HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 4th January, 2013

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 4th January, 2013, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Tristan Godfrey**
Telephone: **01622 694196**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (10):	Mr C P Smith (Vice-Chairman, in the Chair), Mr R E Brookbank, Mr N J Collor, Mr A D Crowther, Mr K A Ferrin, MBE, Mr L B Ridings, MBE, Mr K Smith, Mr R Tolputt and Mr A T Willicombe
Labour (1):	Mrs E Green
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor A Allen, Councillor A Blackmore, Councillor G Lymer and Councillor Mr M Lyons
LINk Representatives (2):	Dr M Eddy and Mr M J Fittock

Webcasting Notice

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

Item	Timings
1. Introduction/Webcasting	
2. Substitutes	

3.	Declarations of Interests by Members in items on the Agenda for this meeting.	
4.	Minutes (Pages 1 - 8)	
5.	Kent and Medway NHS Joint Overview and Scrutiny Committee: Update (Pages 9 - 22)	10:00 – 10:05
6.	East Kent Maternity Services Review: Implementation (Pages 23 - 38)	10:05 – 10:45
7.	Audiology (Pages 39 - 62)	10:45 – 11:15
8.	South East Coast Ambulance Service NHS Foundation Trust: Performance Update (Pages 63 - 74)	11:15 – 12:00
9.	Date of next programmed meeting – Friday 1 February 2013 @ 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
(01622) 694002

21 December 2012

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, 30 November 2012.

PRESENT: Mr C P Smith (Vice-Chairman, in the Chair), Mr R E Brookbank, Mr N J Collor, Mr D S Daley, Mrs E Green, Mr K Smith, Mr R Tolputt, Mr A T Willicombe, Ann Allen, Cllr Mrs A Blackmore, Cllr M Lyons, Cllr G Lymer, Dr M R Eddy and Mr M J Fittock

ALSO PRESENT: Mr L Christie, Cllr J Cunningham, Cllr R Davison, Mr J Ashelford, Mr R Kenworthy and Dr D Goodridge

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

Vice-Chairman in the Chair.

2. Declarations of Interest
(Item)

Councillor Michael Lyons declared a personal interest in the Agenda as a Governor of East Kent Hospitals University NHS Foundation Trust.

3. Mr Michael Snelling in Memoriam
(Item)

(1) The Chairman and Committee wished to recognise that this was the first meeting of the Committee since the sad passing of Mr Michael Snelling, Chairman of the Committee. Mr Smith spoke of the dedicated manner in which Mr Snelling approached the work of HOSC, making it his business to master the health brief. Meetings were chaired masterfully and everyone had the chance to ask their questions.

(2) The Committee noted its gratitude to Mr Michael Snelling.

4. Minutes
(Item 4)

(1) The Committee was informed of an answer to a question asked at the meeting of 12 October 2012 which Kent and Medway NHS and Social Care Partnership Trust had undertaken to supply. In response to a question about the 8% increase in patient satisfaction, the answer supplied was:

- "The question asked was *'overall, how would you rate the care you have received from mental health services in the last 12 months'* the people scoring 'good, very good and excellent' went up by 8% from 71% to 79%."

(2) RESOLVED that the Minutes of the meeting held on 12 October 2012 are correctly recorded and that they be signed by the Chairman.

5. Forward Work Programme
(Item 5)

(1) The Committee had before them a draft Forward Work Programme for the first three meetings of 2013 along with the dates of the meetings for the rest of the year.

(2) Members requested in addition the opportunity to receive a report on performance in the ambulance service. The Chairman undertook to place this on the Agenda as soon as it was practicable.

(3) Questions of detail were asked around the Patient Transport Services item on the Forward Work Programme for February. Members were reminded that there was a written update on this topic on the Agenda and later in the meeting there would then be the opportunity to ask specific questions on this item.

(4) In response to a question about the work of the Kent and Medway NHS Joint Overview and Scrutiny Committee, Members were informed that as it was a standalone Committee with delegated powers over the specific issues it was currently considering, or was scheduled to consider in the future, it did not report as such to any other Committee. However, Members would be kept updated on the progress of this Committee's work.

(5) AGREED that the Committee note the meeting dates for 2013 and approve the Forward Work Programme.

6. Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust: Developing Relationship
(Item 6)

Susan Acott (Chief Executive, Dartford and Gravesham NHS Trust) was in attendance for this item.

(1) The Chairman introduced the item and asked the Committee's guest to provide an overview.

(2) Susan Acott began by giving tribute to Mr Michael Snelling, and echoed the comments made earlier.

(3) Moving on to the substantive matter under discussion, the decision of the Co-operation and Competition (CCP) to approve the merger subject to work being undertaken around choice in urology services was one important event to have occurred recently. In response to a question, it was clarified that

endocrine services were also highlighted but this is a very small practice area with only two surgeons in Kent operating in this area. The CCP looked at services purely from an economic perspective, not clinical. Urology is a big area financially and in terms of clinical activity. Urology had previously been centralised at Medway NHS Foundation Trust (MFT) and East Kent Hospitals. The conflict between clinical and financial drives was being resolved by local commissioners agreeing to monitor the situation.

(4) More broadly than these two services, the image of a pyramid was used to describe those services which needed to be centralised in order to deliver a safe service as being at the top, and other services which could be delivered more locally at the bottom. The Trusts were aiming to make sure the line between the top and bottom of the pyramid was as high as possible.

(5) An Integrated Business Plan for the merger had been produced but the final approval for each Trust to merge with the other would go by two different routes. As a Foundation Trust, MFT would need the approval of Monitor. Monitor was currently reviewing the improvement trajectory of MFT in relation to a breach of its Term of Authorisation and there was a board meeting with Monitor coming up the following week. Monitor was due to conclude and make a recommendation on the merger proceeding by mid February. Dartford and Gravesham NHS Trust (DGH) was not a Foundation Trust and needed Department of Health approval. The dissolution of DGH would also be subject to a Parliamentary process. The anticipated date of merger was now late spring or June. The first meeting of the shadow/designate board had occurred this week.

(6) A specific question was raised about estates, referring to p.57 of the Agenda. Then explanation was given that much of the MFT estate was old and not appropriate for delivering clinical services, but that it still cost money. Options were being considered, including renting rather than selling parts of the estate. 55% of the estate at DGH was used for clinical services and it was planned to increase this.

(7) Weekend service coverage was the subject of another specific question. In response it was explained that this was an area where the benefits of merger could be set out. DGH currently provided 24/7 emergency surgery coverage for GI (gastrointestinal) bleeds but MFT did not. Merging would enable the emergency surgery rota to be covered across 8 surgeons, up from 4 at DGH currently. This would make the service more sustainable and enable 24/7 coverage of both sites.

(8) The implications of the draft report of the Trust Special Administrator of South London Healthcare NHS Trust were also discussed. This had been a merger of three very inefficient Trusts, whereas DGH was in fact one of the more efficient Trusts in the country when measured by EBITDA (Earnings Before Interest, Taxes, Depreciation and Amortization). The future of the Queen Mary's site in Sidcup (QMS) directly involved DGH. One recommendation was for Oxleas NHS Trust, a provider of mental health and community health services to take over the site, but for other providers to provide some services there. QMS was ten miles from DGH and the working relationship was a good one. A related recommendation was for DGH to provide day surgery at QMS.

The estate was of good quality and it was seen as a positive for the Trust as day surgery was less likely to be subject to cancellations as QMS did not have an accident and emergency department (A&E). This would mean more certainty for patients and the Trust. In terms of capacity, the Trust had previously been able to cope with the closure of the QMS A&E at short notice, although changes had been made to the A&E at DGH and more were planned, such as expanding the waiting area. In maternity services as well, numbers were higher than originally thought but the Trust was adapting.

(9) More generally, lessons had been learnt from this South London and other mergers. A post-merger dip is always anticipated, but the two Trusts were looking to mitigate this as much as possible. Clinical directors ran both hospitals in service sectors, and this would be double-run for a period after the merger. In addition, the Board would have two medical directors, one from each site, to ensure the clinical perspectives of both were recognised at the highest level.

(10) The Trust was reminded that some services at both sites were provided by other Trusts, and this would be likely to continue. Plastic surgery, for example, was provided by Queen Victoria Hospital in East Grinstead. Radiotherapy was currently provided centrally by Guy's Hospital, but there was currently a radiotherapy review in Kent and this might lead to a federated structure with better access in North Kent.

(11) The Chairman proposed the following recommendation:

- That the Committee thanks its guest for her valuable contribution and looks forward to further updates at the next stage in this process.

(12) AGREED that the Committee thanks its guest for her valuable contribution and looks forward to further updates at the next stage in this process.

7. Patient Transport Services: Written Update
(Item 7)

Helen Medlock (Associate Director of Urgent Care and Trauma, NHS Kent and Medway), Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway), Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(1) Following up on questions raised during the discussion on Item 5, NHS representatives explained that Patient Transport Services (PTS) referred to a very specific service the NHS was required to provide. There was a national set of guidelines around the eligibility criteria as well as a locally agreed set of eligibility criteria, applying to patients and carers/companions. The problem in the past had been that there were around 20 providers, and they all interpreted the eligibility criteria differently and this led to inconsistencies across the county.

(2) It was explained that the service had gone out to tender in April, and the process had involved much in the way of clinical and patient engagement. The recommendation about future provision was going to the Board of NHS Kent

and Medway in December, with the provider or providers named in January and this would enable this information to be conveyed to the Committee in February.

(3) The Committee was informed that the GP clinical commissioners were comfortable with the process underway. The tender involved a central booking system which would iron out the previous inequalities of access as meeting the eligibility requirements would mean someone had access to the service regardless of location.

(4) Members raised a series of points about communicating the availability of PTS to patients as well as needing to better understand the connection between it, volunteer car services and the wider picture of patient transport and access. Members were thanked for their comments and it was undertaken that these would be taken into account when reporting back to the Committee in February.

(5) AGREED that the Committee note the report.

8. HOSC Report, "Not the Default Option": Responses.
(Item 8)

Helen Medlock (Associate Director of Urgent Care and Trauma, NHS Kent and Medway), Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway), Ian Ayres (Accountable Officer, NHS West Kent CCG), Emma Burns (Head of Media and Communications, NHS Kent and Medway) were in attendance for this item.

(a) Members had before them a copy of the HOSC review report into level of attendance at A&E departments, *Not the Default Option*, along with responses from the local NHS. In introducing the ongoing work, NHS representatives commented on the quality of the report and how the challenges it posed were useful locally in taking the work forward. Clinical Commissioning Groups (CCGs) were taking the recommendations into account as part of their urgent care review. Following one of the recommendations, media and communications were being coordinated across all Trusts in Kent on this issue. Working across sectors was showing dividends in winter planning.

(b) Communication of what services were available where along with clarity over what people could expect from walk-in centres compared to minor injuries units and other services was a major theme in Members comments and questions. Publicity material was being circulated through the *Your Health* magazine, GP practices, GP patient reference groups, acute and community hospitals, to parents through parents' mail, and other methods. Members drew attention to a couple of examples of incomplete or inconsistent information and NHS representatives undertook to note and check on these and ensure they were correct.

(c) Picking up on one of the points raised by Members, NHS representatives confirmed that the issue of nomenclature was being looked at to see if having a number of different terms for different services, walk-in centres and minor injuries units and so on, was helpful or confusing. NHS surveys also

suggested people often had misconceptions about what A&E could provide, such as the belief it was a source of free prescriptions. Minor injuries units were being reviewed in East Kent at the moment and this review was looking at the issue of standardised opening hours, which had been an idea put forward by Committee Members. The location of these centres and units was also raised as an issue, with the response from the NHS being that it was not possible to have a minor injuries unit in every town. The financial and clinical arguments dovetailed; while it would be expensive to do this, it would also be unsafe as it would not be possible to have the right staff skill mix at every site. Responding to a specific question, NHS representatives undertook to check the figures for levels of attendance at the Folkestone minor injuries unit as those quoted in the report seemed too low.

(d) Responding to the issue of whether the real or perceived lack of access to GP services was a reason for people attending A&E, it was pointed out that parents of young children have good access to GP services yet often go straight to A&E with their children because of the increased worry. The Committee was also reminded that all GP practices were part of CCGs, with West Kent CCG having 62 member practices. These did not provide services but did allow peer to peer support in order to improve. The CCG representative present encouraged the use of Patient Advice and Liaison Services (PALS) and similar as patient feedback was very useful for commissioners and providers. Related to this topic, GPs in West Kent were working with Maidstone and Tunbridge Wells NHS Trust on a way to relieve pressure on A&E by instituting a ward where GPs could directly refer patients for tests.

(e) Mental health was another area of concern given the high proportion of people attending A&E with mental health problems. It was reported that improvements had been made to access to Crisis Resolution Home Treatment Teams, working with Kent and Medway NHS and Social Care Partnership Trust, allowing fastracking back to the service where necessary. Work was also being undertaken with SECAmb to ensure mental health emergencies received the appropriate response. Members were also updated with the information that the Liaison Psychiatry Service had now been rolled out to all Acute Trusts in Kent. The point was also made that A&E would still often be the most appropriate place for patients with mental health needs as they would still often have physical health needs.

(f) The new 111 service being introduced into Kent and Medway in 2013 was seen as a way to bridge the gap between the fact that for the individual patient, any health need could be seen as serious, and the need for them to access the most appropriate care. Calling this number would, when the service is launched, connect the caller to someone able to access a database of what services were available at that time. It was believed this would divert a lot of patients from A&E. The NHS undertook to report back on the performance of the 111 service once it had been operational for 6-9 months. In response to a specific question, Members were informed that the 111 service had a call answering target of 60 seconds, compared to the 5 seconds of the 999 ambulance service.

(g) NHS representatives presented the idea that the individual patient was never in the wrong place and often made the most rational decision for them. The challenge was to build a good service around where they were. The importance of accessing services physically and electronically was discussed. A smartphone app was in development and the work of the Kent and Medway Transport Working Group was continuing. The role of pharmacies was also highlighted and it was confirmed pharmacies would be on the 111 database. Robin Kenworthy was invited to speak and he explained he was the sole patient representative of the Health Living Pharmacy project which has worked with the Department of Health and others on 100 pharmacy pilots over the last 18 months looking at the role of the pharmacy. Members were requested to forward any feedback on pharmacy service to him.

(h) The Chairman thanked the guests for attending.

(i) AGREED that the Committee note the report.

9. Tonbridge Cottage Hospital: Change of Use
(Item 9)

Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway), Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(a) The Chairman introduced the item explaining that it had been discussed at the meeting of 7 September, at which he had not been present, but there had been a request to bring it back as there were some outstanding issues. The question revolved around whether the NHS had fallen short of their duties to consult the Committee on the change of use of 12 beds at Tonbridge Cottage Hospital. This issue had been ongoing since 2004 with the location of a stroke rehabilitation unit connected to the new Pembury Hospital initially being planned for Sevenoaks Hospital before the plans changed and it was finally placed in Tonbridge Cottage Hospital. The Chairman could not speak for the Committee as a whole as to whether this would have been classed as a substantial variation of service had it come to the Committee at the appropriate time, but for him there was no question that it was a substantial variation of service. The point was that the Committee did not have the opportunity.

(b) In response, NHS representatives explained that there was no definition of substantial variation of service. The broader changes had come to HOSC, but this specific one had not. The decision was made at the time by the NHS that this particular change did not classify as a substantial variation of service. As it is for the HOSC to make that determination it was acknowledged that this did not happen and apologies were given. A meeting between the League of Friends and Clinical Commissioning Group had taken place the preceding week.

(c) An explanation was then given of the impact of NHS Property Services (Propco) taking on the ownership of Tonbridge Cottage Hospital. This did not mean any uncertainty about the future of the Hospital. Propco would have no ability to declare the Hospital surplus to requirements. The decisions on its

usage would be determined locally and even if local commissioners decided it would no longer be used, which would require consultation, the site would then be offered to other NHS bodies first. In this way the system would be a lot like the current one.

(d) The CCG representative explained that a close examination had been made of general rehabilitation bed use at Tonbridge Cottage Hospital. It was found that there was an even split between people from the local area accessing these beds and those from outside the area. This had meant some people from Tonbridge being placed in rehabilitation beds elsewhere in the county. As a result of work between the CCG, Kent County Council, Kent Community Health NHS Trust and Maidstone and Tunbridge Wells NHS Trust, in the next few weeks a pilot scheme on the grounds of Maidstone Hospital was being commenced. This would provide 26 community rehabilitation beds for patients who were not under the care of a consultant. Consultants would do fortnightly rounds to ensure the case mix was appropriate. This would allow for patients from Tonbridge to be repatriated closer to home. This project would run until March and the offer was made to share the results of the evaluation with the Committee. One Member expressed the hope that intermediate beds in East Kent were also being evaluated.

(e) The NHS explained that lessons had been learnt and the sentiment expressed that it was an appropriate time to draw a line. A Member of the Committee expressed the view that it would be useful to set up a triage system for future issues to prevent this kind of situation occurring in the future while acknowledging that the Committee could not consider every change. The Chairman explained this would be looked at.

(f) The Chairman proposed the following recommendation:

- This Committee acknowledges and accepts the apology offered about the lack of consultation in the past, believes the proposals put forward offer a positive way forward and looks forward to considering the findings of their evaluation in the near future.

(g) AGREED that this Committee acknowledges and accepts the apology offered about the lack of consultation in the past, believes the proposals put forward offer a positive way forward and looks forward to considering the findings of their evaluation in the near future.

10. Date of next programmed meeting – Friday 4 January 2013 @ 10:00 am
(Item 10)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 4 January 2013

Subject: Kent and Medway NHS Joint Overview and Scrutiny Committee: Update.

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1. Kent and Medway NHS Joint Overview and Scrutiny Committee.

(a) This Joint Committee with Medway Council (JHOSC) was established at the meeting of the County Council of 25 March 2004. The arrangements were updated at County Council on 14 September 2006.[1]

(b) The Joint Committee consists of 12 Members: 8 from Kent County Council and 4 from Medway Council. The Kent County Council Members are:

- Mr D Daley
- Mr K Ferrin, MBE
- Mrs E Green
- Mr L Ridings MBE
- Mr C Smith
- Mr K Smith
- Mr A Willicombe
- (One vacancy)

(c) The first meeting of this Committee took place on 3 July 2012 and was established to consider the review into adult inpatient mental health services. It is a standalone Committee convened to look at this specific issue.

(d) A visit to Medway Maritime Hospital's A-Block and Dartford's Little Brook Hospital was arranged for JHOSC Members on 25 June 2012. Individual JHOSC Members have also undertaken fact-finding visits on other occasions to these and other sites.

(e) The Draft Minutes for the 3 July 2012 meeting are appended. Members of the JHOSC were subsequently provided with a range of follow up information requested during the meeting. An update report from NHS Kent and Medway and Kent and Medway NHS and Social Care Partnership Trust is also attached.

(f) The public consultation on *Achieving excellent care in a mental health crisis* ran from 26 July to 26 October 2012. According to the consultation website:

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[1] http://democracy.kent.gov.uk/Data/County%20Council/20060914/Agenda/sep06-item7.pdf

- "All the views and information we have been sent has been logged and sent to the University of Greenwich Centre for Nursing and Healthcare Research, which has been appointed to provide an independent analysis of the responses to the public consultation. Their report is due at the end of November 2012 and will be sent to each clinical commissioning group for their consideration in December.

- "The final recommendations of the Acute Mental Health Board will then go for consideration by KMPT and the NHS Kent and Medway PCT Cluster Board. We hope a final decision will be made early next year."[2]

(g) The date of a **second meeting on this topic has been confirmed as taking place on the afternoon of 13 February 2013**, in the Darent Room, County Hall. The Committee is also likely to meet on the topic of vascular services during 2013 at a date to be determined.

2. Recommendation

That the Committee note the report.

[2] Kent and Medway NHS and Social Care Partnership Trust, *Achieving excellent care in a mental health crisis*, http://www.kmpt.nhs.uk/acute-mental-health-review

KENT COUNTY COUNCIL

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Kent and Medway NHS Joint Overview and Scrutiny Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Tuesday, 3 July 2012.

PRESENT: Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Cllr Sylvia Griffin, Cllr Isaac Igwe (Substitute for Cllr Teresa Murray), Cllr Wendy Purdy, Cllr David Royle, Mr K Smith, Mr C P Smith and Mr M V Snelling (Chairman)

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee) and Ms R Gunstone (Democratic Services Officer, Medway Council).

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Substitutes
(Item 2)

3. Election of Chairman
(Item 3)

Cllr W Purdy proposed and Mr K Smith seconded that Mr M V Snelling be elected Chairman.

Carried Unanimously.

4. Election of Vice-Chairman
(Item 4)

Mr D Daley proposed and Cllr D Royle seconded that Cllr W Purdy be elected Vice-Chairman.

Carried Unanimously.

5. Declarations of Interest by Members in items on the Agenda for this meeting
(Item 5)

Cllr Isaac Igwe declared a personal interest in the Agenda as a practising mental health nurse.

6. Adult Mental Health Inpatient Services Review
(Item 6)

Lauretta Kavanagh (Kent and Medway Director of Commissioning for Mental Health and Substance Abuse, NHS Kent and Medway), Helen Buckingham, (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway),

Sara Warner (Assistant Director Citizen Engagement, NHS Kent and Medway), David Tamsitt (Director Acute Services, Kent and Medway NHS and Social Care Partnership Trust), Rosarii Harte (Assistant Medical Director – Acute Services, Kent and Medway NHS and Social Care Partnership Trust), Adrian Lowther (Head of Communications, Kent and Medway NHS and Social Care Partnership Trust) and Kevin Skinner (Commissioning Consultant, NHS Kent and Medway) were in attendance for this item.

(1) Along with the reports contained within the Agenda, Members had before them copies of a 158 page paper due to go to the Board of NHS Kent and Medway later in the month. This provided an additional level of detail which Members of the Committee would be able to study. Reference to parts of this additional paper was made during the meeting as giving additional information underpinning the answers to specific questions from Members of the Committee.

(2) Representatives of the NHS began by explaining that they welcomed the opportunity to bring their proposals to the Committee (JHOSC). They saw the role of the JHOSC as being to hold the NHS to account in ensuring that the appropriate process was carried out and looked forward to asking the Committee to approve their plans to proceed to a full public consultation. In discussion the consensus was that a second meeting of the JHOSC would be required once the NHS had completed the consultation and subsequent deliberations, but this did not preclude Members taking an active interest in the intervening period.

(3) In 2010, the Secretary of State for Health set out 4 tests. When carrying out any service reconfiguration, it would be incumbent on the NHS organisations involved to demonstrate the plans had met these tests. These are: strong clinical evidence base; support of GP commissioners; appropriate patient choice was maintained and strengthened; and strong engagement with service users, staff and other stakeholders such as local authority Members.

(4) The current plans had been developed by NHS Kent and Medway as the commissioners with the main provider of mental health services, Kent and Medway NHS and Social Care Partnership Trust. A lot of detailed analyses of changes in the way services have been used and the profile of patients who accessed them, along with engagement events with stakeholders and clinicians had led to 4 proposals which would define the outcome sought by service reconfiguration.

(5) Firstly, there was a need to strengthen Crisis Resolution Home Treatment Teams (CRHT). Several years ago there was often no choice but to admit people to hospital out of hours and at weekends when Community Mental Health Teams (CMHTs) were not available. CRHT were able to deliver acute services in people's homes and act as gatekeepers to acute care. The plan was to enhance these with additional Support Time Recovery Workers (STRWs). STRWs would be able to provide more support to enable people to remain at home. There was a connection here with the Liaison Psychiatry service available 24/7 in East Kent which was due to be enhanced in Medway and West Kent.

(6) Secondly, there was a desire to establish 3 centres of excellence for acute mental health inpatient services. This would allow therapeutic services to be enhanced and lead to measurable improvements in outcomes. This was connected to the misalignment of the current location of beds with need. In effect there were too few beds in East Kent which meant that patients from East Kent could be sent to West Kent, were there was capacity. This broke the connection between a patient and local services and led to an increased length of stay and impaired recovery. It also connected with long-standing concerns about A-Block in Medway Hospital. Although the staff were hard working and dedicated, the building itself was not fit for purpose. For example, the women's ward on the first floor had no easy access to outside spaces. Line of sight for safely monitoring patients was also regarded as inadequate. The analogy was given of the recent centralisation of angioplasty at William Harvey Hospital in Ashford which had seen improved outcomes despite longer travel times.

(7) Thirdly, there was a desire to extend Psychiatric Intensive Care Outreach (PICO) teams. This was a peripatetic service which was able to serve acute wards and reach into intensive care. This service was already well established in West Kent but needed to be rolled out across East Kent.

(8) Fourthly, there was a need to consolidate Psychiatric Intensive Care Units (PICU) from 2 to 1. The plan was to have a second ward at Little Brook Hospital in Dartford to consolidate the services. This would mean the PICU at Dudley Venables House at St. Martin's Hospital in Canterbury would be relocated to Dartford, enabling an increase in 8 acute beds in Canterbury.

(9) These 4 proposals in turn underpinned the Options for service change set out in the Agenda paper and to be included in the consultation paper. The first option was to do nothing and leave the status quo. The other 3 Options all involved the relocation of beds available for Medway patients from Medway to Little Brook Hospital. The choice was between patients from Swale and Sheppey going to Priority House in Maidstone, Little Brook Hospital or St. Martins. Excluded from this were patients from Faversham who would continue to access beds at St. Martin's.

(10) NHS representatives set out the argument that maintaining the status quo was not an option. All 8 of the current Clinical Commissioning Groups (CCGs) in Kent and Medway had approved the large Board paper which Members had before them. This had been supplemented by 2 GP practice engagement events. Much of the clinical evidence was based on the changing nature of service use and patient profile. The average length of stay in acute inpatient care had decreased but the acuity of the conditions seen had increased. One third of patients were detained under the Mental Health Act and accounted for over half the total number of bed days. It was explained that this trend was mirrored across England. There was a measure of scepticism on the part of a number of Members about the data which had been presented with the view expressed that data can be selected and presented to demonstrate something which might not be the whole story. There were a number of requests for specific information that NHS representatives undertook to provide in order to address these concerns.

(11) Allied to this discussion was a broader one about possible future increases in demand for mental health services. The current economic climate did mean there was likely to be a rise in cases of depression but that this would not lead to an increase in demand for acute inpatient services but rather psychological therapies, in which there was investment planned. The other main area of predicted increased demand would involve dementia and again there were specific services being enhanced here.

(12) A core focus of discussion was around the closure of A-Block at Medway Hospital. Members of the Committee generally agreed that there were issues at A-Block which needed addressing and which meant it was not truly fit for purpose. However, given the concentration of population and the high proportion of people on Incapacity Benefit with mental health needs in Medway, the view was expressed by a number of Members that for Medway to lose a facility seemed counter-intuitive. The issue of demand for acute beds in Medway was raised and the question posed as to whether there had been a shortfall in the period 2008-2012. Information on the number of patients from Medway accessing services in other areas was requested because this would determine the level of past demand for a local service.

(13) NHS representatives understood this argument and indicated that the Board paper set out the background to the search for a suitable location in Medway. The location would need to be suitable for the purpose to enable a quality service to be delivered. It also needed to be a facility which would allow recruitment and retention of staff as well as being within an appropriate 'cost-envelope.' More generally on the question of finances, cost-saving was not given as a prime driver for the changes, with the overall cost of the changes being about the same or even more than the status quo. However, the budget was not limitless and there were constraints on staffing numbers as well. The NHS undertook to provide the site requirements to Members and write to them formally with a promise to examine any location brought to their attention.

(14) The possible future location of services directly connected to a number of concerns and questions from members about the issue of transport. Along with general concerns about the accessibility of services, some Members expressed the view that there was a tension between centralising some services and the idea that the recovery process was improved when services were part of an integrated local pathway and patients were not separated from their support networks of families and friends. NHS representatives responded by arguing that the proposals taken together would mean more people treated at home and due to the proposed increased in provision in East Kent more people would be treated in their local area. A number of appendices in the Board paper related directly to transport. It was explained that the Kent and Medway Transport Group was being reconstituted and would involve local authorities and NHS commissioners and providers looking at transport issues across the board. Members commented that from the perspective of Medway and Swale patients, Bluewater was easier to get to than either Maidstone or Canterbury, but they had concerns about the next stage of the journey to Little Brook Hospital by public transport, particularly outside regular business hours.

(15) In the context of the discussion around the future of Medway A-block, concerns were expressed about the impact any relocation of inpatient services

would have on the sustainability of CRHTs in the area if there was a lack of a local base.

(16) Part of the response to the transport issue for staff and visitors from the NHS involved the use of mobile technology. For example, supported by the voluntary sector, Skype could be used to talk to patients. On the subject of transport, one Member made the offer that if he could be persuaded that transport from his area on the coast of Kent (Deal and Walmer) could be addressed to his satisfaction, he would promote the proposals and this could help make the case as his area was the furthest place in Kent from Little Brook Hospital. It was added that there was adequate car parking for staff and visitors at Little Brook.

(17) This issue was raised of the knock on effect of the changes to the viability to Acute Trusts across Kent and Medway. NHS representatives responded by saying that recent events in South East London has meant an increase in activity in Darent Valley Hospital, but not Little Brook. The development of Liaison Psychiatric services at Darent Valley was geared to enhancing the capacity of Darent Valley in responding to any increase in presentations of mental health issues at accident and emergency. The services at Medway A-Block were provided by KMPT, but if they were moved this would mean Medway Foundation Trust had two additional wards. No discussions about any possible reconfiguration of services at Medway Hospital this may allow would take place until a final decision had been made.

(18) A specific question was asked about the potential impact of the proposals on Priority House in Maidstone. There were 34 beds here, and it was explained that over the last 4 years, demand was such that 10 fewer beds were required. This meant that the 7 beds required each year for Sheppey and Sittingbourne patients could be available.

(19) On the question of finances, it was explained that work was going on to introduce Payment by Results (PbR) in mental health. As this replaced the old-style block contracts, integrated pathways of care would be more viable.

(20) Members of the JHOSC had been given the opportunity to visits Medway A-Block and Little Brook Hospital the week before the meeting and those Members who had been able to attend expressed their thanks to the patients, staff and others they had met. There was an enthusiastic response to the suggestion that further site visits be arranged in the intervening period before the next formal JHOSC meeting.

(21) Regarding the details of the consultation process itself, the NHS explained that information on the proposals would be available in as many places as possible, such as GP practices and hospital sites. It was conceded that there was a limit to how much background detail could be contained in a consultation document, but all the supporting evidence would be available online. In addition to 6 public meetings, staff would go to as many other events as possible where people interested in the proposals were likely to be, which was a tactic adopted during the recent East Kent maternity services consultation. As had happened with the recent consultation on Older People's Mental Health Services, there are established routes to involving carers and

users of mental health services and those directly affected do make up the majority of respondents.

(22) To assist the deliberations of the Members of JHOSC, representatives of the NHS undertook to provide the following:

- Information on the numbers of Medway residents accessing acute mental health inpatient services outside of Medway, and the associated costs in the last 4 years.

- Details of the levels of staffing at Medway A-Block over the last four years along with an analysis of the changes which could have affected demand.

- Details of the staffing of the different CRHTs across Kent and Medway, with the location of the new and proposed Support Time Recovery Workers indicated clearly.

- CQC reports of all the sites involved in the plans.

- Provide Members with the criteria/site requirements for an alternative to A-Block in Medway and formally write to Members promising to examine any alternative site brought to their attention, giving details of all the options in Medway which have been considered and rejected

(23) The Chairman proposed and the Vice-Chairman seconded the following motion:

- That the Committee approves the NHS decision to take the proposals in the report to three months public consultation between late July and late October 2012 and looks forward to a consultation document which will take into account the concerns expressed at this meeting and that these concerns will also be addressed by the further information to be provided and the further site visits to be arranged.

(24) RESOLVED that the Committee approves the NHS decision to take the proposals in the report to three months public consultation between late July and late October 2012 and looks forward to a consultation document which will take into account the concerns expressed at this meeting and that these concerns will also be addressed by the further information to be provided and the further site visits to be arranged.

7. Date of next programmed meeting

(Item 7)

It was agreed that the date of the next meeting would be determined at a later date.

Achieving excellence in mental health crisis – progress report

Background

Over the last year the acute mental health services have undertaken a review and consultation regarding the future of acute mental health services including the Crisis support provided in the community across Kent and Medway. The review of current services found:

- Reducing hospital bed use over four years, due to successful alternatives established in the community, particularly since 2004

- Too few acute beds in east Kent and too many in west Kent, with people often placed out of the area covered by their community-based Crisis Resolution and Home Treatment (CRHT) team, a situation that prevents seamless care and creates delays

- Long-standing concerns about the quality of the environment in A Block at Medway Maritime Hospital, the inpatient unit for people from Medway and Swale, despite considerable previous effort to identify a local inpatient alternative

- Psychiatric intensive care is supported in west Kent by a very effective acute ward outreach service (PICO), not currently available for east Kent.

The review analysed four years of bed use data, leading to the conclusion that, allowing for the usual variations and the seasonal peak between January and March, 150 beds would be required, plus 12 in one psychiatric intensive care unit (PICU). Beds were allocated proportionately to match actual demand, with each service locality allocated to a specific inpatient ward and an aligned Crisis Resolution Home Treatment team.

The proposals set out to:

- Strengthen the Crisis Resolution Home Treatment teams with 26 Support Time and Recovery workers providing practical help and respite to service users and their families

- Develop three hospital *centres of excellence*, each providing a better patient experience, high quality care, and the opportunity to innovate and demonstrate best practice from a firm research evidence base. Delivered by a stronger staff team able to offer more therapeutic interventions 7 days a week; in a modern facility with a calm, therapeutic environment and individual ensuite bedrooms.

- Consolidate the Psychiatric Intensive Care unit at Dartford – Little Brook hospital. Expanding the psychiatric intensive care outreach service to cover the whole of Kent and Medway, providing support to staff in the Centres of

Excellence so that the need to transfer patients to a psychiatric intensive care unit is reduced.

This means expanding the facilities at St. Martin's in Canterbury, and re-opening an additional ward at Little Brook Hospital for Medway service users in need of acute care, and moving out of the two wards in Medway Hospital A Block.

Following an unsuccessful, 10 year pursuit for a local alternative for A Block it has become increasingly apparent the current ward environments are not clinically sustainable. Clinicians have recommended the alternative solution is to relocate services to Little Brook Hospital. While the outcome of the consultation is awaited steps are being taken to monitor and mitigate any additional pressures that arise out of a prolonged period of change. KMPT Director of Nursing Pippa Barber has committed the organisation to provide additional support to the staff who strive to do the best they can in difficult circumstances.

All Clinical Commissioning Groups, the JHOSC and both Boards supported the need to consult the public on *Achieving Excellent Care in a Mental Health Crisis* in the summer. The 13 week consultation is now completed.

Public Consultation

The formal 13 week consultation ran from 26 July until 26 October. During the consultation a range of methods have been used to promote the consultation process:

The public consultation document and summary was written and tested with various stakeholders including: Non-executive directors, staff, and service users; to ensure it was clear, easy to understand and provided sufficient information without overwhelming the reader with details. It was successfully launched on 26 July 2012 and over 200 individuals, staff, service users and carers responded.

The engagement team sent out 966 invites with a link to the website and the electronic versions of the document to organisations and individuals, with an offer to attend any local meetings or events where people were interested in the review; and provide further information and listen to what people thought of the plans. The commissioning team and KMPT also sent the documents out to key stakeholders and organisations, over 3,000 Foundation Trust members, and staff. Many of the voluntary and community organisations which support service users and carers and are interested in mental health, cascaded the information to their members for instance: 575 individuals registered with MIND for the Locality Planning and Meeting Groups.

The engagement team booked six venues to cover each area, holding the public consultation meetings at a range of times in accessible and well used venues, and wrote to all known service user and carer organisations with the offer of being involved in focus groups. A further two public meetings were added at the request of stakeholders. Over 180 people attended these eight public meetings; with a few dedicated carers attended several meetings.

Kent and Medway NHS and Social Care Partnership Trust had a specific page on their website, with all the consultation information available. This was signposted by

suitable links on the three PCT websites, the Live it Well website and from partners in social care. The website and Intranet contained supporting documents of from the review including:

- Online consultation response form
- Full public consultation document and consultation response form and summary consultation document
- Easy read consultation document and easy read consultation response form
- Large print consultation document and response form

Back-ground papers including:

- The full Board papers
- Summary of Board papers
- Non-financial appraisal
- Risk appraisal
- Risk scores for Appendix B
- Right care, right time, right place
- Equalities Impact Assessment

The communications teams distributed 3,000 public consultation documents and 15,000 summary documents to over 700 organisations in Kent and Medway: GP practices, libraries, voluntary organisations and community centres, KMPT trust community buildings, pharmacies, opticians, hairdressers, Job Centres, fitness centres, citizens' advice and volunteer bureaus. The review and consultation also featured in Your Health and Medway Matters, the NHS magazines with circulations in excess of 50,000. The information was also placed with local councils known to publish residents' papers in Medway and Swale, the LINk and Kent Community Action Network. It was also promoted through social media using twitter and Facebook.

A phone number and email address was offered for any individuals wishing to comment or request more information.

Public Meetings

During the consultation eight public meetings were held at various times. These meetings were advertised as part of the whole consultation as detailed above. Many of the events were chaired by an independent chair from one of the local voluntary and community support organisations to ensure that service users and carers felt comfortable and confident to contribute their views.

At these three-hour public roadshows a panel of clinicians and commissioners presented information on the review, the reasons why it was necessary, the outcome expected of the review, the steps taken during the review, the options arrived at and what would happen following the consultation. There was also a film of a service user's story so that people could hear how the Crisis Response and Home Treatment service worked to treat people at home. A quick question and answer session was followed by an hour of round table discussions to ensure that everyone present was able to give their views. Then finally a further open question and answer session took place and those present were asked to evaluate the events so the engagement

team could ensure they worked. A variety of supplementary information was on display or available in handouts including the detail of previous attempts to find local solutions for A block.

184 people attended the eight meetings: there was a good mix of service users and carers, support organisations, NHS and social care staff and local councillors. We had anticipated that the numbers attending wouldn't necessarily be high due to the specialized nature of the mental health crisis care, or partly due to consultation fatigue. A number of people commented upon the high level of changes happening across the public sector.

Focus groups and outreach

During the consultation we contacted over 50 community and voluntary groups and offered to either attend their meetings to provide information on the consultation and raise people's awareness of the review, or to run a focus group with service users and carers where they were comfortable and felt able to take part in a discussion about the consultation proposals and any issues they wished to raise. A similar offer was made in the emails sent to over 900 stakeholders, and in the public documents and press releases.

13 organisations responded positively to host focus groups: Medway Cyrenians, Monday Hub, Medway Service User Engagement Project, Ashford Rethink carers group, Faces of Kent, Canterbury Rethink carers group, Thanet Rethink carers group, Deal Speakup Forum, DASH (Depression, Anxiety Self Help group), Sittingbourne Rethink support group, Dover Speakup group, Maidstone CVS. These focus groups were recorded and logged and sent onto Greenwich University Centre for Nursing and Healthcare research.

The commissioners and engagement team went to 15 other events (including three roadshows held in Medway shopping centres) to raise awareness and provide information about the consultation and encourage people to respond. Over 290 people were reached in this way. Any questions raised were responded to and any issues raised directly with the team were recorded and fed back to Greenwich.

Next steps

The responses have all been logged during the review: from phone calls and email enquiries for further information, letters, and write ups of public meetings, focus groups and the outreach visits to local groups.

These have all been sent to independent researchers from Greenwich University who have collated and analyzed all the information and sent a report to the commissioners and Trust. They will share this with the eight clinical commissioning groups alongside and discuss the steps which should be taken next when all the evidence is considered and looking at the issues raised by respondents.

This information will also be shared with the JHOSC in February, together with the Commissioners and the Trust medical leads recommendations for taking the proposals forward.

The final report will then go to the Boards of Kent and Medway NHS Partnership Trust and NHS Kent and Medway in February. The Boards will then take the final decision whether to accept their recommendations.

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 4 January 2013

Subject: East Kent Maternity Services Review: Implementation.

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1. Background

(a) The Health Overview and Scrutiny Committee initially received written updates on the East Kent Maternity Services Review at the meetings of 4 February 2011 and 10 June 2011.

(b) Members heard from NHS representatives at the meeting of 22 July 2011. At this meeting the Committee agreed to examine this issue in more depth at a later meeting and that a small working group of Committee Members be established to further investigate and prepare a report for HOSC. The Members of this informal HOSC Liaison Group were Mr Nigel Collor, Mr Dan Daley, Cllr Michael Lyons and Mr Roland Tolputt.

(c) Members of this informal HOSC Liaison Group reported back to the Committee when it further considered this subject on 9 September 2011. It was also decided that Mrs Elizabeth Green should join this Group, which would continue to liaise with the NHS on the subject.

(d) Representatives of the NHS were invited to discuss this topic at the meeting of 14 October 2011. Members were provided with copies of the consultation document at this meeting as the consultation was launched that same day.

(e) The consultation ran until 20 January 2012.

(f) Further written updates were received at the meeting of 3 February and 13 April 2012. In addition, Members were able to attend an informal briefing with NHS representatives on 4 May 2012.

(g) The Committee next discussed this issue at its meeting of 1 June 2012, to which NHS representatives were invited. The following recommendation was passed:

- RESOLVED that the Committee note the decision to proceed with Option 1 and accepts the need to secure a safe and sustainable service, and requests an update report in nine months on the work which has been undertaken on improving access and engaging the affected communities and other ancillary issues, in discussion with the HOSC Liaison Group.

(h) A meeting of the HOSC Liaison Group with NHS representatives on this topic took place at the Kent and Canterbury Hospital on 5 November 2012.

2. Recommendation

That the Committee consider and note the report.

East Kent Maternity Services Review: Implementation Update

Background

The East Kent Maternity Services Review consulted with all stakeholders between 2011 and 2012 and last June presented its findings to this Committee who accepted the recommendations of the review that Option 1 was the most sustainable option that delivered on safety, choice, equity and resource utilisation.

Option 1 provided women with the choice for birthplace at:

- Home
- Ashford Midwifery Led Unit (AMLU)
- Margate Midwifery Led Unit (MMLU)
- Queen Elizabeth the Queen Mother Hospital (QEQMH) Labour Ward
- William Harvey Hospital (WHH) Labour Ward

The option also recommended that Canterbury and Dover birth centres would be reorganised to provide a range of day care services for pregnant and postnatal women but would no longer provide birthing facilities. The reorganisation of services was associated with an investment of £700,468 in midwifery staffing to increase the number of midwives by 16.8 Whole Time Equivalent (WTE). This option was accepted by the HOSC on the 1 June 2012 and it was requested that an update be provided to the committee within 9 months.

Reconfiguring the service

Option 1 was implemented on the 24th of September, 2012, this led to:

- The Midwifery Led Unit at QEQMH opened as place of birth for low risk women
- The Midwifery Led Unit at WHH continued to operate
- The full range of antenatal, labour and postnatal services continued at both the QEQMH and WHH sites.
- The Dover and Canterbury sites provide 7 day a week antenatal and post-natal day care services.

Staffing

The recruitment of additional midwives was successfully achieved by September 2012. This recruitment has resulted in a dramatic reduction in the number of times the Ashford MLU has closed in the last four months (Table 1). The change at Dover and Canterbury has also released staff to move to the Ashford and Margate sites and this has been achieved with very little upset and all staff are now in place.

Table 1: Closures at Singleton Midwifery Led Unit

January	9
February	16
March	27
April	14
May	16
June	7
July	14
August	3
September	5
October	3
November	2
December	1 to date (12.12.12)

The midwife to birth ratio has also improved and the use of midwifery time is set to improve further with a doubling in the number of maternity support workers at both sites in January.

Birth to Midwife ratio

October 2011	34:1
October 2012	30:1

Birth place

From the outset the MLU at Margate has been very successful and based on the current figures is on course to have in excess of 700 births a year. The first baby born in the unit was from Dover!

Births at Midwifery Led Units

Month	Ashford	Margate
Oct	75	40
Nov	84	61
Dec	26 to date	28

As a result of improved staffing and the resulting reduction in closures the birth rate at the Ashford MLU has also increased. The unit is on course to achieve and accommodate an increase in its predicted annual birth rate from 600 to over 800 (603 in 2011 – 2012).

Choice

The information booklet ‘Your Birth, Your Choice’ is being given to all women explaining the range of birthing options on offer to women in East Kent. During the review of maternity services in East Kent we identified that there were four most commonly spoken languages. In order to ensure this information is available to them translated versions of this leaflet were produced. The leaflet is available to all women from their GP, Children Centres and organisations such as Home Start. In addition to this leaflet the Trust have produced a series of short films providing women with

information to prepare them for birth; 'The Journey' and is available from the Trust website and YouTube.
In addition to the above and in response to information received throughout the consultation period women at all venues can now have their partner (or a significant other) remain with them throughout their stay. The feedback from women and families to this initiative has been unanimously positive.

Postnatal Care provision

Postnatal provision has adapted to fit the new model and women can attend either Dover or Canterbury Maternity Centres for a range of support and advice; in particular, breast feeding support is available throughout the day.

Monitoring 1 to 1 care in labour

The Trust have identified that the 'Birth Rate Plus' Acuity tool will enable them to monitor progress against their ambition to deliver one to one care to labouring women. As such, the Trust is looking to purchase the software in the very near future.

In the meantime we will be monitoring this standard by gathering the incidence of 1 to 1 care for a period of five days in each 4 week period.

Accessibility

Both Dover and Canterbury birth centres have now been renamed as Maternity Day Care Centres.
The venue at Buckland hospital has changed and the Centre has now moved into the main building. This new venue is on the ground floor and is much more accessible particularly in the winter time.

Opening times at both venues are:

- Monday to Friday – 8am-8pm
- Saturday & Sunday – 9am -5pm

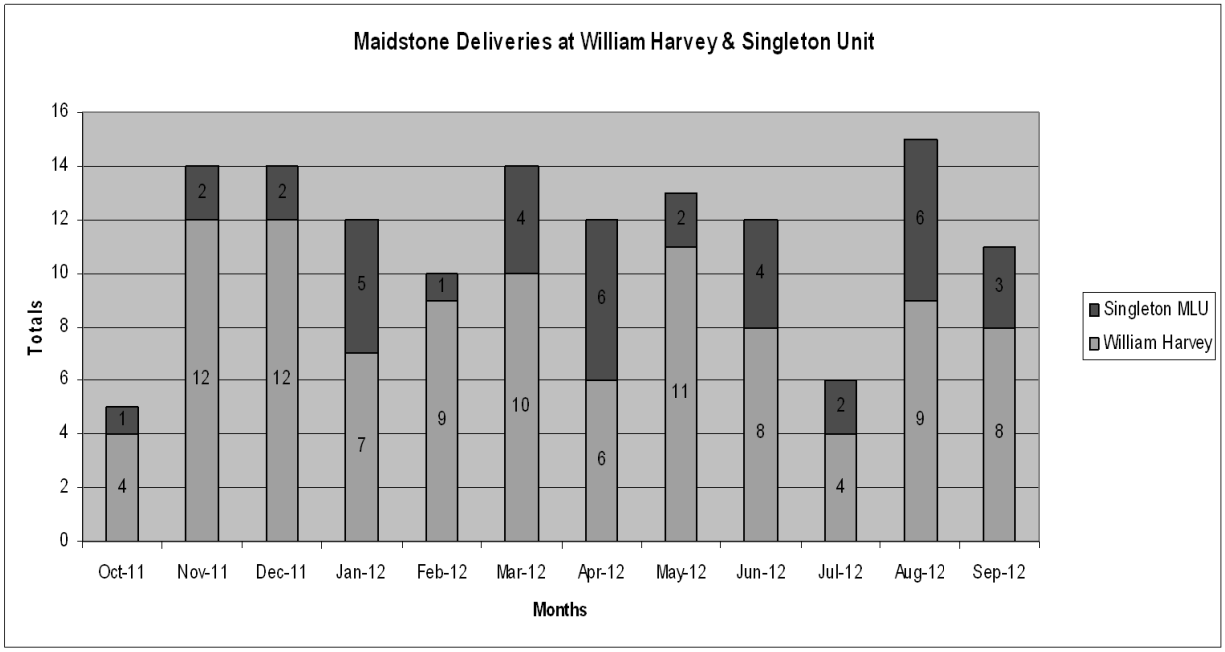
The local press have been involved in promoting the current service (Appendix 1) and ensuring women and families are fully aware of the opening times. An open day has recently been held at the Buckland site providing the local public with an update on the development of the new build. In relation to travel women on benefits are advised how they can reclaim travel costs. Information leaflets and application forms are held at both centres.

Births before the arrival of the midwife (BBA)

In the period from September 24th there have been 17 BBA trust wide.
This is similar to the same period for last year. There have only been 2 such births for Dover women.

Births from Maidstone area

The number of women birthing in East Kent from the Maidstone area has remained unchanged (table below). It is possible that once women feel confident that the MLU at Ashford will be open when they need it the numbers could increase.



East Kent Maternity Services - Communications plan

Event	Audience	Method	Action	Progress/By when
	Media	Press release	Soft launch release issued to those making enquiry	Thanet Gazette see Appendix 1
	Media	Press release	EKHUFT Proactive release looking back at the first month on new unit and other services available	Used by Health Service Journal see Appendix 1
	Media	Press release	EKHUFT Proactive release about services available over the Christmas period	Working on article with Acting Head of Midwifery & Women's Health Nursing
	Media	Media call	Christmas babies and support available over Christmas and new year	Liaison with media for coverage of Christmas and new year babies.
	Public	Leaflet	*PCT to produce Maternity services – your birth, your choice* Leaflet to detail the options available and signposts for more information To be given to mothers-to-be at first appointment with midwife. An A4 pdf version of the leaflet, translated into 5 languages, is available to be printed off on demand at the surgery/clinic.	Printed and distributed to midwives at end of September See appendix 1
		Your Health magazine	Article by PCT	March 2013 edition
		PCT and EKHUFT websites	Article posted on website by both	EKHUFT First baby born news story Appendix 1

Event	Audience	Method	Action	Progress/By when
		Social media	Facebook and Twitter posts with links to web page by PCT	Planned for the official opening
	Staff at EKHUFT	Intranet Trust News Team Brief	Article by EKHUFT	Article in Trust News on first baby being born
	CCGs and GPs	GP bulletin / independent contractors website, locality bulletins	Article by PCT	October.
	FT governors, members, and volunteers	Your Hospital	Article by EKHUFT covering official opening of the MLU and the improved maternity services at Dover and Canterbury	Next issue 15 February 2013
	Kent Health Overview and Scrutiny Committee	Meetings	HOSC liaison group members to be invited to next meeting of implementation group Return visit to HOSC	Members were very complementary regarding the consultation process and the outcomes. March 2013
Official Opening	Various	Official Opening	The Maternity Review Group favoured a celebrity for the opening, but this is proving difficult in January. The Unit are prepared to move the opening to February if they can get the right person. In addition to the Official opening we will also be promoting the improved maternity services in Dover and Canterbury.	Deadline for getting a celebrity set for 21 December.

Event	Audience	Method	Action	Progress/By when
			List of invitations being managed by Communications. Opening plaque sources by communications	
	Media	Release	Pro-active press release by EKHUFT	Prior to opening in January/Feb
	Public	Media	Press release Promoting improved maternity services at Canterbury and Dover	Following opening
		Your Health Magazine	Article by PCT	Following opening
		PCT and EKHFT website	Article by EKHUFT covering official opening of the MLU and the improved maternity services at Dover and Canterbury	Following opening
		Social media	Facebook and Twitter posts with links to web page by PCT	Following opening
	Staff at PCT	Intranet	Article by PCT	Following opening
	Staff at EKHUFT	Intranet Trust News Team Brief	Article by EKHUFT covering official opening of the MLU and the improved maternity services at Dover and Canterbury	Following opening
	CCGs and GPs	GP bulletin / independent contractors website, locality bulletins	Article by PCT	Following opening

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Appendix 1

Margate birth unit to be delivered in months

Isle of Thanet Gazette

Follow

A FLAGSHIP birthing centre will open in Margate in September.

The new midwife-led centre will be located in Thanet after a three-month NHS consultation on the future of maternity care in East Kent concluded.

The NHS will invest more than £700,000 a year in employing 30 midwives at Ashford and Margate to ensure one-to-one care for expectant mothers.

A consultant-led ward next door will offer easy access to emergency and neonatal intensive care.

Ramsgate county councillor and Labour health spokeswoman Elizabeth Green campaigned for Thanet to retain its maternity services.

Mrs Green said: "I am delighted that this has now been given the go-ahead as this is desperately needed.

"We have, by far, a greater need of these facilities, as statistically we have a far larger number of births, including a number to young mothers.

"Mothers can now give birth in the less formal birthing unit, while having consultant-led facilities close at hand in case they are needed."

Dr Sarah Montgomery, an east Kent GP who chaired the Maternity Services Review Group, said: "People agreed we needed to change. They also agreed the Margate unit should open and that mothers like the choice of having a midwife-led unit near a consultant-led unit as they could enjoy the benefits of a natural, calm and home-like birth with the reassurance of rapid access to doctors if need be.

EKHFT's head of midwifery, Lindsey Stevens, added: "We are introducing a number of changes, including an improved helpline staffed by experienced midwives for women in the final stages of pregnancy and we plan to allow partners to stay for 24 hours on postnatal wards."

Other changes included improving postnatal care, support for mothers and antenatal education.

EKHUFT Website

http://www.ekhuft.nhs.uk/patients-and-visitors/services/a-z-of-services/pregnancy-and-childbirth/

Welcome to the maternity services in east Kent

You're pregnant - Congratulations!

Having a baby can be an exciting but daunting time for women and their partners, there is a lot to think about and plan for. There are many questions and choices to make so we hope the information on this website will help you. Our aim is to work in partnership with you, your partner and family to achieve a happy, healthy pregnancy and birth.

Maternity services are provided across east Kent in the community and in four different hospital settings. Midwives work in all areas of the community and in our hospitals. Obstetricians are based at the William Harvey Hospital in Ashford and the Queen Elizabeth, the Queen Mother Hospital in Margate. Every pregnant woman needs a midwife and some need a doctor too.

Facilities

William Harvey Hospital, Ashford

The William Harvey Hospital in Ashford has more than 4,000 births annually. The obstetricians and midwives work hard as a team to keep birth normal and intervene only when necessary.

At William Harvey there is a **neonatal intensive care unit (NICU)** which looks after premature babies from 24 weeks of pregnancy.

- Find out more about having your baby at William Harvey Hospital

Singleton midwifery led unit: This midwife led unit is located at William Harvey Hospital close to the consultant led 'traditional' labour wards. The unit is run by midwives to encourage and support normal birth.

- Find out more about the Singleton Midwifery Led Unit

……

Queen Elizabeth the Queen Mother Hospital, Margate

The Queen Elizabeth the Queen Mother Hospital in Margate has approximately 2,800 births a year. It too offers specialist obstetric care for women with complications and anaesthetists providing the same service as that at William Harvey Hospital in Ashford. The **special care baby uni**t takes babies born after 28 weeks. Those babies born earlier or who are very sick are transferred to William Harvey Hospital.

- Find out more about the facilities at Queen Elizabeth The Queen Mother Hospital

St Peters midwifery led unit: This midwife led unit is located at Queen Elizabeth The Queen Mother Hosptial close to the consultant led 'traditional' labour wards. The unit is run by midwives to encourage and support normal birth.

- Find out more about the St Peters Midwifery Led Unit

Canterbury Maternity Centre and Dover Maternity Centre

These midwife led units provide pre and postnatal services including education classes and breast feeding support. Births take place at either the William Harvey Hospital in Ashford, or at the Queen Elizabeth The Queen Mother Hospital in Margate

http://www.ekhuft.nhs.uk/patients-and-visitors/news/news-archive/first-baby-born-at-st-peters-mlu/

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First baby born at St Peters MLU

St Peters Midwifery Led Unit opens at Queen Elizabeth The Queen Mother Hospital, Margate

On Monday 24 September the St Peters Midwifery Led Unit opened for business. Ten babies have already been born there.

St Peters is the second Midwifery Led Unit to open in EKHUFT - its sister unit opened at William Harvey Hospital, Ashford, three years ago. The units aim to provide a relaxed 'home from home' birthing experience for healthy women who have had low risk pregnancies under the care of the midwives in an acute hospital setting, which allows for easy transfer to the labour ward should medical intervention be necessary.

The facilities at St Peters include four birthing/bedrooms, two of which have birthing pools, which have already been well-used.

Dover and Canterbury hospitals now offer maternity day care and the home birth and community midwifery led services continue as usual.


Proud parents show off baby Molly

Health Service Journal
http://www.hsj.co.uk/hsj-local/acute-trusts/east-kent-hospitals-university-nhs-foundation-trust/midwife-led-maternity-unit-opens-in-east-kent/5050455.article

Midwife led maternity unit opens in East Kent
10 October, 2012

St Peters midwifery-led unit opened last month at Queen Elizabeth The Queen Mother Hospital, Margate.

The unit opened on 24 September and 10 births have already been born there. The facilities include four birthing/bedrooms, two of which have birthing pools.

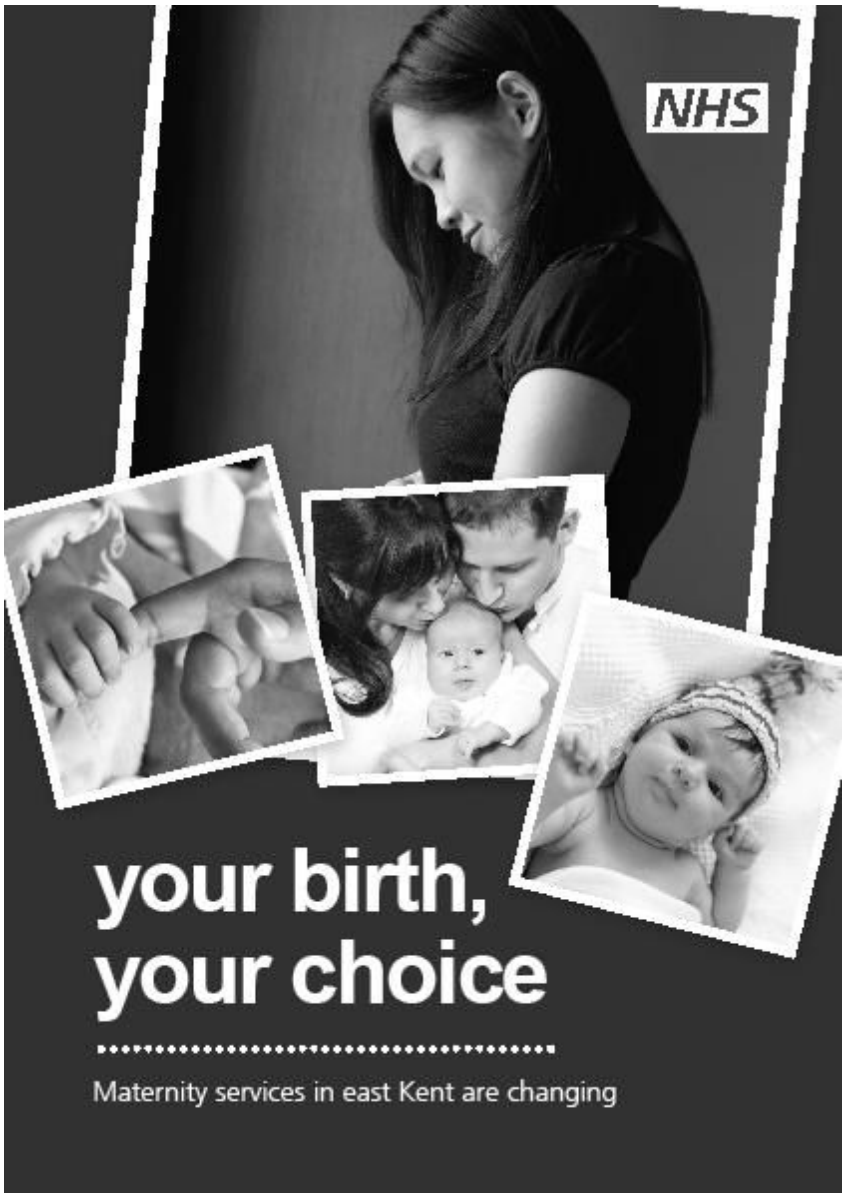
St Peters is the second midwifery-led unit to open at East Kent Hospitals University Foundation Trust. A similar unit opened at William Harvey Hospital in Ashford three years ago.

The units aim to provide a relaxed “home from home” birthing experience for healthy women who have had low risk pregnancies under the care of the midwives in an acute hospital setting.

The opening of the unit follows a reconfiguration of maternity services in East Kent.

Dover and Canterbury hospitals now offer maternity day care only.

Your Birth Your Choice Leaflet.



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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 4 January 2013

Subject: Audiology.

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1. Background

(a) Audiology has been a subject which the Committee has considered periodically over the years. The last general updates were received on two occasions in 2009 – 6 February and 27 July. At the request of a Member of the Committee, these papers are included in the present Agenda for comparative purposes. The Committee also received written information specifically about paediatric audiology in West Kent at its 11 June 2010 meeting.

(b) The following specific questions were submitted to NHS Kent and Medway in advance of the present meeting:

1. Can you provide an overview of the way audiology services have been developed since 2009, the last time the Committee considered audiology services?

2. How much has been spent of audiology services in the last four years?

3. How do audiology services feature in QIPP plans?

4. What are the main referral routes to audiology services and how long are the waiting times? Do the waiting times vary across Kent?

5. How many people in Kent access audiology services and what proportion access them outside Kent and Medway?

6. The Committee received specific information about changes to paediatric audiology service in West Kent in 2010 due to facilities at Preston Hall not being considered fit for purpose. Have the changes proposed at the time to paediatric audiology in West Kent been fully implemented and is the service now considered sustainable?

7. How are paediatric audiology services delivered in East Kent?

8. What future services developments to audiology services (adult and paediatric) are underway or in preparation?

2. Recommendation

That the Committee consider and note the report.

NHS
Eastern and Coastal Kent

Audiology Services in East Kent Briefing Paper
January 2009

This paper is intended to give an update on the services currently provided by the Audiology Service commissioned by Eastern and Coastal Kent PCT and the future plans of the service.

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 referrals from GPs into Audiology and self referrals made by patients who are upgrading their analogue hearing appliance for a digital aid.

Just over a year ago the average wait for the Audiology service in East Kent was 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.

Key milestone achievements:-

Significant developments have been made within this service over the last year, especially with regards to East Kent Hospitals University NHS Trust (EKHUT) 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.

At the end of March 2008 the number of people waiting for audiology services at EKHUT 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, Eastern and Coastal Kent PCT 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, 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.

November 2008

At the end of November 2008 the number of patients waiting for audiology services at EKHUT is 742 (see table 2 below); 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. Over 95% of people on the current waiting list profile will be both assessed, and fitted with a hearing aid within 11 weeks. 67% of people identified on the profile will be assessed and treated within 6 weeks of referral.

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

Table 1 Waiting List Progress

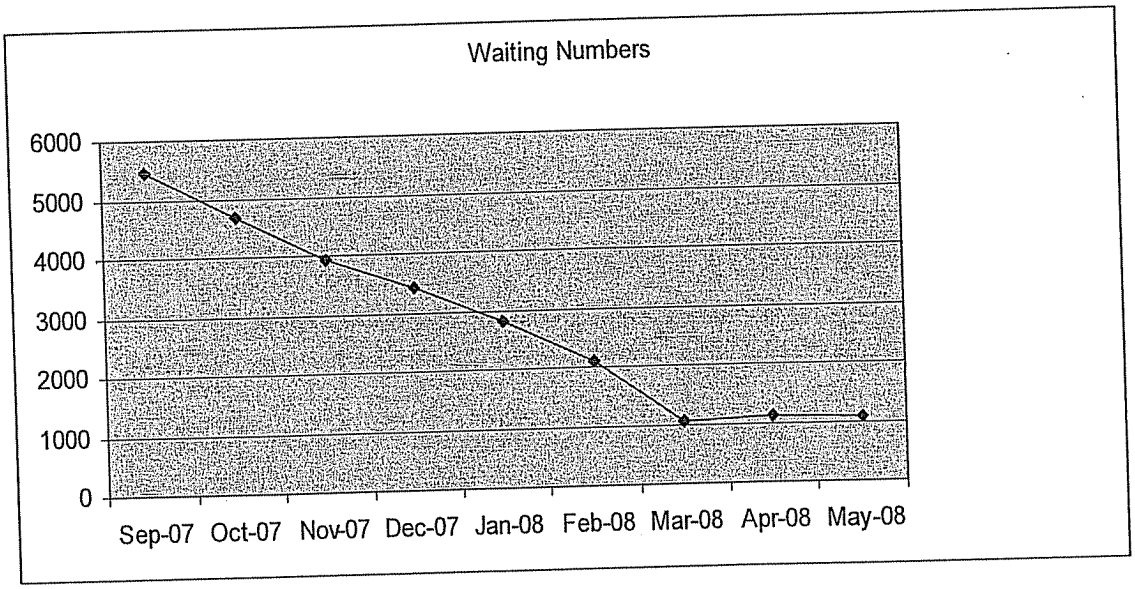
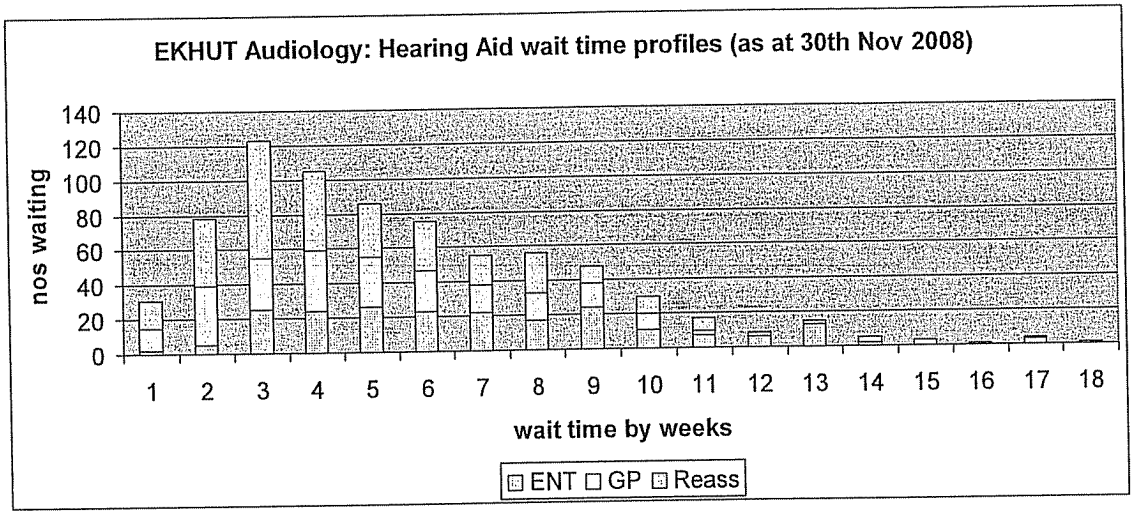


Table 2 Waiting List Profile



Choose and Book

Direct access to audiology at EKHUT 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, 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

Much work has now been done to unbundle the block contract for work at EKHUT 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.

Paediatric Audiology

The World Class Commissioning arrangements recently endorsed by Eastern and Coastal Primary Care Trust will require us to revise the commissioning of paediatric audiology services to ensure a coherent paediatric audiology pathway. This would

suggest that the children's lead commissioner should undertake the commissioning of paediatric audiology services collaborating closely with public health leads (for neonatal hearing screening) and head and neck commissioner (for ENT provision).

Until recently an adult audiologist employed by EKHUT provided the audiology assessments and services for children. However, the Clinical Services Manager recently made a successful internal Trust business case to develop a specific paediatric service. The Service now has a full time Specialist Consultant Community Paediatrician specialising in audio-vestibular medicine who is now leading the team and managing the newborn hearing screening programme. In addition EKHUT have now established two specialist paediatric audiologist posts. One post is now filled and the other is being covered by a locum whilst the second post is being recruited to (in progress). This means that as well as increasing the capacity of the overall audiology services, the standard and quality of provision for children is improved by the establishment of a more specialised paediatric service.

The Kent Children's Trust arrangements strengthen opportunities for collaboration at strategic and local levels and the Children's Commissioning Health Team will also work closely with KCC Education Deaf Services Team and Specialist Teaching Services thus ensuring a coherent pathway to enable children to have access to an early year's services, education and community provision.

In order to determine the level of the required commissioning budget an audit of need over the last three years has now been requested.

Children in the Swale area are provided for by West Kent PCT paediatric audiology team.

Future Planning

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. And in addition ensure that services are established in rural and hard to reach areas.

ECKPCT 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.

NHS
West Kent

Audiology Services in West Kent Briefing Paper
January 2009

This update builds on the previous report submitted to the HOSC in July 2008.

During the past year considerable efforts have been made by NHS West Kent to reduce waiting times for digital hearing aids to the target level of 18 weeks from GP referral to treatment.

An additional contract was awarded to Clinicenta to enable this, with funding made available for 1200 new audiology assessments and hearing aid fittings for people from the Maidstone and Tunbridge Wells areas. Patients treated in this service are both those waiting for first fit hearing aids and those changing from analogue to digital.

This additional capacity extends the services already provided by Maidstone & Tunbridge Wells NHS Trust (MTW) for patients in the south of West Kent. Medway NHS Trust treats patients in the Dartford, Gravesham and Swanley areas. A number of other centres provide audiology services for the people of West Kent, including Bromley Hospitals Trust, Guys and St Thomas' NHS Foundation Trust and a number of other London Hospitals.

Since the previous HOSC update and our success in reducing waiting times, Clinicenta now accepts direct referrals from GPs. Patients referred in this way receive a hearing assessment within 10-14 days and have their hearing aids fitted within 4-6 weeks of referral.

Currently all patients referred for audiology across West Kent are assessed within 6 weeks and treated within 18 weeks.

In line with *"Transforming Adult Hearing Services"*, both MTW and Medway are redesigning their processes to ensure they can provide 3 year reviews for all patients. In the meantime best use is being made of other opportunities to offer such a review, for example Medway re-testing patients who attend for a repair.

Work on improving audiology services sits within the ENT stream of the Elective Care Programme. The Programme forms a key component of the overall Fit for the Future strategy and aligns with the NHS West Kent Operating Plan for 2008/09 for example in achieving and sustaining 18 weeks referral to treatment times, giving fast access to high quality care closer to home, aligning with pathway redesign work required to support the new hospital at Pembury, and the patient choice agenda. Through this Programme the PCT works in close partnership with Trusts across the local health economy.

NHS
Eastern and Coastal Kent

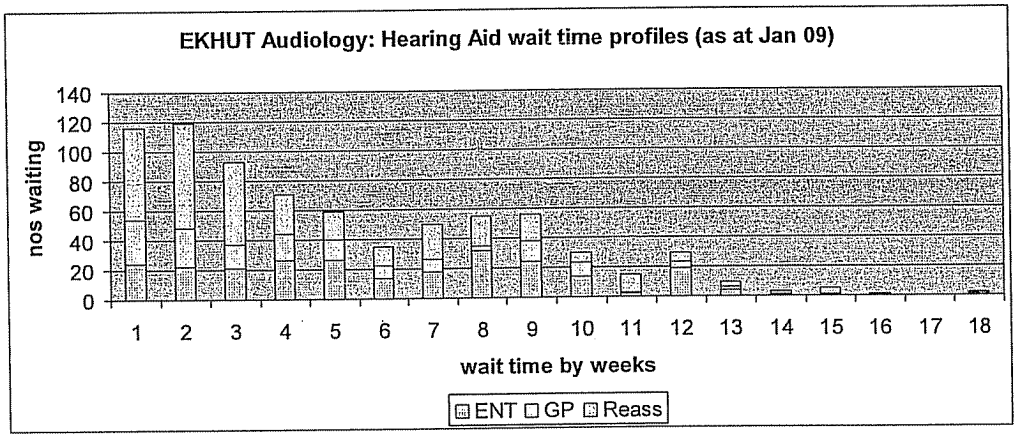
Audiology Services in East Kent briefing paper March 2009

Following an update made at the HOSC meeting of 6th February, this paper is intended to give an additional update on the services currently provided by the Audiology Service commissioned by NHS Eastern and Coastal Kent. It addition it sets out to answer the supplementary questions asked by the HOSC committee.

Current position:- East Kent Hospitals University Foundation Trust (EKHUFT)

As at the end of January 2009, NHS Eastern and Coastal Kent have 748 patients waiting for audiology services at East Kent Hospital University Foundation Trust (EKHUFT). All patients are on an 18 week pathway and will be seen within that time frame unless they choose to extend their pathway through exercising their own personal choice. The average wait for audiology at EKHUFT is now 10 weeks from referral through to the fitting of a hearing device.

Figure 1 waiting list profile at EKHUFT



Current waiting times for patients seen by an audiologist working in a community setting remain at an average of 4 weeks from referral.

Current position:- Medway Foundation Trust

Medway Foundation Trust remain a key provider of audiology for Swale patients, referral into the service is made either directly into audiology for those patients over 65 years of age or through an ENT pathway for all other patients.

The current wait for an ENT 1st appointment is 5 weeks, onward referral into audiology if it is required is 4 weeks. In addition to the provision Swale GPs are able to access an

audiologist placed by ECKPCT at Sittingbourne memorial medical practice this is accessible through local choose and book with current waits of a maximum of 6 weeks.

Supplementary questions following February update

1. Given the importance of testing the hearing of newborns, can the PCTs provide further information on any newborn hearing screening programmes they have and how many children are being screened?

The newborn hearing screening programme within NHS Eastern and Coastal Kent is well established and follows national guidelines. Over the last year the number of babies on the programme was 7334.

Please see appendix 1 for an outline of the screening pathway

2. What provision is made for testing military personnel returning from conflict situations and are they given priority?

Although the DOH has issued a paper on priority treatment for ex servicemen (*meeting the healthcatre needs of Armed Forces Personnel their families and veterans*). This covered specialist care outlining the services provided at hospitals with which the MOD has a contract. Audiology was not covered in this document and as such testing is offered through our current acute and community teams (current waits are outlined above)

3. Can NHS Eastern and Coastal Kent name the sites from which Hearbase operate in Folkestone, Ashford, Canterbury and Dover?

Hearbase operate from the following locations:-

Hearbase Ltd 140 Sandgate Road Folkestone CT20 2TE	Hi Kent 46 Northgate Canterbruy CT1 1BE	Kenneth Bird Opticians 7 Park Place Ladywell Dover CT16 1DF	St Stephens Medical Centre St Stephens walk Ashford TN23 5AQ

In addition to the above, Hearbase are also offering services at the Spencer Wing at Queen Elizabeth the Queen Mother Hospital in Margate.

4. What provision exists for GPs to carry out hearing tests and what encouragement is there for GPs to advertise hearing tests?

Currently GP's do not carry out hearing tests, but patients with hearing difficulties are offered a choice firstly as to whether they would like the opportunity of having an audiometry test and secondly as to where they would like to have that test carried out.

5. Can the PCTs provide more information about progress in searching for willing providers as well as what plans are in place to ensure audiology services are sustainable in the future?

As commissioners we continue to proactively search for interested willing providers to declare their ability and desire to provide services in the future and extend choice for patients. 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 services across the economy, and in addition to this will ensure that services are established in rural and hard to reach areas.

6. What plans are there for encouraging "high street audiologists" in the same way as there are high street opticians?

High street audiologists are encouraged to tender for NHS work through the "Supply to Health" website as and when commissioners identify the need for additional providers. ECKPCT plan to advertise shortly for increased audiology provision in some hard to reach areas (i.e. Tenterden and New Romney)

7. What public education campaigns around the dangers to hearing exist aimed at young people?

The Lead Commissioner for Head and Neck Services within NHS Eastern and Coastal Kent is planning to carry out social marketing work alongside Public Health experts and with the Communications team "HOUSE" initiative specifically to educate teenagers over the dangers of playing music and games through personal sound systems (IPODs) at too loud a volume highlighting the long term damage that can be caused by this behaviour.

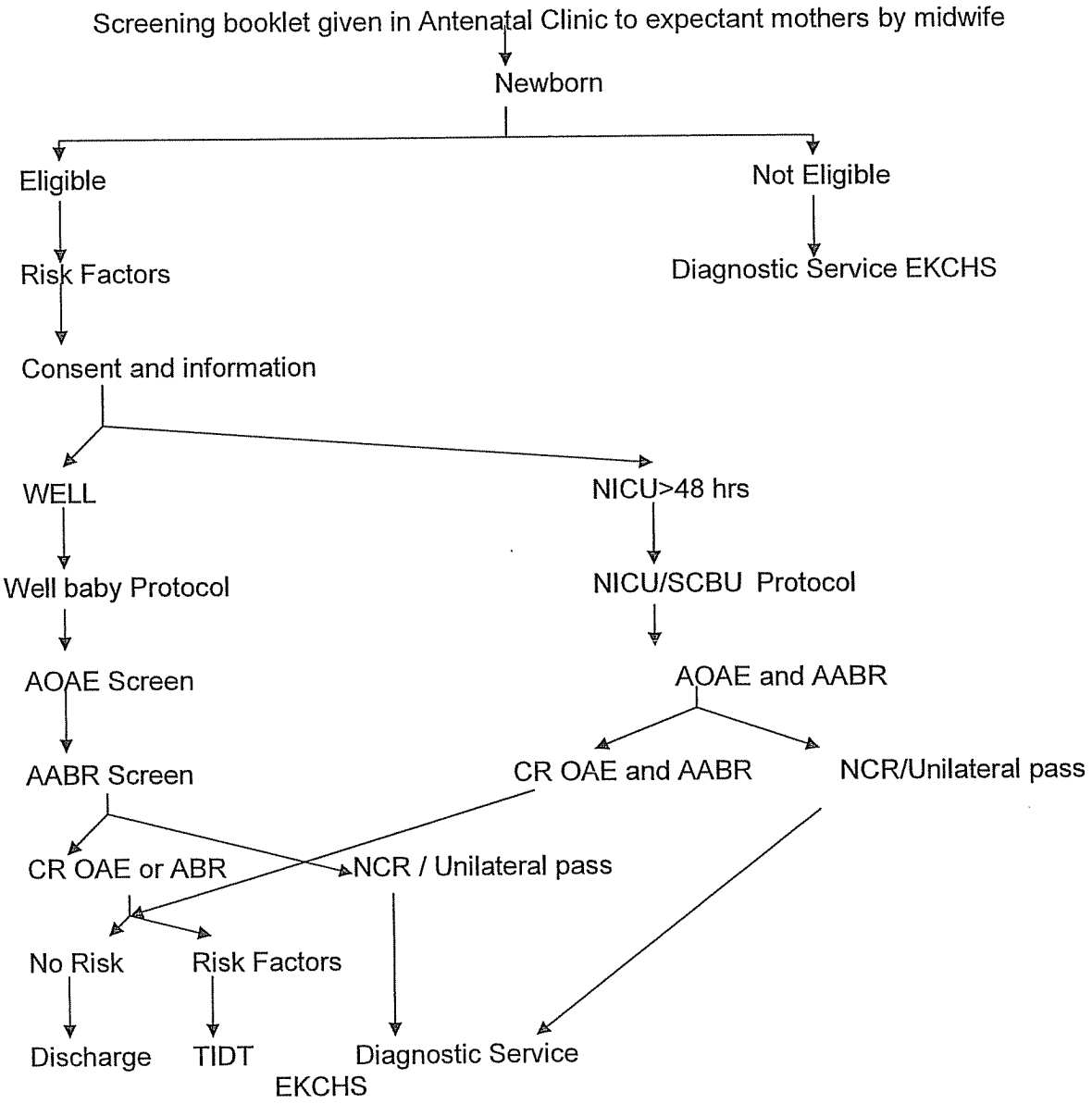
8. What plans are being made to provide services in Kent so that Kent patients do not have to travel to London hospitals?

We have had significant success in providing audiology services closer to home, this means that patients would only travel to London for their treatment if they chose to do so. As such Eastern and Coastal Kent patients are able to choose London providers as a choice option , however a full range of audiology services are fully available through our local acute provider supplemented by community and private audiologists.

9. The reports suggest that adult audiology serviced in Swale are provided by NHS Eastern and Coastal Kent and paediatric audiology services in the same area are provided by NHS West Kent. Can the trusts provide assurances that this does not create confusion in the provision of services?

Whilst paediatric audiology services for Swale patients are largely provided through NHS West Kent, we have been working with EKHUFT to establish opportunities to offer their services as a choice option. Further work is being done to establish options for outreach by EKHUFT into the Swale area. However to assure that the current approach does not lead to confusion, robust adherence to patient pathways is endorsed through communication to General Practitioners and performance monitoring by commissioners is being put into place.

Appendix 1



Diagnostic test currently done by ENT dept, with appointment of Paediatric Audiologist the test will be done under EKCHS along side the Audiological Physician's clinic.

Diagnostic Service

- ABR pass, if click 35 dBnHL and tone pip 40 dBnHL (BC if indicated)
- ABR optional for well babies OAE bilateral pass is sufficient (2 octave=>6 dB)
- Tympanometry high frequency (if less than 4 months old)

NHS
West Kent

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

25 March 2009

Dear Paul

Health Overview and Scrutiny Committee – Audiology Updates

Further to your letter of 3rd March 2009, please find below further details on audiology to answer the committee's questions:

1. Newborn Hearing Screening within West Kent offered screening to 1080 babies in December 2008. This included babies born at Medway Hospital who are mainly Medway and Eastern & Coastal babies. As a programme we are now offering screening to all eligible babies.
2. There is provision for testing military personnel returning from conflict in a timely manner via services provided at Medway Foundation Trust and Maidstone and Tunbridge Wells NHS Trust. Within Medway Foundation Trust, these patients would normally be seen by ENT in the first instance to establish whether there were any conditions requiring immediate surgical intervention but a hearing test would be performed in the audiology clinic. Maidstone and Tunbridge Wells NHS Trust has confirmed that military personnel are prioritised and treated as appropriate.
3. We can confirm that Dartford, Gravesham and Swanley patients receive audiology services, provided by Medway Trust, at Gravesham community hospital and Darent Valley Hospital. These patients are receive a hearing assessment within 6 weeks and are treated within 18 weeks
4. NA
5. Currently GPs do not carry out hearing tests. However, Clinicenta are currently considering providing each surgery that uses their service with handheld initial testers.
6. We have a collaborative approach between the PCT and Maidstone and Tunbridge Wells NHS Trust to establish how a patients needs are met in the best place by the best person. Meetings are shortly to take place to discuss sustaining audiology services and the future of where this service may be best provided, which could be "high street audiologists". We have already used a range of high street providers to assess and treat our patients and we will continue to do so when there is a need. We may move to an any willing provider model in the future, when current contracts expire, and of course 'high street audiologists' will be free to apply for consideration
7. As per question 6

8. Currently the PCT has no public education campaigns in place; however Hi Kent is a member of RNID and actively supports their campaigns, such as the latest campaign 'Don't Stop the Music', so are helping them to get their message out in Kent. In addition, Hi Kent is in the process of acquiring funding for a research project into this issue. They intend to carry out research over the next year with a view to publicising our findings during Deaf Awareness Week in May 2010. We also intend to give a series of talks on the findings to Kent schools reaching as many young people as possible.
   The PCT will need to consider public education on use of for example ipods- which could be done via our volunteer organisations such as Hi Kent, RNI, as the Hi Kent response suggests.
9. Patients currently do not have to travel to London Hospitals for audiology services as hearing assessment and fitting of hearing aids are provided at Maidstone, Kent and Sussex, Sevenoaks, Darent Valley and Gravesham Community hospitals, a service is also provided at Preston Hall Maidstone. A patient, however, may choose to have an appointment in London as outlined in the PCTs Free Choice Strategy.
10. Medway Foundation Trust provide some of the adult services in Swale under a block contract with NHS Eastern and Coastal Kent. Paediatric services are provided in Swale by West Kent Children's Hearing Services based at Preston Hall.
    The adult service at Medway Hospital will see children for specialist testing that cannot be provided by the children's service. This is undertaken by the Consultant Audiological Physician and includes taking impressions for all the paediatric earmoulds.

I hope this addresses the Committee's queries, if you require any further information please don't hesitate to contact me.

Yours sincerely

Steve Phoenix
Chief Executive

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

To: Health Overview and Scrutiny Committee, 4 January 2013

Subject: Audiology: Background Note

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1. Introduction

(a) An estimated 10.7 million people in the UK have some form of hearing loss. 4.9 million adults have a hearing loss where hearing aids/other appropriate aids, with clinical management, would be beneficial.[1]

(b) Hearing loss comes about through three main routes:

1. *Conductive hearing loss* – Sounds are unable to pass from the outer to the inner ear. It is caused by a blockage such as ear wax, fluid build up from an ear infection, perforated ear drum or disorder of the hearing bones.

2. *Sensorineural hearing loss* – Damaged is caused, through ageing or injury, to the hair cells in the cochlea or auditory nerve.

3. *Mixed hearing loss* – Both of the above types are possible at the same time.[2]

2. Hearing Tests

(a) A range of different hearing tests are used, some used specifically for children and others specifically for adults. Common hearing tests include:

- *Automated otoacoustic emissions tests (AOAE)* where a computer attached to an earpiece plays clicks and measures responses.

- *Automated auditory brainstem response tests (AABR)* where sensors are placed on the head and neck to check nerve responses while sound played through headphones.

- *Pure tone audiometry tests* where a button is pressed when sounds, played at different volumes and frequencies, are heard.

- *Bone conduction tests* which tests how well sound travels through the bones in the ear using a vibrating sensor.[3]

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[1] Right Care, The NHS Atlas of Variation in Healthcare, November 2011, p.113, http://www.rightcare.nhs.uk/atlas/downloads/Hearing_AoV_2011.pdf

[2] NHS Choices, *Hearing impairment (deafness)*, http://www.nhs.uk/Conditions/Hearing-impairment/Pages/Introduction.aspx?url=Pages/Overview.aspx

(b) In 2010, the rate of audiology assessments undertaken per 1000 population varied per Primary Care Trust (PCT) from 2.3 to 75.1.[4]

3. NHS Newborn Screening Programme (NHSP)

(a) About 1 in every 842 children is born with some form of hearing loss with the number rising to 3 in every 1000 for babies who have spent more than 48 hours in intensive care.[5] Since 2006 the NHS Newborn Screening Programme (NHSP) has been offered across England and over 5 million babies have been screened.[6] It has been estimated that before the NHSP around 400 of the approximately 900 children born each year in the UK with a significant hearing impairment would have been missed by 1 ½ years of age and 200 of these children by 3 ½ years of age.[7]

(b) Through the NHSP, children are referred to paediatric audiology services if a poor response in one or both ears is found at screening. In 2010, the mean time from referral to assessment for hearing tests in newborns varied by PCT from 10.5 to 57.2 days.[8]

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[3] NHS Choices, *Hearing tests*, http://www.nhs.uk/Conditions/Hearing-tests/Pages/Introduction.aspx
[4] Right Care, The NHS Atlas of Variation in Healthcare, November 2011, p.113, http://www.rightcare.nhs.uk/atlas/downloads/Hearing_AoV_2011.pdf
[5] NHS Newborn Hearing Screening Programme, *National programme*, http://hearing.screening.nhs.uk/nationalprog
[6] NHS Newborn Hearing Screening Programme, *Statistics*, http://hearing.screening.nhs.uk/statistics
[7] NHS Newborn Hearing Screening Programme, *Screening Information*, http://hearing.screening.nhs.uk/screeninginformation
[8] Right Care, The NHS Atlas of Variation in Healthcare, November 2011, p.115, http://www.rightcare.nhs.uk/atlas/downloads/Hearing_AoV_2011.pdf

Audiology update

Following a full report presented to the Health Overview and Scrutiny Committee in 2009 and subsequently a briefing in 2010, this paper is intended to give an update on audiology services currently provided across Kent. In addition it sets out to answer the supplementary questions asked by HOSC.

1. An overview of the way Audiology services have developed since 2009.

Paediatric services

Changes to the provision of paediatric audiology services in west Kent were implemented from 2010 due to the identification of inadequate facilities reported by the Department of Health quality assurance team.

The service was revisited in May 2011 and a further Quality Assurance report rated the service 4.41 out of 5. In addition, the service received organisational awards and those nominated by a parent from the Kent Deaf Children's Society.

In June 2011, new sound proofed facilities were opened in Sevenoaks Hospital, Gravesham Community Hospital and Hawkhurst. The Hawkhurst clinic was replaced in October this year by a new sound proofed facility in Maidstone. A new facility in the Swale Multi Agency Specialist Hub opened in September. In the same month the service was accredited as a centre to deliver the British Academy of Audiology Higher training scheme.

Additional staff have been appointed to the service and following implementation of a new IT system to support paperless working, the administrative processes have been streamlined and standardised. This has led to an increase in the number of patients seen.

Service leads have also worked with commissioners to provide bone conductor hearing aids for appropriate children. This resulted in the following:

- Since October 2009 all patients are seen within 6/18 weeks
- Audiology work from community paediatrics is absorbed into the service
- Ear moulds are undertaken within the service
- The service profile has been raised within the local health economy and within the provider organisation

Audiology services in east Kent benefit from the employment of a Consultant Audiovestibular Physician (AVP) and three full time Paediatric Audiologists (with one supporting the AVP clinic). This represents an increase of one whole time equivalent audiologist since 2009.

Audiologist led clinics are provided in Ashford, Canterbury, Folkestone and Ramsgate with paediatric hearing aid clinics operating at all sites with the exception

of Folkestone. Multi-disciplinary clinics (AVP, audiologists and teacher of the deaf) also provided clinics at these sites. This ensures a coherent pathway to enable children to have access to early year's services and community provision.

Adult services

In December 2010, NHS West Kent was informed by one of the largest providers of adult audiology services that they would no longer be able to continue their contract with NHS West Kent. With just six weeks' notice to find an alternative provider for patients, arrangements were made to transfer the patients concerned to another existing provider.

Due to the urgent transfer of patients and in order to ensure continuity of care there have been no further developments in adult audiology since this date. The priority for NHS West Kent was to ensure that patient care was not interrupted and that the quality of care provided has continued enabling patients to be seen in a timely manner.

In east Kent, adults are seen within the current guidelines and fall within an 18 week pathway. All patients are seen within that time frame unless they choose to extend their pathway through exercising patient choice. The average wait for adult audiology in east Kent is now an average of 13 weeks from referral through to the fitting of a hearing device.

Currently GP's do not carry out hearing tests, but patients with hearing difficulties are offered a choice firstly as to whether they would like the opportunity of having an audiometry test and secondly as to where they would like to have that test carried out. Over the last five years a number of audiology clinics have been established to work alongside GP practices in Whitstable, Sittingbourne, Deal, Dover, Ramsgate, Westgate and Folkestone. This enables patients to be seen at a location closer to their homes and in addition helps to establish a robust pathway approach across the area. In addition, east Kent audiology services are further supported by an independent organisation called Hearbase which offers clinics at a number of centres throughout the area including an additional service at Queen Elizabeth the Queen Mother hospital in Margate.

2. Spend on audiology services in the last two years

Historically audiology activity within the Acute Trust providers was commissioned as part of the contract for all ear, nose and throat services and funded within a block contract arrangement. It was recognised that this activity needed to be reported separately in order to ensure the most appropriate investment was given to audiology. Since this split, NHS Kent and Medway have identified and recorded an overall spend of £6,624,294 over the last two years for NHS West Kent audiology services. Coding systems employed by the Trust however do not record the split of activity or spend between paediatric and adult services.

Over the last two years, service spend in east Kent has totalled £3,114,918 at local acute providers. In addition east Kent CCGs further utilised a number of independent audiology clinics working at locations throughout the area and spend at these as

totalled £2,600.000. Once again hospital coding systems currently do not identify the spend in audiology as split between paediatric and adult services.

3. Audiology services in QIPP plans

Paediatric services

Clinical Commissioning Groups (CCGs) are currently going through transition with a view to becoming statutory organisations from April 2013. Whilst paediatric audiology does not appear on QIPP plans this year or for 2013/14, the Child Health and Maternity Commissioning support team and Integrated Provider Management team will work with CCGs to ensure referral pathways and contracts are monitored and reviewed appropriately.

Adult services

The west Kent QIPP plan for audiology focuses on the long term monitoring of patients who were transferred to an alternative provider in January 2011. In addition to this the referral pathways and contracts are monitored and reviewed appropriately. This programme of work helped west Kent to implement self-referrals for patients to the service within a year of referral in order to improve access to services.

Similarly, in east Kent, the focus will be on contract and performance management.

4. Main referral routes to audiology services and waiting times.

Paediatric services

The main referral routes in to paediatric audiology services are via GPs, ENT, Community Paediatricians, Health Visitors and School Nurses.

In west Kent, waiting times do not vary; all children have access to local services and the service meets its 6 weeks national target of 100%. An increase in referrals in east Kent however, has seen an increase in waiting times which vary across localities. These are set out in Table 1.

Table 1: Waiting times from May- November 2012 for East Kent AVB clinics

Average of Weeks wait	**Month**								
Clinic	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Total**
Folkestone	29.3	13.7	22.2	15.0	18.2	6.5	5.2	5.9	14.5
Ashford	12.5	17.0	22.2	12.3	14.7	8.0	15.4	7.8	13.6
Canterbury	9.6	16.9	17.8	20.5	13.1	12.6	7.7	9.0	13.6
Ramsgate	21.3	11.5	17.7	13.7	16.8	17.7	9.6	7.1	13.6
Total	**18.6**	**14.8**	**18.7**	**15.9**	**15.3**	**12.6**	**9.6**	**8.0**	**13.8**

Waiting times for the Audiologist led clinic also vary with clinics having a slightly longer waiting time for those over 3 years of age. These are set out in Table 2.

Table 2: Waiting times for east Kent Audiologist-led clinic

Age over 3 years	Number of new referrals from October	Waiting times (as at 4/12/12)
Audiologist Clinic – Canterbury	111	Over 3 months
Audiologist Clinic – Folkestone	20	2 months
Audiologist Clinic – Ashford	35	1-2 months
Audiologist Clinic – Ramsgate	83	Over 3 months
Age 0-3 years		
Canterbury	55	2-3 months
Ashford	63	2-3 months
Ramsgate	19	1-2 months

Adult services

The main referral routes to Adult Audiology services in Kent are written GP referral to the Audiology departments or via ENT for complex patients, patient self-referral within a year and referrals from the West Kent Children's service when patients turn 16 years of age. Currently all patients referred for audiology across Kent are assessed within 6 weeks and treated within 18 weeks in line with the Department of Health guidelines.

5. Numbers of people in Kent accessing audiology services and proportion accessing services outside Kent and Medway

Paediatric services

The majority of paediatric patients were seen within the services housed in Kent and Medway however a small number each year are seen outside of Kent due to patient, parent or carer choice or to access specialist services in London (identified below)

- Guys and St Thomas – CLAPA, Cochlear Implant and Bone Anchored Hearing Aid (BAHA) surgery.
- GOSH – Auditory processing disorder clinic, Cochlear Implant and BAHA surgery, Second opinion on management.

- Royal National Throat Nose and Ear Hospital – cochlear implant, second opinion on management.

Adult services

The number of referrals over the last twelve months to audiology in west Kent was 12,560. 5% of these referrals were outside of Kent and Medway mainly being the specialist London Hospitals.

In east Kent, 16,000 referrals were made into the acute service, a further 4,000 referrals were made into the independent providers operating on behalf of the NHS. The number of east Kent patients accessing services outside of Kent and Medway is thought to be very small (less than 1%).

6. Changes to paediatric services in west Kent due to inadequate facilities

As outlined in the overview section of this paper, the changes proposed in 2010 have been fully implemented. Clinics are now being delivered in Sevenoaks, Gravesham, Maidstone and Swale.

Additional staff have been appointed to the service to ensure sustainability and continued delivery of a high quality service.

7. Delivery of paediatric services in east Kent

As detailed earlier in this paper, the East Kent Paediatric service comprises of one Consultant Audiovestibular Physician (AVP) and 3 full time Paediatric Audiologists, one of which supports the AVP clinic.

The clinics are as follows:

- AVP clinic in Ashford, Canterbury, Folkestone and Ramsgate.
- Paediatric hearing aid clinic in Ashford, Canterbury and Ramsgate
- Audiologist –led clinics at Ashford, Canterbury, Folkestone and Ramsgate.
- Multidisciplinary or Joint Clinics (AVP, audiologist and teacher of the deaf at Ashford, Canterbury and Ramsgate.
- Audiologist Auditory Brainstem Response (ABR) clinic at Canterbury as needed with or without oral sedation.
- Hearing aid transition clinic for those moving to adult hearing aid service held twice a year held by paediatric audiologist, adult audiologist and teacher of the deaf.

Please see Appendix 1 for the East Kent Children's Hearing Service care pathway.

8. Future service developments

Paediatric services

Future development for paediatric audiology in west Kent includes constantly reviewing and monitoring progress. An increase in the number of referrals indicates a need for further recruitment which is being considered by the provider. Capital bids to upgrade testing equipment have just been approved. The service is currently undergoing its next round of quality assurance and outcomes from this will be incorporated in future plans.

With regards to east Kent paediatric audiology, a business case is being developed to recruit a fourth Audiologist to support the increase in demand. This will enable the Trust to reduce waiting times to 6 weeks across all sites.

Clinics in the Ashford and Thanet Multi-Agency Specialist Hubs will commence in January 2013 enabling access to newly built, fit for purpose paediatric audiology soundproof rooms.

In addition, the Trust is keen to work with commissioners to secure funding for bone anchored hearing aids on soft headbands for children which will negate the need for patients to travel to specialist sites in London.

Adult services

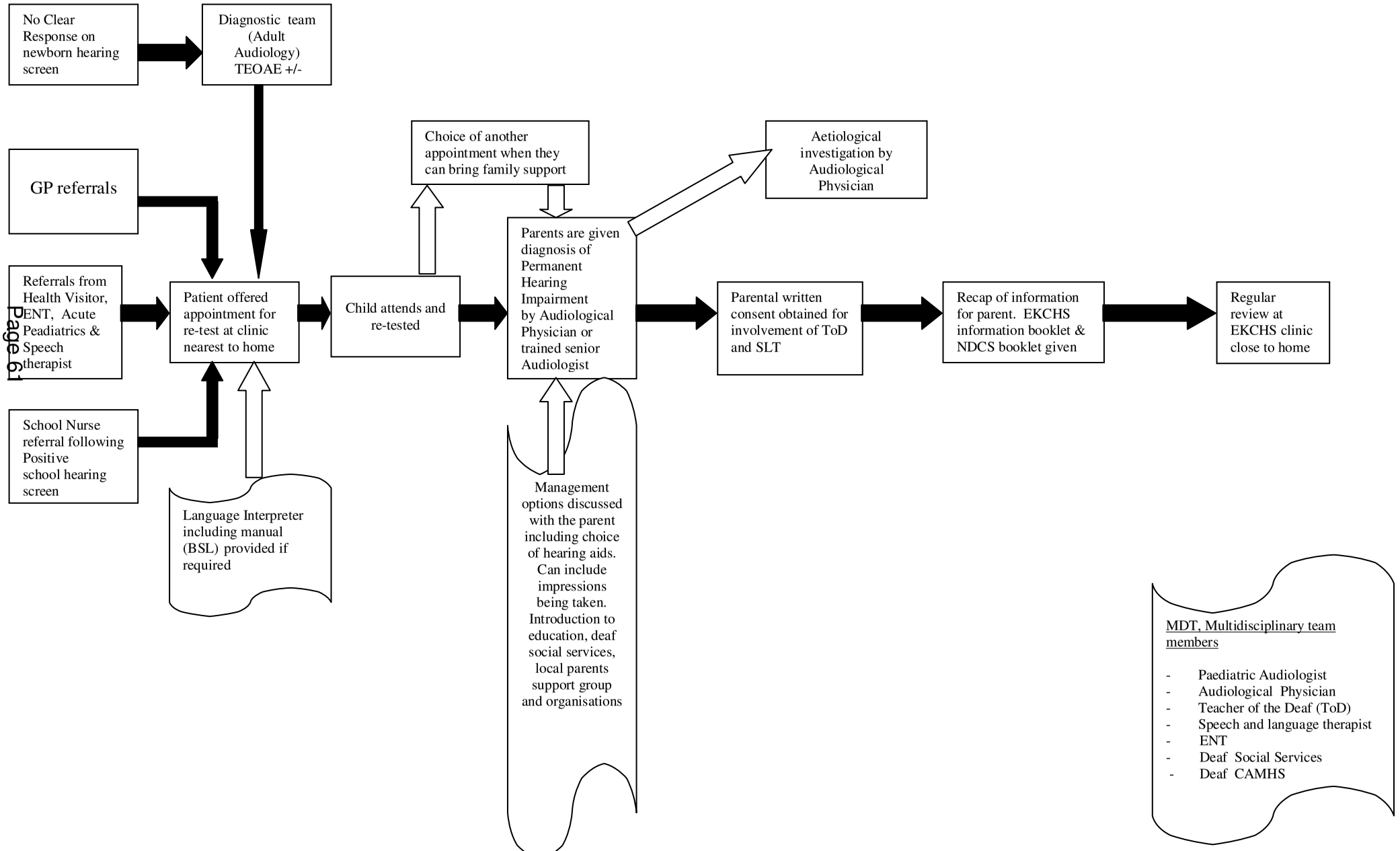
In west Kent, there is currently no new adult audiology commissioning projects planned although this may change if audiology is selected for any future procurement exercises under the Any Qualified Provider (AQP) process.

In east Kent, previous adult audiology commissioning was overseen by a Lead Commissioner. This role has now been subsumed by east Kent Clinical Commissioning Groups - Ashford, Canterbury and Coastal, Thanet and South Kent Coast. As Members are aware, the four east Kent Clinical Commissioning Groups are currently going through transition processes including authorisation to become statutory bodies as from April 2013. In addition they are developing their commissioning intentions for 2013/14 to decide which of their commissioning responsibilities to collaborate on with their adjacent CCGs.

East Kent CCGs have indicated that audiology is an area they would wish to collaborate on with Canterbury and Coastal CCG potentially becoming the lead for this. The discussions between CCGs in this regard are on-going and will need to be finalised. If CCGs agree to work together and for one CCG to lead on audiology, time needs to be allowed for the lead CCG to collaborate with other CCG colleagues with a view to bringing a detailed update to HOSC at a future date.

East Kent Children's Hearing Service (EKCHS) care pathway

Permanent Childhood Hearing Impairment (PCHI) Pathway



EKCHS Clinics are Consultant Audiological Physician led (AVP) or Audiologist-led (AUDLED)

updated 11.12.2012

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 4 January 2013

Subject: South East Coast Ambulance Service NHS Foundation Trust: Performance Update.

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1. Background

(a) The Health Overview and Scrutiny Committee discussed its Forward Work Programme during its meeting of 30 November 2012. One additional request from Members was for the Committee to consider the performance of the South East Coast Ambulance Service NHS Foundation Trust, with particular reference to response times.

(b) The Chairman undertook to put this on the Agenda as soon as was practicable after liaising with the Trust.

2. Recommendation

That the Committee consider and note the report.

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

To: Health Overview and Scrutiny Committee, 4 January 2013

Subject: Ambulance Services: Background Note

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1. Introduction

(a) Emergency ambulance services are delivered by 11 regionally based Ambulance Trusts across England.[1] The National Ambulance Commissioners Group estimates that ambulance service provision directly costs around 1.5% of the total NHS budget, but impacts on around 20%.[2]

2. Key Statistics

(a) For ambulance services across England in 2011/12:[3]

- The total number of emergency calls was 8.49 million, a 5.1% increase on the previous year.
- Of these, 6.71 million calls (81.8%) resulted in an emergency response arriving at the scene of the incident, a 1.6% increase on the previous year.
- The number of emergency patient journeys was 4.92 million, a 0.9% increase on the previous year.
- Of these journeys, 4.40 million (89.4%) were taken to a type 1&2 A&E destination and 0.52 million (10.6%) were taken elsewhere.[4] 1.81 million were treated at the scene and not transported elsewhere, a 2.6% increase on the previous year.

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[1] There are separate arrangements for the Isle of Wight.
[2] NHS Confederation, *Integrated ambulance commissioning in the new NHS,* 5 November 2012, http://www.nhsconfed.org/Publications/briefings/Pages/Integrated-ambulance-commissioning.aspx?utm_source=Web&utm_medium=Promo&utm_term=031212&utm_campaign=1
[3] Adapted from: The Information Centre for Health and Social Care, *Ambulance Services England 2011-12,* 20 June 2012, *http://www.ic.nhs.uk/webfiles/publications/002_Audi8ts/Audits%20and%20performance/Ambulances/amb-svc-2011-12/amb_svc_eng_2011_2012_bul_v2.pdf*
[4] Type 1 = A consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients; Type 2 = A consultant led single specialty accident and emergency service (e.g. dental). Source: The Department of Health, Quarterly Monitoring of Accident and Emergency (QMAE), Guidance, FAQs and Simple form, p.3, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_129783.doc

- Of the 12 NHS organisations providing ambulance services, all 12 met or exceeded the 75% standard for 8 minute response times.

(b) South East Coast Ambulance Service NHS Foundation Trust (SECAmb) covers a geographical area of 3,600 square miles (Brighton & Hove, East Sussex, West Sussex, Kent, Surrey, and North East Hampshire).[5] A selection of sheets comparing SECAmb with the other ambulance service providers against some of these national headline figures are appended to this Background Note. [6]

3. Clinical Quality Indicators

(a) Measurement of the performance of ambulance services against 3 response time targets was introduced in 1996 to improve basic standards and consistency across the country. According to the House of Commons Public Accounts Committee:

- *"… the incentive to meet response time targets has led to some inefficiencies. For example, some ambulance services send more than one team to incidents, over-committing vehicles and staff."*[7]

(b) The target of responding to at least 75 per cent of Category A life-threatening patients within 8 minutes remains. The Category B response target for non-life threatening emergencies was replaced from 1 April 2011 with 11 new clinical quality indicators. These are:[8]

- Outcome from acute ST-elevation myocardial infarction (STEMI).
- Outcome from cardiac arrest - return of spontaneous circulation.
- Outcome from cardiac arrest - survival to discharge.
- Outcome following stroke for ambulance patients.
- Proportion of calls closed with telephone advice or managed without transport to A&E (where clinically appropriate).
- Re-contact rate following discharge of care (i.e. closure with telephone advice or following treatment at the scene).
- Call abandonment rate.
- Time to answer calls.
- Service experience.
- Category A 8 minute response time.
- Time to treatment by an ambulance-dispatched health professional.

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[5] South East Coast Ambulance Service NHS Foundation Trust, *About us*, http://www.secamb.nhs.uk/about_us.aspx

[6] Sourced from: The Information Centre for Health and Social Care, *Ambulance Services England 2011-12,* 20 June 2012, http://www.ic.nhs.uk/webfiles/publications/002_Audits/Audits%20and%20performance/Ambulances/amb-svc-2011-12/amb_svc_eng_2011_2012_bul_v2.pdf

[7] House of Commons Committee of Public Accounts, *Transforming NHS ambulance services*, p.3, http://www.publications.parliament.uk/pa/cm201012/cmselect/cmpubacc/1353/1353.pdf

[8] South East Coast Ambulance Service NHS Foundation Trust, *Clinical Quality Indicators*, http://www.secamb.nhs.uk/about_us/our_performance/response_time_targets/clinical_quality_indicators.aspx

(c) In the Government's response to the House of Commons Public Accounts Committee report, it was stated that:

- *"The removal of the B19 target has already increased flexibility in terms of appropriate responses being deployed. It is anticipated that the publication and review of the ambulance clinical quality indicator data will decrease variation in performance between trusts and will therefore help to improve efficiency."*[9]

(d) From 1 June 2012, a technical amendment was introduced to the Category A8 response time standard. This allowed for a distinction between Red1 and Red2 calls. Red1 calls account for less than 5% of all ambulance calls and cover the most critical – "cardiac arrest patients who are not breathing and do not have a pulse, and other severe conditions such as airway obstruction." Red2 calls "are serious but less immediately time critical and cover conditions such as stroke and fits."[10]

4. Commissioning

(a) In most areas, Primary Care Trusts (PCT) currently commission emergency ambulance services jointly across a region, normally through a lead PCT commissioner. Commissioning responsibility will transfer to Clinical Commissioning Groups on 1 April 2013. It is likely that in many areas joint or collaborative commissioning will continue.[11]

(b) Ambulance services were in the past commissioned on a cost and volume basis but the Operating Framework stated the Department of Health will "seek to amend the scope of ambulance service reference cost data collection to underpin currencies for use in 2012/13".[12] Four currencies were made mandatory for contracting in 2012/13, with locally agreed prices. A national tariff may be introduced in 2013/14.[13]

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[9] HM Treasury, *Treasury Minutes. Government Responses to the Forty Sixth to the Fiftieth Reports from the Committee of Public Accounts: Session 2010*-12, p.7, http://www.hm-treasury.gov.uk/d/hmt_minutes_46_50_reports_cpas_dec2011.pdf#page=4

[10] Department of Health, *Technical amendment to the category A8 ambulance response time standard*, 16 May 2012, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134120.pdf

[11] NHS Confederation, *Integrated ambulance commissioning in the new NHS,* 5 November 2012, http://www.nhsconfed.org/Publications/briefings/Pages/Integrated-ambulance-commissioning.aspx?utm_source=Web&utm_medium=Promo&utm_term=031212&utm_campaign=1

[12] Department of Health, *The Operating Framework for the NHS in England 2011/12*, p.53, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122736.pdf

[13] Department of Health, *Payment by Results Guidance for 2012/13*, 16 February 2012, p.132, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133585.pdf

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Table 2 Emergency calls[1] by ambulance service, 2004-05 to 2011-12

thousands

Ambulance Service	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
England	**5,623.8**	**5,960.1**	**6,333.4**	**7,225.5**	**7,477.2**	**7,867.9**	**8,077.5**	**8,493.0**
North East	279.7	291.8	362.0	398.0	405.0	431.8	458.5	483.2
North West	779.7	832.0	887.0	1,009.8	1,033.6	1,064.1	1,074.4	1,114.2
Yorkshire	522.6	552.6	555.5	627.0	671.7	710.9	725.3	751.9
East Midlands	473.2	459.7	523.3	631.9	667.5	692.9	723.5	776.1
West Midlands [2]	607.7	668.0	666.8	772.2	796.1	844.1	863.8	883.9
East of England	543.3	581.1	625.6	718.3	733.2	778.1	821.2	863.5
London	1,153.9	1,231.6	1,288.8	1,389.7	1,423.5	1,480.3	1,494.2	1,606.0
South East Coast	460.3	493.0	494.4	554.8	580.1	619.2	653.9	688.7
South Central	330.0	336.6	356.1	446.5	432.4	494.7	494.9	510.4
Great Western	200.9	219.8	232.5	278.8	289.6	295.9	303.3	320.8
South Western	259.5	280.5	328.1	380.6	423.7	435.5	442.9	470.6
Isle of Wight	13.0	13.4	13.3	18.1	20.8	20.4	21.4	23.6

Source: Form KA34

[1] From 2007-08 urgent calls were included (previous years relate to emergency calls only), therefore comparisons of absolute numbers from 2007-08 and previous years are not possible.

[2] On the 1st October 2007 Staffordshire Ambulance Service NHS Trust merged with West Midlands Ambulance Service NHS Trust. For comparability, data for these two trusts have been merged for all previous years.

Table 2a Emergency calls by category and ambulance service, 2011-12

thousands

Ambulance Service	Total	*of which*	Category A[1]	Category C[1]
England	**8,493.0**		**2,733.7**	**5,759.3**
North East	483.2		152.3	330.9
North West	1,114.2		376.1	738.2
Yorkshire	751.9		264.4	487.5
East Midlands	776.1		284.4	491.7
West Midlands	883.9		338.3	545.6
East of England	863.5		253.7	609.8
London	1,606.0		412.4	1,193.5
South East Coast	688.7		264.5	424.2
South Central	510.4		112.6	397.8
Great Western	320.8		113.1	207.7
South Western	470.6		154.8	315.8
Isle of Wight	23.6		7.1	16.5

Source: Form KA34

1) Category B was dropped in 2011-12. As a result, incidents previously catagorised as B have been re-categorised into catagories A and C. It is therefore not possible to make direct comparisons between categories in 2011-12 and those in earlier years

Table 4 Emergency incidents [1] (calls resulting in response arriving at the scene of the incident) by ambulance service, 2004-05 to 2011-12

thousands

Ambulance Service	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
England	**4,526.3**	**4,770.1**	**5,068.8**	**5,888.7**	**6,150.4**	**6,415.2**	**6,606.5**	**6,710.6**
North East	228.3	238.9	249.6	321.7	340.7	353.7	361.5	367.1
North West	676.6	698.5	755.2	846.1	873.1	893.1	901.3	919.5
Yorkshire	426.7	451.6	481.4	549.3	564.8	598.9	615.9	631.1
East Midlands	379.9	400.0	430.9	524.9	547.9	573.6	595.4	593.1
West Midlands [2]	481.8	521.1	575.4	657.9	691.8	708.8	730.4	745.7
East of England	458.0	486.5	517.0	604.9	641.6	668.5	693.4	700.0
London	827.4	856.7	865.5	945.8	973.9	1,012.9	1,058.1	1,041.7
South East Coast	377.9	398.7	421.6	503.4	530.4	561.3	581.0	593.1
South Central	254.4	272.0	289.2	349.3	364.7	383.2	390.1	411.3
Great Western	158.9	169.6	177.4	216.8	233.3	256.2	262.8	272.4
South Western	244.2	264.0	292.5	351.4	370.1	387.4	397.9	417.2
Isle of Wight	12.0	12.6	13.1	17.3	18.2	17.5	18.6	18.3

Source: Form KA34

[1] From 2007-08 urgent calls were included (previous years relate to emergency calls only), therefore comparisons of absolute numbers from 2007-08 and previous years are not possible.

[2] On the 1st October 2007 Staffordshire Ambulance Service NHS Trust merged with West Midlands Ambulance Service NHS Trust. For comparability, data for these two trusts have been merged for all previous years.

Table 6 Emergency incidents: response times by ambulance service and category of call[1], 2011-12

thousands and percentages

	Category A calls					
Ambulance service	Total number of incidents with emergency response (thousands)	Response within 8 minutes (thousands)	Response within 8 minutes (percentage of total incidents with response) (%)	Total number of incidents with ambulance vehicle arriving (thousands)	Response within 19 minutes (thousands)	Response within 19 minutes (percentage of total incidents with response) (%)
England	**2,542.5**	**1,937.3**	*76.2*	**2,523.0**	**2,441.3**	*96.8*
North East	148.2	115.4	*77.9*	148.0	145.8	*98.5*
North West	355.7	273.0	*76.7*	352.5	336.7	*95.5*
Yorkshire	252.6	191.3	*75.7*	252.0	246.8	*97.9*
East Midlands	222.4	167.1	*75.2*	222.0	204.9	*92.3*
West Midlands	323.3	246.6	*76.3*	323.3	316.8	*98.0*
East of England	228.6	172.4	*75.4*	226.9	215.4	*94.9*
London	390.2	295.6	*75.7*	378.2	375.0	*99.1*
South East Coast	252.2	195.7	*77.6*	252.1	247.3	*98.1*
South Central	108.0	82.0	*75.9*	107.8	102.7	*95.3*
Great Western	105.0	79.4	*75.6*	104.4	100.6	*96.3*
South Western	149.3	113.6	*76.1*	149.0	142.7	*95.8*
Isle of Wight	7.0	5.4	*76.2*	6.7	6.6	*97.9*

Source: Form KA34

1) Category B was dropped in 2011-12. As a result, incidents previously categorised as B have been re-categorised into categories A and C. It is therefore not possible to make direct comparisons between categories in 2011-12 and those in earlier years

Table 12 Emergency patient destinations by ambulance service and category of call for 2011-1.[1]

thousands

	All emergency patient journeys			of which: Patient Journeys to destination Type 1 & 2 A&E [2]			Patient Journeys to destination other than Type 1 & 2 A&E [2]		
Ambulance Service	Total	Category A	Category C	Total	Category A	Category C	Total	Category A	Category C
England	**4,919.3**	**1,966.1**	**2,953.3**	**4,395.6**	**1,840.6**	**2,555.0**	**523.7**	**125.4**	**398.3**
North East	303.1	124.8	178.3	231.1	106.6	124.5	72.0	18.2	53.8
North West	771.0	304.8	466.2	718.5	300.5	418.0	52.5	4.3	48.1
Yorkshire	512.1	212.7	299.4	486.3	205.6	280.8	25.8	7.1	18.7
East Midlands	422.6	161.8	260.8	363.0	141.2	221.8	59.6	20.6	39.0
West Midlands	531.0	245.3	285.7	464.9	242.8	222.1	66.2	2.6	63.6
East of England	446.3	158.9	287.4	400.4	148.4	252.0	45.9	10.6	35.4
London	809.4	322.9	486.5	735.3	293.9	441.4	74.1	29.0	45.1
South East Coast	406.0	184.8	221.2	370.3	171.4	198.9	35.7	13.4	22.3
South Central	271.2	74.7	196.5	262.9	73.9	189.0	8.3	0.8	7.5
Great Western	173.6	72.3	101.3	143.5	64.2	79.3	30.1	8.1	22.0
South Western	260.2	98.1	162.1	207.8	87.8	120.1	52.4	10.3	42.1
Isle of Wight	12.9	5.1	7.8	11.6	4.5	7.1	1.3	0.6	0.7

Source: Form KA34

[1] Category B was dropped in 2011-12. As a result, incidents previously categorised as B have been re-categorised into categories A and C It is therefore not possible to make direct comparisons between categories in 2011-12 and those in earlier years

[2] Type 1 A&E destination is generally consultant led and has full resuscitation facilities and accommodation for reception of A&E patients whereas type 2 A&E departments are still consultant led but provide a single specialty (e.g. dentistry). Other destinations can include minor injury units, walk in centres etc

Table 13 Emergency incidents : number of patients treated at the scene only by category and ambulance trust, 2009-10 [1] to 2011-12[2]

thousands

Ambulance Service	2009-10				2010-11				2011-12		
	Total	Category A	Category B	Category C	Total	Category A	Category B	Category C	Total	Category A	Category C
England	1,598.6	448.2	759.3	391.1	1,762.9	498.6	825.5	438.8	1,809.3	593.7	1,215.6
North East	81.5	21.3	43.4	16.7	75.9	22.1	39.9	13.9	74.3	29.9	44.4
North West	61.6	29.2	23.0	9.5	127.0	46.6	56.5	23.8	152.6	53.4	99.1
Yorkshire	126.3	40.7	59.1	26.5	111.5	35.5	51.2	24.8	118.0	39.3	78.6
East Midlands	184.6	61.7	91.5	31.5	180.6	60.8	85.8	33.9	169.2	60.5	108.7
West Midlands	202.9	50.2	98.1	54.6	221.2	64.5	102.1	54.6	228.0	85.5	142.5
East of England	245.0	65.9	111.8	67.3	256.1	71.2	111.2	73.7	263.3	74.3	189.0
London	168.3	46.0	83.2	39.1	245.5	58.3	129.7	57.5	232.3	67.4	165.0
South East Coast	175.1	37.2	82.7	55.2	180.0	36.6	82.7	60.7	187.1	67.4	119.8
South Central	140.2	33.2	69.3	37.7	135.0	32.7	62.5	39.8	143.8	33.7	110.1
Great Western	84.7	26.4	38.6	19.7	101.6	33.7	45.4	22.5	98.9	32.7	66.2
South Western	124.5	35.7	57.4	31.4	124.0	35.1	57.1	31.8	136.3	47.6	88.7
Isle of Wight	4.0	0.7	1.4	2.0	4.4	1.3	1.3	1.8	5.5	2.0	3.5

Source: Form KA34

[1] Data prior to 2009-10 is not available

[2] Category B was dropped in 2011-12. As a result, incidents previously categorised as B have been re-categorised into categories A and C. It is therefore not possible to make direct comparisons between categories in 2011-12 and those in earlier years