HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 19th February, 2010

9.30 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 19th February, 2010, at 9.30 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 G Cooke, Mr K A Ferrin, MBE, Mr J A Kite, 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 Ms A Blackmore, Cllr M Lyons, Cllr Mrs J Perkins and Cllr Mrs M Peters

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.	Dentistry (Pages 1 - 40)	
4.	Further Information on Out of Hours Services (Pages 41 - 58)	
5.	Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust (Pages 59 - 156)	
6.	Date of next programmed meeting – Friday 26 March at 10:00	

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

13 February 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.

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 19 February 2010

Subject: Item 4. Dentistry.

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1. Background

(a) The topic of dentistry was originally included in the Agenda for the meeting of 8 January 2010. This meeting was postponed due to adverse weather conditions. An additional meeting was arranged for 19 February 2010.

(b) The Chairman has decided that the Task and Finish Group which has been considering Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust should report back to this meeting and that this should be the only substantive item on the agenda. The written evidence submitted on dentistry has been included in this Agenda, but there will not be any witnesses attending to answer any follow-up questions.

(c) At present the future work programme has the following items on the Agenda for the next two meetings:

a. 26 March 2010. Use of Community Hospitals; and Diagnostics – Waiting Times.
b. 7 May 2010. Update of PCTs' Strategic Commissioning Plans/Operational Plans.

2. Recommendations

(a) The Committee is asked to decide:-

(a) whether they wish to have a full discussion on dentistry at a subsequent meeting; and

(b) whether they wish to amend the work programme for the next two meetings to reflect this.

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

To: Health Overview and Scrutiny Committee – 19 February 2010

Subject: Dentistry

Introduction

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

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

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

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

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

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

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

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

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

Dental Commissioning

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

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

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

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

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

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

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

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

[4] Ibid, p.30.

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

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

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

[8] Ibid, p.28.

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

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

The Impact of the New Contract

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

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

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

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

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

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

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

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

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

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

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

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

Staff Numbers

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

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

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

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

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

Access to Dentistry

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

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

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

[17] Ibid.

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

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

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

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

Care Quality Commission

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

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

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

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

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

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

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

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

[19] Ibid.

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

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

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

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

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

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

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

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

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

- Failed (for an indicator less than 90%)

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

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

Some Key Organisations

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

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

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

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

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

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

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

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

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

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

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

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

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

A better service for patients: accessible and high quality

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

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

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

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

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

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

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

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

Aligning the contract to improve access and quality

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

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

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

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

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

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

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

What the NHS has to do

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

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

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

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

Implementation challenges

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

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

January 2010

Dental Services

1. Introduction

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

2. Context

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

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

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

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

3. What is being commissioned?

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

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

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

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

Table 1

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

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

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

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

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

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

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

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

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

3.1 Out of Hours

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

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

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

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

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

3.2 Community Dental Services

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

4. What is spent on primary care dental services?

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

Table 2

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

5. Children's Oral Health

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

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

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

6. Challenges

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

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

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

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

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

7. Dental Prescribing

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

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

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

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

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

8. Customer Services

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

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

Within the first month of the helpdesk opening:

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

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

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

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

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

9. Conclusion

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

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

Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Currently within West Kent there are:

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

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

NHS West Kent currently holds twelve child only dental contracts.

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 4: UDAs recorded against Courses of Treatment

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

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

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

3. How are dentists remunerated for preventative work?

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

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

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

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

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

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

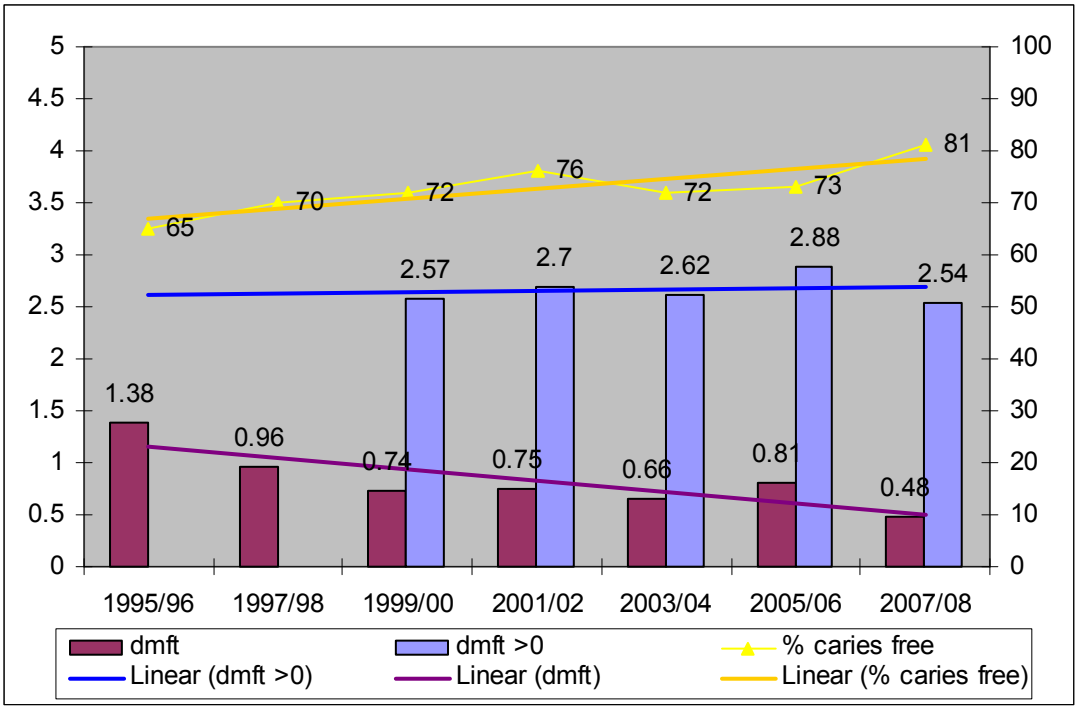
5. What information can be provided on the state of children's oral health in your PCT, and how this has changed over time?

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

The data shown in Table 6 shows the following:

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

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



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

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

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

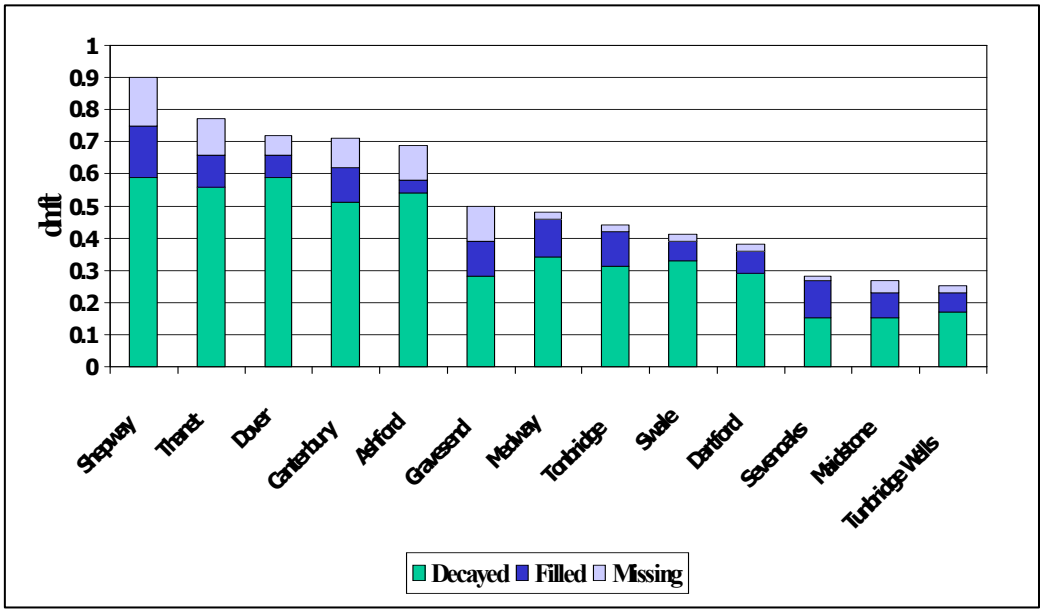


Table 7: Dental disease in 5 year-old children by local authorities across Kent (BASCD data 2007/08).

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

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

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

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

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

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

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

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

NHS charges apply to all out of hours dental services.

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

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

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

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

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

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

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

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

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

The PCT plans to:

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

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

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

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

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

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

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

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

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

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

Table 8: Summary of dental enquiries and complaints

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Tim Hogan BDS
Chair Kent Local Dental Committee.

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Dentistry in Kent

Introduction

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

The concerns

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

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

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

Other issues included:

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

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

The assurances

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

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

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

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

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

- Maidstone
- Swanley
- Tunbridge Wells

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

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

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

In conclusion

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

20/12/09

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 19 February 2010

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

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1. Background

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

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

2. Recommendation

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

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NHS
Eastern and Coastal Kent

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Our ref: AS/cd
11 December 2009

Dear Paul,

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

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

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

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

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

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

Cont'd.

2/

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

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

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

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

Cont'd.

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

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

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

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

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

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

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

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

Clinical Staff:

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

Support staff:

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely,

Ann Sutton
Chief Executive

Enc.

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

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Kent and Medway
Health Informatics Service

Kent and Medway
Health Informatics Service

Eastern & Coastal Kent PCT
Out of Hours Survey
Results Report

June 2009

Wendy Lanng

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

Hosted by Maidstone and Tunbridge Wells NHS Trust

Table of Contents

1 INTRODUCTION

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

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

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

2 BACKGROUND

2.1 Methodology

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

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

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

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

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

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

3 RESULTS

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

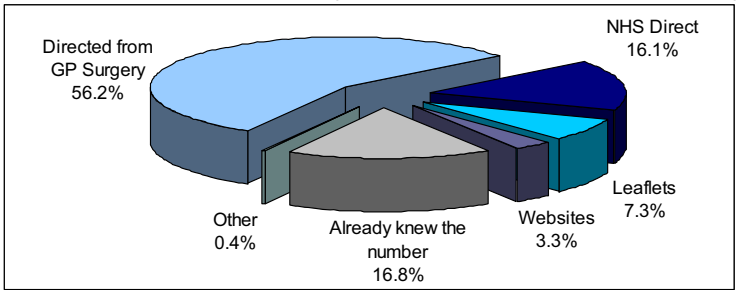
Mark on the envelope: s	18
Mark on the envelope: x	242
Unmarked envelope	1
Online response	46
Grand Total	**307**

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

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

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

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

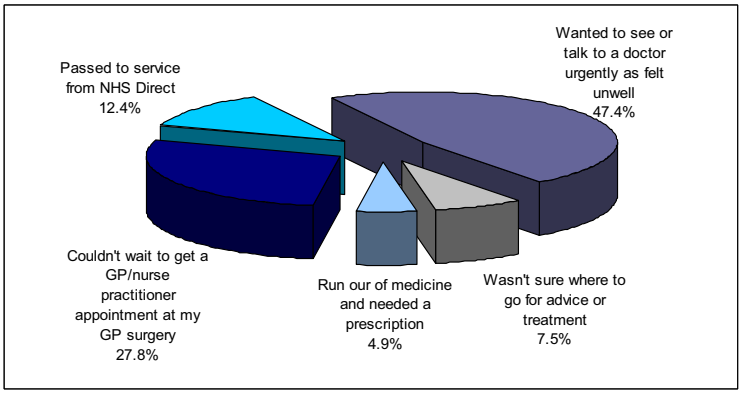


16.8% already knew the number, and 16.1% heard about the service from NHS Direct.

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

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

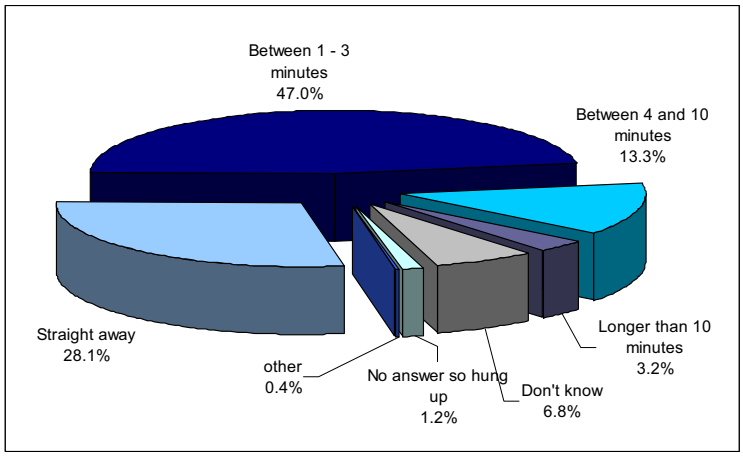
To the question "Why did you phone for advice or treatment" (See Appendix 5.1, question 2), 47.4% of respondents that answered wanted to urgently see or speak to someone as they felt unwell while 27.8% could not wait for an appointment at their GP surgery.



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

3.3 "How quickly did they answer the phone?"

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

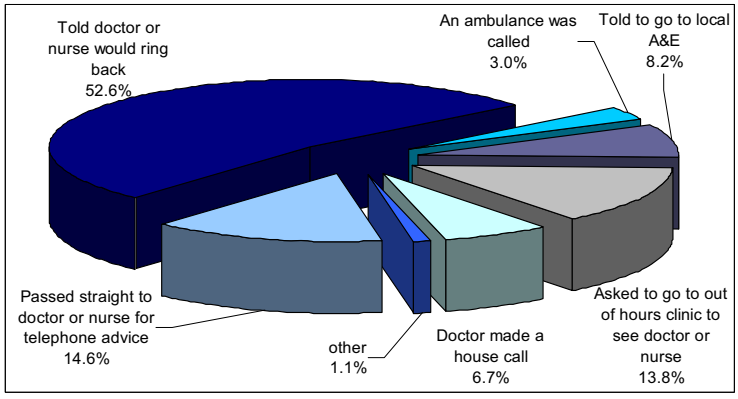


16.5% of respondents reported that it took four minutes or longer for the call to be answered, of which, 3.2% of all respondents waited longer than 10 minutes.

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

3.4 "What happened when you rang?"

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

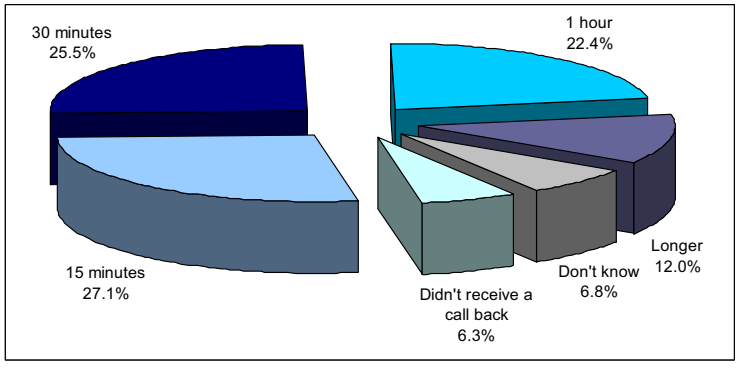


Of the remaining categories, 14.6% were passed straight to telephone advice, and 6.7% had a house call. 13.8% were asked to visit a clinic. The remaining 11.2% of answers were for emergency treatment; with 8.2% told to go to A&E and an ambulance was called for 3.0% of respondents.

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

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

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

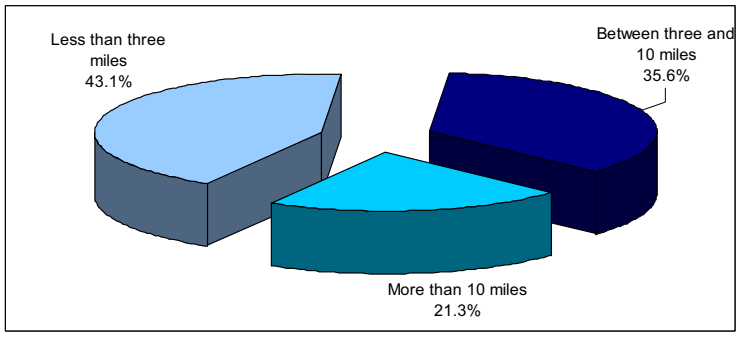


Of the remaining replies, 6.8% of respondents did not know

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

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

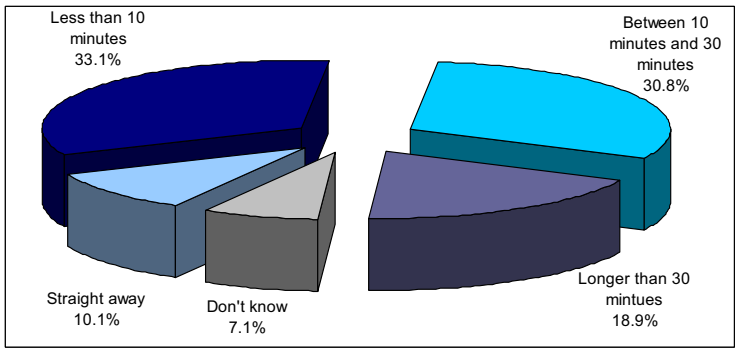
To the question asking how far the respondents travelled (See Appendix 5.1, question 6), 43.1% of respondents that answered the question travelled less than three miles, and 35.6% travelled between three and 10 miles. More than 10 miles was the distance travelled by 21.3% of respondents.



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

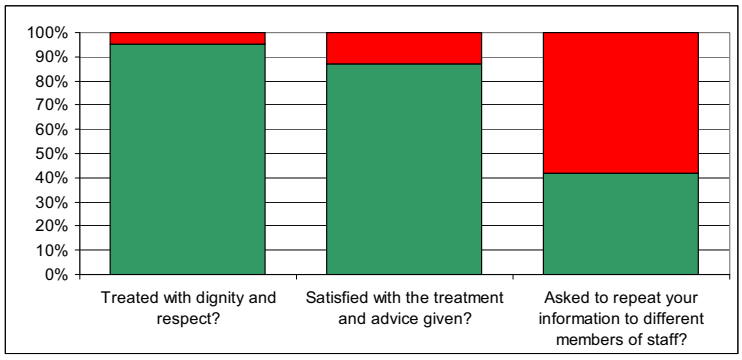
To the question asking how long the respondents waited to be seen (See Appendix 5.1, question 7), 74.0% of those that responded waited less than 30 minutes to be seen, comprising 10.1% of all respondents were seen straight away and 33.1% were seen within 10 minutes.

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



3.8 How were you treated?

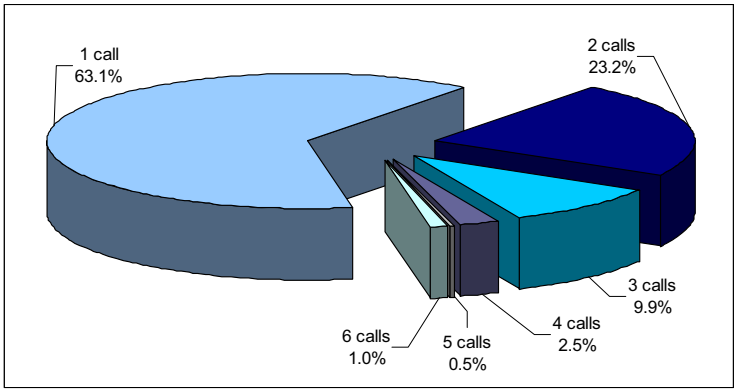
The question asking how the respondents were treated was split into three parts (See Appendix 5.1, question 8). Of those that answered part one, 95.1% felt they were treated with dignity and respect and of those that answered part two, 87.0% were satisfied with the treatment and advice they received.



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

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

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



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

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

4 CONCLUSION

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

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

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

5 APPENDIX

5.1 Example Survey

Out of Hours Survey

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

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

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

2. Why did you phone for advice or treatment?

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

3. How quickly did they answer the phone?

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

4. What happened when you rang?

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

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

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

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

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

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

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

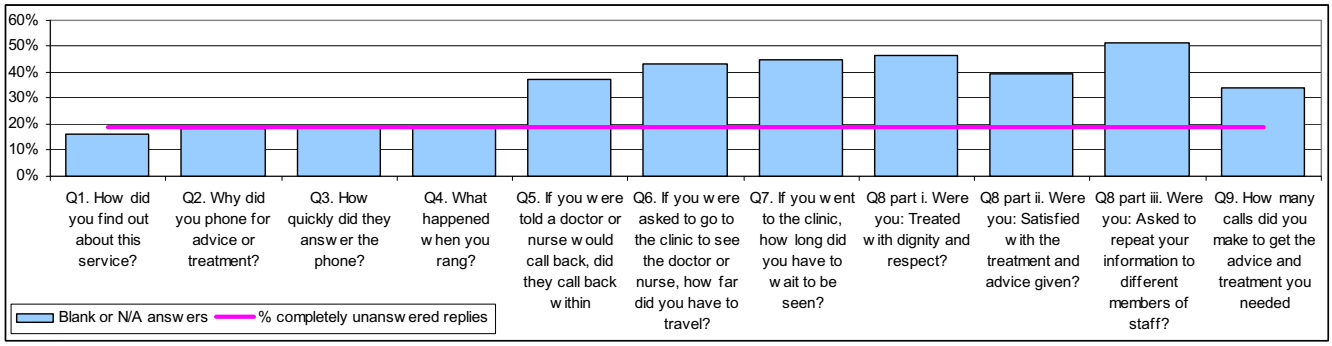
8. Were you:

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

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

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

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



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

End of report

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

To: Health Overview and Scrutiny Committee – 19 February 2010

Subject: Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust

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Background

(1) On 26 September 2003, the NHS OSC (as HOSC was then known) was informed that MTW, South West Kent PCT and Maidstone Weald PCT had embarked on a project to develop proposals for service changes. This built on work carried out in 2000 by the newly formed Maidstone and Tunbridge Wells NHS Trust (MTW) and what was then the West Kent Health Authority[1].

(2) At this meeting an outline of some of the areas which were being examined was provided. Further information on the three stages of the project was provided to the Committee on 14 November 2003. The issue was revisited on 15 March 2004 with the Committee receiving an update on how the project was developing.

(3) On 8 July 2004, the Committee had a presentation on the South of West Kent Health Community Consultation. This covered 'Priority 2' changes and ran from 12 July to 4 October 2004. The consultation document was called "Shaping Your Local health Services." A summary of these proposals, along with the Committee's decision to support them can be found in Appendix 1 - Extract from NHS OSC Minutes, 15 October 2004.

(4) The 'Priority 3' changes primarily related to:

a. Women's and children's services; and
b. Orthopaedics trauma and elective orthopaedics.

(5) The Committee was presented with an overview of the plans for these areas on 30 September 2004. At this meeting, "The Chairman reported that the County Council in conjunction with East Sussex County Council were to establish a Select Committee to look at all these proposals in some detail. The Select Committee would also have representation from the Patient and Public Involvement Forums

[1] Maidstone and Tunbridge Wells NHS Trust was established on 14 February 2000.
Maidstone and Malling PCT was established on 16 February 2001 and changed its name to Maidstone Weald PCT on 1 April 2002.
South West Kent PCT was established in 16 February 2001.
Sussex Downs and Weald PCT was established on 1 April 2002.
On 1 October 2006, West Kent PCT (NHS West Kent) replaced the three former PCTs of Maidstone Weald, South West Kent and Dartford, Gravesham and Swanley.

and the Borough/District Councils which make up the South-West Kent Health Economy."[2]

Women's and Children's Services

(6) The consultation document pertaining to women's and children's services was launched on 4 October 2004 and ran until 31 December 2004. The document was entitled, "Excellence in care, closer to home. The future of services for women and children – a consultation document."

(7) According to p.8 of this document:

This is how services will be provided for both women and children if our proposals go ahead:

Pembury	**Maidstone**
Gynaecology	**Gynaecology**
Outpatient service	Outpatient service
Day care	Day care
Early pregnancy assessment	Early pregnancy assessment
Inpatient service, non-cancer	Gynaecological cancer
Paediatrics	**Paediatrics**
Outpatient service	Outpatient service
Assessment and ambulatory care, including medical and surgical day beds	Assessment and ambulatory care, including medical and surgical day beds
Community nursing team – seven days per week	Community nursing team – seven days per week
Child & Adolescent Health and Development Centre	Treat and transfer facility
Neonatal service	Child & Adolescent Health and Development Centre
Inpatient Service	
Obstetrics/Maternity	**Obstetrics/Maternity**
Midwife-led birthing centre	Midwife-led birthing centre
Outpatient service	Outpatient service
Antenatal care	Antenatal care
Day and fetal assessment	Day and fetal assessment
Community midwifery	Community midwifery
Consultant-led maternity unit	

(8) The Joint Select Committee established to produce a response to this consultation consisted of representatives from Kent County Council, East Sussex County Council, Kent District/Borough Councils, East Sussex District/Borough Councils and the Patient and

[2] Minutes, 30 September 2004, National Health Service Overview and Scrutiny Committee, Kent County Council.

Public Involvement Forum. Its report on the women's and children's consultation was produced in December 2004.

(9) The NHS OSC considered the Joint Select Committee Report at its meeting on 14 December 2004. At the end of this discussion, the Committee passed the following resolution:

"RESOLVED that the Committee Manager (Overview and Scrutiny) be authorised to conclude the report in conjunction with the Joint Select Committee and Mr Ford (as the only spokesman on the County Council's NHS Overview and Scrutiny Committee who does not serve on the Joint Select Committee). This would enable the report to be submitted to NHS colleagues in accordance with the 31 December 2004 consultation deadline."[3]

(10) The NHS Joint Board of Members with delegated powers on behalf of South West Kent PCT, Maidstone Weald PCT, Sussex Downs and Weald PCT and Maidstone and Tunbridge Wells NHS Trust met at Sessions House on 23 February 2005. "Dr Robinson, the Chairman of this Committee and Chairman of the Joint Select Committee was invited to make a presentation to this Joint Board of Members. (15) The report before the Joint Board contained the Executive Summary and recommendations of the Joint Select Committee. It was the decision of the Joint Board that the current model of care for the provision of Women's and Children's Services within the Maidstone and Tunbridge Wells NHS Trust was unsustainable and that the proposed model of care being centralised at Pembury in the new hospital in 2010/1, was the way forward. Having taken the decision to centralise these services at Tunbridge Wells the Joint Board then went on to consider the recommendations of the Joint Select Committee and gave their views on the response. This was attached to the report before the Committee."[4]

(11) Appendix 2 contains a copy of the conclusions and recommendations from the Executive Summary of the Joint Select Committee response to the women's and children's consultation. The version used in the appendix is one that went before the County Council on 24 March 2005. The italicised sections within the Joint Select Committee's recommendations are the summarised responses from the delegated Joint Board of the PCTs and Maidstone and Tunbridge Wells NHS Trust[5].

[3] Minutes, 14 December 2004, National Health Service Overview and Scrutiny Committee, Kent County Council.
[4] Minutes, 15 April 2005, National Health Service Overview and Scrutiny Committee, Kent County Council.
[5] Both the full Joint Select Committee report and the Executive Summary can be accessed from here, http://www.eastsussexhealth.org/programme.html

(12) On 24 March 2005, the County Council discussed the Joint Select Committee report and following a vote on an amendment, which was defeated, passed the following resolution:

> "RESOLVED that the joint response of the Joint Select Committee to the consultation on Women's and Children's Services within the Maidstone and Tunbridge Wells NHS Trust together with the decision and the response of the Joint Board of delegated Members from the South West Kent PCT, Maidstone Weald PCT, Sussex Downs and Weald PCT and Maidstone and Tunbridge Wells NHS Trust, be noted."[6]

(13) A series of updates on the development of women's and children's services was presented to the Committee at regular intervals. On receiving an update at its meeting on 22 September 2006, the Committee passed the following resolution:

> "Resolved that it be noted that the proposal to relocate Women's and Children's services from Maidstone Hospital to Pembury Hospital within the next twelve months had now been withdrawn."[7]

(14) On 20 July 2006, the Committee received an update from Maidstone and Tunbridge Wells NHS Trust on the planned Private Finance Initiative (PFI) hospital at Pembury. Possible changes to services at MTW were also discussed.

(15) Appendix 3 contains the relevant extract of the Minutes of this meeting, along with the post-meeting note. This note was endorsed by the Committee at its meeting of 22 September 2006.

(16) At its meeting of 27 November 2009, the Health Overview and Scrutiny Committee considered the Maidstone and Tunbridge Wells NHS Trust Service Redesign. Women's and Children's services formed a large part of the discussion. At the end of this, the Committee:

> (55) RESOLVED that:-
>
> a) the Committee thank colleagues from the Maidstone and Tunbridge Wells NHS Trust for the information that they have provided on the provision of services across the Trust and the redesign following the opening of the new Pembury Hospital in 2011;
>
> b) a small Sub Committee be established to explore in greater detail with the heath organisations within the health economy the rationale of the provision of women's and children's services to establish whether this best meets the needs of patients who look to the

[6] Minutes, 24 March 2005, Kent County Council.
[7] Minutes, 22 September 2006, National Health Service Overview and Scrutiny Committee, Kent County Council.

Maidstone and Tunbridge Wells NHS Trust for these services and to report back to a meeting of this Committee in February 2010;

c) the Overview, Scrutiny and Localism Manager be given delegated authority in consultation with the Chairman, Spokesmen and stakeholders to determine the membership of the Sub Committee referred to in resolution (2) above; and

d) the Committee accept the Trusts offer to visit the Maidstone and Pembury Hospital sites and the necessary arrangements be made for these visits as soon as possible.[8]

[8] Minutes, Health Overview and Scrutiny Committee, 27 November 2009, http://democracy.kent.gov.uk/Published/C00000112/M00003065/AI00011157/$Minutes.docA.ps.pdf

Appendix 1 - Extract from NHS OSC Minutes, 15 October 2004

49. South of West Kent Health Community – Priority 2, Proposed Changes

(Mr S Ford, Chief executive South West Kent Primary care trust and Mrs R Gibb, Chief executive Maidstone and Tunbridge Wells NHS Trust were in attendance for this item)

(1) The Committee received a presentation from Mr S Ford and Mrs R Gibb on the feedback to the consultation document "Shaping Your Local Health Services" commonly known as Priority 2, Proposed Changes.

(2) To remind the Committee the proposals in Priority 2 were:-

- move Medical Service – Pembury to Kent and Sussex and to local Community Hospitals and Community Rehabilitation Teams
- move the In-Patient Gynaecology – Maidstone to Pembury
- move Children's Planned Routine Surgery from Kent and Sussex, Tunbridge Wells to Maidstone
- move the Kent and Sussex In-Patient Haemotology to Maidstone Hospital at the Kent Oncology Centre to create a Specialist centre

(3) The Committee were then informed of the feedback methodology and feedback received from questionnaires. In general the feedback was that centralisation was welcome to improve standards. Concerns were expressed about the impact on staff but one of the most and consistently identified significant issues was that of transport and travel.

(4) The Chairman then suggested to the Committee that the Committee should support the proposed changes.

(5) RESOLVED that the Committee unanimously support the proposals set out in the consultation document known as Priority 2.

Appendix 2 – Conclusion and Recommendations extracted from the Executive Summary of the Joint Select Committee response to *"Excellence in care, closer to home. The future for women and children."*[9]

(The italicised sections within the Joint Select Committee's recommendations are the summarised response from the delegated Joint Board of the PCTs and Maidstone and Tunbridge Wells NHS Trust).

"11. Conclusion

Making any changes to hospital services can be extremely emotive, however when change is related to women's and children's services this sentiment is heightened. Although the Committee has some reservations with the movement of services from a densely populated area such as Maidstone to Pembury, it is satisfied that the rationale for doing so provides justification. To not move these to Pembury would lead to a severe gap in services for those in East Sussex and the far West of Kent. However, in moving such services the Acute Trust and Local Authorities have a responsibility to ensure there is fair access to these services for all, which will involve thoroughly investigating the transport issues to ensure there is adequate infrastructure to support the new development.

Consequently the Joint Select Committee fully supports the Acute Trusts vision for 'A single Acute Trust, operating from two major hospitals, with centres of excellence that work together in a complementary way'.

12. Recommendations

The Committee supports the proposals for the redesign of Women's and Children's services. However, the Committee would like to make the following recommendations:

- The Committee recommends that the Acute Trust and PCTs conduct future comprehensive consultations with more structured planning and less time restrictions and the process is developed in partnership with relevant Patient and Public Involvement Forums. The Committee also recommends that where possible, options be given for the public to comment on.
- The Acute Trust must satisfy the Committee that the pressures facing the services at present are to be addressed, and produce an intermediate plan for sustaining services until the new development is operational and reports on these issues on a six monthly basis, either in writing or by attendance at the NHS OSCs.

[9] Taken from Agenda Papers, NHS Overview and Scrutiny Committee, 15 April 2005, http://democracy.kent.gov.uk/Data/NHS%20Overview%20and%20Scrutiny%20Committee/20050415/Agenda/$Item%205%20-%20Appendix%203%20-%20JSC%20Response%20.doc.pdf

Summary of Joint PCT Board Response given at meeting on 23 February 2005 :

The Intermediate Plan was in a draft stage and would be complete by the end of March when it would be shared with all the Primary Care Trusts and the two Health Overview and Scrutiny Committees for East Sussex and Kent.

- The Committee recommends that the Maidstone midwife-led birthing centre is situated away from the main hospital site.

Summary of Joint Board response given at the meeting on 23 February 2005:

The Intermediate Plan would show potential locations for this Unit. The Joint Board agreed with the principle that the Birthing Centre would not be on the hospital site.

- The Acute Trust must satisfy the NHS OSCs that when developing the proposals for the midwife-led birthing centre, it follows best practice, such as the Crowborough birthing centre and as informed by the Royal Colleges.

Summary of response given by the Joint Board on 23 February 2005:

There was already an active dialogue between the Maidstone and Tunbridge Wells NHS Trust and the Crowborough Birthing Unit.

- The Committee recommends that the Acute Trust and PCTs develop plans for community services, in terms of midwifery and children's nursing as a matter of priority. This is to ensure these are well established and sustainable and are able to demonstrate a reduction in the reliance on acute hospital services before the service changes are implemented.

Summary of response given by the Joint Board on 23 February 2005:

The plans for community services would be included within the Intermediate Plan.

- The Committee recommends that the PCTs develop and promote a communication strategy specifically for the education of the public on the service redesign, if these proposals are implemented.

Summary of response given by the Joint Board on 23 February 2005:

Following the Joint Board meeting some immediate steps would be taken to communicate the outcomes to the staff and public in the short term. A Joint Communications Plan and Strategy would be finalised by 30 April 2005 and would address issues of education and public communication and involvement etc.

- The Committee recommends that both County Councils, relevant Boroughs and District Councils and the Acute Trust identify dedicated officers, who will recognise the challenges and find solutions in partnership, to ensure there is adequate transport provision to serve the new development at Pembury
- To extend the East Kent Integrated Transport Model, if it is proved to be successful on evaluation, to include West Kent with the involvement of appropriate bodies in East Sussex.

Summary of response given by the Joint Board on 23 February 2005:

Work would continue with the local authorities and others to address the transportation challenges. The trust will continue to explore the East Kent Integrated Transport model.

The NHS Overview and Scrutiny Committees will continue to closely monitor developments and the implementation of these plans, if the proposals are accepted. The NHS Overview and Scrutiny Committees will continue to hold the Trust to account in regard to these proposals."

Appendix 3 - Extract from NHS OSC Minutes, 20 July 2006

29. Maidstone & Tunbridge Wells NHS Trust - update

(Rose Gibb, Chief executive, and Frank Sims, Director of Modernisation, from Maidstone and Tunbridge Wells NHS Trust were in attendance for this item)

(1) The Committee received an update from Ms Rose Gibb, Chief Executive of Maidstone & Tunbridge Wells NHS Trust, regarding the planned Private Finance Initiative (PFI) Hospital at Pembury. Ms Gibb explained that the PFI project was under review by the department of Health and HM Treasury, but she was confident that it would be allowed to proceed; final approval by the Treasury was expected in February 2007. She explained that the scope of the new hospital had been significantly reduced since the drawing up of the original plans. It was anticipated that the hospital would open in December 2010.

(2) Consideration was also given by the Committee to the Trust's proposals for achieving financial balance, including possible changes relating to:

- Trauma and Orthopaedic services;
- Accident and Emergency services;
- Women's and Children's services.
- the growing role of the private sector, including Independent Sector Treatment Centres, in providing NHS care;
- the part played by cottage and community hospitals in providing care outside acute hospitals; and
- the impact of Payment by Results on acute hospitals' finances.

(5) RESOLVED that the update be noted.

POST MEETING NOTE:

Following consultation with the party spokesmen on the Committee, the Maidstone & Tunbridge Wells NHS Trust was advised on 11 August 2006 of the following views – which the NHS Overview and Scrutiny Committee will be asked to endorse on 22 September 2006:

"The spokesmen support your views to consult on the proposed changes to the provision of emergency surgical services, emergency orthopaedic services and inpatient elective surgical services.

The spokesmen accept that the changes proposed to acute medical admissions are part of the normal process redesign of services and that given that patients will not be displaced from Maidstone and Kent and Sussex Hospitals but will now find themselves going to specialist admitting units rather than Accident and Emergency does not require consultation."

Report of the Task and Finish Group considering the provision of Women's and Children's Services within Maidstone and Tunbridge Wells NHS Trust

1. Background

a. In December 2004 the KCC Joint Select Committee of the East Sussex and Kent County Councils' Health Overview and Scrutiny Committees (HOSCs) voted to support the proposals for the reconfiguration of the Women's and Children's Services in Maidstone and Tunbridge Wells NHS Trust (MTW Trust), who run hospitals in Maidstone, Pembury and Tunbridge Wells. The KCC Health and Overview Scrutiny Committee had already agreed to receive an update in respect of the service redesign at MTW NHS Trust. Following the meeting of the committee on November 27th 2009 and a Councillor Call For Action at Maidstone Borough Council a Task and Finish Group was established to review in depth the Women's and Children's Service at Maidstone Hospital and the new Pembury Hospital.

2. Introduction

a. Since the setting up of the Task and Finish group we have considered evidence from a wide variety of sources (see Appendix for details). We understand that this issue surrounding the transfer of the consultant led acute services from Maidstone Hospital is a highly complex and emotive one. Having scrutinised in great detail the wealth of information available and conducted a number of in-depth interviews with a comprehensive range of witnesses, we have produced this report with our key findings. Although the overriding issue relates to health, it is clear that a holistic approach to problem solving is key to the future planning of major projects which feature a variety of interconnecting issues.

3. Location of Services

a. The Group noted that the obstetric clinical led deliveries only are moving to Pembury Hospital but a total of six consultant led clinics will remain at Maidstone Hospital. These will cover antenatal and postnatal care including ultrasound. Presently discussions are continuing in respect of the possible retention of Gynaecology for inpatient emergency and elective gynaecological surgery which is not allied to oncology at Maidstone. These discussions are active and ongoing.

b. A midwife led Birthing Unit will be provided at Maidstone Hospital within the former nurses' home following substantial refurbishment. The criteria for women using the Birthing Unit will be as per NICE (National Institute for Health and Clinical Excellence) guidelines and the centre is intended for women who have had a straightforward and uncomplicated pregnancy. The Birthing Unit is planned to be used by up to 500 women annually.

c. A purpose built Women's and Children's Centre will be situated at Pembury Hospital and will offer single rooms with en-suite facilities.

d. Paediatric day care will be retained at Maidstone Hospital.

e. The Group were advised by the MTW Trust that if ordered by the Department of Health to provide consultant led services on both sites, then they would carry out this instruction. However in the event that the service was unsustainable and ultimately found to be clinically unsafe this could lead to the subsequent closure of the maternity service at Maidstone Hospital.

4. Transfers

a. It is apparent that not all transfers from existing Birthing Units constitute an emergency situation which requires a blue light service. Many are a precautionary measure to ensure that the pregnant woman delivers her baby safely.

b. It must be noted that the although the travelling time to Pembury is stated to be 30 minutes, the total transfer time could be 1 hour from the time of the making of initial telephone call to arrival at the destination ward of the patient.

c. Depending on the circumstances at the time of transfer, patients can go to any hospital of their choice if it is nearer to their home and it is safe for that journey to be undertaken. Not all of the women who undertake transfers from Maidstone Birthing Unit would go to the new Pembury Hospital. Patient choice is paramount unless there is a clinical need which will override patient choice. The Task and Finish Group were advised that arrangements may be made at the William Harvey Hospital in Ashford, Medway Maritime in Gillingham, or even Darent Valley in Dartford for delivering babies.

d. There are clear criteria (guidelines devised by NICE and the Royal Colleges, such as the Royal College of Obstetricians and Gynaecologists) for transfer in labour which will require good liaison with the ambulance services and a subsequent transfer may be to William Harvey Hospital, Medway Maritime, Darent Valley or Pembury.

5. Transport / Travel

a. The Group met with KCC officials who explained the lack of progress relating to the Colts Hill (A228) road improvement. This is a major project under Regional Transport Board priority funding control and with the current economic situation is not considered a sufficient priority to secure the necessary funding, probably until post 2014. The Group concluded that this was not within the control of the MTW Trust, however the Trust, East Sussex County Council, Kent County Council, and the relevant borough and district councils, should actively lobby the relevant bodies for the finance and stress its strategic importance.

b. When the 2004 Joint Select Committee Report was report was written it was assumed a new road scheme though Colts Hill would be progressed. Although £25M was ring fenced for this upgrade, the alteration in the road is not planned until at least 2014 at the earliest. The only prospect for any road improvement is for the extension of dual carriageway of the A21 which is due to start in 2011 /12 and could take two or more years to complete. This would assume a proper interchange at Pembury and would move any potential traffic problems issues away from the Pembury roundabout ensuring a smooth traffic flow.

c. The Group noted the existence of the current public transport situation with only one direct route linking Pembury and Maidstone. There is a potential upgrade, subject to the award of Government Kickstart funding, to the number 6 bus route from Maidstone to Tunbridge Wells via Pembury Hospital to every half hour from 6am to 6pm. Currently, there are no other links for public transport. The MTW Trust indicated that they are prepared to subsidise these routes in cooperation with the County Council.

d. The Group would wish to see an update plan implemented for patient transport services between the two hospitals.

6. Staffing

a. From the research undertaken by the Group there are systemic issues which provide substantial barriers. The European Working Time Directive (limiting junior doctors to 48 hours per week from 2009) and the difficulty of recruiting and retaining middle grade paediatricians remains the most prominent problem to solve.

b. In respect of Paediatric Training there were the following difficulties :-

- an insufficient number of applicants applying to the available posts
- a lack of critical mass of patients in the unit to offer the spread of experience necessary for career progression
- a higher number of female doctors recruited to the speciality of paediatrics who want to work part-time in order to balance family commitments
- a lack of attractiveness in the profession due to potential litigation
- national shortage of paediatricians

c. Within the birthing unit the midwives are confident of their abilities to deliver a first class service without clinical intervention. However at Birthing Units the following services would not be available:

- forceps delivery
- ventouse delivery
- administration of epidurals
- caesareans (both unplanned and elective)

d. The above constitutes about 40% of the deliveries noted in the 2006 birth figures for Maidstone Hospital.

e. The Group was asked to note by the MTW Trust that recruitment in the short term may be hampered whilst it is still unclear what any referral outcome may demand.

7. Choice – local / non local

a. There seems to be a lack of public awareness in respect of the choices which are currently available.

b. These are home births; midwife led birthing unit and a hospital only limited by clinical need.

c. Figures released by the Trust for 2006 at Maidstone Hospital, show the number of births which required clinical assistance was 1,173 which excluded elective caesareans.

d. Whatever choice is made regarding place of delivery the national clinical standards of care apply at each and every location, whether it is a midwife led birth centre, or at a consultant led facility or at a patient nominated unit outside the Trust.

e. It is essential that GP Practices give proper information to expectant mothers about the choices available to them in relation to the actual place of birth of their baby.

8. Visit to West Kent Primary Care Trust (NHS West Kent) Commissioners / views

a. The Task and Finish group engaged in a useful dialogue with the Primary Care Trust (PCT). The PCT's position is to continue with their wholehearted support of the ongoing MTW service redesign programme.

b. We were advised by the PCT Commissioners that in the event that a referral takes place, there would be a potential delay to the implementation of Women's and Children's Services located at Pembury.

9. Buckland Birthing Unit

a. The Task and Finish group visited the Buckland Birthing Unit at Dover which provides an environment for natural birth conditions with the supplement of pethadine and gas and air. There is no access to an epidural on site. With reference to transfers from this unit, only two emergency blue light transfers have been required in the ten years in which the unit has been operational. On both occasions

the outcome was favourable for both baby and mother. The midwives volunteered that 3 in 10 were transferred to other facilities e.g. William Harvey Hospital and Queen Elizabeth the Queen Mother Hospital (QEQM) in Margate as a precaution prior to any difficulties taking place.

b. The same midwife will accompany the woman to the hospital once the decision to transfer is made.

10. Communications

a. After nearly a decade the MTW NHS Trust does not present itself as an integrated workforce. There appears to be a lack of ongoing public engagement about the implementation of the redevelopment of Women's and Children's Services within MTW NHS Trust. Also we noted a lack of ability on the part of the Trust to present this implementation in a structured and positive format to members of the public.

b. During an interview with the Chief Executive of the Strategic Health Authority (SHA) it was confirmed that they were satisfied with the original 2004 consultation but they agreed that within the ongoing communication strategy there were areas which needed improvement.

11. Alternatives

a. The MTW Trust believe no practical alternative has been presented which would allow the status quo. All establishments must conform to the National Guidelines and perform at a level which will give the ability to train staff and maintain their accreditation for such training.

b. The Task and Finish Group were assured that financial resources were not the basis for the reconfiguration. The Trust has requested an alternative solution which is deliverable, workable and acceptable but this has **not** been forthcoming from any of the witnesses and stakeholders that have been interviewed by the Task and Finish Group, except possibly for an issue relating to gynaecological services which is picked up in Recommendation 1.

12. Conclusion and Recommendations

a. With the exception of the additional provisos mentioned in this report, we support the conclusion of the 2004 Joint Select Committee.

b. None of these provisos would by themselves warrant a referral to the Secretary of State for Health.

c. However there has been so much local public concern expressed about the implementation of the decision to reconfigure the Women's and Children's Services,

that in order to reach a definitive conclusion there remains only the option of referral to the Secretary of State for Health to obtain closure.

d. In addition to our conclusion, we wish to make the following recommendations:-

1. We recommend that there is an urgent resolution to the review currently under way concerning the possible retention of elective inpatient and inpatient emergency gynaecological services at Maidstone Hospital.

2. There is concern about the lack of progress in the construction of the A228 Colt's Hill road which had been highlighted in the 2004 Joint Select Committee report. We wish all stakeholders to put pressure on to the Regional Transport Board to implement this work as a matter of urgency.

3. To ensure there is adequate transport provision to serve the new development at Pembury we endorse the 2004 recommendation that the relevant County Councils, relevant Borough and District Councils and the Acute Trust identify dedicated officers, who will recognise the challenges and find solutions in partnership,

4. We endorse the 2004 recommendation that the East Kent Integrated Transport Model be extended to include West Kent with the involvement of appropriate bodies in East Sussex.

5. We endorse the 2004 recommendation that the local NHS develop and promote a communication strategy specifically for the education of the public on the service redesign.

6. It is important that GPs embed in their service provision the dissemination of quality information regarding the birthing choices open to pregnant women.

Appendix: Sources of information

Visits and Meetings

Visit to Buckland Hospital, 11 December 2009

Meeting with MASH (Maidstone Action for Services in Hospital), 18 January 2010

Meeting with NHS West Kent and SECAmb, 20 January 2010

Meeting with MTW midwives and a meeting with MTW consultants, 26 January 2010.

Visit to site of new Pembury Hospital and meeting with MTW clinicians and Executives, 28 January 2010.

Conference call with Candy Morris CBE, Chief Executive, South East Coast Strategic Health Authority, 5 February 2010.

Conference call with Dr Charles Unter, Consultant Paediatrician, Maidstone and Tunbridge Wells NHS Trust, 5 February 2010.

Meeting with Mick Sutch, Head Of Planning & Transport Strategy, Kent County Council, 5 February 2010.

Meeting with Geoff Mee, Director of Integrated Transport Strategy, Kent County Council, 9 February 2010.

Meeting with Dr Tony Robinson, 10 February 2010.

Written Information

"Excellence in care, closer to home. The future of services for women and children – a consultation document." October 2004.

Excellence in care, closer to home. The future of services for women and children. Kent and East Sussex County Councils' NHS Overview and Scrutiny Joint Select Committee response. December 2004.

Maternity Matters: Choice, access and continuity of care in a safe service. Department of Health, Policy Document, April 2007.

Intrapartum care. Care of healthy women and their babies during childbirth, National Institute for Health and Clinical Excellence, Sept 2007.

Safer Childbirth. Minimum Standards for the Organisation and Delivery of Care in Labour, by the Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists, and Royal College of Paediatrics and Child Health. October 2007.

Various reports from the Independent Reconfiguration Panel.

Information also provided by:

Maidstone and Tunbridge Wells NHS Trust

NHS Eastern and Coastal Kent

South East Coast Ambulance NHS Trust

NHS West Kent

Maidstone Borough Council

MASH

Royal College of Paediatrics and Child Health

Individual councillors, midwives, consultants, and members of the public.

NHS West Kent

Maidstone and Tunbridge Wells NHS Trust

Task and Finish Group

Questions and Answers

This document is issued in conjunction with information provided to Maidstone Borough Council Overview and Scrutiny Committee (MBC OSC).

Supporting documents already supplied to the Health Overview and Scrutiny Committee Task and Finish Group include:

- Questions and Answers paper to MBC OSC
- Joint health committee paper (23rd February 2005)
- Birth numbers (2006-2009)

1. What maternity services are provided, where and what times are they provided?

Answer: A full range of maternity services are provided at both Maidstone and Pembury hospitals. These include:

- Labour Ward (delivery suite), Postnatal Ward and Antenatal Ward
- Antenatal Clinics
- Midwifery Day Unit
- Fetal Assessment Unit

Maidstone Hospital has a Level 1 Special Care Baby Unit and Pembury Hospital has a Level 2 Neonatal Unit.

The Level 1 unit provides care for babies born between 32 and 37 weeks and the Level 2 unit provides care for babies born between 28 and 37 weeks.

1a What is the staffing level of these services broken down by staff type?

Answer: Please see table below.

Midwifery staff as follows:

Hospital based staff

Period of 24 hours	**Midwives**	**Support staff**
Pembury unit		
Early shift	9 (+3 for ANC & MDU)	3 (+1 for ANC + MDU)
Late	8	3
Night shift	8	3
The Midwifery staff work a variety of shifts. Early Shift 07.15 – 15.15, Late Shift 13.15 – 20.15, Long Day 07.15 – 20.15 and Night Duty 20.00 – 07.45		

Maidstone unit		
Early shift	7 (+ 4.5 for ANC/MDU/FAU)	3 (2 for ANC +MDU+FAU)
Late shift	7	3
Night Shift	7	3

- ANC = Antenatal Clinic
- MDU = Midwifery Day Unit
- FAU = Fetal Assessment Unit

Community based staff

The service has a total of nine community-based midwifery teams. Each team has one midwife on call per night to provide a homebirth service out of hours.

Team	**Numbers of staff working Monday to Friday**	**Number of staff working Saturday and Sunday**
Tunbridge Wells	4	1
Edenbridge	1	1
Sevenoaks	2	1
Paddock Wood	1	1
Tonbridge	2	1
Malling	4	1
Maidstone	4	1
Leeds	3	1
Hawkhurst	2	1

Neonatal Nurses

Maidstone Level 1 unit

Period of 24 hours	Nursing staff	Support staff
Early shift	2	1
Late	2	1
Night shift	2	1

Pembury Level 2 unit

Period of 24 hours	Nursing staff	Support staff
Early shift	5	1
Late	5	1
Night shift	5	1

1b How many women are seen by these services?

Answer: Birth numbers have been provided. The following additional information also relates to maternity services currently provided within the Maidstone and Tunbridge Wells area:

- 106 community-based midwifery-led clinics a week (49 in Tunbridge Wells and 57 in Maidstone). These will continue without change post 2011. The number of clinics run is not reflective of the scale of their use or indicative of where women give birth. For instance some clinics are larger/busier than others on different weeks etc and `Maidstone' also covers areas within Tonbridge and Malling where women have given birth at Pembury.

- Six Consultant-led clinics are held at Maidstone Hospital each week and seven Consultant-led clinics are held at Pembury Hospital each

week. Approximately 25 women are seen in each clinic. These will continue without change post 2011.

- All women have a minimum of two scans during their pregnancy which are currently undertaken at both Maidstone and Pembury hospitals. These will continue without change post 2011.

- All Women currently have access to maternity day unit and fetal assessment unit services at both Maidstone and Pembury hospitals . These will continue largely without change post 2011.

All women will continue to have antenatal appointments locally, whether they live in Maidstone or Tunbridge Wells. Women expecting their first baby with an uncomplicated pregnancy can expect to have up to 10 antenatal appointments. Should complications arise more frequent contacts will be made as necessary.

Women who require hospitalisation for prolonged periods of care during their pregnancies will be cared for in future in the new women and children's centre at Pembury.

The vast majority of care, with the exception of the actual delivery and any inpatient antenatal care, will continue to be provided locally.

1c In particular, how many live births are there at each site, and how many of these are midwife-led deliveries and how many are consultant-led?

1d How many of these births required unexpected consultant intervention?

Answer: Over the last three years the Trust has delivered 5,232, 5,163 and 5,056 babies a year. These will be a mixture of both midwife and consultant-led deliveries.

	Maidstone	**Pembury**
2008/09	2292	2760
2007/08	2392	2771
2006/07	2441	2791

For 2006 the following breakdown of births at Maidstone and Pembury hospitals were reported by the Kent and Medway Health Observatory:

	Maidstone	**Pembury**
Normal births	1017	1147
Home births	94	135
Induction	465	502
Forceps delivery	105	125
Ventouse delivery	193	269
Elective Caesarean	225	280
Emergency Caesarean	410	378
Total	2415	2701

More recently, the following figures were reported by the Trust for 2009 for Outcomes of Hospital Labours

	PEMBURY NUMBER	**PEMBURY %**	**MAIDSTONE NUMBER**	**MAIDSTONE %**	**MTW NHS TRUST**
Total mothers	2645		2425		5070
Total babies	2710		2463		5173
Vaginal Deliveries	1563	59%	1457	60%	3020
Instrumental deliveries	362	13.6%	345	14%	707
Vaginal Breech	4	0.1%	6	0.2%	10
Elective Caesarean Section	359	13.5%	267	11%	626

Emergency Caesarean Section	257	9.6%	266	11%	523
No Labour Emergency Caesarean Section	90	3.4%	75	3%	165
All Caesarean Sections	706	26.5%	608	25%	1314 25.9%
Homebirth	146	5.4%	99	4%	245 (5%)

Note: These figures differ slightly from the 2008/09 delivery figure on page 5. One covers the calendar year for 2009, the other the financial year 2008/09 (April 2008 to March 2009)

Most importantly, women from Maidstone who give birth in hospital now will continue to have a full choice of all types of care including both midwifery and consultant-led, in the future. Women who give birth in hospital now will continue to be able to do so in the future.

Under these changes, by concentrating its specialist staff on one site, the Trust can also increase the time its obstetricians are physically present in hospital from 40 to 90 hours a week.

As a result, the Trust will be able to achieve higher standards of care for its patients and its middle-grade doctors will also be better supported. This is because its highly experienced and skilled obstetricians will be able to be in hospital for more of the time, between them, on one site, than they can currently achieve spread across two sites. They will be better able to care for more women sooner when their skills are most required. They will also be able to better support and assist their junior staff for more of the time who are on site 24/7.

Paediatric support is vitally important during labour if a baby requires additional specialist care immediately after it is born. That is when the paediatrician comes into their own and is the intrinsic link between paediatrics and obstetrics in maternity.

Under the current plans, the Trust will be better able to properly staff one bigger unit to a higher standard in the future, because it will need fewer paediatric middle grade doctors to achieve this safely 24/7 than it currently needs to run duplicate services over two sites. This is also far more sustainable into the future as the number of paediatric trainees continues to fall.

The standards of expertise and experience held by those middle grade paediatric doctors will be higher as well because the Trust will be better able to attract higher quality candidates wanting to work in the state of the art centre.

By seeing more patients in one centre, these middle grade doctors will also be exposed to a wider and more complex range of conditions. This will help improve and maintain their skills, something that cannot be as easily achieved across two sites.

Our paediatric consultants will also be able to spend more time teaching and overseeing their appropriately staffed teams of middle grade doctors, instead of having to find ways of maintaining services that rely on Locums and agency staff when they are available. The benefits to women and children are clear. They will be treated by more highly experienced and skilled middle-grade paediatric doctors who provide round the clock 24/7 hospital care.

Only low risk women will give birth in the midwifery-led birthing unit, if that is their choice, which is equivalent to homebirth. There is evidence that these types of unit can actually significantly reduce interventions including induction of labour, augmentation of labour, use of opoid and epidural analgesia, rate of episiotomy and rate of vaginal/perineal tears and increase in spontaneous vaginal birth.

As highlighted in information shared with the HOSC separately, it is possible to examine the number of women who require transfer from midwifery-led units in East Kent and their outcomes.

East Kent has risk assessed its midwifery-led services over a long period of time and found them to offer a safe and popular choice for women. The following figures from East Kent on transfer rates have informed our assessment:

- ***The two units had approximately 300 births each in 2008-09, which represents 8% of the Trust's total births***

- ***The distance between the birthing units and the nearest acute site is approximately 20 miles and the transfer times are between 45 and 60 minutes. All transfers are by ambulance.***

- ***Between two and three out of every 10 women who arrive at the birthing units are transferred out to a consultant-led unit for medical review. The reasons for transfer are not normally due to emergency situations – no mother or baby has been lost in transfer. Transfers are normally a precautionary measure.***

- ***The outcomes for those transferred are: 84% had a vaginal birth, 6% had an instrumental delivery and 8% had a Caesarean Section. In***

comparison, of those low risk women who choose to give birth in the Trust's acute hospitals 74% had a vaginal birth, 15% had an instrumental delivery and 11% had a Caesarean Section.

- ***If 300 women or more choose to give birth at the new midwifery-led birthing unit at Maidstone, based on East Kent's experience the Trust is looking at around two transfers a week. To clarify, in East Kent's experience transfers are not normally for emergency reasons, but carried out as a precautionary measure.***

The midwifery-led birthing unit at Maidstone is for low-risk births only and is the same as a homebirth. As happens now in East Kent, if a woman requires consultant intervention, she will be transferred safely to hospital.

2. **For the last three years, broken down by borough, please provide information on where women in West Kent have their children delivered?**

Answer: Please see tables previously provided.

3. **Can you provide a breakdown of the proposed changes to maternity services and a timeline of when you intend them to take place?**

Answer: The current maternity services at Pembury Hospital move into the women and children's zone of the new hospital in January 2011.

The Labour Ward, Antenatal Ward and Postnatal Ward at Maidstone Hospital move to the new hospital six months later in July 2011.

A new midwifery led birthing unit will open in Maidstone before services move from Maidstone to Pembury.

All other related maternity services, such as antenatal clinics and ultrasound scanning as referred to in **1b**, will continue to be provided at Maidstone Hospital. Women in Maidstone will continue to have the vast majority of their care in Maidstone and will only travel to Pembury (or another hospital of their choice) to give birth or if they need more specialist antenatal care that requires an inpatient stay.

Just as importantly, other `changes' that will start to occur once the above happens include:

- Improved clinical care for more women and children with more highly skilled and expert staff available on one site

- Sustainable long-term improvement in standards of care and safety for patients in the future with skilled and experienced staff attracted to work in the women and children's centre (as is already the case)

- Enhanced experience for women and children with better facilities designed solely to meet their individual personal needs and better respect their privacy and dignity.

- Better able to attract the cream of middle grade doctors with higher levels of skill and expertise who want to work in a single centre that sees a wide range of complex cases and is led by a bigger team of specialists.

- Consultants able to sub-specialise and become highly skilled and more experienced in some complex procedures rather than generally skilled in all

- Middle grade doctors better able to enhance their own skills by being exposed to Consultants for more of the time.

- Better working environment for all staff

- Better use made of all highly skilled staff enabling the Trust to reach even higher standards of care in the future, which is not possible across two sites as services currently stand.

4. How many women do you believe will use each of the new services in the future?

Answer: We estimate that between 3,500 and 4,000 women will deliver at the new hospital at Pembury and that between 300 and 500 women will deliver in the new midwifery-led birthing unit at Maidstone.

The new women and children's centre being built in the new hospital at Pembury is purpose-built to deliver this many babies and more if women from other parts of Kent choose to use this service because of the unique facilities, environment and enhanced standards of medical care it will be able to provide.

5. What work is being done around how women will be transferred from the proposed midwifery-led birthing unit at Maidstone to Pembury or other hospitals.

Answer: A great deal of work is taking place to ensure that women are transferred as safely from Maidstone to Pembury as they currently already are from Crowborough to Pembury or from other similar units across East Kent.

South East Coast Ambulance Service is involved in the development of the birthing centre to ensure they have the appropriate resources in place, before this facility opens, to transfer women safely to Pembury, Ashford or Medway, whichever the case may be.

The Trust has set up a midwifery-led birthing unit working group that is developing, among other things, the protocols that will ensure women are transferred safely to reduce any potential risks. This has clinical involvement at many different levels.

As part of this work, the Trust is also liaising with East Kent Hospitals University Foundation NHS Trust who have been running similar midwifery-led units safely now for as long as 10 years. The unit in Maidstone will be as safe as these units. The ambulance service has a high degree of practical experience and knowledge already gained in East Kent that can also be used.

The ambulance service has also had the valuable experience of transferring women safely from the midwifery-led birthing unit in Crowborough to Pembury Hospital for the past 12 years. This is a distance of 14 miles. Pembury receives up to 70% of women transferred from Crowborough.

It has been established that transfer times between Maidstone and Pembury will be similar to those seen in East Kent. It should also be noted that some women, although not many by comparison, are already transferred safely between Maidstone and Pembury in labour.

6. How will it be decided where an expectant mother would be transferred to?

Answer: The majority of transfers carried out by midwifery-led units happen as a precautionary measure. The experience in East Kent is that 80% of women who are transferred go on to have a normal vaginal delivery.

Any transfers will be by ambulance and will go to William Harvey (Ashford), the new hospital at Pembury or Medway Maritime Hospital, depending on whichever is closer in terms of travel time at the time. If there is any issue with the roads between Maidstone and Pembury, for instance, and other routes are not available for whatever reason, Ashford and Medway provide equally safe alternatives. Pembury is seen as the main hospital to transfer women to.

The Trust would not rule out using the air ambulance if such a need ever existed, but from experience elsewhere in Kent, and when looking at the situations in which women are actually transferred, this is highly unlikely to be necessary. No mothers or babies have been lost in road transfer in East Kent in the 10 years that the service has been running there.

7. **How many women do you believe will need to be transferred from the proposed midwifery-led birthing unit at Maidstone and what are your planning assumptions about how long any transfer would take?**

Answer: Experience in other units both locally and nationally is that between 20 and 30% of women are transferred. Again, this is normally a precautionary measure. Reasons for this are varied, but generally include:

- Slow progress in labour
- Meconium staining of the liquor

According to East Kent, less common reasons include epidural anaesthesia and changes of the fetal heart patterns. Again, experience from other units suggests that emergency transfers are rare. (A NICE review of evidence indicates that transfers from midwife-led units to obstetric units ranges between 12.4% and 31%)

Based on this transfer rate of two or three women in every 10, at the very most (500 births/30% transfer rate) the Trust is looking at approximately three transfers a week. At the very least (300 births/20% transfer rate), there would be approximately one transfer a week.

The Trust expects transfers from Maidstone to Pembury to be completed within 45 minutes to an hour. This depends on clinical urgency and is not dissimilar to transfer times in East Kent. There is also the potential to transfer women, via the nearby M20, to William Harvey Hospital, Ashford, or to Medway, should that be necessary.

The ambulance service already transfer premature babies and some women (although not many) in labour safely between Maidstone and Pembury hospitals (see information provided to Maidstone Borough Council, p8/9).

8. **Can we receive the results of the original 2004 consultation and the Minutes of the NHS Joint Board meeting of 23 February 2005?**

Answer: Please refer to information already supplied with Maidstone Borough Council documents.

9. In what ways have your plans changed from those decided on following the NHS Joint Board meeting of 23 February 2005?

Answer: Our plans have not changed since 2005 and our equally long-standing challenges are now more apparent.

Following permissions received from the joint health overview and scrutiny committee, and subsequent NHS approvals, the Trust included plans for a women and children's centre for the whole of Maidstone and Tunbridge Wells in its new hospital development at Pembury.

The women and children's centre has now been built to the necessary size and standard within the new hospital. Members of the Task and Finish Group were able to see this during their tour and were told about the benefits it will provide patients from both Maidstone and Tunbridge Wells.

The only thing to have changed in six years since the consultation was first carried out is that what was predicted then is now a day to day reality.

The Trust does not have and cannot employ enough skilled and experienced middle grade paediatric doctors to maintain high standards of care safely on two sites. This is a national challenge. It also has similar problems, although not as acute, in obstetrics and gynaecology.

As from March, the Trust will have 6.5 (full and part-time) vacancies for middle grade paediatric doctors. This represents more than a third of its entire workforce of middle grade paediatric doctors (it should have 16 to cover Maidstone and Pembury hospitals).

At the same time, the Trust has been given special permission (called derogation) for its middle grade doctors in obstetrics and gynaecology at Pembury Hospital to temporarily work over the European limit of 48 hours a week until the new hospital opens and the challenges are resolved.

The Trust also has vacancies for five paediatric nurses, posts which have a real and significant impact on clinical services for children.

The Trust has looked at various options to meet these challenges, but is almost permanently reliant now on Locums/agency staff to fill the gaps. These are only short-term solutions that will not provide long-term sustainable improvements in standards of care and safety for patients equally and equitably throughout Maidstone and Tunbridge Wells. *See MBC OSC paper, pages 10 and 11 for additional information.*

The opportunity to work in a state of the art hospital has, however, already started to work in patient's favour. The Trust has already been able to recruit additional highly skilled and experienced consultants in women and children's care on the basis that they want to work in the new women and children's centre at Pembury when it opens.

The Trust's lead clinicians fully expect the new centre to have the same positive impact on the recruitment of middle grade doctors.

10. What was the rationale behind the original 2005 decision?

Answer: The rationale for change in 2005 was driven essentially by the European Working Time Directive, which was going to (and now has) significantly reduce doctors working hours to improve patient care.

By reducing doctors hours, however, even more doctors were required by the Trust to maintain the same services and improve patient care. This came into force at the same time as changes to junior doctors training occurred which made paediatrics a less desirable specialty to take up as a career.

As a result, the Trust was facing the start of a situation where on one hand, it would need more paediatric middle grade doctors in the future, while on the other the number of sufficiently skilled and experienced middle grade doctors to choose from was falling.

At the time of the consultation, middle grade paediatric doctors were available, but with varying levels of skill. Today, even these doctors do not exist in the numbers the Trust requires to run duplicate services on two sites.

At the same time, even if the Trust managed to recruit sufficient numbers of highly skilled middle grade paediatric doctors, they would not see enough patients with complex problems, spread across two sites, to each maintain their skills and learn new ones.

While obstetrics and gynaecology faced a similar problem, but not as acute as paediatrics, paediatrics and obstetrics are interdependent. One cannot exist safely without the other on the same site.

The creation of a single centre of expertise was seen as the best way to both maintain and raise standards of care at the time and remains the best and most viable solution to date. No other alternative solutions have been put forward that maintain and raise the standard of care for patients as significantly and convincingly as these changes will.

The Trust has asked its clinical staff for viable alternatives. Despite these efforts, it cannot find a way forward that matches the opportunities to improve patient care that these changes bring.

The Trust fully accepts that campaigners are against change, but believes these concerns can be overcome and that change is safe. It accepts that many members of the public in Maidstone, and some of its staff at Maidstone Hospital, want services to remain as they are, but that is not possible.

As stated, even if the Trust had all the staff it needed of the highest calibre, they will still not see enough patients with the range of complex problems they need to maintain and improve their skills and experience, across two sites.

The centralisation of services solves all of these challenges by focusing these skills in one place to benefit of all as happened in East Kent.

11. What work has been undertaken to see if the assumptions underlying the original decision are still applicable and what has been the outcome of this work?

Answer: The Trust is now physically having to deal with the effects of the problems it envisaged six years ago. They are now a reality. It is now heavily reliant, for instance, on locum/agency doctors to support its paediatric services at both Maidstone and Pembury hospitals.

Whereas previously it could find middle-grade paediatric doctors to employ with varying degrees of skill, even these doctors are now not available in the numbers they once were.

If the Trust continues to run duplicate services on two sites in the future, its clinical leads for both obstetrics and paediatrics are clear that overall standards of care for women and children in both its hospitals will fall.

The Trust accepts that some of its clinical staff at Maidstone have understandably always wanted services to remain as they are, going back as far and further than the original consultation in 2004. If that were possible it would have happened. The Trust was originally asked to look at this as a possibility in 2000.

No one has been able to provide an alternative way of achieving this, however, in the last 10 years. No alternative solutions have been found that are capable of providing the same sustainable and long-term improvements in care as the centralisation of these services can.

As previously stated, the increased number of middle-grade paediatric doctors the Trust now needs to run duplicate services in two hospitals will also be disadvantaged by not seeing enough children between them, with the range of complex conditions they need to see to maintain and improve their skills.

So even if the Trust could employ all the middle-grade paediatric doctors it needs in both its hospitals, it is no guarantee of being able to provide higher standards of care in the future. This is a challenge that hospital health services in East Kent overcame with similar changes to those planned in Maidstone and Tunbridge Wells.

12. How have your staff and the public been involved in the development of these proposals since 2004?

Answer: Initially, the Trust set up a range of working groups with staff and patient representatives to help design many departments and services within the new hospital, before construction started.

More recently it has appointed key members of staff from each of its directorates (women and children's services is a directorate) to act as dedicated leads for their areas on the hospital development. This is creating more staff ownership and input into the development.

Looking at other areas within women and children's services, the midwifery-led birthing unit is being developed at Maidstone with staff input. There are now regular staff meetings to discuss this development and take it forward.

The Trust is developing a wide range of information on the changes to women and children's services. This will be distributed to all audiences to help people better understand the changes being made in 18 months time.

Separate information will go out to all service users closer to the transfer of services to ensure all patients are fully aware of the changes being made and their choices.

The Trust is happy to work with Kent County Council HOSC and local authorities on ongoing communications and public engagement.

13. What was the impact of the 2007 Department of Health "Maternity Matters" document?

Answer: The changes are entirely in keeping with Maternity Matters. The four national choice guarantees to women set out in the document are as follows:

1. Choice of how to access maternity care – When they first learn that they are pregnant, women and their partners will be able to go straight to a midwife if they

wish, or to their General Practitioner. Self-referral into the local midwifery service is a choice that will speed up and enable earlier access to maternity services.

2. Choice of type of antenatal care – Depending on their circumstances, women and their partners will be able to choose between midwifery care or care provided by a team of maternity health professionals including midwives and obstetricians. For some women, team care will be the safest option

3. Choice of place of birth - Depending on their circumstances, women and their partners will be able to choose where they wish to give birth. In making their decision, women will need to understand that their choice of place of birth will affect the choice of pain relief available to them. For example, epidural anaesthesia will only be available in hospitals where there is a 24 hour obstetric anaesthetic service. (As will be available at the new hospital)

The options for place of birth are:

• Birth supported by a midwife at home

• Birth supported by a midwife in a local midwifery facility such as a designated local midwifery unit or birth centre. These units promote a philosophy of normal and natural labour and childbirth.

• Birth supported by a maternity team in a hospital. The team may include midwives, obstetricians, paediatricians and anaesthetists. For some women, this type of care will be the safest option.

4. Choice of postnatal care – After going home, women and their partners will have a choice of how and where to access postnatal care. This will be provided either at home or in a community setting.

Choice of place of birth is supported by the planned changes to services

14. What are the main current reasons for continuing with the planned relocation of services?

Answer: As previously explained, the need for change as outlined in 2004 is now an everyday reality. In 2004, the need for change was around recruiting high calibre staff in paediatrics. Today the Trust is unable to recruit enough staff of any calibre in paediatrics.

From a commissioning perspective, it is necessary to respond to the current Government commitment in Maternity Matters to a “national choice guarantee” that depending on their circumstances, women and their partners will be able to

choose where they wish to give birth: at home, in a midwifery unit or in an obstetric unit.

15. How have community midwifery services been developed since 2005?

Answer: Examples of how these services have developed since 2005 include:

- Community midwifery care is now provided in eight children's centres across the region
- Antenatal and postnatal clinics are provided at the YWCA and GP surgeries
- Antenatal clinics are now running to 7pm in some areas
- Parent education is provided at the weekends by some of the community based teams
- There are dedicated teenage pregnancy midwives
- There are midwives dedicated to healthy weight
- The majority of the teams offer postnatal clinics
- Increased homebirth rate @ 6% is well above local and national averages

16. What assessment has been made of the impact of the proposed relocation of services of recent developments concerning maternity services in neighbouring areas – specifically South East London (Queen Mary's Sidcup) and East Sussex?

Answer: The Trust has looked at and continues to look at the situation in East Sussex, where plans to centralise maternity services were strongly recommended by the NHS, but overturned.

The Trust understands the perception this may have led to here, but there are key differences between East Sussex and Maidstone and Tunbridge Wells. The Trust has spoken to NHS leads there and the very specific issues with paediatric staffing here were not at the forefront of the drivers for change in East Sussex.

As such, the Trust has seen no solutions to emerge from East Sussex that will resolve the specific challenges it faces. The Trust is also able to move forward with these changes because of the proximity of other hospitals to Maidstone that also provide acceptable, although less convenient, levels of access and choice for patients locally. This was not the case in East Sussex.

One of the fundamental reasons why women and children's services are not being centralised at Maidstone – as requested in Maidstone Borough Council OSC's Councillor Call for Action if centralisation is required – is because of this.

If the service was centralised at Maidstone, a large area south of Tunbridge Wells will face journeys in excess of half an hour to their nearest consultant-led maternity unit. Please refer to pages 16-19 of information sent to Maidstone Borough Council's OSC for further information.

The Trust has provided the Task and Finish Group and Maidstone Borough Council Overview and Scrutiny Committee with the contact details for NHS leads in East Sussex to discuss these points in more detail.

17. Has the air ambulance been factored into any of the planning assumptions?

Answer: It is clear that the air ambulance can play a vital role in helping transfer critically injured people to hospital. There is also a possible role for an air ambulance in transferring gravely ill patients if the distances are significant, well in excess of an hour's travel by road. For shorter distances, however, the time taken to transfer the patient, by road ambulance, to the air ambulance more than outweighs the benefit the air ambulance provides.

For these reasons we do not envisage the air ambulance having a role in maternity transfers from the Maidstone locality to the new hospital at Pembury, or indeed to Ashford or Medway, although it certainly could be considered in exceptional circumstances.

It is important to remember that road transfers from birthing units happen safely all around the country.

One of the main reasons why we are confident changes of this nature can happen safely to improve the standard of care for all our patients is because of the proximity of other hospitals as well as Pembury to Maidstone. In the event that an ambulance cannot reach Pembury by road, alternatives exist that are within a safe distance.

The Trust will not exclude any option that may assist in the continued wellbeing of patients, but the air ambulance, in this instance, would not be the first choice when transfers are required. In the rare event of an emergency situation arising, the Trust is confident, based on examples from other midwifery-led units, that this can also be handled safely by road ambulance.

18. In your opinion, what are the barriers to providing consultant-led maternity services at both Pembury and Maidstone?

Answer: There are a number of longstanding barriers to providing consultant-led maternity services at Maidstone. They are the same drivers for change that underpinned the original consultant in 2004, but are now a reality.

- The Trust cannot recruit sufficient levels of middle-grade paediatric doctors to run duplicate services for women and children on two sites.

- There is no indication that the situation will improve in the future. It has visibly and physically deteriorated over the last six years to the point where even middle-grade children's doctors with `varying' levels of skill are now no longer available in the numbers the Trust needs to run duplicate services on two sites.

- Obstetric and paediatric services are interlinked and interwoven. If one service falls, it affects the integrity and continuity of the whole service, in this case at Maidstone and Pembury.

- The European Working Time Directive has improved care for patients by reducing doctors' working hours. Even if the Trust could recruit enough middle-grade paediatric doctors to maintain round the clock services on two sites in the future, the additional doctors required would not see enough patients between them to maintain their experience and learn new skills.

- The Trust has managed to maintain services to this point by using Locum/agency doctors, but this is neither efficient or best practice for patients, nor does it provide the Trust with a platform for delivering future long-term sustainable improvements in patient care from.

- The Trust has been given temporary permission for some of its doctors to work longer hours than the European Working Time Directive allows, at Pembury, in Obstetrics and Gynaecology, on the understanding that this situation will be reversed with the centralisation of services in 2011. It is therefore already running some of its services on the goodwill of staff and temporary exemptions from changes established to improve patient care.

- The Trust has already been able to attract two new obstetric consultants partly because they want to work at the new hospital being built at Pembury, in 18 months time, in its state of the art women and children's centre. This is an attraction that two smaller units do not have.

- The two smaller units will not be able to reach higher standards of care in the future if they continue to standalone. They will not enable clinicians to work as a bigger team and sub-specialise, offering even higher standards in different areas of women and children's care.

- The new hospital at Pembury will be world-leading in public health services. The overall personal experience and levels of privacy and dignity patients will have in the women and children's centre at Pembury will be second to none. It was built with the intension of being the very best hospital of its kind to attract the very best staff and give patients an unparalleled experience. If the Trust continues to run two services, it cannot be ruled out that women from Maidstone will choose to have their children at Pembury because of the clear divide that will undoubtedly exist between services in Maidstone and Tunbridge Wells. If this occurs, and that is likely, it will have a further detrimental affect on the Trust's ability to maintain services at Maidstone.

- The Royal College of Obstetricians has considered the future of 'small' maternity units (those responsible for fewer than 2500 births per year as in the case of Maidstone) and concluded that models such as those proposed for West Kent are an example of a successful model of care. In cases where small obstetric units remain open, they tend to provide care for low/medium risk women which would in any case entail transfers being made to a larger unit in the case of complications. ('Maternity Services: Future of Small Units' RCOG 2008)

  Government guidance also recommends that 'most women should be offered midwife led models of care and should be encouraged to ask for this option'.

- The final point is not a physical barrier that stops duplicate services being run on two sites. If the Trust continues to run duplicate services on two sites, this will be a barrier in itself to improving patient care.

  The Trust has a clear, agreed plan, to improve standards of care that would otherwise be unattainable if services stay as they are. No alternative viable solutions have emerged in six years to solve these unrelenting challenges.

  The Trust has made changes for the better since 2008 and believes this next step, that has been long in the waiting, will enable it to continue its journey of improvement for patients in Maidstone and Tunbridge Wells alike.

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Maidstone Births

Hospital	MAIDSTONE HOSPITAL

Count of Mother ID

		Year								
		2006/07		2006/07 Total	2007/08		2007/08 Total	2008/09		2008/09 Total
LA Name2	EW Name3	Age3 Under 18	Adult		Under 18	Adult		Under 18	Adult	
Maidstone	Allington	0	62	62	1	59	60	0	58	58
	Barming	0	19	19	0	13	13	0	16	16
	Bearsted	2	61	63	0	80	80	0	72	72
	Boughton Monchelsea and Chart Sutton	0	13	13	0	21	21	0	20	20
	Boxley	1	37	38	0	51	51	0	42	42
	Bridge	0	40	40	1	56	57	0	49	49
	Coxheath and Hunton	0	43	43	0	52	52	1	52	53
	Detling and Thurnham	0	21	21	0	29	29	0	33	33
	Downswood and Otham	0	40	40	0	40	40	0	35	35
	East	0	83	83	1	85	86	1	73	74
	Fant	1	102	103	2	120	122	1	114	115
	Harrietsham and Lenham	0	42	42	0	39	39	0	39	39
	Headcorn	1	40	41	0	39	39	1	36	37
	Heath	2	81	83	0	99	99	1	83	84
	High Street	4	114	118	1	132	133	5	119	124
	Leeds	0	18	18	0	16	16	0	19	19
	Loose	0	20	20	0	23	23	0	17	17
	Marden and Yalding	0	39	39	0	55	55	0	46	46
	North	2	108	110	1	106	107	3	96	99
	North Downs	0	19	19	0	20	20	0	11	11
	Park Wood	4	95	99	3	83	86	3	98	101
	Shepway North	9	113	122	6	94	100	3	96	99
	Shepway South	3	71	74	2	67	69	0	57	57
	South	2	111	113	1	92	93	0	76	76
	Staplehurst	0	46	46	0	33	33	1	45	46
	Sutton Valence and Langley	0	27	27	2	20	22	1	17	18
Maidstone Total		**31**	**1465**	**1496**	**21**	**1524**	**1545**	**21**	**1419**	**1440**
Tonbridge and Malling	Aylesford	0	42	42	0	59	59	0	44	44
	Blue Bell Hill and Walderslade	0	6	6	0	7	7	0	6	6
	Borough Green and Long Mill	1	38	39	0	39	39	1	31	32
	Burham, Eccles and Wouldham	0	45	45	2	46	48	1	34	35
	Cage Green	0	1	1	0	1	1	0	1	1
	Castle	0	0	0	0	1	1	0	0	0
	Ditton	0	34	34	0	38	38	2	62	64
	Downs	0	24	24	0	25	25	0	13	13
	East Malling	2	57	59	0	40	40	0	62	62
	East Peckham and Golden Green	0	4	4	0	0	0	0	4	4
	Hadlow, Mereworth and West Peckham	0	17	17	0	5	5	0	5	5
	Higham	0	2	2	0	4	4	0	1	1
	Hildenborough	0	3	3	0	0	0	0	0	0
	Ightham	0	7	7	1	5	6	0	6	6
	Kings Hill	0	94	94	0	80	80	0	79	79
	Larkfield North	0	47	47	1	53	54	0	67	67
	Larkfield South	2	29	31	1	23	24	0	34	34
	Medway	0	0	0	0	1	1	0	0	0
	Snodland East	0	57	57	0	57	57	5	65	70
	Snodland West	2	42	44	2	54	56	2	64	66
	Trench	0	1	1	0	0	0	0	2	2
	Wateringbury	1	24	25	0	14	14	0	10	10
	West Malling and Leybourne	0	67	67	0	45	45	1	51	52
	Wrotham	0	15	15	0	16	16	0	22	22
Tonbridge and Malling Total		**8**	**656**	**664**	**7**	**613**	**620**	**12**	**663**	**675**
Swale	Total	1	108	109	1	90	91	0	50	50
Swale Total		**1**	**108**	**109**	**1**	**90**	**91**	**0**	**50**	**50**
Tunbridge Wells	Twells Total	0	17	17	1	20	21	1	26	27
Tunbridge Wells Total		**0**	**17**	**17**	**1**	**20**	**21**	**1**	**26**	**27**
Other	Total	2	153	155	1	114	115	2	98	100
Other Total		**2**	**153**	**155**	**1**	**114**	**115**	**2**	**98**	**100**
Grand Total		**42**	**2399**	**2441**	**31**	**2361**	**2392**	**36**	**2256**	**2292**

Pembury Births

Hospital	PEMBURY HOSPITAL

Count of Mother ID

		Year	Age2								
		2006/07		2006/07 Total	2007/08		2007/08 Total	2008/09		2008/09 Total	Grand Total
LA Name2	EW Name2	Under 18	Adult		Under 18	Adult		Under 18	Adult		
Tunbridge Wells	Benenden and Cranbrook	2	54	56	2	47	49	1	51	52	157
	Brenchley and Horsmonden	1	47	48	1	37	38	0	49	49	135
	Broadwater	1	43	44	1	40	41	1	65	66	151
	Capel	0	32	32	0	24	24	0	33	33	89
	Culverden	2	83	85	2	89	91	2	102	104	280
	Frittenden and Sissinghurst	0	8	8	0	17	17	0	8	8	33
	Goudhurst and Lamberhurst	0	42	42	0	54	54	1	36	37	133
	Hawkhurst and Sandhurst	2	36	38	1	47	48	0	45	45	131
	Paddock Wood East	2	34	36	0	42	42	0	26	26	104
	Paddock Wood West	1	32	33	0	43	43	0	38	38	114
	Pantiles and St Mark's	0	75	75	1	72	73	1	73	74	222
	Park	1	79	80	0	84	84	1	90	91	255
	Pembury	0	61	61	0	62	62	1	52	53	176
	Rusthall	3	76	79	0	64	64	1	79	80	223
	Sherwood	3	118	121	2	107	109	2	101	103	333
	Southborough and High Brooms	3	127	130	0	101	101	6	140	146	377
	Southborough North	1	38	39	1	40	41	0	37	37	117
	Speldhurst and Bidborough	0	51	51	0	41	41	0	25	25	117
	St James'	1	74	75	0	91	91	1	80	81	247
	St John's	1	114	115	1	93	94	1	107	108	317
Tunbridge Wells Total		**24**	**1224**	**1248**	**12**	**1195**	**1207**	**19**	**1237**	**1256**	**3711**
Tonbridge and Malling	Other	0	51	51	0	50	50	0	46	46	147
	Aylesford	0	2	2	0	4	4	0	2	2	8
	Borough Green and Long Mill	0	20	20	0	22	22	0	33	33	75
	Burham, Eccles and Wouldham	0	0	0	0	2	2	0	2	2	4
	Cage Green	0	23	23	0	28	28	0	33	33	84
	Ditton	0	3	3	0	3	3	0	9	9	15
	Downs	0	2	2	0	11	11	0	4	4	17
	East Malling	0	3	3	0	14	14	0	7	7	24
	East Peckham and Golden Green	0	37	37	0	35	35	0	25	25	97
	Hadlow, Mereworth and West Peckham	0	26	26	0	24	24	1	38	39	89
	Higham	0	46	46	1	46	47	0	42	42	135
	Hildenborough	0	55	55	0	40	40	0	41	41	136
	Ightham	0	8	8	0	7	7	0	10	10	25
	Judd	0	65	65	0	57	57	0	71	71	193
	Kings Hill	1	22	23	0	44	44	0	35	35	102
	Larkfield North	0	4	4	0	4	4	0	5	5	13
	Larkfield South	0	2	2	0	4	4	0	1	1	7
	Medway	1	67	68	1	52	53	1	59	60	181
	Snodland East	0	1	1	0	4	4	0	3	3	8
	Snodland West	0	2	2	0	7	7	0	6	6	15
	Trench	1	46	47	1	50	51	2	33	35	133
	Vauxhall	0	75	75	2	68	70	1	70	71	216
	Wateringbury	0	5	5	0	2	2	0	5	5	12
	West Malling and Leybourne	0	7	7	0	14	14	0	9	9	30
	Wrotham	0	4	4	0	1	1	0	6	6	11
Tonbridge and Malling Total		**3**	**576**	**579**	**5**	**593**	**598**	**5**	**595**	**600**	**1777**
Sevenoaks	Brasted, Chevening and Sundridge	0	37	37	0	32	32	0	35	35	104
	Cowden and Hever	0	23	23	0	13	13	0	18	18	54
	Crockenhill and Well Hill	0	1	1	0	1	1	0	0	0	2
	Dunton Green and Riverhead	1	48	49	0	56	56	0	46	46	151
	Edenbridge North and East	1	38	39	1	44	45	1	32	33	117
	Edenbridge South and West	2	46	48	1	58	59	1	45	46	153
	Fawkham and West Kingsdown	0	2	2	0	1	1	0	1	1	4
	Halstead, Knockholt and Badgers Mount	0	5	5	0	6	6	0	5	5	16
	Hextable	0	1	1	0	0	0	0	0	0	1
	Kemsing	0	31	31	0	25	25	0	27	27	83
	Leigh and Chiddingstone Causeway	0	19	19	0	19	19	0	15	15	53
	Otford and Shoreham	0	23	23	0	14	14	1	20	21	58
	Penshurst, Fordcombe and Chiddingstone	0	23	23	0	24	24	0	23	23	70
	Seal and Weald	1	25	26	1	27	28	0	30	30	84
	Sevenoaks Eastern	1	41	42	0	47	47	1	53	54	143
	Sevenoaks Kippington	0	31	31	0	27	27	0	30	30	88
	Sevenoaks Northern	0	52	52	0	37	37	0	54	54	143
	Sevenoaks Town and St John's	0	73	73	0	64	64	0	53	53	190
	Westerham and Crockham Hill	0	34	34	0	26	26	0	21	21	81
Sevenoaks Total		**6**	**553**	**559**	**3**	**521**	**524**	**4**	**508**	**512**	**1595**
Wealden	Welden Total	3	211	214	3	191	194	2	166	168	576
Wealden Total		**3**	**211**	**214**	**3**	**191**	**194**	**2**	**166**	**168**	**576**
Maidstone	Maidstone Total	1	86	87	2	136	138	1	129	130	355
Maidstone Total		**1**	**86**	**87**	**2**	**136**	**138**	**1**	**129**	**130**	**355**
Rother	Rother Total	1	41	42	0	50	50	1	34	35	127
Rother Total		**1**	**41**	**42**	**0**	**50**	**50**	**1**	**34**	**35**	**127**
Ashford	Ashford Total	0	5	5	0	7	7	0	16	16	28
Ashford Total		**0**	**5**	**5**	**0**	**7**	**7**	**0**	**16**	**16**	**28**
Other	Other	1	56	57	0	53	53	0	43	43	153
Other Total		**1**	**56**	**57**	**0**	**53**	**53**	**0**	**43**	**43**	**153**
Grand Total		**39**	**2752**	**2791**	**25**	**2746**	**2771**	**32**	**2728**	**2760**	**8322**

South West Kent NHS
Primary Care Trust

Mr Frank Sims
Modernisation & Strategic Development Director
Pembury Hospital

17 February 2005

Dear Colleague,

Joint Board Meeting in Public to Consider the Outcome of the Public Consultation Into Services for Women and Children

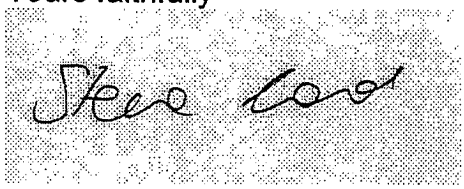
Please find enclosed the papers relating to the above meeting, which is due to take place on Wednesday 23rd February 2005 in the Lecture Theatre, County Hall, Maidstone at 10:00 a.m.

The Joint Board consists of delegated members from each of the Boards of Maidstone Weald PCT; South West Kent PCT; Sussex Downs and Weald PCT and Maidstone and Tunbridge Wells NHS Trust. The members of the Joint Board are the Chair; Chief Executive; and Medical Director / PEC Chair from each of the four organisations. The Chair of each of the PPI Forums for those organisations has also been invited to the meeting.

Because each of the Boards has delegated decision-making powers in respect of this issue to nominated individuals, there is no requirement upon other Board members to attend, although you are, of course, welcome to do so if you wish.

With best wishes

Yours faithfully



Steve Ford
Chief Executive
South West Kent PCT

Enc:

SOUTH OF WEST KENT HEALTH COMMUNITY

SERVICE RECONFIGURATION

MEETING IN PUBLIC OF THE MEMBERS OF THE JOINT BOARD WITH DELEGATED POWERS TO CONSIDER THE OUTCOME OF THE PUBLIC CONSULTATION INTO THE PROVISION OF SERVICES FOR WOMEN AND CHILDREN

Lecture Theatre, Sessions House, County Hall, Maidstone

Wednesday February 23rd 2005 10:00 a.m.

Report of: Steve Ford, Chief Executive, South West Kent Primary Care Trust

Date: 16th February 2005

Subject: Reconfiguration of Services for Women and Children

Recommendation: The Joint Board is asked to consider the results of the consultation on women's and children's services and to approve the proposals as detailed within the consultation document.

Introduction

A detailed analysis and summary of the responses to the public consultation into the reconfiguration of services for women and children is appended to this paper. The Joint Board is asked to consider the results of the consultation on women's and children's services and make recommendations for the future configuration of these services in the light of the response in relation to the reasons set out for the proposed changes.

In considering its decision the Joint Board is asked to take account of the following questions that have come directly from local people and organisations:

- Do these proposals in effect mean the downgrading of services at Maidstone Hospital?
- Are the arguments for centralising specialist services at Tunbridge Wells rather than Maidstone robust?
- Is it not feasible to continue to provide a full range of services at both hospitals?
- Are the Board satisfied that the proposals will lead to the provision of safer services for women and children than is currently the case? What are the current risks to these two groups?
- If travel is the major issue, proportionately which community will be most disadvantaged by the proposals?
- What impact will these changes have on visitors and families?
- Will new community facilities be provided for children?
- Are there other models elsewhere in the country which the Board should consider before making its decision?
- Does the Board accept the recommendations in the Overview and Scrutiny report?

Recommendation

It is recommended that the Joint Board approves the changes as set out in the consultation document and summarised in paragraphs 2.1.1. and 2.1.2 of the attached paper. In making this decision the Board will need to consider the issues that have been raised within the public consultation and whether they have been, or can be, adequately addressed.

The Board should also consider:

- The development of an intermediate plan for sustaining services until new hospital services at Pembury are operational
- The process by which the local health community can agree the wider range of investment in community services that is required to support the proposal
- How the NHS can work with partners to ensure that the transport implications of these changes are addressed
- How to ensure effective communication and ongoing patient and public involvement in the development and implementation of these proposals
- The process by which NHS Boards will monitor progress in implementing these plans.

CONTENTS PAGE

1. Introduction

1.1. Background

In the year 2000 a public consultation into services for women and children concluded that the services provided at Maidstone and Pembury could not be sustained over a long period and that the Trust would need to centralise:

- Neonatal care
- Inpatient care for children
- Consultant-led obstetrics.

Following consultation West Kent Health Authority decided not to implement the proposals at that time, choosing to defer implementation until such a time as the services became unsustainable. However, many of the pressures identified at that time have now worsened and the current configuration of services is no longer sustainable.

At this joint meeting of PCT Boards with the Board of the Maidstone and Tunbridge Wells NHS Trust each organisation has delegated decision-making responsibility to the joint Board.

1.2. Pressures on the system

These currently include the need to:

- provide a modern high quality service and focus our resources where needed reduce working hours for doctors under the European Working Time Directive
- make sure that doctors in training see sufficient patients within their reduced working hours to gain the skills they need
- benefit from improved drug treatments and surgical techniques, including increased day case gynaecological surgery
- follow the National Service Framework for children, including guidelines on how services for children in hospital should be provided
- provide modern services for children, e.g. ambulatory care
- manage the Trust as a single organisation rather than a collection of separate hospitals
- meet the demands of more technological and complex care and the need for skilled staff e.g. paediatric doctors and nurses
- meet national standards e.g. 40 hours labour ward cover
- provide a greater range of both routine and specialist care locally
- Provide a service which reflects guidance from the Royal Colleges on how services for children should be provided
- Provide modern-day services for women, e.g. options for home birth, greater choice
- Address deterioration in services, e.g. special care baby unit expertise and internal transfers

1.2.2. These pressures are by no means unique to our area but we need to address these issues to ensure we can continue to provide high quality, sustainable services. Similar pressures are driving change locally at the following trusts:

- East Kent Hospitals NHS Trust
- Surrey and Sussex NHS Trust
- Brighton & Sussex University Hospitals NHS Trust,

all of whom have undertaken or are currently making proposals for reconfiguration.

In 2000 the Trust's ability to provide the full range of inpatient services was declining, but was maintained by means of major financial investment; revised recruitment and training strategies; the introduction of the first direct entry programme for midwives; and significant expansion of the role of midwives.

However, by 2004 the reality of the culmination of national recruitment problems with key staff, the reduction in working hours resulting from the European Working Time Directive and changes to doctors' training meant that services had reached a critical point where sustainability was, and is, a real issue.

1.2.3. Doctors can now only work a maximum of 58 hours per week, whereas in 2000 there were no restrictions. By 2009 the limit will become a maximum of 48 hours. At the same time the New Deal for doctors reduced working hours to 56 per week in August 2004. The simple effect of this is that we need more doctors in each specialty to cover the same 24 hour rota.

The New Deal also significantly affected the amount of time doctors in training spend providing a clinical service. In 2000 the majority of time was spent providing clinical service with the minority of time in training. By 2004 that balance had been reversed.

The combined effect of reducing the hours available to each doctor to see patients and the increase in the number of doctors means that it now takes longer for an individual doctor to see sufficient patients to reach an acceptable level of competence.

In addition to that the Trust now receives doctors in training in years one and two rather than four and five of their training rotation. The day to day impact of this is that these doctors are less experienced and at the same time providing a reduced service element.

The Trust simply has to recruit more doctors to fill rotas. As the overall number of doctors in training has not fully kept pace with the changes, there is intense competition between trusts for these trainees. Recruitment of these middle grade doctors is a significant problem throughout the NHS, with no early solution in sight.

The overall number of junior doctors is related to the number of consultants required for the clinical work required by the population. Nationally, the number of consultants is about right. Creating more training posts for middle grades is therefore not an option.

1.2.4. There are particular shortages in skilled posts in obstetrics and gynaecology and paediatrics, where both doctors in training and specialist paediatric nurses are in short supply. They are hard to recruit for a number of reasons including a demanding

on call system, a move to resident consultant on call and restricted ability to earn private income. This is particularly acute in the south east because of the cost of living and particularly the cost of housing.

Nationally, the number of nurses who want to pursue a career in paediatrics is limited. These highly trained and relatively scarce staff are attracted by units that offer a wide variety of work, good training and development opportunities. This is especially the case in specialties such as special care baby units (SCBUs). Nurses can choose where they want to work and small units that provide a limited range (for example level 1 SCBU) is generally not attractive.

1.3. Forced closures

1.3.1. Special care is provided broadly at three recognised levels. Level 1 is basic resuscitation and care of the new born. Level 2 allows high dependency treatment and Level 3 is full neonatal intensive care. A fourth level exists for certain highly specialised services on a supraregional basis.

Around one in ten babies need some form of 'special care' with around ten per cent of those needing intensive care. There are therefore fewer neonatal intensive care units (NICUs) than those providing level 1 and 2. In Kent the level 3 (NICU) units are at Medway and Ashford hospitals. Brighton also provides a NICU.

All units act within a network providing a range of services for their local population and for a wider catchment area. Transfers between units are not uncommon to ensure that beds are effectively managed. This is coordinated by the Emergency Bed Service (EBS).

1.3.2. When a SCBU is full or does not have sufficient staff to cover the number of babies in its cots it will notify the EBS. The ultimate option is for the unit to temporarily 'close' for EBS transfers, which means that mothers who deliver prematurely may have the unfortunate experience of having their babies transferred to another unit.

In a three month period during the autumn of 2004 the Trust closed to EBS on 44 occasions. This is not acceptable, is highly disruptive and distressing to parents, and cannot be sustained.

1.4. Minimum labour ward standards

1.4.1. Obstetrics is a specialty in transition. The future nationally is for obstetrics and gynaecology to split, in the same way that paediatrics and neonatology have done. Improvements to the way care is provided require a minimum of 40 hours per week dedicated consultant cover to the labour ward. This requires a minimum of five consultants.

Currently this standard is not being met at Maidstone. Whilst it would be possible to recruit to a fifth consultant post, this will effectively only be a short term measure, as in future obstetrics and gynaecology will be separated. Overall the Trust will have sufficient senior staff but their job plans will need to change in line with the change in the specialty.

If obstetrics and gynaecology are split that will allow sub-specialisation, which will create the capacity to develop centres of excellence for women.

The recent history at Maidstone has also meant that there is no lead obstetrician (a national requirement) at Maidstone, reflecting the relatively low levels of obstetric cover at the hospital.

1.4.2. The provision of safe obstetric services is also only viable with 24 hour paediatric cover. Obstetricians look after women in pregnancy and during labour, but paediatricians care for their new born children. For those babies who are born prematurely or who develop difficulties, midwives are trained to provide immediate resuscitation, but the babies' ongoing care is provided by paediatricians.

It is therefore critical to have paediatricians available 24 hours a day where services are planned to deliver women with high risk pregnancies or premature babies. Currently paediatricians are required to cover two such units and this position is not sustainable because of the staffing issues outlined above.

An alternative to 24 hour cover by paediatricians is to use a new and highly specialised senior nurse, trained for this particular role, known as an Advanced Neonatal Nurse Practitioner (ANNP). However, these nurses can only provide medium term stabilisation of neonates, before transfer to a unit staffed by paediatricians.

This model is not yet nationally recognised, and there are questions over its' long term sustainability, given the difficulties of training and maintaining the ANNPs' skills. At best it could only be considered an option for those hospitals providing a level 3 NICU and with the capacity to train their own ANNPs.

1.5. The National Service Framework for children

1.5.1. Rightly, services for children have been given high priority in the NHS Plan and a national service framework has been developed that outlines best practices.

The NSF includes requirements such as:

- the provision of child-friendly facilities
- access for parents to stay overnight
- an emphasis on treating children outside hospital wherever possible.

Current services need to change significantly if we are to match the NSF guidelines.

2. The 2004 consultation

2.1. Context and consultation programme

2.1.1. Following the 2000 consultation, formal proposals to reconfigure services for women and children, were launched on 1 October 2004, for a period of public consultation which concluded on 31 December 2004.

The proposals, set out in the document **Excellence in care, closer to home,** were:

For children's services:

- To develop rapid assessment and treatment for children in ambulatory care (walking, not overnight) facilities at both Maidstone and Pembury Hospitals, allowing us to see and treat the vast majority of children locally

- To expand community children's nursing to enable more care to take place in the child's home, saving children from having to go into hospital
- To create one Special Care Baby Unit at Pembury to care for children who need specialist help immediately after birth, especially those born prematurely. This would be where our current unit is, close to paediatricians and inpatient care for children
- To further develop specialist paediatric facilities at the new hospital by building on clinical expertise.

For maternity and gynaecology services:

- To create a focus on normal deliveries, give women choice and continue providing outpatient and antenatal care locally
- To develop day case surgery, early pregnancy services, foetal medicine outpatients and diagnostics, and urgent assessment and short stay treatment on both sites
- To create a single, consultant-led unit for high risk obstetrics at the new Pembury Hospital
- To establish midwife-led care at both hospitals, with a high focus on normal deliveries, home births and the provision of birthing centres.

2.1.2. If services are reconfigured in this manner, this is how they will be provided at both hospitals:

Pembury Hospital	**Maidstone Hospital**
Gynaecology:	**Gynaecology:**
Outpatient service Day care Early pregnancy assessment Inpatient service, non-cancer	Outpatient service Day care Early pregnancy assessment Gynaecological cancer
Paediatrics:	**Paediatrics:**
Outpatient service Assessment and ambulatory care, including medical and surgical day beds Community nursing team – seven days per Week Child & Adolescent Health and Development Centre Neonatal service Inpatient service	Outpatient service Assessment and ambulatory care, including medical and surgical day beds Community nursing team – seven days per week Treat and transfer facility Child & Adolescent Health and Development Centre
Obstetrics/Maternity:	**Obstetrics/Maternity:**
Midwife-led birthing centre Outpatient service Antenatal care Day and fetal assessment Community midwifery Consultant-led maternity unit	Midwife-led birthing centre Outpatient service Antenatal care Day and fetal assessment Community midwifery

2.1.3. The communications action plan adopted by local NHS bodies for the consultation process is set out in **Appendix One**. Below we outline the response to consultation as follows:

- The overall nature of the responses and responders is shown and the general tenor of comments on the proposals is summarised.

- A summary of key concerns is set out, identifying where possible the origin of the respondent, and including both members of the public and NHS employees. Details of some of these responses are included in appendices. Particular details are outlined and the NHS response to those concerns is appended.

- Responses from statutory organisations, including local authorities and other NHS bodies are detailed.

- Feedback to benefit other consultations in the future is included.

The detailed responses are available for scrutiny by Board members.

2.1.4. The consultation document did not include a tear-off slip for respondents. Rather, they were asked to write in with their comments, to use email, leave a telephone message or send one to the consultation website. Many people also attended public meetings. Because the consultation document on women's and children's services was published at the same time as the discussion document on trauma and orthopaedics, many respondents made comments on both documents in a single response. Below we list broadly where the responses came from:

Statutory authorities:	**Local organisations:**
Aylesford Parish Council	Diabetes UK, Maidstone and District
Boughton Monchelsea Parish Council	Hawkhurst Village Society
Brighton & Sussex University Hospitals NHS Trust	Maidstone and Tunbridge Wells Maternity Services Liaison Committee
Chart Sutton Parish Council	Patient and Public Involvement Forum
Ditton Parish Council	Postnatal Support Group, Paddock Wood
East Sussex and Kent County Councils Overview and Scrutiny Committee	West Kent Disabled and Sensory Impaired Group
Headcorn Parish Council	The Beacon Church
Kent Ambulance Service NHS Trust	SW Kent PCT Forum
Maidstone Borough Council External Scrutiny Committee	Beacon Community College student group
Maidstone Weald Primary Care Trust	**Individuals from:**
The Medway NHS Trust	Staplehurst (2)
Pembury Parish Council	Maidstone (8)
Sussex Ambulance Service NHS Trust	Antenatal clinic attendees (Maidstone) (2)
West Malling Parish Council	GPs (2)
	Aylesford (2)
Emails:	East Farleigh (3)
6	Teston
	Ward manager, Maidstone SCBU
	Wadhurst
	Allington
	Coxheath (GP)
	Loose (2)
	West Malling (2)
	Ightham
	Langton Green
	Maidstone Hospital consultant
	Tonbridge (2)
	Bearsted (2)
	Bower Grove School Head teacher
	Boughton Monchelsea
	Snodland
	Headcorn
	Barming

2.1.5. A letter opposing the proposals, signed by 55 consultant staff at Maidstone Hospital, was sent to the Chief Executive of the Trust and to the *Kent Messenger.* The text of the letter is as follows:

> *Dear Ms Gibb,*
>
> *We, the consultants of the Maidstone Hospital, representing a broad group of specialties, write to inform you of our gravest misgivings regarding the proposed centralisation of acute services, initially emergency in-patient trauma, at the Kent and Sussex Hospital, Tunbridge Wells.*
>
> *We believe the proposed cuts at the Maidstone Hospital to be dangerous, ill advised and unnecessary. They will place acutely ill patients, particularly the elderly and children, at additional risk of morbidity and death by transferring them to an inaccessible and less suitable site.*
>
> *The loss of this acute service will result in the inevitable haemorrhage of essential skilled staff. We feel the knock-on effect on the remaining acute services will lead to their progressive erosion, reducing Maidstone to an elective hospital only.*
>
> *We believe that whilst it may be financially and politically expedient, there is no justification for the proposed decrease in the quality of acute services that the people of Maidstone deserve.*
>
> *Yours sincerely,*

A list of the signatories to the letter is included within the appendices. The Board should note that following receipt of the letter, the Chief Executive of the acute Trust, Rose Gibb, met with the consultants to discuss their concerns at first hand, and to ensure that they fully understood the reasons behind the proposals. In addition, the Medical Director of the acute Trust, Dr Charles Unter, has also had individual meetings with some individual consultants.

2.1.6 The *Kent Messenger* published a petition in a number of its editions at the outset of the consultation process and delivered the final petition, with over 13,400 signatures, to the Trust in January. The wording of the petition was as follows:

> *"We the undersigned believe the proposed loss of specialist care from Maidstone Hospital for women experiencing complex births, sick children receiving overnight care and people needing operations for serious broken bones amounts to an unacceptable loss of service. We urge you to think again."*

The campaign logo/slogan was: "Say NO to hospital cutbacks, a Kent Messenger campaign." A copy of the covering letter from Bob Dimond, the Editor of the Kent Messenger is contained within the appendices. The letter acknowledges that the current consultation into trauma and orthopaedic services was amended following public discussion to incorporate two possible options, neither of which were up for consideration at the commencement of the discussion period. Both the current

trauma and orthopaedic options include the provision of 24 hour emergency care at both Maidstone and Tunbridge Wells.

The Board should note that the wording of the petition covered more than one issue, and should consider whether the use of the general phrase "hospital cutbacks" may have swayed the opinion of those who signed the petition. It was also noted that over 500 of those who signed the petition do not live in the catchment area of Maidstone and Tunbridge Wells Trust, and that one page of the petition was headed, "Signatures for petition of closure of A&E".

In view of the above concerns, a random sample of 5% of the signatories to the petition have been contacted and asked some further questions to enable us to better understand their views and the reasons for them signing the petition in the first place.

The Board will be given a summary of the responses received to these questionnaires at the meeting.

2.2. Issues and concerns

We have broken down the responses into a number of issues and listed the numbers of respondents who specifically raised that issue or concern. Some of these issues cut across the two consultation/discussion documents and are not specific to either. Many respondents made more general comments. The following tables contain those summarised responses.

Area of Concern	Detailed Points Made	Statutory Organisation	Local Organisation	Indiviual	Response to Concerns
Transport/travel	County town is central to region. Practical difficulties of travelling to see a child in hospital. Inter hospital transport required. I live in Snodland and cannot drive. How would I get to Pembury? 150 members of Beacon Church, Maidstone, would have major travel problems. Visits to sick baby or child need to be made daily. Hospital car service over-stretched. New public transport links needed.	4	3	12	Tunbridge Wells central to the overall catchment area for the Hospital Trust. There would be an expansion of community paediatric services. If transport required for medical reasons, an ambulance or hospital car would be provided, but other means of transport must also be explored. The results of the transport to hospital survey carried out by the Trust are available to Board members on request. The conclusion to the survey comments that, "***From the patients and visitors surveyed, 84% indicated that they had used their own car and 35.6% indicated that nothing would encourage them to use public transport. Question 8 regarding use of public transport was incomplete on 14% of the forms.***"

Area of Concern	Detailed Points Made	Statutory Organisation	Local Organisation	Indiviual	Response to Concerns
Risk to mother/baby in labour	Information needed about frequency of transfers in labour. More babies currently born at Maidstone than Pembury. When having a baby I would wish to have on-site and immediate access to fully qualified doctors. Doctors who see women for antenatal care in Maidstone will not be able to see them post-operatively in Pembury. This will threaten continuity of care.	2		1	A detailed paper on this issue, which also compared arrangements in place in other parts of the country was prepared by Mary Tunbridge, General Manager for Maternity Services, and supplied to the Health Overview and Scrutiny Committee for their consideration. Copies of the paper are available for Board members on request. We need to see the service as a whole. That means 2 hospitals working together in a complementary way. For the future the obstetric service will be provided by a team of doctors and midwives, so continuity of care will be maintained. We will still deliver babies at Maidstone both at home and in the birthing unit(s).This type of service is already well-established and provided elsewhere, for example at Buckland Hospital in Dover.

Area of Concern	Detailed Points Made	Statutory Organisation	Local Organisation	Indiviual	Response to Concerns
Risk to child (paediatrics)	Concerns for children requiring frequent admissions. Would undo progress made in involving parents in care. Decision on location of inpatient unit should depend on number of patients at each centre. Particular problems for Maidstone families of children with cystic fibrosis. Need reassurance that children with diabetes would not have to go to Pembury at night. Would there be 24 hour nurse cover? Proposals represent a genuine threat to the quality and scope of care that our hospital will be able to provide for my patients (Coxheath GP).	1		3	The majority of care for children can and will be provided on a day case, outpatient and ambulatory basis. Around 80% of children will continue to be seen and treated locally. For the minority who require an inpatient stay, it is better to centralise that care to improve the quality of the service we can offer. We would also want to extend the range and scope of our home care team who will be used increasingly to deliver care direct to the child's own home. This is better for them and reduces travel for parents. These specific issues should be given careful consideration to ensure that everything possible is done to remove the need for these patients and their parents to travel unnecessarily. We recognise that the particular needs of some groups of patients justify specific attention as part of the implementation process to ensure that the balance of the provision of specialist care with local provision wherever possible is maintained. Need to recognise the importance of critical mass to provide excellence of care for the whole population served.

Area of Concern	Detailed Points Made	Statutory Organisation	Local Organisation	Indiviual	Response to Concerns
`General rundown of Maidstone Hospital'	Maternity care should be expanded not reduced at Maidstone.			4	Two centres working together will enhance care for women and babies, and allow the critical mass required to provide a centre of excellence to the required standards.
Population growth	Major developments on the way in Maidstone area.			6	We need to be aware of the implications of population growth and the consequent extra births and plan for them across the Trust.
Praise for maternity unit at Maidstone	Six grandchildren all born at Maidstone. Keep it where it is.			3	High quality of service is recognised, but becoming unsustainable.
Proposals driven by new hospital	Why make changes now and not when new hospital is built?			2	Because services have already become unsustainable in the short term.
Proposals driven by staff shortages	Two sites would create more staff shortages. Staff shortages alone driving this proposal.			2	Two hospitals working together would be more efficient, allowing us to focus staff where they are most needed. The current staff shortages are a reflection of the way in which the services are currently configured.
Proposals driven by cost	Extra £2.5m cost worth it for two units.		1	1	Proposals are not about the cost of service.

Area of Concern	Detailed Points Made	Statutory Organisation	Local Organisation	Indiviual	Response to Concerns
Need for two obstetric units	Inequity of one unit having access to specialist support, not the other. Keep both units by staffing on with specialist paediatric nurses (ANNPs). Maternity services essential for flagship hospital.	1	2	1	Access would be provided to senior expert team for both birthing units. ANNPs in short supply. Risk of failing to recruit or retain. The proposals will provide a birthing unit at Maidstone and access to SCBU.
Impact on other trusts	Have other Trusts been consulted?	1			Yes, as part of consultation process.

2.3. Comments on the proposals

Many respondents did not comment specifically on the proposals in the document, preferring instead to make general points similar to those set out above. However, where a clear view was formed on the proposal we have listed it in the table below, which shows in a simple format those in favour of the proposals and those opposed. We have also included those with mixed views.

Expressed views of:	Statutory authority	Local organisation	Individual
In favour of proposals	5	3	8
Opposed to proposals	1	2	21
Mixed views	6	2	3

2.3.1. Statutory bodies and local groups wrote detailed comments on the proposals and we include some of the significant comments within Appendix 3.

3. Analysis

3.1. Major issues

3.1.1. The major issue that concerns local people is that of travel between Maidstone and Pembury and how that could impact on women in labour and children being transferred from one hospital to the other. Linked to this was the expectation that visitors mainly travelled to hospital by car: therefore car parking was a related feature of the debate around travel.

There is considerable support for a major Special Care Baby Unit based at Pembury and for a specialist inpatient paediatric unit at that hospital, and birthing units also gain widespread support.

The Local NHS has put considerable effort into engaging the public in this consultation process and it would appear to be reasonable to comment that we have been effective in undertaking a debate across a wide area. It is apparent, however, from the feedback that most people who responded were from the Maidstone end of the catchment area, and that most of those who opposed the proposals came from that area. Public meetings were on the whole very poorly attended and a judgement needs to be made about the effectiveness of such mechanisms, particularly when the NHS is beginning to use its new Public and Patient Involvement machinery much more than hitherto. Parish Councils showed great interest in debating the proposals, as did local interest groups.

3.1.2. The key local authority involvement in this process was initiated by a joint Health Overview and Scrutiny Committee of both East Sussex and Kent County Councils and a very detailed exercise was carried out by this committee, looking both at the proposals set out in the report and also the manner in which the NHS carried out its consultation. The committee's summary report is attached as **Appendix Two**. After consideration of all the issues, their overall conclusion is as follows:

Making any changes to hospital services can be extremely emotive, however when change is related to women and children's services this sentiment is heightened. Although the Committee has some reservations with the movement of services from a densely populated area such as Maidstone to Pembury, it is satisfied that the rationale for doing so provides justification. To not move these to Pembury would lead to a severe gap in services for those in East Sussex and the far West of Kent. However, in moving such services the Acute Trust and Local Authorities have a responsibility to ensure there is fair access to these services for all, which will involve thoroughly investigating the transport issues to ensure there is adequate infrastructure to support the new development.

Consequently the Joint Select Committee fully supports the Acute Trust' vision for 'A single Acute Trust, operating from two major hospitals, with centres of excellence that work together in a complementary way'.

Later, the committee makes a number of recommendations to the NHS bodies, arising out of the consultation. They say:

The Committee supports the proposals for the redesign of Women and Children's services. However, the Committee would like to make the following recommendations:

The Committee recommends that the Acute Trust and PCTs conduct future comprehensive consultations with more structured planning and less time restrictions and the process is developed in partnership with relevant Patient and Public Involvement Forums. The Committee also recommends that where possible, options be given for the public to comment on.

- *The Acute Trust must satisfy the Committee that the pressures facing the services at present are to be addressed, and produce an intermediate plan for sustaining services until the new development is operational and reports on these issues on a six monthly basis, either in writing or by attendance at the NHS OSCs.*

- *The Committee recommends that the Maidstone midwife-led birthing centre is situated away from the main hospital site.*

- *The Acute Trust must satisfy the NHS OSCs that when developing the proposals for the midwife-led birthing centre, it follows best practice, such as the Crowborough birthing centre and as informed by the Royal Colleges.*

- *The Committee recommends that the Acute Trust and PCTs develop plans for community services, in terms of midwifery and children's nursing as a matter of priority. This is to ensure these are well established and sustainable and are able to demonstrate a reduction in the reliance on acute hospital services before the service changes are implemented.*

- *The Committee recommends that both County Councils, relevant Boroughs and District Councils and the Acute Trust identify dedicated*

officers, who will recognise the challenges and find solutions in partnership, to ensure there is adequate transport provision to serve the new development at Pembury

- *To extend the East Kent Integrated Transport Model, if it is proved to be successful on evaluation, to include West Kent with the involvement of appropriate bodies in East Sussex.*

The NHS Overview and Scrutiny Committees will continue to closely monitor developments and the implementation of these plans, if the proposals are accepted. The NHS Overview and Scrutiny Committees will continue to hold the Trust to account in regard to these proposals.

Appendix One

COMMUNICATIONS/PPI ACTION PLAN FOR CONSULTATION ON WOMEN AND CHILDREN'S SERVICES

All areas with ✓ indicates joint visit/work with Steve Jones, Project Manager for Trauma and Orthopaedic Services

The standard letter refers to the letter "Shaping your local Health Service" which offers meetings and accompanies the consultation document.

WHO TO INVOLVE	LEAD	HOW	VENUE	WHEN
Special Interest Groups Appendix A	Karen Beesley	Letter "Shaping your local Health Services" plus consultation document to all groups		From 11/10/04
Current Patients/Users	Rose Gibb	Questions and Answers on Hospital Radio	Maidstone and Kent and Sussex	1st week in November 04
	Karen Beesley/Pat Graves	Questionnaires – face to face in Outpatient Clinics Paeds, Gynae and antenatal. 10 patients in each of 6 clinics	Maidstone and Pembury	From 11/10/04
	Pat Graves		Maidstone and Pembury	From 11/10/04
	Pat Graves/Karen Beesley	Questionnaire plus consultation document in each hand held Blue Book (Maternity)	Maidstone, Pembury and Kent & Sussex	From 11/10/04 for 6 weeks
		Flyer and questionnaire to go out with Paediatric TCI letters.		
Users and Potential future users	Pat Graves facilitated by Linda Prickett	Visit GP surgery to use face to face questionnaire	TBA	From 11/10/04 Dates to be agreed with surgery
Local Citizens Advice Bureau ✓	Pat Graves	Letter and Consultation document		11/10/04

WHO TO INVOLVE	LEAD	HOW	VENUE	WHEN

Parish Councils ✓	Pat Graves	Letter and Consultation document		11/10/04
PFI Community Work Group	Frank Sims	Confirm attendance, share consultation document from Women and Children	Post Graduate Centre Kent & Sussex	4/10/04
Access to hard to reach groups	Karen to contact Dianne Beeching and Linda Prickett re ethnic groups, travellers groups etc	Letter plus consultation document		
Ensure that transport providers are involved through discussion document e.g. buses	Frank Sims and Simon Johns	Standard letter and discussion document		4/10/04
Church groups ✓	Pat Graves	Identify local church groups send letter and discussion document and offer to come and talk		October 04
League of Friends and Volunteers and local fund raiser Peggy Wood	Karen Beesley	Standard letter and discussion document		4/10/04
General Public	Darren Yates and Karen Beesley	Utilise previous distribution methods to access Libraries etc from Phase 2 work.		
Organise Road Show in front of T.Wells precinct and Maidstone Chequers Centre	Linkage with T & O. Karen to phone centre, boards from PFI Team, Nexus to supply posters. Karen to get volunteers	Organise display stand, posters, consultation documents. Confirm access with centre managers and agree date with executive lead. Arrange staff support to attend. Confirm feedback mechanism.		November 04
Maidstone Weald PCT PEC and Board members Management Team Heads of Service (particularly in/outpatient therapies integrated nursing teams) PALS Officer	Rose Gibb and Frank Sims	Meeting presentation Documents to be distributed by PCT's Comms. Leads Involved in work group		 2 a month

South West Kent PCT PEC and Board members Management Team Heads of Service PALS Officer	Rose Gibb and Frank Sims	Documents to be distributed by PCT's Comms. Leads		
Sussex Downs and Weald PCT PEC and Board members Management Team Heads of Service PALS Officer	Rose Gibb and Frank Sims	Report and Q & A Documents to be distributed by PCT's Comms.Leads		
Kent and Medway Strategic Health Authority Candy Morris, Chief Executive Rebecca Sparks Alison Pemberton – Associate Director of Communications Martin Hawkins Kate Lampard – Chairman	Rose Gibb			
Strategic Health Authority for Sussex Chief Executive Chairman	Rose Gibb			

Primary Care Trusts Chief Executives and Chairmen Ashford Canterbury and Coastal Medway Shepway Dartford, Gravesham and Swanley Swale	Rose Gibb and Frank Sims			
Mental Health Trust West Kent NHS and Social Care Trust	Frank Sims			
Other NHS Partners	Frank Sims Steve Jones	Send consultation document and letter		Initial 3rd Oct

Kent Ambulance NHS Trust	Pat Graves Rose Gibb and Frank Sims	Representatives on Work Groups Presentation to Ambulance Board		
Local Authorities Sevenoaks District Council – Chief Executive Tonbridge and Malling Borough Council – Chief Executive Tunbridge Wells Borough Council – Chief Executive Maidstone Borough Council – Chief Executive	Rose Gibb and Frank Sims			
Overview and Scrutiny Committees Maidstone Borough Council Tunbridge Wells Borough Council Kent Count Council	Rose Gibb and Frank Sims			30th September
Kent County Council Chief Executive Director of Social Services	Rose Gibb and Frank Sims			
MPs Ann Widdecombe Archie Norman Hugh Robertson Sir John Stanley Michael Fallon Charles Hendry Open Public Meetings	Rose Gibb and Frank Sims Rose Gibb and Frank Sims	Meeting		22/09/04 23/09/04 To be arranged

Appendix Two

'Excellence in care, closer to home'

The future of services for women and children

Kent and East Sussex County Councils' NHS Overview and Scrutiny Joint Select Committee response

EXECUTIVE SUMMARY

December 2004

EXECUTIVE SUMMARY

1. Overview and Scrutiny of the NHS

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

Kent County Council established a Pilot NHS Overview and Scrutiny Committee in November 2001, and East Sussex County Council in October 2002. These Committees became a legal entity when the Local Authority Overview and Scrutiny Committee's Health Scrutiny Functions Regulations 2003 were implemented on 1 January 2003.

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

2. Joint Select Committee

Select Committee membership

The Select Committee consists of thirteen members:

Kent County Council Representatives:
- Dr Robinson (Chairman)
- Mr Chell
- Mr Davies
- Mr Fittock
- Mr Rowe
- Mr Simmonds
- Mr J Tolputt

East Sussex County Council Representatives:
- Cllr Bentley
- Cllr Slack

Kent District/Borough Council Representative:
- Cllr Baker/ Cllr Gibson (Sevenoaks District Council/ Maidstone Borough Council)

East Sussex District/Borough Council Representatives
- Cllr Bigg –(Hastings Borough Council)
- Cllr Phillips –(Wealden District Council)

Patient and Public Involvement Forum (PPIF) Representative:
- Mr Reece

Terms of Reference

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

- To prepare a strategic response, on behalf of Kent County Council's and East Sussex County Council's NHS Overview and Scrutiny Committees (OSCs), to the South of West Kent Health Economy consultation, "Shaping Your Local Health Service" –Priority three. This relates to the reconfiguration of Women's and Children's Services and Trauma and Orthopaedic Services.
- To examine the proposals for Maidstone and Tunbridge Wells NHS Trust and to consider them in the wider Kent and East Sussex context.
- To take evidence from stakeholders including relevant Acute Trust staff, partner organisations and community groups.
- To report the Committee's recommendations to both Kent County Council NHS OSC, East Sussex County Council NHS OSC, and to the South of West Kent Health Economy organisations.

The Select Committee agreed this review would be undertaken in two phases. This is the first phase, concentrating on the proposals for the redesign of services for women and children. The second phase will consider trauma and orthopaedic services. This report is only concerned with the services for women and children.

In constructing this report, the Joint Select Committee sought written evidence from various stakeholders, including Acute Trust staff, partner organisations, such as NHS Trusts in the surrounding areas, G.P's surgeries, etc, District/Borough and Parish councils and M.Ps. In addition to the written information, the Select Committee held four hearings and met on a further four occasions to discuss the direction of the report. The Committee also ensured representatives attended Trust public meetings.

3. Strategic Context

In considering these proposals, it is important to acknowledge the drivers influencing changes to services nationally. The main policy documents and initiatives influencing the redesign of services were considered by the Joint Select Committee and include:

- The NHS Improvement Plan
- National Service Framework (NSF) for Children, Young people and Maternity Services
- Department of health consultation: Keeping the NHS Local – A new direction of travel
- Royal College of Midwives position statement on birthing centres
- The Social Exclusion Unit report : 'Making the connections: Final report on transport and social exclusion'.

4. The consultation of 2000

In September 2000, the newly formed Maidstone and Tunbridge Wells NHS Trust consulted on proposals for women's and children's services. The proposals were similar to those currently proposed however the site for the centralised services had not been determined.

Relevant stakeholder groups were reported as agreeing with the need for a 'hub and spoke' model but generally desired the hub to be in their local area. The general public did not accept the case for change and raised concerns related to transport and the safety of transferring patients. Many of the professional staff were reported as accepting the pressure on the system and the case for change. However, there were discrepancies in opinion as to the extent to which those proposals represented the best or most workable options. It was believed this was compounded by the speed of the review process and the recent merger of two Acute Trusts with differing 'clinical practice and priorities'.

As a result of this, the Acute Trust proposed that it should be allowed to make further efforts to provide core women's and children's services at both sites. In November 2000, the West Kent Health Authority agreed to approve the Acute Trust's revised proposals, whilst recognising that, if pressure in the future required further specialisation of women's and children's services, these should be sited in Pembury.

In 2003, a meeting was held and attended by a variety of staff, including 18 senior staff members, to discuss the way forward. It is reported that there was general agreement to gain a critical mass of work in order to develop specialist skills and therefore better services for patients. It was agreed in principle at this meeting by a majority of staff that centralising high risk obstetrics at Pembury was the most suitable option. The Committee has repeatedly requested the minutes from this meeting, however is yet to receive a copy.

5. Process of consultation 2004

The Committee was concerned that the main driver for the timescales of this consultation was the deadline for the Private Finance Initiative in January 2005. It was evident that the consultation process was hastily assembled, a feeling echoed by some clinicians. This was evidenced by the extremely limited time clinicians were reported to have been given in which to comment on the draft consultation document, the late distribution of the consultation document, the lack of thought given to the illustrations within the document and the fact that the public meeting dates were not available and not advertised until November.

However, despite this, the Committee is satisfied that the Acute Trust and the PCTs have met their obligation to consult with the public and stakeholders, who have had ample opportunity to respond to the consultation.

6. The proposals 2004

The proposals are to develop:

- ***Ambulatory care***: This would be provided at both Maidstone and Pembury, providing emergency assessment of children, short stay treatment and stabilisation of complex cases for transfer.

- ***Midwife-led care***: It is proposed to create two Midwife-led birthing units, one in Maidstone and one on the new development in Pembury.

- ***Obstetrics and gynaecology***: High-risk consultant-led obstetrics care would be concentrated on the Pembury site, as would inpatient non-cancer gynaecology, whereas specialist gynaecology for cancer care is at the Maidstone site.

- ***Inpatient children's care and special care baby unit (SCBU)***: Inpatient children's care would move to the new development and the Acute Trust would provide a single SCBU (level 2) at Pembury.

- ***Community children's nurses***: To expand community children's nursing so that more care can take place in a child's home.

- ***Both sites***: To develop rapid access early pregnancy services, antenatal care, day case surgery and out patient departments at both hospitals.

Investment in Maidstone Hospital

Much of the public concern has centred on the perceived downgrading of the services at Maidstone Hospital. The Committee has been assured that this is not the case. The Acute Trust aims to provide two modern hospitals complementing each other in the services they offer.

As the consultation document shows, the Acute Trust has recently opened the £3 million Peggy Wood breast centre, an £11 million eye, ear and mouth unit and is in the process of opening a £1.7 million emergency care department.

7. Geographical Context

To move the inpatient children services and complex obstetrics and routine inpatient gynaecology services from Maidstone to the new Pembury development is the most viable option geographically. The Pembury location is nearer the centre of the 500k population in the Trust's catchment area.

For Maidstone residents needing inpatient care, there are closer alternatives to Pembury such as the Medway Maritime Hospital and the William Harvey

Hospital at Ashford, both of which have good motorway links. If services were to be provided at Maidstone there would be a vast gap in services for those resident both in the far West of Kent and the East Sussex borders.

When looking at the location of alternative Acute Trust services, Pembury appears the most appropriate location for services, if it is agreed that centralisation is necessary. Nevertheless, the Committee would like to stress that the vast majority of services will still be available locally, as the Trust plans to extend the provision of community services and to develop rapid access early pregnancy services, antenatal care, day case surgery and out patient departments at both hospitals

8. Current pressures on services

The Acute Trust services in their current form are not sustainable for a number of reasons, including:

- Lack of middle grade doctors for Maidstone paediatrics
- Problems recruiting and retaining lead obstetrician posts in Maidstone
- High vacancy rate for paediatric nurses
- Tighter restrictions on junior doctor's hours with the European Working Time Directive
- The closure of the SCBU unit at Maidstone that has occurred 44 times in the last three months to the emergency bed service
- The need to comply with the recently published NSF
- Not meeting labour ward minimum standards at Maidstone
- The fact that obstetrics is not viable without paediatrics

Even those not in favour of the proposals agree that the status quo is not sustainable, and that 'doing nothing is not an option'. Many of those the Committee has spoken to agree that two sites are not sustainable for the future. The Committee was advised that if these proposals were not to go ahead then this would lead to:

- Units closing
- A reduction in services
- Increased difficulty in recruiting and retaining staff
- More patients being transferred out of area

The Joint Select Committee unanimously agrees that the services in their current form are not sustainable and is concerned as to how the Acute Trust plans to sustain services until 2010 if the proposals are accepted.

9. The Committee's views on the proposals

A larger specialist unit at Pembury will benefit the community and will aid recruitment and retention of staff. It will be more attractive to the desperately needed specialist staff and will become more popular for those in training.

Any change to hospital services is difficult for a community to accept, however the Committee is convinced that these proposals will provide modern,

sustainable services, which will increase choice for patients and meet safety expectations.

The Acute Trust proposals are a reflection of modernisation programmes happening nationally, where the primary aim is the redesign rather than relocation of services. In doing so, they will also ensure modern efficient services are available locally, and will reduce the need for patients to travel out of areas for more specialist care.

10. Transport

The NHS, National Government and Local Authorities have a responsibility to ensure that there are adequate transport arrangements for those accessing healthcare. However limitations in current transport provision cannot be the defining argument in service location, there is little point in having good local access to a poor service. It is essential that those in deprived and rural areas are not disadvantaged through the movement of services to the new development. The transport solutions cannot be developed in isolation, discussions with Kent and East Sussex County Council representatives have shown there is a willingness to consider these issues in partnership.

11. Conclusion

Making any changes to hospital services can be extremely emotive, however when change is related to women and children's services this sentiment is heightened. Although the Committee has some reservations with the movement of services from a densely populated area such as Maidstone to Pembury, it is satisfied that the rationale for doing so provides justification. To not move these to Pembury would lead to a severe gap in services for those in East Sussex and the far West of Kent. However, in moving such services the Acute Trust and Local Authorities have a responsibility to ensure there is fair access to these services for all, which will involve thoroughly investigating the transport issues to ensure there is adequate infrastructure to support the new development.

Consequently the Joint Select Committee fully supports the Acute Trusts vision for 'A single Acute Trust, operating from two major hospitals, with centres of excellence that work together in a complementary way'.

12. Recommendations

The Committee supports the proposals for the redesign of Women and Children's services. However, the Committee would like to make the following recommendations:

- The Committee recommends that the Acute Trust and PCTs conduct future comprehensive consultations with more structured planning and less time restrictions and the process is developed in partnership with relevant Patient and Public Involvement Forums. The Committee also

recommends that where possible, options be given for the public to comment on.

- The Acute Trust must satisfy the Committee that the pressures facing the services at present are to be addressed, and produce an intermediate plan for sustaining services until the new development is operational and reports on these issues on a six monthly basis, either in writing or by attendance at the NHS OSCs.

- The Committee recommends that the Maidstone midwife-led birthing centre is situated away from the main hospital site.

- The Acute Trust must satisfy the NHS OSCs that when developing the proposals for the midwife-led birthing centre, it follows best practice, such as the Crowborough birthing centre and as informed by the Royal Colleges.

- The Committee recommends that the Acute Trust and PCTs develop plans for community services, in terms of midwifery and children's nursing as a matter of priority. This is to ensure these are well established and sustainable and are able to demonstrate a reduction in the reliance on acute hospital services before the service changes are implemented.

- The Committee recommends that the PCTs develop and promote a communication strategy specifically for the education of the public on the service redesign, if these proposals are implemented.

- The Committee recommends that both County Councils, relevant Boroughs and District Councils and the Acute Trust identify dedicated officers, who will recognise the challenges and find solutions in partnership, to ensure there is adequate transport provision to serve the new development at Pembury

- To extend the East Kent Integrated Transport Model, if it is proved to be successful on evaluation, to include West Kent with the involvement of appropriate bodies in East Sussex.

The NHS Overview and Scrutiny Committees will continue to closely monitor developments and the implementation of these plans, if the proposals are accepted. The NHS Overview and Scrutiny Committees will continue to hold the Trust to account in regard to these proposals.

The Joint Select Committee would like to take this opportunity to thank all of those who took the time to share their views with the Joint Select Committee in writing or in person, this support has been crucial in the development of these recommendations.

For a copy of the full report please contact Abigail Hill, Research Officer, NHS Overview and Scrutiny Committee, at Kent County Council, Legal and

Secretariat. Sessions House, County Hall, Maidstone, Kent, ME14 1XQ, e-mail Abigail.Hill@kent.gov.uk or telephone 01622 694196

- Kent Ambulance NHS Trust provided a response to the Priority 2 Consultation, and asked that it should be considered as their response to the women's and children's consultation

Kent Ambulance NHS Trust

Response to the Consultation on "Shaping Your Local Health Services"

1. INTRODUCTION

1.1. This paper is the formal response of Kent Ambulance NHS Trust (KAT) to the consultation on the proposals to change the provision of some health service provision in the Maidstone and Tunbridge Wells areas as part of what is described as "Priority Two" work. The Trust welcomes the opportunity to respond and contribute to the consultation.

1.2. Although this paper is in direct response to the four proposals made under Priority Two, the response has been considered in the knowledge and recognition that these changes are just one part of a complex process of change and service redesign.

1.3. As an NHS Trust that provides services over the whole of the Kent and Medway Strategic Health Authority area, we need to view and consider these proposals to change services in the context of the overall picture: it is not possible to consider them in isolation.

1.4. We are pleased to have been involved in the consultation process so far, and look forward to our continued active involvement in determining the best outcome for the provision of modern and effective health services for the communities that we jointly serve.

2. SCOPE

2.1. The scope of this response is limited to the views of Kent Ambulance NHS Trust in respect of the potential impact upon the ambulance services that it provides as part of the overall provision of health care to the populations of Maidstone Weald and South West Kent Primary Care Trust areas.

2.2. This paper comments upon each of the four proposals for change set out in the consultation document, but these comments are prefaced with our views on the anticipated cumulative effect of those changes, should they be implemented, as well as their interface with other possible changes in the future.

3. IMPLICATIONS FOR THE AMBULANCE SERVICE AND RECOMMENDATIONS

3.1. The net effect for the ambulance service of any one of these proposed changes is likely to be relatively low. However, when they are considered in conjunction with each other, and also in the context of the changes which are taking place under Priority One, it is our view that they will have a detrimental effect upon ambulance service provision unless some additional resources are allocated to enhance ambulance service provision.

3.2. Given the complexity of these changes when considered in conjunction with Priorities One and Three, we strongly recommend that the local health economy invest in an independent study of the service and resource implications for the ambulance service.

3.3. It should be noted that the lead time to introduce new operational staff, particularly when these new staff are to be based within a relatively small geographical area, is considerable. Additional resources must be in place and operational prior to any significant service configuration changes being implemented, and a lead time of up to 18 months for this to be achieved safely should be included in any planning assumptions.

3.4. Some of the proposals, particularly around the longer term proposals in Priority Three, do identify some potential additional training needs for ambulance staff, for example in the care of paediatric patients. We would strongly recommend that these needs are identified at an early stage, and that a training plan, possibly in partnership with the Acute Trust staff, is agreed well in advance to ensure that all required training has been carried out prior to any changes being implemented.

3.5. Given the need to ensure that patients of varying clinical dependencies will need to be transported and cared for between Tunbridge Wells, Pembury and Maidstone, consideration should be given to the resourcing of a dedicated "shuttle" ambulance service between those locations. This service should be staffed by appropriately-trained personnel, perhaps with a dedicated nursing escort. This would ensure that there would be an available and responsive service for these patients without detriment to the local accident and emergency ambulance service.

3.6. The net effect upon the Patient Transport Service of all the changes being implemented and / or considered should be measured, and resourced accordingly.

4. **PROPOSAL ONE:** Changes to the location of some inpatient care. *These changes relate to the creation of a stroke service for the acutely ill on the Kent & Sussex site; the provision of longer term rehabilitation for patients in community hospitals and an increase in community stroke and rehabilitation teams to look after more people in their own homes.*

4.1. Given that these changes relate primarily to the transfer of some inpatient beds from Pembury to Kent and Sussex, and the provision of longer-term rehabilitation beds in local community hospitals, KAT does not envisage any major impact upon its provision of emergency and urgent ambulance services from this proposal.

4.2. However, as the current provider of Patient Transport Service (PTS) non-emergency ambulance transport services to Maidstone and Tunbridge Wells NHS Trust, we would observe that as part of the commissioning process, due regard must be taken of any changes to PTS patient flows arising from this proposed change, and the service must be adequately resourced to provide any additional services that may be required.

4.3. We would also observe that this change in service provision for stroke patients has the potential to work well in conjunction with the development of alternative referral pathways for stroke patients initially attended by the ambulance service, particularly with the development of community-based stroke care teams. In this respect, we would positively support the exploration and development of opportunities for joint working between the ambulance service and these community teams, to improve the quality and effectiveness of care that can be given to this particular group of patients.

5. **PROPOSAL TWO:** Consolidating inpatient gynaecology at Pembury Hospital. *This change relates to the provision of a centralised inpatient gynaecological service for pre-booked patients at Pembury Hospital, with dedicated beds and access to theatres which are not used by emergency patients.*

   5.1. The current demand placed upon the PTS ambulance service for the routine admission or discharge of pre-booked gynaecology patients is low, and as such we do not envisage that this proposed change will have any significant effect upon KAT as far as elective (i.e. pre-booked) patients are concerned. However, it is possible that with the transfer of some beds from Maidstone to Pembury this will increase the demand for this type of transport, and, in line with the comments in 7(b) above, we would expect that the PTS service would be adequately resourced to provide any additional PTS services that may be required as a result of this proposed change.

   5.2. However, we do have some concerns about the potential for patients admitted as an emergency via Maidstone Accident and Emergency Department to require a subsequent ambulance transfer from Maidstone to Pembury for further interventions. This would be of particular concern if the dependency of these patients were such that they required the services of the Special Transport Service or a full Accident and Emergency crew. We do note the intention that the new service will have dedicated beds and access to theatres which are not used by emergency patients, but feel that it is important to clarify the arrangements for the inpatient care of gynaecology patients conveyed as an emergency case to Maidstone A&E Department.

6. **PROPOSAL THREE:** Moving children's planned routine surgery from the Kent and Sussex Hospital. *This change relates to the move of children's planned routine surgery from the Kent and Sussex Hospital to Maidstone before the move into the new hospital at Pembury.*

   6.1. There is currently very little ambulance activity associated with the admission and / or discharge of paediatric patients for planned routine surgery. It is therefore anticipated that the effect of this proposed change is likely to be minimal upon the ambulance service.

   6.2. However, consideration should be given to the potential for a growth in the requirement for routine transport for admissions and / or discharges from what will be a more remote site for patients in some areas.

   6.3. In common with the proposals around gynaecology inpatients, we also have some concerns about the potential for paediatric patients admitted as an emergency via Kent and Sussex A&E Department or Jacoby Ward at Pembury to require a subsequent ambulance transfer for Tunbridge Wells to Maidstone for further interventions.

   6.4. We would also comment that as the long term plan is to bring all paediatric inpatient surgery back to Tunbridge Wells when the new hospital is built, this will only be a temporary measure. As such, it is especially important that this aspect of the proposal is clearly communicated to the local population to avoid confusion at a later stage when it will revert to a model much closer to the current practice.

7. **PROPOSAL FOUR:** Bringing together inpatient clinical haematology at Maidstone Hospital. *This change involves further development of the haematology service at the Kent Oncology Centre at Maidstone and the consolidation of all inpatient haematology beds on the Maidstone site. Some patients who are currently treated at specialist centres in London and Surrey will instead be cared for at Maidstone. All outpatient and day case work will continue to be treated in local hospitals, as close to the patient's home as possible.*

7.1. Given the difficulties that can arise from the provision of transport to and from London and Surrey hospitals, we support the consolidation of haematology services at Maidstone on the understanding that this will enable the development of a high quality specialist service within the local setting. The reduction in the requirement to transfer these patients to London will assist in the provision of a local accident and emergency ambulance service within Kent.

7.2. We recognise that the number of inpatients on an annual basis is very small, but nonetheless recommend that the provision of appropriately skilled and resourced transport for admission and discharge is made available for these patients.

8. CONCLUSION

8.1. KAT would welcome their continued inclusion, together with their commissioners, in the consultation, planning and change implementation process.

8.2. We recognise and support the need to reform and modernise services. However, the changes being implemented and / or consulted upon within the three Priorities are both complex and very much inter-related: accordingly, Kent Ambulance NHS Trust is only able to support the proposals if any additional ambulance resources, identified as being required to maintain our commissioned level of service by a mutually agreed process, are fully funded by our commissioners. Additionally, funding must be made available at such a time, possibly on a phased basis, to ensure that the staff and vehicles are in place and operational prior to any changes that impact upon the ambulance service being implemented.

- **Sussex Ambulance Service NHS Trust**

The Trust set out the proposals in Priority 2 and 3, including the women and children's proposals. It reported its views together with those of Unison, the Trade Union, as follows:

In principle SAST and Unison are in support of the above reconfiguration proposals as access to full A&E and critical services will be available on the Pembury Hospital site.

Access to the proposed new Pembury Hospital site equitable to the current Kent & Sussex Hospital site. An increase in travel and journey turnaround times will increase as follows:

For category A 999 calls there would be an increase of approximately 5 minutes on inward journey time and 10 minutes on outward journey times. We take an average of 6 patients per week to the current Kent & Sussex hospital as cat As. This would increase our weekly journey turnaround times by 90 minutes in total.
For all other journeys there would be an increase of approximately 10 minutes on inward and outward journey times. We take an average of 27.5 patients per week to the current Kent & Sussex Hospital (excluding cat As). This would increase our weekly journey turnaround times by 550 minutes for these patients.

We would anticipate a total journey time increase of 10 hours and 40 minutes per week which equates to 14 hours including on costs and relief. Total costs for each hour will be in the region of £40 and therefore total cost per annum is likely to be approximately £30000 (tbc by finance).

Impact to all current out patient facilities will be negligible as services will continue to be provided in the main part on both services – changes to Urology with a shift to the Maidstone site has already taken place and effective treat and transfer protocols are being facilitated by Kent Ambulance Service.

SAST are unable to offer a formal response to the proposed reconfiguration of children's services at the moment until definite outcomes of the Princess Royal/Brighton reconfiguration are better clarified.

Conclusion
I would recommend that SAST Board formally support the MTW reconfiguration.

We should seek funding for additional journey times from the MTW reconfiguration programme board once figures are finalised.

We should seek further joint working and partnership opportunities with MTW in working towards delivering the SAST strategy and vision by securing a place on the MTW reconfiguration board.

We should ensure that an analysis of potential shift in both A&E and PTS patient flows is completed based on the potential outcomes of both the MTW and BSUH proposed reconfigurations. Results of this analysis should then be fed into the ongoing reconfiguration developments and negotiations...

Sue Harris
Director of Ambulance Services
Eastern Zone

- **Brighton and Sussex University Hospitals NHS Trust**

Peter Coles, Chief Executive of the BSUH Trust, wrote to the KCC Overview and Scrutiny Committee as follows:

I understand from your letter that the aim is to relocate high risk complicated obstetrics to Pembury and create supporting midwifery led units at Maidstone and Pembury Hospital. Alongside the midwifery unit there will also be two ambulatory care units for paediatrics whereas the complex children's inpatient care would be delivered on a new Pembury Hospital site.

This brief description fits with our local reconfiguration we have undertaken locally but also reflects the national trend in the reconfiguration of both maternity services and paediatric services in response to the key national drivers such as European Working Time Directives, Royal College recommendations for the training of Junior Doctors and critical mass requirements. I appreciate your informing us of these

changes to services and would welcome further discussion on this with the Trust involved in line with our strategic changes to paediatric and maternity services.

- **Letter from ward manager, SCBU, Maidstone**

The following comments were included in a letter from Rosie Reddick, Ward Manager:

- *We are a busy unit for the majority of the time and are aware that the Pembury unit are often up to their full capacity. If the 2 units were to merge as one, with the plans as they are at the moment, we are concerned that there will not be enough cots to cope with the heavier workload.*

- *Recent reports have claimed that we have `closed' on several occasions due to lack of staff and difficulty in recruiting staff. The word `closed' could be perceived in many different ways. We have had several occasions where we have been up to our full capacity (ie: 8 babies or even more) which obviously means that to accept further admissions is difficult; but surely this is a case of being `busy' – something we all experience in our workplaces from time to time. Unfortunately these situations are termed by some as being `closed' – a somewhat misleading phrase. As far as our staffing levels are concerned, we are fully established as far as our budget will allow, and have recently recruited 2 trained nurses without any difficulty. However, if the units were to merge to 1 this would certainly result in a loss of staff who would be unwilling or unable to work at Pembury due to travelling difficulties, child care problems etc.*

- *Not only would there be travelling difficulties for the staff, but more importantly, the mothers and relatives of the babies would find the travelling a major problem. For example, those mothers who have had a caesarean section cannot drive for at least 6 weeks following delivery, and those without their own transport would face an exhausting and tedious journey by public transport. This, in turn, could heavily influence the bonding process for mother and baby as well as trying to establish breast feeding.*

- *Maidstone is a county town – the fact that we would not have a hospital providing full services to the town is surely very poor*

- *The fact that we are a busy unit for the majority of the time can only accentuate the need for the unit at Maidstone.*

- *The proposals suggest that the maternity services should be removed from Maidstone with the alternative of a birthing unit instead, which would be midwifery led with no medical cover. As a result, the only births considered for this type of unit would be those considered as straight forward – without risk. How can we not presume that any birth does not have a certain degree of risk attached? This would not be such a problem if medical assistance was available at a unit relatively nearby, but can we honestly say that Pembury is within a safe enough distance should an emergency situation arise? As mentioned previously, many of our babies are term babies who `in theory'*

should have been delivered without any problem; but instead require immediate medical attention at delivery with ongoing specialist care on the unit. What service would we be offering to these babies if the proposals were approved?

- *The National Service Framework for children sets standards to 'promote high quality, women and children centred services and personalised care that meets the needs of mothers, children and their families'. The standards aim to bring care closer to home. How can this be achieved for the residents living in Maidstone with a unit based at Pembury?*

- **Pembury Parish Council**

The Council wrote in the following terms:

Pembury Parish Council would merely wish to make the following points:

- *To achieve the best medical solutions, however that may be*
- *To ensure proper access to the site*
- *To ensure that all transportation issues are properly addressed allowing full accessibility to all users.*

- **Maidstone Borough Council**

The Council's response included the following comments:

The Cabinet, on behalf of the Council, have adopted the views expressed by the External Scrutiny Committee...with the exception that their view on the proposals for women's and children's services is that the maternity service is not a specialist service and should be provided at Maidstone Hospital as a core Doctor led service.

- **Headcorn Parish Council**

The Council's comments were:

...my Council appreciate that changes must be made to improve these services however the main underlying concern is for our local residents who have expressed fears about the difficulty they would encounter travelling to Pembury Hospital using both the private care and in using the existing public transport network.

We hope that this issue is thoroughly addressed before any decisions are made.

- **The Medway NHS Trust**

Chief Executive of the Trust, Andrew Horne, wrote:

As one of the major stakeholders within the health economy of Kent and Medway, we fully understand the need to review and consolidate services to meet the population needs, professional standards and the national and local service improvement agenda.

We as a Trust have discussed the content of the Consultation paper and believe that the changes proposed within this document will have an impact on the demand for all Women and Children services. It is felt that the population north of the M20 and on Sheppey – who at present are mostly cared for within the Maidstone site – may now require their services at Medway Maritime Hospital.

This issue was highlighted in our discussion with the Women and Children Directorate where they felt that as a single site provider, where all the services from midwifery to full Consultant led obstetrics are provided, the services changes at the Maidstone and Tunbridge Wells NHS Trust will have an impact on patient/client choice.

Another issue is the fact that the midwife led birthing centre at Maidstone site is yet to be decided upon and this could raise concerns with issues around communication with the main hospital site.

Medway Hospital is also the main provider of neonatology Intensive Care services for West Kent and there may also be some increased demand where complications are expected from the Maidstone area.

We are working closely with the Maidstone and Tunbridge Wells NHS Trust on these options to ensure that any changes are effectively managed and high quality care ensured.

- **Chart Sutton Parish Council**

The Clerk to the Council writes:

The Parish Councillors considered your paper when they met recently and I have been asked to convey to you their grave reservations about your proposals. They believe that any degradation of services at Maidstone Hospital to be a retrograde step.

They contend:

- *That Maidstone is a busy and growing town, and is at the hub of much of the Kent transport networks. As such, the local hospital should provide a full range of services.*
- *That important strategic decisions should not be made because of current difficulties in recruiting staff with sufficient expertise.*
- *That reduction in facilities at Maidstone Hospital would be contrary to Government announcements on choice for patients.*
- *That transport links to Tunbridge Wells are totally inadequate, even for those with their own vehicles. Residents of Chart Sutton and other villages to the south east of Maidstone, already face a difficult journey by public transport to Hermitage Lane; the journey to Pembury will be even worse!*

I would ask you, please, to bear these thoughts in mind and implore you to change your thinking on your proposals for delivering services in the future.

- **Staplehurst Parish Council**

The Parish Clerk writes:

...Whilst it would not presume to know how best such services can be spread most effectively across the county, it would wish to draw your attention to the difficulties that the centralisation of services could create for Staplehurst residents with no personal transport.

As you may hopefully already be aware, travel for Staplehurst residents to Tunbridge Wells by public transport is quite difficult, time-consuming and nowhere near integrated or disabled friendly. Getting to the Maidstone Hospital is relatively easier from this parish but Councillors appreciate that wherever services are based some additional measures would be needed to enhance access for those with transport difficulties.

- **Ditton Parish Council**

The Parish Clerk writes:

...Whilst those with whom the Council has discussed these proposals think that it is sensible to provide routine ante-natal and midwifery services locally, separating high risk obstetrics from normal obstetrics for the women of the Maidstone and surrounding areas would be detrimental for that population. Deliveries can be unpredictable, as can the traffic on the route between Maidstone Hospital and the new Pembury Hospital.

It is the contention of the local people that both the population of Tunbridge Wells and the surrounding towns and villages, and the population of Maidstone and the surrounding towns and villages require local services for all the levels of midwifery and obstetric need. Removing the high risk service from the population of Maidstone will be a retrograde step, especially in the light of new housing building priorities and changing local demographics.

The retention of oncology for gynaecological cancer is sensible given the fairly recent establishment of the oncology service at Maidstone Hospital.

Services for children – proposals for change

The proposal is to establish at Pembury Hospital, a similar service to that which already exists in Maidstone Hospital, that of a rapid assessment and treatment service for children in ambulatory care. This is to be welcomed as both populations need access to such services.

The expansion of community children's nursing to assist parents in the nursing care of their children at home is also to be welcomed, assuming that both Maidstone and Pembury Hospitals have such nurses as their own dedicated staff, for the patients within each of the two separate localities.

First class Special Care Baby Units go hand in hand with obstetric units. Whilst the establishment of such a unit is to be welcomed at Pembury Hospital, it is essential that such a service is retained at Maidstone Hospital.

The declining trend in hospital admission for paediatric patients is acknowledged. Notwithstanding this downward trend, residents in this area believe that the paediatric inpatient service with consultants and nurses should be retained in Maidstone Hospital.

- **Boughton Monchelsea Parish Council**

The Parish Council writes:

Women's and Children's Services:

- *The proposals as a whole are welcomed. However , the comments above (Orthopaedic Services) relating to the difficulties of getting to Pembury apply equally to the services to women and children, possibly more so given the patient group.*
- *The Special Care Baby Unit is to be welcomed, if this means cases will not in future need to be transferred to specialist hospitals elsewhere in the country.*
- *Facilities need to be incorporated to allow partners and parents to be able to stay overnight at Pembury if children are to be kept in, not only for the obvious welfare reason but also because of the difficulties of access to Pembury from Maidstone and the surrounding area.*
- *Emergencies during birth should be capable of being treated at Maidstone without the need for patients to be transferred to Pembury until after they have been stabilised.*

- **West Kent Disabled and Sensory Impaired Group**

At its meeting in November the group:

...emphatically endorsed the proposal that the Special Care Baby Unit remains at Pembury.

- Letter from Mr Bob Dimond, accompanying the Kent Messenger petition

Text of the letter sent by Bob Dimond, Senior Editor West Kent, for the Kent Messenger Group, to accompany the petition.

Dear Ms Gibb

The Kent Messenger launched its campaign, Say No to Cutbacks, in October, in response to Maidstone and Tunbridge Wells NHS Trust's announcement to change the key services of orthopaedic trauma and women's and children's provision currently provided at Maidstone Hospital.

We are concerned about the changes that are proposed which, we believe, amount to a cut in services accessible to the people of Maidstone. We are also concerned that these changes, in both specialities, have been driven by a lack of specialist staff, in particular paediatricians and do not feel that this is a genuine reason for a district general hospital to lose services.

We very much welcome the announcement this week that public consultation into orthopaedic trauma services will include two options, both of which involve provision for emergency orthopaedic trauma surgery at Maidstone Hospital.

However, we are still concerned about both the provision for elective orthopaedic trauma services and the future for women's and children's services in the town.

We, backed by a petition signed by more than 13,400 readers, oppose the proposals – which amount to cutbacks – because we believe there should be a full range of key services provided at Maidstone Hospital.

We consider a full range should fundamentally include; proper facilities for the overwhelming number of parents who want to have their babies in Maidstone; wards for ill and injured children to be treated in, close to their families; facilities for emergency treatment and essential care for the elderly.

The KM is happy to see change and innovation and is not saying things shouldn't change, but believe these proposals are a step too far and are not in the best interests of the people of the County Town.

Yours sincerely

BOB DIMOND
Senior Editor West Kent
Kent Messenger

- List of signatories to the letter from the Consultants

GENERAL SURGERY Mrs L M South Mr P Reddy Mr P Jones Mr G Trotter A&E Mr A Soorma X-RAY/RADIOLOGY Dr P McMillan Dr C Brunnell Dr T Johnson Smith Haemotology Dr H Williams ANAESTHETICS AND CRITICAL CARE Dr S Gammanpila Dr J Dickenson Dr J Fonseca Dr M Biswas Dr D Iyer Dr R Williams Dr R Leech Dr Sritharan Dr R Browning Dr A Challiner Dr C Jappie Dr S De Zoysa Dr R Norton CARDIOLOGY Dr P Holt Dr B Mishra MEDICINE Dr C Thom Dr D Hibbert Dr P Powell Jackson Dr G Noble Dr M Batley Dr S Husain Dr G Bird Dr A Hammond NEUROLOGY Dr P Barnes OPTHALMICS Miss C Jones Mr C Jenkins Mr L Amaya Mr A Macfarlane Mr S Hindi ONCOLOGY Dr M Hill Dr Waters Dr Camenos Dr C Abson Dr A Visioli Dr H Taylor PAEDIATRICS Dr J A Hulse Dr B Bhaduri Dr N Pandya OBSTETRICS AND GYNAECOLOGY Miss A Henderson Mr O Devaja Mr J Goodman Mr Mossa Mr A Papadopoulos Mr R Connell HISTOLOGY Dr J Schofield Dr Couts Dr Khan

Appendix Four

Patient & Public Involvement Forums
Reconfiguration Group

29th December 2004

Dear Colleagues,

Consultation – Women and Children's Services

I am writing on behalf of the local Patient Public Forums' Reconfiguration Group in respect of the consultation for "priority 3" proposals concerning Women and Children's Services. As we stated in our response to earlier consultations, the broad role of the PPI Forums is to comment both on the content of the proposals themselves and on the process of consultation that has been put in place. This letter deals with both these aspects and has been agreed by the cross Forum group on reconfiguration.

Forum members have taken part in regular meetings with clinical and other staff involved in the service area, attended public meetings established by the Trusts, met on several occasions with Trust Chief Executives and Directors. In addition we are working closely with representatives and officers of the Overview and Scrutiny Committee and were officially represented on the "Select Committee" review established by the OSC. In addition the Forums continue to bring together their own members to discuss issues amongst themselves in the cross-forum group looking at "reconfiguration".

We note recent media and political comment about the proposed changes. Forum members believe, however, that our role is to play a critical, but constructive role, bearing in mind the current position with respect to local health services and our desire to see improvements. We believe this should involve a more holistic approach to the balance of services across the whole of the West Kent health economy and a responsibility to work on options for change, rather than promote apparently simple solutions.

In light of our involvement the following points have been agreed by PPI Forum members with regard to the consultation around Women and Children's Services.

1. The PPI Forums agree that change is required in the current provision for Women and Children's Services and are broadly supportive of the proposals being put forward. We welcome the emphasis on wider choices being available, particularly in the maternity field.

2. Assumptions about the future take up of, for example, maternity services, is based on projections about the "leakage" of some patients in the north and east of the area (to their more "local" services in Medway or Ashford), as well as movement into the area from the west (as people in East/West Sussex "identify" with Tunbridge Wells as their main "centre"). The Forums are concerned that the choices for women (parents?), created by this situation, as

well as the choices of particular services available, need to be well communicated. As we move into more "Choose and Book" systems we believe that the Trusts will need to pay much closer attention to these issues. It also points to the need for providers of NHS services and local/county authorities to focus more closely on changing demographic structures and social expectations in the planning of health and other wider social services.

3. Not only is communication an issue but so too is investment. We wish to see sufficient investment in the different options for maternity services so that they are "real" choices. Forum members will pay close attention to the effective take up of these options.

4. With regard to paediatric care we are again broadly supportive of the proposed changes. However we have some concerns with regard to staffing, especially in relation to the enhanced community based role proposed for paediatric nurses. There are already shortages of trained staff in this area which may serve to undermine this move. The Forums believe that the Trusts will need to develop a strategy for recruitment, retention and development to ensure staff shortages do not act as a barrier to positive changes. We look forward to seeing plans as to how these issues will be addressed.

5. We continue to recognise that we do have a three-site hospital and that some movement of services in this context will be necessary. This will still be true when the new Pembury Hospital comes into service. In this situation we need to pay on-going attention to the issue of emergency response times for transporting patients to one hospital or another.

6. In addition, the issues of transport for patients (and their carers) to and between the hospital sites continues to be of concern. The Forums are greatly heartened by the way that the Trusts have begun to address this difficult and often contradictory issue. We would like to see further exploration of innovative approaches but we appreciate that the NHS is constrained as to what it can do without the participation of local and county authorities, transport bodies and companies etc.

In relation to the public consultation process we wish to make the following observations:

1. The Forums welcome the more strategic approach that has been developed with respect to public consultation and engagement on Women and Children's Services. The production of an engagement plan and the determination to discuss the proposals with a wide range of external stakeholders rather than to only undertake formal public meetings is to be welcomed. The Forums will be asking for a formal report as to the effectiveness of this strategy as part of its remit to overview consultation and engagement by the Trusts.

2. We welcome the efforts of local Trusts to work with the PPI Forums and the range of contacts and discussions that have taken place as illustrated earlier. However, we remain concerned at the sometimes "patchy", sometimes over-detailed, sometimes rapidly changing, sometimes inconsistent, pieces of information that Forum members receive, often without any clear logic. We are also concerned that on some occasions information requested from the Trusts

could have been provided more quickly. We hope that the regular planned meetings between Forum Chairs and Trust Chief Executives will go some way to help in this respect.

Forum members have played a constructive role in "reconfiguration". We recognise that change is necessary as new ideas come "on stream". To achieve service improvement and legitimacy, public involvement is key. The PPI Forums are contributing our ideas in this spirit. We look forward to this continuing.

Yours sincerely

Graham Shaw, Chair of PPI Forums Reconfiguration Group

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NHS
Eastern and Coastal Kent

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Our ref: AS/cd
06 January 2010

Dear Paul,

Re: Task and Finish Group – Maternity Services

Many thanks for your letter of 08 December regarding the above.

Taking your queries in relation to the stand alone birthing units in East Kent in order, we can confirm the following:-

1. **Where are they located and how long have they been in operation?**

   The birthing units are located in Kent and Canterbury Hospital (CBC) and Buckland Hospital, Dover (DFBC). They have been in operation for 5 and 10 years respectively.

2. **What services do they provide and when are they open?**

   Both units provide 24 hour service for low risk women who have concerns or who are in labour. Women attend the unit(s) to be reassured and assessed during pregnancy in the day care areas whilst in labour. Partners are encouraged to stay for both the birth and during the postnatal period. There are rooms with double and twin beds to enable partners to stay. Both units have pools for women to use as pain relief and many women chose to birth in the pools.

   Both units accommodate midwifery clinics and consultant led high risk clinics, Monday to Friday during working hours. This enables services to be provided closer to home. Parent education classes which include water birth and active birth workshops are held within both units. Yoga classes are also provided by qualified yoga professionals and breastfeeding workshops are facilitated by midwives, with breastfeeding support groups run by the women themselves.

   Following the birth, women and their babies can stay in the unit for anything between 6 hours and 3 days. Women who are high risk and have had to attend an acute unit to birth are able to return to one of the birth units for support in the immediate postnatal period which is particularly helpful for women who wish to establish breastfeeding.

Cont'd.

2/

3. What are the staffing levels?

The staffing levels comprise of a midwife and maternity care assistant 24 hours per day, 7 days per week. When a birth is expected, a second midwife is on call. If a women requires transfer to an acute unit, the same applies hence there is always a midwife available within the unit. There is a robust on-call service available 24 hours a day.

4. How far are they from the nearest consultant-led maternity unit?

See number 8. below.

5. How many births has each unit delivered each year for the past three years?

Canterbury:	2006 – 453, 2007 – 415, 2008 – 387
Dover	2006 – 422, 2007 – 397, 2008 – 347

6. What percentage of births in the area does this account for?

This accounts for 10% of births

7. How many women each year for the past three years entering these units to give birth were transferred to the consultancy-led units?

Unfortunately we are unable to collate figures for 2006 as these were not recorded at the time although audits were carried out, they do not reflect the full year.

2007:- Canterbury – total number of women attending the unit was 465. The total transfers (including neonatal) is 135. In-utero transfers totalled 123.

Dover – total number of women attending the unit was 426. The total transfers (including neonatal) is 126. In-utero transfers totalled 104.

2008:- Canterbury – total number of women attending the unit was 466. The total transfers (including neonatal) is 155. In-utero transfers totalled 137.

Dover – total number of women attending the unit was 361. The total transfers (including neonatal) is 117. In-utero transfers totalled 100.

2009:- These figures will be available mid-end January and will be forwarded onto you as soon as they are available.

Cont'd.

8. Where are these women transferred to, how long do these transfers take and what are the procedures around ensuring these transfers are safe?

The acute units are based at William Harvey Hospital, Ashford or the Queen Elizabeth Queen Mother Hospital, Thanet.

The time taken for a transfer is as follows
DFBC to WHH range is 20-40 minutes
DFBC to QEQM range is 30-45 minutes

CBC to WHH range is 20-40 minutes
CBC to QEQM range is 30-50 minutes

When a women requires transfer an ambulance is arranged (999 called if this is an emergency) the second midwife is called to stay within the birth unit and the women is accompanied by the first midwife who would have provided labour care up to the point of delivery. Women are given full information about transfer rates and how long transfer takes prior to them making a decision to attend either the Canterbury or Dover birthing units.

9. What information can you provide about the number of comments / complaints / compliments received each year by the NHS in East Kent relating to the stand alone birthing units, in particular relating to transfers?

The birthing units are very popular and we have compliments and cards on a daily basis. Complaints have been very few over the last three years and none of them were in relation to transfers.

Yours sincerely,

Ann Sutton

Ann Sutton
Chief Executive

c.c. Ingrid Cobourn, Lead Commissioner

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South East Coast Ambulance Service NHS
NHS Trust

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Sent electronically via email

22 January 2010

Dear Mr Wickenden

Apologies for the delay in our response. I am writing on behalf of Geraint Davies who is currently on annual leave.

The original consultation on women and children's services at MTW was conducted in 2004, two years before South East Coast Ambulance Service NHS Trust's (SECAmb) conception. As such the former Kent and Sussex Ambulance Services were involved in the consultation. The two trusts submitted evidence to the Kent and East Sussex County Councils' NHS Overview and Scrutiny Committee in 2005 stating that they were able to support the changes as long as any additional resources required would be funded by the commissioners. I can confirm that this is still the position today.

It was agreed between the ambulance trusts and MTW at the time that detailed resource planning would need to commence 18 months prior to any changes taking place.

Again, this is still the case for SECAmb and this work starts in earnest this month (January 2010), a year and a half prior to the opening of the new hospital at Pembury. A central part of this work is to ensure that should additional ambulances and training of crews be required that these are in place prior to the changes occurring in June 2011. As detailed resource planning commences this month, we are yet unable to provide you with information about the financial implications.

Finally, please find a table below detailing the number of inter-facility transfers between Kent and Sussex, Maidstone and Medway and Pembury hospitals. Please note that this is the total number of patient transfer for the last calendar year (2009) and covers a range of patient conditions, not just maternity related. This is because it is not possible, because of the way that inter-facility transfer information is recorded, as opposed to 999 incidents, to always obtain the patient's clinical condition.

Originating Site	Transferred to	Numbers
Maidstone	Pembury	48
	Kent & Sussex	112
Pembury	Kent & Sussex	51
	Maidstone	5
Kent & Sussex	Maidstone	43
	Pembury	148

The average journey times under normal driving conditions are as follows:

Kent and Sussex to Pembury / Pembury to Kent and Sussex 10 minutes
3.2 miles

Medway to Pembury / Pembury to Medway 50 minutes
24.6 miles

Maidstone to Pembury / Pembury to Maidstone 26 minutes
13.6 miles

Obviously driving under emergency conditions (blue lights and sirens) these times are likely to be reduced. The decision to drive under emergency conditions will be made by the clinician on board and will be based on the clinical need of the patient.

I hope that this response provides adequate clarification on the points you raised.

With kind regards,

Darren Reynolds
Head of Business Development

Cc: Geraint Davies, Director of Business Development, SECAmb