



## AGENDA

### HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 14th December, 2007, at 10.00 am      Ask for:      Paul Wickenden  
Council Chamber, Sessions House, County      Telephone      01622 694486  
Hall, Maidstone

*Tea/Coffee will be available from 9:45 am*

#### Membership (17)

- Conservative (12):      Lord Bruce-Lockhart (Chairman),      Mr A R Chell,      Mr B R Cope,  
Mr A D Crowther,      Mr J Curwood,      Mr J A Davies,      Mr D A Hirst,  
Mrs S V Hohler, Mr G A Horne MBE, Dr T R Robinson, Mr R Tolputt  
and Mrs E M Tweed
- Labour (4):      Mr M J Fittock (Vice-Chairman),      Mrs C Angell,      Ms A Harrison and  
Mrs E D Rowbotham
- Liberal Democrat (1):      Mr D S Daley

#### **UNRESTRICTED ITEMS**

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

- | Item No                     |   | Timings               |
|-----------------------------|---|-----------------------|
| 1.                          | Substitutes   |                       |
| 2.                          | Declarations of Interests by Members in items on the Agenda for this meeting.   |                       |
| <b>Audiology</b>            |   |                       |
| 3.                          | Eastern & Coastal Kent Primary Care Trust & West Kent Primary Care Trust<br><i>Michelle Ford, Assistant Director of Commissioning and Rob Howard, Technical and Strategic Planning Manager (Audiology), Eastern &amp; Coastal Kent and Bob Deans, Deputy Chief Executive, Bill Millar, Assistant Director of Primary/Community Service Contracting and Lynne Townsend, Locality Commissioning Manager, West Kent Primary Care Trusts will be in attendance for this item to respond to questions about the commissioning of Audiology Services.</i> | 10:05-<br>11:15 am    |
| <b>Break 11:15-11:30 am</b> |   |                       |
| 4.                          | a) East Kent Hospitals Trust, b) Maidstone & Tunbridge Wells NHS Trust, c) Medway NHS Trust and d) West Kent Primary Care Trust   | 11:30 am-<br>12:30 pm |

*Representatives from East Kent Hospitals Trust, Glenn Douglas, Chief Executive, Maidstone & Tunbridge Wells NHS Trust and Andy Horne, Chief Executive, Alex Willoughby, Head of Audiology and Samantha Goldberg, Service Manager for Head and Neck, Medway NHS Trust and Bob Deans, Deputy Chief Executive, Bill Millar, Assistant Director of Primary/Community Service Contracting and Lynne Townsend, Locality Commissioning Manager, West Kent Primary Care Trust will be in attendance for this item to respond to questions about the provision of Audiology Services as provided by their respective Trusts.*

**Lunch break 12:30-1:15 pm**

5. Patient & Public Involvement Fora 1:15-2:00 pm  
*John Beadle, Darent Valley Patient and Public Involvement Fora representative will be in attendance for this item.*

**Dentistry**

6. Eastern & Coastal Kent Primary Care Trust & West Kent Primary Care Trust 2:00-3:00 pm  
*Michelle Ford, Assistant Director of Commissioning and Jayne MacDonald, Head of Primary Care and Community Commissioning (NHS dentistry), Eastern & Coastal Kent Primary Care Trust and Bob Deans, Deputy Chief Executive, West Kent Primary Care Trust will be in attendance for this item to respond to questions about the commissioning and provision of NHS Dentistry.*

**Break 3:00-3:15 pm**

7. Access to NHS Dental Services in the Swale Area 3:15-4:00 pm  
*Jean Spain, Eastern & Coastal Kent PPIF representative from the Swale Locality Group will be in attendance to answer the Committee's questions.*
8. Conclusions 4:00-4:30 pm
9. Response to the Department of Health consultation on the regulations for Local Involvement Networks (LINKs) 4:30-4:40 pm
10. Date of next programmed meeting – Friday 11 January 2008

**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)*

Stuart Ballard  
Head of Democratic Services  
(01622) 694002

**6 December 2007**

## **NHS Overview and Scrutiny Committee Audiology Briefing Note**

### **Background**

Some 219,100 people in England are registered with their local Social Services department as deaf or hard-of-hearing (as at year ending 31 March 2007). But it is estimated that 7.5 million (around a fifth of the population) in England, or more, actually suffer from deafness or are hard-of-hearing.

Around two million people in the UK have been fitted with hearing aids, although it is estimated that only about 1.4 million of these use them regularly. It is believed that a further four million people might benefit from having a hearing aid (some estimates put this figure as high as five to six million).

There are 164 NHS Audiology services in England, mostly provided by acute Trusts in a hospital setting. A few are provided by Primary Care Trusts (PCTs). The audiology services undertake a wide range of work besides fitting hearing aids.

The work of NHS audiology services is commissioned by PCTs through block contracts, audiology not currently being subject to the Payment by Results (PbR) system (whereby providers are paid according to each “spell of care”).

### **Modernising NHS Audiology services**

During 2000–5, the provision of all adult hearing-rehabilitation services within the NHS was transformed by the Modernising Hearing Aid Services (MHAS) project. The two key components of MHAS were: the implementation of an improved rehabilitative process; and the provision of digital hearing aids, which had previously only been available privately, often at high cost. Digital devices have programmable “intelligent” amplification that is considerably better than analogue technology.

The NHS Purchasing and Supply Agency (PSA) was able to get significant discounts on digital hearing aids by large-scale bulk purchasing. Roll-out of digital hearing-aids in the NHS Audiology service was completed in 2005.

### **Growth in waiting times**

Following modernisation, the NHS Audiology service has, unfortunately, been a victim of its own success. There has been a great increase in the demand for the service and in referrals of both new patients and existing patients seeking to access the modernised service – particularly by exchanging analogue hearing aids for digital ones. This has led to greatly increased waiting times, a development compounded by: an improved rehabilitative process (requiring increased appointment times); the fact that prior to MHAS there were already waiting lists for many audiology clinics, exacerbated by shortages of audiologists; and the lengthier assessment and fitting process needed for digital hearing aids.

## **The Public Private Partnership**

Between 2003 and 2005, the Department of Health (DoH), through the NHS PSA, negotiated a national framework contract with two major private-sector suppliers for patients to receive their NHS hearing aids through the private sector, by way of a three-episode patient journey (assessment; fitting; and follow up). This was known as the Public Private Partnership (PPP). It was facilitated by local NHS Audiology services, which also undertook clinical-governance monitoring of the scheme. Patients on the NHS waiting list were invited to take part, and at least 68,600 people received hearing aids in this way during 2004–6.

In some areas, the PPP scheme was effective in reducing waiting times without any loss in quality of service. In other areas, up to 50% of PPP patients needed access to the NHS Audiology service for remedial work.

## **The end of ring-fenced funding**

From 2000 to 2005, the £125 million funding for the MHAS programme was ring-fenced by the DoH. In 2005–6, funding for audiology was given to individual PCTs, to allow them to commission services locally. In 2006–7, the DoH started giving revenue allocations for audiology to Strategic Health Authorities (SHAs), bundled with many other different allocations in “central revenue budgets”, for the SHAs to allocate within their health economies.

These changes, in the context of the financial challenges in many health economies, led to a weakening of the financial position of local NHS Audiology services. In consequence, the PPP scheme effectively collapsed in 2006, as the two private companies involved were unable, in the absence of guaranteed adequate funding, to support the infrastructure required. At the same time, NHS Audiology service posts were frozen and services were unable to maintain or increase capacity by means such as the use of locum staff.

## **National waiting-time target**

The DoH has set as a national target for the NHS that, by the end of 2008, no-one should be waiting more than 18 weeks from GP referral to hospital treatment.

Audiology appeared to represent a significant problem for the NHS in meeting the 18-week target. However, in May 2006, the DoH announced that referral by GPs direct to NHS Audiology Services fell outside the 18-week pathway. Only those cases involving referral to an ENT consultant were deemed relevant to the 18-week pathway. The DoH also indicated that direct-referral audiology patients should not be re-routed to the ENT service in order to get around the bottle-neck in the audiology service and get onto the 18-week pathway.

## **Interim diagnostic targets**

Alongside the 18-week target, the DoH has two interim targets for diagnostic waits that are intended to act as “milestones” on the way to achieving the 18-week target:

- by March 2007, no-one should wait more than 13 weeks for diagnosis;
- by March 2008, no-one should wait more than six weeks for diagnosis.

Although hearing-aid fitting falls outside the 18-week pathway, referral for hearing tests is within these interim targets for diagnostic assessment. It appears that, consequently, the NHS in a number of areas is assessing all patients on the hearing-aid waiting list in order to hit the interim diagnostic targets – regardless of whether there is any realistic prospect of the patient receiving appropriate rehabilitation (including the fitting of a hearing aid). Consequently, by the time the local audiology service is able to provide rehabilitation, the hearing test will be out-of-date and will, therefore, have to be repeated. Even so, the March 2007 milestone target has clearly not been achieved by the NHS overall.

## **Phase 2 Independent Sector Treatment Centre procurement**

The government originally planned for episodes of audiology care (three-stage patient pathways) to be included in contracts for the second phase of centrally-procured Independent Sector Treatment Centres (ISTCs). In July 2006 the government announced that 300,000 three-stage audiology patient pathways per year were being centrally procured from the independent sector, to come on-stream from early 2007.

Audiologists’ representatives expressed alarm at the lack of involvement of the NHS Audiology service itself in making arrangements for the delivery of audiology by ISTCs. They raised a number of concerns around service quality, clinical governance, the interface between the private provider and NHS services, and the possible destabilizing impact on NHS providers of a large private procurement taking both staff and work away from NHS audiology departments.

## ***Improving Access to Audiology Services in England***

In March 2007 the DoH published *Improving Access to Audiology Services in England*. The document stated that delivery of improved audiology services was down to “local health systems” using “the health reform mechanisms of better commissioning and pathway redesign, choice and competition, information and incentives”. Each PCT, as the local commissioning body, was expected to set out in its forthcoming first “Prospectus” the strategic direction for local audiology services.

The DoH, according to the document, estimated that, nationally, around 300,000 extra adult hearing-aid complete pathways “would be needed between April 2007 and December 2008, on top of existing levels of NHS provision, to make a maximum wait of 18 weeks from referral to treatment possible for all audiology referrals ...” (although audiology would remain outside the official 18-week target). This “capacity gap” would

be filled partly through “greater efficiency in existing services where possible” and partly through commissioning new capacity.

The document stated that 42,000 additional audiology patient pathways a year had already been procured as part of “the Phase 2 IS [Independent Sector] diagnostics procurement”, to come on-stream from April 2007. Further independent-sector provision had been prepared through “a Phase 2 IS elective audiology procurement”, apparently to come on-stream by April 2008 – but “the amount to be procured [is] dependent on the outcome of the current planning process”.

The document underlined the requirement to meet the national interim targets on diagnostic waits and said it was “good practice” for the hearing aid to be fitted “soon after or at the same time as the initial assessment”.

In respect of Patient Choice, the document said that patients should already be offered a choice of provider for audiology referrals to ENT consultants; and consideration was to be given to allowing a choice of provider for patients referred direct to audiology services.

The document also stated that the DoH would develop benchmark costs for audiology and consider introducing a standard national tariff for audiology services. In the meantime, PCTs could “develop prices [apparently meaning local tariffs] that support choice and efficiency, rather than block contracts”. (However, in the absence of PbR arrangements, block contracts presumably continue to apply to audiology.)

### **Commons Health Committee report**

In May 2007 the House of Commons Health Committee published a report on audiology services in England. The government confirmed to the committee that it was not pressing ahead with the previously planned massive central independent sector procurement but was asking SHAs and PCTs to come up with plans to commission services from NHS and other providers to deliver an additional 300,000 pathways per year.

The committee recommended:

- that audiology should be included in the 18-week referral-to-treatment (RTT) target “at an early date”;
- that there should be for clarity on the amount of additional capacity needed (some witnesses “described future demand as a ‘bulge’ that could be overcome using short-term measures”, while others told the committee “that demand would continue to grow”);
- that there should be more efficient delivery of NHS-provided services;
- measures to ensure quality, value for money and ethical behaviour on the part of private providers.

The DoH responded that it would not be including audiology in the 18-week target, but expected “local health systems” to show “excellent progress in tackling long waiting

times". It confirmed that SHAs had taken the view that audiology waiting times could be improved by use of existing NHS services and "modest" additional private-sector procurement. Around 50,000 additional pathways were being procured from the independent sector, through the Phase 2 procurement and additional local procurement.

## **DoH Good Practice Guide**

In June 2007 the DoH published *Transforming Adult Hearing Services for Patients with Hearing Difficulty: A Good Practice Guide*. This is an aid for NHS commissioners and providers, advocating improvement of audiology services through: use of new technology; streamlining systems and processes; new models of care; and re-profiling the workforce. It is based on work done during 2006-7 by six "Physiological Measurement Development Sites" – one of which was East Kent Hospitals NHS Trust.

### **The current situation on waiting times**

DoH figures show that in December 2006 the average expected wait for an audiology assessment was 17.6 weeks. The average expected wait in the South East Coast SHA area was the worst in the country – 45 weeks.

The most recent returns from the DoH on numbers waiting for diagnostic tests, for September 2007, show 91,349 people in England waiting for an audiology test – 42,542 had waited more than 13 weeks; and 30,384 had waited more than 26 weeks. This is a significant improvement on past performance – a picture reflected in the figures for Kent. But, both nationally and locally, there is still a long way to go (the March 2007 milestone diagnostic maximum waiting target of 13 weeks is still far from being achieved) – and improvement is not uniform. Also, these data fail to give a complete picture, as they do not include waits for hearing-aid fittings after diagnostic testing.

Research by Grant Shapps MP, published in January 2007, found the average time from referral to fitting was over 40 weeks and reassessments were taking 64 weeks.

In March 2007 the Royal National Institute for Deaf People estimated that around 40 to 45 weeks was the average waiting time for a first hearing aid and 65 weeks was typical for someone being reassessed.

The British Society of Hearing Aid Audiologists (BSHAA) conducts an annual survey on waiting times for hearing aids. In 2007, the survey found that the average complete wait in England for an NHS hearing aid, for someone seeking their first device, was 36 to 38 weeks. Users wanting to upgrade their hearing aids from analogue to digital had to wait on average 44 to 47 weeks; at two hospitals, waits were up to 260 weeks (i.e. five years).

The survey showed that waiting times had improved overall in England compared to 2006 – but not all areas had improved. The BSHAA noted that:

*The South East of England [defined as Kent and neighbouring London Boroughs] continues to be the worst place for patients looking for their first NHS hearing aid,*

*and is the only region in England where waiting times have increased year on year. Now, people with hearing loss will wait between 84 and 92 weeks for their assessment and the fitting of a hearing aid, an increase of between 11 and 18 weeks on the [previous] year ...*

*The South East also has the dubious distinction of having the hospital with the longest waiting list in the United Kingdom. Patients unlucky enough to be referred to the Princess Royal University Hospital, in Orpington, will have their assessment in just 8 weeks – but will then have to wait between two and three years to get a hearing aid fitted.*

*The South East also has more hospitals which have reported an increase in waiting times during the last 12 months. There, 38% said patients were waiting longer ...*

*In an analysis to see how many hospitals had waiting times longer than six months, the South East of England performed worst. At 88% of all hospitals there patients will have to wait over 26 weeks ...*

*The South East is again the region with the longest waiting lists for upgrading from analogue to digital: on average patients will have to wait 87 weeks ...*

*Maidstone District Hospital (waiting time at least a year) said they had been hit by the loss of three members of staff who had not been replaced - and warned our researcher that if a patient hadn't been seen within a year, they would have to return to their GP for another referral letter ...*

Maidstone and Tunbridge Wells NHS Trust state that patients who have a hearing aid fitted following a GP referral are able to attend the hospital for open access to the audiology departments for up to 12 months for repairs, etc. After 12 months, the patient is required to see their GP. This is to allow GPs to re-assess the basic clinical care of the patient and ensure that reported changes to their hearing and / or problems with their hearing aid are not caused by simple, underlying clinical issues, such as the build-up of ear wax.

East Kent Hospitals NHS Trust, and Eastern and Coastal Kent PCT aim to cut the maximum RTT wait for a hearing aid to 18 weeks by the end of March 2008 – and eventually to eight weeks.

Medway NHS Trust, which provides services at Medway Maritime Hospital and Darent Valley Hospital, states that its service at both hospitals is now achieving RTT waiting of 18 weeks or less.

### **The Clinicenta procurement**

On 13 September 2007 PCTs across the South East Coast area entered into a two-year contract with Clinicenta (a private company owned by a consortium that includes Carillion plc) to provide 4,000 audiology patient-pathways per year (for age-related hearing-loss). Both South East Coast SHA and the DoH's Commercial Directorate were actively engaged in formulating the contract.

The contract is being rolled out between October 2007 and January 2008. All PCTs, except Medway PCT, have entered into the contract; Brighton and Hove City PCT, and

Eastern and Coastal Kent PCT are signatories to the contract but are currently commissioning zero pathways through it (Eastern and Coastal Kent PCT currently has its own arrangements with a local private provider). West Kent PCT will apparently be using Clinicenta to provide audiology services in the south of West Kent only (services for the north of West Kent are provided by Medway NHS Trust at Darent Valley Hospital).

As with the planned ISTC procurement, there are questions to be asked about: the quality and type of service to be provided; linkages with the NHS audiology service; and whether NHS audiology departments could lose staff and patients to the private provider.

It seems unclear whether the Clinicenta procurement is just to provide short-term additional capacity to deal with what is perceived to be merely a “bulge” in demand (caused by digital aids becoming available) – or whether it could become a longer-term arrangement.

David Turner  
NHS Research Officer



Written Evidence from **Eastern & Coastal Kent Primary Care Trust** in response to questions on Audiology for the NHS Overview and Scrutiny Committee on Friday 14 December 2007

- 1. Whether the following "milestone" diagnostic target is being achieved for audiology: *by March 2007, no-one should wait more than 13 weeks for diagnosis.***

No, however, Eastern & Coastal Kent PCT (E&CK PCT) has invested heavily this year to implement a waiting list initiative which will mean that anyone who was already waiting for a hearing assessment at the end of November will be seen by the end of March 2008.

- 2. Whether the following "milestone" diagnostic target will be achieved for audiology: *by March 2008, no-one should wait more than six weeks for diagnosis.***

Yes – E&CK PCT has commissioned activity which estimates that 1450 patients will be on lists by the end of March 2008 which will mean patients could be seen within 6 weeks by then.

- 3. Whether it is intended that routine (non-ENT) audiology referrals will conform to the 18-week referral-to-treatment maximum wait standard by the end of 2008 (although these referrals are not formally covered by the 18-week RTT maximum waiting target).**

Yes – since August E&CK PCT has recognised all audiology referrals as being part of an 18 week pathway and has planned to meet this by the end of March 2008.

- 4. How (and when) Eastern and Coastal Kent PCT will meet its stated long-term target of reducing the maximum RTT waiting time to eight weeks.**

This is not a national target but is an *average* that E&CK PCT is aiming for. By commissioning sufficient volumes the PCT plans to have enough capacity from 2008-09 to create this as an average wait for referral to audiology to fitting. However, patients who delay (i.e. can't be contacted, have holidays, or are clinically complex) will extend that average.

- 5. What the level of unmet need for audiology services (including analogue-to-digital upgrades) is and how this has been estimated – and whether current procurement plans will be sufficient to address this.**

Currently the conversion (analogue-to-digital) component of the waiting list accounts for roughly 25% of the waiting list. E&CK PCT is working with the Acute Trusts to identify the numbers of analogue fittings that have already been 'converted' and what number that might leave.

However, the PCT has taken a more prudent approach, and assumed that there will be a growth in demand for services as a result of reduced waiting times for *all* components of the waiting list (rather than focusing on the remaining unmet need of the 'conversions' only). Estimating what impact reduced waits will have on demand is extremely difficult. Once E&CK PCT has identified the appropriate

level of growth, the funding required to meet it will be included in the audiology bid that is submitted in our annual local delivery planning (“LDP”).

**6. Whether providing upgrades to digital hearing aids for patients who already have analogue hearing aids is as important a priority as providing hearing aids for new patients.**

Yes – E&CK PCT are committed to reducing waits for *all* patients including those requiring upgrades to digital, and this will be supported by bids for additional investment if necessary.

**7. Regarding the recent cross-PCT Clinicenta audiology procurement for South East Coast:**

- **Why Eastern and Coastal Kent PCT is a party to the contract but is currently commissioning zero pathways through it; and how it will source additional capacity to clear up excessively long waits.**

E&CK PCT’s original plans for central procurement of diagnostics did not include audiology as it did not expect problems in securing additional capacity locally. When the Clinicenta procurement was promoted by South East Coast SHA, the PCT was already in negotiation with a local independent provider. Those negotiations continued and a contract agreed on the basis it offered a local solution with more flexibility and better value for money, than the Clinicenta contract. The PCT, however, signed up to the Clinicenta contract as a contingency arrangement, with no commitment to Clinicenta for a minimum level of activity or payment for audiology.

- **How the procurement came about and what the respective roles of the PCTs, the SHA and the DoH's Commercial Directorate were in bringing it about.**

The Clinicenta procurement was co-ordinated by the SHA and the Department of Health’s Commercial Directorate. E&CK PCT was reporting to the SHA regularly regarding its alternative plans for audiology.

- **How the procurement relates to the government's previously-announced plan to procure centrally 300,000 Independent Sector audiology pathways p.a. over five years.**

The central procurement of diagnostics as a whole represented circa £6m for Kent & Medway and E&CK PCT was allocated its ‘fair share’ of this, but it was not broken down to specialty level. At that time the PCT felt it would have more difficulty in sourcing additional capacity for MRI and Endoscopy than finding capacity for hearing aid services, and therefore prioritised these diagnostics from the centrally-negotiated independent sector contract.

- **What the effect of the procurement is likely to be on NHS audiology providers, given the fears expressed by some that the planned central Independent Sector audiology procurement could destabilise NHS audiology departments (which provide a much wider range of services).**

E&CK PCT's current contract with its local independent provider is to address part of the waiting list backlog and is until March 2008 only, rather than a 5 year commitment. This minimises risk and gives more flexibility in seeing how effectively the acute Trusts and primary care providers can manage demand after the current years' waiting list initiative. There has been increased investment in the hospital Trusts as well as the independent provider and therefore will not destabilise existing NHS provision.

- **How the contract addresses the following issues:**

Our local private provider contract will address some of the backlog of waiters for an appointment at East Kent Hospitals Trust whilst our Swale patients will continue to be seen by Medway Maritime NHS Trust.

- **quality, repair and maintenance of hearing aids;**

Our local private provider contract stipulates a period of 3 years aftercare for each patient fitted.

- **onward referral of cases requiring a specialist opinion;**

Our local private provider contract means there will be onward referral where necessary within 18 week timelines.

- **follow-up care for patients with complex needs;**

Our local private provider contract stipulates that complex cases will be referred back to East Kent Hospitals Trust where necessary.

- **continuity of care;**

The service specification with our local private provider states that patients already referred to East Kent Hospitals Trust for ENT would stay with East Kent Hospitals Trust as far as possible for continuity of care.

- **clinical governance;**

Our local private provider was assessed for clinical governance aspects as part of the overall provider assessment exercise. Monitoring the quality of the service is also part of the contract and a clinical audit is being undertaken in December by the East Kent Clinical Audit Service (Primary Care Audit Service). In addition to this a patient satisfaction questionnaire is being issued to all patients.

- **sharing of patient records with NHS audiology services;**

If a patient needed treatment elsewhere in the system then full demographic and clinical information would be made available. The contract with our local private provider also stipulates that they must adhere to patient confidentiality.

- **patient selection (whether this will be done through Patient Choice; whether those on waiting lists will be seen first);**

The contract with our local private provider stipulates that existing waiting list patients should be taken from the waiting list in chronological order. Those patients willing to be seen at one of the 4 locations are offered the choice and then booked for assessment and fitting according to patient availability.

- **staffing and "additionality" (given concerns around possible "poaching" of staff from NHS services).**

In an open market E&CK PCT can not influence staff choice regarding their employment but does need capacity across all providers and therefore require additional staff rather than moving staff/capacity around the system.

Commissioning Directorate

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**Response to written questions regarding audiology for NHS Overview and Scrutiny Committee meeting on 14 December 2007**

**1. Whether the following "milestone" diagnostic target is being achieved for audiology: *by March 2007, no-one should wait more than 13 weeks for diagnosis.***

This target was not being met by either of West Kent PCT's NHS audiology providers by March 2007.

**2. Whether the following "milestone" diagnostic target will be achieved for audiology: *by March 2008, no-one should wait more than six weeks for diagnosis.***

We have commissioned services to ensure that no one will be waiting for longer than six weeks from referral to diagnosis by the end of March 2008.

**3. Whether it is intended that routine (non-ENT) audiology referrals will conform to the 18-week referral-to-treatment maximum wait standard by the end of 2008 (although these referrals are not formally covered by the 18-week RTT maximum waiting target).**

Routine (non-ENT) audiology referrals will conform to the 18 week referral to treatment maximum wait standard by December 2008.

**4. What the level of unmet need for audiology services (including analogue-to-digital upgrades) is and how this has been estimated – and whether current procurement plans will be sufficient to address this.**

On the basis of Medway NHS Trust's own business plan, West Kent PCT commissioned additional treatments to secure the delivery of the target waiting time. This plan includes both first fit and analogue to digital hearing aid patients who are on the waiting list and will ensure that the need for audiology services is fully met.

Maidstone and Tunbridge Wells NHS Trust have provided West Kent PCT with a breakdown of their current waiting lists, identifying those patients who will transfer to Clinicenta and those who will remain under the care of the Trust. West Kent PCT has worked with MTW to estimate the level of additional activity required, which is being procured from Clinicenta and will ensure the Trust meets the waiting time targets for all patients.

**5. Whether providing upgrades to digital hearing aids for patients who already have analogue hearing aids is as important a priority as providing hearing aids for new patients.**

Patients requiring upgrades to digital hearing aids are assessed with the same level of priority as those patients requiring a first fit hearing aid.

## **6. Regarding the recent cross-PCT Clinicenta audiology procurement for South East Coast:**

- **Why the procurement allows for additional provision in the south of West Kent but not Dartford and Gravesham.**

The Medway NHS Trust, which provides audiology services for Dartford, Gravesend and Swanley locality, is confident that they will manage the waiting lists and deliver the required increases in activity to meet the waiting time targets. On this basis it was unnecessary to procure additional activity from Clinicenta for this locality.

Medway has further reassured the PCT that they are able to deliver increased activity via additional services, which could be provided at Gravesend Community Hospital. To this end we are in negotiations with the Medway NHS Trust. The additional services would take both direct access patients ie referred by their GPs and provide a supporting service to ENT clinics held at Gravesend Community Hospital. It is envisaged that this service development will commence early next year subject to contractual arrangements.

- **How the procurement came about and what the respective roles of the PCTs, the SHA and the DoH's Commercial Directorate were in bringing it about.**

SEC SHA co-coordinated the local procurement up to the point when the contract was signed (by PCTs). Legal and commercial expertise was provided by the DH Commercial Directorate.

- **How the procurement relates to the government's previously-announced plan to procure centrally 300,000 Independent Sector audiology pathways p.a. over five years.**

The contract was procured by PCTs in South East Coast SHA following the decision not to proceed with the larger Wave 2 Independent Sector Diagnostic Procurement for SEC. Clinicenta had been appointed Preferred Bidder for that scheme and was then contracted to provide audiology services to address local need. The volumes contracted are broadly consistent with SEC's share of the 300,000 Independent Sector pathways over five years.

- **What the effect of the procurement is likely to be on NHS audiology providers, given the fears expressed by some that the planned central Independent Sector audiology procurement could destabilise NHS audiology departments (which provide a much wider range of services).**

Maidstone and Tunbridge Wells NHS Trust have been fully involved in the work up to the transfer of patients from their waiting lists. The initiative is about meeting the unmet demand rather than removing activity, which the Trust could have addressed themselves. The PCT have entered into the agreement with Clinicenta to provide a responsive service to patients waiting for a digital hearing aid, whilst continuing to commission the same level of activity from NHS audiology departments.

Currently, the standards applied in contracts with Independent Sector providers are more detailed and specific than those with NHS providers. It is our intention to apply

these standards across all providers. The PCT believes that contracting based on high standards, along with the introduction of more choices for patients will inevitably drive up the quality of care across the board.

- **How the contract addresses the following issues:**
  - **quality, repair and maintenance of hearing aids;**
  - **continuity of care**

The contract covers a two year period from October 2007 with the potential to extend the contract thereafter. Patients seen within this time will receive as many audiological follow ups as deemed clinically necessary and will be able to ring into the service and make an appointment to have repairs and ongoing maintenance if required. At the end of the contract the ongoing care of the patient and maintenance/repair of the aids will transfer to either Maidstone and Tunbridge Wells NHS Trust or another suitable provider (this may indeed be Clinicenta, dependant on need and success of this provider.

Patient surveys and other methods (e.g. 'secret shopper') will be undertaken to ensure their experience is taken into account throughout the period to both inform contract review and future provision.

For MTW, patients would be referred into the Trust service by their GPs, which is consistent with the current referral pathway.

It is important to remember that patients with digital hearing aids will expect a re-fit assessment every three years. These arrangements will be built into future contracts with all providers.

- **onward referral of cases requiring a specialist opinion;**
- **follow-up care for patients with complex needs;**

Patients on the Maidstone and Tunbridge Wells Trust waiting list are validated for their suitability to be treated by Clinicenta. These will be patients who are waiting for a digital hearing aid and who require an assessment and fitting of the aid. It is unlikely that these patients will require onward referral as they do not have complex audiological needs. Any such patients would be screened out prior to referral to Clinicenta to ensure they receive the appropriate service at Maidstone and Tunbridge Wells Trust.

- **clinical governance;**

There are clear clinical standards described in the contract specification for Clinicenta.

To meet clinical governance standards, Clinicenta will ensure that every Staff member involved with the provision of the Services:

- receives proper and sufficient training and instruction in accordance with Good Clinical and Good Healthcare Practice and the standards of their relevant professional body, if any, in the execution of their duties; and
- receives full and detailed appraisal in terms of performance and on-going education and training in accordance with Good Clinical and Good Healthcare Practice and the standards of their relevant professional body if any.

In addition, Clinicenta, is required to feedback patient experience to the PCTs through surveys (where appropriate), complaints and complements, as well as incident reporting.

- **sharing of patient records with NHS audiology services;**

When sharing patient records the PCTs and Clinicenta acknowledge their respective duties under the DPA and FOIA and comply with their obligations and duties under the said Acts.

Clinicenta shall in providing the Services comply with the following as from time to time amended or replaced:

- the Confidentiality Code of Practice for NHS Staff;
- the NHS Code of Practice on Confidentiality;
- protecting and Using Patient Information (A Manual for Caldicott Guardians);
- the NHS Information Governance Toolkit; and South East Coast PCTs and Clinicenta - Adult Hearing Aid Services
- in accordance with the principles of the security management standard BS 7799-2.
- **patient selection (whether this will be done through Patient Choice; whether those on waiting lists will be seen first**

Patients who are considered to be clinically suitable for transfer from the waiting lists of Maidstone and Tunbridge Wells Trust will be offered the opportunity to access the Clinicenta service. These patients will be seen first. West Kent PCT has procured an additional level of activity starting in April 2008 through to September 2009 to take patients directly referred from their GPs, therefore offering wider choice.

- **staffing and "additionality" (given concerns around possible "poaching" of staff from NHS services).**

Clinicenta have recruited their current workforce through agencies and through advertising on the British Audiological Society website and journal. The PCT contracts with Clinicenta do not have an additionality clause relating to recruitment of staff from the NHS.

Written Evidence from **East Kent Hospitals Trust** in response to questions on Audiology for the NHS Overview and Scrutiny Committee on Friday 14 December 2007

***What they are doing to implement the approach recommended by the Department of Health in "Transforming Adult Hearing Services for Patients with Hearing Difficulty: A Good Practice Guide" (June 2007), encompassing: use of new technology; streamlining systems and processes; new models of care; and re-profiling the workforce?***

The EKHT Audiology department has been actively engaged in progressing service improvements over the past two years. The following are brief examples of the practical initiatives being taken:

EKHT has been selected as a national pilot site for the trialling of new multi-patient testing technology. The equipment, a series of 4 PC screens with attached headsets and earphones, allows up to 4 patients to undergo hearing tests simultaneously, managed by one technician. This system was installed during September on the Rotary Unit, William Harvey Hospital. Use by patients and staff has proved very positive and the department was developing plans to adapt booking arrangements for ENT clinics, to further create additional staff capacity.

The practice of 'open ear fitting' was introduced in the department across all sites in April 2007 and now comprises approximately 35% of all fittings provided. The benefits of this approach are reduced patient visits (no ear mould required) and this is leading to an 'assessment and fit' model of care, where possible. During November, 6 members of staff attended a national training session to develop skills in open ear fittings and this should allow for an increased volume of patients now to be treated using this technique.

Group fitting sessions have been introduced in Margate as an alternative approach to individual patient appointments. This service model is in its first stages and patient feedback is being considered before any roll out to other sites in East Kent is progressed.

In a further bid to promote speedier service provision and increase service capacity, the department have commenced a pilot project introducing a postal service of pre-programmed aid for self referring upgrade patients (analogue to digital aid fittings). Patients are being given the option of attending a clinic if required for either initial aid fitting or for fine tuning of posted aid if not meeting their expectations. Indeed these patients may be most appropriate for support within the new group sessions. Initial response from patients contacted has been positive and aids are now being sent to those willing to be included in the study; feedback from them will be assessed and dependant upon the success of the pilot it is hoped to progress this to a routine system, focused to the self referring group (approx 34% of list). This will greatly improve aid waiting times and free up further capacity for other aid fittings needing patient attendance and technician time.

Considerable attention has been given to the departments staffing, both in terms of establishment and skill-mix. Nationally the Audiology service has faced significant pressures on availability of trained professionals. EKHT has placed specific focus on the development of the

Assistant Technical Officer grade over recent years; this role with supporting competencies and responsibilities now plays a major part in the departments activity delivery plans, in particular the expansion in capacity for the hearing aid service.

A culmination of the above measures has provided the Trust service with an increase in aid fitting capacity of 40 patients per week. In August 2007, the PCT agreed an additional funding allocation to the Trust to provide an increased level of aid fittings to achieve an 18 week maximum wait for all patients by end of March 2008. Given the volume of patients involved (5500 on list in August) this has required yet further capacity increase within the Trust, provided by locum staff and overtime working and the PCT contracting for additional service through an independent sector provider. At the end of November the numbers waiting has decreased to 3900 and on target to be 18 week compliant by end March 2008.

***What role has East Kent Hospitals NHS Trust played as one of six Physiological Measurement Development Sites during 2006-7, testing innovative delivery models and means of reducing waiting times that are referred to in the DoH report?***

As a Physiological Measurement development site the EKHT Audiology department contributed to the national service improvement strategy through a number of key service initiatives, namely:

Centralised waiting list (completed May 2006) – amalgamation of multiple site and service waiting lists into only 2 complete lists, for priority and routine aid fittings. Each list comprises primary and secondary aid patients. This provided clarity in numbers waiting and waiting times and allowed the Trust to implement standardised working practices across all sites to manage the waiting list as one service.

Agreement to service standards – wait times targets for priority and routine patients. Agreement made with PCT that maximum wait time for priority patient to be 8 weeks and that all routine patients (primary and secondary aid fittings) to be seen in strict chronological order.

Waiting list validation and management rules – introduction of clear waiting list process for validation and maintenance in accordance with other Trust waiting list systems. Introducing these measures helped to identify a level of patients who no longer wanted an aid or who had received an aid through other means. This allowed the administration team to concentrate appointment bookings to patients needing an aid and overall to reduce the numbers waiting by removing the invalid waits.

Reorganisation of department administration – first phase (commenced April 2006) centralised administration support to Audiologists, based at Kent & Canterbury Hospital. This offered patients a co-ordinated booking process manned throughout the day with dedicated contact points, improving both the appointment arrangements and use of the Audiology IT system.

Clinic booking systems (from March 2006) – introduction of revised clinic programme and booking process via central team. The Audiologist work programmes were reviewed and new job plans agreed setting out dedicated aid assessment and fitting sessions. This greatly helped the appointment booking arrangements through a central team, particularly where staff work across multiple sites.

Recruitment of an Office Manager to lead central team and manage IT system to support operational and reporting processes (in post July 2006) This post heads up the administration processes for the service and has been invaluable in freeing up valuable technician time from admin duties. Through this postholder considerable progress has been made on information reports and the overall appointment booking systems.

Development of full information reporting from Audiology IT system (from June 2006) and development through 2007 of PTL (patient tracking list) information to support delivery of 18 weeks. The Office Manager has developed a series of operational reports to support working arrangements and to provide commissioning agencies with patient and waiting list information.

Direct Access – revision to system agreed with PCT (May 2006) and revised arrangements implemented. Provided increase in available capacity to reduce hearing aid waiting list. The initial diagnostic assessment for direct access patients was withdrawn due to the lengthy waiting lists and the staff capacity used was converted to increase aid fitting sessions. The audiogram diagnostics for these patients is now done as part of their fitting appointments. With wait times reduced to 18 weeks the diagnostics for all patients will be within the 6 week limits.

Revision of Audiology support to ENT clinics – (from May 2006) pilot arrangement introduced to Deal clinic to reorganise Audiologist clinic time to cover requirements of ENT investigations at same time as providing dedicated capacity for hearing aid provision; net effect is increased capacity for hearing aid service. It was found that audiology requirements at general ENT clinics ranged from 3 to 20 patients and pre-selection of patients has now allowed improved programming of Audiologist work programmes to support both ENT clinics and to the other Audiology service activities.

Positive booking systems – (from June 2006) with developments of the central admin team the booking of hearing aid clinics is done by positive booking (patients contacted by phone to agree date, time and site of clinic). Objective is to maximise clinic capacity and reduce patient 'did not attends'. Staff have found that personal contact with patients in setting their appointment has helped reduce wasted clinic slots and allowed patients to gain access to services across a range of sites rather than just their local clinic.

Revision of clinic practices - (from March 2006) Audiologists have reviewed operational processes and revised assessment and fitting times for clinic slots. Impact is increased clinic capacity to support hearing aid service Through the use of modern techniques and revisions to staff skills fitting times have been reduced; productivity rates per staff member have increased.

Follow Up systems – (from April 2006) patient with aids fitted are now telephoned to confirm satisfaction with aid provided, as appropriate, with consequent reduction in hospital visits and further freeing up clinic capacity for the aid service. In the main patients have found this approach acceptable; where any concerns have been raised they are offered a further appointment to review the specific issues.

Waiting time information - (from June 2006) through the service revisions introduced and planned, clearer and regular statements of service waiting times can be provided to PCT and patients. With the multitude of waiting lists and varying pathways it was

almost impossible to provide a waiting time measure for the service. The amalgamation of lists combined with the capacity assessment and changes to service delivery has allowed the Trusts to share with the PCT a clear performance report, detailing patient issues, service demands, implications for the waiting list numbers and based upon average capacity an assessment of wait times for any patient added to the list at a point in time.

Patient information leaflets – in association with the PCT the patient information leaflet for digital hearing aids was updated to reflect the service changes and introduced in July 2006. This was developed in association with patient groups, including Hi Kent and is sent to all patients as part of their appointment process.

The combination of the above measures has brought the EKHT Audiology service from a 'backroom' service to being at the forefront of service improvements within East Kent. A number of the initiatives taken have been used within the national service improvements and the achievements have been warmly supported by the Chief Scientific Officer and even more so by local patients who can now access a much improved service.

### ***How soon fitting of hearing aids is occurring after diagnostic testing?***

In 2006 in agreement with the PCT on equity of service provision, the EKHT Audiology department adopted a single waiting list for routine hearing aid patients, irrespective of the patient's referral pathway. Patients have then been managed in a strict chronological order, providing the fitting service to the longest waiters other than those identified as a clinical priority who are seen in order within the priority list. Thus waiting times from diagnostic testing vary according to the patient pathway. Patients referred to the ENT service have an audiogram at the time of the ENT clinic appointment usually within 5 weeks of initial referral and if listed for a hearing aid then wait until the aid fitting appointment. Patients referred directly to the Audiology department by GPs for a hearing aid are added straight to the waiting list and then have their diagnostic test as part of the aid fitting appointments. In the latter case, the previous model of care was to do a diagnostic test following GP referral but given the overall waiting times (over 100 weeks) it was agreed with the PCT that this service capacity be converted to aid fitting appointments, as the diagnostics were often duplicated once the patient got to the aid appointment stage.

With waiting times now reducing significantly, the Audiology department plans to develop more one stop clinics, both for ENT and GP referred patients, whereby the diagnostic assessment and aid fitting are undertaken on the same appointment, subject to individual patient circumstances.

At the end of November, using the old measures the maximum waiting time for a patient added to the hearing aid list at 30 November would be 40 weeks. This compares with a max wait of 96 weeks in June 2007. Patients are now advised that anyone added to the waiting list before the end of November will be treated before the end of March 2008. Any added to the list from 1 December will be treated within 18 weeks.

Maidstone and Tunbridge Wells NHS Trust

December 05/12/2007

Transforming Adult Hearing Services for Patients with Hearing Difficulty

Audiology Departmental Action taken to date to deliver safe, effective and responsive Services and to make a maximum wait of 18 weeks from referral to treatment possible for all Audiology referrals:

- Joint Audiologist/Audiology Technical Officer clinical sessions for new GP direct referrals and reassess (upgrade from analogue to digital signal processing hearing aid) patients.
- Group Hearing aid fitting sessions, these have reduced the additional hidden waiting times for patients on both sites EEMU and K/S to within the 18 week target.
- One stop shop exchange (Analogue to DSP conversions) when patients have a serviceable ear mould.
- All ENT Clinic referrals that have a current Audiogram are now streamed to an ATO for an ear impression and GHAB profile so that they can then have their Hearing Aid fitted within the 18week target.
- A hearing aid benefit questionnaire given to patients at the time of the hearing aid fitting which enables them to ascertain whether they need to return to the Department for further follow-up or fine tuning if they are not managing the instrument or not able to hear in all situations.
- PPPI with Clinicentre has been negotiated to clear all of the patients from the waiting lists from both sites that have been waiting longer than 18 weeks, 1200 in total.
- One Stop Shop instant fit Life tip hearing aid fittings.
- Ear impression scanning for a quicker turnaround time for the manufacture of patients earmoulds.
- GP standard referral form which includes Audiology/ENT history, general health, and past/current medication history.
- Extended hours of operation starting at 8.00am and using increased Staff flexibility are currently in operation.
- Strict management of DNA appointments and cancellations.
- Joint Microsuction (Wax removal sessions by Nurse Practitioner) New referral and Reassess appointments.
- Efficient use of the PN patient management system for fittings, recording stock levels and ordering earmoulds.

The above are the main steps that have been taken to deliver the new service model so far

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Written Evidence from **Medway NHS Trust** in response to questions on Audiology for the NHS Overview and Scrutiny Committee on Friday 14 December 2007

## **Part 1**

### **Transforming Adult Hearing Services for Patients with Hearing Difficulty**

#### **A Good Practice Guide by the Department of Health**

**What are Medway doing to implement the approach recommended by the above document?**

#### **Systems and Processes:-**

Understanding the scale of the challenge locally:-

The Audiology Department reports its monthly data and bi monthly census returns to both its commissioners and the Department of Health. We are able to report on and maintain data sets with the use of Auditbase. We can track type of referral, source, referral date, appointment dates and attendance and have specific waiting lists paired to the work we carry out. Using this data we have been able to look at service redesign and capacity planning. We have also been able to monitor fluctuations in demand and capacity over periods of time. This enabled us to continue our hearing aid work without utilising the independent sector to provide extra capacity. This has thus far shown to be successful considering the reduction in waiting times for patients to be fitted and our confidence in attaining next year's targets.

Improving and consistently applying referral criteria:-

Although there is a move forward to improve referral criteria at a Primary Care level, we have a robust system for Direct Referrals in place at present. All GP surgeries have been issued with a specific form from us that must be used in order to make a referral. Each form contains a list of criteria which must be met before a patient can be accepted directly in to the Audiology Department rather than via an ENT clinic. We look at age, presence of wax, infections, perforations, otalgia, vertigo, unilateral tinnitus, previous operations and gradual and equal deterioration in both ears. If the GP is unable to tick all the boxes on the form, the referral must be directed to ENT for further investigation and the ruling out of other ear pathologies. The suggested referral management (Fig 4) of the document reflects our current practice. For those patients who have 'slight difficulty with hearing and/or unwillingness to have an aid' they can access the Hearing Therapy service for counselling and information as can those patients who have tinnitus or have been admitted to A&E for sudden hearing loss.

Waiting list management and better scheduling:-

Medway NHS Trust has employed a dedicated Audiology Co-ordinator to take care of scheduling and management of the waiting lists. This has been an invaluable appointment as it has allowed us to redefine our service. We have refined waiting lists and completed a validation exercise to maintain the accuracy of our data, thus improving capacity and problems with DNA's. We have also been able to introduce flexible working hours for staff so that service provision runs from 8:00 am to 6:00 pm

five days a week. Patients have found this enormously beneficial as appointments can be made out of working hours and lessened the necessity for regularly taking children out of school. Weekend clinics can also be scheduled when the demand arises.

Booked ENT clinics have been introduced to avoid Audiologists spending long periods of inaction whilst waiting for hearing test requests from a Consultant on clinic. By seeing patients on a separate occasion prior to their ENT appointment, we are able to utilise our time better to book more waiting list patients whilst the ENT clinic is taking place. We can also begin the journey of fitting a hearing aid at an earlier stage of the care pathway. The Department of Health have recognised the role we have played in the introduction of this service.

Drop in hearing aid repair sessions have been replaced with booked slots which has also improved capacity and the utilisation of the staff.

#### **Adopting Lean Processes:-**

Some of the lean solutions mentioned in Figure 6 of the document have been discussed in the previous paragraph. Group hearing aid fittings have been an enormous success within the department and have been invaluable in reducing waiting times. Patient response has been excellent and we continue to provide group fittings for both new and conversion patients.

Although our Audiologists do not remove earwax themselves, (there has always been an ongoing debate about the introduction of this as part of an audiological role as it is an invasive procedure) we have a wax clinic supported by a Specialist Nurse Practitioner on a weekly basis at Medway Hospital. This role is under review for extension to other hospital sites.

#### **Technology:-**

##### **Digital Hearing Aids:-**

Medway NHS Trust have been issuing digital hearing aids since 2004 when we came on to the Modernisation Project as a third wave. All new patients are fitted digitally and we are working through the remaining conversion patients with a view to having them all transferred on to digital by March 2008 using the Trust's step down plan.

We work extremely closely with Siemens, our contractual provider of Prisma hearing aids. A company representative, Geoff Whitby, visits the department on a monthly basis to keep us updated as the hearing aid technology changes. He provides staff training with regard to software and the introduction of new aids and advises us on any product difficulties we, or indeed the patients may be experiencing. Patient response and feedback has led to the company making changes and improvements to hearing aid models and we see that as a very important partnership to ensure the standards of care are kept as high as possible.

##### **Universal Open Ear Tip Technology:-**

Audit with regard to the above has been carried out within the department. Open ear tips or 'life tips' have been used successfully within the appropriate fitting range of

patients and has enabled 'assess and fit' appointments to be carried out for both our new and conversion patients. However, we are still auditing the 'life span' of an open fitting for future budgetary projections as there seems to be little research on the subject. We are still able to do 'assess and fit' appointments with some conversion patients using their existing ear moulds, particularly if the mould is relatively new and the hearing has not changed to any great extent on assessment.

#### **Triage Equipment:-**

At present there are no local Primary Care practices using this screening test device and I am unaware of its' general availability. However, the initial trial in Stockport showed very promising results and we would gladly take part in discussions with our colleagues in Primary Care as to it's usage in this area to improve appointment allocation for our patients.

#### **Automated Audiometry:-**

Automated Audiometry is also still to be developed further before trialling in this country, but again we would be happy to liaise with our colleagues over its' introduction.

#### **Workforce:-**

##### **New roles and expanded roles:-**

I have already mentioned the introduction of the Audiology Co-ordinator and this appointment has enabled the Audiologists to focus on clinical rather than administrative roles. The existing Audiology Department has an excellent skill mix spanning the previous MTO grades. This enables us to provide more specialist services to patients in conjunction with the 'bread and butter' work of screening and fitting hearing aids. Amongst these are paediatric ABR screening, vestibular testing, Central Auditory Processing Disorder testing (child and adult), Tinnitus and Hyperacusis assessment and management and Bone Anchored Hearing Aid Assessment and provision.

Two of our Assistant Audiologists are currently on a newly available Foundation Course which will provide a pathway to the Audiological Degree training recently introduced. We have housed students from Southampton University for the past three years and currently have three on placement. A training co-ordinator within the department ensures that everyone's training is kept up to date and staff are actively encouraged to attend external training courses to retain and expand their skills for the benefit of our patients.

#### **Commissioning:-**

Historically Medway NHS Trust has had an excellent relationship with its' Commissioners and we will continue to work in close union to face the new and exciting challenges ahead. The document has certainly highlighted the improvements that could be made at both a Primary and Secondary Care level and I am sure that we will engage with our Commissioners to continually review the service and implement new working practices to ensure our patients receive the best and highest standard of care. We will certainly be looking at the introduction of initial screening

within a Primary Care setting and also the review process of patients in the system. Patient management systems in place within Audiology are unable to provide the required data in their present format.

Having studied the document I feel that Medway NHS Trust Audiology Department are already meeting many of the recommendations made, however, we are a team that will continue to strive to improve all facets of our service provision to the patients under our care.

## **Part 2**

### **Are patients from Dartford and Gravesham all being treated at Darent Valley Hospital or are some obliged to travel to Medway Hospital for group fitting of their hearing aids?**

Some patients from Dartford and Gravesham are given the option to travel to Medway for a group hearing aid fitting. Initial screening will determine whether the patient is suitable for a group (e.g. looking at age, ability, dexterity, hearing levels and mental health). If this is not the case, the patient will be offered a one to one appointment at Darent Hospital.

Medway Hospital is used for group fitting as we have the optimum capacity available to us in the Audiology/ENT waiting room. The majority of patients have been happy to travel to us and we are seeing this as a growing trend with the advent of the 'Choose and Book' system.

### **How soon fitting of hearing aids is occurring after diagnostic testing?**

At present we are fitting approximately 6 weeks after testing. However, it should be noted that things such as wax, infection, and referral back to ENT to rule out ear pathology can prevent us from taking aural impressions and will therefore add time to the above.

**Darent Valley Patient and Public Involvement Forum** – response to questions posed by NHS Overview and Scrutiny Committee in request for written evidence on 26<sup>th</sup> November 2007

### **Audiology**

**1. Do you think that the level of service provision in Kent and Medway (in particular at Darent Valley Hospital) is now sufficient to meet the level of unmet need for audiology services and deal with unacceptably long waiting times?**

Response:-

Basically, no. The staff at Medway must be congratulated for their extreme efforts to reduce the embarrassingly long waiting times both at Medway and Darent Valley. However, provision of a hearing aid does not constitute a complete audiology service.

The requirements for a good audiology service are clearly defined in “best practice standards for adult audiology” published jointly by the RNID and the DoH in 2002 (see chapters 3 page 23 and chapter 6 page 45).

Hospital trusts which do have a good audiology service have carried out an audit against these standards before the introduction of the MHAS programme. No Kent audiology department has done this in a formal manner (CF Manchester).

In our opinion, an outreach clinic arrangement in unacceptable facilities, as at Darent Valley, is totally unsuitable for a catchment area of 300,000.

Provision of a hearing aid is not the finite end-point for a patient with a hearing loss. There is a need for a re-examination of the patient’s hearing at least every three years as the hearing loss increases with age. There could be a need to re-tune the aid after this time or even provide a higher powered aid. Patients should therefore remain on the waiting list. They should be recalled and not be expected to request referral from their GP.

All aspects of the “service” should be provided from one source. At present, patients from Darent Valley are required to attend Medway to obtain their hearing aids at group sessions.

**2. Do you think that the terms of the contract for additional provision from “Clinicenta” are acceptable as regards the following issues:-**

- Quality-repair and maintenance of hearing aids;

Yes

- Onward referral of cases requiring specialist provision;

Yes, also fully covered in the selection of patients for “Clinicenta”.

- Follow-up care for patients with complex needs;

Yes, complex cases should not have been selected for “Clinicenta”.

- Continuity of care;

As defined in the “Clinicenta” clinical specification this is excellent. There is provision for patient review 8 to 12 weeks after an aid has been fitted and also a patient feedback system is in operation.

There is provision for automatic recall of patients after three years for re-testing. Kent NHS audiology departments do not allow for this but expect patients to self refer via their GP.

- Clinical governance;

Excellent on paper, unable to compare with equivalent NHS documents from Kent audiology departments (do they exist?). Provision for patient feedback

- Sharing of patient records;

No problem anticipated. “Clinicenta” expect to provide patients with a copy of their audiogram at the time of the test. Medway will only do this on receipt of a written request.

- Patient selection (whether this be done through patient choice; whether those on waiting lists will be seen first)

Providing patients are selected from waiting lists by PCT/NHS trusts there should be no problem. Once the initial check has been made by “Clinicenta” further visits to them will be at the patient’s request as per their follow-up procedure. This should not be via the PCT/NHS trust.

Once patients know about “Clinicenta” many would choose them if offered a choice (certainly from the D, G & S area).

- Staffing and “additionality” (given concerns around possible “poaching” of staff from NHS services)

This already occurs with private hearing aid companies. In theory there is said now to be no shortage of audiologists, only the funding to employ them in the NHS (CF Maidstone/Tunbridge Wells).

As far as the patient is concerned they require a good overall service staffed by professionals whoever provides it.

## **NHS Audiology Services 2006**

### **Basic causes of current problems in some areas**

1. Issue of “best practice standards for adult audiology” in 2002, by the department of health, but failure to ensure that they were instituted or even read.
2. Failure to identify the numbers of patients expected to require digital hearing aids or even set up a data collection system for that purpose.
3. Failure to adequately fund the MHAS programme. Funding not related to catchment area size.
4. Failure to monitor performance of audiology departments by the healthcare commission either in star rating programme or in current annual healthcheck.
5. Failure to review management of audiology departments and relationship with ENT, as identified in “audiology in crisis” published by the RNID in 2001.
6. Total indifference to “post-code lottery” situation by a succession of health ministers.
7. Too great a concentration on digital hearing aids for new patients by RNID and the department of health.
8. Introduction of a telephone hearing test by the RNID, without discussion with NHS audiologists, which greatly exacerbates existing capacity problems.

John Beadle  
PPI forum representative



## NHS Overview and Scrutiny Committee Dentistry Briefing Note

### Background

Ever since the inception of the National Health Service in 1948, General Dental Practitioners (GDPs – “High Street” or “Family” dentists, providing primary-care NHS dental services) have been independent contractors, working for themselves (alone or in partnership), for another dentist or for one of a few small corporate dental chains.

As such, GDPs have always been free to provide as much, or as little, private dentistry as they wish, alongside their NHS commitment. And they have always had to pay for their own premises, staff, equipment and materials out of their practice incomes (NHS and private). Dentists working in the NHS do, though, receive NHS pensions.

From 1948 until the introduction of the 2006 dental contract, an NHS dental contract was available to any dentist who wanted one (subject to some minor checks on entry to an NHS list); and dentists were free to provide NHS dentistry wherever they wished to.

Also until the introduction of the 2006 contract, remuneration for NHS dentists was based mainly on a “fee per item of service” system – i.e. dentists were paid a “piece-rate” for each individual treatment they carried out, with specified fees for each type of treatment (fillings, crowns, bridges, dentures, etc.). This method of remuneration was introduced in order to give dentists an incentive to tackle the large amount of pent-up unmet need for treatment that existed in 1948. Subsequently, however, the “fee per item” system came to be criticised for:

- giving a potential incentive to “over-treatment” (encouraging dentists to err on the side of “drilling and filling”, going against trends in clinical best practice);
- leading to an emphasis on the speed of treatment, rather than quality; and
- failing to encourage a preventive approach (since dentists were not paid to spend time with patients explaining how they could maintain their dental health).

There has always been (and continues to be) universal entitlement to NHS dental treatment – i.e. anyone who needs it is entitled to access it.

For the first three years of the NHS, dentistry was available to NHS patients free at the point of use. However, patient charges were agreed in 1951 and introduced in the following year (primarily as a means of limiting demand). They have remained ever since, in one form or another. The following are exempt from paying charges:

- children and young people aged under 18;
- young people aged 18 in full-time education;
- women who are pregnant and those who have given birth in the last 12 months;
- people on benefits/a low income (as defined).

In 1990, a new General Dental Services (GDS) contract was implemented, introducing registration of dental patients. The fees set for 1991–2 underestimated the number of patients that would register and this led to a substantial overspend in the NHS dental budget. This was followed in 1992–3 by a 7% cut in the fees paid to dentists, in order to bring spending on NHS dentistry in line with government targets. This fee cut led to much resentment, and mistrust of the Department of Health (DoH), among dentists.

Subsequently, dentists felt themselves to be chronically underpaid for NHS practice, meaning that they had to work on a “treadmill”, spending less and less time with NHS patients in order to ensure sufficient throughput to maintain their income and cover their practice expenses. In consequence, over time significant numbers of dentists changed the balance of their practices substantially (or entirely) away from the NHS and towards private practice. This led to a chronic shortage of access to NHS dentistry in many parts of the country.

Dentists have always maintained that they do not gain much in the way of overall income by going private – rather, they gain the ability to work in a less pressured environment, spending more time with each patient.

Many dentists restricted their NHS practice to children and to adults exempt from paying charges; in some cases, dentists stipulated that they would only see children as NHS patients if their parents attended the practice as private patients (on the grounds that private patients were effectively subsidising NHS patients).

In 1999, the Prime Minister indicated that within two years anyone who wanted to see an NHS dentist would be able to do so. However, the access problem persisted.

The perception that NHS dentistry was chronically underfunded was reinforced by a National Audit Office report in November 2004. This found that, since 1990–1, NHS spending on GDS had increased by 9% – compared with a 75% increase in overall NHS spending per head of population over the same period.

New ways of providing NHS dentistry were piloted through the Personal Dental Services (PDS) and “Options for Change” schemes – including Dental Access Centres for unregistered patients.

### **The new dental contract (2006)**

Subsequently, the passing of the Health and Social Care Act 2003 laid the basis for a radical reorganisation of NHS dentistry, the central aspect of this being a new contract for GPs, which took effect on 1 April 2006.

This means that, for the first time, Primary Care Trusts (PCTs) are responsible for contracting locally with dentists to provide services, as part of PCTs’ “commissioning” role. And remuneration of dentists is no longer based on the “item of service” principle – dentists are now paid per *course* of treatment provided; and they are required to hit a target, based on weighting courses of treatment according to a simple measure of complexity and expressed in “Units of Dental Activity”.

At the same time, the old complex system of patient charges has been replaced by simple charge-bands covering courses of treatment – priced as follows from 1 April 2007:

- Band 1: Diagnosis, treatment planning and maintenance – also urgent and Out of Hours treatment (£15.90)
- Band 2: Diagnosis, etc. *and* simple treatment (£43.60)
- Band 3: Diagnosis, etc. *and* simple treatment *and/or* complex treatment/provision of appliances (£194.00)

Any further treatment required at the same charge-level within two months is free of charge. Replacements for lost or damaged appliances are subject to a charge of £58.20 (30% of the Band 3 charge).

This new patient-charge regime means that the maximum patient charge for a course of treatment is now £194.00 (under the old system the upper limit was £384.00). A simple check-up, with no further treatment, is now substantially dearer (at £15.90) than the £5.84 that it cost under the old patient-charge regime – although a check-up often includes x-rays and scaling, for which additional charges were payable under the old regime.

Under the new arrangements, patients are no longer able to register with a dentist in order to obtain treatment; but a dentist is only required to provide as many courses of treatment as are required to reach the target number of Units of Dental Activity stipulated in his or her contract.

Out of Hours services are no longer provided under the standard dental contract, and PCTs have to commission these through separate Out of Hours contracts with service providers.

For specialist practices (such as those providing orthodontics), a new PDS contract exists, which is broadly the same as the new GDS contract (with remuneration for orthodontists being based on “Units of Orthodontic Activity”).

Dentists are still permitted to see only children and charge-exempt adults on the NHS; but they cannot stipulate that the parents of children seen on the NHS must attend the practice as private patients.

The new contract was available to all dentists who were already practising within the NHS, provided they signed up before 1 April 2006. Dentists who signed before that date were also guaranteed the same yearly gross fees as they earned during a 12-month “reference period” (2004–5) for the next three years for providing broadly the same amount of work. PCT dental allocations are ring-fenced during that time.

At the end of this initial three-year transitional period, PCTs will assume full responsibility for commissioning dental services in their area, using money from a (now non-ring-fenced) budget for this purpose. The intention is that PCTs will structure services according to local need, directing dentists towards areas where access problems exist, as part of their commissioning function. PCTs are currently limited in their ability to do this, due to the transitional protections for dentists who took up the new contract before 1 April 2006.

## Issues around the new contract

When the new contract was introduced, the DoH argued that it would free dentists from the “treadmill” style of working associated with the “fee per item” system and encourage a more preventive approach.

However, dentists’ representatives argued that remuneration through Units of Dental Activity was merely another form of “treadmill”, since it was a target-driven system.

The overwhelming majority of NHS dentists did sign the new contract, although a significant minority did not (1,050 contracts – around 10% – were rejected), thereby withdrawing from the NHS.

Despite this, the DoH insists that the vast bulk of routine NHS dental provision has been secured through the new contract, with service levels, measured in Units of Dental Activity, being successfully maintained. Those dentists refusing contracts were mostly those who had been providing only minimal NHS services; between them they only accounted for 4% of NHS dental provision. The DoH states that PCTs have made good any shortfall in provision through other dentists expanding their NHS commitment and through the commissioning of new services.

A substantial number of dentists signed contracts on an “in dispute” basis. The DoH argued that this would not constitute a significant impediment to service provision – the dentists concerned were merely showing that they were opposed in principle to the new contract.

In August 2007 the DoH published *NHS Dental Reforms: One year on*, in which it stated that:

- the new contract had successfully removed incentives to undertake more complex and invasive treatment than necessary (“over-treatment”) and was encouraging a more preventive approach;
- new dental services had been successfully commissioned – with more NHS dentistry now being provided than in the last year of the old contract;
- there was no shortage of dentists willing to work under the new contract;
- access had stabilised and PCTs were now able to begin building on this more secure basis, identifying local need and commissioning new services appropriately;
- progress had been made in resolving disputed contracts – with over 99% of disputes ending with the dentist deciding to stay in the NHS;
- shortfalls in patient charge revenue (which accounts for about a quarter of PCTs’ primary-care dentistry budgets) were not a major or permanent problem – and interim additional funding would be provided in 2007–8 to help ease the situation.

Despite the DoH’s optimism regarding access to NHS dentistry, there remains a widespread perception that this has not improved since the introduction of the new contract – and may actually have worsened. Recent reports by the Citizens Advice Bureau, *Which?* and the Commission for Patient and Public Involvement in Health have all documented significant continuing problems with access.

Recent government statistics show that 27.89 million people received NHS dental treatment in the two years to June 2007, compared with 28.15 million in the two years running up to the new contract. Critics of the government have argued that the gap of 266,000 is attributable to the new contract. The DoH maintains that provision has remained stable under the contract.

Dentists' representatives have argued as follows:

- The new contract is an obstacle to resolving the access issue. It is so unpopular with dentists that it makes them less likely to work in the NHS. There is still a danger of a mass exodus of dentists from the NHS once the initial guaranteed income period ends in 2009.
- The government's own figures show that 48% of NHS dentists achieved less than 96% of their agreed UDA target during 2006–7. Falling below this threshold puts them at risk of having contract payments “clawed back” by PCTs if agreement cannot be reached about making up the shortfall in 2007–8.
- Government figures show that the shortfall in patient charge revenue in 2006–7 was some 25% (£159 million). Some PCTs are reportedly responding by requiring dentists to take more charge-paying patients (who will tend to have less need for treatment than charge-exempt patients) as a condition of receiving NHS capital funding for premises and equipment.
- Under the new contract, dentists are more likely to “under-treat” – i.e. fail to provide complex (and costly) treatment, even if it is clinically necessary. (While there is some emerging evidence to support this, it is still too soon to say what long-term treatment patterns are.)
- The new contract tends to undermine continuity of care and does not encourage a preventive approach. The end of patient registration indicates a move towards episodic care, mainly orientated towards relief of immediate pain. And pressure to meet targets means dentists cannot spend time with patients discussing their oral health.
- PCTs' ability to determine local need and commission accordingly is weakened by: the precarious position of dental public health (with PCTs raiding public-health budgets as part of attempts to balance their books); and PCTs' inability to commission creatively, due to a lack of support from the DoH.
- It is feared that, once ring-fencing of dental budgets ends in 2009, they could likewise be raided by PCTs, damaging the provision of dental services.

David Turner  
NHS Research Officer



**Response to written questions regarding dentistry for NHS Overview and Scrutiny Committee meeting on 14 December 2007**

**Whether they have a clear and reliable picture of the extent of unmet need for NHS dentistry and where that need is to be found; and what data sources they are using for this purpose.**

The current picture of unmet need has been identified using information from PALS regarding the number and type of enquiry from the public, as well as mapping the dental practices and provision across the PCT, our first priority is to ensure all geographical areas have access to NHS provision in particular those towns & Cities where people may wish to access a dentist near to their place of work/school. As a result of this first assessment, the PCT has increased provision in Swale, Canterbury, Ashford, Margate and Folkestone areas, we plan to undertake a full needs assessment utilizing the skills of Dental Public Health practitioners in order to plot trends, identify populations with unmet need and match this to provision.

**What steps the PCTs are taking to ensure services are provided that address unmet need.**

A scoping exercise has been undertaken and as a result extra investment has been made, e.g. £500,000 for orthodontics and £400,000 for general dentistry in this financial year.

**Whether the current General Dental Services contract is sufficiently attractive to dentists to allow commissioning of adequate levels of provision in all areas – or whether dentists still feel they are having to work "on a treadmill" because of the target-driven nature of the contract (based on Units of Dental Activity).**

It is difficult to tell currently as patient choice in dentistry is not just about where you live but also where you go to work/school, we have dentists wishing to do more activity in those areas the PCT consider as areas of need, dentists are not experiencing difficulties in recruiting. The target driven contract is a very different way of working for dentists and is in line with all other contractors.

**Whether salaried GDS, or Personal Dental Services, provision has been considered as a possible means of commissioning NHS dental services for underserved communities.**

All types of contracts are considered by the PCT when commissioning all services, the PCT currently holds contracts for PDS and many contractors employed salaried dentists

**To what extent they have experienced shortfalls in expected patient-charge revenue and whether this is affecting their ability to provide adequate dental services.**

PCR shortfall was anticipated and the PCT has made allowances this will be an on going process as PCR estimate will be dependant upon the type of patients attending dentists, there may well be a variation year on year. This is not preventing the PCT from providing adequate dental services as allowances were made, and this will be an on going process.

**Whether, if they have experienced shortfalls in patient-charge revenue, the investment of additional funds (£30m nationally) by the Department of Health, as a one-off measure to offset shortfalls in 2007-08, is going to resolve the problem.**

The PCT will continue to plan for any shortfall in PCR as above.

**Whether they have sought, as some PCTs reportedly have, to link capital funding for dentists with a commitment to see more patients who are eligible to pay NHS charges, in order to reduce the risk of a shortfall in patient-charge revenue.**

The contract does not allow contractors to discriminate against groups of patients i.e. patients who are eligible for free treatment under the NHS, this PCT does not link any of the dental funding to commitment to see any particular group of patients.

**Whether they have clawed back contractual payments to dentists failing to achieve the 96% threshold of contracted Units of Dental Activity and, if so, how many dentists this has affected.**

Yes, this process is currently underway, many dentists have been aware of the need to re pay the PCT since the mid year reviews carried out at the end of 06. This process is still on going. The PCT has met with those under performers to decide on a way forward, some will pay back, others agreed to increase their capacity to see more patients during 07/08.

**Whether they can guarantee that dental budgets will not be raided after ring-fencing of those budgets ends in 2009.**

No guarantee can be given however the dental services should be commissioned as far as possible to match the needs of the population.

**What steps they are taking to ensure that dentists: provide more complex treatment where clinically appropriate; spend more time with patients, allowing a more preventive approach to oral health; provide proper continuity of care for patients.**

This will be a part of the contract monitoring process which will include a full breakdown of the types of treatments carried out, the more complex treatments may be commissioned closer to home preventing onward referral where possible.

**Whether they are putting into Dental Public Health the resources necessary to allow the identification of unmet need for dentistry and inequalities in oral health, so that dental services can be properly planned to address those issues.**

We currently have a service agreement with dental public health, there is a resource for dental needs assessment to assist in the commissioning of the service.

Jayne Macdonald  
Head of Primary Care & Community Commissioning  
Eastern & Coastal Kent PCT  
Protea House  
New Bridge, Marine Parade  
Dover CT17 9HQ

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## Commissioning Directorate

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### **Response to written questions regarding dentistry for NHS Overview and Scrutiny Committee meeting on 14 December 2007**

**1. Whether they have a clear and reliable picture of the extent of unmet need for NHS dentistry and where that need is to be found; and what data sources they are using for this purpose.**

On the basis of new NHS dental contract, West Kent PCT commissioned dental services in line with the National contract securing over 80% of all practising NHS dentists in April 2006. This enabled the PCT to secure a high proportion of the historic activity in the PCT area. The majority of these dentists continue to provide services to the community.

The PCT is currently undertaking a needs assessment of its area to fully document the unmet need and to help speed up the tendering process when funding becomes available. Information from the department of Dental Public Health is being used.

**2. What steps the PCTs are taking to ensure services are provided that address unmet need.**

The PCT is developing a commissioning plan supporting this work will be a health needs assessment of the PCT which will identify the key areas in which to develop services.

Currently new contracts are being commissioned as part of the PCTs tendering arrangements for Staplehurst, Tonbridge, Tunbridge Wells, Larkfield and Sevenoaks.

**3. Whether the current General Dental Services contract is sufficiently attractive to dentists to allow commissioning of adequate levels of provision in all areas – or whether dentists still feel they are having to work "on a treadmill" because of the target-driven nature of the contract (based on Units of Dental Activity).**

A dentist or dental practice must have a contract with the PCT in order to provide NHS dental services. Dentists are provided with a guaranteed income for three years for delivering a set amount of activity. The contract sum is based on gross fees and additional payments from 1 October 2004 – 30 September 2005. The activity was based on treatments carried out in the same timeframe and translated into a number of units of dental activity with a 5% reduction.

The PCT is unable to change the nature of the contract but can offer incentives by increasing the £/UDA offered to new providers. The PCT recognises that lower UDA/UDO values do not necessarily provide good value for money.

**4. Whether salaried GDS, or Personal Dental Services, provision has been considered as a possible means of commissioning NHS dental services for underserved communities.**

Dental access centres are provided by Medway primary care salaried services to offer pain relief for patients who did not have a dental practice and did not want to register with a practice. A review of this contract will shortly be underway to compare the service offered against that of an independent dentist.

Part of the dental strategy will include an assessment of the various contracts available for commissioning services.

**5. To what extent they have experienced shortfalls in expected patient-charge revenue and whether this is affecting their ability to provide adequate dental services.**

The amount of funds collected from patient charges has not been as the Department of Health predicted and was £1.7m below forecast. The PCT was cautious in committing all funds due to the unpredictability of patient charges.

**6. Whether, if they have experienced shortfalls in patient-charge revenue, the investment of additional funds (£30m nationally) by the Department of Health, as a one-off measure to offset shortfalls in 2007-8, is going to resolve the problem.**

Any additional monies that the PCT receive nationally would go some way to offsetting the shortfall.

**7. Whether they have sought, as some PCTs reportedly have, to link capital funding for dentists with a commitment to see more patients who are eligible to pay NHS charges, in order to reduce the risk of a shortfall in patient-charge revenue.**

There are no plans to link capital funding with an increased number of fee-paying adults being seen – this would be seen as discriminatory and not in the spirit of the contract.

The PCT plans to recover a proportion of patient charge income shortfalls in 2006/7 by the additional activity contractors are performing this year.

**8. Whether they have clawed back contractual payments to dentists failing to achieve the 96% threshold of contracted Units of Dental Activity and, if so, how many dentists this has affected.**

In 2006/7 46% of our contractors delivered on their contract. In cases where a number of our contractors have failed to deliver at least 96% of the agreed activity levels the PCT did earlier in the year review this with each contractor to highlight its concerns. Where there is under-provision of UDAs/UOAs the national contract stipulate that there is no breach of contract if the under-provision amounts to 4% or less of the total number of UDAs/UOAs required during the financial year and the contractor agrees to provide, and does provide, the shortfall within the time specified by the PCT. This time period cannot be less than 60 days.

Part of the review also identified that there were a number of contractors who had failed to deliver at least 96% of the agreed contract activity. Detailed discussions have taken place with contractors and agreement reached with all 15 contractors

who's underperformance was not less than 90% to undertake the shortfall during 2007/8 (£203,000). In all other cases of performance below 90% the PCT sought recovery of the shortfall by reducing the contractor's payments against the 2007/8 contract period which amounted to £0.6m.

**9. Whether they can guarantee that dental budgets will not be raided after ring-fencing of those budgets ends in 2009.**

The PCT have no plans to change the dental budget allocations in 2009. Part of the work that will underpin the strategy will be about how we commission services longer term.

**10. What steps they are taking to ensure that dentists: provide more complex treatment where clinically appropriate; spend more time with patients, allowing a more preventive approach to oral health; provide proper continuity of care for patients.**

Each month the PCT receives reports from the Dental Services Division which shows what activity each contract has carried out. This is compared to the local and national averages and any significant differences highlighted. This information is used at mid-year review meetings with practices along with any feedback received from patients.

**11. Whether they are putting into Dental Public Health the resources necessary to allow the identification of unmet need for dentistry and inequalities in oral health, so that dental services can be properly planned to address those issues.**

The local Dental Public Health department has a consultant and registrar and is funded by all three PCTs in Kent and we would work with this team in terms of our health needs assessment.

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# Eastern and Coastal Kent

## Patient Public Involvement Forum - Swale Locality Group



Item 7

<b>Report:</b>	<b>Access to NHS Dental Services in the Swale Area</b>
<b>Date:</b>	<b>22 May 2007</b>
<b>Report by:</b>	<b>Iris and Dennis Hawes</b>

### Introduction

The population of Swale overall is 95,000 which is made up of 57,000 in Sittingbourne and 38,000 on the Isle of Sheppey, these figures were obtained from Swale Borough Council. The objective of the survey was to ascertain whether the population of Swale are adequately covered for Dental Services. This was in particular reference to the new dental contract (circa April 2006). It must also be borne in mind that the Swale area, as a whole, is considered to be one of 'fairly high deprivation' and the withdrawal of dental services would have a large impact on those families on low incomes.

Surveys were carried out in Sittingbourne and Sheerness which showed that people were concerned about:

1. Non availability of NHS Service
2. Cost
3. Most considered that the PCT had not funded dentistry sufficiently

Actual percentages will be shown later in the report

### Methodology

The Swale Locality Group decided to do a survey of its own to obtain a clearer picture of people's experiences and together (as far possible) obtain statistical evidence of dental services in the Swale area.

The questions asked in the Swale patient survey were:

1. Do you believe that NHS dental treatment is now more difficult since the new dental contract?
2. Are NHS dental charges too high?
3. NHS medical care is free at point of access, should NHS dental services be the same?
4. Should all dental charges (except cosmetic) be abolished?

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***All correspondence should be addressed via our Forum Support Organisation:***

**Kent & Medway Networks Ltd**

**Office Hours: Monday - Friday 8.30 am - 4.30 pm**

**Unit 24, Folkestone Enterprise Centre, Shearway Road, Folkestone, Kent, CT19 4RH**

**Tel: No: 01303 297050**

**Fax No: 01303 297069**

**Email: janine@kmn-ltd.co.uk**

5. Has your PCT adequately funded dentistry and made provision for out of hours services?
6. Is NHS dentistry under funded?
7. Do you have a NHS dentist?

During conversation with members of the public during the compilation of the survey, it was obvious that they had serious concerns.

## **Results**

The following percentage responses and the statistical graphical representation indicate the concern of those questioned. The percentage responses have been broken down into Sittingbourne and Sheerness.

<b>Sittingbourne</b>	<b>Sheerness</b>	
75.9%	80%	Answered by stating that the NHS dental treatment now is more difficult to obtain since the new dental contract commenced.
67.7%	83.7	Answered by stating NHS charges are too high.
82.8%	96.5%	Answered that dental treatment should be free at point of need.
63.4%	80%	Answered all dental charges except cosmetic should be abolished.
24.7%	16.5%	Thought that the PCT had not adequately funded dentistry or made provision for out of hours dentistry.
71%	66.2%	Thought NHS dentistry is under funded.
47.3%	52.3	a - Said that they had an NHS dentist.
47.3%	46.5%	b - Said that they did not have an NHS dentist.

Therefore, a and b indicate that approximately 5-% of the people did not have an NHS dentist, thus contradicting the findings of replies received from dentists themselves, 36% of whom offered NHS services to exempt patients only.

Of the 22 replies received from dentists in the area, the following results were obtained:

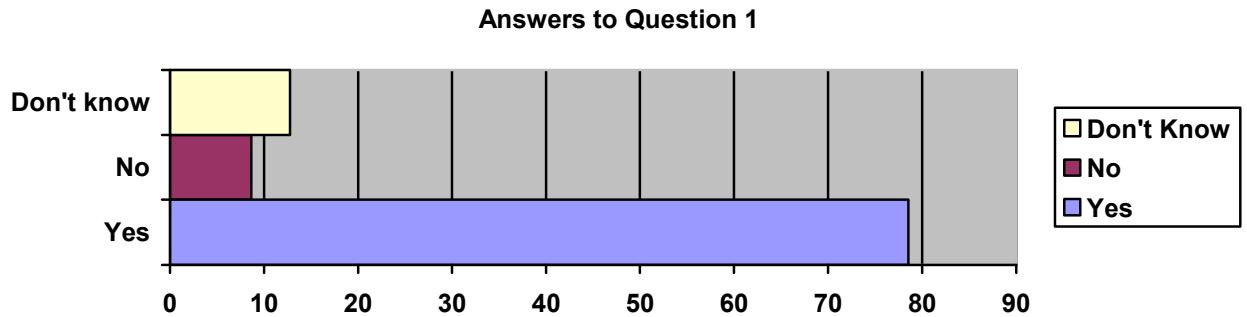
<b>Percentage Reply</b>	<b>Dentists Response</b>
*64	Offered all NHS services
36	Offered NHS services to exempt patients only
100	Offered information re Practice
100	Offered urgent appointments on the day but this was qualified by 'Mostly'.
95	Did not offer home visits
5	Offered home visits
36	Had provision for disabled patients
64	No provision for disabled patients
63	Had no hygienist
34	Had hygienist in Practice but on a private basis only

\*This figure more or less corresponds with the figure obtained from people not having a NHS dentist.

## Completed Surveys

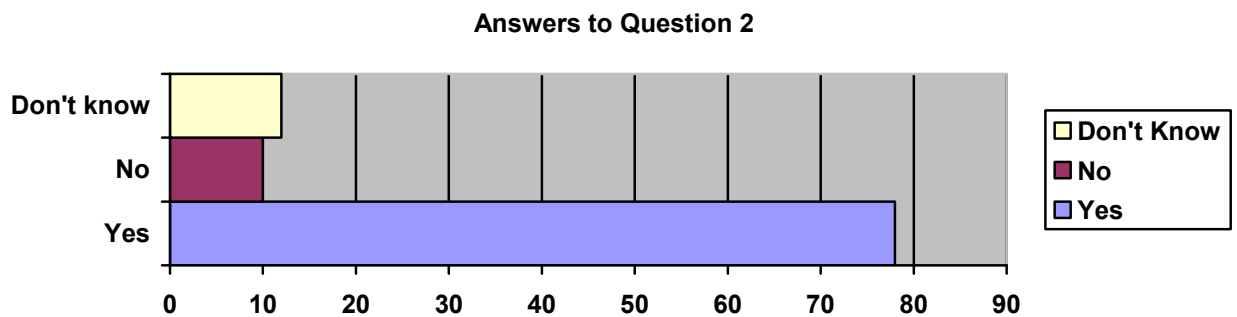
### Question 1

Do you believe that the NHS dental treatment is now more difficult to obtain since the commencement of the new dental contract?



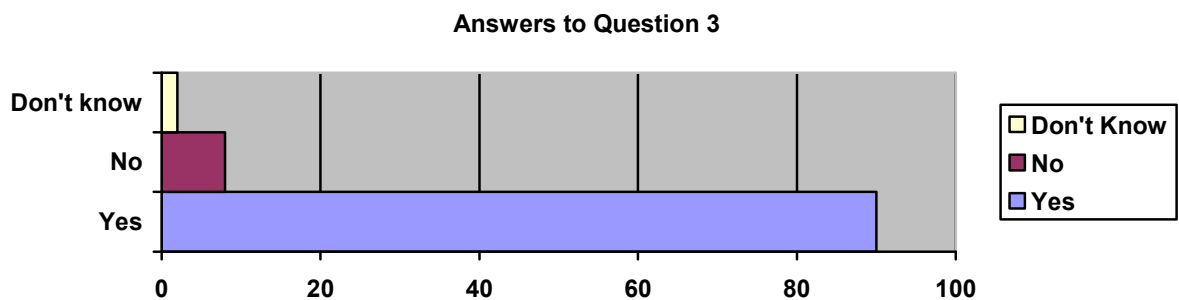
### Question 2

Are NHS dental charges too high?



### Question 3

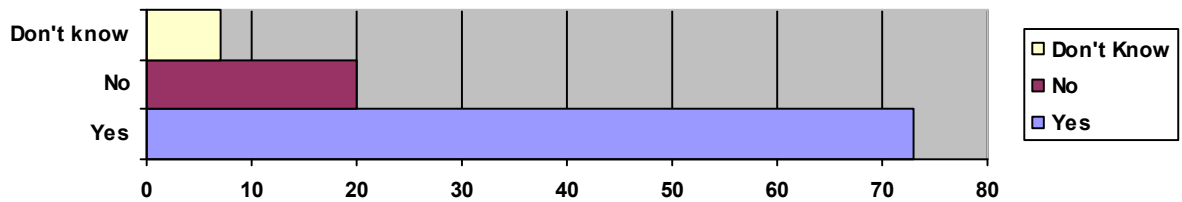
NHS medical care is free at point of access, should NHS dental services be the same?



**Question 4**

Should all dental charges (except cosmetic) be abolished?

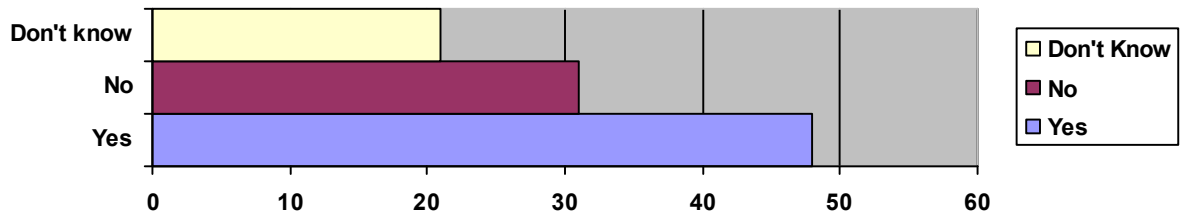
Answers to Question 4



**Question 5**

Has your Primary Care Trust adequately funded dentistry and made a provision for out of hours services?

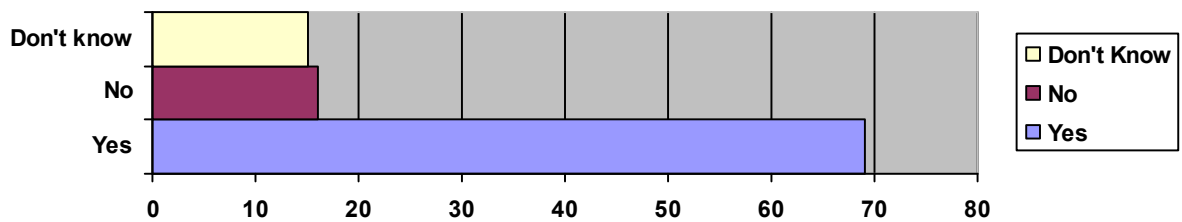
Answers to Question 5



**Question 6**

Is NHS dentistry under funded?

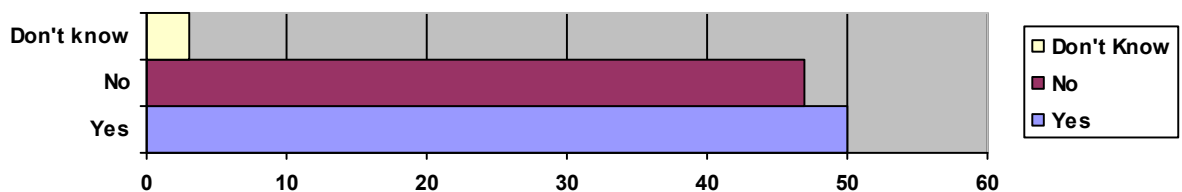
Answers to Question 6



**Question 7**

Do you have an NHS dentist?

Answers to Question 7



Other additional comments indicated that there were no NHS dental places locally and patients had to travel out of town for treatment and those children needing orthodontic treatment had to wait 12 to 18 months for treatment. One response indicated that the person had to go as far as Surrey for emergency treatment re Dentine.

### **School Children Dental Services**

School children should be reviewed regularly via school dental services, until the end of their junior school years. After that they are encouraged to see a dental practitioner, though it was ascertained that this was not always possible due to the lack of NHS dentists in the area.

It has also been ascertained that children with special needs used to be seen at the Memorial Hospital, but under the new contract, they now have to attend the Medway Hospital. This results in parents having to take additional time off work, loss of earnings and travel expenses etc.

It has also been ascertained that should a patient require emergency treatment and go to both Community Hospitals, they have to pay up front regardless of whether they are on benefit or not. If they are on benefit, they are told to pay and claim back the treatment costs. It should also be noted that many people on benefits do not comprehend the claims procedure thereby causing added deprivation.

### **Conclusion**

It has become apparent during this relatively small survey that there is a crisis within the dental services in Swale. There would seem to be a lack of sufficient dentists with many providing only private service, thus ensuring that people on low incomes do not have any access to dental treatment that is needed because of the cost. It would seem from this survey that the concerns shown nationally are more than apparent in Swale.

The neglect in children's oral health is of particular concern. Ensuring good oral health for children would go a long way to ensuring good health for all people, not only in Swale. An added benefit in the long term would be the saving of funds. This opinion is internationally supported by the joint US/AK study carried out which showed that good dental hygiene significantly reduced gum disease and greatly enhanced flexibility in arteries generally, potentially reducing the risk of stroke or heart disease. (The source of this study is Tomato M, D'Aiuto F, Nibali L et al New England J Med. 2007).

### **Recommendations**

1. It would appear from the survey that the people responding to the questionnaire are of the opinion that the Primary Care Trust are not funding dental service requirements and that more funding (which is understood to be available) should be channelled into encouraging dentists to undertake more NHS work as a whole and limiting MHS work to patients who are on benefits.

2. Funding supplied by Central Government should be ring fenced (if they are not already) thus ensuring that the funds are used for what they were intended and not diverted elsewhere.
3. Rose Winterton, Secretary of State for Health, stated in 03/06 (Hansard) "The Department has undertaken a wide ranging review and consultation on modernising salaried, Primary Dental Care Services. We intend to announce shortly how we propose to support the NHS in taking forward the main outcomes of services and consultation". It is to be hoped that this is so and that by encouraging more dentists to be salaried, dental services will be available to all in need.

This survey was written following the side parameters of the survey conducted by the West Cornwall PPI.