusts Devolve prescribing budgets to GP Practices to match accountability with responsibility for prescribing

5.3.5. Staffing

Whereas the Prescribing budget is a Primary Care Trust problem, staffing costs are the problem in Hospital Trusts and Mental Health Trusts.

Pay costs represent around 65% of a Hospital Trust's expenditure, by far the biggest item. In an area where housing costs are high, and wage rates are nationally controlled, it is difficult to recruit and retain all types of medical staff. The NHS has traditionally employed locums and agency staff when staff are needed to cover sickness or vacancies. The cost of this has risen to such heights that this cost alone has been the main factor in causing one Hospital Trust overspend its budget.

It is essential that Hospital Trusts meet their access targets, and ensure there is sufficient staff for proper patient care. At the same time, it is important that staff costs are kept within budget, and that the cost of medical staff represents value for money with as few agency and locum costs as possible.

Changes such as the restructuring of junior doctors working hours and the introduction of the Working Time Directive have led to greater cost pressures on the staffing budget. There have also been changes in National Insurance contributions, as well as the usual need to increase budgets in line with national pay awards.

The Hospital Trusts have adopted a variety of strategies to tackle these problems:-

Maidstone and Tunbridge Wells NHS Trust
Reducing Agency Staff Initiatives
Identifying Best Practice:
Weekly meetings with Director of Nursing

Maidstone and Tunbridge Wells NHS Trust is concentrating in recruiting permanent staff and displacing agency staff. While currently identifying best practice in this field, there are regular weekly meetings with the Director of Nursing, studying the staffing position and taking into account annual leave schedules, vacancies and sickness.

Capping on Agency Staff for Each Ward

Although the Trust uses a bureau, they control the appointment of agency staff by having a cap on every ward of the amount of agency staff employed each month, ensuring that the vacancy areas are in proportion to the cap to ensure fairness and continuing patient care.

Building Up a Bank of Staff

To dispense with private agency staff altogether the Trust needs to build up spare capacity, and so they are working with the NHS Professionals initiative to compile a bank of directly employed staff for greater value for money

(Currently Maidstone and Tunbridge Wells NHS Trust are spending:-

£300,000 *per month on agency nursing staff*
£100,000 *per month on medical locums, as well as other amounts on X-Ray staff.*

Their dependence on agency staff is such that without them, the Trust would need to review their available beds to assess whether any patients could be cared for in the community).

Aiding Recruitment and Retention

They are refurbishing accommodation at hospitals to attract junior doctors; funded by sales of redundant little-used buildings.

An indication of the intractability of this problem is the history of NHS Professionals initiative, with which many of the Kent Health organisations that gave evidence have signed. Originally launched in 2000, it has now been re-launched, as a Special Health Authority, to provide a nationwide service by 2005. Its Board Members include former Chief Executives and Human Resource specialists from private sector recruiting companies. The Department of Health is obviously now taking the problem much more seriously and is determined to solve it, but the timescale is now more protracted and benefits are unlikely to be seen before financial year 2005/6.

Budget difficulties make adapting for new working conditions even more protracted. One of the savings made by East Kent Hospitals NHS Trust this financial year is to develop more slowly to achieve what is required in the Junior Doctors new deal. Rotas need to be compliant with the new deal, which becomes statutory in 2004. East Kent Hospitals are 60% compliant, and will be 80% compliant by April 2004. They must become 100% compliant with the Working time directive by autumn 2004.

There are risks in this strategy – as they will be faced with making more rapid progress in 2004/05, and recruitment will be more difficult with a possible need for locums. The size of the savings required to reach the financial recovery plan targets means there is an emphasis on short-term savings rather than medium term planning.

5.3.6. Staffing Problems in Mental Health

Mental Health Trusts spend around 68% of their budgets on staffing. They are subject to many of the same staffing pressures, but have greater flexibility in controlling staff costs, and less historic debt to jeopardise budget management.

As main commissioners, Primary Care Trusts have been very closely involved with the management of their local mental health Trusts. East Kent Coastal PCT commissions the whole of East Kent mental health services, and Swale PCT commissions the whole of West Kent mental health services. While Primary Care Trusts all have lead commissioner roles, all Primary Care Trusts are still individually accountable for their services, their commissioning and their expenditure.

East Kent Community and Partnership Trust had a projected overspend of £1.8m in October unless management action was introduced. A letter to all staff from the Chief Executive, outlining this management action is shown in Appendix 4. As lead commissioners, East Kent Coastal PCT have been working with them to reduce this, as it is judged not to be caused by increased activity, but rising costs. As well as housekeeping and estate planning, strategies include helping the mental health trust towards a better use of staff. For example, locum psychiatrists who have worked for the Trust for some time will be negotiated towards substantive contracts. In some cases senior practitioners rather than psychiatrists could do some of the work.

In West Kent, the trust has an underlying problem with recruitment and retention. They are using some agency nurses, and if a locum psychiatrist has to be used, this costs £5,000 per week. West Kent NHS and Social Care Trust are keeping within balance by not filling vacancies - they have identified that to fill all their vacancies would cost £1.5m. This leaves gaps in the services to patients. The strategies adopted by the trust are to:-

- plan to increase the number of psychiatric beds;
- make the Mental Health Trusts more attractive as an employer for Psychiatrists;

- establish clinical links with London hospitals to enable specialists to visit;

- establish and extend, where possible, services using other income streams;

- aim to become a three star trust and become a foundation trust to gain extra freedoms. The trust has currently two stars.

Swale PCT, their main commissioner, made the point that mental health beds at Medway Hospital had actually been reduced due to difficulties in recruitment. Although the PCT were investing in new models of care, these were as yet to be implemented. Even though the demand for mental health in-patient provision could be met, there remained unmet need in the community.

Although mental health trusts are able to control their staffing costs more easily than acute trusts, this may be at the expense of closing wards, providing facilities part time or restricting hours. These may be unacceptable ways to balance the budget from the patients' or patients' families' point of view. Mental Health is also an area where there is a measure of un-met need in the community, which is more difficult to measure than physical illness. The use of unfilled vacancies as a savings strategy needs further investigation by management to assess whether budgets are currently matching current service delivery or whether services are being cut.

Both Mental Health Trusts were unhappy that they were not able to invest what they feel is required to improve services. East Kent Coastal PCT commissions mental health services on behalf of the four East Kent PCTs. They feel that they have made significant progress in implementing the National Service Framework and delivering their targets.

Their need to contribute towards East Kent Hospitals Trust's deficit problem had prevented them from investing in Mental Health Services, but they have been able to put a recurrent £1m extra investment into the budgets, which has bought improvements, and they feel is reasonable in the context. East Kent NHS and Social Care Partnership Trust is the smallest trust in the Area, and this must make its overheads correspondingly higher. The Strategic Health Authority has encouraged both Trusts to work closely together and this will encourage them to provide a seamless service for the whole of Kent and develop alternative provisions together with Social Care Partners.

Recommendation
The two Mental Health Trusts should work much closer together across Kent and Medway, for the benefit of all the patients in Kent, to make management more cost effective and make best use of scarce resources.

5.3.7. Staffing Problems – Some Ways Forward

- All health organisations are seeking strategies to cut staffing costs. This must be set in a context of higher costs due to Pension contributions, National Insurance contributions, Working Time Directive legislation and higher housing costs.

- Health organisations are seeking ways to deliver health care in different ways with other staff.

East Kent Coastal PCT

For some procedures, using an appropriately trained healthcare assistant has increased patient choice in terms of who they can see and also frees-up GP and nursing time.

Healthcare assistants can undertake many tasks for example taking blood; practice nurses currently undertake blood pressure monitoring and new patient screening. This means patients can be seen quicker and it releases time for doctors and nurses to treat more serious conditions.

(It also allows more patients to be seen at less cost)

- PCTs are giving management support and guidance to providers. For instance, East Kent Coastal PCT is helping East Kent NHS and Social Care Partnership Trust to implement their CHI action plan.

- Although often overlooked, the evidence received from Mental Health Trusts and their commissioning PCTs is that they desperately need investment in staffing rather than further budget cuts.

- Although resource allocations have already been announced for the next three years, if pay rises and ancillary costs rise faster than the amounts allowed, there will be a case to request further allocations to enable health organisations to meet their targets.

5.3.8. Referral Patterns

London Referrals

In Kent and Medway patients who need care in a hospital are usually referred to the nearest hospital which provides the care they need, but this may not be their local hospital.

All the organisations seen, and written evidence provided, commented on the cost of referrals to London Hospitals. These referrals are of two types:-

- Tertiary referrals – these are patients who have been referred to an Acute Trust in their local area and the treatment they need can not be done locally.

- Direct referrals by GPs. There is a tradition of referring patients to London hospitals, which has developed over time in all areas of Kent, who could be treated locally in Kent. For some procedures, like kidney transplants, there will not be an alternative to these referrals because the 'critical mass' of patients to be treated needs to be greater than the 1.6m population in Kent and Medway.

The cost of out of county referrals is significantly higher and can impact on local services, and lead to deficits in the health economy.

As technology advances and there are more procedures available by specialists at London Teaching Hospitals which are currently not available elsewhere, there has been a relative increase at London hospitals for tertiary referrals for cardiac services and neuro-sciences. This causes significant financial pressure across the whole of Kent.

Possibilities for providing services locally is limited, but there have been some innovative ways of doing this:-

Successful examples of services provided in Kent and Medway

East Kent Coastal PCT has developed a neuro-rehabilitation unit at **Buckland Hospital**, Dover, where patients can recover from head injuries. These patients formerly went to the private sector at a higher cost.

The angiography suite was opened at **William Harvey Hospital, Ashford**, to investigate heart conditions, and this is cost effective. The East Kent PCTs are working on schemes to move back further cardiac work to East Kent.

There are two constraints on rehabilitation; whether it is possible to provide services in a clinically effective way, and whether the service would be cost effective. Neuro-surgery could not be done economically because of the specialist skills and equipment needed for the small number of cases in Kent.

Action by PCTs to Reduce Expenditure

- There are other problems with London hospital contracts, in that they have been notoriously late with their billing and it has been sometimes difficult to confirm the activity billed. PCTs have written to all London providers to avoid a recurrence of this.

- Dartford Gravesham and Swanley PCT have attributed the reason for their overspend to be partly caused by London referrals, but there appears to be a growth in all activities, including their local providers. Maidstone Weald PCT has had some success in reducing their tertiary referrals by negotiating with Maidstone and Tunbridge Wells NHS Trust for them to take over the work.

- The reorganisation of vascular services will avoid referrals to London. There have been problems with providing 24-hour acute vascular services, and once two vascular units are open in Kent, this will be avoided, and there will be better outcomes for the patients.

Growth in London referrals has not been matched in under performance in local contracts – this has been absorbed in growth due to increased activity in local hospitals and technological advances.

Where there is no chance of providing services in Kent, the Department of Health should recognise this and reflect the higher cost of London providers in resource allocations by adjusting the Market forces factor. This factor is part of the Weighted Capitation formula, which is the basis of Primary Care Trusts' budgets. The market forces factor reflects the cost of salaries and wages within the Primary Care Trust Area, not the area from where the PCT must commission. The tradition of providing services in London is long standing and not easily broken.

Where there is a chance of being able to provide services in Kent, this should be pursued with assiduity. There will be better outcomes for patients treated locally where their relatives can support them. For the Kent and Medway population this will also provide best value services at Kent and Medway tariffs rather than London prices. The Kent cardiac centre at Ashford is likely to provide virtually all the diagnostic and therapeutic services for Kent patients whilst cardiac surgery will still be provided in London. The number of Kent patients travelling to London will be very greatly reduced. The Outline Business Case for the Kent Cardiac centre is still being prepared.

The introduction of patient choice means it is important that a viable Kent alternative is available for as many procedures as possible if this is to be a real choice. There are many issues to be solved with the introduction of patient choice; not least how Primary Care Trusts would afford the cost of high cost London alternatives if patients wanted to choose them. It would be advantageous for Kent and Medway if the market forces factor relates to where commissioning takes place once payments by results is implemented.

One of the key aspects of the choice philosophy will be the balancing of choice with fairness and equity. Choice will still have to be managed within a limited resource allocation and based on evidence.

Recommendations

For all Health organisations and Overview and Scrutiny Committee:-

Promote the revision of the market forces factor (the cost of providing services between one area to another) so that it properly reflects the costs of providing services in Kent and Medway.

For the Strategic Health Authority:-

Continue to develop the options for a Business case for the establishment of a Cardiac Centre in Kent.

For the Overview and Scrutiny Committee:-

Actively support the formulation of options for a Business case for the Kent Cardiac Centre.

For Primary Care Trusts:-

Commission services within Kent and Medway for as many patients as possible who are currently being referred to London hospitals

5.3.9. Placements

The Interim Report studied the rising costs of specialist placements and health organisations were at that time pursuing measures to address the number and the high cost of specialist placements with private providers. In 2003/4, this has continued. While some PCTs have reported a low rise in number of placements, they have often been high cost individual placements

When East Kent PCTs contributed towards funding the deficit at East Kent Hospitals' Trust, they reduced the mental health and learning disability placements' budgets. They are now facing an overspend on this budget. Placements and tertiary referrals have caused Ashford PCT to predict in November a £500,000 overspend. A management expenditure freeze has been imposed to absorb this.

The placement budget is one which must be constantly monitored and managed. Without pro-active management, placements can rise. However, there is always a risk in reducing this budget too low because new individuals are always moving into the community or have worsening conditions which will necessitate new placements. Residential placements are now only used when there is really no alternative and these individuals have very specialised needs which cannot be catered for in the normal way within the community. The answer for PCTs will only be found by experience for their populations and this knowledge will be gained as these organisations mature.

5.4. NHS Financing Arrangements and Effects of 2002/3 Overspends

5.4.1. The NHS Bank Loan

The main effect of the 2002/3 overspends was that the Strategic Health Authority applied for a loan from the NHS bank. The Bank has been set up with £100m, to act as a safety net for health organisations that are going through structural change. The decision-making panel comprises the Director of Finance of the Department of Health and representative Chief Executives from Health organisations. East Kent Hospitals Trust's application was supported by an independent report from the Public Service Consultants Secta. Kent and Medway is one of only four Strategic Health Authorities who have been granted loans or grants by the NHS bank in 2003/4. The others are Avon Wiltshire and Gloucester, Thames Valley and Surrey Sussex.

The loan was announced early in the summer, following the decision by the Minister of State on the IRP's recommendations and it is now clearer what the repayment terms are.

The use of the NHS bank is in theory a replacement for the use of brokerage, which was the practice of applying underspends in one part of the Health economy to fund overspends in others. The aim is to make health organisations' accounts more transparent; it is certainly true that it is impossible to identify brokerage in the summarised accounts unless a health organisation shows this clearly in the financial review narrative.

The £17m loan has been granted to the Kent and Medway Strategic Health Authority with the following incentives:-

- An incentive to repay within the next three years }
  }
- An incentive to reach Local Delivery Plan targets. }

In more detail, the terms are:-

- None of the £17m has to be repaid within the three years of the current Local Delivery Plan – that is 1 April 2003 to 31 March 2006. (Local Delivery Plans include the targets imposed by the NHS Plan, and also are the basis of the 'star rating' system).

- When repaid, it may be spread over the following three years – with the Strategic Health Authority deciding when between 1 April 2006 to 31 March 2009.

- The Strategic Health Authority also has the discretion as to how much is to be repaid out of Capital allocations and how much from revenue.

If they can pay the loan off quicker, there are incentives:-

- If the whole of the Kent and Medway health economy meets the targets within its Local Delivery Plan, parts of the loan will abate to grant.

The Strategic Health Authority will model these options and decide which is the most beneficial. This loan has introduced two new principles to the health economy:-

- **Incentives** to the health economy to meet their targets

- **Discretion** granted to the Strategic Health Authority as to the timing and mode of repayment

This loan will help the health organisations in Kent and Medway to engage in detailed medium term planning, and it is hoped that a similar clarity will now continue in all NHS funding arrangements.

Recommendation for the Strategic Health Authority
Stabilise the whole of the Kent and Medway health economy, using the flexible terms of the £17m loan from the NHS bank

5.4.2. Staffing Changes

Since the beginning of the review period in autumn 2002, there have been a significant number of new appointments in the health organisations at Director level. Especially where a health organisation did not meet its targets, or had financial difficulties, there were changes in Chief Executives and Directors of Finance. Obviously some element of change is expected through natural career progression, but these changes were concentrated on the organisations with problems.

For instance, in 2002/3, there were three different Directors of finance at East Kent Hospitals Trust[29]. Chief Executives agree that the pressures on managers in the health service are great. High qualities of leadership, clear direction and management competency are required of them. However, there is the question of how long managers and Directors are given to bring in organisational change. Often there has been a change in Personnel but the underlying organisational and structural problems have remained. Perhaps some problems need alternative strategies to solve them rather than a change of manager; these could involve management support from experienced successful managers, mentoring, and 'support teams' from the modernisation organisations.

In the first 18 months after reorganisation, demands were placed on the competence of managers who had not developed the skills to deal with the new design. Across the NHS, reorganisation caused turbulence. Because of the increase in the numbers of organisations, posts could not be filled for some months. Now the change in the system is complete, the Strategic Health Authority considers that staff turnover is similar to any other very large organisation, and this will not be so significant in the future.

There is no doubt that organisational change is unsettling and health organisations have just been through a vast change in structure and there are more changes to come. Structural reorganisation and recruitment is expensive and causes dislocation.

5.4.3. CRES (Cash Releasing Efficiency Savings)

At the time of the Interim Report health organisations were implementing recovery plans and performance improvement plans to avoid deficit budgets and hit targets. They ended the year with varying levels of success. However, because the Strategic Health Authority has the responsibility of ensuring that the health economy of Kent and Medway balances overall, it pointed out to PCTs that higher savings targets would be needed to balance local delivery plans and that there should be equity in approach.

- All public sector organisations have efficiency targets of 2% per year imposed on them, and this is represented within the overall 4%. The 2% efficiency saving includes 1% efficiency and 1% which is to be re-invested into further developments. The other 2% represent a contribution, from each health organisation in Kent and Medway, towards the overall deficit problem.

- There is a strong feeling throughout the health service that financial responsibility is shared between the Primary Care Trusts and the Acute Trusts. With the dismantling of the Internal Market and the greater move towards PCTs and Trusts sharing responsibility for financial challenges, commissioning services on a price quantity basis is distorted where a commissioner is paying extra money to a Trust to prevent it overspending. This issue is expected to be explicitly resolved with the introduction of payment by results.

- The savings targets are deducted from resource allocations so that they have already been deducted from budgets at the start of each financial

[29] Annual Report and Accounts 2002-3

year. (Additionally in East Kent Hospitals trust, there are further savings of 5.4% in total to enable them to repay their large deficit.)

- This level of savings does, as predicted in the Interim Report, prevent investment in local services by the Primary Care Trusts. These are young organisations and Chief Executives are keen for them to be successful; hopefully they will not be judged on their results in Kent and Medway until the whole health economy has reached stability and is in balance.

- CRES savings are now affecting the service that is delivered in mental health trusts. West Kent NHS and Social Care Trust has frozen development for Attention Deficit Hyperactivity Disorder, they are cutting back on community placing, and not filling £1.5m of vacancies. All health organisations make savings by delaying the start of their developments. Most recovery plans in 2002/3 focused on housekeeping and savings measures such as reviewing unused reserves, freezing non critical expenditure, freezing vacancies, deferring developments, identifying capital to revenue transfers, reviewing activity and waiting list targets and expenditure, and did not review service delivery. There has been a realisation that more radical solutions are now required to reach this level of savings; a true review of patient pathways.

- There has also been an audit of estates, with a view to site rationalisation. Dartford and Gravesham NHS Trust has made substantial savings by renegotiating its PFI agreement to take advantage of lower interest rates.

The search for better value for money will continue as a part of constant part of budget management in the NHS.

Recommendation for the Strategic Heath Authority and All Health Organisations in Kent

Keep a tight control on budget management in view of the high level of savings targets set in 2003/4. Savings at this level have never previously been achieved.

5.4.4. NHS Financing Arrangements

NHS accounting arrangements have changed at the same time as the organisational, managerial and clinical changes. The subject of NHS finances is higher up in the public and political agenda, and financing details are now subject to more public scrutiny than ever before.

The 30% growth in Primary Care Trusts' budgets over the next three years shows political commitment to setting up local health services on a sure footing. But as has been shown in Kent and Medway there was a legacy of debt, and there are future financial commitments, which reduce the amount of money available for growth. The NHS is a huge, complex organisation, with a budget of £1.3bn in Kent and Medway in 2003/4, moving up to £1.6bn in 20005/6, and has grown incrementally with correspondingly complex financing arrangements. It is difficult for outsiders to penetrate the financial systems and jargon, which have clothed the accounts in mystery. The current format of Health accounts is not easy for non-NHS staff to

understand, and interested members of the public have been reliant on the narrative in the annual report and accounts to explain the true financial situation.

The old system of brokerage meant that underlying deficits could be concealed if money could be 'borrowed' from underspending parts of the NHS.

The Select Committee heard evidence that all parts of the Health economy are working hard to provide good quality health services that are value for money. A greater transparency and clarity in financial information would demonstrate this and show the public that the Strategic Health Authority is discharging its duties in public accountability. The NHS Overview and Scrutiny Committee has not always ensured that Health organisations' documents, particularly board papers, are obtained and distributed to the committee members.

The NHS Bank loan terms, while welcome, have the potential for making the issues less clear. In the future, KCC's Overview and Scrutiny Committee should focus in its open committee meetings on quarterly financial monitoring of the health economy in Kent. There are also examples nationally where successful attempts have been made by Strategic Health Authorities to issue clear financial information. For example, Surrey Sussex SHA have published a combined list of the financial results of all their health organisations, and Bedfordshire and Hertfordshire SHA have published an easy to read narrative to accompany their Local Delivery Plan, including financial details.[30]

The Strategic Health Authority's web site could include simple features like this to be more accessible to members of the public.

Recommendations

For the Strategic Health Authority:-

- To provide consistent and transparent information on financial strategies and in the monitoring of outcomes within the health economy in Kent and Medway.
- The Strategic Health Authority to offer help as required in understanding financial information from other parts of the health economy in Kent and to provide the information in a mutually agreed format to the NHS Scrutiny Committee on a regular basis.

For the NHS Overview and Scrutiny Committee:-

- The NHS Overview and Scrutiny Committee Manager to obtain the Strategic Health Authority and all Trusts Board meeting papers.
- To request the Directors of the Strategic Health Authority to continue to attend open meetings of the NHS Overview and Scrutiny Committee on a regular basis in order to answer questions on the financial position of all parts of the health economy in Kent and Medway.

[30] Local delivery plan 2003/04-2005/06 executive summary (revised) – Beds & Herts. SHA

6. MODERNISATION OF EAST KENT HOSPITALS

6.1. East Kent Hospitals Trust – Financial History

In Kent and Medway, the Health Organisation with the largest deficit and greatest financial problems at 31 March 2003 was East Kent Hospitals Trust.

The deficit of £11.4 m seems at first sight to be a huge jump since the previous year, but difficulties date back to 1998/9 when the Trust was formed from three separate hospital Trusts and brought forward into the new trust almost £2m of debt. The five years' results are:[31]

East Kent NHS Hospitals Trust					
Year	Surplus/Deficit	Income and Expenditure reserve balance	Creditors	Debtors	Creditor/ Debtor balance
	£'000s	£'000s	£'000s	£'000s	£'000s
1998/1999	- 1,957	544	21,497	10,684	-10,813
1999/2000	- 1,197	-653	23,973	24,806	833
2000/2001	+ 601	394	21,647	23,846	2,199
2001/2002	+ 600	994	27,009	13,656	-13,353
2002/2003	-11,371	-10,377	40,089	11,877	-28,212

The Select Committee concluded that there had been an element of brokerage to prevent the Trust showing a deficit in 2001/2. The East Kent Financial recovery plan shows that the £11.37m outturn concealed an underlying deficit of £22.5m.[32]

After the merger from the three former hospital trusts on 1 April 1999, as required by the Department of Health to help the modernisation of the Hospital Services, East Kent Hospitals Trust has suffered four years of uncertainty while modernisation issues were in dispute. This was finally settled with the findings of the Independent Reconfiguration Panel (IRP) in July 2003. In all, East Kent's healthcare has been under almost constant review and consultation for almost eight years. At the same time the Trust has been carrying on its core business – providing health care to east Kent – from three main centres.

6.2. Savings Plans

From 1999/2000 onwards the Trust had claimed to have savings plans in place.

From the published accounts:-

1999/2000

In 1998/9 the Trust paid out £2.6m in redundancy costs, and in 1999/2000 another £2.7m plus £0.7m in Working Time Regulations payments, making a total of £5.3m in redundancy payments over the two years. The Trust wrote in the annual report:-

[31] Annual Report and Accounts – 1999-2003
[32] East Kent NHS Trust Financial Recovery Plan – presentation to OSC July 2003.

'By maintaining effective financial control and absorbing these costs, the Trust avoided a potential deficit of £3.4m, but regrettably was unable to fully contain these additional costs. Financial plans are in place however to make good this deficit over the next two years. By taking difficult decisions regarding redundancies this year, the Trust has created a management structure that will save £1.5m a year in the future'

It is clear from these redundancy costs, if there were no other staff savings, it would then take three and a half years before there were any savings made by the Trust from the reduced staffing structure (£1.5m saved each year to recover the total of £5.3m).

2000/2001

'The surplus of £601,000 means the Trust is on target to make good last year's £1.2m losses by the end of March 2002. This was not achieved easily…corrective action was taken to re-establish financial control…although planned, the achievement of this surplus is remarkable.

There are service enhancements to which the Trust is committed, for which funding is simply not available…the Trust needs to generate savings of £5m… to realise these savings, a target programme has been established to tease out avoidable costs and improve efficiency'

2001/2002

'It was another very difficult financial year for the Hospitals Trust…The required surplus of £600k was achieved through a variety of one-off measures. The Trust enters the new financial year with a challenging programme of efficiency savings to address the underlying deficit.'

2002/2003

'The previous year's financial targets had only been met through the use of non-recurrent funds and as these sources of income were no longer available, a restrictive financial strategy was required to achieve financial stability. However, Government priorities for improved access and quality of health service treatment also had to be delivered…. A savings target in excess of £25m was set in order to address the potential shortfall, which ultimately proved to be beyond reach.

The Trust is now entering a period of financial recovery in order to achieve not only ongoing financial stability but also to repay any monies borrowed during the period of deficit.

Achieving financial balance will not be easy.'

The only conclusion that can be made was that the underlying deficit problem was not solved.

At the end of 2002/3, the Strategic Health Authority's application was approved and the Trust received the offer of a £17m loan from the NHS Bank. The repayment details of this loan have been tied in with the business case for the East Kent Hospitals Reconfiguration Plan, which was duly delivered to the Department of Health by 31 October. The Trust has said that the current service configuration is not financially

sustainable, and the savings are dependent on an element of the modernisation beginning in 2003/4. Savings targets have been calculated based on a three year repayment time for the £17m loan and to reach these will need to be:

East Kent Hospitals Trust Savings Targets		
2003/04	£14.4m	5.5%
2004/05	£9.1m	3.5%
2005/06	£9.1m	3.5%
Total	**£32.6m**	**12.5%**

The Trust's recovery plan for 2003/4 demands savings of 5.5% overall. It is clear that there is a risk they will not be able to reach these savings targets; yet if they are able to, the £17m loan can be used to benefit the whole of the Kent and Medway Health economy. By October 2003 the Trust had identified £10m of recurrent savings. They will meet the £14.4m target with non-recurrent savings:-

- A conversion from capital to revenue of some of the sale proceeds of the Nunnery Fields Hospital Site
- £1/2m from slowing down the implementation of Junior Doctor's Working Time Directive compliant contracts.
- The four PCTs in East Kent – East Kent Coastal, Canterbury Coastal, Shepway and Ashford – have contributed £3m between them towards the Financial Recovery Plan. This use of PCT funds will need to continue until the East Kent Health economy becomes stable; however the effect of this cut in budget available for PCTs is to prevent investment in local primary care.

The reconfiguration plans are continuing but not without difficulties, as some clinicians are still in disagreement about the remaining details.[33]

It is clear that budget managers have not in the past been able to make the required savings. This could have been due to several reasons:-

- Savings levels were too high and not possible with the structure in East Kent and the level of activity demanded.
- Budget managers were not sufficiently trained, communicated with or supplied with appropriate activity and financial information.
- Budget managers were not committed to the savings plans.

6.3. Department of Health Grants

The deficit at the end of 2002/3 was partly caused by the withdrawal of transitional support the Trust was receiving for modernising the services in East Kent. This represented the extra cost of providing services in outlying locations. East Kent Hospitals received £7m transitional support each year while the service reconfiguration was taking place, from the South East Regional Office of the Department of Health.

[33] CHEK report on reconfiguration of East Kent Hospitals – letter from Professor Field.

It ceased when the Regional Office closed and all local transitional support was put into overall NHS allocations. The Strategic Health Authority did make a contribution to East Kent Hospitals Trust to help.

As the reconfiguration had never happened, this loss caused difficulties. As this was a transitional grant, contingency plans should have been made to manage within baseline revenue budgets until the reconfiguration could be completed.

'The uncertainty about the time limit for this money does not remove the responsibility of the Board for financial planning; its transitional nature was known.'[34]

East Kent Hospitals Trust is now looking forward and feels confident they have the commitment of the Clinical Directors who are the budget managers.

6.4. Deficits – The National Picture

6.4.1. East Kent Hospitals Trust were by no means the most financially challenged Health Trust at 31 March 2001, possibly because they were able to obtain brokerage to maintain their financial position.

The five NHS Trusts with the Highest Deficits as a Percentage of Income[35]		
NHS Trust	**Deficit for 2001/2 £m**	**In-Year Deficit as a Percentage of Income**
West Hertfordshire Hospitals NHS Trust	11.5	6.6%
East Berkshire Community Health NHS Trust	1.2	4.7%
Somerset Partnership NHS and Social Care Trust	1.8	4.6%
Sussex Weald and Downs NHS Trust	2.3	4.3%
Bedford Hospitals NHS Trust	3.1	4.1%

By 2002/3, the results for these trusts had altered:-

The five NHS Trusts with the Highest Deficits as a Percentage of Income[36]		
NHS Trust	**Surplus- +Deficit for 2002/3 £m**	**Reason**
West Hertfordshire Hospitals NHS Trust	11.6	Met savings target and received brokerage of £10.5m
East Berkshire Community Health NHS Trust	Not known	Trust wound up and work taken over by three PCTs
Somerset Partnership NHS and Social Care Trust	9.4	Secured funding to repay deficit.
Sussex Weald and Downs NHS Trust	Not comparable	Reorganisation – and support from DoH and NHS Bank
Bedford Hospitals NHS Trust	Re-organised	Subject to one off measures, further reorganisation to come.

[34] Director of Finance, SHA, 17 November 2003
[35] NHS Accounts Summary 2001-2
[36] Individual reports and accounts (where available) 2002-3

It is clear from the tables above that Health organisations that are undergoing radical reorganisation are more likely to go into deficit. Conversely, those organisations who have large deficits are more likely to be re-organised because there are underlying structural problems which will prevent their coming into balance at the declared level of funding.

The question remains – why is organisational restructure thought to be needed before modernisation of health services can be embarked upon?

6.5. East Kent NHS Hospitals Trust – Lessons Learned

6.5.1. The National Audit Office in its report on Achieving the NHS Plan maintains:-

> *'Local NHS trusts should look beyond a 'lack of resources' as the excuse for poor performance, and concentrate on achieving efficiency improvements, using resources such as the Modernisation Agency's programmes and advice, involvement with the collaboratives, and the action plans delivered by local auditors.'*

Gordon Brown in his speech to the Social Market Foundation stated:-

> *'It is difficult to let a hospital go bust'*[37]

6.5.2. It is to be applauded that after continuing on a knife-edge of funding security, East Kent Hospitals Trust can now look forward with surety. Although there still remain some elements of uncertainty in the East Kent Reconfiguration plan, the resource levels for the next three years are clear.

A radical approach to budget planning and monitoring is required to keep within these allocations and push forward modernisation plans. East Kent Hospitals Trust will need to sustain its engagement of budget managers and ensure they have everything they need to remain within cash limits.

6.5.3. Current activity reports show that East Kent is trying hard to meet access targets and thus have been able to achieve a one star rating, despite their financial problems. The maintenance of their targets is seen as their overall imperative.

6.5.4. Past misunderstandings with the Department of Health are no longer appropriate under the present financial regime. When health organisations have a statutory duty to break even, there must be certainty and clarity from the Department of Health to allow for proper financial planning by Trust Boards. The terms of loans and grants must be made clear.

6.5.5. It is unreasonable to change the financial regime and expect health organisations to pick up the remnants from the previous financial system. When deficits did not need to be repaid and brokerage was national, it was not unreasonable at that time for Clinical Directors to believe that financial management was less important than clinical and access targets.

[37] Speech to Social Market Foundation, February 2003.

6.5.6. Financial probity has moved up the agenda, but Health Trusts who labour to repay long-standing debts are less able to serve their populations than those who were more fortunate. The allocation of debt on a local basis has doubly hampered those areas like East Kent who have been trying to modernise their services with split sites and a variety of buildings. The newly announced loan terms will help the whole of the Kent and Medway health economy.

6.5.7. While it is clearly inequitable to labour to repay a debt caused in another financial regime, this does not mean that financial performance should not be treated very seriously. To obtain value for money for the extra money put into the health service, the population of Kent must be sure that:-

- All budget managers are managing their allocations effectively.
- They are acting on the recommendations of the annual audit letter.
- They are being monitored on their CHI action plans.
- The savings target for East Kent Hospitals Trust remains higher than has ever been viewed as deliverable in the NHS economy; and this is ostensibly in a time of growth for NHS investment. However, clinicians have shown that they are able to improve their clinical practice, and by the use of strategies to re-plan patient pathways they have saved 40,000 bed days through Accident and Emergency in a year.
- In past years there has been a reliance on non-recurrent savings, which have not finally solved the deficit problem. This can only be justified if there is an accompanying strategy to assess the opportunity cost of not developing initiatives or in using capital allocations for revenue purposes.
- East Kent needs the backing of the Strategic Health Authority and the Department of Health to provide good health services for Kent people, reach its NHS plan targets, implement its modernisation plans, and run within its budget.

Recommendations for the Strategic Health Authority and All Health Organisations in Kent

All parts of the health economy should recognise the changes in the financial regime which now require them to:-

Continue to take seriously the fact that they must balance their budgets, live within their means and not overspend.

Monitor the realism of savings plans and their implementation whilst maintaining high quality care and access targets.

Maintain the level of capital investment that is sufficient to maintain the value and quality of the estate and equipment.

7. MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

7.1. Maidstone and Tunbridge Wells NHS Trust had a troubled year in 2002/3, losing their Chief Executive, Chairman, Director of Strategic Development, Director of Human Resources and a Director of Operations (on a secondment). They were also graded with no stars by CHI. They look forward to a more stable future with a new management team, after an interim period being guided by a Chief Executive from a three star trust. Their permanent Chief Executive, Rose Gibb, joined the trust on 1 November.

At over £4m, this deficit was the second highest in Kent and Medway.

Their financial results over the four-year period are:-

Year	**Deficit(-), Surplus (+)**	**Cumulative Deficit**	**Deficit as % of Turnover**
	£'000s	£'000s	
2000/2001	+104	-	
2001/2002	- 4153	-4049	2.59%
2002/2003	- 4040	-8089	2.28%
2003/2004 – projected	-	-4000*-7900	2%-3%

* Projected at November 2003

However, in the Chairman's report for 2002/3, James Lee says:-

> *'We have already agreed a financial recovery plan. This shows that, in order to break even and repay our debt by the end of the current financial year, the whole of South West Kent must address a potential deficit of nearly £12m. This will be very challenging. If we are to succeed we need more creative thinking by everyone involved, including those working for the Primary Care Trusts'*

7.2. The overspend in 2002/3 was caused by over performance in the contracts – ie the Trust treated more patients than the PCTs commissioned – the use of the independent sector to meet access targets, and the Diarrhoea and Vomiting outbreak which is estimated to have cost £500,000. In November, the Trust was still hoping to break even at 31 March 2004, but as is shown by the projection from November 2003 this is becoming unlikely unless non-recurrent savings can be found.

7.2.1. The Trust has prepared a Financial Recovery Plan, which has been submitted to the Strategic Health Authority. They have requested that the debt is repaid over five years and this has been rejected.

7.2.2. The 'Local Health Community' – which includes Maidstone Weald PCT and South West Kent PCT will work together to tackle the savings gap. The Trust is working with its PCT partners to identify a range of further measure and initiatives to fund the deficit.[38] The two PCTs are contributing just over £3m towards the Acute Trusts' Recovery Plan.

[38] Maidstone & Tunbridge Wells NHS Trust Report & Accounts 2002-3

7.2.3. In 2002/3 there was cash brokerage (to aid cash flow) from Maidstone and Tunbridge Wells PCT of £17m and this has been repaid in 2003/04. There will be a maximum cash brokerage of £23m for 2003/04.

7.3 The story of this Trust shows how vulnerable a Health service organisation can be to sudden financial crises, which have caused it to go into deficit. This is particularly difficult for this Trust which suffers from recruitment and retention problems due to its nearness to London. The Trust is now taking steps, already noted, to reduce its agency staffing.

7.3.1. The question of 'over performance' of commissioned levels of activity will need to be monitored, as there is no further funding available from the PCTs. In 2003/4 there has been an assumption that activity will be at the commissioned level. South West Kent has a risk sharing agreement with Maidstone and Tunbridge Wells NHS Trust of £3m – if activity rises above a specified level, this extra amount would be paid to the Trust to recompense their extra expenditure.

7.3.2. If Acute Trusts were able to build up reserves of at least 2% this would allow them to fund sudden calls upon their budget and to develop medium and long term strategies rather than 'fire fighting' ones.

7.3.3. The use of PCT funds appears to be an expected path to recovery for Acute Trusts, but it has affected the ability of PCTs to invest. Professor Malcolm Forsythe, Chairman of SW Kent PCT says in the foreword to his annual report and accounts for 2002/3:-

> *'…One of the most challenging aspects of our work has been to keep within balance financially. It is very difficult for our population to understand how we have financial difficulties with such a large increase in resources. Our local acute trust has been in serious difficulty and we have to share some of that burden'.*

The discretion now allowed to the Strategic Health Authority will perhaps help the South of West Kent to come within financial balance; in addition the SHA have arranged for the NHS Modernisation Agency to bring support and advice to improving systems, processes and procedures.

8. DARTFORD GRAVESHAM AND SWANLEY PCT

8.1. 2002/3 Results

Dartford Gravesham and Swanley PCT, despite attaining many of their targets, ended the financial year in deficit and was graded a 'no-star' trust.

Failing to achieve implementation plans for single telephone access, and on the 'Improving Working Lives' criterion, together with their underachievement on financial management, ensured they were downgraded.

In addition, because they ended 2002/3 financial year with a £1.189m revenue deficit and a small overspend on capital expenditure, their final accounts were qualified. This unplanned deficit was in excess of an anticipated deficit, which was bridged by £2m brokerage.

From the 2002/3 Annual report:-

> *'This report, for the year 2002-03, describes how we have built on these earlier initiatives to achieve some significant successes – for example by commissioning acute services in a way which reduced waiting times, and by producing significant improvements in services for both older people and children. It also describes how we have had to take stock of our strategies and operations, in the realisation that we now need to stand back from innovation and to focus more on making sure our business processes are robust and on bringing our various initiatives through to completion by strengthening our operational capacity.*
>
> *CHI… Acknowledged that our PCT is energetic and enthusiastic; and we have forged constructive partnerships with arrangements of statutory and voluntary organisations but it also concluded that we have sometimes lacked the necessary resources to fully enact our strategic vision or to adequately monitor and fulfil our operational agenda.*
>
> *Our significant under-achievement in two of the key target areas attracted a large number of penalty points which resulted in a 'zero star' rating.'*

8.2. 2003/4 Progress

8.2.1. Since this time, the Primary Care Trust has worked hard to improve business processes. The Acting Director of Finance has looked at all budget levels and implemented savings plans. However, the PCT will not achieve full financial balance this year, as they cannot repay the entire deficit. They are discussing with the Strategic Health Authority ways to repay and hope to bridge the gap in this financial year with further brokerage – a loan from within the Kent and Medway health economy. They had a budget gap of £7.5m at the beginning of the financial year, and this has been reduced to £4m, which represents 2% of their annual budget, by reviewing budget levels. To make the savings they have been able to do so far, they have had to delay developments, adopt a vacancy freeze, and look for non-recurrent savings through deferrals of activity.

8.2.2. At the end of 2003/4, the Trust will still have a carried forward debt, but hope to solve this over time. Some money saving schemes cannot be brought in without sufficient lead-in time for investment and planning.

Their main areas of overspend were, and remain, prescribing and commissioned services from London providers.

8.2.3. Prescribing

Dartford Gravesham and Swanley PCT have found that only 80% of their GPs have been compliant with regard to their savings strategy for prescribing, but they are attempting to keep the growth of this budget within the national 12% growth limit, and continuing to employ savings strategies.

8.2.4. Non-Local Providers

With regard to services commissioned with London hospitals, the PCT is taking a fresh look at their service level agreements. They have written to the Strategic Health Authority to review how they are managed. Maidstone and Weald PCT currently manage their speciality commissioning in a pool, though Dartford, Gravesham and Swanley PCT negotiates with Greenwich and Sidcup hospitals locally.

This case demonstrates one of the dangers of joint commissioning, in that it may not adequately represent local interests. Their geographical nearness to London must mean that there is a tradition of London referrals and possibly the PCT themselves need to review their services to see if moving more services back to nearby Dartford and Gravesham NHS Trust could be achieved. As this three star trust has increased activity by 13% in this financial year this may already be happening, but none of the PCTs who gave evidence felt that there was any decrease in activity with London providers. There is an additional danger for the Acute Trust in that the PCT will not be able to support their higher level of activity because of their own financial difficulties. Support as received in South of West Kent and East Kent for their local Acute trust is not possible in Dartford and Gravesham.

However, because of the long tradition of London referrals, and the expectation by London hospitals that North West Kent patients will go to London, it could be said that there are different financial flows in the Dartford and Gravesham area. As this PCT will always need to have contracts with London hospitals, then funding to pay for these contracts should reflect this. As well as this, Dartford Gravesham and Swanley PCT is on the horns of a dilemma; it is currently able to provide more services because of the improved capacity for elective (non-emergency) procedures at Darent Valley Hospital. The Strategic Health Authority is helping to judge exactly what is required for the PCT's population.

With regard to non-elective or emergency activity, the Strategic Health Authority believes that the new patient pathways at Darent Valley Hospital have created a need to review ways of measuring patient activity. Alternative pathways may be being counted as increased activity, and thus affecting patient activity figures. The experience of working with this PCT to solve these problems will help to inform the commissioning process in the future.

8.2.5. This case also demonstrates the continuing need for local brokering. Dartford, Gravesham and Swanley PCT have over committed their budget so short term cash flow allocations do not solve the problem. It also demonstrates the weakness of being a single Primary Care Trust within a health economy; in East Kent the four Trusts have been able to band together to reach targets. An example of this is the 'improving working lives'[39] target which has been achieved by a Human Resources Consortium hosted by East Kent Partnership Trust on behalf of that Trust plus all the East Kent PCTs. This is a good use of scarce management resources, and Dartford, Gravesham and Swanley PCT may suffer unless another way of supporting it managerially can be found. Primary Care Trusts are being encouraged by the Strategic Health Authority to work even more closely together and despite its geographical differences from the rest of Kent, this should help Dartford, Gravesham and Swanley PCT.

[39] Glossary explains this target in detail.

9. CURRENT ISSUES

9.1. CRES and Budget Management

9.1.1. The level of Cash releasing efficiency savings that has been imposed on the Kent and Medway is 4%, with 5.4% in East Kent Hospitals' Trust. This is higher than is generally thought to be achievable in the Health service, and possibly only sustainable because of the 9% growth put into the budget to fund developments. The result has been to slow developments down and to prevent Primary Care Trusts from doing what they were set up to do; to extend the range of health services in Primary Care.

9.1.2. Primary Care Trusts must be given time to develop on a stable basis. Although funding has been allocated to start off projects, recurrent funding of these developments means a further stretching of scarce resources.

Currently they need to spend time assessing the needs of their local population, including providing adequate base budgets for commitments that were not funded properly before.

As well as allocating adequate budgets, health organisations must have the full support of their budget managers if they are to remain within them, many of whom are primarily clinicians with their first priority to provide health services.

The organisations which have been able to make savings and stay on budget are those who have been able to engage their budget managers. Strategies include: -

Kent Ambulance Trust Strategies for Involving Budget Managers

- Budget managers have been on a management development programme, which includes financial control systems.
- Work has been completed on the base budgets to ensure allocations are accurate and realistic – this work with budget managers identified their need for more training.
- Accountability for budget management has been devolved as far down as possible, so those Managers now have responsibility and control.
- Managers are part of the decision making process, particularly those who have responsibility for estates.
- The Chief Executive believes it is about communicating with people, and staff having a say in the decision making

South West Kent PCT Strategies for Controlling the Prescribing Budget

- They have a good pro-active prescribing team.
- The PCT supports changes in GP's prescribing practice, giving them advice and input,
- To get the GP's to 'own the resources', with eventual devolution of budgets.
- The PCT has tried hard to find ways to motivate GPs through their incentive scheme, and now aim to extend the prescribing team to improve their support
- Detailed work needs constant monitoring, and giving feedback

It is clear that in the past, as has been seen by the history of East Kent hospitals, it is supremely difficult to maintain budgetary control in times of organisational change. Changing an ethos takes time and if the Strategic Health Authority, guided by the Department of Health wants to achieve success, they could support and encourage best practice in devolved budget management. Currently in an acute trust, the access targets are non-negotiable, so these will be attained regardless of the cost. It is striking the balance that is important, and budget levels must be achievable to engage budget managers' commitment.

9.2. Commissioning Process

PCTs spend by far the greater part of their budgets on commissioning from the secondary sector. Just how much can be seen from the example of East Kent Coastal:-

The figure below shows East Kent Coastal PCT's split of expenditure. Although including the commissioning process for the whole of East Kent for mental health, the net figures shown below show 93% of the expenditure is spent on commissioning, and less than 7% on providing all its local services.

East Kent Coastal PCT	£m	%
Commissioning	214,040	93.35
Providing	15,237	6.65
	229,277	100.00

At the present time, most contracts are commissioned on a block contract basis – that is, between certain levels of activity a fixed amount is paid, based on the previous year's contract, budget up-dated for changes in population and activity level since the previous year. Negotiating contracts begins in September to complete the Service Level Agreements by the following March.

Canterbury Coastal PCT negotiates on behalf of the four East Kent PCTs for Acute Services with, primarily, East Kent NHS Hospitals Trust.

The Strategic Health Authority will intervene when agreement cannot be reached.

While contracts are closely related to historical amounts, there is no measure of whether PCTs are receiving value for money. Despite the complex negotiating process, both in East and West Kent, extra money has been contributed towards the deficits in the Hospitals' Trusts. This devalues the detailed commissioning process. The process is changing with the introduction of national tariffs over the next five years, which will produce a fixed national price for all clinical procedures, and should be complete by 2007/08. PCTs are already working towards this process:

9.3. Working Towards the Introduction of National Tariffs.

Primary Care Trusts co-ordinate the Local Delivery Plan process. This uses current activity measures of health care and projects future needs by adjusting for changes in numbers.

After the introduction of national tariffs, the price for each procedure should be fixed. The problem of price will still remain if a Trust's costs are above the national tariff, as is currently the case in Kent Hospitals, but under the tariff in Medway Hospitals Trust. (The actual reference costs for 2002/3 are not available until December and are expected to show high costs have been lowered.)

In planning the new system, there have been some discussions about price. It has been made clear that trusts will deliver against the national tariff, and the bottom line for hospitals' trusts is getting to tariff rate over the next few years.

Canterbury Coastal PCT is working on collecting comparative data for benchmarking work with East Kent Hospitals Trust. This work is urgently needed but there is a shortage of management time to do this. If PCTs are to concentrate on their core business, there is an issue of how far they should be expected to drawn into work for a separate organisation, albeit they are linked as part of the health economy.

The Primary Care Trusts have a complex network of commissioning on behalf of each other; some within the four health economies and some across the whole of Kent. For instance, Maidstone and Weald PCT negotiate on behalf of the whole of Kent and Medway for specialty commissioning with hospitals trusts outside of Kent – primarily in London, but also elsewhere. This practice can be enormously beneficial because it prevents duplication, and a Hospital Trust has only one PCT with which to negotiate. It also has disadvantages in that some local interests may be overlooked. For example Dartford, Gravesham and Swanley may have a special case for negotiating separately with London hospitals because of their geographical position.

The commissioning process, once National Tariffs have been introduced, will concentrate on the volume and quality of activity rather than the price. Currently there is no way of measuring the quality of services apart from reports on clinical governance. PCTs, as budget holders and commissioners for all health care in their locality, are accountable for performance managing agreed service level agreements.

The 'added value' of the commissioning process has to be questioned as it can take up a huge amount of management time without necessarily being satisfactory for either partner. For instance, Swale has not yet signed the 2003/4 risk sharing agreement with Medway Hospital trust. This agreement would define at what volume of activity Swale PCT would pay more than their block contract to the Hospital Trust. This increases the amount of risk in financial management for both partners.

Recommendation for NHS Hospital Trusts

For trusts with above average reference costs:-

Reduce local costs to the national average while maintaining the highest standards of quality and safety thus using the national tariff as a lever for eliminating unnecessary variation in levels of cost and quality and boost the use of local health facilities when patient choice is extended in December 2005.

10. OUTLOOK – THE TENSIONS

10.1. Effect of Financial Constraints on Performance

There is no doubt that the health organisations have battled enormously over the last two years to deal with the vast organisational changes that have been imposed on them. As well as total reorganisation, they have been subject to constant changes of management; the imposition of access targets, inspection and star ratings and in some cases constant changes in personnel and non-executive Directors. The NHS has always been on a 'knife edge' of funding, and even though the announcement of three-year funding is a step forward, this has been coupled with an expectation of high performance.

Coupled with this in East Kent there has been a long running struggle to modernise services to comply with clinical governance, while maintaining split sites. The South of West Kent has also suffered because of the uncertainty about their new hospital.

It is a tribute to the health organisations that they have coped so well and that there are new developments throughout the area which are improving the treatment of patients and offering wider choices of care.

There are signs that the extreme financial constraints that some health organisations are working under are affecting performance. This is particularly noticeable in the Mental Health sector. Because there is a concentration on reaching targets in the acute sector, investment by the PCTs is not as much as they would like. They feel that the service is at a standstill.

Mental health trusts are making savings by reducing levels of service, and this can only be sustainable if they are supported to provide services in different ways – for example the 24-hour crisis teams are a way forward. They are also susceptible to delayed discharge problems because there is a lack of provision for older people with mental health problems.

The other major cause of worry is East Kent Hospitals Trust, where there is a risk they will not meet their savings targets. The levels of savings expected, as a cut in base budget year on year, is higher than is considered to be attainable.

Primary Care Trusts have been very successful in improving the health care for their localities. However they have not been able to invest as much as they would like because of financial constraints. It is important that this is taken into account when they are benchmarked against their peers nationally.

10.2. Access Targets v Over Performance

There is an acute tension between the targets set for Acute Trusts and their contracts commissioned with the PCTs. As they are delivering on block contracts, they are not paid for activity over set levels. However, at Dartford and Gravesham NHS Hospitals Trust because they have worked hard to shorten patient pathways, their activity is 13% higher than 2002/03.

They are protected this year from a deficit because they have been able to make savings in refinancing their PFI agreement.

However, this will eventually cause them to run at a deficit on services unless they can negotiate a ‘cost and volume’ contract with their main commissioner Dartford and Gravesham PCT. As already reviewed, this PCT has a financial problem. As Acute Trusts push towards reaching their access targets over the next two years, they will increase activity. Unless this is negotiated in the commissioning agreement they will over perform on contracts which they will not be paid for; as the National tariffs begin to be charged, the PCTs will pay for the whole of the heightened activity.

Further work is needed to discover what levels of activity will be reached when the access targets are reached and financial modelling of the level of budgets necessary to pay for this.

10.3. Population Growth

In Ashford and the Thames Gateway, huge population growth is expected in the next few years.

The current population served by Ashford PCT is 105,000 - by 2016 there will be 13500 more houses and by 2030 there will be 30,000 more houses. Ashford PCT are considering the future strategy for the health economy together with Ashford Borough Council. Demographics have informed them that there are already increasing numbers of children and the very elderly.

The intensity of their efforts to improve health services will have to be greater than the other PCTs. At any one time, over the next thirty years, the PCT will be constantly involved in various stages of development of three to five health centres at any one time to provide health care for their rising population. In Ashford, as in other areas of East Kent, there is already a shortage of GPs. To maintain GP services to patients, Ashford PCT is currently managing three out of the 16 GP practices directly. The use of the 2001 census in budget calculations helped to improve allocations, but the PCT is still catching up to provide services for the population growth that has already occurred. The Strategic Health Authority has written to the Department of Health to address this. It is clear that Ashford needs transitional support between census changes.

The capacity of William Harvey Hospital has already been stretched when patients have to be diverted to other hospitals for Accident and Emergency. Work is being done by Ashford PCT to study how the growth of Ashford has increased demands on William Harvey Hospital and this needs to go on with further modelling against projected population growth.

Dartford and Gravesham Hospitals Trust have confidence that the ‘footprint’ of Darent Valley is sufficient to cope with the increase in population in the Thames Gateway. There is also a further £10m of PFI expansion available.

Recommendation for the Strategic Health Authority and Primary Care Trusts

Continue to lobby, with Kent County Council, the Department of Health regarding favourable transitional support for Ashford and the Thames Gateway, as the resource allocation formula will only reflect population change retrospectively.

10.4. Patient Choice and Consultation

As yet the concept of patient choice is still out to consultation and health organisations were unsure about how it would work. The mental health trusts felt that it could only be interpreted in a limited way. The PCTs were concerned about managing possible greater costs of patient transport after the introduction of patient choice. This is an area in its early stages and will need to be the subject of further study when the impact of patient choice is clear. It is imperative this happens soon to complete the work within the time scale. Patient consultation has been seen in the area already with the Renal and Vascular services consultation and further consultation on parts of the East Kent reconfiguration plan. This has been a welcome improvement in transparency on the part of the health economy. Patient Forums have recruited 4000 volunteers[40] so far, and their full membership will be between 8,565 and 11,420.[41] Community Health Councils will cease operation on 1 December 2003.

10.5. Star Ratings

Some of the targets for star ratings are based on 'rates of change' rather than absolute values. High achieving PCTs felt that this unfairly handicapped those who already achieved high absolute values – if they had reached the target, they could not improve further. The loss of stars by some organisations who were high achieving showed that despite good work, they would be judged by the main targets and they had to prioritise these, perhaps at the expense of more worthy and relevant objectives.

10.6. Organisational Change

This has been the first full year for some Primary Care Trusts.

As Dartford Gravesham and Swanley PCT said in their annual report and accounts:-

> *'The main impact of all these changes has been to shift the balance of power towards those who have the best knowledge of patient needs – patients themselves, the frontline staff who are most closely in touch with them, and local communities. Each of these groups will in future have a progressively greater say in how health services are developed.'*

It has been a very difficult year for the whole of the Kent health economy, and all the organisations that gave evidence were keen for a period of stability. They were all working collaboratively to strengthen the structure; this was especially marked in east Kent. The effect of organisational change on staff and non-executive directors can be illustrated by the case of Kent Ambulance Trust:-

> *'This has been a year of many changes for the Trust…During the last three years the Trust was subject, along with the other ambulance Services of the South East, to a series of organisational reviews, which inevitably caused a degree of uncertainty for all our staff… By September 2002 the Board had only one substantive Executive Director.*[42]

[40] Department of Health Press release 28 November 'Patient and Public Involvement forums go live'
[41] Commission for Patient and Public Involvement in Health - Frequently Asked Questions,
[42] Report and Accounts 2002-3

Change continues, with the secondment to Social Services of Learning Disability Staff working in the community – in East Kent they moved to Ashford PCT from 1 April 2003. Staff who are subject to continual organisational change find it difficult to improve their core service and manage budgets at the same time and must be supported through this.

Despite all these tensions, there have been some examples of innovations, which show the way forward to a modernised health service for Kent and Medway.

Recommendation for Primary Care Trusts

Work with other Primary Care Trusts to capitalise on the efficiencies that can be achieved by making best use of scarce resources, while still retaining a local focus.

11. INNOVATIONS

11.1. Re-Engineered Patient Pathways and Treatment Centres

To meet the access targets for Accident and Emergency Departments, the Health organisations have worked together collaboratively to improve patient pathways and thus the whole patient experience – and meet their access targets. Members of the committee admire these examples of good practice, and if their initial indications of improved quality and efficiency are confirmed by evaluation we would encourage Kent and Medway health organisations to spread them more widely.

Kent Ambulance Trust

A Paramedic has moved into a role working within a local A&E Department, demonstrating how skills can be transferred and enhanced for patients within the local emergency care system.

Kent Ambulance Trust

Recognising that transport to an A&E Department is not always the most appropriate course of action for some patients to whom they make a '999' response, they are developing a range of alternative patient referral routes for our crews, many of these utilising existing primary care services within the community. To facilitate this they have installed mobile telephones into all their emergency ambulances, and new technology will also assist with the transmissions of the data showing a patient's vital signs in the future.

Treatment Centres are to be set up in England to improve access for patients in elective care. There is to be a private Treatment Centre at Maidstone Hospital, which will do day surgery. This will not detract from the work of the rest of the hospital and, at the same time, will shorten the waiting list for patients. There are still issues to clarify with regard to the staffing for private Treatment Centres as some staff will be recruited from outside the National Health Service, and some will be NHS employees. Dartford and Gravesham NHS Trust is developing an NHS Treatment Centre within Darent Valley hospital, also for day surgery, and the capital costs funded through an extension of the PFI scheme. The Department of Health has promoted the development of Treatment Centres as a way of cutting down waiting lists and offering wider patient choice. When they are more widespread their effect can be studied.

11.2. Innovations in Primary Care

Primary Care Trusts, although constrained financially, have been active in initiating schemes which keep patients in their own homes as long as possible:

East Kent Coastal PCT Rapid Response Team

Keeping patients in their own home and out of hospital or residential care is the aim of the rapid response Team. The team assesses and provides nursing and social care for up to 72 hours when someone suddenly falls ill to avoid going into hospital because they have no one to look after them at home.

Kent Ambulance Trust

When a patient is discharged from hospital, and becomes ill later, the Ambulance service considers that it is not always appropriate for the patient to be taken to the Accident and Emergency Centre at the Hospital, if the patient could be dealt with in a Primary Care setting. There is now a learning exchange between the ambulance service and A&E to improve pre-hospital skills.

The first stage of A&E takes place inside ambulances, as they are now so technically sophisticated. New models of care are being developed which may mean that in the future, ambulances will attend to calls, which currently can only be done by GPs. This improves the patient experience by providing extra provision

West Kent Mental Health Trust

Are investing development money into a Crisis Team for younger adults, which will reduce the number of beds needed and keep patients at home.

11.3. Innovation Forum

Local authorities are assessed and ranked under the Comprehensive Performance Assessment, carried out by the Audit Commission. Kent is ranked as an "excellent" authority after assessment and is thus ranked as a 'three-star' local authority. The three star ranking brings with it some freedoms and some responsibilities. One of these responsibilities is to take part in 'Innovation Forum'**.** This brings together excellent Councils and Government, to pioneer ways of delivering a better quality of life and improved public services for local communities.

All the three star Local authorities take part in this and have pioneered new schemes to achieve their Public Service Agreement targets. Their responsibility is to initiate the scheme in their own local authority and facilitate similar schemes in other three star authorities.

Kent's proposal for a scheme is designed to improve the care and quality of life of older people. Hospital admissions of older people form roughly half of all hospital admissions and this proposal is designed to reduce the rising demand for acute hospital care, through **reducing unscheduled inpatient bed days occupied by older people (over 75) by 20%.**

The objective of the scheme will be full achievement (or over-achievement) of this target by the end of year three.

Pilot Councils will be prepared to enter into a three-year Public Service Agreement[43] style agreement with the Government to achieve the target.

Mechanisms will need to be agreed for reallocating the investments into improved community care for older people. This would involve Primary Care Trust commissioners containing the levels of activity purchased through Service Level Agreements, and redirecting the funds either for commissioning alternative services with partners (where the admissions target is being achieved), or purchasing additional

[43] Public Service Agreement is defined in the Glossary

hospital care (where admission reductions are slower than planned). So far, in Kent, Ashford, Maidstone Weald and South West Kent PCTs have joined the scheme. The scheme is in its very early stages and begins 1 April 2004

There are issues yet to be solved with the design and implementation of the scheme. As the target is a reduction rather than an absolute target, it will be difficult for those PCTs who have low figures already. For instance, Ashford is already ½% below the benchmark. There are also issues about a health scheme being managed from outside the NHS, but this is a step forward in partnership working which could be groundbreaking in offering a cohesive Health and Social care service. In Maidstone Weald PCT the Chief Executive believes the objective is challenging but deliverable, where there is already good joint working and a good relationship with Social Services locally.

11.4. Recruitment and Retention

All the health organisations had put plans in place to improve recruitment and retention. 'NHS professionals' will be used as a solution to temporary staffing.

Work is being undertaken across Kent and Medway to roll out the initiative beginning in April 2003 with organisations joining gradually. As already found, this organisation has been re-launched and there may be more fundamental questions to be asked such as why people do not want to work for the National Health Service.

A contrast can be made with Kent Ambulance Trust. They have invested in their staff and have been recommended by CHI for their counselling, support and treatment of their staff.

Ashford PCT supports the highest standards of clinical governance. In 2002/3 they were the first PCT locally to commence a programme of appraisal of the general practitioners.

Kent Ambulance Trust Recruitment Initiatives

Although part of NHS professionals, the Ambulance Trust does not use agency staff; in fact there are waiting lists for people to become paramedics. If they have gaps, they cover with overtime and move staff to other ambulance stations. They also have relief staff, who maintain a variable shift pattern to cover sickness and busy times.

There is also a bank of part time staff which addresses welfare issues as this provides a career for those who want to look after their families during the day on week days.

11.5. Delayed Discharges

11.5.1. On 1 October 2003, the Delayed Discharges Regulations came into force. From 1 January 2004 Social Services Departments can be charged if they delay the discharge of older people by not providing suitable care within a time limit. Kent Social Services has set up alternative arrangements in a partnership agreement with the PCTs and the acute Trusts.

11.5.2. This statute was originally set up to impose a financial penalty or ‘fine’ on Social Services Departments who did not have appropriate places for patients to go when

their treatment was complete. Money was allocated which would be lost if Social services did not assess and relocate patients within time limits.

To make better use of the £1.2m allocated to Kent, schemes have been set up between Health organisations and Social services so that the £1.2m allocated for six months can be used to invest in preventing delays in patients leaving hospital because they have nowhere suitable to go.

11.5.3. The schemes began on 1 October 2003, and there is a guarded optimism about the new systems. Some of the issues that have arisen are:-

- Schemes must be available out of working hours and at weekends.

- Schemes must be flexible to adjust to varying demands in different geographical areas.

- There could be some out of area hospital issues – ie patients could be taken ill while away on holiday and Social services will not know about this until the time limit had passed and a financial penalty was payable. They then would be subject to fines from the Hospital where the patient was treated.

- There have been problems in Swale PCT because there are delayed discharges of patients who are the responsibility of Medway Social Services.

Since the beginning of the scheme in October, strong monitoring processes have been put in place. This financial year there have been six months funding allocated and only 3 months of operation with real financial penalties, so Social Services will be protected to some extent. Kent must aim to have less than a target number of patients waiting for discharge at any one time, monitored on a monthly basis.

11.5.4. There are some innovative schemes around the county for addressing delayed discharge:-

East Kent Coastal PCT

Victoria House in Margate currently looks after older people recently discharged from the main acute hospitals and helps them to get ready to return back into the community whether it be their own home or elsewhere with a stay between two and six weeks. It is very much focused on a multi-disciplinary approach with doctors, nurses, occupational therapists and physiotherapist who work with patients to re-build their confidence to reach their goals enabling many of the to return home and live independently. A new building is being built next door to the existing one and this will be is a 60 bed Public Private Partnership Integrated Social and Health Care Centre from April 2005 which will provide local recuperative care, health intermediate care and services for older people with mental health needs. The scheme will be led by KCC Social Services with the close engagement of the PCT

Ashford PCT

Westview Hospital in Tenterden is a Public Private Partnership Scheme also being developed as a 60 bed Integrated Social and Health Care Centre from February 2005. Currently providing recuperative care, it will provide local recuperative care in a residential setting, intermediate care, services for older people with mental health needs, support services for older people and their carers and day care provision. The scheme will be led by KCC Social Services with the close engagement of the PCT.

Ashford PCT – Community Assessment and Rehabilitation team (CART) and the rapid response service have made real improvements in helping people to stay at home rather than having to be admitted to hospital and also in enabling people to come home from hospital sooner.

Ashford PCT hosts the learning disability service for East Kent and works closely with KCC.

There is a budget of £17m for this service with management costs of only £120,000. The service is provided in a range of ways; the majority of clients are cared for by both Health and Social Services.

11.5.5. Delayed Discharges in Mental Health

Although not covered by the 'fining' statute, delayed discharge is a major problem for Mental Health Trusts.

In West Kent NHS Community and Partnership Trust, numbers of patients who could not be discharged in November 2003 are between 42 and 50. This costs £250,000, each year for each bed.

East Kent Community and Partnership Trust have currently (November 2003) 43 people who have delayed transfers of care. This 43 represents 23% of the available bed stock and are causing a £1m overspend on this budget heading. The younger adults need an accommodation strategy to move them on. 23 are older people, and one third of these are the responsibility of Social Services. Some homes are closing and others are too expensive for these patients to be placed. A County-wide project, led by the Chief Executive of the West Kent Trust, has been set up in partnership with both Trusts and the County Council to work on these issues.

11.6. Pilots in Partnership

The setting up of Primary Care Trusts have given impetus to joint working.

Kent Ambulance Service has developed a number of initiatives working closely with partners across the Health and Social Care Community. One example is the recent introduction of a combined community nurse and Paramedic in a response car in the Thanet area, giving the opportunity to provide real patient benefits through innovative joint working arrangements.

The use of this service is rising by 11% monthly, and it creates a better experience for the patient than going to Accident and Emergency Department in Hospital.

Kent Ambulance service are keen to try to pilot new schemes. They can then build results into the Local delivery plan, and aim for recurrent funding. Cost comparisons have yet to be done; however, of whether this sort of service is actually less expensive than established patient pathways.

Dartford Gravesham and Swanley is the only PCT in Kent that has a Social Services manager as a full member of the board. It demonstrates the importance that the PCT places on an integrated health and social care agenda. Its effect can be seen in the way that they have all worked together to put a greater focus on the PCT's children's services, to move them centre-stage, and also in the strides made, in partnership with the acute trust, to reduce delays in hospital discharges.

Dartford Gravesham and Swanley Primary Care Trust

'The redevelopment of The Limes was a good exercise in partnership. Although it is a Social Services establishment, the work done with the PCT has resulted in a great recuperative care/rehabilitation facility which is streets ahead of the old-fashioned care concept and really helps people get back home again'[44]

Ashford Primary Care Trust

Community nursing staff have been working with Social Services to provide services. They have strengthened links with residential homes, and many now have a named District nurse assigned to them.

As part of the Community Assessment and Rehabilitation Team, Ashford has developed new rapid response service. However, for them, provider services represent just 3.69% of the budget.

The introduction of partnership working and alternative patient pathways is to be encouraged to provide a seamless cohesive service for patients. There is further work to be done to measure the cost effectiveness of new initiatives.

Recommendation for Primary Care, Mental Social Services and Ambulance Trusts

Encourage initiatives in partnership innovations where they provide a better service for patients and expand those services which give best value for money.

[44] Annual report and accounts 2002-3

CONCLUSION

Kent and Medway Health organisations had a difficult financial year in 2002/3. The advent of the Primary Care Trusts has brought a local dimension, but financial constraints have hampered performance. Health organisations have moved into a new phase of the National Health Service, where all parts of the Health economy must take seriously the fact that they must balance their budgets, live within their means and not overspend. At the same time they must meet the targets of the NHS plan for access and performance.

Accountants, managers, clinicians and Directors have been diligent and determined to find the answers to the problem of balancing the budget, achieving the Department of Health's targets, and providing locally focused health services. The Select Committee felt that these were the biggest risks to Health Services in Kent:-

Risk	Possible outcomes
Health Organisations not meeting savings targets (The savings target remains higher than has ever been viewed as deliverable in the NHS economy)	• Patients in the primary care sector would suffer further slow down in developments • Health Trusts who must repay long-standing debts are less able to serve their populations than those who had been more rigorous in living within their financial envelope. Implementation of East Kent Hospitals Reconfiguration Plan could be delayed. • Managers lose their tight grip on their budgets.
• Changes in government, or ministerial responsibilities could change the terms of the loan before the six year time limit.	Financial strategies would have to be re-considered.
Hospital Trusts not meeting their key access targets	Patients would suffer worse service in those areas. Hospitals Trusts star ratings would be adversely affected.
Kent and Medway health economy continues to labour under brought forward debt.	Extreme difficulty in planning investment on medium and long term basis for future of health services in Kent. PCTs unable to develop local services as they would like. Destabilisation of economy as resources concentrated where debt is greatest
The use of capital money for revenue budgets without sufficient review of capital programme needs.	Investment in maintenance and information systems would be stunted
Continuing delay in Trust reconfiguration Plans	Inability to modernise and reach required clinical governance standards
No transitional support given to areas of high growth particularly in Ashford and (to a lesser extent) Thames Gateway	People may have difficulty in registering with a GP near their new homes. Patients may not be able to access local health services such as District Nurses. Local hospitals may not have sufficient capacity to treat growing population

The health economy, despite 9% extra budget this financial year is still struggling to achieve balance. The deficits, although large amounts of money, are not proportionately large compared to the size of the £1.3bn budget. The recent clarification of the loan terms by the Department of Health is welcome, and with continuing vigilance and hard work, the Kent and Medway health economy should be stabilised and move forward with the NHS plan.

RECOMMENDATIONS

The Select Committee's Terms of Reference were:-

> *"To investigate and identify any improvements to the financing of the Health Economy in Kent and its impact on Health, Social Care and Community including clarifying the following:-*
>
> *(a) the current position with regard to financing the Health Economy in Kent;*
>
> *(b) the demographic and cost issues for the South East of England; and*
>
> *(c) the financial flows and the transactional costs".*

For the Strategic Health Authority and All Health Organisations in Kent

All parts of the health economy should recognise the changes in the financial regime which now require them to:-

1. Continue to take seriously the fact that they must balance their budgets, live within their means and not overspend. (6.5.7)

2 Monitor the realism of savings plans and their implementation whilst maintaining high quality care and access targets. (6.5.7.)

3. Maintain the level of capital investment that is sufficient to maintain the value and quality of the estate and equipment. (6.5.7.)

4. Keep a tight control on budget management in view of the high level of savings targets set in 2003/4. Savings at this level have never previously been achieved. (5.4.3.)

For the Strategic Health Authority

5. Stabilise the whole of the Kent and Medway health economy, using the flexible terms of the £17m loan from the NHS bank. (5.4.1.)

6. To provide consistent and transparent information on Financial Strategies and in the monitoring of outcomes within the Health Economy in Kent and Medway.

7. The Strategic Health Authority to offer help as required in understanding financial information from other parts of the health economy in Kent and to provide the information in a mutually agreed format to the NHS Overview and Scrutiny Committee on a regular basis.

8. Promote the revision of the market forces factor (the cost of providing services between one area to another) so that it properly reflects the costs of providing services in Kent and Medway. (5.3.8.)

For the Strategic Health Authority and Primary Care Trusts

9. Continue to lobby, with Kent County Council, the Department of Health regarding favourable transitional support for Ashford and the Thames Gateway, as the resource allocation formula will only reflect population change retrospectively. (10.3)

10. Continue to develop the options for a Business case for the establishment of a Cardiac Centre in Kent. (5.3.8)

For the Primary Care Trusts

11. Devolve prescribing budgets to GP Practices to match accountability with responsibility for prescribing. (5.3.4)

12. Work with other Primary Care Trusts to capitalise the efficiencies that can be achieved my making best use of scarce resources, while still retaining a local focus. (10.6)

13. Commission services for as many patients as possible within Kent and Medway who are currently being referred to London hospitals. (5.3.8)

For NHS Hospital Trusts

14. For Trusts with above average reference costs:-

Reduce local costs to the national average while maintaining the highest standards of quality and safety thus using the national tariff as a lever for eliminating unnecessary variation in levels of cost and quality and boost the use of local health facilities when patient choice is extended in December 2005. (9.3)

For the Mental Health Trusts

15. The two Mental Health Trusts should work much closer together across Kent and Medway, for the benefit of all the patients in Kent, to make management more cost effective and make best use of scarce resources. (5.3.6)

For Primary Care, Mental Health, Social Services and Ambulance Trusts

16. Encourage initiatives in partnership innovations where they provide a better service for patients and expand those services which give best value for money. (11.6)

For the NHS Overview and Scrutiny Committee

17. Actively support the formulation of options for a Business case for the Kent Cardiac Centre. (5.3.8)

18. The NHS Overview and Scrutiny Committee Manager to obtain the Strategic Health Authority and all Trusts Board meeting papers.

19. To request the Directors of the Strategic Health Authority to continue to attend open meetings of the NHS Overview and Scrutiny Committee on a regular basis in order to answer questions on the financial position of all parts of the health economy in Kent and Medway. (5.4.4)

Appendix 1 – Primary Care Trusts' Lead Responsibilities

Body	Lead Responsibilities
Dartford, Gravesham and Swanley PCT	• Manages contract with Kent Primary Care Agency* • Kent Drug Action Team • West Kent Child Protection Consortium • Children and Adolescent Mental Health Services • Ambulance Services (WK) • Emergency Planning • Older people (WK)
Canterbury and Coastal PCT	• Acute services commissioning • Service modernisation • Physical Disabilities (Adults) • Older people (WK)
East Kent Coastal PCT	• Commissions mental health services for all EK Primary Care Trusts • Provides Health Promotion Service to EK PCTs • Children's Services and Child protection (EK) • Children and Adolescent Mental Health Services • Paediatric Audiology
Ashford PCT	Ashford provides:- • Learning Disabilities (East Kent) • Community Dental Services (EK) • Community Physiotherapy Services (EK) Ashford Commissions:- • Learning Disabilities (East Kent) • Coronary Heart Disease (EK) • Independent Sector and Overseas (Kent and Medway)
Shepway PCT	Ambulance Services (EK) Emergency Planning
Swale PCT	Mental Health (West Kent)
Medway PCT	Dental services (WK)
South West Kent PCT	Learning Disabilities (WK)
Maidstone Weald PCT	• Out of County Acute specialties • Learning Disability (WK) • Cancer • Forensic Medicine • Paediatric Audiology

Kent Primary Care Agency

Manages a central register of patients.

Makes payments to GPs, pharmacists, dentist and opticians.

Organises breast and cytology screening and sends out invitations to attend

Also

Examines claims for payment.

Administers regulations which prevent pharmacists from setting up in each other's patch.

Overall custody of medical records.

Manages independent conciliation and review process for GPs complaints.

Manages a courier service to GPs.

Appendix 2 -Summary of the Review Process

The Select Committee requested written evidence from each of the health bodies in Kent and from Social Services, these bodies included:-

- The Strategic Health Authority
- Acute Trusts: - Dartford and Gravesham NHS Trust, Maidstone and Tunbridge Wells NHS Trust and the East Kent Hospitals NHS Trust.
- West Kent NHS and Social Care Trust and East Kent NHS and Social Care Partnership Trust.
- Kent Ambulance Trust
- PCTs: - Dartford, Gravesham and Swanley PCT, South West Kent PCT, Maidstone Weald PCT, Swale PCT, Canterbury and Coastal PCT, Ashford PCT, East Kent Coastal PCT and Shepway PCT
- Kent County Council Social Services.
- Non Executive Directors of all the Health organisations.

Hearings:-

Friday, 26 September 2003	Mr Bob Alexander, Director of Finance, Kent and Medway Strategic Health Authority.
	Mr M Bull, Director of Finance, Maidstone and Tunbridge Wells NHS Trust
	Mr D Price, Director of Finance, Maidstone Weald Primary Care Trust
	Mr R Middleton, Director of Finance, South West Kent Primary Care Trust
Friday, 3 October 2003	Jennie Kingston, Director of Finance, Canterbury and Coastal Primary Care Trust
	Mr T Taylor, Director of Finance, East Kent Coastal Primary Care Trust
	Mrs A Sutton, Chief Executive, and Mr. B Jones, Director of Finance – Shepway Primary Care Trust
	Mr J Bates, Director of Finance, Ashford Primary Care Trust
	Mr R Egginton, Director of Finance, East Kent Hospital NHS Trust
	Mr B Allpress, Director of Finance, East Kent NHS and Social Partnership Care Trust
	Mr J Devereux, Director of Finance, Swale Primary Care Trust
	Mr I Davies – West Kent NHS and Social Care Trust
Wednesday, 22 October 2003	Alaisdair Thomson, Assistant Chief Executive, and Rob Peters, Acting Director of Finance, Dartford, Gravesham and Swanley PCT
	Sue Jennings, Chief Executive, and Shipley, Director of Finance, Dartford and Gravesham NHS Trust

	Peter Gilroy, Director of Social Services and Caroline Highwood, Assistant Director – Resources, Social Services
	Hayden Newton, Chief Executive and Paul Traynor, Director of Finance, Kent Ambulance Trust
Friday, 24 October 2003	Darren Grayson, Chief Executive, East Kent Coastal PCT
Wednesday, 5 November 2003 (Visits)	Wilf Williams, Chief Executive, Canterbury and Coastal PCT
	Marion Dinwoodie, Chief Executive, Ashford PCT
	John Mangan, Chief Executive, Swale PCT
	Nigel Howells, Chief Executive, Maidstone Weald
Tuesday, 11 November 2003 – Visit	Rupert Egginton, Director of Finance, East Kent Hospitals NHS Trust
Thursday, 13 November – Visit	Steve Ford, Chief Executive, South West Kent PCT
Monday, 17 November 2003	Bob Alexander, Director of Finance, Marianne Griffiths, Director of Strategic Development , Rebecca Sparks, Director of Development and Partnerships

Mr Noel Plumridge acted as a consultant on this topic review and the Select Committee is grateful for his advice and guidance.

The Select Committee wishes to thank all those who wrote, telephoned, attended hearings or who kindly allowed members of the committee to visit them.

Appendix 3 - Star Rating Targets for Kent Health Organisations

Targets - Kent Ambulance Trust	
	Kent Ambulance NHS Trust
Star Rating	***1 star***
Key Target	
Category A calls meeting 14/19 minute target	✓
Category A calls meeting 8 minute target	-
Financial management	✓
Improving Working Lives	✓
Clinical Focus	
Clinical Negligence	2
Thrombolysis protocols and procedures: Training of paramedic staff	1
Patient Focus	
Category B/C calls meeting national 14/19 minute target	3
GP urgent calls meeting national 15 minute target	3
Patient complaints procedure	1
Capacity and Capability	
Fire, Health and Safety	5
Information Governance	1
Sickness absence rate	3
Staff opinion survey	3

Targets – Acute Trusts and Star ratings

	East Kent	***Maidstone and Tunbridge Wells***	***Dartford and Gravesham NHS Trust***	***Medway NHS Trust***
Star Rating	***1 star***	***0 stars***	***3 stars***	***1 star***
Key Targets				
A&E emergency admission waits (12 hours)	✓	x	✓	✓
Cancelled operations not admitted within 28 days	✓	✓	✓	✓
Financial management	x	x	✓	-
Hospital cleanliness	✓	✓	✓	✓
Improving Working Lives	✓	✓	✓	✓
Number of inpatients waiting longer than the standard	✓	-	✓	x
Number of outpatients waiting longer than the standard	✓	x	✓	✓
Total time in A&E	✓	x	✓	✓
Two week cancer waits	-	✓	✓	✓

Clinical Focus				
Clinical Negligence	4	4	4	4
Deaths within 30 days of a heart bypass operation	n/a	n/a	n/a	n/a
Deaths within 30 days of selected surgical procedures	3	3	3	3
Emergency readmission to hospital following discharge	1	5	5	5
Emergency readmission to hospital following discharge for children	3	3	3	1
Emergency readmission to hospital following treatment for a fractured hip	3	3	3	3
Emergency readmission to hospital following treatment for a stroke	3	3	3	3
Infection control procedures	5	3	3	2
Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia improvement score	3	3	3	A
Thrombolysis treatment time	3	B	3	4
Patient Focus				
A&E emergency admission waits (4 hours)	4	1	2	5
Better hospital food	3	3	5	3
Breast cancer treatment	1	2	5	5
Cancelled operations	3	3	2	B
Day case booking	3	2	4	2
Delayed transfers of care	3	2	1	3
Nine month heart operation waits	n/a	n/a	n/a	n/a
Outpatient A&E survey - access and waiting	3	3	2	2
Outpatient A&E survey - better information, more choice	2	2	2	2
Outpatient A&E survey - building relationships	2	3	2	2
Outpatient A&E survey - clean, comfortable, friendly place to be	3	2	3	2
Outpatient A&E survey - safe, high quality, co-ordinated care	2	2	2	3
Paediatric outpatient did not attend rates	3	4	2	3
Patient complaints procedure	2	3	3	3
Privacy and dignity	5	1	5	1
Six month inpatient waits	2	1	3	1
Thirteen week outpatient waits	2	2	3	3
Total inpatient waits	2	3	4	4
Waiting times for Rapid Access Chest Pain Clinic	3	3	3	5
Capacity and Capability	5			
Consultant appraisal	2	B	5	B
Data quality	3	2	1	2

Fire, Health and Safety	3	3	5	2
Information Governance	2	2	5	3
Junior doctors' hours	3	1	5	3
Sickness absence rate	2	3	3	1
Staff opinion survey	2	3	3	3

Targets – Mental Health Trusts		
	East Kent Community NHS Trust	***West Kent NHS and Social Care Trust***
Star Rating	***1 star***	***2 stars***
Key Target		
Assertive Outreach Team implementation	✓	✓
Community Mental Health Team integration	✓	✓
Mental Health Minimum Dataset implementation	✓	✓
Number of outpatients waiting longer than the standard	✓	✓
Improving Working Lives	✓	✓
Hospital cleanliness	✓	✓
Financial management	-	✓
Clinical Focus		
Clinical negligence	3	5
CPA systems implementation	1	1
Psychiatric re-admissions (adults of working age)	B	A
Psychiatric re-admissions (older people)	B	A
Suicide rate	4	A
Patient Focus		
Transition of care between adult Services and OPMH	5	1
Transition of care between CAMHS and adult Services	5	5
Patients with copies of their own Care Plan	5	5
Patients complaints procedure	1	2
Better hospital food	5	3
Privacy and dignity	5	5
Capacity and Capability		
Missed outpatient appointments	3	3
Crisis Resolution Team implementation	3	4
Out of catchment area treatments (adults)	2	A

Out of catchment area treatments (older people)	2	A
CAMHS service mapping	n/a	3
Data quality	3	A
Staff opinion survey	1	3
Junior doctor's hours	5	5
Consultant appraisal	3	1
Sickness absence rate	2	4
Information governance	4	5
Fire, health and safety	5	5

Legends	
Achieved	**✓**
Under achieved	**-**
Significantly under achieved	**x**
Not applicable	**N/A**

Legend	
Significantly below average	1
Below average	2
Average	3
Above average	4
Significantly above average	5
Not applicable	N/A
Data not available	A
Data not provided	B

Targets – Primary Care Trusts and Star Ratings									
	Ashford PCT	***Canterbury and Coastal PCT***	***Dartford, Gravesham and Swanley PCT***	***East Kent Coastal PCT***	***Maidstone Weald PCT***	***Medway PCT***	***South West Kent PCT***	***Shepway PCT***	***Swale PCT***
Star Rating	***2 stars***	***1 star***	***0 stars***	***2 stars***	***1 star***	***1 star***	***1 star***	***2 stars***	***1 star***
Key Targets									
Access to a GP	✓	-	✓	-	-	✓	-	✓	x
Access to a Primary Care Professional	✓	-	✓	✓	✓	✓	✓	✓	✓
Number of inpatients waiting longer than the standard	✓	✓	✓	✓	✓	x	✓	✓	✓
Number of outpatients waiting longer than the standard	✓	✓	✓	✓	-	-	-	✓	✓
Total time in A&E	✓	✓	✓	✓	x	✓	x	✓	✓
Single Telephone Access - Implementation Plans	✓	✓	x	✓	✓	✓	✓	✓	✓
Four-week smoking quitters	✓	x	✓	-	-	✓	-	✓	✓
Improving Working Lives	✓	✓	x	✓	✓	✓	**N/A**	✓	✓
Financial Management	✓	✓	-	✓	✓	-	✓	-	✓
Access to Quality Services									
Emergency readmission to hospital following treatment for a fractured hip	3	3	3	3	3	3	3	3	3
Substance Misuse – Percentage of GP practices in a shared care scheme	3	3	3	3	4	2	3	2	2
Sexual health - Access to services for early unintended pregnancy	5	5	5	4	5	4	4	5	5

Targets – Primary Care Trusts and Star Ratings									
Level of 24 hour access to specialist mental health services	4	4	3	4	3	3	3	4	3
A&E Emergency admission waits (12 hours)	3	3	5	3	1	3	1	3	3
Twelve month heart operation waits	5	5	5	5	5	5	5	5	5
Delayed transfers of care	3	3	2	3	2	3	3	3	3
Access to NHS Dentistry	5	5	5	5	5	5	5	5	5
PCT Survey - Access and waiting	4	3	2	3	2	2	4	3	3
PCT Survey - Better information, more choice	3	3	2	3	3	2	3	2	1
PCT Survey - Building closer relationships	3	3	3	3	4	2	5	2	1
PCT Survey - Clean, comfortable, friendly place to be	3	3	2	3	3	2	4	2	2
PCT Survey - Safe, high quality, co-ordinated care	3	2	3	3	3	2	4	3	1
Prescribing of atypical antipsychotics	4	4	5	3	4	3	4	4	3
Improving Health									
Death rates from circulatory diseases, ages under 75 (change in rate)	3	3	3	3	3	3	3	3	3
Death rates from accidents, all ages (change in rate)	3	3	3	3	3	3	3	3	3
Death rates from cancer, ages under 75 (change in rate)	3	3	3	3	3	3	3	3	3
Breast Cancer Screening	3	3	3	2	4	3	3	3	3
Cervical Screening	4	3	3	3	4	3	4	3	3
Flu Vaccinations	5	2	2	3	3	2	3	2	2
Teenage pregnancy – Conceptions	3	3	3	3	3	3	3	3	3

Targets – Primary Care Trusts and Star Ratings									
below age 18 (change in rate)									
Diabetes services baseline assessment	5	5	5	5	1	5	5	5	5
CHD Audit	5	3	2	5	3	5	3	5	5
Suicide audit	5	5	5	5	5	5	5	5	5
Service Provision									
Emergency admissions (change in rate)	3	1	4	5	5	5	5	3	5
Emergency admission to hospital for children with lower respiratory tract (LRT) infections (change in rate)	3	3	3	3	3	3	3	3	3
Primary Care Management - Acute conditions (change in rate)	2	3	2	3	3	3	3	3	3
Primary Care Management - Chronic conditions (change in rate)	3	3	3	3	3	3	5	3	3
Community equipment	3	3	2	5	2	2	2	3	2
Patient complaints procedure	2	4	3	3	4	2	3	3	2
Prescribing rates of antibacterial drugs	3	3	2	2	3	2	4	2	2
Prescribing rates for drugs acting on benzodiazepine receptors	5	4	3	2	4	3	3	3	1
Staff opinion survey	1	3	3	3	3	3	4	4	2
GP Appraisal	2	5	5	5	2	5	2	5	5
Sickness absence rate	3	2	2	3	B	2	4	4	1
Fire, Health and Safety	3	5	5	5	5	5	5	5	5
Generic prescribing	3	3	3	4	3	3	4	3	3

Appendix 4 – Letter from Chief Executive of East Kent NHS and Social Care Partnership Trust

Included with the kind permission of David Parr, Chief Executive.
Circulation to All EKPT Staff

17 November 2003

Dear Colleagues

TRUST FINANCIAL POSITION

I am writing to update you on the latest financial position and the measures we are developing to address it. Also, I hope that this letter will dispel any speculation that may have arisen and clarify the situation.

The key messages remain the same ie:-

- The Trust is incurring a significant overspend in the current financial year, currently forecast at £1.75m, by year end (31 March 2004)

- This is due to cost pressures, such as the high cost of medical locums and drugs and because the Trust has been unable to find all of the cash releasing efficiency savings required of us in recent years from the annual financial settlement (Local Delivery Plan)

- Next year's Local Delivery Plan will demand more efficiency savings from the Trust so if we do not take action now, the 2004/05 overspend will be even higher.

- In addition, any overspend this year will have to be repaid next year, further increasing the potential overspend.

- It is therefore vital that further steps are taken now to reduce the current year's overspend and to put the Trust in a position as early in the new year as possible where we can be confident of financial balance.

I am in no doubt of the enormity of these challenges, but we must find ways to quickly bring expenditure into line with income. So, what are we doing about this situation?

First of all we are taking steps to minimise this year's overspending. You already know about vacancy management; and non-pay expenditure controls, and the efforts to control out of area placements. In addition we are:-

- Reducing the expenditure on medical locums, either by recruiting permanent staff into these posts, or, in some cases, managing without a locum post, taking into account the effects on medical rotas, service to patients and workload on other colleagues

- "Mothballing" one of our sub-acute wards providing we can find suitable alternative care for the patients and redeploying the staff. At the moment,

we propose that this would be implemented for Gregory Ward at St Martins

- Re-aligning locality intake teams in Younger Adults to a sectorised arrangement

- Participating in a “Peer Review” with our colleagues in West Kent Mental Health and Social Care Trust. We hope this review might identify areas where savings or efficiencies can be realised.

- Reducing by 50% our currently high transport costs for Older Peoples’ Mental Health (OPMH) day hospitals

- Undertaking a review of management and administration costs

These measures should enable the Trust to report a lower overspend at the end of the year, but they will be insufficient to solve the underlying problem. This requires some fairly significant reconfiguration of how and where our services are provided.

Fortunately in this respect we have some additional funding from the PCTs to enable us to introduce a Crisis Resolution and Home Treatment Service (CRHT) in Adult Services and this should provide the catalyst for change. In other areas of the country similar services have significantly improved both patient care and cost structures.

The CRHT will form the basis of our longer term strategy. For staff it will mean some changes as the emphasis shifts more towards supporting patients in the community rather than in hospitals. Structurally, therefore, we are likely to need fewer beds. Life will be better for patients as many of them will increasingly be cared for in the community and at home; and financial savings will be achieved through the reduced cost of fabric and through lower expenditure on temporary nurses and doctors.

We are currently developing more detailed plans as to how these savings will be achieved and will share these with you when available.

At this stage there is no expectation of staff redundancies but there will be a requirement for all staff to embrace full the modernisation agenda and look to new ways of working so that we can continue to provide high standards of care for the patients we serve.

Undoubtedly, some in-patient capacity will be reduced. We are currently examining a scheme whereby OPMH patients in Kelston could be re-provided, enabling the building to be re-used as a ‘Step Down’ facility in Adult Services. We want to achieve this in parallel with a developing CRHT to provide opportunities to review bed usage and configurations across the services.

So that is how things stand now. We have been working alongside our staff side representatives and the next steps will be to consult with you in each locality. Where staff groups are directly affected we will hold face to face discussions in the next week. In addition, we will hold a staff forum in each locality during the next few weeks, where you will have the opportunity to discuss these issues with managers and staff side representatives.

Once again, thank you for your continued co-operation during this very challenging period. I am very aware of all the efforts you have already made and know you will understand our need to search for even more solutions.

Yours sincerely

David Parr

David Parr
Chief Executive

BACKGROUND MATERIAL

Shifting the Balance of Power: The Next Steps, Department of Health

Reforming NHS Financial Flows, introducing payment by results (October 2002), Department of Health.

Improvement, Expansion and Reform: The Next 3 Years. Priorities and Planning Framework 2003 – 2006, Department of Health.

Resource Allocation Weighted Capitation Formulas (June 1999), Department of Health.

Report of the Advisory Committee on Resource Allocation 1998 (July 1999), Department of Health.

Health Authority Revenue Resource Limits 2002/03, Health Service Circular 2001/024 (December 2001), Department of Health

History of the Staff MFF, RAWP 1, Department of Health

Population Data for Allocations, RAWP 2, Department of Health

The years of life lost index and the health inequalities adjustment, Department of Health.

Kent County Council Response to consultation on proposals to introduce a system of reimbursement around discharge from hospital 18/09/02.

Report to Social Care and Community Health Policy Overview Committee – 21 November 2002. A Preliminary review of the Social Services budget position for 2003-04.

Procurement and Support (May 2002), Audit Commission

New NHS Resources, Secretary of State for Health announces new allocations. Hansard, 11 December 2002.

NHS Resources, Lord Hunt of Kings Heath announces changes to the allocation formula. Hansard, 11 December 2002.

West Kent Health Improvement Programme 2000 – 2003.

Securing our Future Health: Taking a Long-Term View. Derek Wanless, April 2002.

Kent and Medway Strategic Health Authority Board Papers, 27 November 2002.

Shifting the Balance of Power: The Next Steps, Department of Health

Reforming NHS Financial Flows, introducing payment by results (October 2002), Department of Health.

Improvement, Expansion and Reform: The Next 3 Years. Priorities and Planning Framework 2003 – 2006, Department of Health.

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NHS Resources, Lord Hunt of Kings Heath announces changes to the allocation formula. Hansard, 11 December 2002.

West Kent Health Improvement Programme 2000 – 2003.

Securing our Future Health: Taking a Long-Term View. Derek Wanless, April 2002.

Kent and Medway Strategic Health Authority Board Papers, 27 November 2002.

GLOSSARY OF TERMS

Acute Care	Medical and surgical treatment usually provided by a hospital – acute sector is anywhere where acute care can be given.
EFL – External Financing LImit	A calculation of the actual cash needed to finance capital expenditure, after taking into account depreciation, leases, grants and sales.
Electronic Booking System	• Provides means for GP and patient to identify the choices available • Enables patient to choose by booking with preferred provider • Electronic booking will be accessible to GPs and the primary care team • After seeing their GP, Patients will be able to access the system through the internet and telephone.
HRG	Healthcare Resource Group – groupings of treatment episodes which are similar in resource use and in clinical response.
Improving Working Lives	This was a key target for 2002/3,to achieve Improving Working Lives (IWL) Standard 'practice' or 'pledge' status (dependent on formation date of the organisation) by 31 March 2003. Pledge status requires a public commitment to work towards delivering the standard; practice status requires clear evidence that the organisation is delivering against the standard. The IWL standard is reached by health organisations compiling evidence to prove that NHS as an employer:- • Recognises that modern health services require modern employment services • Understands that staff work best for patients when they can strike a health balance between work and other aspects of their life outside work • Accepts joint responsibility with staff to develop a range of working arrangements that balance the needs of patients and services with the needs of staff • Values and supports staff according to the contribution they make to patient care and meeting service needs • Provides persona and professional development and training opportunities that are accessible and open to all staff irrespective of their working patterns • Has a range of policies and practices in place that enable staff to manage a health balance between work and their commitments outside work.
MFF	Market forces factor
NHS Bank	An organisation set up by the Department of Health to support health organisations going through periods of change. • Comprises 4 SHA Chief Executives • 4 Strategic Directors • DoH National Director of Finance. They formulate terms and conditions for repayment of loans which will be agreed with the relevant Strategic Health authority. The Bank was granted £100m as 'special assistance' funding, to support parts of the

	health economy that are experiencing difficulties in the short term. It is to acknowledge that structural changes will need extra temporary support. In 2002/3, the first year of operation it supported these areas:- Avon, Gloucester and Wiltshire Surrey and Sussex, Bedfordshire and Hertfordshire In 2003/4 it has supported:- Avon Gloucester and Wiltshire Surrey and Sussex Kent and Medway Thames Valley
NICE	National Institute of Clinical Excellence
NSF	National Service Framework
PCG	Primary Care Group
PRICCE Primary Care Clinical Effectiveness Project	Primary Care Clinical Effectiveness Project. This programme sources the most cost effective drugs over 14 main disease areas:- Angina Heart disease including angina, hypertension, atrial fibrillation, chronic heart failure Diabetes Epilepsy Urinary Tract Infection Venous Leg Ulcers Asthma Dyspepsia Osteoporosis Stroke Benzodiazepenes Colorectal Cancer Palliative care Menorrhagia Chronic Obstructive Pulmonary Disease
Primary Care	The first port of call for patients when they develop a health problem – generally a general practitioner (GP) Also includes NHS Direct and NHS walk-in centres
Public Service Agreements	The Government introduced Public Service Agreements (PSAs) in 1998, setting ambitious goals for key service improvements across the whole of Government. PSAs outline what departments plan to deliver in return for the significant extra investment in public services over the next three years as set out in the 2002 Spending Review White Paper. In each area of service delivery from housing to education, from policing to defence, new resources are tied to new reform and results, developing a modern way of running good efficient public services. This requires effective monitoring of performance through independent and open audit and inspection; giving front line staff the power and flexibility to deliver results; extending choice; rewarding success and turning round failing services and organisations.

	PSAs provide demanding national targets reflecting the Government's key priorities and focusing on the outcomes that matter most to the public - on education, health, crime and transport and right across public services. Departments produce delivery plans for all the targets, with clear milestones and trajectories showing how the targets will be met, which are summarised in published Service Delivery Agreements. PSAs represent an agreement between the Government and the public. Accountability is key. Previously departments have published progress against their targets annually. From now on, they will provide these reports twice a year. The aim of PSAs is to focus efforts and help to deliver results.
Resource Allocation Budgeting	Published in February 2001, this document marked a new way of accounting for NHS organisations. Under the old cash based Government accounting systems, income was shown when cash was received; and costs were shown when payment was made. All receipts and payments made in the financial year were included in the cash accounts for that period. Resource allocation budgeting changed this to the form of accounting with accruals and capital accounting. The DH also introduced new rules for health organisations with regard to keeping in financial balance.
Secondary Care	Specialised treatment usually provided by a hospital; secondary sector refers to anywhere where secondary care can be given.
Tertiary care	Tertiary care is a specialised health service which will not have a centre in every SHA area, for example for Kent patients, kidney transplants or neuro-surgery.
Weighted Capitation	The weighted capitation formula is used to inform revenue allocations to primary care trusts (PCTs) for 2003/04 to 2005/06. In those three years, the formula has been applied to some £148 billion. This represents a significant proportion of public expenditure. The Weighted capitation formula is based primarily on population figures from the most up to date census, up-dated each year for projected population and demographic changes
Weighted Capitation Formula	The weighted capitation formula is used to determine Primary Care Trust's target shares of available resources to enable them to commission similar levels of health care for populations with similar healthcare need. It has five components:- • Hospital and Community Health service • Prescribing • General practice infrastructure • HIV/AIDs • General Medical Services - non cash limited. Each component is used to produce a weighted population for each PCT and these weighted populations are converted into monetary targets.