

6. Audiology (Pages 19 - 28) 11:35 am - 12:05 pm
- Lynne Selman, Director of Citizen Engagement and Communications and Alison Davis, Assistant Director Delivery and Performance, Eastern and Coastal Kent Primary Care Trust and Bob Deans, Deputy Chief Executive and Julia Ross, Director of Civic Engagement, West Kent Primary Care Trust will be in attendance for this item*
7. Dentistry (Pages 29 - 40) 12:05 pm - 12:35 pm
- Lynne Selman, Director of Citizen Engagement and Communication and Jayne MacDonald, Head of Primary Care & Community Commissioning, Eastern and Coastal Kent Primary Care Trust and Bob Deans, Deputy Chief Executive, Bill Millar, Assistant Director of Primary Care and Julia Ross, Director of Civic Engagement will be in attendance for this item.*
8. Diabetes Services (Pages 41 - 48) 12:35 pm - 1:15 pm
- Pamela Akhurst, Head of Physical Disabilities, Eastern & Coastal Kent Primary Care Trust and Valerie Gooding, Secretary, Diabetes UK Maidstone and District Office will be in attendance for this item.*
9. Date of next programmed meeting – Friday 5 September 2008 at 10.00 am

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

10 July 2008

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 at Council Chamber, Sessions House, County Hall, Maidstone on Friday 13th June, 2008.

PRESENT: Lord Bruce-Lockhart (Chairman), Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr A R Chell, Mr B R Cope, Mr A D Crowther, Mr J Curwood, Mr D S Daley, Ms A Harrison, Mr J F London, Mr R A Marsh, Mr M J Northey, Dr T R Robinson, Mrs E D Rowbotham and Mrs E M Tweed.

OTHER MEMBERS PRESENT: Mr G K Gibbens (Cabinet Member for Public Health).

ALSO PRESENT: Mr M Ayre, Mr G Bridgland and Mr D Oxlade (KCC); Fran Witherden, John Larcombe, John Cunningham, Angela Evennett, Paul Bryden.

IN ATTENDANCE: Mr P D Wickenden, Overview, Scrutiny and Localism Manager and Mr A Tait, Democratic Services Officer.

UNRESTRICTED ITEMS**22. Minutes**

RESOLVED that the Minutes of the meeting held on 9 May 2008 are correctly recorded and that they be signed by the Chairman.

23. Monitoring of outcomes from conclusions and recommendations of previous Health and Overview Scrutiny Committee meetings

(Item 4 – Report by Overview, Scrutiny and Localism Manager)

(1) The Chairman informed the Committee that he had written to the Leader seeking resources for the Committee. He had sought agreement to appoint an additional Research Officer and Administration Officer to support the Committee.

(2) The Chairman suggested the formation of an Informal Sub-Group to consider these rolling monitoring reports.

(3) RESOLVED that the report be noted.

24. Application for Foundation Trust status by Kent and Medway NHS and Social Care Partnership Trust

(Item 5 - Report by Research Officer, Health Overview and Scrutiny Committee)

(Mr E Millar, Chief Executive and Mr J Sinclair, Director of Social Care, Kent and Medway NHS and Social Care Partnership Trust and Mr S Leidecker, Director of Operations: Kent Adult Social Services were in attendance for this item)

(1) Mr Millar gave a brief presentation to the Committee on the application by the Trust to achieve Foundation Trust status before answering questions from Members of the Committee.

(2) Questions included:-

- (a) Whether there was any option not to go down the Foundation Trust route. Mr Millar responded that it was unlikely there would be NHS Trusts and Foundation Trusts. He referred to the possibility of other Trusts taking over Mental Health Trust and he cited an example in Shropshire. He and his Chairman were ensuring that the Trust were fit for purpose and ready for Foundation Trust status;
- (b) Responding to a question about what improvements would there be to services Mr Millar said there would be improved Government arrangements. He spoke of the partners involved as governors which included the County Council, Medway Council, voluntary sector organisations, PCTs and probation. The second improvement concerned the finance arrangements whereby if a surplus is now made by the Foundation Trust it was possible for that surplus to be retained;
- (c) Responding to a question about the existing Trust and a Foundation Trust working in tandem and the model for Mental Health Mr Millar said there was a 'healthy model' for Mental Health. He added that what was important was adding value; and
- (d) In answer to a question about cleanliness Mr Millar said in the Patient Environment Action Team report two facilities were under-performing which the HOSC will wish to take an interest in. One of the facilities had subsequently closed.

(3) RESOLVED that the report be noted.

Mr M J Fittock assumed the Chair for the remainder of the meeting.

25. GP- led Health Centres

*(Item 6 – Report by Research Officer, Health Overview and Scrutiny Committee)
(Lynne Selman, Director of Citizen Engagement and Communications, Eastern and Coastal Primary Care Trust; Julia Ross, Director of Primary Care, and Bill Millar, Assistant Director of Primary Care West Kent Primary Care Trust were in attendance for this item. They were accompanied by Paul O'Brien and Michelle Ford, Dr R Hart, Maidstone Division of the British Medical Association, Dr Jenny Gill and David Barr, (Secretary) and Dr A Doyle, representatives of the Kent Local Medical Committee)*

(1) Dr Robinson said that as a believer in the NHS which was free at the point of delivery, he was concerned at the prospect of private companies entering into health care. He added that there was widespread confusion over whether there was a difference between GP-led Health Centres and polyclinics. He asked whether there was any truth to the suggestion that GPs would lose their jobs as a result of the implementation of this initiative. He had recently attended an open meeting in Sittingbourne and discovered that there were several single-handed GP practices on the Isle of Sheppey, that no less than 6 GPs in the area were shortly due to retire, whilst 26% of the local population were not registered. The establishment of a GP-led Health Centre in the Swale District would be an excellent idea.

(2) Lynne Selman and Julia Ross said that the purpose of setting up GP-led Health Centres was to target under-doctored areas and provide equitable access to primary medical services. It would involve investment in bolt-on services. Surgeries would be open from 8 am to 8 pm seven days per week and would be able to treat unregistered patients. There would be one such Centre per PCT, requiring an additional 600 new GP posts in the UK (3 or 4 per PCT). As a result, there would be no redundancies resulting from this initiative.

(3) Ms Harrison welcomed the initiative, saying that the population of the Isle of Sheppey tended to double during the summer months as a result of tourism. There was a considerable number of single-GP practices on Sheppey which were open at times which did not necessarily suit all concerned.

(4) Lynne Selman said that the location of the Centre on the Isle of Sheppey was still being considered. A number of consultation meetings had been arranged with the aim of gathering the views of as many members of the public as possible. Members of the Committee were most welcome to attend. She noted Ms Harrison's view that all HOSC Members should automatically receive invitations.

(5) Dr Gill said that as a Swale GP she was well aware of the problems faced in the District. This initiative represented a new model of a general practice with additional services included. It was nevertheless very important to ensure the maintenance of continuity of care which was valued by older patients in particular. The question was whether the current holistic, generalist approach to primary care would be jeopardised by the new centres. The creation of 2 or 3 new GP posts in Swale would not address the problems of the District where there was a shortage of up to 20 GPs.

(6) Mr Millar said that the service in West Kent was being developed within the community by expanding the service offered to a significantly increasing population. They were looking to build on the current pattern of general practices locally and identifying the needs of continuity.

(7) Dr Hart said that the BMA had identified a threat to doctor – patient relationships. GPs got to know the families they treated very well and became responsible for their welfare. This was a priceless asset. There was also a threat arising out of privatisation. It was quite possible that private companies could run a chain of polyclinics and seek to make profits, thereby taking away money that should be spent on improving healthcare.

(8) Mr Barr, the Clerk of the Gravesend Medical Committee said that Gravesend had a walk-in centre, an A & E and a co-operative of GPs. The addition of another centre could result in confusion and problems of providing continuity of care. To this day, there was no electronic communication system to enable the transfer of records. In West Kent, 75% of medical practices already offered extended hours. One of the consequences of this was that when blood tests were taken at 8 pm, the samples were not collected until the next morning. Gravesend wanted to extend the model of general practice to provide long term continuity. This had not proved possible as the PCT had not been able to provide the necessary finance. Now it was funding an untested initiative. A further problem lay in the fact that the Government set the bidding rules. As a result, it was possible that private companies could be successful, putting long term care in jeopardy.

(9) Mr O'Brien from the West Kent Primary Care Trust said that local practices had been successful in the notional bidding process. In GP-led Health Centres, local Members would be part of the Evaluation Panels, whilst the focus of Scrutiny would be on quality rather than price. The PCT Board had approved a three year investment programme of improvements for 31 practices. This would be complemented by the extended hours brought in by the Centres. This was an opportunity to address the health needs of the community through additional investment. The major issue was accommodation. It was possible that temporary accommodation would need to be used to provide an interim solution.

(10) Mrs Tweed noted that funding of £790,000 was being made available per Health Centre. She asked whether there was a danger of a private company setting up a walk-in clinic and then withdrawing from the project. Were there sufficient GPs available to put the plan into practice and was it really possible for the new GP-led practices to come on line by March 2009?

(11) Mr O'Brien replied that a detailed analysis had been undertaken which had led the West Kent PCT to the conclusion that resources would reflect the cost. Companies who put in bids would be subjected to a vigorous validation process. It was never easy for the Health Service to match the requirements of the Service to the needs of the population. It involved identifying local needs and gaps in order to improve access and outcomes and reduce health inequalities. A key factor in this process was local integration. An example of this was outside hours local diagnostic testing. As a result of technological advances, it was now possible to make this available on site.

(12) Mr Chell said that funding for GPs was based on population density at a rate of 10 Doctors per 1000 patients. The danger of providing GP-led Health Centres was that if they resulted in the optimum rate being exceeded, the local community would become "over-doctored" thereby jeopardising local surgeries. Lynne Selman replied that the locations for the Centres were chosen in those areas where there was a demonstrable lack of GPs.

(13) RESOLVED that the report be noted.

26. Accessing Healthcare – establishment of Select Committee
(Items 7 – Report by Overview, Scrutiny and Localism Manager)

RESOLVED to note the report and approve the establishment of an Accessing Healthcare Select Committee and the terms of reference.

27. "Fit for the Future" Workstreams – including decision on joint scrutiny of Urology Plans with Medway Health Overview and Scrutiny Committee
(Items 8 – Report by Health Overview and Scrutiny Committee Manager)

The Committee agreed Dr Robinson's suggestion that (on behalf of the Committee) he, together with colleagues from Medway Council, should be briefed on Stage 2 of the Commissioning process, to determine the site from which the core case-mix for specialist urology will be developed in West Kent.

Urology Services

1. At the meeting of the Health Overview and Scrutiny Committee on 13 June 2008 the Committee agreed that Dr Robinson should, together with representatives of Medway Council's Health Overview and Scrutiny Committee, meet with Health colleagues regarding the proposed reconfiguration of Urology Services across Kent and Medway and in particular the potential proposed site for Urology Services in West Kent. This meeting took place at the offices of Medway Council on the evening of Thursday 26 June 2008. The meeting was attended by Dr Fiona Craig, Interim Director of Commissioning, Medway Cancer Network, Lynne Whiteford, Executive Support, Medway Primary Care Trust, Councillors Brake, Murray and Sheila Kearney, Medway Council Health and Adult Social Care Overview and Scrutiny Committee, Rosie Gunstone, Overview and Scrutiny Co-ordinator, Medway Council, Dr Robinson, Kent County Council Health Overview and Scrutiny Committee and Paul Wickenden, Overview, Scrutiny and Localism Manager, Kent County Council.
2. The meeting were informed that the Urology Commissioning Review was part of the Kent and Medway Fit for the Future Specialised Services Review. The Urology Review had now reached Stage Two in its process. Stage One concluded at the end of December 2007, which primarily focussed on the number of Multi-Disciplinary Teams (MDTs) in Kent and Medway. The Evaluation Panel agreed there should be two MDTs, one in East Kent (at the Kent and Canterbury Hospital, Canterbury and not subject to this discussion) and one in West Kent. The external surgical members of the Panel went further to state that in West Kent there should be one surgical site for highly specialised urology. It is this element that had lead to the creation of Stage Two in the process.
3. Stage Two commenced in February 2008 to determine the site from which the core case mix for specialised urology would be delivered to West Kent. Two providers, representing three organisations, completed the site feasibility questionnaire; Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust (jointly as MDU) and Maidstone and Tunbridge Wells NHS Trust (MTW).
4. The responses have now been reviewed and clarification questions raised. Interviews have taken place with the two respective providers so that the Evaluation Panel could receive clarification on any outstanding queries.
5. It was explained that the guidance of Kent and Medway Health Overview and Scrutiny Committees was being sort as to whether they supported the current process and procedures so far undertaken as part of the review.
6. All through the process the views of expert patients had been sought. Members from both Kent and Medway HOSCs concluded that they were content that no further more formal consultation needed to be undertaken.
7. It was agreed that the Primary Care Trusts would now take the recommendations of the Evaluation Panel to the respective Primary Care Trust Boards for approval (*since the meeting the recommendation has been made*

that specialist urology services in West Kent should be sited at the Medway Maritime Hospital).

8. Members are asked to note that the patients who are affected by these proposals are in the region of 150 per year. Although the specialist urological procedures across West Kent will take place at the Medway Maritime Hospital patients' pre and post operative care will take place in their nearest district general hospital i.e. patients would be repatriated as soon as possible after their procedure.

Redesign of Inpatient Services for Older People with Mental Problems in the Eastern and Coastal Directorate of the Kent and Medway Partnership Trust

Introduction

In 2004, a comprehensive review of all mental health inpatient services (i.e. both younger and older adult) in east Kent was undertaken. The recommendation for younger adult services presented to and accepted by the Health and Social Services Joint Decision Making Committee, was the centralisation of all acute inpatient beds in a new unit on the St Martin's site in Canterbury.

However, the Joint Decision Making Committee did not accept the proposals for older adult services as they were devised in the absence of a whole systems strategy. The one recommendation which was accepted by the Joint Decision Making Committee was that, wherever possible, beds for older people with mental health problems should be co-located with District General Hospitals (DGHs) in recognition of the fact that this care group very often has co-existing physical problems.

The Strategy

A strategy which was agreed by both health and social services was completed in 2005 and was also presented to and supported by the HOSC. It describes a five tiered model, ranging from health promotion at one end of a continuum to long term care at the other. Tier four is concerned with acute assessment beds.

One of the principles described in the strategy is the delivery of services locally and caring for individuals in their own homes wherever possible and was to be achieved by increasing community services.

No changes to inpatient beds were proposed in the strategy as it was not possible to do this until the impact of increased community services was known.

Significant investment has been made into community services over the last two years. Additional investment has been made in the community mental health teams (CMHTOPs). A home treatment service and an Admiral nurse service has been established in Canterbury, Dover/Deal and Thanet. The home treatment service delivers support to individuals in their own homes and its aim is to prevent hospital admission and facilitate discharge. The development of this service has allowed the closure of 15 beds on the St Martin's site. It is proposed to establish home treatment services in the remaining localities, i.e. Ashford, Shepway and Swale in 2009/10.

The investment is part of a five year joint commissioning plan between health and social services and 2008/09 is year 3 of that plan.

Inpatient Redesign

The increase in community services has allowed the Kent and Medway Partnership Trust (KMPT) to develop a proposal for the future configuration of its inpatient services.

An additional driver for the redesign of inpatient beds is the fact that the beds currently located in the old St Martin's hospital were refurbished in 2005. This was achieved by the use of temporary buildings, for which the City Council granted temporary planning consent which expires in 2010. It is KMPT's long held intention to move out of these buildings, which are over 100 years old, by that date.

However, two units (Kelston and Discovery) have been taken out of use in recent years. They were stand alone units, with the associated risks identified in the Rowan Ward enquiry.

The loss of these beds has not resulted in any pressure on the remaining bed stock. This is a result of increased community support as well as changes to processes, ie

- More patients eligible for NHS continuing healthcare being cared for at home.
- The introduction of a more robust assessment and review process and beds no longer being a 'home for life'.
- Greater use of the private sector for patients eligible for NHS continuing healthcare.
- The introduction of the home treatment service which allows individuals to receive rehabilitation in a community setting.

The HOSC is invited to support these developments in line with the 2005 Strategy, which has enabled the closure of the Kelston and Discovery units.

Current Position

There are currently 91 beds for older people with mental health needs. There are no plans to reduce the number of beds at this time, but what will differ is where they are provided. The proposed number of beds has been validated by an external expert in 2006, and will be subject to ongoing review to take account of changes in need and demand, and service redesign.

The current distribution of beds is given below:

Arundel Unit, William Harvey Hospital, Ashford	20 beds
St Martin's, Canterbury	45 beds
Thanet Mental Health Unit, QEQM, Margate	26 beds

A long list of options for the future provision of inpatient services was developed by a multi agency stakeholder group. These options were assessed against a set of agreed criteria. The outcome of this exercise was that four potential options (including a do minimum option) were identified.

The options are described in more detail below. However, there are two constants in all the options.

- i) In order to reinforce that services are delivered on the basis of need (rather than age), 15 of the beds currently provided on the St Martin's site will be provided in the proposed new functional unit which was agreed by the Joint Decision Making Committee.
- ii) The number of beds in the Arundel Unit will be increased from 20 to 30 which reflects current patient flows.

The proposed distribution of beds in each of the options is shown below:

Location	Number of Beds		
	Option 1	Option 2	Option 3
New unit, St Martin's	15	15	15
Arundel Unit	30	30	30
Thanet Mental Health Unit	31	46	31
St Martin's (in addition to new unit)	0	0	15
Kent and Canterbury Hospital	15	0	0
Total	91	91	91

Consultation Process

The three options described above (plus a do minimum option) are currently the subject of a consultation process. The consultation will be concluded in August 2008.

Acknowledgements:

Linda Caldwell – Commissioner for OPMH Services, Eastern & Coastal Kent Primary Care Trust, Protea House, New Bridge, Marine Parade, Dover, Kent CT17 9HQ
 Tel 01304 222219, linda.caldwell@eastcoastkent.nhs.uk

John Carey – Director of Capital Planning and Major Projects, Kent & Medway Partnership Trust, Eastern & Coastal Area Office, Trust HQ, Littlebourne Road, Canterbury, Kent CT1 1AZ
 Tel: 01227 865819, john.carey@kmpt.nhs.uk

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Involving people in ...
**Mental Health Services
in east Kent**

June – July 2008

**What's your
preferred option for
inpatient services
in east Kent?**



Introduction

The Kent and Medway NHS and Social Care Partnership Trust is preparing to invest in the modernisation and improvement of some of its inpatient facilities in Margate, Ashford and Canterbury. These inpatient services are focused mainly on the needs of people with dementia-related mental health problems. However, some of these hospital beds also cater for people with other mental health needs. These services are mainly used by older people, though they may be accessed by people of any age, whose needs would be best addressed in these environments.

Before committing substantial resources to improving these environments, the Trust wants to understand the views of those people who may be affected by these changes themselves, or who care for others who may be affected. The Trust is also seeking the views of other partners and stakeholders prior to finalising its investment decision.

Which areas are included in the review?

Included in the review are the council areas of Ashford, Canterbury, Thanet, Shepway, Dover (and Deal).

Background

In 2005 local health and social care agencies agreed a multi-agency strategy for providing mental health services to older people in particular. That strategy confirmed the principles that underpin the investments we are now planning. These are:

- 1) Services should be delivered as locally as possible, supporting and caring for individuals in their own home whenever possible.
- 2) Services should always be provided, according to need, to everyone who is eligible throughout our area.
- 3) Services should be efficient and demonstrate value for taxpayers' money.
- 4) Most inpatient services for this group should be located on district general hospital sites as many older people with mental health problems also have physical problems which require access to diagnostic (eg x-ray, scan, etc) and other medical services. This is particularly true for people with dementia.

Why are we planning these changes now?

A significant amount of additional resources have been invested in community mental health services in the last two years, providing better support for service users and carers and enabling people to be cared for in their own homes. The most recent example is the home treatment service, which provides treatment for patients with dementia and includes specialist mental health professionals who can support and advise carers, enabling them to continue caring for their loved ones at home for longer.

In line with the strategy agreed in 2005, the increased availability of community services means fewer inpatient beds are needed for this client group and, as a result, over recent years the number of inpatient beds has reduced in line with investments and community alternatives. The Trust believes that any further significant reduction in bed numbers is unlikely in the foreseeable future and so the time is right to ensure that those inpatient beds which remain in the system are provided in modern, fit for purpose environments.

Furthermore, the beds currently located in the old hospital at St Martin's were refurbished in 2005 and have a limited lifetime. To achieve this it was necessary to construct temporary buildings for which the City Council granted only temporary planning consent. This expires in 2010 and it is the Trust's long-held intention to move out of these buildings, which are over 100 years old, by that date.

What is the situation at the moment?

The inpatient environments we are planning to improve are currently situated on three sites:

- 1) The Arundel Unit, William Harvey Hospital Ashford (20 beds on Winslow Ward).
- 2) St Martin's Hospital, Canterbury (45 beds on Ramsey, Cranmer and Edmund Wards).
- 3) Thanet Mental Health Unit, Queen Elizabeth The Queen Mother Hospital, Margate (26 beds on Sevenscore and Woodchurch Wards).

The focus of this consultation is on these 91 beds, which are primarily used by older people with mental health needs.

This document outlines the three different options for investment that the Trust is considering, alongside a further option known as the 'do minimum' option.

Options for change

The Trust has carefully developed three different options for new investment. To do this a long list of all the available options was developed by a group of relevant stakeholders which were

then rated against a set of criteria that had previously been agreed with service users and their carers, as well as a large number of mental health professionals. This work was supported by the local Primary Care Trust (PCT), which is responsible for commissioning services for the east Kent population. This exercise allowed the Trust to shortlist the options described in this document.

Criteria for short-listing options for consultation

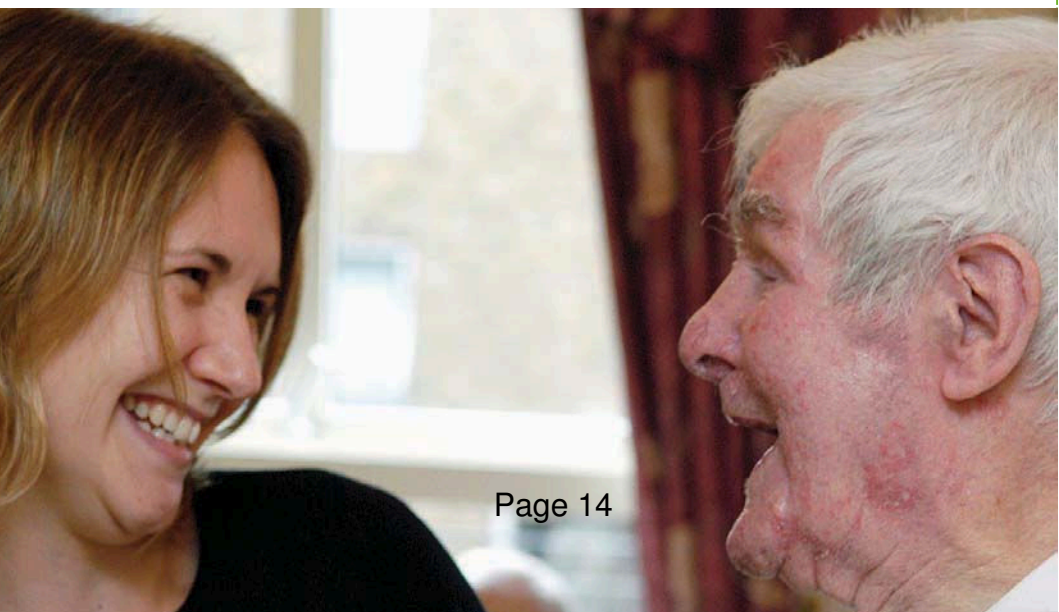
Every option was tested against the following criteria:

- 1) Does the option provide locally accessible services?
- 2) Does the option support best practice/national guidance?
- 3) Does the option provide the best environment for the client group?
- 4) Does the option provide appropriate access to the range of services?

Background to the options

All mental health services should be provided to people on the basis of their needs and not determined solely by other factors such as, for example, age. However, significant numbers of older people with mental health problems also have a range of age-related, mainly physical, needs that make it sensible to provide care on a district general hospital site for the reasons referred to earlier.

However, the Trust is keen to ensure that it provides a flexible mix of options for people who need to use its services and, for this reason, all three of the options for change include the relocation of 15 of the beds described above in the proposed new mental health unit at St Martin's Hospital, which was agreed after public consultation in 2004. That new unit is due to be available from late 2010 onwards and it is the Trust's intention to upgrade and modernise its remaining 76 mental health beds – the subject of this consultation – in broadly the same time scale.



Feedback Form

Over to you.....

1 Which of the four options you think is the most appropriate for people who need inpatient treatment. Please tick which option you prefer.

Option 1 Option 2 Option 3 Option 4

Please explain why you think this is the best option.
(Continue on a separate piece of paper if necessary.)

2 If you have experience of older people's mental health care in the community, do you consider that the service user has sufficient support for their needs? Please tick one

Yes Mostly No

3 If you are a carer do you consider that you get enough support for your own needs? Please tick one

Yes Mostly No

4 If you have answered no to either question 2 or 3 please tell us what extra support you feel you would like to receive, and give any suggestions for service improvement

5 Are you:

A carer A service user

A representative of a group A member of the public

6 Please give your postcode

Thank you for taking the time to respond to the above questions we value your input greatly. We are committed to developing services to meet your needs and the needs of future service users. Please detach this response form and post it to us. There is no need for an envelope or a stamp.

**Business Reply Plus
Licence Number
RRTH-AATU-CYUA**



**Eastern and Coastal Kent PCT
Brook House
Reeves Way
Whitstable
CT5 3SS**

Options

The options for the remaining 76 beds in the service, therefore, are as follows:

Option 1

Three units providing mental health inpatient services located on the three district general hospital sites in East Kent as follows:

31 beds on two wards at the Queen Elizabeth the Queen Mother Hospital, Margate.

30 beds in two wards at the Arundel Unit, William Harvey Hospital, Ashford.

15 beds in a new mental health unit on the Kent and Canterbury site in Canterbury.

Option 2

Two units providing mental health inpatient services on two district general hospital sites at opposite ends of the East Kent area as follows:

46 beds on three wards at the Thanet Mental Health Unit at the Queen Elizabeth the Queen Mother Hospital, Margate.

30 beds on two wards at the Arundel Unit, William Harvey Hospital, Ashford.

Option 3

Three units providing mental health inpatient services (two on district general hospital sites and one on a mental health site) as follows:

31 beds in the Thanet Mental Health Unit at the Queen Elizabeth the Queen Mother Hospital, Margate.

15 beds in a Mental Health Unit at St Martin's Hospital, Canterbury.

30 beds in the Arundel Unit, William Harvey Hospital, Ashford.

As stated above, all three of these options are in addition to the 15 beds that will be provided in the new unit at St Martin's Hospital in 2010.

Option 4

This is what is known as the 'do minimum' option and would involve changing as little as possible in the current arrangements, while focusing investment on meeting minimum standards throughout the service.

Summary

In all options it is proposed to increase beds at the Arundel Unit in Ashford.

In all options it is proposed to provide 15 of the existing 91 beds in the new unit proposed for St Martin's in 2010.

The main differences between the options are that:

In option 1): 15 beds for the Canterbury population are provided in a new unit on the Kent and Canterbury site.

In option 2): 15 beds would be provided in Thanet (totalling 46 beds) at the Queen Elizabeth The Queen Mother Hospital site.

In option 3): 15 beds would be provided in a separate mental health unit at St Martin's Hospital, Canterbury.

The options will obviously differ in terms of investment levels, in terms of local access and in terms of the location of 15 beds for the Canterbury population. The purpose of this consultation is to gather interested parties' views on each of these options so that the Trust can take account of these in confirming its investment decisions. That decision will also be informed by independently conducted financial and non-financial appraisals due to take place during the consultation period. The Trust Board hopes to make its decision in the early autumn of 2008.

How can you be involved?

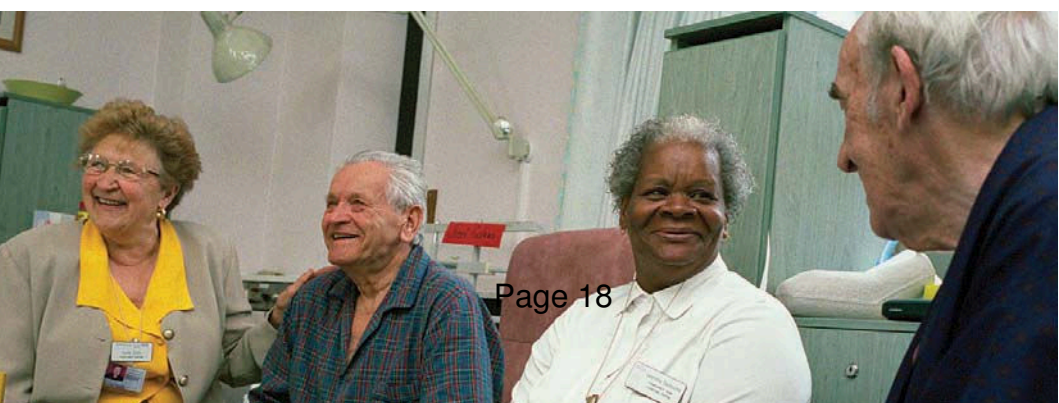
You are being invited to become involved in this review because the decision to be made can potentially affect all of us at some time in our lives – either as a relative, a carer, or as a patient.

Please read and carefully consider the details in this consultation leaflet about the proposals for Older Peoples Mental Health Services in eastern and coastal Kent.

Kent and Medway Partnership Trust would like to find out from you what is working well, what needs to be improved and which of the four options you favour.

Having read the information in the leaflet, please answer the questions in the Feedback Form. Once completed, detach it from the leaflet and send it to the address on the reverse of the form. The response form is self-addressed and there is no need for a stamp. All responses will be collated and taken into account when the final decisions are being made.

If you would like any further information in respect of this review, you will find details of a series of meetings to discuss its implications on our website at www.kmpt.nhs.uk/ekmhredesign. If you would like to organise your own group meeting to discuss these issues in more detail, please contact: Communications Department, Trust Headquarters, 35 King's Hill Avenue, King's Hill, West Malling, Kent ME19 4AX. Email: communications@kmpt.nhs.uk, or phone 01732 520441 and we will do all we can to arrange a meeting with your group.



To: Health Overview and Scrutiny Committee – 18 July 2008

By: John Beadle, Former PPIF member

Subject: Kent Audiology Services July 2008

During the past six months there has been a considerable reduction in waiting times for both new and replacement hearing aids with the result that the government targets of 18 weeks is now being met in most cases. However, this has been achieved, primarily, by the efforts of audiology staff and considerable overtime working. There has been little improvement in facilities and staffing levels.

In west Kent, many patients have had to attend clinics at Medway Maritime Hospital where group fittings of the hearing aid occur in groups of twenty. Facilities provided at Darent Valley Hospital are totally inadequate for the catchment area and thus many patients still have to travel to Medway for both regular and emergency appointments.

The follow-up system for audiology patients in Kent remains poor. "Best Practice Standards for Adult Audiology" published in 2002 and "Improving Access to Audiology Services" published in 2007, both state that patients should be reviewed regularly. This should be at least every three years, preferable less. For digital aids this review is vital to ensure that the aid is providing the best level of assistance. This is particularly necessary for patients with a severe and changing hearing loss. Nowhere in Kent currently provides a pro-active, re-testing programme. Patients are expected to obtain an appointment, via their GP, "if required". This is totally unacceptable for patients who are totally reliant on their aid for normal communication.

Patients should expect a review programme at least as good as that provided for spectacles, with a shorter time scale for those most dependent on their aids.

Unfortunately many NHS managers have the notion that the provision of a digital hearing aid is sufficient to provide an audiology service. With the accepted "life" of a digital aid only three to five years the crisis in this vital service will return unless the overall total service is improved.

John Beadle
Former PPI forum member

4th July 2008

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Directorate of Commissioning

Report on Audiology Services

The following timeline gives a high level summary of work undertaken by West Kent PCT to improve audiology services over the last 8 months. The attachment shows the PCT's response to the HOSC's detailed action sheet.

November 2007: West Kent PCT recognised the need to improve Audiology services. Maidstone & Tunbridge Wells NHS Trust had at this time 1380 patients on the Audiology Waiting List, with waiting times for hearing assessments at Kent and Sussex Hospital, 14 months and at Maidstone Hospital 12 months.

The PCT made a decision to invest an additional £480k into Audiology Services and contracted alternative providers to assist Maidstone & Tunbridge Wells NHS Trust in clearing the backlog of patients.

March 2008: By March 2008 alternative providers (Clinicenta, Specsavers, 21st Century Hearing Centre), and additional capacity at MTW had provided assessments for 574 patients and 386 of these patients had received digital hearing aids.

The PCT invested further funding in order to achieve the 6 week diagnostic target by the end of March 2008 and an additional 474 patients were seen.

March – June 2008: Further progress has been made and a total of 1050 patients have received hearing assessments with 900 patients receiving Binaural aids and 90 with single aids. 60 of this number either did not attend their appointments or did not require hearing aids.

Currently the number of patients on the Audiology Waiting List stands at 608 with no patients waiting longer than 6 weeks to be seen.

Having achieved a significant reduction in the number of patients waiting, the PCT is now in a position to begin to offer direct access, in a managed and gradual way allowing for GPs to directly refer their patients to Clinicenta so that patient will receive a hearing assessment within 6 weeks, and when required hearing aids within a further 3 weeks.

The PCT has established a robust performance system and the pathway is now well within the 18 week treatment target, achieving a significant improvement overall in Audiology services for West Kent patients.

Response by West Kent PCT to the Kent County Council's Health Overview and Scrutiny Committee Action Sheet: Audiology – Minute Reference 72, 14
December 2007

NHS (or other) body concerned – Eastern & Coastal Kent PCT, East Kent Hospitals NHS Trust, Kent Adult Social Services, Maidstone & Tunbridge Wells NHS Trust, Medway NHS Foundation Trust and West Kent PCT

Deadline/ bring forward date – August 2008

Recommendation/ action point	Action taken to date
<i>The Committee concluded that:-</i>	
<i>(a) further work needed to be done to inform the public of the new services being provided by Clinicenta;</i>	The backlog of patients on the waiting list has nearly been eliminated and the PCT will shortly be in a position to open up Direct Access for patients.
<i>(b) work needed to be undertaken on transport issues in relation to accessibility of healthcare services (the Committee noted that this was a piece of work that it had set aside for a Topic Review Select Committee to undertake early in the New Year);</i>	Transport arrangements have been made for audiology patients that meet the standard transport criteria.
<i>(c) the issue of the Joint strategic Needs Assessment should be picked up by the Health Overview and Scrutiny Committee in conjunction with both Health and Adult Social Care colleagues;</i>	
<i>(d) Public Health colleagues should ensure (possibly using Kent TV) that the public were made aware of the risks to their hearing posed by prolonged exposure to loud music;</i>	
<i>(e) data collection and collation for audiology services must be improved, to enable commissioners to commission services effectively;</i>	MTW has agreed to install practice navigator IT system to assist in data collection which will significantly improve collation of data.
<i>(f) it needed to be recognised that dealing with a patient with audiology needs was about more than just fitting a hearing aid;</i>	MTW are aware that treating patients with audiology needs is more than just fitting hearing aids and do refer patients to hearing therapy when appropriate.
<i>(g) patients were entitled to copies of their audiograms;</i>	MTW have in the past provided audiograms and will do so when patients ask for them
<i>(h) audiology should be recognised as an important service in the strategic plans</i>	Audiology has been recognised as an important service in several ways by the PCT.

Recommendation/ action point	Action taken to date
<i>of the Primary Care Trusts;</i>	It is recognised as part of the improving access which is a national target whereby patients must be seen within 18 weeks and within this the 6 week diagnostic target. 18 week and diagnostic targets are included within the PCT operating plans.
<i>(i) Hi-Kent Kent provided a valuable and well-respected service;</i>	The PCT maintain an agreement with Hi-Kent and Continue to provide funding towards their work
<i>(j) further work should be undertaken by the Primary Care Trusts and others to see whether it might be feasible to provide audiology services through "High Street" practitioners (along the same lines as dental and optical services);</i>	High Street practitioners have already been included in providing additional capacity. Specsavers and 21 st Century hearing centres were contracted in March 2008 to assist in helping to reduce the waiting list. The PCT is aware of the need to provide care closer to home and for the need of plurality of services
<i>(k) the Healthcare Commission Annual Health Check should take account of RTT waiting times for audiology services;</i>	
<i>(l) a written report on audiology services should be received by the Health Overview and Scrutiny Committee every four months;</i>	A system will be put in place to provide a 4 monthly Audiology report. Report to be provided by November 2008.
<i>(m) audiology patients should be subject to an automatic recall;</i>	Follow up and after care appointments are offered and patients can contact the Audiology department at anytime to make appointments.
<i>(n) as there had been no audit of audiology needs across the population of Kent, this needed to be undertaken as a matter of urgency;</i>	Audiology audit took place in March 2008 and a further audit in June 2008 took place.
<i>(o) patients should be encouraged to return hearing aids where they were no longer required or are not being used;</i>	Leaflets/Flyers to be given out or placed in GP practices and audiology practices with this information. September 2008
<i>(p) PCTs and others needed to consider carefully the mental health needs of people with hearing impairment.</i>	
RESOLVED that:- <i>(a) the conclusions of the Committee be conveyed to all those identified as having matters to take forward; and</i>	

Recommendation/ action point	Action taken to date
<i>(b) the Committee would expect an update on how these issues were being dealt with when it received the first written review of audiology services in four months' time.</i>	Topic provisionally scheduled for HOSC meeting, 18 July 2008

Audiology Services in East Kent

This paper is intended to give an update on the position of Audiology services currently commissioned by Eastern and Coastal Kent PCT (E&CK PCT) and the future plans of the service.

Waiting lists and times for Audiology have dramatically reduced since the last report to HOSC in December 07. The number waiting is down from 5000 in September 07 to 1091 (all on an 18 week pathway or less) in May 08 and from 96 weeks wait in July 07 to an average 12 weeks from referral to fitting in May 08.

Background and need for change:-

Referrals for Audiology services are made through one of three routes, via ear nose and throat Services, via direct access and self referrals made by patients who are upgrading their analogue hearing appliance for a digital aid.

Historically the average waits for Audiology services in East Kent have been in excess of 52 weeks, peaking in July of 2007 when the average wait was 96 weeks.

In September 2007 East Kent recognised over 5000 patients waiting (see table 1 below) with an average wait of 85 weeks.

The challenge for East Kent was to radically reduce the long waiting list and to bring waiting times in line with the national commitment to the 18 week referral to treatment target.

In December 2007 the E&CK PCT and East Kent Hospitals Trust (EKHT) were invited to discuss the current position and plans for recovery with the HOSC.

Key milestone achievements:-

Significant developments have been made within this service over the last year, especially with regards to East Kent hospital waiting lists.

In direct response to the challenge to reduce the long waiting list the PCT commissioned Hearbase as independent audiologists to help reduce long waiters; they agreed to treat circa 2000 patients by the end of March 2008. Hearbase currently work out of four sites based in Folkestone, Ashford, Canterbury and Dover.

In addition the PCT commissioned a community audiologist to work out of three GP practices (Whitstable, Deal and Ramsgate) to further reduce the backlog of waiters.

March 2008

At the end of March 2008 the number of people waiting for audiology services at EKHT were reduced below the target to 1056 of these only 449 patients were waiting

longer than 18 weeks through their own choice and the remaining 605 patients were all on 18 week pathways.

In recognition of the continued challenge to the provision and sustainability of audiology services in East Kent, E&CK PCT have made provision for an additional £1.7m to be made available through the Local Delivery Plan process to be used in securing additional capacity through the local hospital provider and an increase in community based services. In addition this funding will assist in dealing with an anticipated up turn in demand based on the success of securing reduced waits into the service, a Department of Health initiative that suggest that people over 55 years of age should be screened for hearing loss and the continued number of patients that might take up the opportunity to change their analogue aids for digital equipment.

April 2008

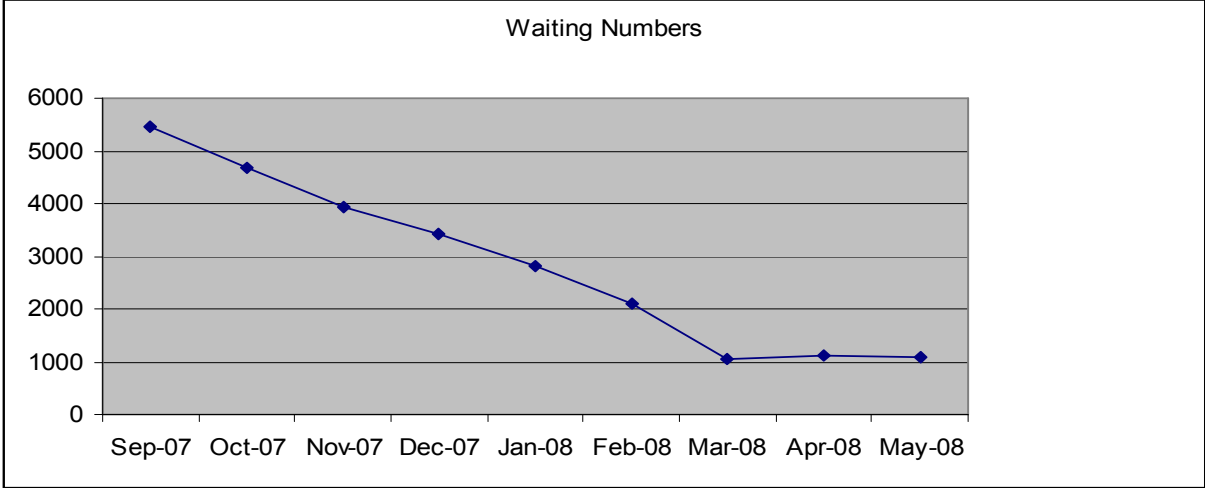
In April 2008 a fourth community audiology clinic was opened at Sittingbourne, to further support the drive for care closer to the home and to bring a much needed choice alternative to swale patients. Historically Swale patients have been referred to Medway NHS foundation trust for all audiology treatment.

May 2008

At the end of May 2008 the number of patients waiting for audiology services at EKHT is 1091; all patients are on 18 week pathway (assessment - fitting) which is in line with the national standard for all elective services. Direct access patients all have their assessment within 6 weeks and wherever possible and medically appropriate patients are often assessed and fitted on the same day. The average length from referral to the fitting of a hearing aid at EKHT is 12 weeks.

Open ear testing is also widely used, again where medically appropriate.

Table 1: Waiting List Progress



Choose and Book

Direct access to audiology at EKHT is now available via Choose and Book and the waits are in line with the national diagnostic target of a maximum of 6 weeks.

Hearbase and the community based audiologist have been given extended contracts and are now receiving referrals via the Choose and Book system. Average waits for these services is 4 weeks patients with a large majority of patients being seen with three weeks.

Performance Management

Throughout this time data collection has improved and the Audiology Service has been performance managed with the PCTs lead commissioner on a monthly basis on progress against the agreed action plan for full roll out of services. The following key performance indicators are also monitored and reported against –

- Number of new referrals received by source
- Number of new patients seen
- Number of bilateral fittings

In addition much work has now been done to unbundle the block contract for work at East Kent hospitals and Audiology work is now paid for on a cost per case basis, this enables a much more detailed understanding of performance as a whole.

In addition to the above a whole system service improvement group has been established that has a membership that includes GP's, Consultant Audiologists, Finance and Practice based commissioning representatives and a representative from HI-Kent.

Future Planning

E&CK PCT are undertaking a base line audit to look at the current referral trends over the first quarter of 2009/09 to assess any increase in demand and to establish where patients are accessing the service. As commissioners we continue to proactively search for interested willing providers to declare their ability and desire to provide services in the future. As we establish the future levels of demand we will be working in partnership with all interested parties and stakeholders to establish a platform for sustainable service across the economy.

In addition we continue to work with Medway NHS Foundation Trust to further establish links and opportunities for Swale residents to be able to receive services closer to their homes and enable swifter access to Audiology services and for GPs to be able to make such referrals through the Choose and Book system.

Alison Davis
Assistant Director Delivery & Performance
alison.davis@eastcoastkent.nhs.uk

July 2008

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Summary of the House of Commons Health Committee Report on Dental Services

Fifth of the Session 2007-2008

Introduction

The nation's oral health has improved significantly since the establishment of the NHS General Dental Service (GDS) in 1948. As recently as the 1960s the proportion of the adult population in England and Wales who were edentate (toothless) was 37%. The latest figure is estimated to be 6%.

Nevertheless, by the 1990s there was a powerful case for reform of the GDS contract. It was widely agreed that, while in some areas of the country provision of NHS dentistry was good, overall it was patchy. Moreover, the payment system lacked sufficient incentives for the provision of preventive care and advice. In addition, the Department argued that there were too many incentives to provide complex treatment.

In April 2006 the Department reformed the GDS making a number of far-reaching changes: Primary Care Trusts (PCTs) were given the power to commission dental services; the patient charging system was simplified; and under the terms of a new dental contract, dentists were remunerated according to the number of Units of Dental Activity (UDA) completed. The Department issued a number of criteria for success: patient experience; clinical quality; NHS commissioning and improving dentists' working lives. We looked at whether they had been met.

The patients' experience

The Department's original goal that patient access to dental services would improve from April 2006 has not been realised. The Chief Dental Officer admitted this, but claimed that the situation had stabilised and that improvements would soon be realised as a result of new facilities being established. However, the various measures of access all indicate that the situation is deteriorating. The total numbers of dentists working for the NHS and the activity (number of courses of treatment) they have provided for the NHS has fallen, albeit slightly. In addition the total number of patients seen by an NHS dentist between December 2005 and December 2007 has fallen by 900,000 compared with the two years up to March 2006. Although in some places access to dentistry has improved since 2006, it remains uneven across the country. In some areas severe problems remain.

The introduction of the new charging system has simplified the system for patients. However, there are problems. Some courses of treatment such as those involving a single filling have become more expensive. In addition, different patients are charged the same amount for very different treatments which fall within the same charging band. We heard concerns that some low-income patients store up dental problems and delay visiting their dentist, at some cost to their long-term dental health.

Clinical quality

While the Department argued that the new contract would improve preventive care, this was disputed by dentists who claimed that the new contract failed to provide the time and the financial incentive to do so. We recommend the Department undertake research to determine the extent to which preventive advice is being given and its cost-effectiveness.

Some PCTs and the Department have made efforts to provide dental care for those people who visit a dentist infrequently. However, we received no evidence about how many PCTs conduct similar initiatives or about how cost-effective they are. The Department should monitor the impact of outreach initiatives with particular attention to their cost effectiveness.

The number of complex treatments involving laboratory work fell by 50% during the first year of the contract. The number of root canal treatments has fallen by 45% since 2004. At the same time the number of tooth extractions has increased. The reason for the decline in the number of complex treatments since 2006 has not been explained satisfactorily and we are very concerned that some patients do not receive the quality of care they need within the NHS. There is no evidence for the Department's claim that the decline is to be explained by more appropriate simpler treatments. The Department must publish an explanation for this trend and commission research into the effect of this decline within the NHS system and its impact on oral health.

The Department has acknowledged that changes in 2006 to the way treatments were recorded led to a decline in the quality assurance mechanisms for dentistry. Although the Department responded in April 2008 by introducing an "enhanced data set", it is too early to determine at this stage whether this will prove sufficient to improve both clinical and financial accountability.

PCTs

The Minister admitted that PCT commissioning of dental services has been poor. Many PCTs possess weak in-house commissioning skills and fail to make full use of Specialists and Consultants in Dental Public Health when assessing local dental needs and commissioning services. SHAs, which have responsibility for managing the performance of PCTs, have failed to do this adequately. PCTs with low numbers of dentists committed to the GDS have suffered from the Department's decision to allocate funds to PCTs on an historic basis.

Dentists' working lives

The new remuneration system based on UDAs has proved extremely unpopular with dentists. To make matters worse too many PCTs seem to have set unrealistic activity targets and have applied UDAs too rigidly. It is extraordinary that the Department did not pilot or test the UDA payment system before it was introduced in 2006.

Looking ahead, there are fears that many established dentists will leave the GDS following the end of their income guarantee in 2009, but the Department argues that no

such exodus of dentists will occur. We lack the evidence on which to judge the more likely outcome, and recommend that the Department monitor closely the career plans of NHS dentists.

There are also concerns that some overseas dentists are insufficiently familiar with the dental equipment and treatment provided within the NHS. PCTs must ensure that all dentists, irrespective of where they were trained initially, are of the standard necessary to provide high quality dental care.

Improvements to the system

We make a number of recommendations for improving dental services. PCTs should improve their commissioning by drawing on advice from dental public health specialists and SHAs must improve their performance management of PCTs. In addition, the Department must base future PCT dental funding on a local needs assessment, not on an historic basis.

We recommend that patient registration be reinstated because dental care is most effective when delivered over time and as part of a trusting dentist-patient relationship.

In the short term the Department should consider increasing the number of UDA bands so that dentists are rewarded for providing appropriate treatment. In the longer term we recommend that the Department review the UDA system and consider whether it is the best mechanism for delivering oral health care. In addition, the Department should consider the introduction of a Quality Outcomes Framework (QOF) style reward system for dentists who improve the dental health of their patients. It is vital that any changes to the system should be piloted and tested rigorously.

Finally, we welcome the Department's decision to analyse how dental services might develop over the next five years. The analysis should identify the Department's response to the changing nature of dentistry. In particular, it should clarify the level of service which should be provided by the NHS and it will need to address the extent to which NHS dentistry should offer the growing number of treatments which do not address clinical ill health but are concerned with improving the quality of life.

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Commissioning update for Dental Services

The objectives of the new models of care are to:

- Ensure that we commission safe, high quality services that deliver improved health outcomes for the local population.
- Reduce health inequalities and secure excellent levels of patient satisfaction.
- Prioritise investment of our resources in services that will both meet the health needs of the local population and deliver excellent value for money.

Introduction

The new dental contract which was implemented in April 2006 introduced a completely new system of registration, activity monitoring and patient charging for patients and PCTs. Patients no longer register with dentists as under the new contract 'registration' no longer formally exists – patients are able to contact a practice offering NHS dentistry and ask for an appointment.

The PCT is now responsible for local NHS dental services and:

- commissions local dental services
- agrees contracts with NHS dentists for services that best meet local needs
- can influence where new practices are established
- is responsible for urgent and out-of-hours care in the area

Dentists' performance against contract is now measured in **Units of Dental Activity** (UDAs), or **Units of Orthodontic Activity** (UOAs), depending on the contract held. Each contract has a target of UDAs or UOAs to achieve for the year.

Activity is awarded to the contract in UDAs on the basis of the band of treatment carried out. For example one unit of dental activity includes an examination, diagnosis and preventive care. If necessary, this will include X-rays, scale and polish, and planning for further treatment (band 1). The patient charges collected by dentists are netted off the regular monthly payment made against the contract. The PCT is funded on a net budget basis, i.e. assuming a level of patient charge revenue (PCR). The risk associated with fluctuations in that income rests with the PCT.

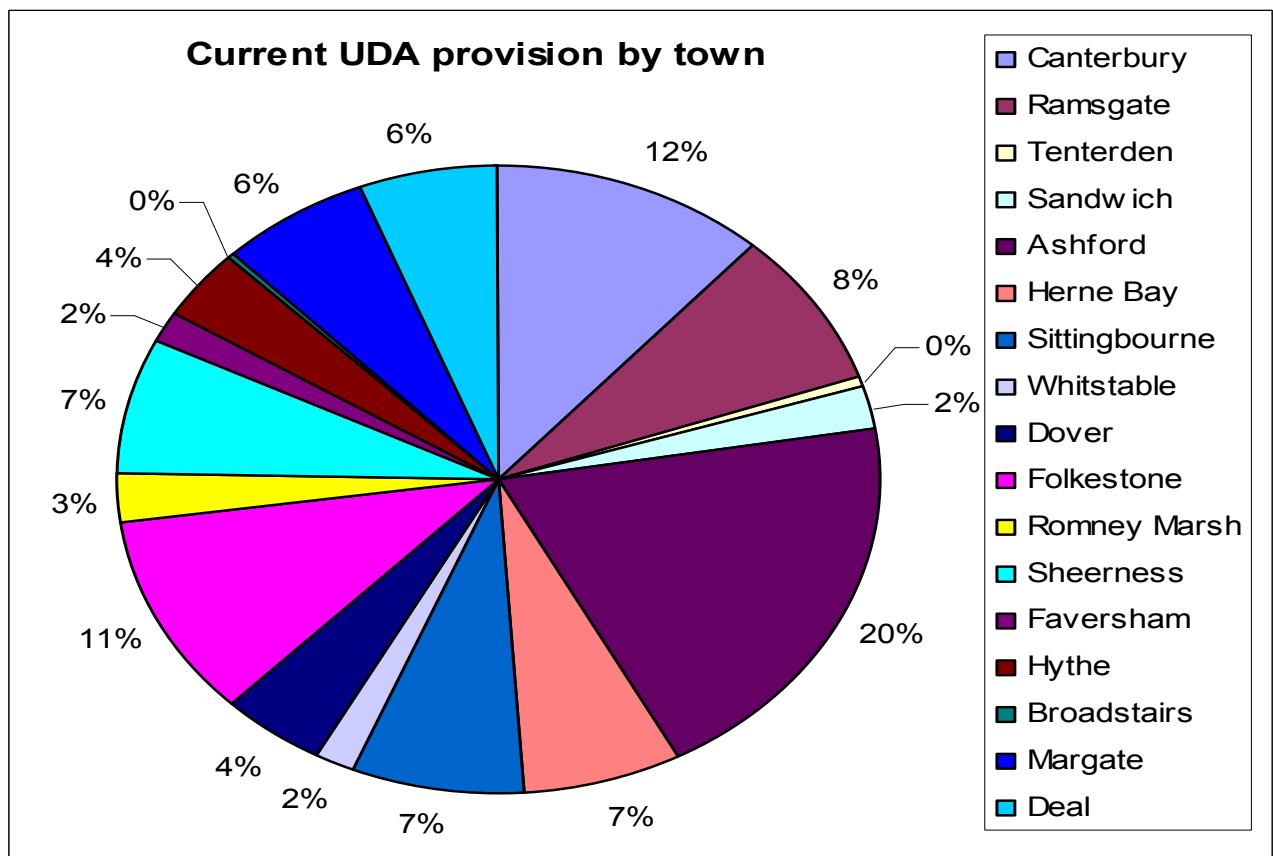
PCT Dental Activity & Financial Performance Targets

When the new dental contract was introduced each PCT was allocated funding and activity associated targets based on the historic provision of dental services in their area. This funding is ring fenced for three years for dental services and the PCT receives a net allocation. The allocation for Eastern & Coastal Kent PCT is as per table below.

SHA allocation	£	
SHA allocation 2008/09	22,840,000	(Net allocation £23,840,000 less estimated £1M for community dentistry)
Vocational trainees		Additional funding from SHA for trainees
LDP funding		
LDP funding (recurring from 2007/08)	500,000	Orthodontic (recurring)
LDP funding (recurring from 2007/08)	309,460	Routine general dentistry pt 1 (recurring)
LDP 2 (recurring from 2007/08)	250,000	recurring
Orthodontic funding	1,800,000	Recurring for 1400 waiting list
Total funding	25,699,460	

LDP funding was allocated to address any over performance of the General Dental Services (GDS) contracts during 06/07 and also to look at reducing waiting times for orthodontics.

The PCT currently has 100 dental contracts providing around 964,000 UDAs per year. The following graph shows the PCT's UDA provision by town.



Many of the PCT's practices have been encouraged to increase their provision where possible and have been awarded temporary contracts, 25 practices have taken up this offer and are providing an additional 91,000 UDAs and 37,000 UOAs at a cost to the PCT of £4.01m.

This spare funding, along with an increased budget of 11% from the Department of Health, means that the PCT is in a position to tender for permanent dental services in all major towns in its area including many areas that currently have poor provision. These include: Ashford, Broadstairs (Thanet), Canterbury, Cliftonville (Thanet), Deal, Dover, Eastchurch (Sheppey), Folkestone, Sittingbourne and Tankerton/Whitstable. There is a total of £1.9m being invested in dentistry which will provide approximately 90,000 additional UDAs each year.

The Department of Health recently announced that the ring-fenced allocation for dentistry will continue beyond the original financial year of 2008-09 to 2010-11. This will enable PCTs to concentrate resources on dentistry for a longer period to ensure that the service is stable.

How we monitor contracts

The total number of UDAs provided up to the end of March 2008 was expected to be 1,167,499 although the number reported to date is 900,109 the data collection method used introduces a time lag of up to six weeks and final position will be known in mid June. Where a dental provider appears to have significant underperformance the dental contract team has met with them to understand any in year issues and agree actions to resolve the shortfall making sure the allocated resources are used appropriately. The PCT has a robust policy to ensure that any underperformance funding is paid back to the PCT via the payments on line system.

The PCR collected is regularly monitored against target.

Needs assessment

Whilst no formal needs assessment for dentistry exists currently, the PCT does have a good knowledge of where particular gaps in the service lie and is looking to fill these with the upcoming tenders. It has, however, invested in additional specialist work by the Department of Dental Public Health to create an assessment.

Service gaps

One particular area is around domiciliary care, for the PCT as a whole. Work is underway to address this issue using the PCT's salaried service with a plan to provide a domiciliary service to nursing homes.

Orthodontics:

The PCT has invested in reducing the waiting times for orthodontics in line with the 18 weeks in place in secondary care.

LDP funding has been allocated to existing contractors to reduce the existing waiting times and ensure the waits are no longer than 18 weeks. A Service Improvement

Group (SIG) has been set up to look at care pathways for orthodontics in both primary & secondary care.

New services

The new health centre in Sheerness has two dental chairs for GDS, it is proposed that these are tendered for.

The new Health Centre in Aylesham is designated as a community dentistry function, the service will re locate to the new building and activity will be increased for those children and young people with special needs.

Training Practices

There are five dental contractors who are training practices, vocational trainees (VT) are attached to the practice for a year following university qualification as a dentist. These posts are funded in addition to the PCT GDS contract .This provides a strong basis for the development of dentistry and improvement in access as these dentists are able to take on an additional caseload of patient care. The PCT needs now to develop a strategy to encourage VTs to remain in the area on a permanent basis once their training is complete.

Jayne Macdonald
Head of Primary Care and Community Commissioning
Jayne.macdonald@eastcoastkent.nhs.uk
July 2008

Directorate of Commissioning

Update on NHS Dentistry

This paper provides a summary of the progress West Kent PCT (WKPCT) has made in improving access to NHS dentistry.

1. New Contracts

The PCT awarded in March 2008, 5 new dental contracts totalling £1.8m to provide an additional 87,000 units of dental activity. Each of these contracts was to improve access in the following areas;

- Tonbridge
- Tunbridge Wells
- Sevenoaks
- Maidstone
- Staplehurst

1.1 Current Position

Sevenoaks & Tonbridge Contract was awarded to Oasis Dental Care and commenced from April 2008 providing a total of 29,000 units of dental activity.

Staplehurst contract was awarded to Beaconsfield Dental Services and commenced in June 2008 providing a total of 18,000 Units of Dental Activity.

Maidstone contract was awarded to ADP Healthcare and the contract for 20,000 units of dental activity commencing from the 18 August 2008.

Tonbridge contract was awarded to ADP Healthcare and the contract for 20,000 units of dental activity commences on 8 September 2008.

2. Commissioning Plan for Oral Health services

The PCT board approved at its May public meeting a Strategic Commissioning Plan outlining how oral health services can be delivered most effectively for the population of West Kent in order to:

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

The key challenges for the PCT to address include:

- Delivery of NHS access to meet population needs
- Establish appropriate PCT resources focused on oral health
- Improve performance management throughout oral health services
- Limited PCT ownership and financial transparency for Salaried and Emergency Service contracts

The needs assessment undertaken as part of the commissioning plan indicated that the PCT has enough planned Units of Dental Activity (UDAs) to meet the current needs of its population. The PCT estimate that the additional £1.4m will be sufficient to cover the growing demand through increased population and people returning to the NHS. There is evidence of both under performance and over performance across the full spectrum of providers. The balance of which is a significant under performance across the board, which will be addressed through the new contract management arrangements. The first step is to ensure that current providers are performing to the level commissioned and therefore additional commissioning of services should complement the PCT’s commitment to oral health, demonstrated by the renewed rigour for performance management, rather than replace it. This performance management should closely monitor projected performance and to take appropriate with the dental performers.

2.1 Service Priorities

Through stakeholder meetings the following priorities for the oral health service have been highlighted:

PRIORITY AREA:	Individual Priorities:
ACCESS	<ul style="list-style-type: none"> • Improve access to NHS dental services in order to meet both the baseline set in April 2006 and subsequent annual uplifts (for example 8% uplift in 2008/09); • Transfer appropriate services from secondary to primary care supporting the provision of the appropriate range of services in primary care settings at required capacity levels.
COMMISSIONING CAPACITY & CAPABILITY	<ul style="list-style-type: none"> • Establish a PCT dental commissioning team; • Agree a commissioning process which achieves the required capacity targets and also specifically addresses areas where access is not adequate (regardless of reason such as retirement, move to private practice, etc.); • Increased transparency of financial decisions relating to dental services – e.g. capital monies allocation – which should be clearly aligned to the agreed commissioning processes and associated operational action plans.
PERFORMANCE	<ul style="list-style-type: none"> • Review the variance in contracted UDA rates across the PCT (currently between £17.29 to £38.65); • Incentivise performers to provide NHS services; • Effectively manage contract performance; • Improve relations with dental performers; and • Quality monitoring and performance delivery.
HEALTH PROMOTION & PREVENTION	<ul style="list-style-type: none"> • Deliver co-ordinated oral health promotion and prevention across the PCT as part of a structured and funded oral health promotion programme;
TRAINING &	<ul style="list-style-type: none"> • Improve commissioning liaisons with the Deanery for

EDUCATION	<p>professional training and CPD in order to attract the increased number of trainee posts in local practices and subsequently encourage newly qualified dentists to remain in the area;</p> <ul style="list-style-type: none"> • Training programmes for Dental Care Professionals (DCPs) and Vocational Training (VTs)
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These priorities have each been addressed in turn in the Strategic Commissioning Plan.

3. Current work programme to address the recommendations of Dental commissioning plan

3.1 Contract Performance 2007/8

The PCT has recently received information from all of its contractors for last year showing an improvement on performance in 2006/7 from 84% to 95% in 2007/8 an increase of 11%. Discussions have now commenced with contractors who have under and over performed their contracts.

3.2 Dental Commissioning Team

The PCT during July is recruiting a new team to take the lead in implementing many of the recommendations contained within the commissioning plan

3.3 Salaried Dental Service

The PCT will by August 2008 produce a revised service specification with Medway PCT to establish that the salaried service delivers the requirements of West Kent PCT. This specification will redefine the standards of service and outline the outcomes expected by the PCT. This specification will seek to incorporate the intended changes with the GDS within the PCT. This will also explore the options to incorporate domiciliary activity within the salaried service.

3.4 Emergency Dental Service

The PCT will by August 2008 have revised the existing service specification with Medway PCT to establish that the emergency service delivers the requirements of West Kent PCT. This specification will redefine the standards of service and outline the outcomes expected by the PCT.

This specification will seek to incorporate the intended changes with the GDS within the PCT. It will be important that this specification also reflects the on-going urgent care programme within West Kent PCT, which could include the national intention of introducing HRG tariff prices for urgent care treatment which will take in dental emergency treatment.

3.5 UDA Incentivisation

The PCT has commissioned a review of the existing rates of pay given to contractors in order to reduce the disparity in UDA rates and provide equity across the system.

This work will be completed by August 2008 to create greater transparency on the treatment of 'basic' and 'complex' procedures.

3.6 Procurement Process

The PCT has commissioned a review of the existing process to award new contracts in order that the timescales can be reduced which will include a revised specification for new NHS dental contracts and undertake further procurement for additional activity later this year.

Diabetes – Local Health Economy Position – July 2008

1. Introduction

This briefing describes the following areas:-

- National Perspective
- Local Health Needs Assessment
- Local priority

2. National Perspective

Diabetes is a metabolic disease which is characterised by hyperglycaemia (raised blood glucose concentration). This results from defects in insulin secretion or insulin action, or both.

In 2007 the estimated prevalence of diabetes, (diagnosed and undiagnosed), was 4.82% of population of England (2,465,000 persons). People living in deprived areas are about 40% more likely to have diabetes compared to those living in less deprived neighbourhoods.

2.1 Obesity

Being obese and having a sedentary lifestyle significantly increase the risk of developing diabetes. The National Audit Office suggests that 47% of Type 2 diabetes can be attributed to obesity. Body Mass Index data from the Health Survey for England indicates that the proportion of obese adults has risen dramatically since 1991. A linear extrapolation of this trend indicates that 29.4% of men and 28.6% of women may be obese by 2010.

By the year 2010, diabetes prevalence is forecasted to be 5.05% of the population of England. This means there will be a 15% increase in prevalence between 2001 and 2010, (6% increase due to ageing population and 9% due to increasing obesity).

2.2 Mortality and morbidity

It is estimated that global excess mortality attributable to diabetes was 2.9 million in 2000. This equates to 5.2% of world causes of mortality, making diabetes the fifth most common cause of death. Deaths from diabetes in upper and middle income countries are predicted to increase by 80% between 2006 and 2015.

3. Local Health Needs Assessment

A local needs assessment for the population of Eastern and Coastal Kent is currently being undertaken which is pivotal in agreeing commissioning priorities for the future.

In 2006/2007, approximately 28,913 people were diagnosed with Type 1 and Type 2 diabetes in the Eastern and Coastal Kent area. It is estimated that this equates to approximately 94% of people with diabetes, therefore 6% remain undiagnosed. Eastern and Coastal Kent has a diabetes prevalence of 3.8%, compared to 3.55% nationally.

Evidence suggests that the prevalence of diabetes is closely linked to social deprivation. 22% of the Eastern and Coastal Kent population live in areas classified amongst the 20% most deprived nationally. Only 2.6% of the local population reside in wards in the most affluent national deprivation quintile. Deprivation is highest in urban areas, particularly in Thanet, Sheppey, Dover, Folkestone and parts South Ashford.

The highest prevalence rates of diabetes appear to be largely along the North Kent coast, notably in Thanet, Herne Bay and in Sheppey. Other concentrations are immediately to the West of Ashford Town, with further high prevalence in the Romney Marsh area and Hawkinge. Rural areas around Canterbury, Ashford and to the North-West of Shepway have the lowest prevalence rates.

Prevalence of diabetes increases in those who are obese, have a poor diet, lack of exercise and those with a family history of the disease. 23% of people in the local area are estimated to be obese.

The percentage of local prescribing spent on drugs used in diabetes in the 2007 calendar year was 7.39%. Costs are likely to rise at least in line with population increase, ageing population and obesity levels

4. Local Priorities for the Diabetes Service Improvement Group

Following the formation of Eastern and Coastal Kent PCT in 2006, the Local Health Economy Diabetes Service Improvement Group was established. This group is undertaking a complete review of diabetes services across the whole of the East Kent and Swale area. This involves all diabetic service providers for both adults and children.

National drivers such as the Diabetes National Service Framework and NICE guidance will inform many of the key priorities for the forthcoming year. In addition to addressing top priorities, the Diabetes Service Improvement Group will be updating the diabetes strategy to address longer term goals, ensuring that services commissioned for diabetes are of a world class standard.

Key priorities for 2008/09 are described below.

4.1 Care pathways

The current diabetes care pathway was agreed in 2005/6 and needs to be reviewed in the light of new evidence-based practice and national guidance. This will also be informed by the local needs assessment. The pathway will span the initial GP intervention through to the specialist involvement within secondary care. The revision of the care pathway will include how patients' needs are met and care delivered, wherever possible, closer to home. Priority areas are foot care provision and access to insulin pump services.

4.2 Patient and Public Involvement

The diabetes Healthcare Commission service review focused on Patient and Public Involvement and was timed to make maximum use of the National Diabetes Patient Survey. The results published in July 2007, scored the PCT as 'fair' for the following elements:

- Adults with diabetes feel supported to self care through care planning, information and education
- Adults with diabetes have key tests and measurements carried out
- Adults with diabetes are looking after their condition

The priority areas of work and new investments are addressing these findings to improve the patients' experience.

4.3 Patient Education

The PCT continuously aims to empower patients and encourage them to become actively involved in making choices that will improve their level of well being. Education is key to this and Eastern and Coastal Kent PCT has commissioned two areas of education for diabetes both Type 1 and Type 2:

DAFNE – This stands for Dose Adjustment for Normal Eating. It is a way of managing Type 1 diabetes and provides people with the skills necessary to estimate the carbohydrate in each meal and to inject the right dose of insulin. DAFNE usually involves attending a 5-day training course plus a follow-up session around 8 weeks after the course and yearly half-day top-up sessions. The structured teaching program is delivered by dieticians and diabetes specialist nurses to groups of 6-8 participants.

So far there has been good attendance at the sessions provided by Eastern and Coastal Kent Community Services, with positive patients' reports.

DEREK – This stands for Diabetes Education and Review in East Kent and is based on the national DESMOND programme for type 2 diabetes. It fulfils all of DESMOND criteria and extends it to include education related to exercise and podiatry.

4.5 Diabetic Retinopathy

The PCT commission the Paula Carr centre, located at the William Harvey Hospital in Ashford, to deliver the retinal screening programme and the target of 100% is now being achieved. This service applies to people over the age of 12 years. They will be screened annually or given a 6 monthly follow up if concerns are identified. If further problems are identified they will be referred onto the appropriate Consultant.

The residents of Swale currently access Medway Foundation Trust and it is proposed that the Paula Carr will be commissioned to provide services for Swale from 1st April 2009 to enable equitable access across the PCT area.

4.6 Insulin Pumps

Additional investment has been made to support services for Type 1 diabetics who require insulin pumps this service aims to increase patient choice, improve clinical care and reduce health inequalities. This will ensure that patients receive a local service as currently the service is provided by Kings, London.

4.7 Specialist Interventions

Additional investment has been made for dietetics and diabetes specialist support to address the inequalities across the local health economy. This addresses the inequity of service for patients across East Kent as per aims of the white paper, 'Our Health, Our Care, Our Say' which clearly states that "services should be designed around the individual rather than the needs of the person being forced to fit around the service that already exists" and "the need to have more support for patients with long term conditions within the community".

Sally Allum
Assistant Director Clinical Performance
Sally.allum@eastcoastkent.nhs.uk

Pam Akhurst
Commissioning Lead for Physical Disabilities and Long Term Conditions
Pamela.akhurst@eastcoastkent.nhs.uk

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Directorate of Commissioning

Update on Diabetes

This paper provides a summary of the proposed primary care procurement of West Kent PCT for diabetic services.

Diabetes has a major impact on the health of the population of West Kent. There are approximately 22,000 people with diabetes among the registered population of the PCT (this represents 3.3% of the population). Currently the PCT is estimated to spend approximately £13.3m on the prevention, identification and treatment of diabetes for the population in West Kent.

The number diagnosed with diabetes is increasing and this represents a considerable challenge to healthcare professionals in providing high quality care. At a stakeholder event in November 2007 a wide range of multi-disciplinary professionals involved in diabetes care collectively defined a clinical pathway for diabetes. Building on this expertise and other National recommendationsⁱ, the Chief Executive delivered a presentation to Diabetes UK in Tunbridge Wells, sharing the vision for a Diabetes Community-Based Model of Care to provide rapid access to the right care, at the right time, from the right person.

Diabetes Community-Based Model of Care

The Diabetes Community-Based Model of care provides a framework to reduce inequalities and to provide high quality care for all. The model is similar to the principles adopted on other models for Long Term Conditions, whereby 80% of care is provided within primary, community and self-management settings. This means that 15% of care will be offered through intermediate care with only the most complex 5% of patient care being provided in specialist secondary care settings.

Practice based commissioning leads and diabetic consultants have been consulted and the Diabetes Community-Based Model of Care has been modified taking account of these views. The model is to be adopted formally at the PBC Board on the 29th July 2008 prior to working up the full commissioning strategy for local delivery.

Primary Care

Patients with stable type 2 diabetes are generally managed in primary care. However, many patients are being inappropriately followed-up by specialists in secondary care. This is not effective use of limited resources.

As part of the community based diabetes model of care to provide a high quality integrated diabetes service, every single general practice will be required to reach the awareness and capability of diabetes consistent with providing a Warwick

Diploma level trained practice nurse to ensure that all patients can be appropriately managed within primary and intermediate care, with only those requiring more specialised care being referred to secondary care. This will mean a substantial improvement in the knowledge and awareness of a number of practices and assure that high quality care is provided for all patients across West Kent.

Quality of care will be monitored by looking at primary care data and creating profiles of practices based on a basket of indicators such as; expected verses observed prevalence, HbA1c, Lipids, BP etc.

Intermediate Care

At present there are 3 diabetes centres in West Kent. The diabetes centres are located in secondary care at Darent Valley Hospital, Maidstone Hospital, and Pembury Hospital. Currently patients with intermediate care needs i.e. poorly controlled type 2 diabetes or relatively stable type 1 diabetes are currently being referred to diabetes centres. This group of patients could be more effectively managed in intermediate care settings in the community. Referring these patients to Diabetes centres in secondary care makes inefficient use of limited resource.

The community based diabetes model aims to provide a one-stop diabetes service supported by a multi-professional healthcare team in the community. Some elements of care currently provided in diabetes centres will be shifted to intermediate care settings in the community. It is envisaged that intermediate care can be provided either in GP surgeries or other community settings in a hub-and-spoke fashion. Consultants will be commissioned to provide system supervision and community outreach services and will work closely with local GPs who have a special interest in Diabetes (GPwSI) and will oversee the training programmes for all levels. This arrangement will also provide opportunities for all GPs to work alongside consultants to continue their professional development and update their knowledge and skills in diabetes. This will ensure specialist knowledge is shared to benefit the widest number of patients.

Once established it will be possible to shift care that was previously in the dominion of secondary care to an intermediate care setting in the community. For example, diabetic young adults (aged 16-25), insulin initiation and titration clinics, pre-pregnancy counselling.

As well as providing fair, personalised, effective and safe careⁱⁱ it is anticipated that service redesign and reconfiguration will yield cost efficiencies. Savings achieved will be re-invested to address any gaps in service and inequity of care. For example, psychological support for people with diabetes and diabetes services in residential care.

Specialist Care

The most complex care will continue to be provided by specialists in secondary care. These will include all in-patients, all patients with newly diagnosed type 1 diabetes, children, pregnant women and those patients with complications (significant eye, kidney or nerve damage) and co-morbidities (Cardiovascular).

There will be a progressive shift towards this model of care with business and workforce development plans for implementation in autumn 2008 for full implementation by 2011.

In conclusion, we are putting in place a commissioning strategy, underpinned by a health needs assessment and workforce development plans that will make more efficient use of resources and ensure we provide a high quality integrated diabetes service with seamless care for all patients between primary, intermediate and secondary services.

ⁱ The Way Ahead, The local challenge –improving diabetes services; 2007; DH

ⁱⁱ Our NHS Our Future: NHS Nest Stage Review – Interim Report; 2007; DH

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