HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 8th January, 2010

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 8th January, 2010, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

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

Tea/Coffee will be available from 9:45 am

Membership

Conservative (10):

Labour (1):

Liberal Democrat (1):

District/Borough Representatives (4):

UNRESTRICTED ITEMS

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

Item		Timings
1.	Substitutes	
2.	Declarations of Interests by Members in items on the Agenda for this meeting.	
3.	Minutes	
4.	Dentistry (Pages 1 - 42)	
5.	Further Information on Out of Hours Services (Pages 43 - 60)	
6.	Date of next programmed meeting – Friday 5 February 2010	

EXEMPT ITEMS

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

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

30 December 2009

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

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 8 January 2010

Subject: Item 4. Intended Outcomes: Dentistry.

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1. Background

(1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on the outcomes it would like to achieve. Another has been the need to make the work of the Committee more accessible to members of the public.

(2) This paper is intended to be a way to progress towards achieving these twin aims. Two sets of questions are set out below, both of which the meeting will look to having answered by the end of the meeting: one for members of the public and the other for the Scrutiny Committee.

2. Outcomes for the Dentistry Agenda Item

(1). Public Question

a) How can I access NHS dentistry and be certain I will receive quality treatment?

(2). Scrutiny Questions

a) Are the Primary Care Trusts commissioning sufficient dental provision to meet the needs of their resident populations?
b) Is the care being provided of an appropriate quality?
c) What can be done to improve dental service provision in Kent?

3. Background Questions

(1) The following questions are those that have been asked in advance of the meeting:

(a) Questions asked of NHS Eastern and Coastal Kent and NHS West Kent:

1. Please provide some key facts about the levels and types of dentistry activity in your PCT area, including:
    a. Numbers of dentists providing NHS dental treatment, and the percentages working under the different types of contract;
    b. Numbers of dentists providing NHS dental services to children but not adults;

c. Information on the levels of dental activity (Units of Dental Activity) and Courses of Treatment, broken down into patient type (i.e. adults and children); and
d. Total number of patients seen by an NHS dentist, and what this is as a proportion of the resident population.

(For comparison purposes, could the above information be provided for 2007/8 and 2008/9 along with the most current information you have)

2. How much is spent on commissioning dental services and how do dentists receive remuneration for providing services?
3. How are dentists remunerated for carrying out preventive work?
4. Does the PCT provider arm provide any dental services directly?
5. What information can be provided on the state of children's oral health in your PCT, and how this has changed over time?
6. Who provides out of hours dental services and how do patients access these?
7. What is the patient pathway for those with advanced oral health needs (such as cancer, and/or courses of treatment involving referral to a consultant)?
8. Are there any particular geographical areas where there are issues around commissioning adequate dental provision?
9. Are there any particular times of year where there are issues around commissioning adequate dental provision?
10. What are the challenges faced by PCTs in commissioning adequate dental provision and what plans does the PCT have to develop dental services in the future?
11. What powers of prescription do dentists have and how much prescribing is carried out by them?
12. Please provide the following information relating to customer services (including information from PALs):
    a. How many enquiries are received each quarter relating to dental services and what trends can be identified regarding the nature of these enquiries?
    b. How many complaints/compliments/comments have been received about accessing dental services?
    c. How many complaints/compliments/comments have been received about the quality of dental services?
    d. How has information from customer services about dentistry informed service development?

(b) Questions asked of LINk:

1. From the information received by LINk, have any trends emerged about the problems faced by people in Kent in accessing dental services, and any specific areas of the county where issues exist?
2. From the information received by LINk, have any trends emerged about the problems faced by people in Kent in the quality of the dental services provided?
3. Is the LINk involved in, or planning to get involved in, any work relating to dentistry in Kent?

(c) Questions asked of the Local Dental Committee:

1. Does the Local Dental Committee consider that the provision of dentistry in Kent is sufficient to meet the needs of the people in Kent?
2. Is the provision of NHS dentistry uniform across the county, or are there some areas where issues exist?
3. If the answer is no to either of the questions above, what does the Local Dental Committee consider to be the main issues limiting dental provision in Kent?
4. What suggestions does the Local Dental Committee have for improving dental provision?
5. A list of the key questions which we have asked NHS Eastern and Coastal Kent and NHS West Kent is attached to this letter. This is for your information, but if there are any areas about which you would like to provide additional information, please do so.

4. Recommendations

(1) The Committee is asked to assess whether the outcomes in section 2 above have been achieved or if further information on this topic is required by the Committee.

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By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee – 8 January 2010

Subject: Dentistry

Introduction

In 2006, a new system of dentistry was introduced. There were three main components:

- Three payment bands were brought in to replace a system of around 400 possible charges.
- Responsibility for commissioning services was devolved to local Primary Care Trusts (PCTs).
- A new General Dental Services (GDS) contract was introduced. The previous system had been based on dentists receiving fees for items of service. Under the new system, dentists would now be paid an annual sum in return for delivering an agreed number of courses of treatment (UDAs, or Units of Dental Activity).

The charges for the different bands of treatment from 1 April 2009 are:

- Band 1. £16.50. "This covers an examination, diagnosis (e.g. X-rays), advice on how to prevent future problems, a scale and polish if needed and application of fluoride varnish or fissure sealants. If you require urgent care, even if your urgent treatment needs more than one appointment to complete, you will only need to pay one Band 1 charge."
- Band 2. £45.60. "This covers everything listed in Band 1 above, plus any further treatment such as fillings, root canal work or if your dentist needs to take out one or more of your teeth."
- Band 3. £198.00. "This covers everything listed in Bands 1 and 2 above, plus crowns, dentures or bridges."[1]

There are various groups that are exempted from dental charges (including those under 18), or who receive help with costs.[2]

Charges offset 29% of the cost of NHS dentistry[3]. In 1997/8, NHS dentistry accounted for 2.9% of NHS net expenditure. By 2007/08, this had reduced to 2.1%.[4]

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[1] All quotations relating to bands taken from Department of Health leaflet, "NHS dental services in England", http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_096611.pdf

[2] Ibid, this leaflet also contains details of exemptions.

[3] NHS Dental Services in England, An Independent Review led by Professor Jimmy Steele, Department of Health, June 2009, p.25,

Dental Commissioning

Primary Care Trusts commission most dental services through either a GDS (General Dental Service) or PDS (Personal Dental Service) contract.

PCTs can also commission services of a more specialist nature through the DwSIs (Dentist with Special interest scheme) – the scheme was launched with four initial key competencies, Orthodontics, Minor Oral Surgery, Endodontics, and Periodontics.[5]

Alongside the independent contractors there are a number of dentists who work as salaried dental primary care dentists. They often provide generalist and specialist dental care for vulnerable groups and are involved in public health work.[6]

Under the new GDS contract that was introduced in 2006, a provider is contracted to undertake a specified number of Units of Dental Activity (UDAs). There is no specified number of patients who must receive treatment. This number can sometimes be provided before the end of the contract period. If a provider has not undertaken all the UDAs by the end of the contract period, money can be 'clawed back' by the PCTs.

A dentist is awarded 1, 3, or 12 UDAs for each course of treatment, depending on its complexity:

- Band 1 treatment = 1 UDA
- Band 2 treatment = 3 UDAs
- Band 3 treatment = 12 UDAs
- Urgent treatment = 1.2 UDAs[7]

As a result of the way the transition from the old to the new contracts was regulated, there is no set value for 1 UDA. In other words, different dentists receive differing amounts of money for delivering a course of treatment. The average is £25, with a range of between £17 and £40.[8]

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http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101180.pdf

[4] Ibid, p.30.

[5] Details of the different contracts can be accessed through the Primary Care Commissioning website, http://www.pcc.nhs.uk/89.php. Information can also be found in the British Dental Association's Independent Local Commissioning Working Group Report, available here: http://www.bda.org/dentists/policy-research/bda-policies/local-commissioning/index.aspx

[6] Salaried Primary Dental Care Services (SPDCS) were formally known as Community Dental Services.

[7] NHS Dental Services in England, An Independent Review led by Professor Jimmy Steele, Department of Health, June 2009, p.68, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101180.pdf

[8] Ibid, p.28.

The same dental practice is currently allowed to provide both NHS and private dental services. There is no prescribed list of what treatments should be offered on the NHS.[9]

While there has never been a requirement for a patient to 'register' with an NHS dentist, between 1990 and 2006, a portion of a dentists' remuneration was linked to the number of patients registered. "Since 2006, this feature of the remuneration system has no longer applied, but this does not prevent patients from receiving continuity of care."[10]

The Impact of the New Contract

There has been a lot of discussion about the impact the new GDS contract, both prior and subsequent to its introduction on 1 April 2006.

On the introduction of the new contract, around 4% of NHS provision was lost with some dentists choosing to convert to private care[11].

One of the higher profile pieces of work to have been carried out on the impact of the new contract was a report by the House of Commons Health Select Committee published in June 2008[12].

The interim Government response was published in October 2008 with the final response published in January 2009[13]. In the interim report, the Government confirmed that it would carry out "a review of how dental services should develop over the next five years and what action is needed to ensure that, nationally and locally, dental commissioning evolves continuously to reflect public needs."[14]

In December 2008, The Secretary of State for Health (then Alan Johnson MP), asked Professor Jimmy Steele to undertake this independent Review of

[9] NHS Dental Services in England, An Independent Review led by Professor Jimmy Steele, Department of Health, June 2009, pp.22-23, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101180.pdf

[10] Government Response to the Health Select Committee Report on Dental Services, October 2008, p.18, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_088997.pdf

[11] NHS Dental Services in England, An Independent Review led by Professor Jimmy Steele, Department of Health, June 2009, p.14, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101180.pdf

[12] House of Commons Health Select Committee, NHS Dentistry, July 2008, http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/289/28902.htm

[13] Both Government responses can be accessed here: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093318

[14] Government Response to the Health Select Committee Report on Dental Services, October 2008, p.20, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_088997.pdf

NHS Dental Services in England. This was published in June 2009. The executive summary and key recommendations of this independent review are appended to this Briefing Note.[15]

Staff Numbers

The workforce statistics which are collected by The Information Centre for Health and Social Care provide a breakdown of dentists by contract and dentist type, as well as by gender and age. A selection of this information is provided below.

Table 1: Population per dentist and dentists per 100,000 of population[16]

Area	*Population per dentist*		*Dentists per 100,000 of population*	
	2007/08	*2008/09*	*2007/08*	*2008/09*
England	2,455	2,394	41	42
South East Coast SHA	2,052	1,998	49	50
NHS Eastern and Coastal Kent	2,422	2,422	41	41
NHS West Kent	2,242	2,176	45	46

Table 2: Total number of dentists with NHS activity[17]

Area	*Total number of dentists with NHS activity*		
	2007/08	*2008/09*	*% difference*
England	20,815	21,343	2.5
South East Coast SHA	2,087	2,144	2.7
NHS Eastern and Coastal Kent	300	300	0.0
NHS West Kent	298	307	3.0

Access to Dentistry

The data that the NHS collects centrally on how many people have accessed NHS dentistry is given as a total number and as a percentage of the population receiving treatment in a given PCT area that have been seen by an NHS dentist in the previous two years.

[15] The full version of the report and associated material can be accessed here: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101137

[16] The Information Centre for Health and Social Care, NHS Dental Statistics for England 2008/09, http://www.ic.nhs.uk/webfiles/publications/Primary%20Care/Dentistry/dentalstats0809/NHS_Dental_Statistics_for_England_2008_09_Annex_2a_PCT_Factsheet.xls

[17] Ibid.

Table 3: Number of total patients seen in the previous 24 months ending at the specified dates (percentage of population in brackets)[18]

Area	*31 Mar 2006*	*30 Sep 2008*	*30 Sep 2009*
England	28,144,599 (55.8)	27,033.495 (52.9)	27,873,252 (54.2)
NHS Eastern and Coastal Kent	351,681 (49)	333,034 (45.8)	349,071 (47.7)
NHS West Kent	319,438 (48.7)	265,231 (39.7)	271,873 (40.3)

Table 4: Number of total child patients seen in the previous 24 months ending at the specified dates (percentage of population in brackets)[19]

Area	*31 Mar 2006*	*30 Sep 2008*	*30 Sep 2009*
England	7,796,750 (70.7)	7,594,160 (69.1)	7,658,923 (69.6)
NHS Eastern and Coastal Kent	107,656 (67.9)	101,004 (63.8)	101,817 (64.4)
NHS West Kent	112,146 (74)	94,538 (62)	94,720 (61.7)

Care Quality Commission

As part of the Annual Health Check carried out by the Care Quality Commission for 2008/09, Primary Care Trusts were given an overall grade for 'quality of commissioning services'. This grade is either:

- Excellent (2.0%)
- Good (50.7%)
- Fair (44.7%)
- Weak (2.6%)

The numbers in brackets refer to the percentage of Primary Care Trusts that were awarded each grade.

It should be noted that the Annual Health Check 2008/09 covered performance for the year ending 31 March 2009.

This grade is aggregated from separate grades for 'meeting core standards', 'existing commitments', and 'national priorities' (which in turn have a number of component parts).

One of the 23 national priorities which PCTs were assessed about is 'Access to primary dental services'. The rationale for this, as expressed by the Care Quality Commission, is as follows:

> "According to guidelines issued by the National Institute for Clinical Excellence (NICE, 2004), the recommended longest period a patient

[18] The Information Centre for Health and Social Care, NHS Dental Statistics for England Q1 30 June 2009, http://www.ic.nhs.uk/webfiles/publications/Primary%20Care/Dentistry/dentalstats0910q1/NHS_Dental_Statistics_for_England_Quarter_1_30_June_2009_Annex_2a_PCT_Factsheet.xls

[19] Ibid.

over the age of 18 should go without an oral review is 2 years. However, many patients experience difficulty in accessing a NHS dentist, and recent figures show that during the 24 months leading up to 31 March 2008, only 53.3% of the total population of England were seen by an NHS dentist (NHS Dental Statistics England, 2007/2008, published by the Information Centre). Of the remaining population, some patients will opt to receive private treatment, a proportion of which, in itself, is likely to be a direct result of difficulty accessing an NHS dentist. A recent survey commissioned by the Citizens Advice Bureau estimated that approximately 7.4m people in England and Wales say they would like to access NHS dentistry, but cannot. Of these, 2.7m say they are not able to access a dentist at all. Consultations by two SHAs have shown that the public consider this to be a major problem for the NHS to resolve.

"The Government has responded to this issue of access by increasing funding for NHS dentistry in England from April 2008, by 11 per cent, as part of the comprehensive spending review. The NHS 'Vital Signs' framework contains an indicator in the second tier (national priorities for local delivery) to measure improvements in access to primary dental care. PCTs will therefore be assessed on their performance in terms of access to NHS dental services using data compiled centrally by the Dental Services Division of the NHS Business Authority and the NHS Information Centre. PCTs will be expected to demonstrate improvement in 24-month access to a NHS dentist against a baseline of the two year period ending 31 March 2006, when the new dental contract system was introduced.

"Numerator
The number of patients seen in the 24 month period ending 31 March 2009

"Denominator
The number of patients seen in the 24 month period ending 31 March 2006

"Indicator
The indicator is the numerator divided by the denominator, expressed as a percentage.

"Data source and period
NHS Dental Statistics, England, financial year 2008/2009."[20]

In relation to the indicator explained above, PCTs were given one of the following grades:

- Achieved (for an indicator greater than or equal to 99%)
- Under Achieved (for an indicator greater than or equal to 90%)

[20] Care Quality Commission, Access to primary dental services, http://www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/annualhealthcheck2008/09/qualityofservices/exis/accesstoprimarydentalservices.cfm

- Failed (for an indicator less than 90%)

Table 5: Annual Health Check Scores for 'Access to primary dental services' 2008/09

Primary Care Trust	*Quality of commissioning services*	*Access to primary dental services*	
		Performance	*Indicator value*
Eastern and Coastal Kent[21]	Fair	Under Achieved	98.11%
West Kent[22]	Fair	Failed	83.78%

Some Key Organisations

Local Dental Committees – Established in 1948, LDCs became statutory bodies in 1977. "Primary care trusts/health boards consult with LDCs on matters of local dental interest and, following the NHS reforms in 2006, local commissioning and developments in the provision of NHS dental services."[23]

British Dental Association – Founded in 1880, the BDA is the professional association and trade union for dentists in the United Kingdom. It has a voluntary membership of around 23,000[24].

General Dental Council – "Anybody who wants to work in the UK as a dentist, dental nurse, dental technician, dental hygienist, dental therapist, clinical dental technician or orthodontic therapist must be registered"[25] with the GDC.

Care Quality Commission – From April 2010, all NHS Trusts must be registered with the CQC. "From April 2011, primary care services that directly provide dentistry (NHS and private) must be registered."[26]

[21] Care Quality Commission, Performance ratings for 2008/09, NHS Eastern and Coastal Kent, http://2009ratings.cqc.org.uk//findcareservices/informationabouthealthcareservices/overallperformance/searchfororganisation.cfm?cit_id=5QA&widCall1=customWidgets.content_view_1
[22] Care Quality Commission, Performance ratings for 2008/09, NHS West Kent, http://2009ratings.cqc.org.uk//findcareservices/informationabouthealthcareservices/overallperformance/searchfororganisation.cfm?cit_id=5P9&widCall1=customWidgets.content_view_1
[23] British Dental Association, Local Dental Committees, http://www.bda.org/dentists/representation/gdps/ldcs/index.aspx
[24] For further information, see http://www.bda.org/.
[25] General Dental Council, Who we regulate, http://www.gdc-uk.org/About+us/Who+we+regulate/
[26] Care Quality Commission, Who needs to register?, http://www.cqc.org.uk/guidanceforprofessionals/registration/newregistrationsystem/whoneedstoregister.cfm

Appendix: Executive summary and key recommendations of *NHS dental services in England An independent review led by Professor Jimmy Steele, June 2009*[27]

"Oral health should be for life. The two common dental diseases, dental decay and gum disease, are chronic and the damage they cause is cumulative and costly. The NHS in 2009 is still dealing with, and paying for, the consequences of disease that developed more than 50 years ago. The trends in disease prevalence and the way it has been managed are visible in the oral health of different generations. We still need to deal with this burden of the past and manage the demands of the present, but keep a very clear focus on the future so that we can minimise the risk, discomfort and costs for future generations.

Almost everyone in the population is a dental patient at some time and, for many, a dental visit is a regular occurrence. But not everyone is the same and providing for the varying needs and aspirations of all of the consumers of dental care is a particular challenge. Clarifying what it is that NHS dentistry offers, what the NHS commissions, what dentists provide and what patients get is an essential step in this process.

Much NHS dentistry is already outstanding, reflecting the quality of the workforce. The basic structures we have in place now provide the opportunity to move on to the next, and most challenging, stage.

Just as health is the desired outcome of the rest of the NHS, so health should now be the desired outcome for NHS dentistry, while good oral health and the quality of the service should be the benchmarks against which success is measured. Through the NHS, dentistry could take a huge step forward but in order to do that, one concept is critical. So long as we see value for taxpayers' money as measured by the production of fillings, dentures, extractions or crowns, rather than improvements in oral health, it will be difficult to escape the cycle of intervention and repair that is the legacy of a different age.

Making the transition from dental activity to oral health as the outcome of the NHS dental service will be a challenge for everybody, but it is essential if NHS dentistry is to be aligned with the modern NHS. In this review we have tried to set out a framework for care and we have tried to provide a rationale for that framework.

In doing so we were also mindful of the current economic circumstances. Ensuring an efficient and well-aligned service was an underpinning principle in the way we approached our task.

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[27] NHS Dental Services in England, An Independent Review led by Professor Jimmy Steele, Executive Summary, Department of Health, June 2009, pp.2-5, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101181.pdf

A better service for patients: accessible and high quality

Access to care is a problem, but not a universal problem, as it tends to be concentrated in particular areas of the country. The Department of Health (DH) access team is working alongside the review team to address these issues. **We recommend the continuation of this process but that the access programme uses the opportunity for new procurement to pilot some of the key components of our recommendations.**

However, perceptions of problems with access are compounded by simple problems of information. People are uncertain how to find a dentist and the information they require is often not available in the right places, is not co-ordinated or is not kept up to date.
PCTs and the NHS should communicate clearly how people might find a dentist through the most appropriate media and what to expect from a dentist when they get there. This is much more a matter of organisation than resource and would make a big difference to patients and their perceptions of access. People have a right to access an NHS dentist; the NHS now needs to work to make this a reality and to extend this to a meaningful oral health service.

Good oral health depends on more than just access: prevention and high-quality provision are also essential. These are related concepts which depend on the dental profession and the dental team working towards a common oral health goal. The clarity of that goal is important.

We have identified an approach to allow the NHS offer to dental patients to be based on some basic national priorities. **We recommend that NHS primary care dentistry provision should be commissioned and delivered around a staged pathway through care which supports these priorities.** The proposed pathway allows and encourages continuity of the relationship between patients and dentists, for those who want it, built around the most appropriate recall interval for the patient and uses oral health as an outcome.

Continuity of care matters to patients and to dentists. It is important in building a relationship of trust and a philosophy of lifelong care. This is at the heart of the pathway, but a continuing care relationship implies responsibilities and rights on both sides. **We recommend that patients registered in a continuing care relationship with a practice have an absolute right to return to that practice for both routine and urgent care.**

Not everyone wants to have a continuing care relationship with a dentist and it is important that their needs are met too. Provision of urgent care is a fundamental responsibility for the NHS and for PCT commissioners and **we recommend that urgent care services should be accessible and commissioned to a high and consistent level of quality**.

While meeting local need is important, the level of variation in the quality of care is too great. The basics of good practice are well understood. **We recommend that strong clinical guidelines are developed to support dentists and patients through specific pathways of treatment.** These would allow determination of thresholds for treatment, ensuring that some of the costly and complex care can be targeted to the patients where it will provide greatest benefit.

As dentists are paid as professionals to perform high-quality services, neither the patient nor the taxpayer should bear the cost of unnecessary premature failure of restorative care. **We recommend that the free replacement period for restorations should be extended to three years and that the provider should bear the full cost of replacement rather than the PCT or the patient.**

Aligning the contract to improve access and quality

The incentives for dentists are not as precisely aligned as they could be to a goal of oral health and consequently there are inefficiencies within NHS dentistry. The pathway we describe should be supported by an altered contractual structure for dentists.

We therefore recommend that dental contracts are developed with much clearer incentives for improving health, improving access and improving quality.

The basic structure of the existing contract is quite flexible and we suggest that much could be achieved within existing regulations or with relatively minor adjustments.

We recommend that the current contract is developed specifically to allow payments for continuing care responsibility, blended with rewards for both activity and quality. We further recommend that these are piloted and then nationally applied.

There are limited incentives for dentists to see patients and to take on new patients. As part of the blended contract system **we specifically recommend introducing an annual per person registration payment to dentists within the contract** to provide greater security for dental practices, and greater accountability on all sides.

For the 60 years that NHS dentistry has been in existence the focus of the service has been mainly on treatment rather than prevention or quality. This means that there is little visible reward for good dentists who are improving oral health and providing a service that patients like, and little sanction for poor ones. **We recommend that the quality of a service and the outcomes it achieves are explicitly recognised in the reward system of the revised contract.**

To do this there will need to be robust measures of quality. These will need continuous development and should concentrate on oral health outcomes and patients' perceptions of quality. This process has started and **we recommend that a high priority is given to developing a consistent set of quality measures**. Local PCTs should not need to develop their own quality measures – this represents a waste of resource that could be used elsewhere.

What the NHS has to do

The process and skills in commissioning dental services have been highly variable. There are excellent examples but the standard of all commissioning needs to be brought to the level of the best. In the best there are structures and processes in place to ensure good communication with the profession and advice from specialists in dental public health. **We recommend that PCTs should be required to demonstrate good organisation and structures, including in senior leadership in the PCT and strong clinical engagement, and that strategic health authorities (SHAs) and DH oversee this process.**

There is relatively little information available about what is happening in NHS dentistry, who wants and gets NHS care, what happens when they receive it and, crucially, whether the services they receive are making a contribution to oral health. A rich body of information is critical to our ability to monitor progress, reward quality and learn what works best for patients and what does not. **We recommend that DH develops a clear set of national data requirements for all providers.**

Technology can help to facilitate the collection and organisation of data. Software systems are available to record what happens chair-side and link it to national datasets. Around 25% of practices do not even have the very basic computer hardware that can allow this to happen. **We recommend that PCs are used in all dental surgeries within three years and are, ultimately, centrally connected to allow clinical data to support shared information on quality and outcomes.**

Historically, money has followed activity, not patients' needs. The process of reallocation of the resource to align it with need has already begun. **We recommend that this process continues and we have proposed a basis for a funding formula that can allow that to happen.**

Implementation challenges

While it may seem relatively easy to set out a vision and possibly even to get agreement on high-level principles, achieving change and remembering why we need it is much more difficult. The real task now is to implement that vision and this will require dedicated work and commitment across the dental profession and the NHS."

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Bill Millar
Head of Primary and Community Care Commissioning
NHS Eastern and Coastal Kent

January 2010

Dental Services

1. Introduction

This paper provides a summary of dental services in NHS Eastern and Coastal Kent.

2. Context

In April 2006 the Department of Health introduced changes to the provision of dental services. The objective of these reforms was to:

- make NHS dentistry more attractive to dentists,
- promote a more preventive approach to dental care,
- facilitate steady improvements in local access to NHS dentistry.

The PCTs Dental Commissioning Plan outlines how oral health services are being delivered most effectively for the population of NHS Eastern and Coastal Kent in order to:

- best meet local oral health needs,
- address national guidance where this is not already being achieved.

3. What is being commissioned?

The PCT commissions dental services from dental practices either under a General Dental Services contract (GDS) or as part of Personal Dental Services contract (PDS).

The GDS contract is between the PCT and each individual practitioner. The individual practitioners may then join together to form a partnership or group practice.

PDS contracts are for the provision of “specialist” high street services such as practices limited to orthodontics, and those providing other services on referral which the PCT may want to commission.

A summary of contract information is shown on table 1 below:

Table 1

	2007/8	2008/9	2009/10
Contracts	98	98	105
GDS contracts	82%	88%	91%
PDS contracts	18%	12%	9%
Children only contracts	7	7	7
Unit Dental Activity (UDA Children	43.9%	40.6%	35.4%
UDA's – Adults	29.3%	26.9%	23%
% of population seen	301,002 (41%)	345,047; 47%	349,071; 47% of population (quarter ending September 2009)

Note: -children only contracts are historical pre 2006.
-Information on patients seen is based upon the previous 24 months

In December 2008 the PCT approved an investment of £728,000 to increase access to dental services in Ashford, Sittingbourne and Canterbury. All three new surgeries are now operational. In addition to this a further investment of £4.5m was made following a needs assessment that will see new surgeries operational in all of the following localities by early 2010:

Deal, Dover, Chestfield, Whitstable, Faversham, Broadstairs, Cliftonville, Isle of Sheppey and Hawkinge

All of these new contracts will provide extended opening hours and provide support with oral health promotion. In procuring new contracts the PCT has not experienced any difficulties in attracting existing or new providers to any of the geographical areas of the PCT.

The waiting times for Orthodontic treatment have been reduced to 3 months following increased investment during 2008.

As part of the GDP and PDS contract, providers are expected to carry out preventative work on examinations and hygiene visits.

Locally within the PCT agreed pathways are in place for advanced oral health needs (such as cancer, and/or courses of treatment involving referral to a consultant). General Dentist can refer to the hospital consultants directly who will triage the patients based on evidence from the referral letter.

In addition to the GDS and PDS contracts NHS Eastern and Coastal Kent also commission the following services in primary care;

3.1 Out of Hours

DentaLine is the PCTs NHS's emergency dental service. DentaLine can treat patients who:

- Are bleeding heavily (haemorrhaging) from the mouth
- have an injury to their teeth or mouth
- have severe facial swelling
- are in pain that started suddenly and cannot be eased by pain killers

Normal opening hours: 7pm-10.30pm every day plus weekends and bank holiday mornings 9.30am to 11am.

Patients should telephone the DentaLine before attending and will be assessed during their call to determine how urgently treatment is needed.

For emergency advice or help in finding a local service residents of East Kent can call DentaLine service on 01634 890300.

3.2 Community Dental Services

Eastern and Coastal Kent Community Services provide Community Dental Service. The service provides a range of functions; they include specialist dentistry to patients who are unable to access mainstream dentistry because of a physical, mental or social disability. In addition to specialist care in periodontology, geriodontology, domiciliary care, bariatric dental care, general anaesthetics, epidemiology and dental health education.

4. What is spent on primary care dental services?

All providers of NHS dental services receive one twelfth of the value of the contract each month. A breakdown of spend is shown on table 2 below:

Table 2

	2007/8	**2008/9**	**2009/10 (forecast)**
	£'000	£'000	£'000
Gross Spend	30,169	29,732	30,859
Patient Charge Revenue	(6,425)	(7,338)	(7,099)
Net Spend	23,744	22,394	23,760

5. Children's Oral Health

NHS Eastern and Coastal Kent participates in the national dental epidemiology programme which is sponsored by the Department of health and the British Association for the study of Community Dentistry (BASCD). BASCD studies have been undertaken for many years recording annually the decayed missing and filled (DMF) data of five year old, eight year old and

twelve year old children on rotation. The DMF has decreased over the last 15 years but with some children experiencing high levels of decay. Caution should be given in interpreting data from year to year as the organisational boundaries have changed to which the data relates. Access to national and local results are available on the BASCD website.

In Eastern and Coastal Kent 73.2% of children are caries (decay) free compared with the England average of 69%. The average number of decayed missing and filled teeth (DMFT score) is 0.86 against and England average of 1.1.

6. Challenges

Ultimately funding will be a constraint on the levels of new services that can be commissioned and new measures are being put in place to ensure value for money from existing contracts. Contract monitoring of existing services will give increased efficiency and productivity therefore increasing capacity to treat more patients.

NHS Eastern and Coastal Kent are committed to achieving its national target to provide access to NHS dental services to 55% (409,000 people) of the population of East Kent in the next 5 years, currently the PCT is achieving 47% (360,000 people) so there are plans to improve access and meet the target. The national average is 54%.

Emergency/OOH services are currently under review to improve services and access and therefore the patient experience.

Specialist services historically provided predominantly by secondary care trusts are being reviewed to determine to what level these types of treatment can be carried out in primary care and therefore improve patient experience and bring services closer to people's home.

An oral health promotion campaign is planned to bring the message to as many people, especially children, as possible. Schools will have sessions on oral hygiene and brushing techniques, care homes will be visited where possible to help raise awareness of good oral hygiene later in life, the general public as a whole will be targeting by an advertising campaign.

7. Dental Prescribing

There is a national dental practitioners' formulary which provides guidance on what NHS dentists can prescribe. These relate mainly to the management of dental and oral conditions and include analgesics, drugs to treat or prevent infection, anaesthetics and drugs to sedate as well as specific preparations for oral conditions.

There is no way of ascertaining how much prescribing is carried out by dentists. Dental prescriptions, after dispensing in a community pharmacy, are sent to the Prescription Pricing Division (PPD) in Newcastle where they are priced and the community pharmacy remunerated. The DH has not

commissioned the PPD to collect any data on dental prescribing so it is impossible to know how much has been prescribed. There are two main areas where this could potentially pose a problem for the PCT:

- Hypnotic prescribing – we know that temazepam and diazepam have a street value to addicts and we routinely monitor GP prescribing in this area. Because we have no access to data on dental prescribing, we are not able to see if a dentist might be under pressure to prescribe these drugs inappropriately.

- Antibiotics – because of the national high priority of tackling Healthcare Acquired Infections, the PCT regularly monitors GP prescribing of antibiotics which contributes to the build up of resistant strains of micro-organisms. There is no way of knowing the level of dental prescribing in this area or the antibiotic chosen.

8. Customer Services

A dedicated dental freephone helpdesk (0808 238 9797) and texting service (07943 091 958) was launched on 9 November 2009. This helpdesk provides non clinical advice that includes:

- Helping patients, who currently don't have a dentist, access emergency dental treatment.
- Provide information on where patients can receive NHS treatment
- Explain the NHS charges and the treatment included in each price band
- Provide information on specialist dental services such as orthodontics.

Within the first month of the helpdesk opening:

- 700 calls were taken from patients wishing to access an emergency appointment, of which 423 resulted in booking an appointment.
- 388 callers have been given details of practices with capacity to treat patients
- 130 callers have made general enquiries that include for example dental costs
- 184 text messages have been received requesting details of where their nearest NHS dentist is located.
- 1,460 names have been added to the new practice waiting lists for Dover, Cliftonville, Broadstairs, Hawkinge, Deal, Eastchurch and Chestfield.

A promotional campaign is underway to raise awareness of the new dental helpline and to raise the public's awareness that it is now much easier to get an NHS dentist than in the past.

During this period the PCT received six verbal complaints along with four letters of complaint relating to access and six complaint letters relating to concerns about the quality of the service they received during the past twelve months. Feedback from the public about the helpdesk has been very positive.

Prior to the opening of the helpdesk the PCTs PALS service was the point of contact for the public although no detailed recording was kept of general dental enquiries. It was however recognised by the PALs service that the volume of calls they received was consistent with the calls now recorded by the helpdesk. This earlier information from PALs helped support the plans to invest additional resources in dental care.

In future the PCT will be better placed from more detailed information from the new helpdesk to enable a more targeted approach to future investment and performance management of existing contractors.

9. Conclusion

In summary, huge progress has been made this year to improving NHS dentistry and NHS Eastern and Coastal Kent will continue to ensure dental care is a priority to enable more of our population to easily access NHS dental care and treatment.

NHS West Kent's response to Kent County Council's Health Overview & Scrutiny Committee enquiry relating to dentistry.

Executive Summary

The NHS is responsible for providing services that help prevent diseases of the mouth, teeth and gums, and provide appropriate care and treatment where disease occurs. The main diseases are caries (tooth decay), periodontal disease (gum disease) and oral cancer.

NHS hospitals provide some specialist dental services (usually on referral), including specialist orthodontic treatment, oral surgery and complex restorative dentistry, but the vast majority of dental care is appropriately provided in primary care (i.e.: in high street or community based settings).

Most NHS primary dental care is provided by independent contractors, working either as single-handed practitioners or in partnerships. Independent contractors providing NHS services must have either a General Dental Services (GDS) or Personal Dental Services (PDS) agreement with the PCT. These contracts cover the NHS services provided to any patient that accesses them, regardless of the PCT in which that patient is resident or the GP practice with which they are registered. Primary dental services are therefore contracted on a 'catchment' rather than 'residence' basis.

It should be noted that dental providers have no patient list or practice boundary. Consequently patients do not actually register with any particular dental practice and therefore have an open and free choice about where they wish to receive treatment.

Commissioning dental services has only recently become a mainstream activity for most PCTs. Up until 2006, the majority of dentists worked under a national contract with centrally fixed fees. Dentists could decide where they set up practice and how much or how little NHS work they carried out from one month to the next, submitting claims to a central payments board for each item of NHS treatment carried out.

Under this old system, the pattern of NHS services grew out of the business decisions made by individual dentists, rather than any systematic analysis of population needs. The availability of NHS dental services declined from the early 1990s onwards, particularly in areas of the country where dentists found that they could establish a market for private dental services.

The old system was also based on a fee-per-item approach that rewarded a 'drill and fill' approach to dental care. This may have been appropriate in the early years of the NHS when there were high levels of dental decay. However over the last 40 years, oral health in England has improved dramatically, and it had become increasingly clear that some treatments under the old system were unnecessarily invasive. The 2006 reforms introduced:

- A new statutory responsibility for PCTs to secure dental contracts that meet local needs
- Local commissioning, with PCTs managing devolved budgets to dentistry and local contracts with dental providers.

The budgets and contracts that PCTs were devolved largely reflect the level of NHS dental care provided by dental providers during a 12-month baseline period leading

up to the new contracts in April 2006. Consequently PCT dental allocations are not based on a weighted capitation formula to reflect the equitable need and size of their populations but rather upon historic patterns of provision. In this respect it should be noted that NHS West Kent receives one of the smallest dental allocations of any PCT in England when this is expressed on a per 100,000 population basis.

The majority of the dental contracts delegated to NHS West Kent following the 2006 reforms are General Dental Services contracts. These contracts have no specified end-date. The nature of these contracts therefore restricts the PCTs ability to re-commission services within the associated dental budget. However the PCT did recently receive an increase to its dental allocation and has commissioned a number of new dental contracts. These new contracts will significantly enhance provision across West Kent. The PCT also has plans to commission further capacity in 2010 in line with the findings of a revised needs assessment which is currently being finalised.

1. Please provide some key facts about the levels and types of dentistry activity in your PCT area, including:

a. Numbers of dentists providing NHS dental treatment, and the percentages working under the different types of contract;

Table 1: Number of dental performers working under different types of contract

	2007/08		2008/09	
	Number	**%**	**Number**	**%**
Providing performer	90	32.8%	82	26.7%
Performer only	208	69.8%	225	73.3%
Total	**298**	**100%**	**307**	**100%**
General Dental Services (GDS)	260	87.2%	300	97.7%
Personal Dental Services (PDS)	29	9.7%	7	2.3%
Mixed	9	3.0%	0	0
Total	**298**	**100%**	**307**	**100%**

Table 1 shows West Kent dental provider information. The source of this data is the Information Centre website.

Currently within West Kent there are:

- 110 separate contracts for primary dental services (of which 99 are General Dental Services contracts and 11 Personal Dental Services contracts).
- 11 practices that hold contracts for the provision of orthodontics only.
- 3 practices that hold contracts for the provision of both primary dental and orthodontic services.
- 27 practices that hold contracts for the provision of domiciliary services and primary dental services.

b. Numbers of dentists providing NHS dental services to children but not adults;

NHS West Kent currently holds twelve child only dental contracts.

c. Information on the levels of dental activity (Units of Dental Activity) and Courses of Treatment, broken down into patient type (i.e.: adults and children);

Table 2: Data on Courses of Treatment and UDAs by Patient Type.

	2007/08		2008/09	
	CoT	UDAs	CoT	UDAs
Band 1	**194,441**	**194,441**	**200,097**	**200,097**
Children	86,360	86,360	87,907	87,907
Adult	108,081	108,081	112,190	112,190
Band 2	**104,491**	**313,473**	**106,078**	**318,234**
Children	33,371	100,113	33,255	99,765
Adult	71,120	213,360	72,823	218,469

Band 3	**13,970**	**167,640**	**14,915**	**178,980**
Children	464	5,568	477	5724
Adult	13,506	162,072	14,438	173,256
Arrest of bleeding	16	19	12	14
Bridge repairs	120	144	96	115
Denture repair	1,335	1,335	1,260	1,260
Removal of sutures	97	97	71	71
Issue of prescription	6,275	4,706	6,426	4,820
Urgent	**24,677**	**29,612**	**25,986**	**31,183**
Children	3,485	4182	4,045	4,854
Adult	21,192	25,430	21,941	26,329
Other COT*	Figures not collected		**7865**	
Children			968	
Adult			6897	
Total	**345,422**	**711,467**	**354,941**	**734,774**

d. Total number of patients seen by an NHS dentist, and what this is as a proportion of the resident population (for comparison purposes, could the above information be provided for 2007/8 and 2008/9 along with the most current information you have).

Table 3: Number of Unique Patients Seen over previous 24-month period

Patients	**Sept 08**	**Sept 09**
Adults	170,649	Breakdown figures
% of population	33.1%	not
Children	94,538	available
% of population	62.0%	until end Dec
Total	**265,187***	**271,873***
% of population	**39.7%**	**40.3%**

* These figures relate to the total number of individual patients receiving NHS treatment under a dentist in West Kent during the proceeding 24-month period. This is a key performance indicator (a 'Tier 2 Vital Sign' target) for PCTs, underpinned by a NICE guideline which recommends patients to attend a dentist at least once every two-years in order to maintain healthy teeth and gums.

2. How much is spent on commissioning dental services and how do dentists receive remuneration for providing services

In 2008/09 NHS West Kent spent £23.36M gross on commissioning primary dental services. This amount does not however net off Patient Charge Revenue which totalled £5.62M. The PCTs net spend was therefore £17.74M.

Dental contractors get paid a monthly sum in line with contract values. The PCT then performance manage the provider with regard to the value of activity delivered against contract plan. The dental providers, as independent contractors, determine how much they, and the staff they employ, receive in terms of salaries, taking into account the expenses incurred in running their business.

Each NHS dental contract has an associated number of Units of Dental Activity (UDA) which make up the contracts overall activity plan. Each contract has a specified UDA value – in NHS West Kent the average UDA value is £23.00. UDAs are calculated in relation to type of treatment provided to the patient through the Course of Treatment they receive. Each Course of Treatment may require the patient to attend the practice several times to receive their treatment plan. However each Course of Treatment must be completed within a two month timeframe.

Each Course of Treatment is categorised in a "band" which attracts varying UDAs depending on the treatment provided. Please see the tables below for the various values. Dental contractors submit claim forms in respect of each NHS patient they treat (entitled 'FP17'), either manually or electronically to the NHS Business Services Authority – Dental Division. This treatment activity is then counted as UDAs against the value of the dental contractors plan.

Table 4: UDAs recorded against Courses of Treatment

Type of course of treatment	Units of Dental Activity counted
Band 1 course of treatment (e.g.: check-up, scale and polish, x-rays but excluding urgent treatment)	1.0
Band 1 course of treatment (urgent treatment only)	1.2
Band 2 course of treatment (fillings, root canals)	3.0
Band 3 course of treatment (crowns, bridges)	12.0

Table 5: Units of dental activity provided under the Contract in respect of charge exempt courses of treatment

Type of charge exempt course of treatment	Units of Dental Activity counted
Issue of a prescription	0.75
Repair of a dental appliance (denture)	1.0
Repair of a dental appliance (bridge)	1.2
Removal of sutures	1.0
Arrest of bleeding	1.2
Conservation treatment of deciduous teeth in a patient who is aged under 18 years at the beginning of a course of treatment	3.0

3. How are dentists remunerated for preventative work?

Preventive care and treatment is part of the mandatory services that all dental contractors must perform as part of their primary dental service contract. Therefore dentists do not receive specific, separate remuneration for preventive work because

this element of the care pathway is included within the price of the activity they are contracted to perform.

4. Does the PCT provider arm provide any dental services directly?

West Kent PCTs provider arm (West Kent Community Health) does not provide any dental services. Community dental or salaried services are currently provided through Medway PCTs community provider arm, although the service they provide into West Kent is entitled West Kent Primary Care Dental Service. The community dental service aims to provide patient care in the most appropriate facility for individual patients who cannot, due to special needs, access a general dental practitioner.

The primary objective of the Community Dental Service is to deliver the following salaried dental services:

- To provide care for people with special needs
- To complement the current general dental services and specialist services available in the PCT through effective patient pathways
- To have a public health role and oral health promotion targeted both at populations and individuals
- To develop domiciliary services for those who are house bound or for whom there are barriers to care.

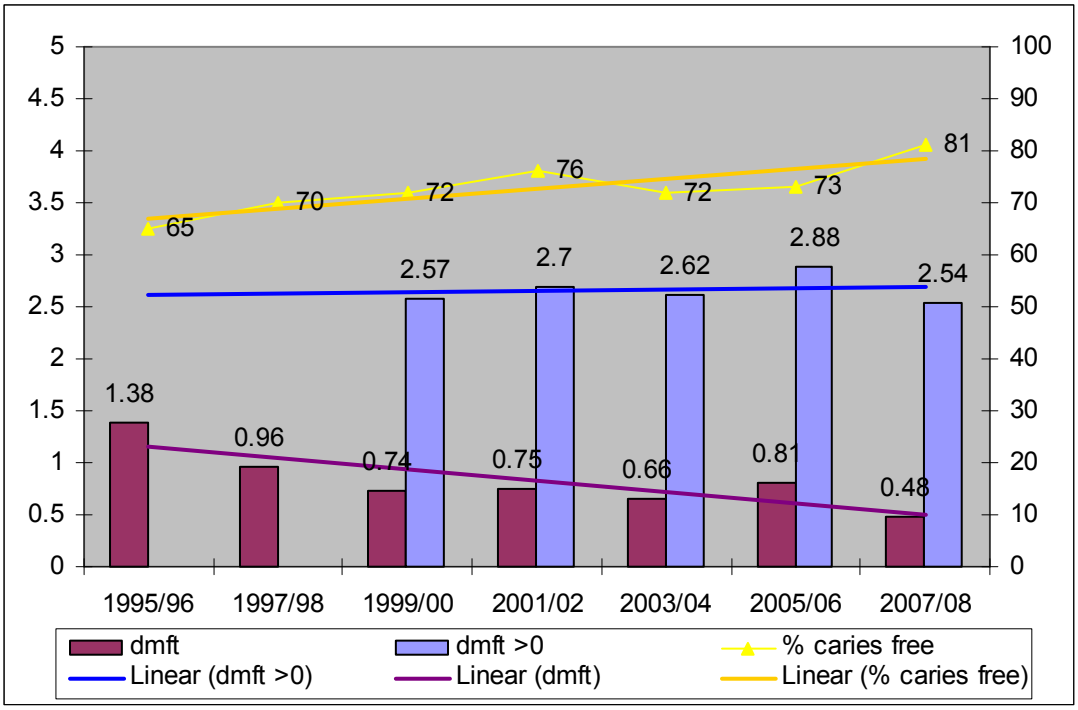
5. What information can be provided on the state of children's oral health in your PCT, and how this has changed over time?

The oral health of children is monitored regularly by carrying out epidemiological surveys to standards set by The British Association for the Study of Community Dentistry (BASCD). Levels of disease are measured using the Decayed, Missing and Filled Teeth (dmft) index which records the number of decayed, missing and filled teeth in a child's mouth. Table 6 shows the dmft average values and trends from 1995 to 2008 in respect of 5-year olds.

The data shown in Table 6 shows the following:

- The % of 5 year olds living in West Kent who have no caries (dental disease) has risen from 65% in 1995/96 to 81% in 2007/08.
- The average number of dmft's per 5 year old in the entire population has reduced consistently from 1.38 in 1995/96 to 0.48 in 2007/08.
- However the average number of decayed, missing and filled teeth in those children with caries has remained fairly constant throughout the period of measurement. The average number of teeth that were decayed, missing or filled in those 5-year children with caries was 2.57 dmft's in 1995/96. The equivalent number was 2.54 in 2007/08.

Table 6: Dental disease in 5 year-old children living in West Kent



Children in the South East and Kent in particular have some of the best levels of oral health in the United Kingdom. However, there are pockets of our county were some children suffer high levels of disease.

It can be seen that overall there is a downward trend in the amount of dental disease in the 5 year-old population with the number of caries free children increasing. What is interesting is that the level of disease suffered by those with decay (dmft>0) appears to be little changed. This would imply that there are a smaller number of children suffering higher levels of dental disease. This is supported anecdotally by the Community Dental Service who treat many of these high need children.

We know that in common with many diseases there is a strong correlation between oral disease and socio-economic deprivation. Table 7 shows the latest data for the whole of Kent and shows the variation of disease across local authorities.

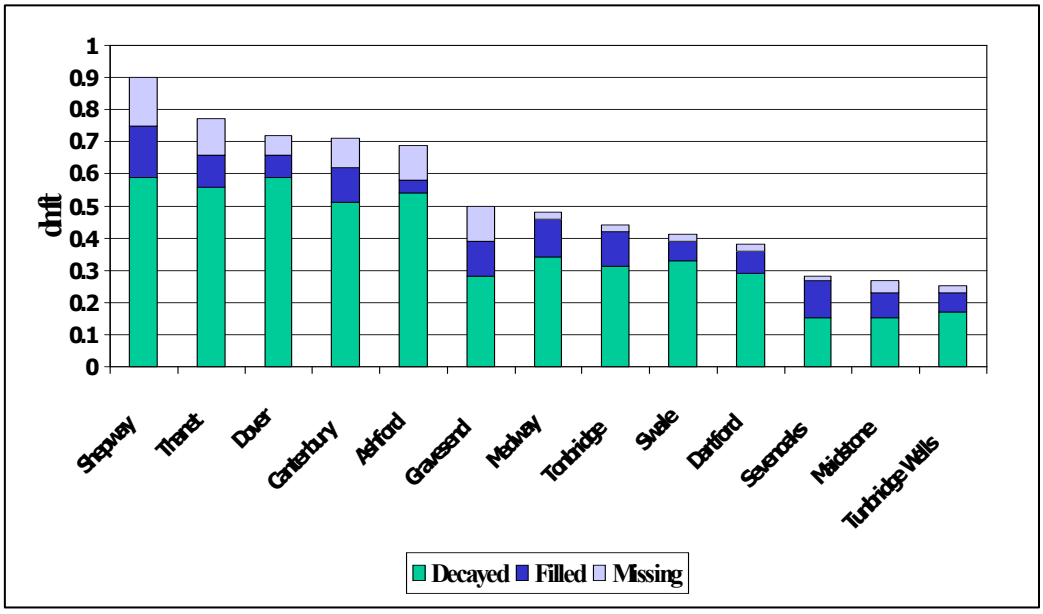


Table 7: Dental disease in 5 year-old children by local authorities across Kent (BASCD data 2007/08).

These data are used to target local schools and population for oral health promotion. There are a number of Sure Start schemes that include 'Brushing for Life' as part of their operation. In addition the Community Dental Service target those schools in West Kent with pupils who have the poorest oral health for intensive health promotion programmes. Furthermore the PCT is developing plans to introduce topical fluoride varnish pilots.

The PCT will also be undertaking an ongoing social marketing campaign in dentistry and dental care. This will highlight the importance of good oral health and why it is necessary for everyone to see a dentist at least once every two years in order to maintain healthy teeth and gums. It is hoped that these measures will address known inequalities in oral health.

6. Who provides out of hours dental services and how do patients access these?

Most practices in West Kent do not provide their own out of hours service for NHS patients. Practices opting out of out of hours are required to signpost patients to the arrangements with DentaLine which are outlined below.

DentaLine is commissioned by NHS West Kent to provide an emergency dental service. DentaLine is part of community dental or salaried services hosted by Medway Community Health Care (provider arm of NHS Medway). This service is provided at a number of designated dental access centres by booked appointment. Patients need to telephone the Kent DentaLine on 01634 890300 and will be given an appointment slot at a centre if urgent treatment is considered necessary.

This service is available between 7.00PM - 10.30PM during weekdays and between 09.30AM and 11.00AM. DentaLine treat patients who:

- are bleeding heavily (haemorrhaging) from the mouth
- have an injury to their teeth or mouth

- have severe facial swelling
- are in pain that started suddenly and cannot eased by pain killers

NHS charges apply to all out of hours dental services.

7. What is the patient pathway for those with advanced oral health needs (such as cancer, and/or courses of treatment involving referral to a consultant)?

The general dental practitioner refers the patient to secondary care services following standard protocols for cancer referrals to Maidstone and Tunbridge Wells NHS Trust; Dartford and Gravesham NHS Trust; The Queen Victoria NHS Foundation Trust; Guy's and St Thomas' NHS Foundation Trust plus others. The specialties referred to are maxillo-facial and/or oral surgery.

8. Are there any particular geographical areas where there are issues around commissioning adequate dental provision?

The PCT are refreshing their dental needs assessment in relation to access issues. This is being led by colleagues in Dental Public Health and should be completed in January 2010. Geographical areas where there is a priority need for further capacity to be commissioned will be highlighted by this report.

9. Are there any particular times of year where there are issues around commissioning adequate dental provision?

The PCT is not aware of any seasonal issues relating to the demand for dental care. The supply side could however be affected by significant outbreaks of seasonal flu etc. However with over 100 providers of NHS dental care across West Kent this risk is considered to be small and to date we have not experienced any seasonal related issues.

10. What are the challenges faced by PCTs in commissioning adequate dental provision and what plans does the PCT have to develop dental services in the future?

The key challenges faced by PCTs in commissioning adequate dental provision are:

- Public awareness of oral health and dentistry and stimulating the demand for dentistry and highlighting its essential role in primary prevention
- The amount allocated to the PCT for dentistry – in 2009/10 this is £23.08 million net
- The timescales associated with full tendering processes are lengthy and can take almost a year before contracts are signed and new services mobilised
- The PCT has recently had its Tier 2 Vital Sign target relating to the number of Unique Patients Seen over the 24 month period ending March 2011 increased from 320,873 to 357,500
- Some dental performers do not always strictly follow NICE guidelines relating to the recall of patients. These are attached in the link below. http://www.nice.org.uk/nicemedia/pdf/CG019quickrefguide.pdf
- Robust and transparent contract monitoring to ensure contractors deliver best quality and value for money is time-consuming with regards to management resources.

The PCT plans to:

- Undertake a social marketing campaign to stimulate the demand for dentistry and public awareness across West Kent.
- Secure additional capacity, through contract variations on a non- recurrent basis for 2009/2010.
- Look at different ways of procuring additional capacity and new contracts in order to mobilise the extra services for patients in a timely way.
- Procure significant additional recurrent capacity from 2010/11.
- Improve the performance and delivery against our existing dental contracts (e.g. to ensure NICE guidance followed).

11. What powers of prescription do dentists have and how much prescribing is carried out by them?

Dentists can only prescribe items listed in the Dental Prescribing Formulary (Part XVIIA of the Drug Tariff) and are prescribed on Form FP10 (D). Although the Dental Formulary displays products by their generic titles and dentists are strongly encouraged to prescribe generically, a product may be ordered on Form FP10 (D) by its brand name providing that the brand is not listed in Part XVIIIA of the Drug Tariff (the blacklist).

Relevant information is attached in the links below:
http://www.psnc.org.uk/pages/prescribing_rights.html
http://www.psnc.org.uk/pages/introduction_to_the_drug_tariff.html
http://www.nhsbsa.nhs.uk/PrescriptionServices/Documents/Drug_Tariff_Guidance_Notes.doc

b. How much prescribing is carried out by them?
Dental data is only available at a national (England) level as the prescription forms do not identify the Primary Care Trust (PCT) of the prescriber or the patient and therefore the prescriptions cannot be attributed.

Relevant information is attached in the links below:
http://www.ic.nhs.uk/webfiles/publications/PrescribingDentists08/Prescribing%20by%20Dentists%202008.pdf

12. Please provide the following information relating to customer services (including information from PALS)

- ***a) How many enquiries are received each quarter relating to dental services and what trends can be identified regarding the nature of these enquiries?***
- ***b) How many complaints/compliments/comments have been received about accessing dental services?***
- ***c) How many complaints/compliments/comments have been received about the quality of the services?***
- ***d) How has information from customer services about dentistry informed service development?***

Table 8 below shows the total of enquires, including complaints, received by NHS West Kent Customer Services in quarterly periods from July 2007 to the present time.

The information is used primarily for two main purposes. Firstly to identify any issues that relate to individual dental contractors or dental practitioners which the PCT will then investigate and manage accordingly. Secondly we use the intelligence to inform service development and specifically future procurements. In this respect, the information that underpins some of the data in Table 8 will be used as part of the refreshed dental needs assessment through which the PCT will determine where to place further additional contracts and capacity.

Table 8: Summary of dental enquiries and complaints

	2007/08			**2008/09**				**2009/10 up to 9th December 2009**		
Period	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Requests for details of how to access an NHS dentist	285	158	1024	1075	1317	749	652	1015	1063	584
Request for a domiciliary visit	0	0	2	2	2	2	5	14	12	31
Request to be put on waiting list for new practices following procurement							45	10	3	5
Complaints re dental charges	1		2	2	1	3	6	12	11	10
Complaints re treatment/diagnosis	1		3	2	4	8	15	13	13	12
Complaints re attitude/communication				1		1	1	5	5	4
Request re referrals					2	1			2	2
Orthodontic query						1	1		1	2
Wheelchair access							1			
Miscellaneous							5	6	8	13
Total Dental Queries	**287**	**158**	**1031**	**1082**	**1326**	**765**	**731**	**1075**	**1118**	**663**

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1. Does the Local Dental Committee consider that the provision of dentistry in Kent is sufficient to meet the needs of the people in Kent?

This question does not draw a distinction between NHS dentistry and private dentistry. However the best answer to it, based on the number of patients who access out of hours of emergencies who do not have a dentist, has to be "no". There is a significant number of patients who do not have access to a dentist but who are also not interested in attending for regular dental care. Many of these patients are really only interested in the availability of a dentist when they actually need one. There is certainly a lack of dentists willing to accommodate these emergency presentations, which is why many will end up in the out of hours emergency dental clinics (DentaLine).

Most dentists will have an acceptance policy for private patients so we feel that there will not be an access problem for the provision of private dentistry. However the new NHS contract of April 2006 which pays the dentist the same fee for whether they do 1 filling or many fillings results in a financial disincentive for the acceptance of new NHS patients. This is because new patients usually have not been to a dentist for some time and have higher treatment needs as a consequence. The system we have at present does not allow a dentist to first examine the patient to see whether they are willing to accept them under the terms of the NHS contract or whether the amount of treatment the patient requires would be a financial disadvantage to that dentist. This then results in some dentists creating a blanket policy of non-acceptance of new patients under the NHS contract. It would be interesting if it was possible for a dentist to be allowed to make a patient dentally fit under private contract as an initial course of treatment with a view to then accepting as an NHS patient for maintenance provided the patient agreed to attend at least once a year thereafter. This country does not allow these arrangements but other countries do. The policy would be that if a patient fails to attend annually then they lose access to State funded assistance and this you will find in 1 or 2 of the Scandinavian countries.

It is clear that that there are pockets in Kent where there are fewer NHS dentists available per head of population as for instance in the Tunbridge Wells areas. An initial needs assessment document has recently been completed by Chris Allen, who is the consultant in Dental Public Health, for West Kent PCT. This document has focused on what is the current provision of NHS care and how it is linked to population densities. However what is very much less clear is what the actual demand for NHS dentistry is. How you go about assessing the actual demand is very much harder and currently thought is being given to this question. In West Kent we are hoping to explore this before developing a strategy best placed to deal with it. The West Kent PCT has a new Director for Primary Care Commissioning called Stephen Ingram and he is developing a framework for addressing commissioning and hopes to involve a number of stakeholders to create momentum in this area. The LDC feels positive about this.

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2. Is the provision of NHS dentistry uniform across the county, or are there some areas where issues exist?
3. If the answer is no to either of the questions above, what does the Local Dental Committee consider to be the main issues limiting dental provision in Kent?

Some of the responses to the above questions lie in the answer to the first question.

4. What suggestions does the Local Dental Committee have for improving dental provision?

Medway PCT has developed a relatively successful system for dealing with patients who have daytime need of urgent care. There are many more NHS dentists in this PCT and it has one of the best access percentages for NHS care in that about 60% of the population has an NHS dentist. Dentists have been incentivised to see urgent cases for occasional treatment when they do not have to accept the patient to make them dentally fit but merely treat their presenting problem. They are given an enhanced UDA rate for having open access slots and provided they treat a sufficient number of these cases in a year they will receive their enhancement. In general Medway have done a lot better in being able to deliver on NHS dentistry because they have been able to allocate the full dental budget to dentistry. There are other financial constraints for the East Kent and Coastal PCT and West Kent PCT that has prevented them from being able to spend the full NHS dental budget on NHS dentistry.

In the main the New NHS Contract for dentistry introduced in 2006 has been extremely unpopular with dentists. If dentists wanted to continue to provide dental care under the NHS they had to sign it. A number of dentists refused to and went private there and then. Some dentists have moved into private sector since. Although the new contract has strived to improve the quality of dental care patients receive in the NHS and also improve access to NHS care the contract conflicts with the business of dentistry that any dentist, however ethical he or she may be, cannot ignore. The costs of providing dentistry in terms of business costs and staff wages is high and dentists must ensure their continuing profitability to remain commercially viable. A bankrupt dentist ceases to trade and by extension cannot serve anyone. Although the public may find this hard to believe bankruptcy has happened and continues to do so in dentistry. The Department of Health never properly consulted the profession about what would best work as agreements usually have to be a compromise taking into accounts the objectives of both parties. Win/Lose outcomes rarely work in the long run.

Dentists who wish to sell their business are no longer able to pass on their NHS contract to a potentially interested buyer as the PCT are now required to put the contract out to tender (if the contract value is £25k or over). The tendering or procurement process is protracted and involved and results in a disincentive for the purchasing party. This particular issue has been highlighted by the shadow government and it is their stated intent to change this aspect of the new contract. They will also bring back registration by trying to reintroduce a financial incentive for having patient registered with a practice under the NHS. The LDC feels that these would be positive measures but it would be a case of don't hold your breath as politicians have often promised much and failed to deliver. The Conservatives would need to win the election first.

Relations in Kent between the LDC and various PCTs have in the main been good. Although the LDC statutory requirement is to advise the PCT on NHS dentistry we feel that it must do so by representing the interests of dentists and their patients. We do feel that in the main the PCTs do appreciate this but there are times when the PCT finds itself caught

between a rock and hard place as it has to follow the directives of the SHA and Department of Health.

5. A list of the key questions which we have asked NHS Eastern and Coastal Kent and NHS West Kent is attached to this letter. This is for your information, but if there are any areas about which you would like to provide additional information, please do so.

At this point we would like to make you aware of the new decontamination policy being rolled out across the country. This is the Health Technical Memorandum 01-05 abbreviated HTM 01-05. The development of this policy by the Department of Health was in response to a perceived potential risk of developing variant Creutzfeldt-Jakob disease (vCJD), which is an abnormal prion protein, from contaminated instruments used in dentistry. There have been 167 deaths from vCJD in the last 20 years with a sudden fall off since 2000. The current prediction is that there is likely to be 1 or 2 deaths a year from now. The number of patients acting as carriers of this abnormal protein and the reason for the sudden fall off in deaths is not known. Not one of the deaths so far has been linked to dentistry. The cost of the implementation of the requirements of HTM 01-05 in dentistry is £millions with individual practices having to spend £1000s. It will not be possible for some practices to achieve the essential standards required and they will be faced with closure if the PCT insists that these standards have to be met. Some PCTs do not have funds available to assist with the costs and they will be faced with tough decisions such as do they turn a blind eye or do they insist on closure? If they do turn a blind eye how can this be equitable when other practices will be forced into this sort of expenditure?

So we do have problems in dentistry to come but at least nothing has changed in this respect. If you have any further specific questions you would like to ask then please feel free to approach the LDC at a later date.

Tim Hogan BDS
Chair Kent Local Dental Committee.

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Dentistry in Kent

Introduction

The parlous state of NHS general dentistry has been one of the most frequently raised issues by Local Involvement Network (LINk) Participants when they first register with the LINk. The issue was the subject of debate at the LINk's Quarterly Event in April earlier this year at which a presentation was given by NHS West Kent. This report is based on the debate at that time and the assurances that were given by the NHS in West Kent and, subsequently, NHS Eastern and Coastal Kent Primary Care Trust.

The concerns

The principal concern related to the difficulty patients were having in finding an NHS dentist in certain areas. The areas identified by LINk Participants included:

- Ashford
- Crowborough
- Dartford
- Folkestone
- Maidstone
- Sevenoaks
- Thanet
- Tonbridge
- Tunbridge Wells

Particular concern had been expressed about the Tonbridge and Tunbridge Wells areas where earlier this year just one practice – the High Brooms Dental Clinic – was taking on new patients. However, when contacted that practice was putting patients on a waiting list for an appointment and it could take anything up to six months.

Other issues included:

- NHS Dentists not taking on children
- The disappearance of routine six monthly check ups
- High price of dental care deterring people from going to the dentist
- Unable to obtain lists of NHS Dentists

- Poor dental care can make people seriously ill, e.g. those with cardiac problems and pregnant women

The assurances

NHS West Kent has given the LINk the following assurance of actions they are taking to address the shortfall of NHS dentists in their area.

Phase 1 - £1.7m to recruit the equivalent of 6 new dentists and more orthodontic activity in:

- Aylesford
- Dartford
- Gravesend
- Longfield
- Maidstone
- Sevenoaks
- Tonbridge
- Tunbridge Wells

The measures were set to be in place by September 2009 if the new activity could be accommodated by existing dentists in the area or January 2010 if new dentists were to be employed.

Phase 2 - £900,000 to recruit the equivalent of approximately a further six new dentists in:

- Maidstone
- Swanley
- Tunbridge Wells

As previously, these extra resources would be deployed by September 2009 if dentists in the area could take up the new activity or January 2010 if new dentists were to be deployed.

LINk enquiries of NHS Eastern and Coastal Kent Primary Care Trust established that they too were investing in new dental activity amounting to an investment of £4.5 million that will see new dental surgeries operational in:

- Broadstairs,
- Chestfield,
- Cliftonville,
- Deal,
- Dover,
- Faversham,
- Hawkinge.
- Isle of Sheppey
- Whitstable,

In conclusion

The Committee's review comes at an opportune time to hold NHS Eastern and Coastal Kent and NHS West Kent Primary Care Trusts to account for their promised improvement in access to NHS dentistry in the above areas.

20/12/09

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 8 January 2010

Subject: Item 5. Further Information on Out of Hours Services.

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1. Background

(1) The Health Overview and Scrutiny Committee examined the issue of out of primary care out of hours services at its meeting on Friday, 30 October 2009.

(2) During the course of the discussion, colleagues from NHS Eastern and Coastal Kent and NHS West Kent agreed to supply further information to answer a range of enquiries from Members. This was followed up subsequent to the meeting and the information received is attached.

2. Recommendation

(1) Members of the Health Overview and Scrutiny Committee are asked to note the information supplied.

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Eastern and Coastal Kent

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Our ref: AS/cd
11 December 2009

Dear Paul,

Further to the Health Overview and Scrutiny Committee meeting on 30 October and your subsequent letter of 09 November 2009, please find below further information as requested on the Primary Care out-of-hours service provided for the residents of Eastern and Coastal Kent.

1. How are clinical outcomes of out of hours care measured? What has been the performance against these measures?

NHS Eastern and Coastal Kent (NHS ECK) currently contracts out-of-hours Primary Care across the PCT with South East Health Limited (SEHL). Performance is monitored and managed through a number of mechanisms including:

- The use of Key Performance Indicators (KPIs) linked to the 13 Department of Health National Quality Requirements (NQRs)
- Quarterly performance reporting by SEHL to NHS ECK;
- Quarterly reviews of SEHL's performance with NHS ECK; and
- Monthly exception reporting by SEHL.

The 13 NQRs submitted by SEHL provide the principle performance reporting and quality assurance mechanism to NHS ECK on a monthly basis; these are shown below together with the most recent performance ratings:

1. Compliance with quality requirements – compliant
2. OOH consultations – compliant
3. Comprehensive Systems Information – compliant
4. Random audit samples – compliant
5. Random samples of patient's experiences – compliant
6. Complaints procedures – compliant
7. Capacity to meet fluctuations – compliant

Cont'd.

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8. Initial telephone call:
   - engaged – 0.00%;
   - abandoned – 1.7%;
   - answered within 60secs – 89.6%
9. Telephone clinical assessment:
   - ILTs passed to 999 within 3mins – 100%;
   - urgent calls returned within 20mins – 91.9%;
   - less urgent calls returned within 60mins – 94.6%
10. Face to face clinical assessment:
   - ILTs passed to acute response within 3mins – 100%;
   - urgent patients assessed within 20mins – 100%;
   - less urgent patients assessed within 60mins – 97.4%
11. Clinical workforce – compliant
12. Face to face consultations:
   - Base consultations:
     - Emergency patients assessed within 1hr – 100%
     - Urgent patients assessed within 2hrs – 100%
     - Less urgent patients assessed within 6hrs – 100%
   - Home consultations:
     - Emergency patients assessed within 1hr – 100%
     - Urgent patients assessed within 2hrs – 93.2%
     - Less urgent patients assessed within 6hrs – 99.3%
13. Patients unable to communicate effectively in English – compliant

2. What information can be provided about the number and nature of complaints, compliments and comments about out of hours services? What has been the outcome of these? Have the outcomes informed service improvements?

SEHL operates a complaints procedure that is consistent with the complaints procedure for NHS ECK. Anonymised details of each complaint are reported to NHS ECK including the manner in which it has been dealt with.

NHS ECK performance (complaints per patient contact) is currently running at 0.04% compared with an average across other local PCTs served by SEHL of 0.05%. All complaints are audited in relation to individual staff in order that appropriate action can be taken where necessary. In addition, a random sample of patient contacts (4% of calls per clinician per quarter) is audited to ensure appropriate standards of care across the areas of patient access, clinical treatment and provider organisation.

Cont'd.

Furthermore, SEHL regularly audits a random sample of patients' experiences of the service. Most recent survey results indicate 90% of patients surveyed rated the service they received as either Excellent or Good. SEHL continue to take appropriate action to address those areas that are identified by the 10% of responses which rated the service they received as either Satisfactory or Poor.

3. **The committee is always interested in patients' views informing the development of services, and any additional information you could provide on this would be appreciated. In particular, both written submissions discussed patient surveys that had been carried out, and copies of these would be welcomed by the committee.**

In mid-2009, NHS ECK Eastern & Coastal Kent PCT undertook a piece of work to understand better the quality of the Out of Hours service, as perceived by the public. To inform further work in this area, a survey was circulated through the Eastern & Coastal Kent Virtual Panel, the Health Matters Reference Group, and also to seldom heard groups to measure the public's experience of the Out of Hours service. The Kent and Medway Health Informatics Service is subsequently commissioned to analyse the results and to report their findings.

A copy of the survey results is attached to provide a more detailed response, however in summarising the key findings, the survey found that the majority of respondents:

- Were directed to the service from their GP surgery,
- Wanted to talk to a doctor urgently,
- Had their call answered between one and three minutes,
- Were told a doctor or nurse would call them back,
- Were called back within one hour,
- Travelled 10 miles or less,
- Were seen within 30 minutes,
- Were treated with dignity and respect,
- Were satisfied with the treatment and advice they received,
- Only needed to make one call.

4. **What are the numbers and types of staff involved in delivering out of hours care (from call-handling and advice to treatment)? How do these numbers compare to the relevant national guidance for staffing levels?**

The contract with the current OOH providers is a service-based contract and is expected to be able to deliver relevant skilled staff and Health Care Professionals to meet the demand across the PCT and cope with any seasonal variations. As such it does not stipulate in the contract the exact number of staff required to deliver the service. The provider undertakes workforce planning using both historical data and current trends to ensure that service provision can be maintained regardless of any external pressures.

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Although not a contractual requirement, the following provides an indication of current staffing levels (figures are shown as whole time equivalent):

Clinical Staff:

- GPs (nominally 23WTE) – typically 20–30 GPs are available during the OOH sessions, depending on time of day, expected call volume etc.
- Nursing staff (6WTE) – covering telephone assessment and face to face to consultation.
- Pharmacist (0.13WTE) – covering medicines management and shared with other areas.
- Pharmacy staff (0.4WTE) – managing drugs at base.
- Medical Director – responsible for the GPs, is a GP himself
- Director of Clinical Services – qualified Allied health Professional

Support staff:

- Drivers/receptionists (15WTE)
- Receptionists (7.5 WTE)
- Call handlers and shift managers (9.2 WTE)

5. How many calls are dealt with by the call-handling services and what are the outcomes of these (what percentage lead to home visits, or an ambulance being called)?

Approximately 9,500 calls are received per month by SEHL from residents of NHS ECK. Of these approximately 2.2% (212 from 9,526 in October 2009) were identified as immediate life threatening requiring 'blue light' ambulance transfer to an acute hospital. For the same period, approximately 31.6% of calls (3,011 from 9,526) received face to face consultations at one of the SEHL base locations and 14.9% (1,420 from 9,526) received face to face consultations at home.

6. What is the current performance of the out of hours providers measured against the current key performance indicators?

This response is reported fully in answer to question 1 above.

7. What new key performance indicators will the PCTs be including in the new contracts?

As indicated in the paper presented to the HOSC on 30 December, NHS Eastern and Coastal Kent is in the process of re-tendering the current Out of Hours provision. The tendering process is due to complete by the end-Dec 2009 with a decision by the PCT Board at end-Jan 2010. Contractual arrangements will be established through end-Mar 2010 to enable a transitional phase from Apr 10. The new Primary care contract will take effect from 01 July 2010.

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The re-tendering process has enabled a number of amendments to the existing service specification, principal amongst which is the separation of the access, assessment and treatment elements into two 'lots': Lot 1 – Access and Assess; Lot 2 – Treat.

In addition, the re-tendering process has enabled a more thorough revision of the key performance indicators across the areas of patient access, clinical assessment and treatment. Whilst the 13 NQRs and many of the current KPIs will be retained, the revised service specification will enable more detailed performance analysis and management. In summary, Key Performance Indicators will cover the following areas:

- Patient access – call handling response, appointment punctuality and equity of access
- Patient outcomes – clinically safe system of prioritisation, specific requirements for palliative care, face to face contacts, waiting times, communication with patient's practice, repeat contacts,
- Patient experience and engagement – patient satisfaction surveys, marketing and communications, patient/public engagement, equality and diversity, seamless pathway with single point of information
- Quality and governance – NICE guidance, National Service Frameworks, incident management (minor and SUI), complaints, patient and clinician audits, patient safety and infection control, staff training
- Contract management – formal reporting, periodic reviews, management of inappropriate referrals
- Information Management and Technology (IM&T) – Information governance, IT and telephony support, disaster recovery and business continuity
- Delivery partners – satisfaction of delivery partners, links with routine care contractors, case-mix
- Workforce and training – workforce planning, recruitment and retention, staff performance

I hope this provides full and satisfactory answers for your colleagues on the Health Overview and Scrutiny Committee. If anything requires further explanation or clarification, please don't hesitate to contact me.

Yours sincerely,

Ann Sutton
Chief Executive

Enc.

c.c. Steve Phoenix, Chief Executive, NHS West Kent

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Kent and Medway
Health Informatics Service

Kent and Medway
Health Informatics Service

Eastern & Coastal Kent PCT
Out of Hours Survey
Results Report

June 2009

Wendy Lanng

Delivering the best information services to enable excellent patient care
Professionalism | Teamwork | Respect

Hosted by Maidstone and Tunbridge Wells NHS Trust

Table of Contents

1 INTRODUCTION

Eastern & Coastal Kent PCT has undertaken work to better understand the quality of the out of hours service, as perceived by the public.

To inform further work in this area, a survey was circulated through the Eastern & Coastal Kent Virtual Panel, the Health Matters Reference Group, and also to seldom heard groups to measure the public's experience of the out of hours service.

The Kent and Medway Health Informatics Service was commissioned to analyse the results and to report their findings to the Urgent Care Team.

2 BACKGROUND

2.1 Methodology

The surveying took place in the Spring of 2009 with the aim to collect baseline data to add to anecdotal evidence, and Appendix 5.1 details the questions in the survey.

There were no set sampling techniques used and there was no previously agreed margin of error or set sample size and no strict surveying methods.

Although different groups were approached, there were no set parameters on who should complete the survey; so gender, age, ethnicity and general health of the respondents were not considered.

There were no incentives given for completing the survey, only the more intangible incentive of providing an assessment of the out of hours services and therefore potentially influencing future service improvements. Completion of the survey was also entirely voluntary.

The answers given are all tick box responses, although many additional comments were also added by the respondents. There were some instances where an answer could not be understood in the context of the question, or which was left blank and these have been recorded as "blank" for analysis purposes. There are also a few returned surveys that have been identified as possible duplicate replies, but this accounts for less than half a percent of all responses received, so these possible duplicates have been included in the analysis.

Where there were specific issues with the data set, it has been recorded in the body of this report.

3 RESULTS

As the survey was distributed across different groups, the return envelope was marked to denote which group the reply was from. Overall there were 307 surveys returned, which can be categorised as follows:

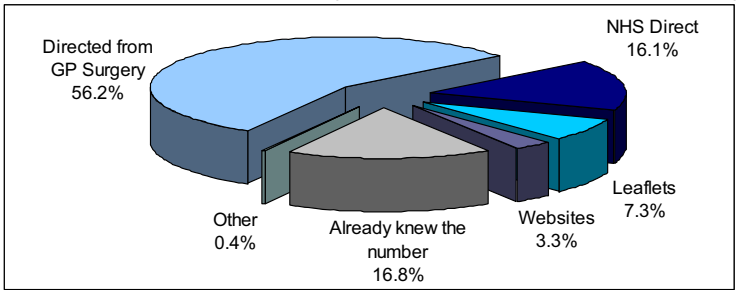
Mark on the envelope: s	18
Mark on the envelope: x	242
Unmarked envelope	1
Online response	46
Grand Total	**307**

Additional comments were written on many of the returned surveys, and 18.8% of all returned paper surveys were not completed but had the additional comment that the respondent had not used the service. Online responses did not have the facility for additional comments to be made, but for the purposes of evaluation, it can be assumed that it would not have been submitted by respondents that did not know the service.

The following analysis has been done on the replies received for each question, and has not included the blank responses in the figures. It should be noted that some questions had a high proportion of "blank" responses, as can be seen in Appendix 5.2. The increase in blank answers in the later stages of the questionnaire may have been reduced with the addition of a "not applicable" option.

3.1 "How did you find out about the service?"

To the question "How did you find out about this service" (See Appendix 5.1, question 1), 56.2% of those who answered, said they were directed from their GP surgery.

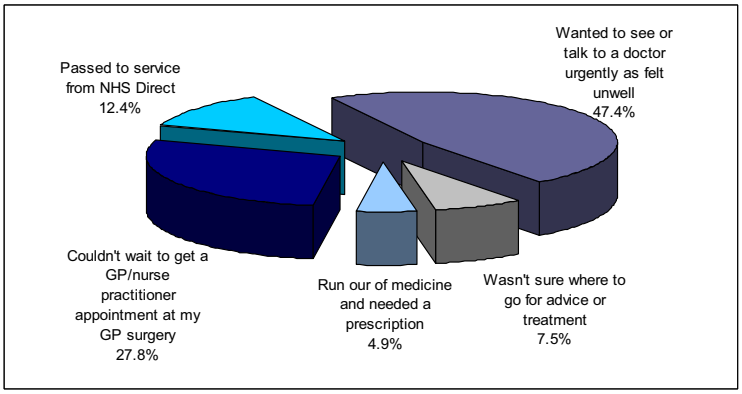


16.8% already knew the number, and 16.1% heard about the service from NHS Direct.

The "other" was a respondent who wrote on the survey that they heard about the service through a friend.

3.2 "Why did you phone for advice or treatment?"

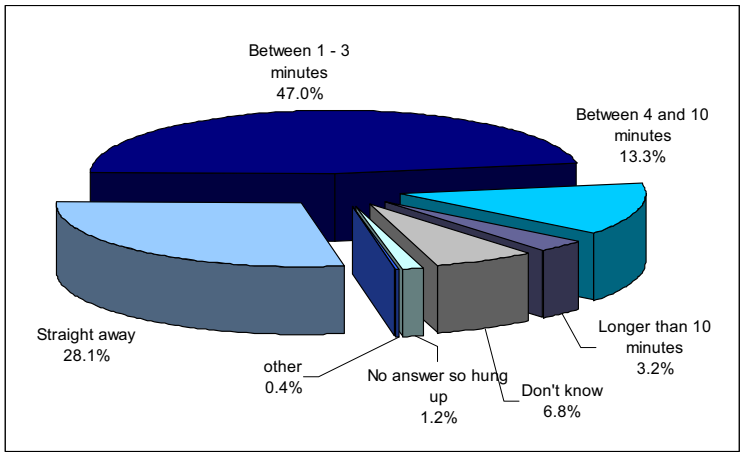
To the question "Why did you phone for advice or treatment" (See Appendix 5.1, question 2), 47.4% of respondents that answered wanted to urgently see or speak to someone as they felt unwell while 27.8% could not wait for an appointment at their GP surgery.



12.4% attended the service at the guidance of NHS Direct, and of the remaining replies, 4.9% needed prescriptions and 7.5% were unsure of where to go for advice and treatment.

3.3 "How quickly did they answer the phone?"

To the question "How quickly did they answer the phone?" (See Appendix 5.1, question 3), 75.1% of those that answered the question said that their call was answered straight away or in less than three minutes.

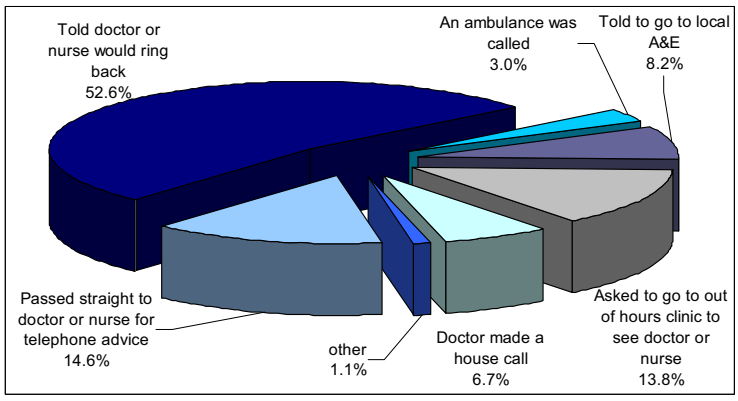


16.5% of respondents reported that it took four minutes or longer for the call to be answered, of which, 3.2% of all respondents waited longer than 10 minutes.

8.0% of answers were for "don't know" or "no answer so hung up" and the "other" was a respondent who wrote on the survey that they did not call, but "just turned up" at the service.

3.4 "What happened when you rang?"

To the question "What happened when you rang?" (See Appendix 5.1, question 4), 52.6% of those that answered were told that a doctor or nurse would ring them back.

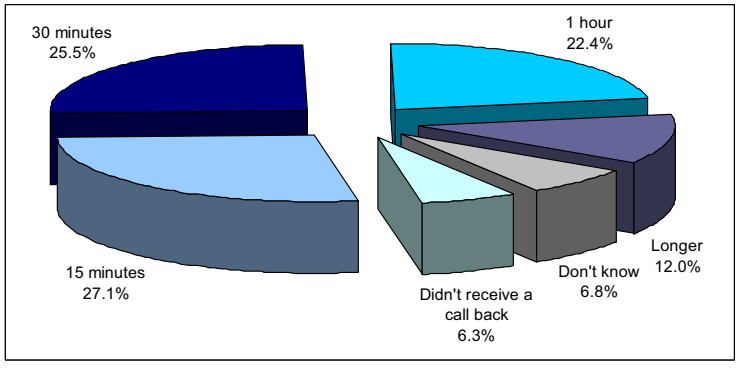


Of the remaining categories, 14.6% were passed straight to telephone advice, and 6.7% had a house call. 13.8% were asked to visit a clinic. The remaining 11.2% of answers were for emergency treatment; with 8.2% told to go to A&E and an ambulance was called for 3.0% of respondents.

The "other" category comprises three respondents; one wrote that they "arranged an appointment", one that they visited the service, and one who commented "none of these - told to take paracetamol".

3.5 How long did it take for a doctor to call back?

To the question asking how long it took for a doctor to call the respondent back (See Appendix 5.1, question 5), 52.6% of those who answered the question were called back within 30 minutes, of which, 27.1% of all responses were within 15 minutes. 22.4% received a call within one hour, but a further 12.0% felt they had to wait longer than this.

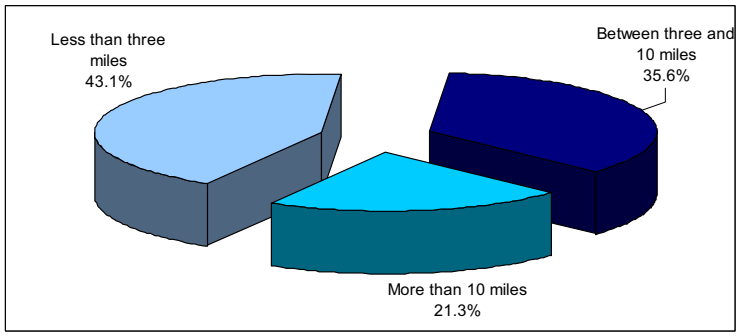


Of the remaining replies, 6.8% of respondents did not know

how long they waited, and 6.3% did not receive a return call.

3.6 How far did you travel if you visited the clinic?

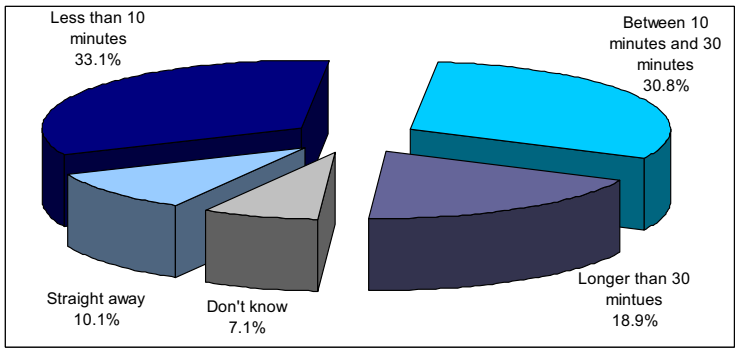
To the question asking how far the respondents travelled (See Appendix 5.1, question 6), 43.1% of respondents that answered the question travelled less than three miles, and 35.6% travelled between three and 10 miles. More than 10 miles was the distance travelled by 21.3% of respondents.



3.7 How long did you wait to be seen if you visited the clinic?

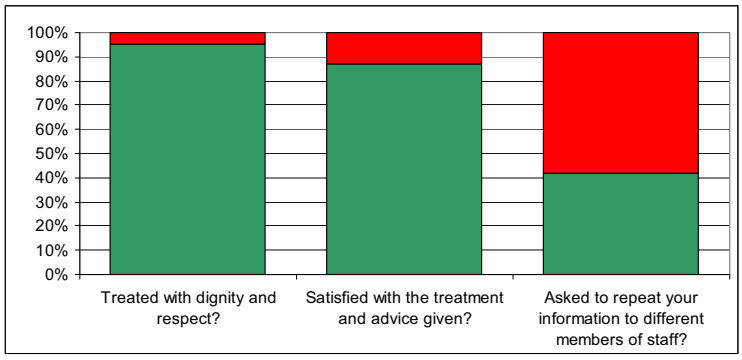
To the question asking how long the respondents waited to be seen (See Appendix 5.1, question 7), 74.0% of those that responded waited less than 30 minutes to be seen, comprising 10.1% of all respondents were seen straight away and 33.1% were seen within 10 minutes.

18.9% of respondents had to wait for longer than 30 minutes and 7.1% did not know how long they had waited.



3.8 How were you treated?

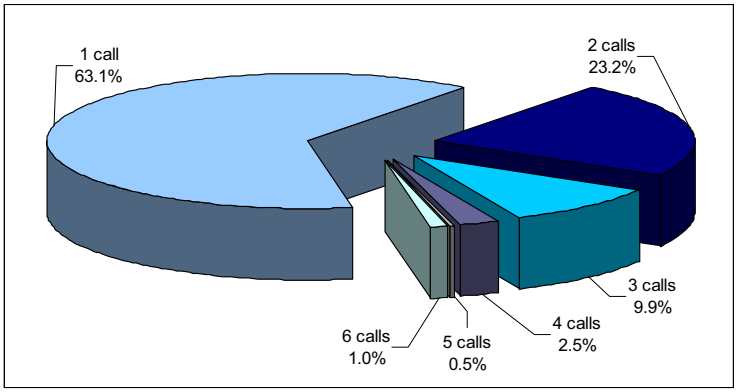
The question asking how the respondents were treated was split into three parts (See Appendix 5.1, question 8). Of those that answered part one, 95.1% felt they were treated with dignity and respect and of those that answered part two, 87.0% were satisfied with the treatment and advice they received.



Part three was a question asking if information had to be repeated by the patient to different members of staff. Of those that replied, 58.4% said they did have to repeat their information, and the remaining 41.6% of respondents did not.

3.9 "How many calls did you make to get the advice & treatment you needed?"

To the question "How many calls did you make to get the advice and treatment you needed?" (See Appendix 5.1, question 9), 63.1% of those that responded to the question only called the service once.



Of those who had to make repeat calls, 23.2% called twice, 9.9% called three times and 4.0% called four times or more.

Two respondents added a comment that they called an ambulance as they could not get an answer.

4 CONCLUSION

The responses to some questions had an answer that accounted for approximately half of all replies, others were more evenly split across the categories, and there was only one question that divided the respondents (58.4% and 41.6%) and this was when asked if they needed to repeat information to different members of staff.

From the answers given it can be surmised that the majority of respondents;

- Were directed to the service from their GP surgery,
- Wanted to talk to a doctor urgently,
- Had their call answered between one and three minutes,
- Were told a doctor or nurse would call them back,
- Were called back within one hour,
- Travelled 10 miles or less,
- Were seen within 30 minutes,
- Were treated with dignity and respect,
- Were satisfied with the treatment and advice they received,
- Only needed to make one call.

5 APPENDIX

5.1 Example Survey

Out of Hours Survey

There may have been occasions when you or a relative have needed urgent medical advice or treatment outside the normal opening hours of your own GP surgery. This out of hours service is currently provided by South East Kent Ltd. We would like you to complete this survey so that we can assess the quality of service you have received.

1. How did find out about this service? **please tick**

Directed from GP surgery ☐
NHS Direct ☐
Leaflets ☐
Websites ☐
Already knew the number ☐

2. Why did you phone for advice or treatment?

Run out of medicines and needed a prescription ☐
Couldn't wait to get a GP/nurse practitioner appointment at my GP surgery ☐
Passed to service from NHS Direct ☐
Wanted to see or talk to a doctor urgently as felt unwell ☐
Wasn't sure where to go for advice or treatment ☐

3. How quickly did they answer the phone?

Straight away ☐
Between 1 – 3 minutes ☐
Between 4 and 10 minutes ☐
Longer than 10 minutes ☐
Don't know ☐
No answer so hung up ☐

4. What happened when you rang?

Passed straight through to doctor or nurse for telephone advice ☐
Told doctor or nurse would ring back ☐
An ambulance was called ☐
Told to go to local A&E ☐
Asked to go to out of hours clinic to see doctor or nurse ☐
Doctor made a house call ☐

5. If you were told a doctor or nurse would call back, did they call you back within

15 minutes ☐
30 minutes ☐
1 hour ☐
Longer ☐
Don't know ☐
Didn't receive a call back ☐

6. If you were asked to go to the clinic to see the doctor or nurse, how far did you have to travel?

Less than three miles ☐
Between three and 10 miles ☐
More than 10 miles ☐

7. If you went to the clinic, how long did you have to wait to be seen?

Straight away ☐
Less than 10 minutes ☐
Between 10 minutes and 30 minutes ☐
Longer than 30 minutes ☐
Don't know ☐

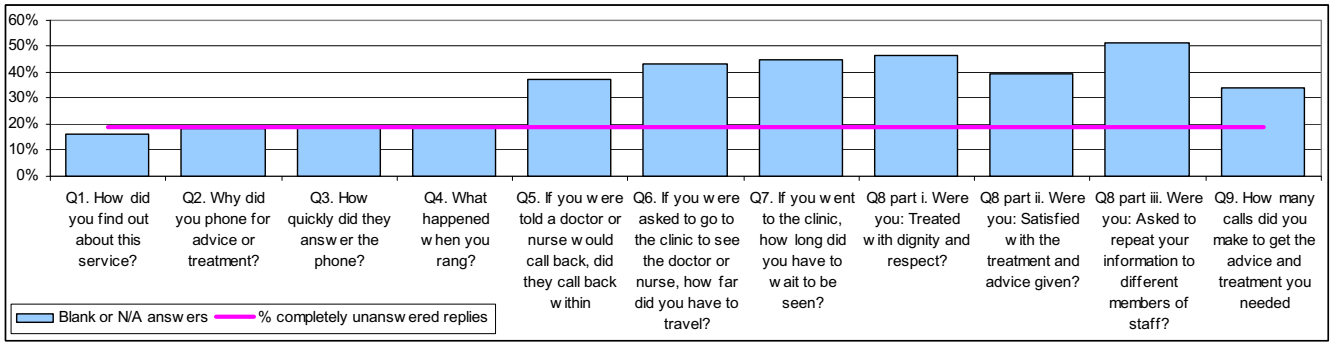
8. Were you:

	yes	no
Treated with dignity and respect?		
Satisfied with the treatment and advice given?		
Asked to repeat your information to different members of staff?		

9. How many calls did you make to get the advice & treatment you needed

Please send your responses back
by Tuesday 5 May in the enclosed envelope

5.2 Graph to show the number of responses left blank for each survey question



Note: Question 1 had multiple replies and so the overall percentage of blank responses is lower than the questions that only had one answer per respondent.

End of report

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