HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 26th March, 2010

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 26th March, 2010, at 10.00 am	Ask for:	**Paul Wickenden**
Council Chamber, Sessions House, County Hall, Maidstone	Telephone:	**01622 694486**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (10):	Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr G Cooke, Mr K A Ferrin, MBE, Mr J A Kite, Mr R L H Long, TD, Mr C P Smith, Mr R Tolputt, Mrs J Whittle and Mr A Willicombe
Labour (1):	Mrs E Green
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Cllr Ms A Blackmore, Cllr M Lyons, Cllr Mrs J Perkins and Mrs M Peters

UNRESTRICTED ITEMS

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

Item | Timings

1. Substitutes

2. Declarations of Interests by Members in items on the Agenda for this meeting.

3. Minutes of the meetings held on 5 February and 19 February 2010 (Pages 1 - 18)

4. Dentistry (Pages 19 - 54)

5. Forward Work Programme (Pages 55 - 62)

6. Update on Referral to the Secretary of State for Health (Pages 63 - 72)

7. Date of next programmed meeting – Friday 14 May 2010 at 10.00am

EXEMPT ITEMS

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

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

18 March 2010

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

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 5 February 2010.

PRESENT: Mr B R Cope (Vice-Chairman, in the Chair), Mr G Cooke, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr R L H Long, TD, Mr C P Smith, Mr R Tolputt, Mrs J Whittle, Mr A Willicombe, Cllr Ms A Blackmore, Cllr C Kirby (Substitute for Cllr Mrs J Perkins), Cllr M Lyons, Mr M J Fittock and Mr R Kendall

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

UNRESTRICTED ITEMS

1. Minutes - 27 November 2009
(Item 3)

(1) Mr Wickenden informed the Committee that some Members of the Task and Finish Group looking at the reconfiguration of Women's and Children's services by Maidstone and Tunbridge Wells NHS Trust had visited the new Pembury Hospital. He was aware that other Members of the Committee would also to visit the Hospital and he would contact Mr Douglas to arrange this.

(2) RESOLVED that the minutes of the meeting held on 27 November 2009 are correctly recorded and that they be signed by the Chairman.

2. Dover Healthcare
(Item 4)

Mr Dawson (Head of Development and Public Protection, Dover District Council), Ms Donovan (Planning and Communications Manager, Environment Agency), Ms Harrison (Director of Assurance and Strategic Development, NHS Eastern and Coastal Kent), Mr Ingleton (Head of Regeneration, Dover District Council), Mr Morley (Associate Director of Estates, East Kent Hospitals University NHS Foundation Trust (EKHUFT), Caren Swift, Director of Strategic Development, (EKHUF),and Mr Tutton (LINk) were present for this item.

(1) The Chairman invited Ms Harrison to give the Committee a brief update on progress since this matter was considered at the meeting on 30 October 2009.

(2) Ms Harrison referred to papers circulated with the agenda which showed the outcomes of stakeholder events. These outcomes had been considered by the Primary Care Trust (PCT) Board in November 2009. At this meeting the PCT Board had considered the three original sites, Buckland, Whitfield and mid town and also two further sites, Buckland Hospital and Charlton Green. The Board considered all of

these sites and resolved at this stage to rule out the mid town site, because of flood risk, and the two newer sites as they did not have any significant advantages. The PCT Board requested the business case from East Kent Hospitals University NHS Foundation Trust (EKHUFT) for these two sites before making a decision. Ms Harrison confirmed that the PCT's priority was to deliver the most affordable and rapidly deliverable option. The business case from the EKHUFT was considered at the PCT Board on 27 January 2010 where it was decided to develop a full business case for the Buckland hospital site.

(2) Mr Tolputt asked whether the Buckland Hospital site had adequate land available for expansion, and what impact there would be on services at Buckland Hospital whilst the site was being developed. Mr Morley replied that there was extensive land available at the Buckland Hospital site and that none had been sold to a third party. He explained that the new Hospital would be built on the existing car park and therefore at no point would the development of the site adversely affect services.

(3) Mr G Prosser, MP was invited to speak. He explained that his consistent position was that what Dover wanted was a local community hospital that was deliverable, affordable and which could be developed quickly. He expressed his respect for those in Dover who supported and campaigned for their favourite site option and acknowledged that many of those, including Mr Hansell, had been critical of the mid town site which had been supported by many including Dover District Council and himself. However, the flood issue prevented the use of the mid town site - in time it might have been possible to ameliorate the effects of flooding but not within the timescale necessary for the development of the hospital. He stated that the Buckland Hospital site was in the ownership of the Hospital Trust, there was additional land available on the site, and it did not have an issue with flooding. The issue of using the monies available was still the priority and any further time slippage would put the scheme in jeopardy. Mr Prosser expressed his support, without reservation, to site Dover's new Community Hospital on the Buckland Hospital site.

(4) Mr Hansell was invited to speak. He set out the reasons why he believed that Whitfield was the most suitable site and why he believed that the Buckland Hospital site was unsuitable. These included lack of room for expansion on the Buckland site and inadequate parking. He also stated that the Whitfield site was closer to more areas of deprivation than Buckland Hospital. In conclusion he stated that Dover had been promised a £20m hospital and what was on offer was a £11m clinic.

(5) Councillor Heath (Dover District Council) expressed concern about the access problem for the Buckland Hospital site. He referred to a visit 3 years ago by the Dover District Councils Scrutiny Committee to Buckland Hospital where Councillors had been told that Buckland Hospital was not fit for purpose and that the Mid Town site was preferable. He asked what had changed the Hospital Trusts mind and whether this was this based on financial considerations.

(6) Councillor Lyons stated that the Environment Agency had made it clear that the only place that would not flood was the Buckland site and it was in the ownership of the NHS, whereas the Whitfield would have to be purchased. He expressed concern at the length of time that it had taken to get to this stage.

(7) Ms Harrison explained that the PCT and EKHUFT had been in dialogue about this issue for a long time and she reminded the Committee that it had been decided some time ago to build on the Buckland site. However, at a meeting of this Committee they were asked to reconsider using the mid town site, which had delayed the process. However, the issue of flooding had ruled out the mid town site and therefore the opportunity had been taken to consider all site options again. The most important consideration was ensuring that any site met the health needs of the people of Dover. Therefore, the development of new build on Buckland Hospital car park was the best option. At this meeting health colleagues were looking for an understanding from the Committee so that they could go forward in a timely way as any delay would put the funding for this scheme at risk.

(8) Mr Daley stated that the Committee had listened to the arguments for and against these sites on a number of occasions and had listened to all interested parties, including Mr Hansell and elected representatives at all levels. The key factor for any site was that it must be capable of being delivered now. All sites had issues but the Buckland site was deliverable within the timeframe. There were planning issues in relation to the Whitfield site which could cause delay and lead to the funding being reallocated.

(9) Mr Tutton (Kent LINk) gave details of discussion on the Whitfield site with Planning Officers from Dover District Council that he had attended with Mr Hansell. He expressed the view that public engagement on this issue had been haphazard. The operation of the proposed Community Hospital by the EKHUFT rather than the PCT was confusing for the public. He disputed the statement that the majority of the pubic in Dover were in favour of the mid town site as an on line survey had shown that only 14% of those who responded thought that mid town was the best site. It was important to ensure that the new Hospital would serve the community not only in Dover but also in Deal, Sandwich etc. He also highlighted the difficulty faced by Dover residents in accessing some services such as blood tests.

(10) Mr Dawson set out Dover District Councils' current planning position which was that in terms of planning policy there was no identified site for the new Hospital. In an earlier version of their Core Strategy there was reference to a Community Hospital on the mid town site but this had been removed as it had not been possible to resolve flooding problems at that point. In an attempt to help EKHUFT to resolve this issue Dover District Council had made available all their site information. In a couple of years time the mid town site may be the best site but not within the timescale for this development.

(11) Councillor Kirby acknowledged that the mid town site was not available due to circumstances beyond Dover District Council's control. Therefore, it was necessary to move forward. He asked the PCT to confirm that using the Buckland site would involve a new build and not a refurbishment of the existing building and that there would be adequate parking on site. Also he sought confirmation that the Deal Hospital would be retained to provide facilities to Sandwich, Deal and the rural area to relieve pressure on Buckland.

(12) Ms Donovan explained that the Environment Agency had provided information to the PCT Board to help it to understand the environmental issues for the various sites. She stated that both Buckland and Whitfield had the lowest level of flooding. The Environment Agency believed that the environmental issues for both sites could

be managed and they wanted to assist Dover get its hospital as soon as possible. She referred to a meeting that was due to take place at County Hall later in the day to look at how surface water risk in Dover could be managed

(13) Mr Ferrin stated that he was happy to support the suggestion to use the Buckland site as long as there was adequate parking. He also asked if parking on the Buckland site was going to be free of charge.

(14) In relation to the parking issue, Mr Dawson stated that Dover District Council, as the Planning Authority would require a travel plan and County Council highways staff would get involved at that time.

(15) Mr Morley confirmed that the business case considered at the EKHUFT Board recommended £19m as an outline cost of the scheme for the Buckland site. He confirmed that the Trusts' landholding at Buckland was extensive and the scheme would consolidate development into a single facility on a smaller footprint which would provide the opportunity for adequate parking. A desk top study had been carried out and the risk of contamination on the Buckland had been identified as low.

(16) RESOLVED that the Committee unanimously supports the NHS Eastern and Coastal Kent Primary Care Trust and the East Kent Hospitals University NHS Foundation Trust with moving forward with an affordable and rapidly deliverable facility in Dover.

3. Emergency Care Pathways (Cardiac, Stroke, and Trauma)
(Item 5)

Mr Roche, Medical Director (South East Coast Strategic Health Authority). Ms Evans, Head of Business Planning and Strategy, and Mr Reynolds, Head of Business Development,(South East Coast Ambulance Trust were present for this item.

(1) The Chairman welcomed health colleagues to the meeting and invited them to introduce each of the care pathway areas and to answer questions from Members.

Cardiac

Dr Mishra, Clinical Lead Cardiology and Ms Andrews CBE, Director of Nurses and Director of Infection Prevention and Control, Ms Hiscox - Lead Commissioner Cardiovascular (NHS Eastern and Coastal Kent), Mr Wheat, Director of the Cardiac Network, Ms Stewart, Senior Service Improvement Project Manager (Kent Cardiovascular Network) and Mr Lawson, Patient Representative were present.

(2) Mr Wheat set out the current treatment pathway for a suspected heart attack following a 999 call. He referred to the new treatment which was being rolled out nationally which would reduce admission time for patients.

(3) Dr Mishra stated that the way that heart attacks were treated was changing, nationally 47% of people who had heart attacks had primary angioplasty compared to 6% in Kent it had taken time to get this service developed. It was hoped that by April

2010 Kent would have 100% of heart attack patients going to the Heart Centre and having balloon angioplasty rather than drug therapy.

(4) Mr Daley commended the upward trend in good outcomes and asked if there were plans for angioplasty to be carried out more locally in east Kent.

(5) Mr Wheat explained that over the past 5 years five cardiac catheter laboratories had been opened at various locations across Kent and Medway so that patients could be treated closer to home. The first was at the William Harvey Hospital, Ashford in 2004 and the latest had opened in Maidstone at the end of 2008.

(6) Dr Mishra stated that the reason it had been decided to concentrate on one Heart Centre was the need to have a certain number of patients coming through to maintain the expertise both for the unit and the operators. It had been decided to base this at Ashford as it was the first cardiac catheter laboratory and therefore had a high volume of patients. In future if it was found that there is a high enough demand consideration would be given to locating a second centre in East Kent.

(7) In response to a question from Mr Smith, Mr Wheat explained that whenever he designed a care pathway he argued that decisions regarding where a patient was taken for treatment was for the clinician from the ambulance service who was with patent.

(8) Mr Tolputt asked whether all ambulance staff were now trained in administering thrombotic drugs. Mr Reynolds explained that the care pathway had moved away from using thrombotic drugs and now a paramedic would attend all 999 calls for heart pain, even if they were not the first to attend, and following an ECG would decide if it was a heart attack and deal with it appropriately.

(9) In response to a question from Councillor Blackmore on the comparative length of stay in hospital following treatment, Doctor Mishra explained that currently if a patient was admitted to hospital with a heart attack they were likely to stay seven days (or longer if it was over a weekend), with the new treatment the patient should be able to go home on the third day and after that have their rehabilitation at a local hospital. This saved 3 to 4 overnight stays in expensive beds. She acknowledged that there was a financial as well as a health benefit to this change in practise. In relation to rehabilitation, as patients were spending less time in hospital there was a danger that they would not recognise the seriousness of what had happened to them, therefore part of the rehabilitation was convincing them of this.

(10) In relation to transfer time, from call to balloon angioplasty, Dr Mishra stated that the national prescribed limit was 150 minutes and the Trust were aiming for 120 minutes and were hoping to get below that.

(11) Mr Ferrin expressed the view that there was too much emphasis placed on travel time and that patients would be prepared to go to the hospital that gave them the best chance of a good outcome. Dr Mishra explained that it was only possible to have cardiac intervention at high volume centres and that all of the Trust's cardiac consultants also worked in London. Therefore it was the doctors that were travelling to and from London rather than the patients.

Stroke

Ms Hunt, Director of Nursing and Quality (NHS West Kent), Mr S Duckworth, Stroke Network Director (Kent Cardiovascular Network) and Ms Hiscox - Lead Commissioner Cardiovascular (NHS Eastern and Coastal Kent) were present.

(12) The Chairman invited health colleagues to introduce this item and to take questions from Members.

(13) Ms Hunt gave some background to the service and stated that a couple of years ago the service was poor in patches compared to the rest of England. Rapid improvements had been made over the last 18 months particularly in relation to hyper acute stroke services. Two years ago there were not any acute stroke services in Kent now there were acute stroke services in all hospitals in Kent and Medway and all could provide acute thrombolysis. They had worked with the ambulance trust in relation to response times and acute strokes were now regarded as a medical emergency. It was not possible for ambulance staff to administer thrombolysis, therefore patients needed to get to hospital as soon as possible so that they could be treating with three hours of the symptoms.

(14) Ms Hunt explained that there were currently different approaches to treatment in East and West Kent. In East Kent patients could be taken to any acute hospital for assessment and treatment remotely by a consultant, this was facilitated by telemedicine equipment. In West Kent there was currently a rota with the service always available at one acute hospital at least, ambulances would take patients to this hospital for initial treatment and when they were stable they would be transferred to their local hospital. The Network had recently received an innovation award from the Strategic Health Authority which would enable them to purchase telemedicine equipment for West Kent and Medway so that patients in those areas could also be taken straight to their local acute hospital and would be able stay in the same hospital throughout.

(15) In response to a question from the Mr Kendall, Ms Hunt confirmed that currently clinical outcomes were equally good in East and West Kent. The introduction of the telemedicine equipment in the summer would just provide a logistically better service.

(16) Mr Daley referred to the increase in public awareness of the importance of acting quickly in the case of a stoke for the best outcomes.

(17) Ms Hunt agreed that the public awareness campaign had been very helpful in enabling the public to recognise a stroke and the importance of getting help as quickly as possible. Also if the patient was within the 3 hour timeframe a stroke team would be waiting at Accident and Emergency to receive them and if appropriate arrange for thrombolysis to be administered by either a consultant or a specialist nurse. In East Kent the time from a patient arriving at hospital to treatment being administered had been reduced to 40 minutes.

(18) Mr Duckworth explained that it was not possible to give thrombolysis to all patients who had a stroke, however, even for those patients who could not have it if they got onto a dedicated stroke pathway they would have better outcomes. Therefore, the thrombolysis service improved processes and outcomes for all stroke patients even those were not able to receive this treatment.

(19) Mr Duckworth confirmed that the time of day the stroke occurred made no difference to the outcome and that the current mortality rate was 12%.

(20) Regarding the care pathway for a transient ischaemic attack (TIA), Mr Duckworth explained that people who were regarded as a high risk were seen within 24 hours and were given treatment if necessary. Anyone of a lower risk would be seen within seven days. Two years ago the average waiting time for a TIA appointment was 4 – 5 weeks. Approximately 50% of patients go on to have stroke following a TIA within the first few weeks, therefore waiting weeks for an appointment not appropriate. He highlighted the great progress that had been made in this area.

(21) Mr Roach emphasised the importance of having a comprehensive package for all stroke patients even those who do not have thrombolysis. He also mentioned the advertising campaign which was a national success story. Real progress had been made in this area by colleagues who were passion about the service provide to these patients.

Trauma

Ms Thomas, Director of Service Redesign (NHS West Kent) and Andrew Cole, Head of Commissioning Urgent and Continuing Care (NHS Eastern and Coastal Kent) were also present.

(22) Mr Roche referred to the major trauma report that had today been issued by the National Audit Office. Major trauma was not currently a success story, the UK was just starting to look at major trauma services. In Kent one of the issues was logistics, in 2008 66 people in Kent died in road traffic accidents, and most of these were in the coastal area away from the major road network. Patients with complex trauma need to be rapidly assessed by ambulance crews. Approximately 60% of those with complex trauma had head injuries. Many patients from Kent were taken to King's College Hospital, London. However King's could not accept transfers by air ambulance at night. It was recognised that there was a problem with trauma treatment in Kent and a review had already been commissioned across the Strategic Health Authority area. Trauma Leads had been appointed in Brighton and Kent who would form the basis of a trauma board. The message was that major trauma patients like heart attack patients needed a 24/7 service available with senior staff and urgent access to further services if necessary. He stated that he was determined to come back to the Committee in the future with a success story for trauma.

(23) The Chairman stated that he was encouraged that Mr Roche approached this Committee at this early stage and sought the Committees vies our views as representatives of the layperson.

(24) In relation to a question from Councillor Blackmore seeking clarification on the air ambulance and night flying, Mr Roche explained that only police pilots could fly at night, but another issue was the affect of adverse weather on the air ambulance. Accidents involving major trauma were more likely to occur in poor weather conditions.

(25) Councillor Lyons asked whether there were likely to be a number of dedicated centres in Kent or whether there would be a shared facility with Sussex. Mr Roche

explained that 600 – 700 patients a year were needed to support a fully equipped trauma centre. It was anticipated that Kent would produce less than 100 patients a year and therefore it was very unlikely Kent could host a centre. In Kent the issue was logistics and there was a need to ensure that patients were assessed, any immediate problems resolved and then were able to access good pathways to appropriate care in a timely manner. It was then necessary to repatriate and properly rehabilitate these patients. This needed to be put in place across Kent to ensure the best outcomes for the patient.

(26) In response to a question from Mr Cooke, Mr Roche confirmed that the most significant number of road deaths in Kent occurred outside of the M25 and M20 corridor, along class “A” roads and in the coastal areas. The aim was to provide the best possible service and not disadvantage people because of where they lived or where an accident occurred.

(27) Mr Daley asked whether when Pembury Hospital was open it would be able to deal with aspects of the major trauma services that patients currently had to go to Brighton or London to receive. Mr Roche replied that patients with brain or chest injuries would still need to go to other centres. He stated that Kent was to be congratulated in centralising its heart treatment, which had been done by clinicians working together to provide a service that was best for patients and he was keen that the same principle would drive the reconfiguration of acute trauma.

(28) In response to a question from Mr Lyons, Mr Roache confirmed that the trauma leads would inform him of relevant organisations to seek views from, However, the service would be developed around the benefits to the patients and not any vested interests.

(29) In answer to a question from Mr Kendall, Mr Roache stated that very few cyclists were killed in Kent but that there was evidence from America that the use of helmets reduced injuries for cyclists.

RESOLVED That the Committee supports the developments taking place in emergency care pathways and heath colleagues be thanked for bringing the paper on trauma to this Committee to enable Member to have an input at an early stage.

4. Date of next programmed meeting – Friday 19 February at 9:30
(Item 6)

It was noted that the substantive item for this meeting would be Women’s and Children’s Services in Maidstone and Tunbridge Wells NHS Trust.

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 19 February 2010.

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

IN ATTENDANCE: Mr P D Wickenden (Overview, Scrutiny and Localism Manager) and Ms D Fitch (Assistant Democratic Services Manager (Policy Overview))

UNRESTRICTED ITEMS

5. Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust

(Item 5)

*Ms Luffingham, Deputy Chief Executive, Ms Duffey, Head of Midwifery, Dr Unter, Clinical Lead for, Dr Bolsover, Clinical Lead for Women and Children's Services (Maidstone and Tunbridge Wells NHS Trust), Ms Thomas, Director of Service Redesign (NHS West Kent). Mr Reynolds, Head of Business Development, (South East Coast Ambulance NHS Trust), Mr Fowle, Dr Hart and Mr Pentecost **(**Maidstone Action for Services in Hospital – MASH), Councillor Garland, Leader and Councillor Fran Wilson (Maidstone Borough Council) were present for this item.*

(1) Further to Minute 22/2009 the Chairman invited representatives from the Maidstone and Tunbridge Wells NHS Trust to explain the impact of the plans which were now being implemented for Women's and Children's Services.

(2) Ms Luffingham thanked the Task and Finish Group for carrying out their review. Although this had covered the same points and questions as the previous Joint Select Committee of the Health Overview and Scrutiny Committee (formally know as the NHS Overview and Scrutiny Committee) in December 2004, different members of staff had been involved for the first time and the same outcome had been reached. She supported the view that the changes needed to go ahead for patient care. The Task and Finish Group had visited the new Pembury Hospital and viewed where the new Women's and Children's Department would be located within the hospital. Despite public concern regarding future services at Maidstone Hospital no viable alternative solution(s) to the retention of full maternity services at both Maidstone and Pembury Hospitals had been put forward.

(3) Ms Luffingham stated that she understood the public anxieties around these proposals and the Trust would like to work towards giving the public the same level of re-assurance that they had given the Task and Finish Group. She explained that any

delay in developing the services would be a delay in improving patient care. She wanted a quality and safe service for the 0.5m population.

(4) Dr Bolsover gave some background to the reconfiguration. He explained that Consultants in Maidstone and Tunbridge Wells trust began to express concern about the future of services for women and children about 10 years ago. There was also an awareness of the impact that the introduction of the European Working Time Directive would have on the number of junior doctors required to operate the service. In the past paediatrics at both sites were supported by 3 registrars who worked an on a rota, the Working Time Directive reduced their hours to 42 a week which meant that in order to provide the service, with cover for absence, 8 registrars were required. Ahead of the introduction of the Directive the Trust expanded the number of Registrars from 3 to 8. However, they did not need to increase the number of Consultants so training opportunities did not exist. Over the last year they had attempted to maintain rotas on both sites. However, the best solution was to combine services on one site, this would give enough clinical experience to attract the calibre of staff that the public needed. The situation had got worse with national changes meaning that the number of doctors coming to the UK from overseas had been greatly reduced. It was no longer a question of can we recruit the best doctors but can we find any to recruit. As from the beginning of March 2010 the Trust would have 6 vacant posts out of sixteen (3 at Maidstone and 3.5 at Pembury). These posts were currently being filled by locums who were not familiar with the local environment, working practices etc.

(5) Dr Bolsover confirmed that what was proposed and agreed in 2004/05 was that in-patient services for paediatrics would be concentrated at Pembury Hospital. In order for paediatrics to support obstetrics, it was necessary to move obstetrics to the Pembury Hospital, to support deliveries. He emphasised that all other related services would continue to be provided on both sites including outpatient obstetrics and paediatric care**.** In order to minimise the impact on the local population, access to paediatricians from 10.00am to 10.00pm had been introduced at both hospitals, which could deal with urgent GP referrals and which would provide better care than using Accident and Emergency services. The reconfiguration of services would provide many advantages for obstetrics, for example there would be a consultant providing physical supervision on the delivery suite for a large amount of time. Currently a consultant was only available on for 40 hours a week on each site and on call at other times.

(6) Dr Bolsover stated that a small number of women did not need or want a medicalised birth, the Midwife led birthing unit would enable them to be offered an alternative to a home birth. He made it clear that the midwife led birthing unit was not a replacement for the consultant led unit at Maidstone, the replacement for this was at Pembury Hospital. Dr Bolsover acknowledged that concentrating services in Pembury Hospital would cause significant inconvenience to women in Maidstone who would have to travel a greater distance. The point of going to hospital to have a baby was to have relevant staff there to assist if necessary and this would still be the case at Pembury Hospital.

(7) Dr Bolsover explained that if the changes were not made in 2011, the Trust would have 2 mediocre units which would not be able to attract high calibre staff or training staff. It was his belief that if this happened, both units would wither away over 3 or 4 years which would not be in the best interests of the populations of

Maidstone or Tunbridge Wells. Over the past three years nobody who had opposed the changes had been able to produce a plan showing how services could be sustained in another way. He urged the Committee to support its previous decision.

(8) Ms Duffey expressed her support for everything that Dr Bolsover had said and stated that this service reconfiguration was about quality care. She accepted the concerns that women in Maidstone had about having to travel further but it was about the Trust being able to provide a quality service. The birthing unit would provide an improved choice for women but would not provide a high risk obstetrics service in Maidstone. Currently the midwife service provided a one to one experience, this maternity service provided by the Trust was the only one in the NHS South East Coast area, if a woman had to be moved to another site during labour the midwife went with her.

(9) Ms Duffey express concern about the effect that any delay in moving the obstetrics service to the new hospital would have on staff morale and the impact on recruitment. It would also delay engagement with the public, it was important that women in Maidstone and Tunbridge Wells were clear about the changes and what was on offer. She emphasised that all ante-natal and post-natal services would continue to be provided at both sites. Ms Duffery expressed her view that she was confident that women would be prepared to travel for a quality service.

(10) Dr Unter stated that it was important to understand the link between paediatric and maternity services. Any problems that occurred with a child after it was born were dealt with by middle grade paediatricians. There was a national shortage of these staff. The only way to sustain the service was to bring it together on one site. If this change was not made, he believed having obstetrics unit on two sites was not sustainable. He expressed the view that the current plans would provide a better standard of services for children.

(11) The Chairman then invited Members of the Committee to ask any questions of clarification. These included the following:-

(12) In response to a question from Mrs Stockell about whether the plans were too far developed to be changed, Ms Duffey explained that the decision taken in 2005 involved a huge change to the service and therefore the Trust would have been in dereliction of its duty if it had not been planning for the necessary changes to the workforce and to operational practices.

(13) Mr Cooke referred to the recent inclement weather and asked about the problem of getting to Pembury Hospital from Maidstone. Dr Bolsover acknowledged that the travelling time was an issue. He regularly made the journey between the two sites and most of the time it took him 25 minutes. When the decision was taken to concentrate services on the Pembury and not the Maidstone site, one of the factors taken into account was that everyone would still be half an hour from a consultant led unit. This would not be the case if this unit was sited at Maidstone. Mr Reynolds stated that the ambulance service did their upmost to get patients from one place to another. He pointed out that the number of ambulance transfers from home to the place of birth were minimal as the majority of patients were not transported by ambulance.

(14) Mrs Green asked about whether similar birthing units in other parts of the country, for example Oxford, worked well. Dr Bolsover explained that there were birthing units all over the country including one in Crowborough which had a similar travel time to Pembury as the Maidstone birthing unit. He stated that the trust had always recognised that people living to the north or east of Maidstone could book their births at Medway or Ashford Hospitals as travelling would be easier - it was a matter of patient choice.

(15) Mr Tolputt referred to the shortage of consultant paediatricians and ask if the issue related to the uncertainly around the Maidstone service. Dr Bolsover confirmed that the shortage was in middle grade staff, his personal view as that part of the issue was that these Doctors preferred to base themselves in London so that they could be closer to home. A larger unit would be more attractive to staff as it would provide them with more experience.

(16) Councillor Lynes asked that if there was a delay in occupying the site once it had transferred to the Trust would that mean that the Trust would be funding both the Kent and Sussex and Pembury. Ms Thomas explained that when the business case for the new hospital had been approved, at that point a date for the new building to be handed over to the Trust had been agreed, the Trust would start paying rent on the new hospital it and the sale of the Kent and Sussex site would fund equipment for the new hospital. Should there be a delay in implementing the planed reconfiguration the PFI partners would still hand over the new hospital on the agreed date and the rental would need to be paid by the NHS. Any delay would mean funding the current site and the new site.

(17) Councillor Blackmore asked whether the Trust had been lobbying government regarding the shortage of doctors choosing to specialise in paediatrics. Dr Bolsover stated that the trust had not directly lobbied government but the Royal Colleges of Obstetricians & Gynaecologists and Paediatrics & Child Health had lobbied hard about this issue. As a result the government had put more funding into the service and had increased the number of training opportunities. However, increasing the number of suitable training posts did not alter the number of people suitable to take up these posts. He confirmed that the areas of Paediatrics, Obstetrics, and Gynaecology were the least popular areas for graduates.

(18) Mr Ferrin referred to discussions between KCC and Health Service colleagues regarding the road between Maidstone and Tunbridge Wells which pre-dated the service reconfiguration.

(19) Mr Daley agreed that discussions on the road between Tunbridge Wells and Maidstone had been taking place since 1998 at the time when there were discussions about the two trusts merging. He referred to information given to the Task and Finish Group, including information from MASH which suggested that staff shortages might no longer be an issue as the Secretary of State for Health had stated that there was no shortage of midwives and doctors. Dr Bolsover stated that there was a national problem, in West London three hospitals were looking to do the same as Maidstone and Tunbridge Wells also a unit in Solihull had been closed due to the lack of staff.

(20) Mrs Whittle stated that Department of Health had indicated that the number of registrars had increased by 40%. She also asked for data on the number of beds in Maidstone and Pembury in 2000, 2005 and currently.

(21) Ms Luffingham stated that since 2004 there had been a reduction in the number of maternity beds due to a reduction in the length of stay and she undertook to supply the numbers requested. Ms Duffey explained that the number of delivery beds had not changed since 2004.

(22) Dr Bolsover accepted that the number of registrars had increased by 40% but the European Working Time Directive meant that they needed double the number of registrars. Consultants did not provide hands on immediate care to women in labour, consultants were only on site for 40 hours a week and the majority of the time the senior Doctor was the registrar. Maidstone and Tunbridge Wells did not have enough Doctors in post. He explained that because of the planned changes the Department of Health had given the trust permission not to implement the working time directive.

(23) In response to a question from Mr Willicombe about whether this reconfiguration was about saving money, Ms Luffingham stated that the trust believed that this was about quality of care and that this plan was the only way forward to provide a quality service for patients. Dr Bolsover confirmed that this was about quality not about saving money. When the process started it was about making improvements so that it would be possible to recruit good quality doctors, it was not about being able to sustain the service.

(24) Mr Smith asked how many births were carried out in Maidstone and if the majority were transferred to Pembury would the Trust have sufficient staff in place. Ms Duffey stated that the number of deliveries in 2009 in Pembury was 2645 and in Maidstone was 2425, there would therefore potentially be up to 5000 births in the new hospital and it was anticipated that there would be adequate staff due to the amalgamation. The birthing unit at Maidstone would accommodate between 300 and 500 women a year.

(25) In response to a question from Mrs Stockell, Dr Bolsover stated that locums cost £60 per hour, other areas ran their services using locums but he was concerned about the quality of those staff.

(26) Following a brief adjournment the Chairman invited Councillor Lyons, the Chairman of the Task and Finish Group to present the conclusions and recommendations of the group.

(27) Councillor Lyons stated that the Task and Finish Group had concluded that although they supported the conclusions of the 2004 Joint Select Committee report they recommended that the Committee refer this matter to the Secretary of State for Health in light of local public concern.

(28) Members were invited to ask questions of the Members of the Task and Finish Group.

(29) Mr Ferrin asked where the Group had got their information from about there not being any funding of the Colts Hill improvement until post 2014 as it was his

understanding that there was no prospect of there being any funding for Colts Hill in the foreseeable future. Mr Daley stated that the Group had received evidence from KCC's Head of Planning & Transport Strategy, who had suggested that as this was in the remit of the Regional Transport Board he had no idea when funding would be available. The Group had used the best information available to it.

(30) The Chairman then invited the two representatives from Maidstone Borough Council to address the Committee.

(31) Councillor Garland, Leader of Maidstone Borough Council, stated that he believed that the consultation in 2004 had been flawed and carried out under a discredited Chief Executive. One of the key points that should be taken into account was that Maidstone was a growth area with 11,000 new houses, including 5,000 to 8,000 being built near Maidstone Hospital. Therefore the current population of 150,000 would increase, this compared to a population on 90,000 in Tunbridge Wells. He expressed the view that the trust had taken a flawed decision as they had overlooked the increase in population in Maidstone. He also referred to the Parkwood area of Maidstone which was an area of high teenage pregnancy. He stated that Maidstone Borough Council had been consistent in their opposition to this plan.

(32) Councillor Wilson, who was Vice Chairman of MASH as well as being a Member of Maidstone Borough Council and the Councillor who made the Councillor Call for Action to Maidstone Borough Council, stated that she represented the most deprived ward in the South East of England, a large number of people in that area did not have their own transport and there was a high level of teenage pregnancy. She stated that this matter should be referred to the Secretary of State for Health as local residents did not feel that they had been properly consulted. She referred to the previous Chief Executive of the Trust who had damaged public confidence in the Trust, and therefore a definitive decision was required from the Secretary of State.

(33) The Chairman then invited two representatives from MASH to address the Committee.

(34) Dr Hart, Member of MASH and Honorary Secretary of the Maidstone branch of the British Medical Association, stated that all Maidstone obstetricians and paediatricians with the exception of one, were opposed to the plan. Maidstone consultants and midwives felt unable to be present at this meeting out of loyalty to their employer. The main reason given by the Trust for the closure of the Maidstone obstetrics unit related to staffing. However, he understood from his Members that the three mid-grade post vacancies in Maidstone would be filled by mid March and that there were a number of good calibre candidates for the Consultant vacancies. Maidstone GPs believed that a large number of women would choose to go to Medway or Ashford for their births rather than Pembury, which would mean that Pembury would have fewer complex cases and there would be a loss of income to the Trust. The Maidstone branch of the BMA urged the Committee to refer this mater to the Secretary of State.

(35) Mr Pentecost, who was the first obstetrician appointed to Maidstone Hospital and now retired, stated that he believed it was cruel to expect women in labour to travel the 14 miles to Pembury Hospital. Although the birthing unit was available to women who were low risk, one in ten of low risk pregnancies had complications. He

was not opposed to midwife only care. He pointed out that Pembury would not be a centre of excellence but would be the same grade as the previous hospital. There was evidence that the paediatric service was fully staffed and he questioned why if this was the case obstetrics should be moved.

(36) The Committee were invited to ask questions of the invitees.

(37) In response to a question from Mr Cooke, Mr Pentecost stated that there was an increase in premature labour in teenage mothers, who were prevalent in Parkwood area of Maidstone. Also due to transport issues it would be difficult for them to access the unit at Pembury and for partners and others to visit or accompany them.

(38) Mr Daley asked Dr Hart whether the local BMA had opposed the birthing unit in East Kent when it was established and if so, in spite of the good outcomes from it, were they still keeping up that opposition. Dr Hart explained that there were different branches of the BMA across Kent. The East Kent and Tunbridge Wells branches had been inactive for a number of years. The Maidstone branch had been active for the past 10 -15 years.

(39) Mr Ferrin referred to Dr Harts belief that most patients from Maidstone would choose to go to other hospitals rather than Pembury and asked if he knew how many were likely to take this option. Dr Hart referred to patient choice, which did not necessarily coincide with a GP's advice. Women must be advised of transfer time to Pembury and the time ran from when the midwife made the call to transfer.

(40) In relation to the statement by Dr Hart that he understood that the 3 mid grade posts at Maidstone would be filled shortly. Dr Bolsover stated that neither he nor Dr Unter were aware of this. Information that came to the Trust from MASH and the BMA was difficult to assess as it was from anonymous sources.

(41) In response to a question Mr Fowle (MASH) was allowed to explain that MASH had been formed in 2008. Prior to that, opposition to the reconfiguration was strong but fragmented in Maidstone. MASH had incorporated the local BMA.

(42) As there were no sitting Members of Parliament present the Chairman asked Mr Wickenden to read out the statement received from Rt. Hon. Mr Hugh Robinson MP and the Rt. Hon. Ann Widdecombe MP. Both statements requested the Committee to refer this matter to the Secretary of State for Health.

(43) The Chairman referred the Committee to the views of the Conservative and Liberal Democrat prospective Parliamentary Candidates which had been circulated to Members of the Committee.

(44) The Chairman then gave Local County Councillors who were present but not Members of the Committee the opportunity to speak.

(45) Mr Chell made a number of points in support of referring the reconfiguration to the Secretary of State. These included poor management of the Pembury project leading to more services needing to be located there to justify the new hospital. He expressed the view that services should be located in the area of most need i.e.

nearer areas of deprivation. He added that the working time directive should be ignored and the Trust should do what was best for the people of Maidstone.

(46) Mr Chittenden expressed the view that the decision not to have a consultant led maternity services in Maidstone was wrong, due to factors such as the lack of adequate road access to Pembury from Maidstone and the strength of public feeling.

(47) Ms Thomas referred to the outcome of the consultation exercise in 2004 which had been reviewed by the Task and Finish Group who had supported it. This reinforced the decision which would guarantee optimum safety for women and children. She added that if it was decided not to go ahead with the plan then it would compromise safety.

(48) The Chairman stated that now the Committee had heard form all parties and had had the opportunity to ask questions it was time for a decision to be taken. He made a proposal from the Chair which was duly seconded by Mrs Stockell and is set out in the resolution below.

(49) The Committee then discussed this proposal.

(50) Before the vote was taken Ms Thomas reiterated the Trust's thanks to the Task and Finish Group for their hard working in looking at the 2004/5 consultation and for supporting it. The Trust recognised that there was more that they could do in relation to public engagement and there was still a need to communicate with the public going forward. She suggested that the local NHS and the Task and Finish Group form a co-design group, with formal terms of reference and look at the transition and the ongoing issue of medical staff.

(51) On being put to the vote the following resolution was passed unanimously

(52) RESOLVED that

(a) In noting the conclusions of the Task and Finish Group which the Health Overview and Scrutiny Committee support the weight of public concern is sufficient to refer the issue of the provision of Women's and Children's Services across the Maidstone and Tunbridge Wells NHS Trust to the Secretary of State for Health to review the decision taken by the West Kent Health Economy in 2005 – with particular emphasis on the services to be provided at the Maidstone Hospital; and

(b) The Overview Scrutiny and Localism Manager be authorised to prepare the letter of referral in consultation with the Chairman. Vice Chairman, Chairman of the Task and Finish Group, the Liberal Democrat and Labour Group spokesmen of the Committee.

6. Dentistry
(Item 3)

(1) The Committee considered whether they wished to have a full discussion on dentistry at a future meeting.

(2) Mr Ferrin stated that there needed to be a way for the papers submitted to the Committee to be more helpful in aiding Members to get to the issues. If it was decided to have a session on dentistry research needed to be carried out into what the key issues were, Committee Members should have the opportunity to consider what issues they would like covered at the meeting and then NHS colleagues should be invited to address these. He also reminded the Committee that a lot of Kent residents accessed their health services commissioned by Medway PCT and it was important that they were included in any discussions on relevant issues.

(3) Mr Daley also referred to the need for the Committee to have access to expertise so that they could understand what the key issues were. He stated that when he had been a Member of a PCT board dentistry had been the poor relation, some dental budgets held by PCT's were not fully used. He also gave the Overview, Scrutiny and Localism Manager a list of questions that he had been given by the Chairman of the Local Dental Committee, who had indicated that he would be willing to attend a meeting of the Committee subject to work commitments.

(4) Mr Kendall referred to the LINks comments on dentistry containing a list of complaints that the Kent LINk had received.

(5) The Chairman stated that it would be helpful to know exactly what the role of a dentist should be and also the question of how the service was financed should be explored.

(6) Mr Wickenden referred to the forward work programme which was normally circulated with the agenda for each meeting. Regarding the Task and Finish Group which had considered the reconfiguration of women's and children's services by Maidstone and Tunbridge Wells NHS Trust, this group had, over a two and a half week period interviewed a whole range of stakeholders and members had written the report. This had been a very powerful process for Members. He referred to the agenda setting process where health colleagues came together with the Chairman, Vice Chairman and Spokesman on the this Committee on a 6 weekly basis to focus the way that the Committee did business. Mr Wickenden undertook to e-mail to the work programme to Members of the Committee.

(7) Councillor Blackmore referred to the four District Council representatives co-opted onto the Committee and stated that only two attended on a regular basis and asked if there was anything that could be done to encourage District Councils to make full use of this opportunity. Mr Wickenden stated that this was a matter for District Councils and it relied on them to ensue that they operated a system, including the use of named substitutes, to ensure that there were always four District Council voting representative at each meeting.

(8) RESOLVED that at the next agenda setting meeting consideration be given to programming a session on Dentistry.

7. Further Information on Out of Hours Services
(Item 4)

(1) It was noted that no information had been received from West Kent and therefore the Committee felt that they needed to consider this issue further at a future meeting.

(2) RESOLVED that the information supplied by NHS Eastern and Coastal Kent be noted and at the next agenda setting meeting consideration be given to programming a session on Out of Hours services.

8. Date of next programmed meeting – Friday 26 March at 10:00
(Item 6)

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 26 March 2010

Subject: Item 4. Intended Outcomes: Dentistry.

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1. Background

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

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

2. Outcomes for the Dentistry Agenda Item

(1). Public Question

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

(2). Scrutiny Questions

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

3. Recommendations

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

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

To: Health Overview and Scrutiny Committee – 26 March 2010

Subject: Dentistry

Introduction

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

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

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

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

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

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

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

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

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

Dental Commissioning

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

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

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

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

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

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

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

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

[4] Ibid, p.30.

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

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

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

[8] Ibid, p.28.

Dentists are allowed to provide both NHS and private dental services (for different patients and for the same patient). There is no prescribed list of what treatments should be offered on the NHS.

While there has never been a requirement for a patient to 'register' with an NHS dentist, between 1990 and 2006, a portion of a dentists' remuneration was linked to the number of patients registered. "Since 2006, this feature of the remuneration system has no longer applied, but this does not prevent patients from receiving continuity of care."[9]

The Impact of the New Contract

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

On the introduction of the new contract, around 4% of NHS provision was lost with some dentists choosing to convert to private care[10].

One of the higher profile pieces of work to have been carried out on the impact of the new contract was a report by the House of Commons Health Select Committee published in June 2008[11].

The interim Government response was published in October 2008 with the final response published in January 2009[12]. In the interim report, the Government confirmed that it would carry out "a review of how dental services should develop over the next five years and what action is needed to ensure that, nationally and locally, dental commissioning evolves continuously to reflect public needs."[13]

In December 2008, The Secretary of State for Health (then Alan Johnson MP), asked Professor Jimmy Steele to undertake this independent Review of NHS Dental Services in England. This was published in June 2009. The

[9] Government Response to the Health Select Committee Report on Dental Services, October 2008, p.18, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_088997.pdf
[10] NHS Dental Services in England, An Independent Review led by Professor Jimmy Steele, Department of Health, June 2009, p.14, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101180.pdf
[11] House of Commons Health Select Committee, NHS Dentistry, July 2008, http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/289/28902.htm
[12] Both Government responses can be accessed here: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093318
[13] Government Response to the Health Select Committee Report on Dental Services, October 2008, p.20, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_088997.pdf

executive summary and key recommendations of this independent Review are appended to this Briefing Note.[14]

The Department of Health has subsequently established a 'Steele Implementation Programme' to pilot the key recommendations. PCTs have been asked for expressions of interest in running local pilots.[15] On 12 March 2010, it was announced that at least 30 NHS dental practices had been selected.[16]

Decontamination

On 1 December 2009, *Health Technical Memorandum 01-05: Decontamination in Primary Care Dental Practices*, was published "to reflect a reasonable and rational response to emerging evidence around the effectiveness of decontamination in primary care dental practices, and the possibility of prion transmission through protein decontamination of dental instruments."[17]

According to the covering letter from the Barry Cockcroft, the Chief Dental Officer, "the aim is that all practices will have met the HTM's essential quality requirements within 12 months of receiving this guidance."[18]

Staff Numbers

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

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

[15] Department of Health, Steele Implementation Programme, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_112295

[16] Department of Health Press Release, 12 March 2010, http://nds.coi.gov.uk/clientmicrosite/Content/Detail.aspx?ClientId=46&NewsAreaId=2&ReleaseID=412116&SubjectId=36

[17] Department of Health, *Health Technical Memorandum 01-05: Decontamination in Primary Care Dental Practices*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109363

[18] Department of Health, Chief Dental Officer Letter, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_109366.pdf

Table 1: Population per dentist and dentists per 100,000 of population[19]

Area	*Population per dentist*		*Dentists per 100,000 of population*	
	2007/08	*2008/09*	*2007/08*	*2008/09*
England	2,455	2,394	41	42
South East Coast SHA	2,052	1,998	49	50
NHS Eastern and Coastal Kent	2,422	2,422	41	41
NHS West Kent	2,242	2,176	45	46
NHS Medway	920	934	109	107

Table 2: Total number of dentists with NHS activity[20]

Area	*Total number of dentists with NHS activity*		
	2007/08	*2008/09*	*% difference*
England	20,815	21,343	2.5
South East Coast SHA	2,087	2,144	2.7
NHS Eastern and Coastal Kent	300	300	0.0
NHS West Kent	298	307	3.0
NHS Medway	274	270	-1.5

Access to Dentistry

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

Table 3: Number of total patients seen in the previous 24 months ending at the specified dates (percentage of population in brackets)[21]

Area	*31 Mar 2006*	*31 Dec 2008*	*31 Dec 2009*
England	28,144,599 (55.8)	27,272,083 (53.4)	28,162,628 (54.7)
NHS Eastern and Coastal Kent	351,681 (49)	339,720 (46.8)	352,244 (48.1)
NHS West Kent	319,438 (48.7)	267,231 (40.0)	276,404 (41.0)
NHS Medway	135,083 (53.7)	161,886 (64.2)	166,768 (65.8)

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

[20] Ibid.

[21] The Information Centre for Health and Social Care, NHS Dental Statistics for England Q2 30 September 2009, http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/nhs-dental-statistics-for-england-quarter-2-30-september-2009

Table 4: Number of total child patients seen in the previous 24 months ending at the specified dates (percentage of population in brackets)[22]

Area	*31 Mar 2006*	*31 Dec 2008*	*31 Dec 2009*
England	7,796,750 (70.7)	7,612,302 (69.2)	7,685,509 (69.8)
NHS Eastern and Coastal Kent	107,656 (67.9)	102,013 (64.5)	102,062 (64.5)
NHS West Kent	112,146 (74)	94,514 (61.9)	95,412 (62.2)
NHS Medway	45,807 (75.4)	48,759 (82.1)	49,557 (83.8)

Care Quality Commission

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

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

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

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

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

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

> "According to guidelines issued by the National Institute for Clinical Excellence (NICE, 2004), the recommended longest period a patient over the age of 18 should go without an oral review is 2 years. However, many patients experience difficulty in accessing a NHS dentist, and recent figures show that during the 24 months leading up to 31 March 2008, only 53.3% of the total population of England were seen by an NHS dentist (NHS Dental Statistics England, 2007/2008, published by the Information Centre). Of the remaining population, some patients will opt to receive private treatment, a proportion of which, in itself, is likely to be a direct result of difficulty accessing an NHS dentist. A recent survey commissioned by the Citizens Advice Bureau estimated that approximately 7.4m people in England and Wales say they would like to access NHS dentistry, but cannot. Of these, 2.7m say they are not able

[22] Ibid.

to access a dentist at all. Consultations by two SHAs have shown that the public consider this to be a major problem for the NHS to resolve.

The Government has responded to this issue of access by increasing funding for NHS dentistry in England from April 2008, by 11 per cent, as part of the comprehensive spending review. The NHS 'Vital Signs' framework contains an indicator in the second tier (national priorities for local delivery) to measure improvements in access to primary dental care. PCTs will therefore be assessed on their performance in terms of access to NHS dental services using data compiled centrally by the Dental Services Division of the NHS Business Authority and the NHS Information Centre. PCTs will be expected to demonstrate improvement in 24-month access to a NHS dentist against a baseline of the two year period ending 31 March 2006, when the new dental contract system was introduced."[23]

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

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

Table 5: Annual Health Check Scores for 'Access to primary dental services' 2008/09[24]

Primary Care Trust	*Quality of commissioning services*	*Access to primary dental services*	
		Performance	*Indicator value*[25]
Eastern and Coastal Kent	Fair	Under Achieved	98.11%
West Kent	Fair	Failed	83.78%
Medway	Fair	Achieved	120.4%

Some Key Organisations

Local Dental Committees – Established in 1948, LDCs became statutory bodies in 1977. "Primary care trusts/health boards consult with LDCs on

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

[24] Annual Health Check information for specific organisation can be accessed from the Care Quality Commission website, http://2009ratings.cqc.org.uk/findcareservices/informationabouthealthcareservices/overallperformance/searchfororganisation.cfm

[25] The indicator is the numerator divided by the denominator, expressed as a percentage. The numerator is the number of patients seen in the 24 month period ending 31 March 2009 and the denominator is number of patients seen in the 24 month period ending 31 March 2006.

matters of local dental interest and, following the NHS reforms in 2006, local commissioning and developments in the provision of NHS dental services."[26]

British Dental Association – Founded in 1880, the BDA is the professional association and trade union for dentists in the United Kingdom. It has a voluntary membership of around 23,000[27].

General Dental Council – "Anybody who wants to work in the UK as a dentist, dental nurse, dental technician, dental hygienist, dental therapist, clinical dental technician or orthodontic therapist must be registered"[28] with the GDC.

Care Quality Commission – From April 2010, all NHS Trusts must be registered with the CQC. "From April 2011, primary care services that directly provide dentistry (NHS and private) must be registered."[29]

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[26] British Dental Association, Local Dental Committees, http://www.bda.org/dentists/representation/gdps/ldcs/index.aspx
[27] For further information, see http://www.bda.org/.
[28] General Dental Council, Who we regulate, http://www.gdc-uk.org/About+us/Who+we+regulate/
[29] Care Quality Commission, Who needs to register?, http://www.cqc.org.uk/guidanceforprofessionals/registration/newregistrationsystem/whoneedstoregister.cfm

Appendix: Executive summary and key recommendations of *NHS dental services in England An independent review led by Professor Jimmy Steele, June 2009*[30]

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

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

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

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

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

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

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

A better service for patients: accessible and high quality

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

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

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

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

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

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

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

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

Aligning the contract to improve access and quality

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

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

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

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

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

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

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

What the NHS has to do

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

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

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

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

Implementation challenges

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

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

Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Currently within West Kent there are:

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

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

NHS West Kent currently holds twelve child only dental contracts.

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

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

	2007/08		**2008/09**	
	CoT	UDAs	CoT	UDAs
Band 1	**194,441**	**194,441**	**200,097**	**200,097**
Children	86,360	86,360	87,907	87,907
Adult	108,081	108,081	112,190	112,190
Band 2	**104,491**	**313,473**	**106,078**	**318,234**
Children	33,371	100,113	33,255	99,765
Adult	71,120	213,360	72,823	218,469
Band 3	**13,970**	**167,640**	**14,915**	**178,980**
Children	464	5,568	477	5724
Adult	13,506	162,072	14,438	173,256
Arrest of bleeding	16	19	12	14
Bridge repairs	120	144	96	115
Denture repair	1,335	1,335	1,260	1,260
Removal of sutures	97	97	71	71
Issue of prescription	6,275	4,706	6,426	4,820
Urgent	**24,677**	**29,612**	**25,986**	**31,183**
Children	3,485	4182	4,045	4,854
Adult	21,192	25,430	21,941	26,329
Other COT*	Figures not collected		**7865**	
Children			968	
Adult			6897	
Total	**345,422**	**711,467**	**354,941**	**734,774**

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

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

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

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

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

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

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

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

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

Table 4: UDAs recorded against Courses of Treatment

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

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

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

3. How are dentists remunerated for preventative work?

Preventive care and treatment is part of the mandatory services that all dental contractors must perform as part of their primary dental service contract. Therefore dentists do not receive specific, separate remuneration for preventive work because this element of the care pathway is included within the price of the activity they are contracted to perform.

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

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

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

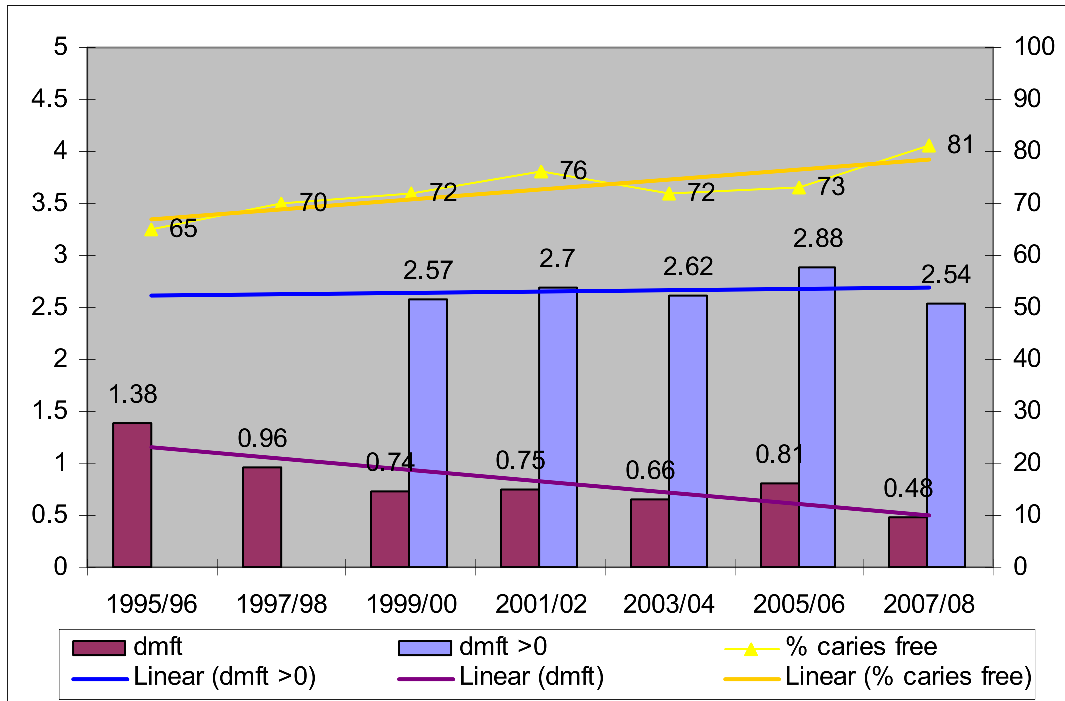
- To provide care for people with special needs
- To complement the current general dental services and specialist services available in the PCT through effective patient pathways
- To have a public health role and oral health promotion targeted both at populations and individuals
- To develop domiciliary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

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

The oral health of children is monitored regularly by carrying out epidemiological surveys to standards set by The British Association for the Study of Community Dentistry (BASCD). Levels of disease are measured using the Decayed, Missing and

Filled Teeth (dmft) index which records the number of decayed, missing and filled teeth in a child's mouth. Table 6 shows the dmft average values and trends from 1995 to 2008 in respect of 5-year olds.

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



The data shown in Table 6 shows the following:

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

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

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

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

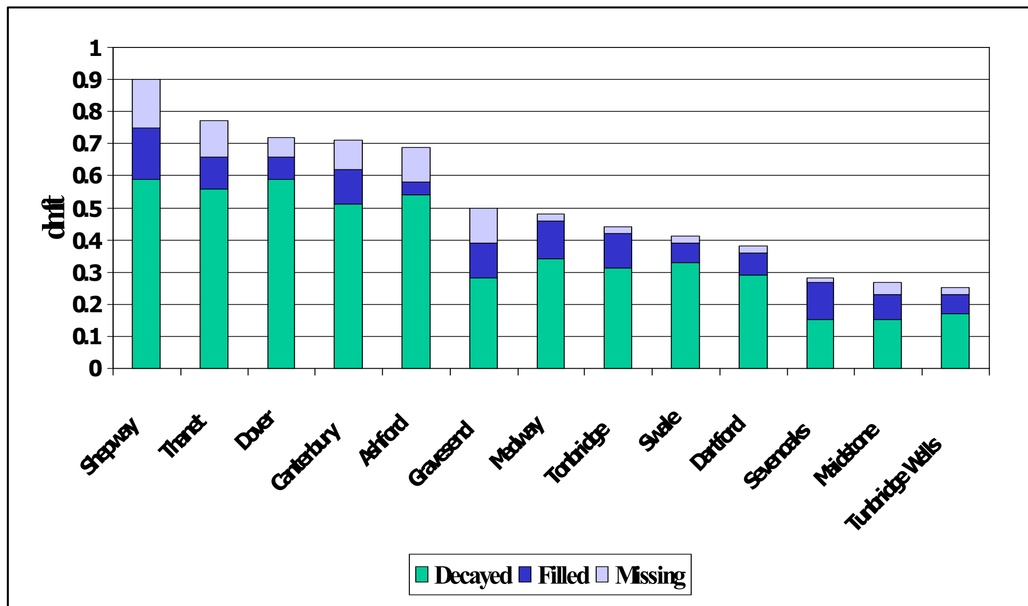


Table 7: Dental disease in 5 year-old children by local authorities across Kent (BASCD data 2007/08).

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

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

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

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

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

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

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

NHS charges apply to all out of hours dental services.

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

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

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

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

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

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

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

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

- Public awareness of oral health and dentistry and stimulating the demand for dentistry and highlighting its essential role in primary prevention
- The amount allocated to the PCT for dentistry – in 2009/10 this is £23.08 million net
- The timescales associated with full tendering processes are lengthy and can take almost a year before contracts are signed and new services mobilised
- The PCT has recently had its Tier 2 Vital Sign target relating to the number of Unique Patients Seen over the 24 month period ending March 2011 increased from 320,873 to 357,500

- Some dental performers do not always strictly follow NICE guidelines relating to the recall of patients. These are attached in the link below. http://www.nice.org.uk/nicemedia/pdf/CG019quickrefguide.pdf
- Robust and transparent contract monitoring to ensure contractors deliver best quality and value for money is time-consuming with regards to management resources.

The PCT plans to:

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

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

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

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

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

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

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

a) How many enquiries are received each quarter relating to dental services and what trends can be identified regarding the nature of these enquiries?
b) How many complaints/compliments/comments have been received about accessing dental services?
c) How many complaints/compliments/comments have been received about the quality of the services?

d) How has information from customer services about dentistry informed service development?

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

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

Table 8: Summary of dental enquiries and complaints

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

Supplementary briefing for KCC HOSC meeting 26th March 2010 - Dentistry

Context in West Kent

Particular factors relating to the population in West Kent have guided our investment in NHS dentistry

- There is generally low tooth decay in the population
- Most people have very good outcomes relating to their dental health care
- Many have chosen private dentistry in preference to NHS dentistry

This has meant we have not required the same level of NHS dental provision as some of our neighbouring PCTs.

NHS West Kent commissioned a MORI survey in 2009, which highlighted a number of issues relating to dentistry in West Kent. Key findings were as follows:

- 66 per cent of people polled were happy not to be registered with an NHS dentist, or content to use a private dentist
- 10 per cent of those polled reported they were struggling to find an NHS dentist

This shows that although a majority of people were happy with their access to dentistry, whether they preferred to use an NHS or private dentist, a significant number wished to have better access to NHS dentistry.

The current situation in West Kent

The current financial climate has meant that although many people do not wish to use an NHS dentist, an increasing number of people have sought NHS dentistry. As a result in 2009 NHS West Kent announced an £2.7 million investment to increase access in areas with lower cover. This has led to new dental surgeries in Tonbridge, Maidstone and Malling, and existing dentists seeing more NHS patients in Tunbridge Wells and Dartford & Gravesham.

There have also been further contracts awarded for orthodontic treatment.

The latest performance data shows an increase in the number of patients who have seen an NHS dentist in the last two years. In the last quarter, the figures were 5,000 up on previous quarter. This shows that access has improved, and that that more people than previously want to access NHS dentistry

Given the changing circumstances, we want to ensure that we have made an adequate investment in NHS dentistry and that there is sufficient cover. We are therefore carrying out needs assessment to ascertain if we need to make further investment, and if so where in West Kent it is most needed.

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Eastern and Coastal Kent

NHS Eastern and Coastal Kent's response to Kent County Council's Health Overview and Scrutiny Committee enquiry relating to dentistry

1. Introduction

The nation's oral health has improved significantly since the establishment of the NHS General Dental Service (GDS) in 1948. As recently as 1968 the proportion of the adult population in England and Wales who were edentate (toothless) was 37%. The latest figure is estimated to be 6%. The improvements in oral heath are due to a combination of developments, including fluoridation (of toothpaste and, in some areas, the water supply).

The way in which NHS dental services are provided and commissioned has recently undergone significant change. Although there have been great improvements in oral health over the last fifty years, the provision of dental services has attracted negative public and media attention for over a decade. The 1990s were marked by increasingly difficult relations between the DH and dentists. Later, reports of long queues of patients hoping to register with a newly established NHS dentist added a vivid, if in many places misleading, image of a system that was under intolerable strain. In 1999, faced with increasing disquiet at the state of NHS dental services, the then Prime Minister, Rt Hon Tony Blair MP, committed the Government to ensuring that, within two years, access to an NHS dentist would be available to any one who wanted it.

2. Drivers of Change

- 2000: Commitment to improving access to dentistry in the NHS Plan: A Plan for Investment, A Plan for Reform
- 2000: Modernising NHS Dentistry: Implementing the NHS Plan
- 2002: NHS Dentistry: Options for Change
- 2004: Personal Dental Service (PDS)
- 2006: new General Dental Service (GDS) contract introduced
- 2006: Primary Care Trusts (PCTs) given powers to commission services to meet local needs (previously commissioning had been done centrally by the NHS).
- 2006: Charging system for patients was simplified.

3. The pre-2006 system

NHS dentistry was founded in 1948 with the establishment of the General Dental Service (GDS). The GDS provided patients with "dental care via general dental practitioners (GDPs)" who mainly worked as independent contractors from high street local surgeries. In 1993 the history of the management of the GDS since 1948 was described by some as one of

"supervised neglect". In effect the way that services were delivered through the GDS had remained largely unaltered for nearly sixty years.

Until 2006 those dentists and orthodontists who chose to work within the GDS did so as independent practitioners and were able to choose where they established their practice and which services they provided to patients. Many dentists operated in what the British Dental Association (BDA) described as "a mixed economy" providing both NHS dentistry and private treatment according to the level of demand in their locality. Secondary dental care, usually for particularly complex cases, was provided in hospitals by dental specialists. Another important element of NHS dentistry was the Community Dental Service (CDS). The CDS comprised approximately 1,000 dentists who were employed by local health authorities and received an annual salary. CDS dentists provided a service for particular categories of patient: for example, those with an extreme phobia of dentists and those with special needs. Dentists recorded the treatment given to patients and payment for the work claimed came from a central budget.

4. Changes to the system, 1948–2006

Since the establishment of an NHS dental service in 1948 there have been three major developments:

- the introduction of patient charges in 1951
- a revised dental contract between the DH and dentists in 1990
- the new GDS contract between dentists and Primary Care Trusts in 2006

NHS dental charges were introduced in 1951 for adult patients, with exemptions for those in receipt of income support or who were pregnant or nursing mothers. Charges were made according to an itemised list of treatments which, by 2006, had mushroomed to over 400 items ranging from a simple check-up to more complex root canal treatment and crown work.

The next significant change occurred in 1990 when the DH introduced registration for adult patients. Capitation payments for treating children up to the age of 16 were also introduced. The declared intention of the new arrangements was to place greater emphasis on continuing dental care.

However, following the changes, in 1991–92 the DH had overspent its dental budget by £190 million. In 1992–93, in an attempt to bring the expenditure on dental services under control, the DH reduced the amount paid for each item of treatment by 7%. This action resulted in great discontent amongst the dental profession and resulted in a haemorrhage of dentists away from the NHS.

5. Need for Dental Services

Within the overall positive picture of reduced dental disease, there are generational differences in oral health. Dental practitioners sometimes refer to 'the heavy metal generation', that is people aged over 45 who did not benefit

from fluoridated toothpaste or water supplies when they were children. This cohort has, unlike previous generations, maintained their teeth but frequently has had large fillings (which from time to time require replacements involving more complex treatment). In comparison, people aged under 45 generally have better dental health. For children, the figures for oral health are even better with many having experienced no dental disease. Decay rates have fallen in all social groups albeit significant disparities remain between socio-economic groups and between regions of the country.

While oral health has generally improved, demand for dental services has not diminished. The DH explained that there had been a change in demand as "patients' focus has moved from simply ensuring their teeth are healthy and pain-free to an ever-stronger desire that they should also be cosmetically pleasing."

5.1 The case for change

During the 1990s the DH argued that the GDS no longer met the oral health needs of the population and required substantial reform

5.2 The new dental contract

From April 2006 the new arrangements made three key changes to the dental system.

5.2.1 PCTs were given the power to commission dental services to meet local needs. In essence, the changes involved a switch from the General Dental Services (GDS) contract, under which dentists were paid by the NHS for the work they had done, to a system whereby Primary Care Trusts commissioned dental practitioners to provide an agreed level of activity. This brought dentistry in line with other NHS services. The DH argued that PCTs were best placed to tailor dental services according to local needs.

5.2.2 The patient charging system was simplified from more than 400 possible charges into three charging bands. In place of the more than 400 possible charges, the DH introduced a three-tier payment structure covering treatments ranging from check-ups and fillings to more extensive and complex work such as crowns and dentures. The DH argued that that reform of the fee per item charging system would benefit patients by removing confusion about what they could expect to pay for their treatment. It was also argued that reform would bring greater clarity for patients regarding which treatment was available under the NHS and which treatment was provided under private arrangements.

5.2.3 Dentists were remunerated according to Units of Dental Activity (UDA). The new contract replaced the old fee per item payment system with a remuneration system which provided dentists with an annual income in return for an agreed amount of dental treatment measured in Units of Dental Activity (UDAs). The DH argued that the UDA system gave dentists an incentive to switch the focus of their treatment from active treatment of patients to prevention.

5.3 Patients seen by an NHS dentist

Until 2006 the Department's chosen method of determining usage of dental services was the number of patients seen by a dentist in a 12 month period. With the introduction of NICE guidelines this has been increased to a 24 month period. Following the introduction of the new contract in 2006 there was a fall in the number of people being seen by an NHS dentist. This prompted the Government to invest a large amount of money, over and above inflation and year on year growth to procure more General Dental Services. This money was ring fenced and targets on access for all by 2011 appeared in the NHS Operational Framework.

6. What is being commissioned in NHS Eastern and Coastal Kent?

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

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

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

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

Table 1

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

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

In December 2008 the PCT approved an investment of £728,000 to increase access to dental services in Ashford, Sittingbourne and Canterbury. All three new surgeries are now operational. In addition to this a further investment of

£4.5m was made following a needs assessment that will see new surgeries operational in all of the following localities by early 2010;

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

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

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

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

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

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

6.1 Out of Hours

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

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

Normal opening hours: 7pm-11.20pm every day plus weekends and bank holiday mornings 9.30am to 11am.

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

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

6.2 Community Dental Services

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

periodontology, geriodontology, domiciliary care, bariatric dental care, general anaesthetics, epidemiology and dental health education.

7. What is spent on primary care dental services?

All providers of NHS dental services receive one twelfth of the value of the contract each month. A breakdown of spend in 2009/10 is shown on table 2 below:

Table 2

	£'000
Budget	20,479
Actual spend (up to Jan 2010)	17,880
Variance	2,599
Forecast	2,700

Currently the PCT is forecasting a £2.7m underspend on its allocation for 2009/10. This position is due mainly for two reasons, firstly the predicted underperformance by existing contracts along with delays by contractors to mobilise new contracts awarded by the PCT during 2009.

8. Children's Oral Health

NHS Eastern and Coastal Kent participates in the national dental epidemiology programme which is sponsored by the DH and the British Association for the study of Community Dentistry (BASCD). BASCD studies have been undertaken for many years recording annually the decayed missing and filled (DMF) data of five year old, eight year old and twelve year old children on rotation. The DMF has decreased over the last 15 years but with some children experiencing high levels of decay. Caution should be given in interpreting data from year to year as the organisational boundaries have changed to which the data relates. Access to national and local results are available on the BASCD website.

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

9. Challenges

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

NHS Eastern and Coastal Kent are committed to achieving its national target to provide access to NHS dental services to 55% (409,000 people) of the

population of East Kent in the next 5 years by its commitment of £4.5m, currently the PCT is achieving 47% (360,000 people) so there are plans to improve access and meet the target. The national average is 54%.

Maintaining the commitment of dentists to the NHS- the PCT actively encourages and supports practices to approach the PCT should they have concerns or problems that they are experiencing. The Steele report of 2008 has identified a need to change certain aspects of NHS dentistry, in particular the contract and subsequently pilots are being run around the country to determine a better way forward.

NHS Eastern and Coastal Kent have expressed an interest with the DH to be part of Wave 2 pilots that are expected to start in October 2010, with a view to help involve local dentists in the possible new developments within the NHS dental provision. Local GDP engagement is key to ensure that all are assured of the importance of local opinion.

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

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

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

Implementation of the decontamination guideline HTM01-05 – The PCT is currently carrying out an audit to determine a baseline of compliance to help inform the risk assessment prior the December 2010 deadline. The PCT is working with practices to support their action plans to ensure compliance. At this stage it is not possible to know the level of risk and therefore, what extra support the PCT may need to provide.

10. Dental Prescribing

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

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

impossible to know how much has been prescribed. There are two main areas where this could potentially pose a problem for the PCT:

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

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

11. Customer Services

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

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

During the first 4 months of the helpdesk opening:

- 6582 calls were taken from patients, 3483 wishing to access an emergency appointment.
- 5083 callers have been given details of practices with capacity to treat patients
- 339 callers have made general enquiries that include for example dental treatment costs
- 300 text messages have been received requesting details of where their nearest NHS dentist is located.

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

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

Prior to the opening of the helpdesk the PCTs PALS service was the point of contact for the public although no detailed records were kept of general dental

enquiries. It was however recognised by the PALs service that the volume of calls they received was less than the calls now recorded by the helpdesk. This earlier information from PALs helped support the plans to invest additional resources in dental care.

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

12. Summary

In summary, huge progress has been made this year to improving NHS dentistry and NHS Eastern and Coastal Kent will

After little change for 60 years in the way General Dental Services have been delivered, from 2006 Primary Care Trusts have been taxed with delivering a needs lead service from a devolved budget. This has taken some time to establish and for General Dental Practitioners to accept the changes but now more services are opening giving the public more access and choice. NHS Eastern and Coastal Kent has been making huge progress to continue to ensure dental care is a priority to enable more of our population to easily access NHS dental care and treatment.

Of course the service is continually being scrutinised and following the Health Committee report in 2008 a review of the GDS carried out by Professor Jimmy Steele[1] was published in 2009 and will result in further GDS pilots and possible further changes.

[1] NHS dental services in England: An independent review led by Professor Jimmy Steele June 2009 DH

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 26 March 2010

Subject: Item 5. Forward Work Programme.

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1. Background

(1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on adding value to the planning, provision and operation of healthcare in Kent.

(2) Recent events have meant that the scheduling of important topics has had to be revised. This paper sets out:

a) A revised work programme for the next sequence of meetings;

b) An outline of how it is proposed topics for discussion during meetings will be developed in future and how the input of Members will be invited at an earlier stage.

2. Revised Work Programme

(1) It is proposed that the main items at the next three meetings will be as follows:

a) 14 May 2010 (NB: please note revised date) –

1) The Future of PCT Provider Services and the Use of Community Hospitals.

b) 11 June 2010 –

1) Diagnostics – Waiting Times.
2) PCT Strategic Commissioning Plan Update.

c) 23 July 2010 –

1) Accessing Mental Health Services.
2) Update on Health and Transport.

(2) Meetings have also been scheduled for:

a) 3 September 2010;

b) 15 October 2010; and

c) 26 November 2010.

(3) No topics have been decided for these meetings, but a draft work programme will be presented to the Committee at a future meeting following the regular meetings with the Chairman, Vice-Chairman, spokesmen of the other political groups and partner colleagues.

3. Topic Development

(1) Attached to this report are a series of summaries of the next few topics which will come before this Committee. Background information is provided along with a series of suggested questions to ask of attendees in advance of the meeting.

(2) Members of the Committee are invited to discuss these topics with a view to making suggestions as to what should be the appropriate focus of discussion and are asked to submit any additional questions they would like answered so that these can be incorporated into the letter requesting information for inclusion in the Agenda.

(3) There will still be topics on occasion which will need to be discussed but for which time will not allow this process to be used.

4. Recommendations

(1) The Committee is asked to consider whether this proposed method will enable more value to be added to the overview and scrutiny of health matters;

(2) The Committee is asked for its suggestions as to questions they would like to see answered as part of the discussion on scheduled topics and items for inclusion in the future.

Topic	The Future of PCT Provider Services and the Use of Community Hospitals
Date of Meeting	**14 May 2010**

Background

Provider Services

On 30 October 2009, Members of the Committee heard from representatives from NHS Eastern and Coastal Kent and NHS West Kent on the future of the part of the PCT which provided community health services as part of the national policy of separating commissioner and provider functions. Work was still ongoing as to the choice of final model of provider services and both PCTs present agreed to seek the Committee's views once the shape was clearer.

The NHS Operating Framework for 2010/11 requires PCT proposals to be agreed with the SHA by 31 March 2010. Guidance published the Department of Health on 5 February 2010 said that any new provider form will have to be implemented by 31 March 2011 (or otherwise as agreed with the Strategic Health Authority).

Community health services cover a range of services provided by a number of different staff groups. It can include allied health professionals such as physiotherapists, community nurses, health visitors, community dentistry, family planning and community rehabilitation. This is not exhaustive.

Community Hospitals

Eastern and Coastal Kent Community Services are responsible for the services at Faversham Cottage Hospital, Queen Victoria Memorial Hospital (Herne Bay), Sheppey Community Hospital (Minster), Sittingbourne Memorial Hospital, Victoria Hospital (Deal) and Whitstable and Tankerton Hospital.

West Kent Community Health is responsible for the services at Edenbridge and District Memorial Hospital, Gravesham Community Hospital (Gravesend), Hawkhurst Community Hospital, Livingstone Hospital (Dartford), Sevenoaks Hospital, and Tonbridge Cottage Hospital.

NHS Medway (the provider arm is called Medway Community Care) is responsible for St. Bart's Hospital in Rochester, Wisdom Hospice in Rochester and three Healthy Living Centres across Medway.

The Royal Victoria Hospital at Folkestone and Buckland Hospital at Dover are part of East Kent Hospitals University NHS Foundation Trust.

Suggested Attendees

• NHS Eastern and Coastal Kent (commissioner and	• NHS Medway Provider Services

provider) • NHS West Kent (commissioner and provider)	• East Kent Hospitals University NHS Foundation Trust • Kent Adult Social Services • LINk
Suggested Questions	
1. What decisions have been made about the future direction of community services in Kent? 2. What is the timeline of key organisational and service changes? 3. What are the plans for the use and development of community hospitals in the future? 4. Can you outline the differences between the commissioner and the provider functions of your organisation? 5. What services does your PCT Provider Service (PCTPS) provide? 6. How many staff are employed by your PCTPS, and what staff groups does this include? 7. How many properties, including the community hospitals, does your PCTPS own or manage? 8. What are the governance arrangements of your PCTPS and how does this connect with the commissioning side of the PCT? 9. How much is spent on community services each year? 10. How are community services commissioned and funded? 11. What may be the impact of the current financial situation? 12. What role have other organisations played in the development of your proposals – for example other PCTs, other provider Trusts in Kent and Medway, NHS South East Coast? 13. What is the definition of a 'community hospital'? 14. What is the difference between the community hospitals you are responsible for and hospitals like the Royal Victoria Hospital in Folkestone run by an Acute Trust? 15. Can you provide a list of what services you currently provide at each community hospital? 16. Are there any plans to add to or remove any of these services in the future? 17. Are there any inpatient beds at your community hospital? 18. If there are, how many are there and what is the average length of stay? 19. How do community hospitals work with other Trusts and Social Services (such as receiving patients discharged from Acute Trusts)?	
Members are invited to name the five questions they feel should have priority and/or suggest additional questions.	

Topic	Diagnostics – Waiting Times
Date of Meeting	11 June 2010

Background

A diagnostic test or procedure is one which is used to identify a person's disease or condition and which allows a medical diagnosis to be made. As such they are regarded as a key component of the 18-week referral to treatment pathway. In this context diagnostics covers imaging (such as ultrasound), endoscopy, pathology and the elements of physiological measurement (such as ECGs and audiology assessment).

The Department of Health collects and publishes information on the number of patients waiting for imaging, physiological assessments and endoscopies and within this focuses on those waiting longer than 6 weeks and those waiting longer than 13 weeks. In the NHS Operating framework for 2010/11, one of the supporting measures for the 18-week target is the number of patients waiting less than 6 weeks for a diagnostic test.

Diagnostic tests are increasingly available in community settings as well as acute hospitals and are carried out by a range of different staff groups.

Suggested Invitees

- East Kent Health Economy (team representing PCT and Acute sector)
- West Kent Health Economy (as above)
- LINk
- Kent Local Medical Committee

Suggested Questions

1. How many people resident in your PCT area receive the key diagnostic tests (imaging, physiological assessments and endoscopies) and how long do they wait?
2. How many people have their diagnostic tests carried out in a) acute hospitals b) community and primary care settings?
3. How much is spent on diagnostics?
4. How patients exercise choice when choosing where to have a diagnostic test?
5. Are there any areas of weakness which have been identified and what measures have been put in place to improve the situation?
6. What changes have there been to how and where diagnostic tests are carried out in recent years?
7. Specifically, what plans have been, or are being made, to modernise pathology services across Kent?
8. How are test results communicated to a patient's GP, how long does this normally take, and are there any specific challenges in this area?

Members are invited to name the five questions they feel should have priority and/or suggest additional questions. This information is requested by: 1 April 2010 (please send to the HOSC Researcher)

Topic	**Primary Care Trust Strategic Commissioning Plans – An Overview**
Date of Meeting	**11 June 2010**
Background	
Strategic Commissioning Plans (SCPs) are rolling five-year plans in which each Primary Care Trust sets out its overarching aims for the future and provides details of the priorities for investment and updates of programmes underway. SCPs are produced in consultation with a variety of stakeholders and feedback is received from the Strategic Health Authority before the final version goes to the Department of Health. By their very nature, SCPs cover a wide area and contain a lot of detail.	
Suggested Invitees	
• NHS Eastern and Coastal Kent • NHS West Kent	• LINk
Suggested Questions	
1. What are the overarching aims of your SCP? 2. What are the priorities for investment and developments over the next five years? 3. How has the changing financial climate impacted on the development of your commissioning intentions? 4. How is your organisation looking to make savings from improved efficiencies? 5. How have you been involving stakeholders? 6. Are there any plans for major service reconfigurations in Kent? 7. What role does the Strategic Health Authority and Department of Health play in the development and implementation of the SCP? 8. What key challenges remain from previous SCPs? 9. In absolute terms and as a proportion of your overall budget, how much are you planning to spend and invest in the following areas:	

- Primary and community care
- Acute care
- Mental health
- Ambulance services
- Continuing care
- Specialised commissioning

10. How will you ensure the messages contained in your SCP are communicated to the public, key stakeholders and staff?

Members are invited to name the five questions they feel should have priority and/or suggest additional questions.

This information is requested by: 1 April 2010 (please send to the HOSC Researcher)

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 26 March 2010

Subject: Item 6. Update on Referral to Secretary of State for Health.

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1. Recommendations

(a) The Committee is asked to note the attached letter setting out reasons for referral following the unanimous decision of the Committee on 19 February 2010; and

(b) Note the response from the Department of Health and the further response of the Committee.

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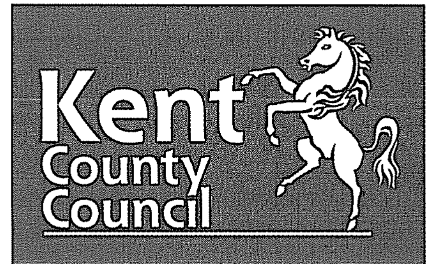

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Date: 24 February 2010

To:
The Right Honourable Andy Burnham MP,
Secretary of State for Health,
Department of Health,
Richmond House
79 Whitehall,
London, SW1A 2NS

Dear Secretary of State,

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

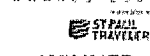
I am writing to you on behalf of the Kent Health Overview and Scrutiny Committee (HOSC) to advise you of our decision to exercise the Committee's power to refer NHS proposals for substantial change to local health services to you for independent review.

The Maidstone and Tunbridge Wells NHS Trust (MTW) currently operates from three acute sites – Maidstone, Kent and Sussex (in Tunbridge Wells) and Pembury. Pembury is the site of a new PFI hospital which is currently under construction. Once completed, the Trust will consolidate its services on two acute sites – Maidstone and Pembury. The Trust plans to remove consultant-led inpatient obstetric services (including elective and emergency caesarean sections) from Maidstone in order to centralise them at Pembury. A midwife-led birthing unit separate from the main hospital building will be provided at Maidstone.

In October 2004, the local NHS produced a consultation document entitled "*Excellence in care, closer to home. The future of services for women and children – a consultation document.*" A Joint Select Committee was established to produce a response to this consultation consisting of representatives from Kent County Council, East Sussex County Council, Kent District/Borough Councils, East Sussex District/Borough Councils, and the Patient and Public Involvement Forum. This response was produced in December 2004. Following this consultation, a Joint Board Meeting of Maidstone Weald PCT, South West Kent PCT, Sussex Downs and Weald PCT and Maidstone and Tunbridge Wells NHS Trust on 23 February 2005 agreed the plans for the reconfiguration of women's and children's services.

Geoff Wild LL.B, Dip.LG, Solicitor
Diretor of Law & Governance

CHIEF EXECUTIVE'S DEPARTMENT



Since this time, there has been a growth in public concern about the proposals alongside doubts that some of the project planning assumptions made by the NHS in 2004 are no longer applicable. The HOSC had already agreed to receive an update on the progress of the broader service redesign at Maidstone and Tunbridge Wells NHS Trust on 27 November 2009, when a Councillor Call for Action at Maidstone Borough Council gave a particular focus to the women's and children's aspect of the service redesign plans. The Minutes of this meeting are enclosed.

At the November meeting, the HOSC agreed to establish a Task and Finish Group to examine the plans for women's and children's services at MTW. The report of the Task and Finish Group is enclosed. This report was presented to the HOSC at its meeting of 19 February 2010, during which evidence was also received from MTW, NHS West Kent, South East Coast Ambulance Service NHS Trust and a range of other stakeholders. Due to the Committee's ongoing concerns about the plans, and our inability to reach a local resolution, the HOSC voted to refer this issue to you. The Minutes of the meeting will be available in due course and will be sent on to you as soon as possible.

In summary form, the ten main grounds on which the Committee believes a referral is justified are as follows:

1. **Transport.** When the response to the 2004 consultation was produced, it was assumed that improvements to the A228 connecting Maidstone and Pembury would be made by the time the new hospital was due to be completed. The plans are for women's and children's services to move into the new hospital in January 2011, but the new road scheme is unlikely to be progressed until 2014, at the earliest. The Committee understands that the majority of transfers of women in labour from the planned midwife-led birthing unit at Maidstone Hospital will not be made under emergency 'blue-light' conditions, and that these small number of cases may not be directed to Pembury, but the Committee still feels that the transport connection between the two sites is currently unsatisfactory and transfers that are too long will be distressing and not in the best interest of women.
2. **Original consultation.** Although the HOSC formed part of the Joint Select Committee that produced a response to the 2004 consultation, there remain questions held by many local people about just how effectively the NHS presented a range of alternatives and engaged the public, particularly in the Maidstone area.
3. **Lack of ongoing communication/engagement with public.** Since the local NHS agreed these plans in 2005, there has been a lack of information coming

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out of MTW to explain what progress was being made, and what the practical impact of these changes will be. This has led to a lot of confusion in the public mind and has led to a degree of loss of public confidence in the Trust. The PCT and Trust has failed to convince the local community of the validity of their plans.

4. **Lack of ongoing communication/engagement with staff.** Similarly, the Task and Finish Group heard from a number of members of staff at the Trust that they too have not been kept up to date with developments and have often felt excluded from the unfolding decision making process. Evidence has been provided by several consultants, along with others, of their reasons for dissatisfaction. All this may potentially be having an impact on staff morale.
5. **State of Trust's readiness.** The Committee is not confident that the Trust will be able to provide all the relevant services in facilities that are fit for purpose by the intended deadlines. The Task and Finish Group understands that planning permission has yet to be requested for the midwife-led birthing unit at Maidstone, and the Committee has yet to receive a finalised list of where all services will be provided in the new two-site configuration (this includes services being provided in the community as well).
6. **Lack of integration across the Trust.** MTW was formed in 2000, but over the course of the subsequent decade appears to have done little to integrate the staff and cultures at the two geographical ends of the Trust, Maidstone and Tunbridge Wells. This may have a negative impact on patient care when services are centralised on one site and staff are asked to relocate.
7. **Patient choice**. One of the main concerns of the Task and Finish Group was the lack of promotion of patient choice as it relates to women's and children's services. There is a public perception that going to Pembury will be the only option for some services, and this will de facto be the case if women are not informed of the range of choices. This is not directly the responsibility of MTW, but is something that needs addressing before any changes are fully implemented.
8. **Demographics.** Since the original consultation was carried out, Maidstone has been awarded Government Growth Point status which will significantly increase the local housing stock and population, with a consequent belief that full hospital services should continue to be provided at Maidstone Hospital.
9. **Health Inequalities.** Connected with the point above, the Maidstone area has some of the most deprived areas in the county with high rates of teenage pregnancy. These women are excluded from exercising choice through lack of money and their own transportation and will require a full service locally more than any other.
10. **Other IRP decisions.** Finally, we would like to point out that a number of recent decisions by the Independent Reconfiguration Panel have decided

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against analogous plans to centralise obstetric services, such as those in East Sussex.

HOSC is not against change where it is necessary and the Committee recognises that there are real pressures faced by the NHS which often require substantial changes in order to be able to provide the best service possible. However, the Kent HOSC is not convinced that the present situation is one of these cases. We therefore ask you to give careful consideration to our request that this decision be reviewed.

As I have said, the Minutes of the 27 November 2009 meeting and the report of the Task and Finish Group are appended in support of our request and we will send you the Minutes of the 19 February 2010 meeting as soon as they become available. If you would like any additional information to support the referral or have queries about specific aspects of the evidence, please contact Paul Wickenden, Overview, Scrutiny and Localism Manager, in the first instance on 01622 694486 or at paul.wickenden@kent.gov.uk.

I look forward to hearing from you.

Yours sincerely

Councillor Godfrey Horne MBE
Chairman
Health Overview and Scrutiny Committee

Cc:
Glenn Douglas, Chief Executive, Maidstone and Tunbridge Wells NHS Trust
Tony Jones, Chairman, Maidstone and Tunbridge Wells NHS Trust
Steve Phoenix, Chief Executive, NHS West Kent
David Griffiths, Chairman, NHS West Kent
Candy Morris CBE, Chief Executive, NHS South East Coast
Kate Lampard, Chairman, NHS South East Coast

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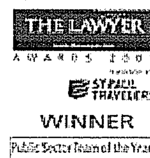

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Councillor Godfrey Horne MBE
Chairman
Health Overview and Scrutiny Committee
Legal & Democratic Services
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12 March 2010

Dear Councillor Horne

WOMEN'S AND CHILDREN'S SERVICES AT MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

I refer to your letter of 24 February 2010 to the Secretary of State for Health regarding plans for the reconfiguration of women's and children's services at Maidstone and Tunbridge Well NHS Trust.

As you will be aware, an Overview and Scrutiny Committee has the right to refer under the Local Authority (Overview and Scrutiny Committee Health Scrutiny Functions) Regulations 2002. Having read your letter and taken Departmental legal advice on the matter, we do not believe there is sufficient information in your referral to enable the Secretary of State for Health to consider this in its current form.

We understand that in December 2004 the then Kent Health Overview and Scrutiny Committee agreed with the proposed changes you now appear to be contesting and that the current Kent Health Overview and Scrutiny Committee's task and finish group recently agreed that the original proposals are right.

We note that you have referred on the grounds of a growth in public concern. Essentially, however, there are two grounds for the basis of referral (i) reg 4(5) where it provides the OSC can refer when it has not been satisfied that there has been adequate consultation and (ii) reg 4(7) where the OSC considers that proposals for change are not in the best interests of the local health services.

You should formally outline your grounds for referral in full. Your referral should make clear whether you are referring under regulation 4(5) inadequate consultation, or 4(7) proposals not in the interest of the local health service, or indeed both, and should fully explain your reasons in either case.

Finally, we have not yet received a copy of the minutes of the task and finish group 19 February 2010 you refer to in your letter. I would be grateful if you could forward a copy of these minutes with your reply.

I look forward to your response.

Yours sincerely

James Skelly
Head of NHS Reconfiguration
email: james.skelly@dh.gsi.gov.uk

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Date: 18 March 2010

Dear Mr Skelly,

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

Thank you for your letter dated 12 March relating to the referral by the Health Overview and Scrutiny Committee at Kent County Council of the plans for the substantial variation to women's and children's services at Maidstone and Tunbridge Wells NHS Trust.

I am disappointed that although you acknowledge the Committee's right to refer matters of this kind to the Secretary of State for Health, this issue is being protracted and we have had no indication that as yet the referral has been laid before the Secretary of State personally for a decision in this important matter.

To clarify this matter, the primary grounds of referral are under section 4(7) of The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (No. 3048). As my original letter made clear, there remain questions about the original consultation, but the other nine main grounds which were outlined all provide support for the case that 'the proposal would not be in the interests of the health service in the area of the committee's local authority.' For your convenience, the original letter of referral is enclosed as this explains these main grounds in detail.

In large part due to the lack of ongoing effective communication of the developing proposals and dearth of effective local engagement, it may have taken time for public concerns to manifest themselves, but once the level of public unhappiness became apparent the Committee set up a Task and Finish Group to explore the issues further and to see if there were any grounds for local compromise.

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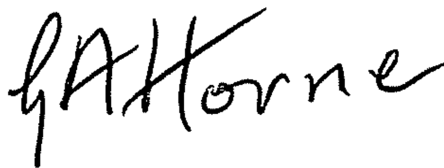
This process led to the unanimous decision by the Health Overview and Scrutiny Committee on 19 February to refer this matter to the Secretary of State for Health. The draft Minutes of this meeting are now available and are enclosed for your information.

Section 4(7) states the Committee 'may report to the Secretary of State in writing who may make a final decision on the proposal and require the local NHS body to take such action, or desist from taking such action, as he may direct.' It is to him we now look for a resolution.

I trust this provides the clarity you were seeking. If you have any further questions, please contact Paul Wickenden, Overview, Scrutiny and Localism Manager, in the first instance on 01622 694486 or at paul.wickenden@kent.gov.uk.

I look forward to hearing from you.

Yours sincerely



Councillor Godfrey Horne MBE
Chairman
Health Overview and Scrutiny Committee