HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 11th June, 2010

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 11th June, 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):	Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr A D Crowther, Mr G Cooke, Mr K A Ferrin, MBE, Mr R L H Long, TD, Mr C P Smith, Mr R Tolputt, Mrs J Whittle and Mr A Willicombe
Labour (1):	Mrs E Green
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Cllr J Cunningham, Cllr C Kirby, Cllr M Lyons, Cllr Mrs M Peters
LINk Representatives (2):	Mr M J Fittock and Mr R Kendall

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 (Pages 1 - 4)	
4.	Accessing Mental Health Services: Adult and Older People's Inpatient Services (Pages 5 - 58)	10:10 – 12:30

This item will be examined in two sections as follows:-

a) East Kent Health Economy 10:10 – 11.15

BREAK

b) West Kent Health Economy 11:25 – 12.30

5.	Further Information on Dentistry (Pages 59 - 74)	12:30 – 12:40
6.	Paediatric Audiology Services in West Kent	12:40 – 12:50
7.	Committee Topic Discussion (Pages 75 - 76)	12:50 – 13:00

8. Date of next programmed meeting – Friday 23 July 2010 @ 10:00am

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

3 June 2010

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

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 14 May 2010.

PRESENT: Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr G Cooke, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr C P Smith, Mrs P A V Stockell (Substitute for Mr J A Kite), Mr R Tolputt, Mrs J Whittle, Mr A Willicombe, Cllr Ms A Blackmore, Cllr M Lyons, Mr R Kendall and Mr M J Fittock

ALSO PRESENT: Cllr Mr J Avey (Medway Council), Mr M Ayre (Senior Policy Manager), Ms C Bostock, Ms C Davies (NHS Eastern and Coastal Kent), Ms T Gailey (Public Health Policy Manager), Ms R Gunstone (Medway Council), Mr R Kenworthy, Mr J Larcombe, Mr A Marsh (Cabinet Member for Public Health), Miss N Miller (Media Relations Officer (CFE & Health), and Mr M Willis (NHS West Kent)

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee), Mr P D Wickenden (Overview, Scrutiny and Localism Manager)

UNRESTRICTED ITEMS

1. Minutes
(Item 3)

(1) Further to Minutes of 26 March 2010 the Chairman informed the Committee that the Department of Health had confirmed that the initial assessment of the Committee's referral to the Secretary of State for Health was ready for the attention of the Secretary of State.

(2) RESOLVED that the Minutes of the meeting held on 26 March 2010 are correctly recorded and that they be signed by the Chairman.

2. The Future of PCT Provider Services and the Use of Community Hospitals
(Item 4)

John Ashelford (Chief Executive, Hospice in the Weald), Dr David Goodridge, Oliver Mills (Managing Director, Kent Adult Social Services) and Anne Tidmarsh (Director of Commissioning and Provision, East, Kent Adult Social Services) were present for this item.

(1) The Committee had previously considered the Plans of the two Primary Care Trusts in Kent concerning their proposals for the future development of their provider services at the meeting of 30 October 2010.

(2) The Committee had before them a briefing paper prepared by the Research Officer to the Committee, and supplementary briefing material provided by Kent Adult Social Services, NHS Eastern and Coastal Kent, and NHS West Kent.

(3) The Chairman informed the Committee that both Primary Care Trusts had been in receipt of advice from the Department of Health stating that until there was clarity over the direction of Government policy on this topic, the attendance of NHS officers at the Committee should be postponed. The Overview, Scrutiny and Localism Manager was requested to liaise with the Chairman, Vice-Chairman, Political Group spokesmen and colleagues in the NHS with a view to scheduling an alternative time for them to meeting with Members and answer questions on this topic.

(4) Officers attending on behalf of Kent Adult Social Services (KASS) were first invited to introduce their paper on this topic. Mr Mills explained that the proposed changes presented an opportunity to build on the joint work already being done between Social Services and the Community Services as currently organised in both halves of the county. The idea of moving towards a whole county Community Foundation Trust was an opportunity to develop care pathways and bring care closer to home. There could also be a role for elected Members in the governance of any Community Foundation Trust, although details would have to come from the NHS. Other public service organisations could also be involved, and there was scope for reducing costs and working more efficiently.

(5) Dr Goodridge outlined what he saw as the current perverse incentives in the way NHS finances were structured, with acute services subject to a tariff and community services a block contract meaning hospitals tended to absorb any additional NHS spending. The capability to develop a local currency for community services has existed since April 2009. He raised the suggestion that if there was a need to cut management costs, one Primary Care Trust for the whole of Kent and two community service providers would be more sensible and retain the closeness of service providers to their relevant community.

(6) Mr Ashelford spoke from the experience of having been Chief Executive of the Hospice in the Weald to provide information about palliative care and the connection between hospices and community services. He argued that although the NHS has recognised the importance of end of life care, the role of community services has been diminishing in recent years with a reduction in the number of visits from community nurses and subsequent loss of shared knowledge. There was a need to better integrate community hospitals as currently 60% of people die in acute beds, but the admissions criteria for community hospitals does not encourage end of life care being given in community hospitals. The Hospice in the Weald had only 17 beds and delivered very specialist care, Mr Ashelford explained that although Hospices received on average 32% of their funding from Government sources, his Hospice received half of that.

(7) Mr Mills explained that Kent Adult Social Services provided a complete range of adult services, and community hospitals were an important aspect of this. He could not speak for children's services or public health, but KASS worked with the PCTs on commissioning and were looking towards developing a single assessment process of people's individual needs in order to prevent duplication of effort and facilitate a partnership approach to care. This fitted into the lessons which are being learnt from Kent being one of the Total Place pilots.

(8) His colleague Mrs Tidmarsh supplemented this information with examples of how there were numerous examples of jointly funded arrangements, such as integrated care teams, and joint working, such as the provision of step down beds in community hospitals, the work of community matrons and use of telehealth and telecare technologies to support patients with long-term conditions. At a time where the numbers of acute beds were being reduced, this was seen as even more important.

(9) A representative from the Kent LINk expressed his support for the KASS paper included in the Agenda and explained that the question of who paid for which services was important but confusing and often did skew provision.

(10) All Members of the Committee stressed their support of community hospitals and the important role they play in delivering effective health care to the people of Kent. One Member indicated the details of the different services provided at each hospital given in the information supplied by the NHS and indicated how each one was different and that it was difficult to form judgments about the future direction of these facilities without clarity concerning NHS plans for what services would be provided in the future. This also indicated the lack of precision about what exactly the role of a community hospital could and should be. A member of the public invited to speak pointed out the differential coverage of community hospital services across the county. Other questions raised by Members about community hospitals about which Members would like answers were the definition of 'local' used by PCTs, the status of legacies left to community hospitals, the role and status of volunteers at them and the comparative cost of a bed in a community hospital compared to those in the acute sector, as well as more details on the availability of beds in community hospitals for use by KASS.

(11) Members of the Committee then took the opportunity to have a broader discussion of the structure of the NHS and there was a general view expressed that continual reconfigurations were a distraction from focussing on patient care but that there were a number of perverse financial incentives within the system.

(12) The central role of GPs, both now and in the future, was discussed. One Member felt that in practice it was GPs who often exercised patient choice as patients did not have the appropriate information to make changes and that the much discussed Practice Based Commissioning would come up against the problem of GPs preferring to concentrate on treating people and not becoming managers.

(13) RESOLVED that colleagues be thanked for their attendance and that the Overview, Scrutiny and Localism Manager be authorised to discuss the most appropriate time for colleagues in the NHS to appear to answer questions on this subject with the Chairman, Vice-Chairman, the Liberal Democrat and Labour Group spokesmen as well as the Borough Representatives on the Committee.

3. CQC Registration Update
(Item 5)

(1) Members had before them papers received from Medway NHS Foundation Trust providing information on how its registration with the Care Quality Commission. Mr Wickenden was able to provide a verbal update based on information received from the Company Secretary that the Trust has applied to have the condition

concerning training on the Safeguarding of children lifted as the requisite training has now all taken place and that the Care Quality Commission had acknowledge receipt of the application.

(2) Members were also reminded that a briefing with local staff from the Care Quality Commission was scheduled to take place on 25 May.

(3) RESOLVED that the report be noted.

4. Forward Work Programme
(Item 6)

(1) Mr Wickenden provided Members with a general overview of how the best practice of the Committee in agreeing a forward work programme with stakeholders and focussing more on outcomes in the development of scrutiny questions was potentially a model for adoption across more areas of Overview and Scrutiny.

(2) Clarification was also provided to Members of the Committee that the proposed Select Committee on dementia would involve Members of the Health Overview and Scrutiny Committee while the parent Committee would be the Adult Social Services Policy Overview and Scrutiny Committee. A representative from LINks requested that his organisation be included in the work of the Select Committee in some way and the Chairman felt that there would be numerous opportunities for this to occur because of the value they would be able to add to the process.

(3) It was observed that much Committee time had been devoted to the issue of a new hospital in Dover and that as the scheme should be progressing there would be little need to include the issue on the work programme again. However, Mr Wickenden was asked to request a written update from East Kent Hospital Trust for Members' information.

(4) The Researcher to the Committee indicated Appendix B to the Forward Work Programme and requested additional questions for the July meeting from Members.

(5) RESOLVED that the Forward Work Programme be approved.

5. Committee Topic Discussion
(Item 7)

(1) Members felt that as the main item on the Agenda would be returned to at a later date as agreed in Item 4, they had no further comments to make at this point in time.

6. Date of next programmed meeting – Friday 11 June 2010 @ 10:00 am
(Item 8)

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 11 June 2010

Subject: Item 4. Intended Outcomes: Accessing Mental Health Services: Adult and Older People's Inpatient Services.

---

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: the strategic (or public), overarching questions, and the more detailed questions. The detailed questions have been sent to the attendees in advance of the meeting (and include versions of the strategic questions).

2. Hierarchy of Questions

(1). Strategic Questions

1. What planned changes are being carried out in adult and older people's inpatient mental health services?
2. What changes are planned for the future?

(2). Detailed Questions

1. What adult mental health inpatient services are commissioned for your resident population under the following headings:
    a. adult mental health;
    b. older people's mental health;
    c. acute inpatient services;
    d. other (please specify).
2. For each of the services listed above please give the following:
    a. Name and location
    b. Provider
    c. Number of beds, including occupancy rates, and average number of bed days per patient.
    d. Staffing
    e. Route of referral
    f. Specific details of the types of conditions dealt with by the service.

3. Are any changes to these inpatient services being carried out or being planned?
4. How much do you spend on adult mental health services each year, and how much is spent specifically on inpatient services?
5. How much is this as a proportion of your overall spend and how does this compare to the other Primary Care Trusts across the SEC SHA area?
6. What are your expectations for both of these amounts in coming years?
7. How are community mental health services being developed and how is it anticipated that these will complement or replace inpatient services?
8. What actions are you taking to reduce mental health inpatient admissions?
9. Are any tertiary or Tier 4 adult mental health services commissioned outside of Kent and Medway?
10. How is commissioning of adult mental health services integrated with that of other Primary Care Trusts in Kent and Medway and Kent Adult Social Services?
11. Can you please provide any relevant PALs data relating to adult mental health inpatient services?
12. More broadly, has there been any increase in mental health referrals that are thought to result from the effects of the economic downturn? And if so, is there sufficient capacity to deal with them?

3. Recommendations

(a) 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.

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

To: Health Overview and Scrutiny Committee – 11 June 2010

Subject: Accessing Mental Health Services: Adult and Older People's Inpatient Services.

NB: This briefing note is intended to provide an overview of the context in which this subject has developed and within which people have operated in recent years and may not reflect the latest national policy developments.

1. Introduction.

(a) Mental health and mental health services are both terms with a very wide scope:

1. Around 14% of the annual NHS budget is spent on mental health services.

2. Approximately 1 in 6 adults will experience a mental health problem at any one time and the problem will last longer than a year for half of these.

2. Definitions and Terminology[1].

(a) **Mental health** is a core component of psychological wellbeing, and hence everyday life, and is as important as physical health. The two issues are interlinked; poor physical health may increase the likelihood of developing poor mental health, and poor mental health may increase risks of developing or not recovering from serious physical health problems.

(b) **'Mental health problem'** is a loose term which can be used to describe the full range of mental health issues, from common experiences such as 'feeling depressed' to more severe clinical symptoms such as 'clinical depression' and enduring problems such as schizophrenia.

(c) Mental health problems have traditionally been divided in several ways:

1. **Organic** (identifiable brain malfunction) versus **functional** (not due to structural abnormalities of the brain).

2. **Neurosis** (severe forms of normal experiences such a low mood, anxiety) versus **psychosis** (severe distortion of a person's perception of reality).

[1] Section 2 has been adapted from definitions supplied by the London Health Observatory (LHO), http://www.lho.org.uk/LHO_Topics/Health_Topics/Diseases/MentalHealth.aspx

(d) Terminology for mental health problems varies considerably across professions and cultures, according to prevailing attitudes towards mental health and current understanding.

1. **Common mental health problems** include problems such as anxiety, depression, phobias, obsessive compulsive and panic disorders.

2. **Severe and enduring mental health problems** include those mental health problems such as psychotic disorders (including schizophrenia) and bipolar affective disorder (manic depression).

3. **Personality disorder** is defined as 'an enduring pattern of inner experience and behaviours that deviates markedly from the expectation of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment'.

(e) **Dementia** is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. Consciousness is not clouded. The impairments of cognitive function are commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation. This syndrome occurs in Alzheimer's disease, in cerebrovascular disease, and in other conditions primarily or secondarily affecting the brain.[2]

3. The Structure of Mental Health Services

(a) Commissioning mental health services is a joint activity for health and social services. Money can be pooled between health bodies and relevant health-related local authority services for mental health (under a framework set up by the National Health Service Act 2006). More broadly there are a range of partnerships and structures through which decisions around mental health services commissioning are driven – Joint Strategic Needs Assessment (JSNA), Local Area Agreements, Local Strategic Partnerships, Joint Commissioning Boards and Practice Based Commissioning (PBC) consortia.

(b) A number of specialised services where the number of affected patients is relatively small are commissioned either regionally by one of the ten Specialised Commissioning Groups, or nationally by the National Commissioning Groups. In mental health this includes secure services and some personality disorder services.

(c) Mental health services have been commissioned through block contracts, but there have been recent developments towards local

[2] Definition of dementia taken from *International Statistical Classification of Diseases and Related Health Problems, 10th Revision*, World Health Organisation, http://www.who.int/classifications/icd/en/

currencies (a unit of care for which payment is made) and the extension of Payment by Results (PbR) to mental health. This has involved using mental health outcome measures from HoNOS (Health of the Nation Outcome Measures).[3] Recent years have seen the introduction of systems aimed at incentivising an improvement in the quality of health services, including mental health. The Quality and outcomes Framework (QOF) has aimed at monitoring and rewarding activity in primary care, specifically GPs. The CQUIN (Commissioning for Quality and Innovation) scheme was developed to complement PbR by making a proportion of provider income conditional on quality and innovation.

(d) Across England, 90% of those receiving care for mental health problems do so within a primary care sector, yet around 80% of mental health NHS spending is spent of inpatient services. The last 30 years have seen a scaling back of psychiatric hospital services. In England there are 23 mental health beds per 100,000 population.[4]

(e) GPs treat many patients, and usually refer those they cannot help to directly to community mental health teams (CMHTs) or psychiatric outpatient clinic. CMHTs are the main source of specialist help for mental health problems. These teams can include social workers, community psychiatric nurses, doctors, psychologists, occupational therapists and support workers.

(f) Some of the ways in which mental health services have been developed in the community include[5]:

1. Early intervention teams which aim to treat psychotic illness during its early onset.

2. Assertive outreach teams to provide intensive support for those difficult to engage in traditional services.

3. Crisis resolution home treatment teams providing acute care in patients' homes in crises (a 24-hour service).

(g) Recent years have also seen the development of the Improving Access to Psychological Therapies (IAPT) programme aimed at extending 'talking therapies' and encouraging provision outside hospitals.

(h) In the acute sector, acute admission wards provide inpatient care with intensive support for patients in periods of acute psychiatric illness. Inpatient Assessment Units assess functional and organic type illness in older adults, and take referrals from Community Mental Health Teams for Older People, GPs and Consultant Psychiatrists. Patients who are in an acutely disturbed phase of a serious mental health

[3] For further details see The Royal College of Psychiatrists website, http://www.rcpsych.ac.uk/quality/honos.aspx
[4] The NHS Handbook 2009/10.
[5] The names given to services can vary between areas of the country.

disorder, are detained in Psychiatric Intensive Care Unit (PICU) facilities.

(i) Other mental health inpatient services aim to provide rehabilitation services and provide care to people with an enduring mental illness and for whom a residential placement in the community has been judged to be unsuitable.

(j) Forensic mental health services are there to deal with patients whose behaviour is beyond the scope of general psychiatric services and who may require a degree of physical security. Some will be mentally disordered offenders. These services fall into three categories:

1. Low-security services, often near general psychiatric wards in NHS hospitals.

2. Medium secure services operating regionally with locked wards.

3. High-security services provided by the three specialist hospitals of Ashworth, Broadmoor and Rampton.

(k) CAMHS services are arranged in four linked tiers. These range from tier 1 services which contribute to mental healthcare, but where it is not the primary function, such as schools, to tier 4 dealing with the most severe and complex cases and includes inpatient and specialist services such as eating disorders.

4. Mental Health Services in Kent and Medway

(a) In Kent and Medway there is a Strategic Commissioning Board for Mental Health (covering both LA areas) and three Joint Commissioning Boards for Mental Health (one for each Primary Care Trust area). There is PCT and Local Authority Social Services representation on all of these. Amongst the PCTs, NHS Medway is the lead commissioner for mental health services.

(b) These three PCTs and two local authorities have recently produced *Live it Well*, a draft joint strategy for improving the mental health and wellbeing of people in Kent and Medway in April 2010[6]. This draft strategy did not cover dementia care and services, child and adolescent mental health services (CAMHS), or drug and alcohol services, for which there are separate strategies.

(c) Kent and Medway NHS and Social Care Partnership Trust (KMPT) is the major provider of mental health services in Kent and Medway, but there are a range of other public and private sector providers. A number of social care staff are seconded to KMPT from Kent County Council.

[6] See Item C1, Adult Social Services Policy Overview and Scrutiny Committee, 30 March 2010, http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=127&MId=2944&Ver=4

Appendix - Maidstone and Tunbridge Wells Borough Councils Joint Mental Health Services Working Group

1. Introduction

   (a) In March 2010, the Borough Councils of Maidstone and Tunbridge Wells published a Joint report on Adult Public Mental Health Services. The Executive Summary, Recommendations and Conclusion are below for reference.

   (b) The full report can be accessed here:

   http://www2.tunbridgewells.gov.uk/pdf/Joint%20Scrutiny%20Review%20of%20Mental%20Health%20Care%20Provisionintranetx.pdf

2. Report Extract.

Executive Summary

The range of issues encompassed by the term "mental health" is expansive, and this report does not aim to give a definitive picture of services for those with mental health problems in Maidstone and Tunbridge Wells. The report does, however, seek to outline the range of services available (particularly for more common mental health conditions) the coordination between service providers, and the areas that clearly require attention.

Mental health service provision across the boroughs is fragmented and complicated; the working group spent a significant amount of time simply trying to map service provision and establish what services were available for residents in the public, community and voluntary sectors. The group found that there was a lot of support for those with mental health issues, however this was not always clearly publicised and members felt that for those residents in distress, the time and effort required to identify available services was prohibitive. The need for improved coordination between service providers from all sectors was clear, particularly in increasingly difficult financial times when coordinating services could make more efficient use of limited funding.

Throughout the review, the group became increasingly concerned about the waiting times for counselling and other psychological therapies. Although encouraged by the Improving Access to Psychological Therapies (IAPT) programme, the group felt that this was an issue that urgently needed to be addressed in order to prevent mild to moderate mental health issues becoming more severe.

A survey of GPs in Maidstone and Tunbridge Wells reflected the concerns of councillors, with only 18.75% of respondents agreeing that the current provision of mental health services was adequate. Waiting times, the limited variety of available treatments and knowledge of voluntary sector provision were all specifically highlighted as issues by GPs.

As a result of their enquiries, members of the working group were keen to emphasise the need to:

- monitor access to psychological therapies and establish whether more funding needs to be directed at tackling mild to moderate mental illness to prevent deterioration of patients' mental health;
- improve access to information about voluntary, community, public and private mental health services for all sectors of the community; and
- encourage joined-up working between service providers to ensure seamless and complementary provision of services for the benefit of all residents experiencing mental health problems.

….

Recommendations

The Mental Health Services Working Group recommends that:

<u>To Local Authorities</u>

1. Local authorities embrace the Time to Change Campaign as a route to tackling the stigma attached to mental health disorders.

To West Kent PCT and the Kent and Medway NHS and Social Care Partnership Trust

2. The PCT engages with local authorities in the development of its Wellbeing Strategy.

3. Information on voluntary, community, public and private mental health services for all sectors of the community be made more easily available.

4. A website be developed, along with an accompanying leaflet, outlining all local mental health services in Kent along with details on how to access these.

5. The local website referred to in recommendation 4 be advertised in GP surgeries, Gateways and libraries alongside the NHS Choices website and highlighted to GPs new to the area to improve knowledge of services.

6. Clarity is ensured over developments or cuts in mental health services to reduce uncertainty over services, which can be worrying for vulnerable patients.

7. Consultations should be in a variety of formats, with short versions available containing only priority questions, to ensure that carers and service users can participate even where time is limited.

8. Consultation results should be clearly publicised along with proposed follow up actions, including for the recent listening exercise.

9. The following areas of concern are focussed on:

Access to psychological therapies and availability of funding for services which tackle mild to moderate mental illness;
Tackling long waiting lists for talking therapies in order to prevent deterioration of patients' mental health;
Improving access to secondary care for a broader range of patients;
Ensuring an emphasis is placed on listening to the needs of service users in secondary care; and
Improving access to information on patient healthcare, budgets and statistics, in particular via websites.

To Local Authorities and the Health Trusts

10. In light of evidence that physical activity contributes to good mental health, local authorities and the health trusts should work together to provide exercise on prescription.

To Local Authorities, the Health Trusts and the Third Sector

11. Joined-up working between service providers should be encouraged to ensure seamless and complementary provision of services for the benefit of all members of the public experiencing mental health problems.

12. Patients should be supported in undertaking voluntary work as a precursor to returning to paid employment.

. . . .

11. Conclusion

11.1 It is now recognised that mental ill health is a serious problem which affects a large proportion of people at some point in their lives. The NSF saw significant increases in the money spent on the services and the available support particularly for those with more serious mental health problems. However, additional funding will not be available in the future and public finance will be much tighter, which does pose a threat to the continuation of progress that has been made as well as the capacity of local mental health services in the statutory and voluntary sectors.

11.2 Maidstone has benefited from being chosen as an expansion site for the improvement of access to psychological therapies and, as identified, will receive up to £2 million of funding for CBT. Nevertheless, there continues to be a need for improvement in services, particularly in waiting times for talking therapies. There are many factors which support mental health care being a priority both at a local and national level and as a service which should be protected. Consideration should be given to the level of unmet need, service user satisfaction, health problems – particularly related to the recession. Both Maidstone and Tunbridge Wells continue to have high levels of recipients on incapacity benefit as a result of mental health problems. This suggests that improvement of mental health care and the promotion of good mental health are required.

11.3 Research has indicated that greater community based treatment is required in order to ensure that those suffering with long term mental health problems are able to cope with their mental health issues whilst living as near to a normal life as possible in the way they want to. General mental health promotion for the whole population is also very much on the agenda but should not be at the expense of those who are most in need of care and support.

11.4 Additionally, Members have raised concern with regard to the apparent lack of communication between individual service providers and suggest that greater interaction should increase service efficiency. Sharing information on the resources, skills and knowledge with different services may help people to access the help they require quickly and recover more effectively.

11.5 The working group was, overall, encouraged by the ongoing work to improve access to mental health services and to address inequalities in this. However, until all services are clearly publicised and working together seamlessly, there remains a very real concern that residents suffering from mental health problems may not receive the help that they need - particularly not in time to prevent a mild or moderate problem becoming more serious.

For further information on this report, please contact:

Kat Hicks, Interim Overview and Scrutiny Manager, Tunbridge Wells Borough Council,
E-mail: kat.hicks@tunbridgewells.gov.uk
Tel: 01892 554085

Kent and Medway NHS
NHS and Social Care Partnership Trust

Trust Headquarters
35 Kings Hill Avenue
Kings Hill
West Malling
Kent
ME19 4AX
Tel: 01732-520479
Fax: 01732-520460

Our Ref: EM/sd/10-098

25 May 2010

PRIVATE – IN STRICT CONFIDENCE

Paul Wickenden
Overview, Scrutiny and Localism Manager
Democratic Services
Kent County Council
Legal and democratic Services
Sessions house
County Hall
Maidstone
ME14 1XQ

In hard copy and via email: Tristan.godfrey@kent.gov.uk

Dear Paul

RE: HEALTH OVERVIEW AND SCRUTINY COMMITTEE [HOSC] MEETING: 11 JUNE 2010

Thank you for your letter of 4 May 2010. Please find below the information as requested:

1. ***What adult mental health inpatient services are commissioned for your resident population under the following headings:***
   - *a. Adult mental health;*
   - *b. Older people's mental health;*
   - *c. Acute inpatient services;*
   - *d. Other (please specify).*

2. ***For each of the services listed above please give the following:***
   - *a. Name and location;*
   - *b. Provider;*
   - *c. Number of beds, including occupancy rates, and average number of bed days per patient;*
   - *d. Staffing;*
   - *e. Route of referral;*
   - *f. Specific details of the types of conditions dealt with by the service.*

Eastern and Coastal Kent

WARD TYPE / TYPE OF CONDITIONS	LOCATION	NUMBER OF BEDS	BED OCCUPANCY (2009/10)	AVERAGE LENGTH OF STAY: DAYS (2009/10)	ROUTE OF REFERRAL
Adult Acute	The Arundel Unit, Ashford St Martins, Canterbury Thanet Mental Health Unit [TMHU], Margate	78	97%	41	Referrals accepted from secondary services, community services, under section of the Mental Health Act
Psychiatric Intensive Care Unit [PICU]	St Martins Hospital, Canterbury	8	90%	38	
Rehabilitation	Units in Ashford, Canterbury, Sandwich and Ramsgate	49	84%	753	
Older Adult Acute	The Arundel Unit, Ashford St Martins, Canterbury TMHU, Margate Memorial Hospital, Sittingbourne	91	94%	85	
Continuing Care	St Martins, Canterbury and Rook Lane, Sittingbourne	30	96%	751	

West Kent:

WARD TYPE / TYPE OF CONDITIONS	LOCATION	NUMBER OF BEDS	BED OCCUPANCY (2009/10)	AVERAGE LENGTH OF STAY: DAYS (2009/10)	ROUTE OF REFERRAL
Adult Acute	Little Brook Hospital, Dartford Priority House, Maidstone	66	89%	23	
PICU	Little Brook Hospital, Dartford	12	86%	42	
Rehabilitation	Units in Maidstone and Dartford	21	84%	369	
Older Adult Acute	Jasmine Centre, Dartford Priority House, Maidstone	40	85%	62	
Continuing Care	Greenacres, Dartford	20	88%	920	

Kent and Medway:

WARD TYPE / TYPE OF CONDITIONS	LOCATION	NUMBER OF BEDS	BED OCCUPANCY (2009/10)	AVERAGE LENGTH OF STAY: DAYS (2009/10)	ROUTE OF REFERRAL
Medium Secure Mental Health	Trevor Gibbens Unit, Maidstone	62	95%	815	Referrals accepted from secondary services, high secure services and criminal justice system
Low Secure Learning Disabilities	The Tarentfort Unit, Dartford	20	95%	300	

Ward Staffing: Inpatient units in KMPT are spread across the geographical area of Kent and Medway with all units offering 24 hours 365 days per year service.

There would always be a proportion of qualified nursing staff on duty on the units, although the qualified to unqualified ratios from one unit to another vary. In addition, there are variances in the staff to bed ratios. This is largely a result of differing clinical needs in each specialty. For example, Forensic Services and PICUs support patients who present higher levels of risk and / or disturbance and therefore require a higher ratio of qualified staff. On the other hand, wards for older people with continuing care needs have patients who have higher basic care needs and subsequently often have a higher unqualified staff ratio.

In any mental health unit, staff may also be needed to ensure that the heightened observation levels can be safely met on a 24 hours basis. Many wards will have more than one client needing within arms length or within eyesight observations at any one time along with others who need observing at intervals between 10 and 30 minutes. More clients now need this level of care as a result of a more acutely ill inpatient population.

Some of our units however have lower nursing figures because other staff, such as occupational therapists and psychotherapists contribute significantly to the daily patient care in those areas; this is particularly the case in Eating disorders and CAMHS wards.

11. Can you please provide any relevant Patient Advisory Liaison Services [PALS] data relating to adult mental health inpatient services?

April 2009 / March 2010:

ISSUE	RESOLUTION ACHIEVED
Signage at A Block, Medway	New signage ordered
Receptionist awareness of new ward names	Awareness training given
*Inappropriate mix of dementia and functional beds	Being addressed as part of the development of the Older Adult's Strategy
*Waiting times for mental health assessment at Accident and Emergency [A&E]	New staff posts to increase capacity
Ward staff reported to threaten informal patient with section 5(4)	Staff awareness raised
*Attention to physical health support	Staff awareness raised; quality improvement focus (2010/2011)
Issues around palliative care provision	Staff training provided; protocols reviewed
Escorted leave procedure	Staff discussion
Communication issues for patient and carer	Awareness raised
**Lack of beds leading to out of area treatment	Service looking at re-targeting resources to create better support at home
Clarity of information around accessing second opinion	Executive Medical Director asked to clarify and information leaflet planned
Difficulties in visiting patient treated in other area	Support provided in accessing financial support

ISSUE	RESOLUTION ACHIEVED
*Issues relating to accessing items from home when detained	Staff awareness; communication improved with patients and carers
Patient support in managing expectation and concerns	Support provided
Independent Mental Health Advocates [IMHA] provision for older adults	Service now available to older adults
Confidentiality issues for patient in dormitory accommodation	Improved protocols
Telephone charges for reverse charge calls	Notice provided next to telephone
Staff awareness of IMHA	Staff informed; enhanced training; PALS volunteers highlight service on visits
Need for private space for patients to see advocates	Space provided; new staff made aware
Delays in providing information about Mental Health Act to detained patient	Staff training and awareness
Patient safety	Liaised with ward staff

** denotes issue raised more than once*
*** denotes issue raised often*

The other questions (3, 4, 5, 6, 7, 8, 9, 10 and 12 as outlined in your letter of 4 May 2010) relate to commissioning and funding of mental health services; these will be addressed by NHS Medway.

I can confirm Erville Millar, Chief Executive, and James Sinclair, Executive Director of Social Care and Partnerships, will be attending the HOSC on 11 June 2010.

With best wishes

M. Dodd.

ERVILLE MILLAR
Chief Executive
(signed by Marie Dodd, Executive Director of Operations / Acting Chief Executive to avoid delay in the absence of the Chief Executive)

Committee:	Kent Health Overview and Scrutiny Committee
Date of Meeting:	11 June 2010
Subject:	Accessing Mental Health Services: Adult and Older People's Inpatient Services
Lead Director:	Lauretta Kavanagh, Kent and Medway Director of Commissioning for Mental Health and Substance Misuse

1. Introduction

The approach taken to responding to the 12 questions asked has been to respond to them under three categories:

- Adult acute beds provided by Kent and Medway Partnership Trust
- Older people's acute beds provided by Kent and Medway Partnership Trust
- Specialist and secure beds provided by both KMPT and contracted across other NHS or independent sector providers (not split by age but older people spend and utilisation is minimal)

Our strategic changes to bed utilisation focus on reducing acute admissions and lengths of stay in acute settings, delivered by a range of service alternatives. These range from:

- Improving primary care interventions
- More effective Crisis Resolution and Home Treatment Services (e.g. fewer admissions, more support to stay at home)
- Earlier response in crisis
- Widening therapy alternatives
- Improving recovery
- Supporting choice and personalisation
- Supporting some specific high-risk groups such as those with dual diagnosis and those in the Criminal Justice System

These are a significant area of focus of the Live It Well strategy that is coming to fruition.

Investigating spend on acute mental health in-patient services requires an understanding of three sets of figures:

a. *PCT contracted spend (on behalf of both the PCTs and the Councils as a lead commissioner).* We are able to provide spend on inpatient services by locality for specialist or secure secures services outside of the KMPT contract. In the KMPT contract neither the adult inpatient nor older people's inpatient contract value is broken down by locality.

b. *Adult and older people mental health mapping data (supplied by Mental health Strategies).* Mental Health financial mapping data includes the PCT and Local Authority spend on mental health services, adults and older people separately, and spend on provider categories (NHS, LA, non-statutory) but with no separate expenditure line for inpatient services. The data does give points of comparison, i.e. against the SHA spend, the ONS cluster spend and the English national average.

c. *NHS programme budgeting by PCT.* The NHS programme budgeting data shows spend by PCT only, by any type of provider on clients categorised as having a primary mental health diagnosis, and of any age. NHS programme budgeting data has five subcategories (including CAMHS services, substance misuse services, dementia, and covers far more than expenditure on beds or on contracted services with mental health providers. No specific subcategory relates to in-patient care.

Wherever relevant or possible, all these figures are provided.

The document attached goes on to describe how mental health commissioning is integrated across health and social care for all three PCTs in Kent and both Councils and gives a short summary of developments in accessing talking therapies in primary care.

2. Conclusions

In our strategy we would certainly anticipate less acute beds across Kent in five years time than we have now, and less expenditure on high-cost placements.

Live it Well sets an expectation that we develop new care pathways. These will emphasise more support for service users in primary care and community settings, with primary care services being better supported to access more and wider resources for service users, so needing less recourse to an acute bed. These supports would include access to more information, access to helplines for those in distress, more crisis response in primary care, wider voluntary sector help and service delivery, wider access to liaison psychiatry, more support for achieving recovery, and more support for carers and relatives.

West KENT - KMPT adult in-patient services

Commmissioners: Tony Goss / Paul Absolon

		Adult	PICU	Rehab
1	What we commission:	See attached schedule of Wards and bed numbers	See attached schedule of Wards and bed numbers	See attached schedule of Wards and bed numbers
	Service specification available: Yes / No	Yes	Yes - within Adult specification	Yes
2	For each of the service listed above please give the following:			
	1. Name and location	See attached schedule of Wards and bed numbers	See attached schedule of Wards and bed numbers	See attached schedule of Wards and bed numbers
	2. Provider	KMPT	KMPT	KMPT
	3. Number of beds, including occupancy rates, and average number of bed days per patient.	66 beds, across Little Brook, Dartford, and Priory House, Maidstone. 89% occupancy ALOS 23 days	12 beds at Little Brook, Dartford 86% occupancy ALOS 42 days	21 beds, Maidstone and Dartford units 84% occupancy ALOS 369 days

	4. Staffing	See Appendix 1	See Appendix 1	See Appendix 1
	5. Route of referral	Referrals accepted from secondary services, community services, under section of the Mental Health Act	Referrals accepted from secondary services, community services, under section of the Mental Health Act	Referrals accepted from secondary services, community services, under section of the Mental Health Act
3	Are any changes to these inpatient services being carried out or being planned?	No	No	No
4	How much do you spend on adult mental health services each year, and how much is spent specifically on inpatient services?	Mental health spend is mapped in two ways, by LIT data and by programme budgets. LIT figures are the sum of both NHS and Local Authority spend on MH services. The programme budget MH spend is the sum of all costs attributed to MH expenditure by all NHS providers (excluding primary care contractors) aggregated back to the commissioning PCT. Total spend of West Kent PCT on MH programme budget was 10.73%. Total investment in adult MH services in 2009-10 (including indirect costs, overheads, capital charges) was £59,788k (LIT data). 63.1% of the direct spend (excluding indirect costs, overheads, capital charges) was spent with NHS providers.		
5	How much is this as a proportion of your overall spend and how does this compare to the other Primary Care Trusts across the SEC SHA area	The overall contract value with KMPT for Adult Inpatient Service including PICU for <u>all</u> of Kent and Medway for 2010-11 is £34,319k. It is <u>not</u> broken down by locality.	The overall contract value with KMPT for Community and Inpatient Rehabilitation Services for <u>all</u> of Kent and Medway for 2010-11 is £32,366k. It is <u>not</u> broken split between community and inpatient rehab <u>nor</u> split down by locality.	
		The LIT Results of Financial mapping 2009-10 (Appendix 2) report compares the total adult investment within this LIT, with the total adult investment of SEC Strategic Health Authority, the ONS cluster of the LIT and the English national average.		
6	What are your expectations for both of these amounts in coming years?	The projected change in the total MH programme budget spend for Eastern and Coastal Kent is from £97.3m in 2008-09 to £91m in 20014-15. We do not have projections for change in spend by KCC.		

7	How are community mental health services being developed and how is it anticipated that these will complement or replace inpatient services?	Increase in talking therapies; increase in dual diagnosis support; currently developing with KMPT the roll out of the First Response and Intervention Service (FRIS) aimed at providing quicker access to services and a liaison function with primary care. We are also developing a recovery model approach in CMHTs which will lead to more people who are stable being returned to primary care for their future care, with easy access back into services should they require this.
8	What actions are you taking to reduce mental health inpatient admissions?	Creation of Liaison Psychiatry service based in acute hospitals. Work with ambulance service to prevent people attending A&E where appropriate. Wider advertising of Mental Health Helpline. Focus on efficiency and effectiveness of Crisis Response Home Treatment Team.
9	Are any tertiary or Tier 4 adult mental health services commissioned outside of Kent and Medway?	See secure sheet
10	How is commissioning of adult mental health services integrated with that of other Primary Care Trusts in Kent and Medway and Kent Adult Social Services?	All 3 PCTs and both LAs in Kent have a single MH commissioning service for adult mental health (functional / 18+) and wellbeing. Medway PCT is the lead commissioner. The MH Directorate has 4 lead health commissioners, 3 for adult services (including OP functional illness) engaged on a locality basis, and a lead commissioner across Kent and Medway for specialist and secure services. KCC (KASS) has 2 mental health commissioners for adult social care, one for East Kent and one for West Kent. In addition, Eastern and Coastal Kent PCT has a commissioner for OPMH services (not joint with KCC), and Medway PCT and West Kent PCT each have a joint commissioners with the respective councils for dementia services.
11	Can you please provide any relevant PALs data relating to adult mental health inpatient services?	See Appendix 3

12	More broadly, has there been any increase in mental health referrals that are thought to result from the effects of the economic downturn? And if so, is there sufficient capacity to deal with them?	The contract for Primary Care Psychological Therapy services (PCPTS) was awarded to KMPT from October 1 2009. At the same time funding from the national IAPT programme allowed the expansion of psychological therapy in primary care across the whole PCT area. There had previously been only partial coverage. This situation coupled with the introduction of a new data collection system, means that current data cannot be reliably compared with previous data. An increase related to the economic downturn is currently unknown. It is worth noting that employment support (either to retain jobs or support to gain one) is integral to the IAPT programme but the posts described in DH documents have not been funded. Ongoing DH funds have been ring fenced for clinical posts only. The PCT has recently commissioned a review of employment support services to ascertain whether they have the capacity and capability to work with primary care as to date they have been secondary card focused. Based on modelling carried out prior to the economic downturn, PCPTS requires 106.5 CBT staff. Currently there are shortfalls though staff numbers are increasing. There are currently 48 staff in post (including 18 trainees due to complete in September 2010). A further 15 trainees are being recruited to start in October 2010. A planned workforce mapping exercise will help to determine whether there is any shortfall in the other key therapies.

West KENT - KMPT older people in-patient services

Commmissioners: Emma Hansen

		Acute	Continuing Care	Rehab
1	What we commission:	40 assessment and treatment OPMHN acute beds. 20 at the Jasmine Centre in Dartford and 20 at The Orchard Ward Priory House Maidstone.	11 CHC beds at Littlestone Lodge in Dartford and 9 catergory 'x' old long stay preserved rights patients who moved from Stone House when it closed.	None though rehab if appropriate is undertaken in both Aute and NHS CHC beds.
	Service specification available: Yes / No	Yes	No	Rehab specification is same for adults and older people.
2	For each of the service listed above please give the following:			

	1. Name and location	See attached schedule of Wards and bed numbers	See attached schedule of Wards and bed numbers	See attached schedule of Wards and bed numbers
	2. Provider	KMPT	KMPT	KMPT
	3. Number of beds, including occupancy rates, and average number of bed days per patient.	40 beds, across Jasmine Centre, Dartford, and Priory House, Maidstone. 85% occupancy ALOS 62 days	20 beds, Greenacres, Dartford 88% occupancy ALOS 920 days	Not separated
	4. Staffing	See Appendix 1	See Appendix 1	See Appendix 1
	5. Route of referral	Referrals accepted from secondary services, community services, under section of the Mental Health Act	Referrals accepted from secondary services, community services, under section of the Mental Health Act	Referrals accepted from secondary services, community services, under section of the Mental Health Act
3	Are any changes to these inpatient services being carried out or being planned?	Recently closed 13 Acute beds at Leedham Ward, Highlands House in Tunbridge Wells. Remaining beds at Jasmine Centre and Priority House are mixed organic(Dementia) and functional. Need to review model of care and ensure best practice model of care and most efficient use of resources.	Full review of model of care and current patients at Littlestone Lodge is being completed to understand need for high end placements for people with challenging behaviour and complex care needs.	Considering model of care utilising resource at Gravesham Place to provide OPMHN step up step down to avoid admission to acute beds and provide slow stream rehab.
4	How much do you spend on adult mental health services each year, and how much is spent specifically on inpatient services?	Mental health spend is mapped in two ways, by LIT data and by programme budgets. LIT figures are the sum of both NHS and Local Authority spend on MH services. The programme budget MH spend is the sum of all costs attributed to MH expenditure by all NHS providers (excluding primary care contractors) aggregated back to the commissioning PCT. Total spend of WK PCT on MH programme budget in 2008-09 was 10.73%. Total OPMHS investment in 2009-10 (including indirect costs, overheads, capital charges) was £38,240 (LIT data). 34% of the direct spend (excluding indirect costs, overheads, capital charges) was spent with NHS providers.		

5	How much is this as a proportion of your overall spend and how does this compare to the other Primary Care Trusts across the SEC SHA area	The LIT Results of Financial mapping 2009-10 (Appendix 2) report compares the total OPMH investment within this LIT, with the total OPMH investment of SEC Strategic Health Authority, the ONS cluster of the LIT and the English national average.
6	What are your expectations for both of these amounts in coming years?	As Adult worksheet
7	How are community mental health services being developed and how is it anticipated that these will complement or replace inpatient services?	West Kent Dementia Strategy aims to provide more proactive and joined up support. Previous model of service delivery for people with dementia not joined up or designed to be proactive enough to identify people early provide personalised support and prevent people reaching crisis point. Consequently too many resources tied up in expensive acute in patient care. The Strategy describes a redesigned community pathway, with resources invested earlier, to raise awareness of dementia, ensure people with suspected dementia are identified earlier, encouraged to seek diagnosis and receive proactive support, which enables them to maintain their independence and 'live well' with dementia. We have numerous projects running looking at doing things differently. There is a pilot in Maidstone area with Admiral Nurse working in Primary Care encouraging GPs to support people to seek early diagnosis and support. Kent successfully bid to become a DH Demonstrator site to develop better support for people with dementia and their carers by establishing models of peer support to this end. There are now two peer support groups for peope post diagnosis and three planned dementia cafes.
8	What actions are you taking to reduce mental health inpatient admissions?	Developing an Inter-related Intermediate care strategy to deliver the expectations contained in Halfway Home the 2009 refresh of the 2001 Intermediate Care Guidance. Recently commissioned a Dementia Crisis Support Service which is designed to avoid admission, looking at post discharge bridging services to et people home and give them a chance to return to their own home and not have to enter permanent care setting straight from an acute bed. DementiaWeb and the 24 hour helpline ensure ease of access to information and availability of emotional support. Many admissions to acute beds have been proven to be for non medical reasons and often linked to the carers inability to continue to provide care. Reviewing all respite provsion to ensure that we have the right mix of services that are flexible and what people want.
9	Are any tertiary or Tier 4 adult mental health services commissioned outside of Kent and Medway?	See secure worksheet

10	How is commissioning of adult mental health services integrated with that of other Primary Care Trusts in Kent and Medway and Kent Adult Social Services?	All 3 PCTs and both LAs in Kent have a single MH commissioning service for adult mental health (functional / 18+) and wellbeing. Medway PCT is the lead commissioner. The MH Directorate has 4 lead health commissioners, 3 for adult services (including OP functional illness) engaged on a locality basis, and a lead commissioner across Kent and Medway for specialist and secure services. KCC (KASS) has 2 mental health commissioners for adult social care, one for East Kent and one for West Kent. In addition, Eastern and Coastal Kent PCT has a commissioner for OPMH services (not joint with KCC), and Medway PCT and West Kent PCT each have a joint commissioners with the respective councils for dementia services.
11	Can you please provide any relevant PALs data relating to adult mental health inpatient services?	See Appendix 3
12	More broadly, has there been any increase in mental health referrals that are thought to result from the effects of the economic downturn? And if so, is there sufficient capacity to deal with them?	As Adult worksheet

West KENT - Specialist and Secure in-patient services (all ages)

Commissioners: Vanessa Fowler

	KMPT		Other providers	
	Specialist services	**Secure services**	**Specialist services**	**Secure services**
What we commission:	Eating Disorder Services	Medium Secure Inpatient Service	Inpatient personality disorder, eating disorder, mother & infant, complex care and rehabilitation, autistic spectrum conditions	Medium secure and low secure specialist service provision
Service specification available: Yes / No	Yes	Yes	Yes	Yes

For each of the service listed above please give the following:				
1. Name and location	Red House, Maidstone	Trevor Gibbens Unit, Maidstone (for all of Kent and Medway)	Various out of area locations i.e. Ticehurst, Heathfield	Various out of area locations i.e. Milton Keynes, Northampton
2. Provider	KMPT	KMPT	Various out of area providers i.e. Cygnet Healthcare Ltd, Priory Group	Various out of area providers i.e. Priory Group, St Andrews Healthcare
3. Number of beds, including occupancy rates, and average number of bed days per patient.	10 beds (for all of Kent and Medway), occupancy ranges 75%-95%	62 beds 95% occupancy ALOS 815 days	N/A as provision is for service users from various PCTs	N/A as provision is for service users from various PCTs
4. Staffing	See Appendix 1	See Appendix 1	N/A as provision is for service users from various PCTs	N/A as provision is for service users from various PCTs
5. Route of referral	Normally a secondary care consultant referral	Prison transfers, local acute and PICU services, MoJ, recalls, CMHT, repatriation of service users from out of area independent sector secure services	Tertiary panel and out of area treatment panel approval, step down from secure services provision.	Tertiary panel and out of area treatment panel approval, local medium secure unit gate keeping, prison transfers, step down from high secure service provision
Are any changes to these inpatient services being carried out or being planned?	Yes, service review planned	No	No, services reflect and meet current clinical needs of Kent and Medway service users.	No, services reflect and meet current clinical needs of Kent and Medway service users.

How much do you spend on adult mental health services each year, and how much is spent specifically on inpatient services?	KMPT Contract value for Community and Inpatient services combined is £1,377k	£3,679k	£7,081k (this amount is for all specialist inpatient hospital based treatments)	£4,573k (this amount is for all secure independent sector inpatient hospital based treatments)
How much is this as a proportion of your overall spend and how does this compare to the other Primary Care Trusts across the SEC SHA area	<1% of total contract value	7.1% from overall adult mental health spend. Due to the lack of comparative data we are unable to provide a comparison between different SHA areas.	13.8% from overall adult mental health spend. Due to the lack of comparative data we are unable to provide a comparison between different SHA areas.	8.9% from overall adult mental health spend. Due to the lack of comparative data we are unable to provide a comparison between different SHA areas.
	* %s above relate to the Direct spend figure for in adult MH LIT for 2009/10			
What are your expectations for both of these amounts in coming years?	As Adult worksheet	NHS Medway has blocked purchased all 62 available medium secure beds	Trend analysis shows that specialist inpatient treatments are remaining at the same level	Trend analysis shows that secure inpatient treatments are remaining at the same level
How are community mental health services being developed and how is it anticipated that these will complement or replace inpatient services?	We are currently developing with KMPT the roll out of the First Response and Intervention Service (FRIS) which is aimed at providing quicker access to services and a liaison function with primary care. We are also developing a recovery model approach in CMHTs which will lead to more people who are stable being returned to primary care for their future care, with easy access back into services should they require this.			
What actions are you taking to reduce mental health inpatient admissions?	Tertiary panel and out of area treatment panel approval ensuring that local NHS outpatient provision has been maximised, local medium secure unit clinical team ensures that only service users who require inpatient admission due to their risk or offence committed are referred to a relevant secure provision. PCT works closely with forensic case manages for high, medium and low secure services ensuring that only service user who require this type of secure or specialist provision are accessing these types of services. Introduction of NHS Standard Contract, PCT monitors all providers on their performance against set QPIs, KPIs and CQUINs. Close working relationship with all providers ensuring that they report any delayed discharges directly to the PCT.			

Are any tertiary or Tier 4 adult mental health services commissioned outside of Kent and Medway?	N/A - local NHS service	YES (please refer to point 1)	YES (please refer to point 1)
How is commissioning of adult mental health services integrated with that of other Primary Care Trusts in Kent and Medway and Kent Adult Social Services?	All 3 PCTs and both LAs in Kent have a single MH commissioning service for adult mental health (functional / 18+) and wellbeing. Medway PCT is the lead commissioner. The MH Directorate has 4 lead health commissioners, 3 for adult services (including OP functional illness) engaged on a locality basis, and a lead commissioner across Kent and Medway for specialist and secure services. KCC (KASS) has 2 mental health commissioners for adult social care, one for East Kent and one for West Kent. In addition, Eastern and Coastal Kent PCT has a commissioner for OPMH services (not joint with KCC), and Medway PCT and West Kent PCT each have a joint commissioners with the respective councils for dementia services.		
Can you please provide any relevant PALs data relating to adult mental health inpatient services?	See Appendix 3	N/A	N/A
More broadly, has there been any increase in mental health referrals that are thought to result from the effects of the economic downturn? And if so, is there sufficient capacity to deal with them?	Data analysis shows that the only increase in referral rates were relating to ADHD outpatient assessments and treatments		

Kent and Medway NHS
NHS and Social Care Partnership Trust

Ward Staffing in KMPT

Inpatient units in KMPT are spread across the geographical area of Kent & Medway with all units offering a 24 hour 365 day per year service.

There would always be a proportion of qualified nursing staff on duty on the units, although the qualified to unqualified ratios from one unit to another vary. In addition, there are variances in the staff to bed ratios. This is largely a result of differing clinical needs in each specialty. For example, Forensic services and Psychiatric Intensive Care Units (PICUs) support patients who present higher levels of risk and/or disturbance and therefore require a higher ratio of qualified staff. On the other hand, wards for older people with continuing care needs have patient who have higher basic care needs and subsequently often have a higher unqualified staff ratio.

In any mental health unit, staff may also be needed to ensure that the heightened observation levels can be safely met on a 24 hour basis. Many wards will have more than one client needing within arms length or within eyesight observations at any one time along with others who need observing at intervals between 10 and 30 minutes. More clients now need this level of care as a result of a more acutely ill inpatient population.

Some of our units however have lower nursing figures because other staff such as occupational therapists and psychotherapists contribute significantly to the daily patient care in those areas; this is particularly the case in Eating disorders and CAMHS wards.

This page is intentionally left blank

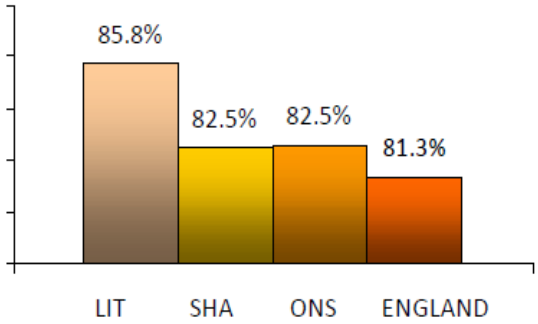
Department of Health

Mental Health STRATEGIES

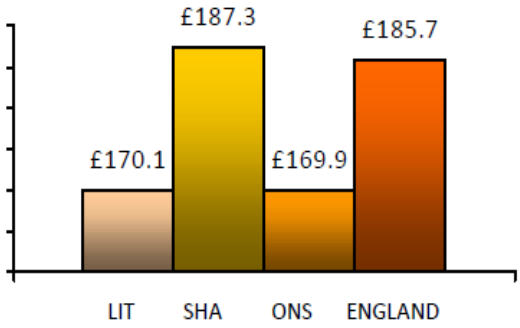
LIT Results of Financial Mapping 2009/10 for

West Kent

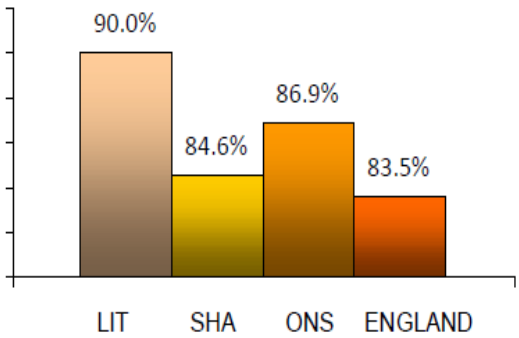
% Investment in Adult Direct Services



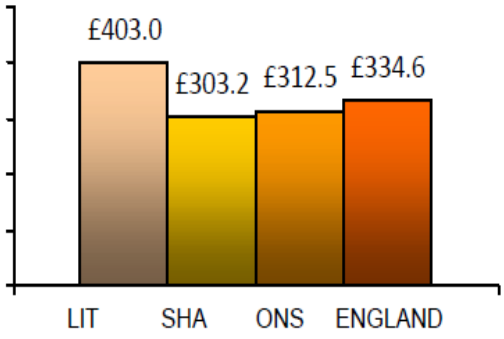
Adult Weighted Investment per Head



% Investment in OPMH Direct Services



OPMH Weighted Investment per Head



This page is intentionally left blank

Kent and Medway NHS
NHS and Social Care Partnership Trust

In-patient issues raised with PALS
April 2009/March 2010

Issue	Resolution achieved
Signage at A Block, Medway	New signage ordered
Receptionist awareness of new ward names	Awareness training given
*Inappropriate mix of dementia and functional beds	Being addressed as part of the development of the Older People's Strategy
*Waiting times for MH assessment at A&E	New staff posts to increase capacity
Ward staff reported to threaten informal patient with section 5(4)	Staff awareness raised
*Attention to physical health support	Staff awareness raised. Quality improvement focus (10/11)
Issues around palliative care provision	Staff training provided, protocols reviewed
Escorted leave procedure	Staff discussion
Communication issues for patient and carer	Awareness raised
**Lack of beds leading to out of area treatment	Service looking at re-targeting resources to create better support at home
Clarity of info around accessing second opinion	Medical director asked to clarify and information leaflet planned
Difficulties in visiting patient treated in other area	Support provided in accessing financial support
*Issues relating to accessing items from home when detained	Staff awareness. Communication improved with patients and carers
Patient support in managing expectation and concerns	Support provided
IMHA provision for older patients	Service now available to older adults
Confidentiality issues for patient in dormitory accommodation	Improved protocols
Telephone charges for reverse charge calls	Notice provided next to telephone
Staff awareness of IMHA	Staff informed, enhanced training, PALS volunteers highlight service on visits
Need for private space for patients to see advocates	Space provided. New staff made aware and
Delays in providing info about MH Act to detained patient	Staff training and awareness
Patient safety	Liaised with ward staff

* denotes issue raised more than once

** denotes issue raised often

Committee:	Kent Health Overview and Scrutiny Committee
Date of Meeting:	11 June 2010
Subject:	Accessing Mental Health Services: Adult and Older People's Inpatient Services
Lead Director:	Lauretta Kavanagh, Kent and Medway Director of Commissioning for Mental Health and Substance Misuse

---

1. Introduction

The approach taken to responding to the 12 questions asked has been to respond to them under three categories:

- Adult acute beds provided by Kent and Medway Partnership Trust
- Older people's acute beds provided by Kent and Medway Partnership Trust
- Specialist and secure beds provided by both KMPT and contracted across other NHS or independent sector providers (not split by age but older people spend and utilisation is minimal)

Our strategic changes to bed utilisation focus on reducing acute admissions and lengths of stay in acute settings, delivered by a range of service alternatives. These range from:

- Improving primary care interventions
- More effective Crisis Resolution and Home Treatment Services (e.g. fewer admissions, more support to stay at home)
- Earlier response in crisis
- Widening therapy alternatives
- Improving recovery
- Supporting choice and personalisation
- Supporting some specific high-risk groups such as those with dual diagnosis and those in the Criminal Justice System

These are a significant area of focus of the Live It Well strategy that is coming to fruition.

Investigating spend on acute mental health in-patient services requires an understanding of three sets of figures:

a. *PCT contracted spend (on behalf of both the PCTs and the Councils as a lead commissioner).* We are able to provide spend on inpatient services by locality for specialist or secure secures services outside of the KMPT contract. In the KMPT contract neither the adult inpatient nor older people's inpatient contract value is broken down by locality.

b. *Adult and older people mental health mapping data (supplied by Mental health Strategies).* Mental Health financial mapping data includes the PCT and Local Authority spend on mental health services, adults and older people separately, and spend on provider categories (NHS, LA, non-statutory) but with no separate expenditure line for inpatient services. The data does give points of comparison, i.e. against the SHA spend, the ONS cluster spend and the English national average.

c. *NHS programme budgeting by PCT.* The NHS programme budgeting data shows spend by PCT only, by any type of provider on clients categorised as having a primary mental health diagnosis, and of any age. NHS programme budgeting data has five subcategories (including CAMHS services, substance misuse services, dementia, and covers far more than expenditure on beds or on contracted services with mental health providers. No specific subcategory relates to in-patient care.

Wherever relevant or possible, all these figures are provided.

The document attached goes on to describe how mental health commissioning is integrated across health and social care for all three PCTs in Kent and both Councils and gives a short summary of developments in accessing talking therapies in primary care.

2. Conclusions

In our strategy we would certainly anticipate less acute beds across Kent in five years time than we have now, and less expenditure on high-cost placements.

Live it Well sets an expectation that we develop new care pathways. These will emphasise more support for service users in primary care and community settings, with primary care services being better supported to access more and wider resources for service users, so needing less recourse to an acute bed. These supports would include access to more information, access to helplines for those in distress, more crisis response in primary care, wider voluntary sector help and service delivery, wider access to liaison psychiatry, more support for achieving recovery, and more support for carers and relatives.

Eastern and Coastal KENT - KMPT adult in-patient services

Commissioners: Joanne Ross / Dave Woodward

		Adult	PICU	Rehab
1	What we commission:	See attached schedule of Wards and bed numbers	See attached schedule of Wards and bed numbers	See attached schedule of Wards and bed numbers
	Service specification available: Yes / No	Yes	Yes - within Adult Specification	Yes
2	For each of the service listed above please give the following:			
	1. Name and location	Arundel Unit, Ashford St Martins, Canterbury Mental Health Unit, Margate William Harvey Hospital, Ashford	St Martins, Canterbury	Units in Ashford, Canterbury, Sandwich and Ramsgate
	2. Provider	KMPT	KMPT	KMPT
	3. Number of beds, including occupancy rates, and average number of bed days per patient.	78 beds 97% occupancy ALOS 41days	8 beds 90% occupancy ALOS 38 days	49 beds 84 % occupancy ALOS 753 days
	4. Staffing	See Appendix 1	See Appendix 1	See Appendix 1
	5. Route of referral	Referrals accepted from secondary services, community services, under section of the Mental Health Act	Referrals accepted from secondary services, community services, under section of the Mental Health Act	Referrals accepted from secondary services, community services, under section of the Mental Health Act

3	Are any changes to these inpatient services being carried out or being planned?	Total acute bed change will be from 86 currently to 66 by April 2012. Two new wards, each with eighteen beds, on the existing KMPT-owned St Martin's site, Canterbury (phase one). The provision of two new wards will enable the closure of the working age adult wards at the Arundel Unit situated on the William Harvey Hospital site at Ashford.	Improve and refurbish Dudley Venables House and Anselm Ward (phase two). Will be 24 beds providing acute and intensive care. Additionally there will be 6 PICU beds	None known
4	How much do you spend on adult mental health services each year, and how much is spent specifically on inpatient services?	Mental health spend is mapped in two ways, by LIT data and by programme budgets. LIT figures are the sum of both NHS and Local Authority spend on MH services. The programme budget MH spend is the sum of all costs attributed to MH expenditure by all NHS providers (excluding primary care contractors) aggregated back to the commissioning PCT. Total spend of ECK PCT on MH programme budget in 2008-09 was 11.73%. Total investment in adult MH services in 2009-10 (including indirect costs, overheads, capital charges) were £66m (LIT data). 66% of the direct spend (excluding indirect costs, overheads, capital charges) was spent with NHS providers.		
5	How much is this as a proportion of your overall spend and how does this compare to the other Primary Care Trusts across the SEC SHA area	The overall contract value with KMPT for Adult Inpatient Service including PICU for <u>all</u> of Kent and Medway for 2010-11 is £34,319k. It is <u>not</u> broken down by locality.		The overall contract value with KMPT for Community and Inpatient Rehabilitation Services for <u>all</u> of Kent and Medway for 2010-11 is £32m It is <u>not</u> split between community and inpatient rehab <u>nor</u> split down by locality.
		The LIT Results of Financial Mapping 2009-10 (Appendix 2) report compares the total adult investment (NHS and Local Authority spend) within this LIT, with the total adult investment of SEC Strategic Health Authority, the ONS cluster of the LIT and the English national average (see attachments showing spend comparisons)		

6	What are your expectations for both of these amounts in coming years?	The projected change in the total MH programme budget spend for Eastern and Coastal Kent is from £130.8m in 2008-09 to £126m in 20014-15. We do not have projections for change in spend by KCC.
7	How are community mental health services being developed and how is it anticipated that these will complement or replace inpatient services?	The key developments of community mental health services will be: Increase in talking therapies, and dual diagnosis support. Development of specialist services such as local Mother and Infant Mental Health Services and Eating Disorders services to meet population needs as identified in JSNA. Horizon Scheme - supported accommodation with better range & types of social housing. Improved Early Intervention in Psychosis to target first episode Police custody diversion services to ensure appropriate early identification of people who have a mental health condition Crisis Resolution and Home Treatment Team has been introduced. Number of in-patient beds has been reduced from 104 in 2006.
8	What actions are you taking to reduce mental health inpatient admissions?	Introduction of First Response and Intervention Team (FRIS) in primary care to provide more responsive earlier interventions to avoid escalation of problems. CMHTs with extended operating times. Liaison psychiatry services in acute care settings to give early expert opinions and easier access to appropriate services. And see Section 7 above.
9	Are any tertiary or Tier 4 adult mental health services commissioned outside of Kent and Medway?	See secure worksheet
10	How is commissioning of adult mental health services integrated with that of other Primary Care Trusts in Kent and Medway and Kent Adult Social Services?	All 3 PCTs and both LAs in Kent have a single MH commissioning service for adult mental health (functional / 18+) and wellbeing. Medway PCT is the lead commissioner. The MH Directorate has 4 lead health commissioners, 3 for adult services (including OP functional illness) engaged on a locality basis, and a lead commissioner across Kent and Medway for specialist and secure services. KCC (KASS) has 2 mental health commissioners for adult social care, one for East Kent and one for West Kent. In addition, Eastern and Coastal Kent PCT has a commissioner for OPMH services (not joint with KCC), and Medway PCT and West Kent PCT each have a joint commissioners with the respective councils for dementia services.

11	Can you please provide any relevant PALs data relating to adult mental health inpatient services?	See Appendix 3
12	More broadly, has there been any increase in mental health referrals that are thought to result from the effects of the economic downturn? And if so, is there sufficient capacity to deal with them?	Referral numbers have increased by 20% in the past year. As providers are working with a new data collection system we are currently unable to link the increase to known areas of deprivation. The system provider has been tasked with facilitating this level of interrogation. Nevertheless Primary Care Psychological Therapy services were deemed to require 122.5 staff (excluding employment support) prior to the downturn. By the end of next year we will have tripled the clinical workforce in this area, though there are still expected to be shortfalls. There are 17 trainees due to complete in September 2010 and a further 25 trainees are currently being recruited to start in October 2010. A planned workforce mapping exercise will determine the shortfall in other key therapies. DH funding does not ring fence funds for employment support even though retaining or regaining employment is integral to the IAPT programme. Demand is therefore greater than capacity.

Eastern and Coastal KENT - KMPT older people in-patient services

Commissioner: Linda Caldwell

		Acute	Continuing Care	Rehab
1	What we commission:			
	Service specification available: Yes / No	Yes	No	Rehab specification is same for adults and older people.
2	For each of the service listed above please give the following:			
	1. Name and location	Arundel Unit, Ashford St Martins, Canterbury Mental Health Unit, Margate Rook Lane, Sittingbourne	St Martins, Canterbury Rook Lane, Sittingbourne	See attached schedule of Wards and bed numbers
	2. Provider	KMPT	KMPT	KMPT
	3. Number of beds, including occupancy rates, and average number of bed days per patient.	91 beds 94% occupancy ALOS 85days	30 beds 96% occupancy ALOS 751days	Included in Adult rehab figures
	4. Staffing	See Appendix 1	See Appendix 1	See Appendix 1

	5. Route of referral	Referrals accepted from secondary services, community services, under section of the Mental Health Act	Access to continuing care beds is via the PCT's continuing care team following assessment for eligibility for NHS continuing healthcare.	Referrals accepted from secondary services, community services, under section of the Mental Health Act
3	Are any changes to these inpatient services being carried out or being planned?	See number 7 below.	See number 7 below.	No rehab beds specifically for older people.
4	How much do you spend on adult mental health services each year, and how much is spent specifically on inpatient services?	Mental health spend is mapped in two ways, by LIT data and by programme budgets. LIT figures are the sum of both NHS and Local Authority spend on MH services. The programme budget MH spend is the sum of all costs attributed to MH expenditure by all NHS providers (excluding primary care contractors) aggregated back to the commissioning PCT. Total spend of ECK PCT on MH programme budget was 11.73%. Total OPMHS investment in 2009-10 (including indirect costs, overheads, and capital charges) was £48,995k (LIT data). 43% of the direct spend (excluding indirect costs, overheads, capital charges) was spent with NHS providers.		
5	How much is this as a proportion of your overall spend and how does this compare to the other Primary Care Trusts across the SEC SHA area	The LIT Results of Financial mapping 2009-10 (Appendix 2) report compares the total OPMH investment within this LIT, with the total OPMH investment of SEC Strategic Health Authority, the ONS cluster of the LIT and the English national average (see attachments showing spend comparisons).		
6	What are your expectations for both of these amounts in coming years?	See Adult section		

7	How are community mental health services being developed and how is it anticipated that these will complement or replace inpatient services?	East Kent has a Home Treatment service which is an intermediate care service provided to people with dementia in their own homes to help prevent admission to hospital or facilitate discharge. Currently, the service operates Monday to Friday, 9am to 5pm. It is planned to redesign the service to extend its hours and remit and to ensure that it responds to people's needs in a timely manner. Whilst it is probable that this particular service will not be required 24/7, it is proposed to ensure that support can be provided in people's own homes 24 hours a day. Older people with a functional illness are already able to access the crisis and home treatment service which is managed by the younger adult service. Memory services are now available in each district in east Kent. Work is planned to agree the role of primary care both pre and post diagnosis of dementia to ensure that people can be supported as locally as possible. Kent is also a national pilot site for peer support groups which are currently being piloted in east Kent by the Alzheimer's Society. A 24 hour helpline has also recently been commissioned from the Alzheimer's Society. As the number of community services increases and more people are supported in their own homes, the need for hospital admission will be reduced. This reduced reliance on inpatient beds will present an opportunity to review the number, function and location of inpatient beds. The number of older people with mental health needs who are eligible for NHS continuing health care is also increasing, so it is proposed to review continuing care provision to ensure sufficient and equitable capacity which will meet the needs. This increased provision is likely to be within the private sector.
8	What actions are you taking to reduce mental health inpatient admissions?	Increasing the amount and types of community support and looking for options to redesign existing services.
9	Are any tertiary or Tier 4 adult mental health services commissioned outside of Kent and Medway?	See Specialist and Secure section

10	How is commissioning of adult mental health services integrated with that of other Primary Care Trusts in Kent and Medway and Kent Adult Social Services?	All 3 PCTs and both LAs in Kent have a single MH commissioning service for adult mental health (functional / 18+) and wellbeing. Medway PCT is the lead commissioner. The MH Directorate has 4 lead health commissioners, 3 for adult services (including OP functional illness) engaged on a locality basis, and a lead commissioner across Kent and Medway for specialist and secure services. KCC (KASS) has 2 mental health commissioners for adult social care, one for East Kent and one for West Kent. In addition, Eastern and Coastal Kent PCT has a commissioner for OPMH services (not joint with KCC), and Medway PCT and West Kent PCT each have a joint commissioners with the respective councils for dementia services.
11	Can you please provide any relevant PALs data relating to adult mental health inpatient services?	See Appendix 3
12	More broadly, has there been any increase in mental health referrals that are thought to result from the effects of the economic downturn? And if so, is there sufficient capacity to deal with them?	As Adult Section

Eastern and Coastal KENT - Specialist and Secure in-patient services (all ages)

Commissioner: Vanessa Fowler

		KMPT		Other providers	
		Specialist services	**Secure services**	**Specialist services**	**Secure services**
1	What we commission:	Eating Disorder Services	Medium Secure Inpatient Service	Inpatient personality disorder, eating disorder, mother & infant, complex care and rehabilitation, autistic spectrum conditions	Medium secure and low secure specialist service provision
	Service specification available: Yes / No	Yes	Yes	Yes	Yes
2	For each of the service listed above please give the following:				
	1. Name and location	Red House, Maidstone	Trevor Gibbens Unit, Maidstone (for all of Kent and Medway)	Various out of area locations i.e. Ticehurst, Heathfield	Various out of area locations i.e. Milton Keynes, Northampton
	2. Provider	KMPT	KMPT	Various out of area providers i.e. Cygnet Healthcare Ltd, Priory Group	Various out of area providers i.e. Priory Group, St Andrews Healthcare

	3. Number of beds, including occupancy rates, and average number of bed days per patient.	10 beds (for all of Kent and Medway), occupancy ranges 75%-95%	62 beds 95% occupancy ALOS 815 days	N/A as provision is for service users from various PCTs	N/A as provision is for service users from various PCTs
	4. Staffing	See Appendix 1	See Appendix 1	N/A as provision is for service users from various PCTs	N/A as provision is for service users from various PCTs
	5. Route of referral	Normally a secondary care consultant referral	Prison transfers, local acute and PICU services, MoJ, recalls, CMHT, repatriation of service users from out of area independent sector secure services	Tertiary panel and out of area treatment panel approval, step down from secure services provision.	Tertiary panel and out of area treatment panel approval, local medium secure unit gate keeping, prison transfers, step down from high secure service provision
3	Are any changes to these inpatient services being carried out or being planned?	Yes, service review planned	No	No, services reflect and meet current clinical needs of Kent and Medway service users.	No, services reflect and meet current clinical needs of Kent and Medway service users.
4	How much do you spend on adult mental health services each year, and how much is spent specifically on inpatient services?	KMPT Contract value for Community and Inpatient services combined is £1,377m	£4,387m	£5,623m (this amount is for all specialist inpatient hospital based treatments)	£3,569m (this amount is for all secure independent sector inpatient hospital based treatments)

5	How much is this as a proportion of your overall spend and how does this compare to the other Primary Care Trusts across the SEC SHA area	<1% of total contract value	7.6%* from overall adult mental health spend. Due to the lack of comparative data we are unable to provide a comparison between different SHA areas.	9.7%* from overall adult mental health spend. Due to the lack of comparative data we are unable to provide a comparison between different SHA areas.	6.2%* from overall adult mental health spend. Due to the lack of comparative data we are unable to provide a comparison between different SHA areas.
		* %s above relate to the Direct spend figure for in adult MH LIT for 2009/10 - £57,520m			
6	What are your expectations for both of these amounts in coming years?	As Adult worksheet	NHS Medway has blocked purchased all 62 available medium secure beds	Trend analysis shows that specialist inpatient treatments are remaining at the same level	Trend analysis shows that secure inpatient treatments are remaining at the same level
7	How are community mental health services being developed and how is it anticipated that these will complement or replace inpatient services?	Crisis Resolution and Home Treatment Team has been introduced. Number of in-patient beds has been reduced from 104 in 2004. Police custody diversion services to ensure appropriate early identification of people who have a mental health condition. Specialist services such as local Mother and Infant Mental health Services and Eating Disorders services to meet population needs as identified in JSNA.			
8	What actions are you taking to reduce mental health inpatient admissions?	Tertiary panel and out of area treatment panel approval ensuring that local NHS outpatient provision has been maximised, local medium secure unit clinical team ensures that only service users who require inpatient admission due to their risk or offence committed are referred to a relevant secure provision. PCT works closely with forensic case manages for high, medium and low secure services ensuring that only service user who require this type of secure or specialist provision are accessing these types of services. Introduction of NHS Standard Contract, PCT monitors all providers on their performance against set QPIs, KPIs and CQUINs. Close working relationship with all providers ensuring that they report any delayed discharged directly to the PCT.			
9	Are any tertiary or Tier 4 adult mental health services commissioned outside of Kent and Medway?		N/A - local NHS service	YES (please refer to point 1)	YES (please refer to point 1)

10	How is commissioning of adult mental health services integrated with that of other Primary Care Trusts in Kent and Medway and Kent Adult Social Services?	All 3 PCTs and both LAs in Kent have a single MH commissioning service for adult mental health (functional / 18+) and wellbeing. Medway PCT is the lead commissioner. The MH Directorate has 4 lead health commissioners, 3 for adult services (including OP functional illness) engaged on a locality basis, and a lead commissioner across Kent and Medway for specialist and secure services. KCC (KASS) has 2 mental health commissioners for adult social care, one for East Kent and one for West Kent. In addition, Eastern and Coastal Kent PCT has a commissioner for OPMH services (not joint with KCC), and Medway PCT and West Kent PCT each have a joint commissioners with the respective councils for dementia services.
11	Can you please provide any relevant PALs data relating to adult mental health inpatient services?	See Appendix 3
12	More broadly, has there been any increase in mental health referrals that are thought to result from the effects of the economic downturn? And if so, is there sufficient capacity to deal with them?	Data analysis shows that the only increase in referral rates were relating to ADHD outpatient assessments and treatments

Kent and Medway NHS
NHS and Social Care Partnership Trust

Ward Staffing in KMPT

Inpatient units in KMPT are spread across the geographical area of Kent & Medway with all units offering a 24 hour 365 day per year service.

There would always be a proportion of qualified nursing staff on duty on the units, although the qualified to unqualified ratios from one unit to another vary. In addition, there are variances in the staff to bed ratios. This is largely a result of differing clinical needs in each specialty. For example, Forensic services and Psychiatric Intensive Care Units (PICUs) support patients who present higher levels of risk and/or disturbance and therefore require a higher ratio of qualified staff. On the other hand, wards for older people with continuing care needs have patient who have higher basic care needs and subsequently often have a higher unqualified staff ratio.

In any mental health unit, staff may also be needed to ensure that the heightened observation levels can be safely met on a 24 hour basis. Many wards will have more than one client needing within arms length or within eyesight observations at any one time along with others who need observing at intervals between 10 and 30 minutes. More clients now need this level of care as a result of a more acutely ill inpatient population.

Some of our units however have lower nursing figures because other staff such as occupational therapists and psychotherapists contribute significantly to the daily patient care in those areas; this is particularly the case in Eating disorders and CAMHS wards.

This page is intentionally left blank

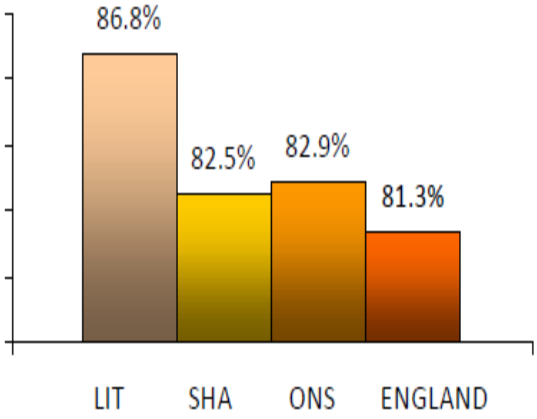
Department of Health

Mental Health STRATEGIES

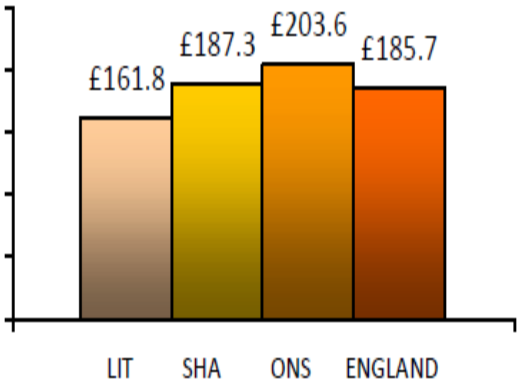
LIT Results of Financial Mapping 2009/10 for

East Kent

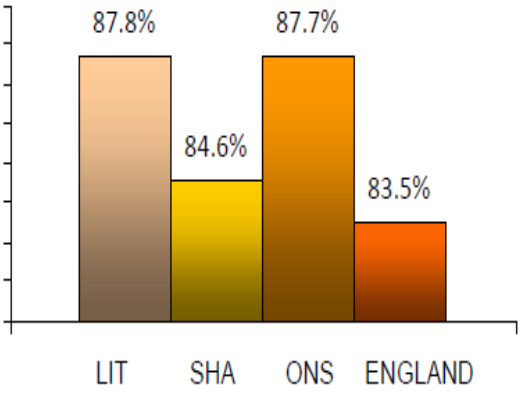
% Investment in Adult Direct Services



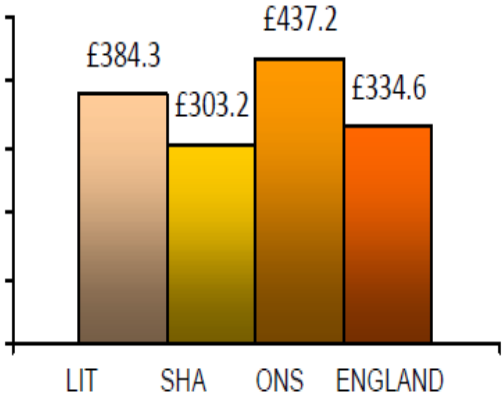
Adult Weighted Investment per Head



% Investment in OPMH Direct Services



OPMH Weighted Investment per Head



This page is intentionally left blank

Kent and Medway NHS
NHS and Social Care Partnership Trust

In-patient issues raised with PALS
April 2009/March 2010

Issue	Resolution achieved
Signage at A Block, Medway	New signage ordered
Receptionist awareness of new ward names	Awareness training given
*Inappropriate mix of dementia and functional beds	Being addressed as part of the development of the Older People's Strategy
*Waiting times for MH assessment at A&E	New staff posts to increase capacity
Ward staff reported to threaten informal patient with section 5(4)	Staff awareness raised
*Attention to physical health support	Staff awareness raised. Quality improvement focus (10/11)
Issues around palliative care provision	Staff training provided, protocols reviewed
Escorted leave procedure	Staff discussion
Communication issues for patient and carer	Awareness raised
**Lack of beds leading to out of area treatment	Service looking at re-targeting resources to create better support at home
Clarity of info around accessing second opinion	Medical director asked to clarify and information leaflet planned
Difficulties in visiting patient treated in other area	Support provided in accessing financial support
*Issues relating to accessing items from home when detained	Staff awareness. Communication improved with patients and carers
Patient support in managing expectation and concerns	Support provided
IMHA provision for older patients	Service now available to older adults
Confidentiality issues for patient in dormitory accommodation	Improved protocols
Telephone charges for reverse charge calls	Notice provided next to telephone
Staff awareness of IMHA	Staff informed, enhanced training, PALS volunteers highlight service on visits
Need for private space for patients to see advocates	Space provided. New staff made aware and
Delays in providing info about MH Act to detained patient	Staff training and awareness
Patient safety	Liaised with ward staff

* denotes issue raised more than once

** denotes issue raised often

Fact Sheet for Health Overview and Scrutiny Committee

East Kent Younger Adult Inpatient Accommodation

St Martins, Canterbury

As part of its commitment to the delivery of high quality community focused mental health care services to the people of Kent, the Trust (KMPT) has developed, through its ongoing service redesign work with users and staff, a new model of care for younger adults. This model of care focuses on early intervention, local community access and high quality inpatient services and is underpinned by the centralisation of younger adult inpatient beds for the east Kent locality onto the St Martins Hospital site in Canterbury.

The work to develop and agree this care model has been in progress since 2004, when it was initiated by the then PCT commissioners at East Kent and has been undertaken in collaboration with service users, carers, clinicians, SSD partners, staff and the wider community. The PCT continues to provide strong support for the project.

These wide ranging discussions and local inputs have resulted in an agreement for 36 new inpatient beds at St Martins, replacing existing beds in the Arundel Unit, William Harvey Hospital, Ashford and complemented by the beds in the existing Anselm and Dudley Venables Wards on the site.

The Outline Business Case for capital investment was formally considered by the Trust Board, PCT Board and South East Coast Strategic Health Authority at the end of February 2010, and approved.

The Trust is working with Kier Health, its Procure 21 Partner to develop the detailed design for the new wards. The design will provide a high quality patient care environment and is being developed to ensure that the total complement of four wards are situated around a focal ‘village green’ style campus.

Key facts

Two purpose built 18 bedded inpatient wards with supporting accommodation.
All new facilities to feature individual bedrooms with ensuite facilities
Two bedrooms will provide comprehensive facilities for physically disabled service users
Total value £9.5 million approx (build, fees, equipment)
Building will conform to all Department of Health and Government guidance on hospital accommodation and meet standards for sustainability and carbon reduction

Indicative date for construction start November 2010
Indicative date for use by service users April 2012

18 May 2010

This page is intentionally left blank

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 11 June 2010

Subject: Item 5. Further Information on Dentistry.

---

1. Background

(1) The Health Overview and Scrutiny Committee examined the issue of out of dentistry at its meeting on Friday, 26 March 2010.

(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. The following questions were submitted to both NHS Eastern and Coastal Kent and NHS West Kent and the information received is attached:

1. Financial allocations. Can you please provide comparative data showing where your PCT resides in the national and regional table for dental funding? How is this allocation determined?

2. Dental charges. Is there any information available on the number and/or reasons for people refusing to pay NHS dental charges, perhaps extracted from PALS data?

3. Mobile dentists. Is there any mobile dentistry provision within your PCT area, and is this something you have considered?

4. The gypsy and traveller community. What specific actions have you undertaken in order to ensure dental care is provided to the gypsy and traveller community? More generally, what actions are you taking to ensure dental care is provided to hard to reach groups?

5. Dental screening of children. To what extent is it carried out within your PCT area, have you any plans to extend this further and what evidence have you considered for and against the benefits of screening?

2. Recommendation

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

This page is intentionally left blank

NHS
Eastern and Coastal Kent

Paul Wickenden
Overview, Scrutiny & Localism Manager
Kent County Council
Legal and Democratic Services
Sessions House
County Hall
Maidstone ME14 1XQ

Trust Headquarters
Brook House
John Wilson Business Park
Reeves Way
Chestfield
Whitstable
Kent CT5 3DD

Tel: 01227 795021
Fax: 01227 795025
david.meikle@eastcoastkent.nhs.uk

Our Ref: DM/ah-cd
01 June 2010

Dear Paul,

Re: HOSC Meeting 26 March on Dentistry – Further Questions

Thank you for your letter of 12 April seeking clarification on a number of supplementary questions relating to dental services. I would like to respond to each question as follows:

1. Financial Allocations

Table 1 below sets out the detailed allocations for each of the PCTs in the South East Coast SHA compared to the national average and average costs for all England SHAs. The information on population is taken from the National Statistics data for population sizes by PCT area for the mid-year 2008. Of the 8 PCT's in SEC SHA, NHS Eastern and Coastal Kent are 6th in the level of funding per head of population. The Dental Allocation for the SHA is based upon the PCT's share of the nationally available dentistry resources for 2004-5 and 2005-6. There was an exercise whereby new contracts were awarded based upon the volume and type of NHS dentistry work undertaken by each practice within a defined reference period. The allocations have been uplifted for growth each year and in 2009/10 there was an additional uplift to PCTs to improve provision (in the case of Eastern and Coastal Kent this was an additional £1.35m).

Table 1

PCT	Net Allocation £000s	Population '000's	£ per population
Medway PCT	13,442	254	53.03
Brighton and Hove City PCT	12,392	254	48.83
West Sussex PCT	32,717	789	41.49
East Sussex Downs and Weald PCT	12,766	333	38.35
Hastings and Rother PCT	6,768	178	37.98
Eastern and Coastal Kent PCT	**25,944**	**728**	**35.64**
West Kent PCT	23,112	674	34.31
Surrey PCT	37,102	1,089	34.08
England	**2,192,000**	**51464.6**	**42.59**

Cont'd.

2/

PCTs summed by SHA			
North West SHA	328,136	6,874	47.74
London SHA	353,729	7,668	46.13
North East SHA	116,042	2,571	45.14
Yorkshire and the Humber SHA	230,405	5,218	44.16
West Midlands SHA	228,066	5,408	42.17
South West SHA	214,865	5,210	41.24
East of England SHA	233,297	5,717	40.80
South Central SHA	156,371	4,059	38.52
South East Coast SHA	164,243	4,309	38.11
East Midlands SHA	166,246	4,429	37.53
Allocation awaiting confirmation	600		

2. Dental charges

Information is collected from both the PAL's telephone calls and from the newly commissioned dental helpdesk and there has not been a case recorded to date where patients have refused to pay the appropriate dental charges. There are also no known complaints from dentists that they have been unable to collect charges for treatment provided.

3 Mobile Dentists

The PCT did explore the use of mobile dental units in the development of a local business case however when the business case came under further scrutiny the health and safety issues and overall costs could not be justified as offering value for money.

4. Gypsy and Travelling Community

Several years ago the Eastern and Coastal Community Dental Service did operate a mobile dental unit specifically for the Gypsy communities. The uptake was very small and as a result the service stopped.

Patients do not need to register with a dentist they are able to visit any NHS dentist that has availability, alternatively they are able to use a Dental Access Centre (DAC) where services are provided by Community Dental Team. DAC's are located across East Kent area and are accessed either by calling the dental helpdesk or by presenting to the centre where an appointment will be allocated. Dentists will also accept all referrals or "phone and go" patients regardless of a fixed address. The FP17 form that is completed at the time of treatment does need an address but this could be a caravan park or hostel address.

Cont'd.

5. Dental Screening of Children

Screening for children which did occur three times in their school life has not been undertaken nationally for several years. There is evidence that shows that screening has had no positive effect on population levels of dental disease. Since 2008 it has been necessary to gain parental "positive consent" rather than the historical "opting out" system and this has severely curtailed the effectiveness of screening. Studies have shown that parents who give consent are generally more dentally aware than those who don't and therefore it is more likely that children who do not need treatment are those which are screened.

We know from previous years that the Pareto rule exists in dental disease in the population in that 80% of children have little or no dental disease whilst 20% have severe disease. It is generally the 20% who do not consent to screening.

There are other ways of identifying the school children with high levels of dental disease without screening which is also cost effective. There is a strong correlation between free school meals and oral health. 10% of those schools with high levels of free school meals are currently targeted for dental health education. The challenge for the community dental service is identifying which schools offer free school meals and accessing schools for dental health education when there are already time constraints in schools timetables.

NHS Eastern and Coastal Kent endeavours to allocate the funding it receives where it will be best be utilised, giving the greatest benefit to oral health in the most efficient way, whilst also ensuring value for money. Continual review of demand data collected by our dental helpdesk is assisting with this process and informing commissioning decisions that will best serve the population now and for the future.

Kind regards.

Yours sincerely,

David Meikle
Acting Chief Executive

NHS West Kent

Dentistry - HOSC MEETING 11TH JUNE 2010

1.	**Financial Allocations**: Can you please provide comparative data showing where your PCT resides in the national and regional table for dental funding? How is this allocation determined?

NHS West Kent PCT has one of the lowest financial allocations of any PCT in England. This is illustrated in Appendix A which shows that the range of dental allocations on both a resident population and registered population basis across England. This shows significant variation in allocation between PCTs.

In so far as the 2010/11 financial allocation is concerned NHS West Kent receives one of the lowest PCT allocations in England at £34 per resident. The average allocation per resident for England is £43. This means that NHS West Kent receives 20% less funding than the average for England.

NHS West Kent PCT is also disadvantaged in terms of its dental budget allocation within PCTs across NHS South East Coast (Strategic Health Authority) having the lowest level of funding per resident population, along with Surrey PCT. The SHA range being £34 to £53 per head. See Table 1 below.

Table 1: Primary Dental Services
Indicative 2010-2011 non recurrent allocations

PCT	Net Allocation £000s	£000s	Resident population (000s) - ONS mid 2008	Registered population (000s) - attribution data set Mar 09	Allocation per patient (resident)	Allocation per patient (registered)
Surrey PCT	37,102	37,102	1,089	1,155	£34	£32
West Kent PCT	**23,112**	**23,112**	**674**	**699**	**£34**	**£33**
Eastern and Coastal Kent PCT	25,944	25,944	728	762	£36	£34
Hastings and Rother PCT	6,768	6,768	178	182	£38	£37
East Sussex Downs and Weald PCT	12,766	12,766	333	346	£38	£37
West Sussex PCT	32,717	32,717	789	816	£41	£40
Brighton and Hove City PCT	12,392	12,392	254	299	£49	£41
Medway PCT	13,442	13,442	254	279	£53	£48

We would also like to draw the HOSCs attention to the fact that the above allocation of £23.1M is a significantly improved allocation from that which NHS West Kent received in previous years. In 2009-2010 NHS West Kent PCT dental allocation was increased by almost 20% to £23.1M. Prior to this NHS West Kent's dental allocation was £19.325M, which is equivalent to £28.67 per resident population and £27.65 for each registered patient . This meant that NHS West Kent received one of the lowest financial allocations for dentistry in England.

This recent increase to our allocation of £3.8M has largely been to secure a number of new contracts following tender. However, due to the procurement

	timeline, the new contracts have only started to become active within the last quarter. Consequently, the population of NHS West Kent is yet to benefit fully from the additional funding. Current access levels therefore reflect the £19.3M level of historic funding received, rather than the allocation for 10/11 shown in Appendix A. Arrangements for the initial allocation of funding by DH are set out in NHS Dentistry Reform Update[1], gateway 4449. Allocations were based on historical spend on NHS Dentistry by PCT. This is 'the traditional approach to resource allocation modelling (Carr Hill et al 1994 Fair Shares for All, 2000) which assumes that the use of services can be used as a proxy for the need for service'[2] Essentially, the assigned allocation would have been directly related to historical expenditure including any new PDS pilots and other services already commissioned by PCTs (i.e. emergency dental services, dental access centres and section 56 salaried dentists), plus the uplifted actual outturn for GDS from 2004-05 and in-year funding for PDS pilots.
2	**Dental charges.** Is there any information available on the number and/or reasons for people refusing to pay NHS dental charges, perhaps extracted from PALS data?
	Currently data is not routinely collected either nationally or locally relating to the specific question above. However the PCT has received 45 telephone enquiries in the past year relating to dental charges. These are listed below: 1. Someone becoming 19 before treatment ended and being charged 2. Querying what the charge bands are 3. Charged for filling that fell out after a year 4. Charged for private treatment as no funding left for NHS work 5. Told cosmetic and been given quote for £400 6. Charged for emergency appointments (several in one year) 7. NHS Choices giving NHS status when dentist has been private for a long time 8. Charged for an emergency appointment whilst having a treatment plan – chipped another tooth – patient refunded. 9. Private dentist charging £200 to extract a tooth from patient in nursing home – arranged for NHS dentist to do the extraction 10. Patient charged twice when changed practitioner in practice – refunded as contract is with practice not clinician **In addition, a patient questionnaire is currently being developed which will collected data relating to this question.**
3	**Mobile dentists.** Is there any mobile dentistry provision within your PCT area, and is this something you have considered?
	The PCT dental commissioning team has considered mobile dental units and as a result obtained some projected costs and specifications. However, on further investigation, this model of dentistry was not pursued because the PCT received advice from NHS Primary Care Commissioning that both they and the DH felt these units were only suitable in extremely remote areas. This is because the units have proven very difficult to manage in many areas, not least with matters

[1] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4104008.pdf

[2] Deloitte (August 2005)

	of waste disposal and decontamination, which might ultimately present health risks to patients.
4	**The gypsy and traveller community.** What specific actions have you undertaken in order to ensure dental care is provided to the gypsy and traveller community? More generally, what actions are you taking to ensure dental care is provided to hard to reach groups?
	The locations of gypsy, traveller community sites managed by Kent County Council are shown in Appendix B attached. We have listed the nearby dental surgeries where the PCT hold a contract. This information has been provided to Sally Jeffery[3] in her role as Site and Community Liaison Manager. Furthermore, Richard Lucas from Kent County Council further confirmed by telephone on the 7th May 2010 that all these communities seemed to be very well served for all their health care needs including dental. Since dental practices do not operate geographic boundaries then individuals from gypsy and traveller communities can access any NHS dentist that has capacity within their contract to see them. The PCT is currently exploring the opportunity through the next procurement exercise to reach out to all groups who might be defined as hard to reach. Furthermore, the PCT is developing plans to further improve access to domiciliary services which cater for those people who are not able, for disability reasons, to attend a dental practice.
5	**Dental screening of children.** To what extent is it carried out within your PCT area, have you any plans to extend this further and what evidence have you considered for and against the benefits of screening?
	NHS West Kent currently screens 10% of schools and also all special needs schools. This is based on the recommendations from the UK National Screening Committee[4] supported by evidence from a randomised controlled trial that demonstrated school dental screening is not effective at reducing levels of active caries and increasing dental attendance[5]. A helpful DH guidance paper has been published to advise PCTs on taking forward these recommendations[6]. The PCT will continue to follow guidance from DH in line with new clinical evidence as it emerges. The PCT is currently exploring alternative usage of screening resources to ensure more effective ways of reducing oral health inequalities. This might involve targeting resources in line with evidence based practice[7] on preventative measures in schools in areas of high deprivation. In addition, the PCT will continue to participate in the national dental epidemiological programme working with schools and local authorities.

[3] Sally Jeffery, Site and Community Liaison Manager, Gypsy and Traveller Unit, Brenchley House, 123-125 Week Street, Maidstone, Kent ME14 1RF

[4] http://www.screening.nhs.uk/dental

[5] http://www.nature.com/ebd/journal/v8/n1/pdf/6400460a.pdf

[6] GUIDANCE: Dental Screening (Inspection) in Schools and Consent for Undertaking Screening and Epidemiological Surveys. DH. Gateway Approval Reference Number: 7698.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_064171.pdf

[7] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102982.pdf

APPENDIX A

Primary Dental Services
Indicative 2010-2011 non recurrent allocations

Primary Dental Services
Indicative 2010-11 non-recurrent allocations

SHA code	PCT code	PCT	Primary Dental Services Net Allocation £000s	Total £000s	Resident population (000s) - ONS mid 2008	Registered population (000s) - attribution data set Mar 09	Allocation per patient (resident)	Allocation per patient (registered)
Q36	5M6	Richmond and Twickenham PCT	4,741	4,741	187	198	£25	£24
Q36	5LA	Kensington and Chelsea PCT	4,896	4,896	171	186	£29	£26
Q36	5A5	Kingston PCT	5,000	5,000	165	190	£30	£26
Q32	5NW	East Riding of Yorkshire PCT	10,789	10,789	336	314	£32	£34
Q33	5PA	Leicestershire County and Rutland PCT	21,915	21,915	680	672	£32	£33
Q33	5N9	Lincolnshire Teaching PCT	22,841	22,841	698	740	£33	£31
Q39	5K3	Swindon PCT	6,625	6,625	201	213	£33	£31
Q36	5AT	Hillingdon PCT	8,618	8,618	258	269	£33	£32
Q35	5PT	Suffolk PCT	19,793	19,793	593	611	£33	£32
Q39	5QM	Dorset PCT	13,556	13,556	406	399	£33	£34
Q34	5PK	South Staffordshire PCT	20,344	20,344	607	616	£33	£33
Q34	TAM	Solihull Care Trust	6,930	6,930	204	221	£34	£31
Q36	TAK	Bexley Care Trust	7,640	7,640	225	227	£34	£34
Q37	5P5	Surrey PCT	37,102	37,102	1,089	1,155	£34	£32
Q37	5P9	West Kent PCT	23,112	23,112	674	699	£34	£33
Q33	5N8	Nottinghamshire County Teaching PCT	22,977	22,977	662	664	£35	£35
Q34	5PH	North Staffordshire PCT	7,390	7,390	212	210	£35	£35
Q36	5A7	Bromley PCT	10,769	10,769	308	325	£35	£33
Q35	5PP	Cambridgeshire PCT	21,124	21,124	601	612	£35	£34
Q30	5D8	North Tyneside PCT	6,951	6,951	196	214	£35	£32
Q37	5QA	Eastern and Coastal Kent PCT	25,944	25,944	728	762	£36	£34
Q33	5ET	Bassetlaw PCT	3,976	3,976	111	111	£36	£36
Q38	5QC	Hampshire PCT	46,085	46,085	1,284	1,309	£36	£35
Q39	5QK	Wiltshire PCT	16,341	16,341	454	457	£36	£36
Q38	5QG	Berkshire East PCT	14,360	14,360	394	416	£36	£34
Q36	5M7	Sutton and Merton PCT	14,338	14,338	392	396	£37	£36
Q32	5EF	North Lincolnshire PCT	5,745	5,745	157	167	£37	£34
Q30	TAC	Northumberland Care Trust	11,448	11,448	311	321	£37	£36
Q38	5QD	Buckinghamshire PCT	18,727	18,727	505	527	£37	£36
Q35	5PQ	Norfolk PCT	27,856	27,856	751	747	£37	£37
Q35	5PV	West Essex PCT	10,413	10,413	280	285	£37	£37
Q31	5NF	North Lancashire Teaching PCT	12,152	12,152	326	338	£37	£36
Q39	5QH	Gloucestershire PCT	21,977	21,977	586	608	£37	£36
Q36	5K6	Harrow PCT	8,484	8,484	225	234	£38	£36

Q32	5H8	Rotherham PCT	9,547	9,547	253	255	£38	£37
Q34	5PJ	Stoke on Trent PCT	9,342	9,342	247	279	£38	£33
Q34	5PE	Dudley PCT	11,604	11,604	306	315	£38	£37
Q37	5P8	Hastings and Rother PCT	6,768	6,768	178	182	£38	£37
Q37	5P7	East Sussex Downs and Weald PCT	12,766	12,766	333	346	£38	£37
Q38	5L1	Southampton City PCT	8,983	8,983	234	260	£38	£35
Q34	5M3	Walsall Teaching PCT	9,792	9,792	255	269	£38	£36
Q39	5M8	North Somerset PCT	7,950	7,950	207	207	£38	£38
Q33	5N7	Derby City PCT	9,373	9,373	243	291	£39	£32
Q33	5PD	Northamptonshire Teaching PCT	26,304	26,304	679	698	£39	£38
Q34	5PL	Worcestershire PCT	21,541	21,541	555	573	£39	£38
Q34	5PG	Birmingham East and North PCT	15,764	15,764	405	442	£39	£36
Q38	5QE	Oxfordshire PCT	23,907	23,907	611	675	£39	£35
Q35	5P2	Bedfordshire PCT	16,022	16,022	409	429	£39	£37
Q39	5A3	South Gloucestershire PCT	10,265	10,265	260	255	£39	£40
Q31	5HQ	Bolton PCT	10,432	10,432	264	289	£40	£36
Q33	5N6	Derbyshire County PCT	28,796	28,796	724	711	£40	£40
Q38	5QT	Isle of Wight NHS PCT	5,585	5,585	140	140	£40	£40
Q31	5NE	Cumbria Teaching PCT	19,768	19,768	496	519	£40	£38
Q32	5NV	North Yorkshire and York PCT	31,429	31,429	788	794	£40	£40
Q30	5ND	County Durham PCT	20,303	20,303	505	530	£40	£38
Q36	5LG	Wandsworth PCT	11,435	11,435	284	355	£40	£32
Q35	5PX	Mid Essex PCT	14,892	14,892	368	375	£40	£40
Q34	5M2	Shropshire County PCT	11,824	11,824	291	296	£41	£40
Q35	5PW	North East Essex PCT	13,316	13,316	322	322	£41	£41
Q36	5K7	Camden PCT	9,383	9,383	227	238	£41	£39
Q37	5P6	West Sussex PCT	32,717	32,717	789	816	£41	£40
Q32	5N1	Leeds PCT	32,428	32,428	779	804	£42	£40
Q35	5P1	South East Essex PCT	13,955	13,955	335	361	£42	£39
Q32	TAN	North East Lincolnshire Care Trust Plus	6,622	6,622	159	170	£42	£39
Q31	5NQ	Heywood, Middleton and Rochdale PCT	8,560	8,560	204	222	£42	£39
Q35	5PY	South West Essex PCT	16,857	16,857	401	422	£42	£40
Q30	5KF	Gateshead PCT	7,992	7,992	190	205	£42	£39
Q38	5QF	Berkshire West PCT	19,625	19,625	460	496	£43	£40
Q39	5QQ	Devon PCT	31,893	31,893	747	758	£43	£42
Q32	5NY	Bradford and Airedale Teaching PCT	21,543	21,543	501	542	£43	£40
Q39	5QP	Cornwall and Isles of Scilly PCT	22,873	22,873	532	545	£43	£42
Q36	5C3	City and Hackney Teaching PCT	9,663	9,663	224	269	£43	£36
Q36	5A9	Barnet PCT	14,583	14,583	338	357	£43	£41
Q38	5FE	Portsmouth City Teaching PCT	8,670	8,670	199	209	£43	£41
Q39	5QL	Somerset PCT	22,937	22,937	524	536	£44	£43
Q38	5CQ	Milton Keynes PCT	10,429	10,429	238	253	£44	£41
Q36	5K9	Croydon PCT	15,090	15,090	341	377	£44	£40
Q34	5MD	Coventry Teaching PCT	13,765	13,765	311	356	£44	£39
Q31	5HP	Blackpool PCT	6,237	6,237	141	152	£44	£41
Q36	5C1	Enfield PCT	12,846	12,846	289	300	£44	£43
Q34	5MV	Wolverhampton City PCT	10,591	10,591	238	260	£44	£41
Q34	5PM	Warwickshire PCT	23,775	23,775	533	546	£45	£44
Q36	5A4	Havering PCT	10,458	10,458	232	252	£45	£41
Q31	5NP	Central and Eastern Cheshire PCT	20,541	20,541	456	467	£45	£44
Q31	5J5	Oldham PCT	9,840	9,840	218	237	£45	£41

Q35	5P4	West Hertfordshire PCT	24,565	24,565	543	584	£45	£42
Q33	5PC	Leicester City PCT	13,760	13,760	304	355	£45	£39
Q32	5J6	Calderdale PCT	9,066	9,066	200	209	£45	£43
Q36	5K8	Islington PCT	8,543	8,543	189	211	£45	£41
Q35	5P3	East and North Hertfordshire PCT	24,663	24,663	541	582	£46	£42
Q36	5NC	Waltham Forest PCT	10,111	10,111	221	271	£46	£37
Q31	5NM	Halton and St Helens PCT	13,564	13,564	295	319	£46	£43
Q39	5QN	Bournemouth and Poole Teaching PCT	14,064	14,064	305	361	£46	£39
Q39	5QJ	Bristol PCT	19,647	19,647	426	458	£46	£43
Q32	5JE	Barnsley PCT	10,416	10,416	225	243	£46	£43
Q32	5N2	Kirklees PCT	18,678	18,678	404	418	£46	£45
Q30	5D7	Newcastle PCT	12,864	12,864	278	280	£46	£46
Q39	5FL	Bath and North East Somerset PCT	8,230	8,230	177	196	£46	£42
Q31	5NH	East Lancashire Teaching PCT	17,718	17,718	381	388	£47	£46
Q36	5LD	Lambeth PCT	13,146	13,146	281	370	£47	£36
Q31	5J2	Warrington PCT	9,239	9,239	196	204	£47	£45
Q30	5KL	Sunderland Teaching PCT	13,233	13,233	281	284	£47	£47
Q31	5J4	Knowsley PCT	7,057	7,057	150	159	£47	£44
Q31	5LH	Tameside and Glossop PCT	11,752	11,752	248	238	£47	£49
Q39	5F1	Plymouth Teaching PCT	12,121	12,121	256	272	£47	£45
Q31	5NG	Central Lancashire PCT	21,761	21,761	458	468	£48	£46
Q39	TAL	Torbay Care Trust	6,386	6,386	134	145	£48	£44
Q30	5E1	Stockton-on-Tees Teaching PCT	9,057	9,057	190	192	£48	£47
Q32	5N4	Sheffield PCT	25,812	25,812	540	562	£48	£46
Q30	5QR	Redcar and Cleveland PCT	6,620	6,620	138	136	£48	£49
Q31	5F7	Stockport PCT	13,583	13,583	283	297	£48	£46
Q34	5M1	South Birmingham PCT	16,386	16,386	340	386	£48	£42
Q37	5LQ	Brighton and Hove City PCT	12,392	12,392	254	299	£49	£41
Q35	5GC	Luton PCT	9,311	9,311	191	207	£49	£45
Q31	5HG	Ashton, Leigh and Wigan PCT	14,944	14,944	305	318	£49	£47
Q31	5NR	Trafford PCT	10,530	10,530	214	231	£49	£46
Q31	5JX	Bury PCT	8,969	8,969	182	194	£49	£46
Q32	5N3	Wakefield District PCT	16,037	16,037	323	351	£50	£46
Q36	5NA	Redbridge PCT	13,342	13,342	264	263	£51	£51
Q31	5NJ	Sefton PCT	13,933	13,933	274	280	£51	£50
Q31	5NK	Wirral PCT	15,835	15,835	309	332	£51	£48
Q36	5C2	Barking and Dagenham PCT	8,814	8,814	172	181	£51	£49
Q35	5PR	Great Yarmouth and Waveney PCT	11,027	11,027	214	230	£52	£48
Q31	5NT	Manchester PCT	24,432	24,432	473	538	£52	£45
Q34	5CN	Herefordshire PCT	9,268	9,268	179	180	£52	£51
Q36	5A8	Greenwich Teaching PCT	11,633	11,633	224	264	£52	£44
Q36	5LC	Westminster PCT	12,855	12,855	247	245	£52	£53
Q31	5NN	Western Cheshire PCT	12,151	12,151	233	259	£52	£47
Q34	5MK	Telford and Wrekin PCT	8,448	8,448	162	170	£52	£50
Q30	5D9	Hartlepool PCT	4,745	4,745	91	95	£52	£50
Q31	5NL	Liverpool PCT	23,351	23,351	441	484	£53	£48
Q34	5MX	Heart of Birmingham Teaching PCT	14,548	14,548	274	315	£53	£46
Q37	5L3	Medway PCT	13,442	13,442	254	279	£53	£48
Q36	5LE	Southwark PCT	15,058	15,058	283	311	£53	£48
Q36	5LF	Lewisham PCT	14,399	14,399	262	298	£55	£48
Q33	5EM	Nottingham City PCT	16,304	16,304	297	331	£55	£49
Q36	5K5	Brent Teaching PCT	14,038	14,038	255	353	£55	£40

Q30	5KG	South Tyneside PCT	8,352	8,352	151	155	£55	£54
Q36	5HX	Ealing PCT	17,330	17,330	312	359	£56	£48
Q35	5PN	Peterborough PCT	9,503	9,503	170	175	£56	£54
Q36	5HY	Hounslow PCT	13,227	13,227	230	251	£57	£53
Q34	5PF	Sandwell PCT	16,754	16,754	289	336	£58	£50
Q32	5N5	Doncaster PCT	16,870	16,870	289	308	£58	£55
Q36	5H1	Hammersmith and Fulham PCT	9,898	9,898	169	188	£59	£53
Q36	5C4	Tower Hamlets PCT	13,318	13,318	227	245	£59	£54
Q30	5J9	Darlington PCT	5,907	5,907	100	106	£59	£56
Q32	5NX	Hull Teaching PCT	15,423	15,423	261	288	£59	£54
Q31	5F5	Salford PCT	13,200	13,200	223	240	£59	£55
Q30	5KM	Middlesbrough PCT	8,570	8,570	140	153	£61	£56
Q31	5CC	Blackburn with Darwen PCT	8,587	8,587	139	166	£62	£52
Q36	5C5	Newham PCT	15,239	15,239	242	327	£63	£47
Q36	5C9	Haringey Teaching PCT	14,834	14,834	225	275	£66	£54

APPENDIX B - GYPSY AND TRAVELLER COMMUNITY SITES

Gypsy site address	CONTRACT CODE	CONTRACT NAME	ADDRESS1	ADDRESS2	ADDRESS3	ADDRESS4	POST CODE	TELEPHONE1	child only	child & exempt	all patients
Barnfield Park Ash Road Sevenoaks Kent TN15 7HR	210307/0001	New Ash Green Dental Centre	Meadow Lane	New Ash Green	Longfield		DA3 8PR	01474 873455			
Coldharbour Caravan Site Maidstone Kent ME20 7NZ	913383/0001	The Dental Practice	38 Larkfield Road	Larkfield		Kent	ME20 6BJ	01732 521123	x		
	999148/0001	Green Acres Dental Practice	67 The Avenue	Greenacres	Maidstone	Kent	ME20 7LQ	01622 710284			
Heartenoak Caravan Site Heartenoak Road Hawkhurst TN18	921882/0001	The Crane Dental Surgery	57 High Street	Cranbrook		Kent	TN17 3EE	01580 713609			
Polhill Caravan Park Pohill Dunton Green Sevenoaks Kent TN14 7BG	8299940001	T M J Mckenzie	9 London Road	Sevenoaks		Gravesend	TN13 1AH	01732 455191			
Stilebridge Caravan Park Stilebridge LaneLane Marden Kent TN12 9BJ	570850/0001	The Dental Surgery	Church Green		Marden	Kent	TN12 9HR	01622 831556			
Water Lane Caravan Park Water Lane Ulcombe Kent TN17 1DH	742678/0001	Golding House Dental Practice	High Street	Cranbrook		Gravesend	TN17 3EJ	01580 713230			
	921882/0001	The Crane Dental Surgery	57 High Street	Cranbrook		Kent	TN17 3EE	01580 713609			
Windmill Lane Caravan Park Windmill Lane West Malling Kent	913383/0001	The Dental Practice	38 Larkfield Road	Larkfield		Kent	ME20 6BJ	01732 521123	x		
	999148/0001	Green Acres Dental Practice	67 The Avenue	Greenacres	Maidstone	Kent	ME20 7LQ	01622 710284			

This page is intentionally left blank

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 11 June 2010

Subject: Item 7. Committee Topic Discussion.

---

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.

(2) At the meeting on 26 March, Members of the Committee requested an opportunity at each meeting to discuss what they had heard and decide whether the outcomes for each main agenda item had been achieved, or whether there was a need for further information to be requested, and from whom.

2. Recommendations

(a) The Committee is asked to assess whether the outcomes for this meeting have been achieved or if further information on any topic is required by the Committee.

This page is intentionally left blank