AGENDA

NHS OVERVIEW AND SCRUTINY COMMITTEE

Friday, 11th May, 2007, at 10.00 am
Darent Room, Sessions House
County Hall, Maidstone

Ask for: **Paul Wickenden**
Telephone: **01622 694486**

Tea/Coffee will be available 15 before the start of the meeting in the meeting room

Membership

Conservative (12): Mr A R Chell (Chairman), Mr M J Angell, Mr A D Crowther, Mr J Curwood, Mr C Hibberd, Mr D A Hirst, Mrs S V Hohler, Mr G A Horne MBE, Mr R Tolputt and Mrs E M Tweed

Labour (4): Mr M J Fittock (Vice-Chairman), Mrs C Angell, Ms A Harrison and Mrs E D Rowbotham

Liberal Democrat (1): Mr D S Daley

UNRESTRICTED ITEMS

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

1. Substitutes

2. Minutes - 23 March 2007 (Pages 1 - 40)

3. Maidstone & Tunbridge Wells NHS Trust - a new direction for surgical and orthopaedic care (Pages 41 - 152)

Rose Gibb, Chief Executive, Maidstone & Tunbridge Wells NHS Trust and Steve Phoenix, Chief Executive, West Kent PCT will be in attendance for this item.

Break 11:15-11:30 am

3. Business Plan for the Private Finance Initiative (PFI) - Pembury (Pages 153 - 172)

Rose Gibb, Chief Executive, Bernard Place, Commissioning & Healthcare Director and Laurence Bunnett, PFI Director, Maidstone & Tunbridge Wells NHS Trust and Steve Phoenix, Chief Executive, West Kent PCT will be in attendance for this item.

4. Fit for the Future update

Julia Ross, Director of Civic Engagement, West Kent Primary Care Trust will be in attendance for this item.

5. NHS Overview and Scrutiny Committee - Work Programme and update on Committee activity (Pages 173 - 200)

6. Date of next programmed meeting - Friday 8 July 2007

Council Chamber, Sessions House, County Hall, Maidstone commencing at 10:00 am

EXEMPT ITEMS

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

Stuart Ballard
Head of Democratic Services
(01622) 694002

2 May 2007

KENT COUNTY COUNCIL

NHS OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the NHS Overview and Scrutiny Committee held at the Guildhall, Westgate, Canterbury on Friday 23 March 2007.

PRESENT: Mr A R Chell (Chairman), Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr M J Angell, Mr D S Daley, Ms A Harrison, Mr W A Hayton (substitute for Mr A D Crowther), Mr C Hibberd, Mr D A Hirst Mr M J Northey (substitute for Mrs P A V Stockell), Mr R Tolputt and Mrs E M Tweed.

OTHER MEMBERS PRESENT: Mr M Dance, Mr G Gibbens, Mr W Newman and Mr L Ridings.

OBSERVERS: Mr Julian Brazier, MP, Cllr N Eden-Green, Cllr Mrs J Law, Cllr Mrs J Seath and Wayne Gough, Scrutiny and Research Officer, Canterbury City Council; Ms S Napier, Kent Messenger, Ms L Burley and Ms M Rolfe, Kent & Medway Networks Ltd, Mrs L Selman, Director of Citizen Engagement and Communication and Mr N Fisher, Eastern & Coastal Kent Primary Care Trust, Mrs J Bentley and Mrs F Witherden, Patient and Public Involvement Fora representatives and a number of members of the public.

IN ATTENDANCE: Mr P D Wickenden, Overview and Scrutiny Manager.

UNRESTRICTED ITEMS

URGENT BUSINESS

16. Minutes – 9 March 2007

(1) The Overview and Scrutiny Manager apologised that, because of the limited time available since the last meeting of the Committee on 9 March 2007, the Minutes had only just been prepared. He sought and gained the Committee's approval to deal with the Minutes and any outstanding issues arising from the Minutes. The Chairman suggested that the Committee should do so at the end of the ordinary business which would allow the Committee the opportunity to read the Minutes. This was agreed and the Minutes of the meeting on 9 March 2007 were tabled and circulated.

(2) The Committee agreed to consider the Minutes at the end of the ordinary business and to treat the Minutes as urgent business recognising that the requisite statutory notice had not been given but it would be expedient to deal with the Minutes at this meeting.

17. Provision of Services – East Kent Hospitals NHS Trust

(Item 3)

(Mr D Shortt, Concern for Health in East Kent (CHEK), Ms R Gibb, Chief Executive Maidstone & Tunbridge Wells NHS Trust, Mr M Kershaw, Chief Operating Officer

and Ms E Shutler, Director of Strategic Development, East Kent Hospitals NHS Trust were in attendance for this item)

Cancer Services – Kent and Canterbury Hospital, Canterbury

(1) Concerns had been raised locally by Concern for Health in East Kent that the linear accelerators at the Kent and Canterbury Hospital, Canterbury were working at best only 50% of the time and that resources and staff were being moved to the Maidstone Oncology Centre.

(2) As a consequence, patient waiting time for radiotherapy which had been down to six weeks had now increased to 12 weeks.

(3) Concerns were also expressed about how the provision of cancer services across Kent was managed. The specific question raised was: is the service managed through the Kent and Medway Cancer Network or through the Maidstone and Tunbridge Wells NHS Trust? Ms Gibb responded that management of cancer services across Kent was not via the Kent and Medway Cancer Network but was provided by the Maidstone and Tunbridge Wells NHS Trust through the Kent Oncology Centre.

(4) Ms Gibb added that the provision of cancer services nationally was very costly. What Kent had was a different model of cancer services with a Kent Oncology Centre in Maidstone and a satellite centre in Canterbury as a consequence there was an oncologist working across the whole of East Kent. Ms Gibb made it clear that the Kent Oncology Centre could only deliver work commissioned by the Primary Care Trusts.

(5) Ms Gibb informed the Committee that as many cancer services as possible would continue to be delivered at Kent and Canterbury Hospital. It was only the highly complex cases of radiotherapy that would need to be treated in Maidstone, generally services for cancers such as breast and lung cancer would continue to be dealt with in Canterbury.

(6) Mr Brazier, the Canterbury Member of Parliament, expressed the view that there was only so much money available in the PCT budgets for all health services, including cancer. He said that the provision of cancer services at Maidstone was an expensive operation and he did question why, in some instances, very sick people were unable to access their nearest linear accelerator – instead having to travel from Canterbury to Maidstone or vice versa. Ms Gibb responded that there was no point a patient accessing their nearest linear accelerator if what the patient was going to receive was sub optimal treatment because the staff available at the nearest linear accelerator were the wrong staff.

(7) Ms Gibb acknowledged that cancer services were very expensive. It was important that the more complicated services were dealt with in the most appropriate place. What was happening across the County was that patients were receiving a London service but locally.

(8) In answer to questions relating to the skills required by an oncologist and the minimum number of patients an oncologist needed to see to maintain those skills, Ms Gibb responded that it was important within the NHS that staff were continually improving their skills. The point was well made about doctors having the access and ability to undertake procedures regularly to retain their skill base.

(9) Ms Gibb said the proposals known as "Fit for the Future" (a review of all the health services to be provided across Kent and Medway) did not impinge on the Kent Oncology Centre. Ms Gibb added that there had been no debate on this aspect of the Health Service at all.

(10) Asked about cancer services provided elsewhere such as at the Royal Marsden, and Guys and St Thomas's or in Brighton, Ms Gibb said there were some areas of specialist cancer services which had to be dealt with by specialists elsewhere. It was important that patients in Kent had a service provided by the Kent Oncology Centre.

(11) Members of the Committee and Canterbury City Council members asked a range of questions relating to:-

(a) the usage of the linear accelerators;
(b) the recruitment and retention of oncologists in East Kent; and
(c) how appropriate was it for patients and visitors to have to travel often from Canterbury to Maidstone or vice versa, especially in the case of frail and elderly people, when public transport links were poor and car parking at the locations concerned was also difficult.

(12) Ms Gibb informed the Committee of the opening hours for the Kent Oncology Centre and the work being undertaken to improve capacity by looking at the possibility of opening the Oncology Centre on Saturdays and Bank Holidays. Ms Gibb added that one of the issues for the expansion of services was recruitment of staff to run an extended service. Ms Gibb advised the Committee of a recent recruitment drive which had extended as far as Australia.

(13) Transportation across Kent and Medway, particularly in rural areas, was a big issue. Ms Gibb stressed the importance of all the various partners working together to address this significant issue. It was important that as much cancer treatment as possible was provided locally – but patients needed to receive the specialist care that was most appropriate to them.

(14) Mr Gibbens, Kent County Council Cabinet Member responsible for Public Health, reminded the Committee of a letter that had been sent by the Leader of the County Council to the Primary Care Trusts and the South East Coast Strategic Health Authority, setting out the County Council's view that the provision of health services across Kent and Medway must be in the best interests of the people of Kent. He acknowledged that it was important that the County had a cancer centre and referred to the Maidstone Oncology Centre as "the Royal Marsden of Kent".

(15) However, Mr Gibbens went on to say that he thought it was unreasonable for patients to have to travel when they are often feeling extremely unwell on unpleasant

long journeys to access health facilities for cancer treatment. As a local member for Canterbury, he said that to access Maidstone early in the morning he needed to be away from Canterbury at 7:30 am to ensure that he was able to avoid congestion at Detling Hill.

(16) On behalf of the Cabinet and Kent County Council, he was keen to ensure that as many health services as possible were delivered locally.

(17) Ms Gibb responded that the cancer services provided by Maidstone and Tunbridge Wells NHS Trust across the county were extremely leading-edge. Ms Gibb added that patients would not get better treatment anywhere else. She asked whether it was better to travel for cancer services from Dover to Maidstone or from Dover to London.

(18) Mr Shortt concluded the discussion, saying he felt that cancer services were being lost locally. He cited the issue of pelvic and gynaecology cancer, previously dealt with in the Queen Elizabeth the Queen Mother Hospital at Margate, which was now being dealt with in Maidstone. He added that even the more common cancers, such as breast cancer, were also now being dealt with at Maidstone.

(19) Mr Shortt added that it was unreasonable to expect people to travel five days a week from East Kent to Maidstone for these services. He concluded that the cancer centre at the Kent and Canterbury Hospital felt that they were the poor partner in the cancer services provided across Kent and Medway.

Chronic Pain Clinic – Queen Elizabeth the Queen Mother Hospital, Margate (QEQM)

(20) Mr Hayton raised particular concerns relating to the chronic pain clinic provision at the QEQM and the number of chronic pain services which were now being provided at the Kent and Canterbury Hospital, Canterbury. Mr Hayton spoke about the experiences of members of a chronic-pain support group in which he was involved.

(21) Mr Hayton advised the Committee that he felt that it was unreasonable to expect patients to travel from Thanet, for example, to the Kent and Canterbury Hospital for pain relief. This was particularly difficult when drugs were administered to numb the body. Mr Hayton cited an example where a patient had to travel to the Kent and Canterbury Hospital where drugs to numb parts of the body were administered which meant the patient lost full control of their urinary function.

(22) Mr Daley added that the issue of chronic pain clinics was a national debate. He stressed the importance of NHS Overview and Scrutiny Committee looking at this at a future meeting.

(23) Mr Kershaw responded that the chronic pain service was a particular challenge for the Health Service and hospitals. He informed the Committee of the East Kent Hospitals Trusts work being undertaken to improve the services to ensure that the vast majority of care was undertaken locally and would stay local.

(24) In conclusion, there was an acknowledgement that services for chronic pain needed to be delivered as locally as possible. The complete range of models to deliver a local service needed to be revisited.

RESOLVED:-

that the Committee should continue to monitor the development of cancer services across Kent and Medway; and

that Chronic Pain Clinics should be the subject of a debate at a future meeting of the Committee.

18. Whitstable Polyclinic

(Item 4)

(Mr D Shortt, CHEK, Dr R Stewart, Medical Director and Dr J Ribchester, Professional Executive Committee Member, Eastern & Coastal Kent PCT, Mr M Kershaw, Chief Operating Officer and Ms E Shutler, Director of Strategic Development, East Kent Hospitals NHS Trust and Mr J Pearce, Centres of Clinical Excellence were in attendance for this item)

(1) Dr Stewart informed the Committee that the proposed development of a Polyclinic at Whitstable was a response to the Government White Paper on Our Health, Our Care, Our Say a new direction for community services published by the Department of Health in January 2006. This document sets out the agenda for providing NHS care "closer to home".

(2) Dr Stewart said GPs were responding to this Government policy and what would be presented to the Committee by Dr Ribchester was a proposal for the provision of services more locally. This work was evidence-based.

(3) He added that Primary Care Trusts were working collaboratively with the East Kent Hospital's Trust on this current policy. Dr Stewart concluded by saying that there should be more investment in services locally. The proposals that were to be presented by Dr Ribchester did not yet have the formal approval of the Eastern and Coastal Primary Care Trust. Dr Ribchester of the Whitstable Medical Practice and Jonathan Pearce of the Centres of Clinical Excellence then made a presentation to the Committee on the proposal to open a new GP surgery at Wraik Hill, Seasalter, co-located with a community pharmacy, an NHS ambulance response-base and a surgical polyclinic.

(4) A copy of Dr Ribchester's presentation is attached as Appendix 1 to these Minutes.

(5) Mr Kershaw, on behalf of the East Kent Hospitals NHS Trust, said that a vast amount of what Dr Ribchester was proposing was uncontentious. However, it was proposed that some surgical services would be provided at the polyclinic and this would have potential implications for services provided by the East Kent Hospitals Trust at Canterbury and Margate. Mr Kershaw acknowledged that what was being proposed at Wraik Hill, Whitstable was linked to the national agenda. However, it was important that preparatory work was done in collaboration to ensure that all health services were viable.

(6) Ms Shutler added that it was important that the Primary Care Trust, the East Kent Hospitals Trust and other partners worked together to do some joint modelling to ensure that the implications of this additional capacity in a polyclinic were being fully taken into account.

(7) A document produced by Centres of Clinical Excellence, entitled "Our Credo", was tabled at the meeting.

(8) Members of the Committee, local Kent County Council members, Canterbury City Councillors, local Patient and Public Involvement Fora representatives and others then asked a range of questions.

(9) Regarding whether the cost of the service to be provided by Centres of Clinical Excellence at the polyclinic would be cheaper than the NHS national tariff, the response was that the service would be delivered at NHS tariff prices. The Committee was informed that what was being proposed was not unique. Other private companies, such as Asda, Sainsburys, Virgin and UnitedHealth Europe, were also looking to provide NHS services.

(10) The Committee was told that the polyclinic proposal would rely on the use of local consultants who were currently working for the East Kent Hospitals Trust. This would be an advantage for patients because of the local knowledge of the clinicians.

(11) It was evident from the questions raised that there were a number of people that were fully supportive of the proposal for a polyclinic at Wraik Hill, Whitstable – but others needed further reassurance.

(12) A number of those persons present spoke about the role of Centres of Clinical Excellence in the proposals. The view was expressed that they would only be involved because they were a "profit-making body".

(13) There was a general acknowledgement that the proposal was in an area of new development and would be a facility that would be required. However, it was equally important that the joint modelling proposed by Ms Shutler was undertaken by the Primary Care Trust, East Kent Hospitals Trust, Centres of Clinical Excellence and the Whitstable Medical Practice to ensure that the proposal did not destabilise other health services.

(14) Mrs Walker, on behalf of the PCT Patient and Public Involvement Forum locality group, said that, from the patient–user point of view, she was very supportive of the proposal. She saw that there was a distinct advantage in the proposal for the whole area – and especially for the residents in the immediate vicinity of the polyclinic, because it would cut down travel time to other facilities. Mrs Walker concluded that the project was innovative and should be welcomed.

RESOLVED:-

that the development of a polyclinic at Whitstable be kept under review; and

that the Committee welcome the proposed joint modelling by all the partners on the proposed project so that a reassessment of the project proposals could be reviewed before decisions were taken.

19. The Dover Project and East Kent Neuro-Rehabilitation Services
(Ms A Harrison, Director of Assurance and Strategic Development and Ms S Brown, Project Manager for Eastern & Coastal Kent PCT and Mr H Jones, Director of Facilities for East Kent Hospitals NHS Trust were in attendance for this item)

(1) Ms Harrison made a presentation to the Committee on the Dover Project and the East Kent Neuro Rehabilitation Services. A copy of Ms Harrison's presentation is attached as Appendix 2 to these minutes.

(2) The Committee noted the feedback from the consultation exercise on the Dover project.

(3) The Committee also noted:-

(a) the commissioning framework for delivery;
(b) the models for care;
(c) the establishment of a local practice through "Fit for the Future".

(4) However, it was noted that there were still a number of complex issues which needed to be resolved before full implementation of the improved models for care could be achieved.

(5) With respect to the East Kent Neuro-Rehabilitation Service, the Committee noted the outcome of a Neuro-Rehabilitation working group which had involved representatives from patients, carers, clinicians, Social Services, Primary Care Trusts and East Kent Hospitals Trust. The Committee noted that a focussed discussion had taken place, in accordance with advice from the Committee on the conduct of the consultation.

(6) A document had been produced which had been sent to past and current neuro-rehabilitation patients, staff, and supporting voluntary and community organisations. The consultation process had begun on 14 February 2007 and would end on 30 March 2007.

(7) The Committee noted that 203 responses had been received to date and received a summary of the responses to the four questions posed.

(8) The Committee welcomed the update and suggested that there should be a further meeting of the Committee in the Dover area at a date to be arranged.

RESOLVED:-

that the position be noted.

20. StourCare Out of Hours Provision

(Mr P Robinson, Eastern & Coastal Kent Patient and Public Involvement Forum representative was in attendance for this item)

(1) Mr Robinson submitted a paper setting out details relating to:-

- the history of Out of Hours service provision by StourCare;
- ongoing work by the Eastern & Coastal Kent Primary Care Trust, who were reviewing the decision to close the Out of Hours base in Herne Bay;
- plans to co-locate the Out of Hours service with the Emergency Care Centre at the Kent and Canterbury Hospital as soon as possible; and
- ensuring that a weekend service remained at Herne Bay.

(2) Work undertaken by the Canterbury & Coastal locality group of the Eastern & Coastal Kent PCT Patient and Public Involvement Forum demonstrated that the demography and geography of the area indicated the need for two Out of Hours bases. Mr Robinson said the group would like to see that patients, whatever their location, were offered the base of their choice. The number of patients using Herne Bay was substantial, making it clear to the Forum that patients from coastal areas should continue to be offered the option of attending either Canterbury or Herne Bay or other locations and that Herne Bay Out of Hours base should continue in existence until further notice.

(3) The Committee noted that this recommendation had been conveyed to Ann Sutton, Chief Executive of Eastern & Coastal Kent PCT.

(4) The Committee noted that the Primary Care Trust Co-location Review Group was to meet later on that afternoon and it was agreed that the Committee would be updated on this at its next meeting.

RESOLVED:-

that the position be noted.

21. MINUTES – 9 MARCH 2007

RESOLVED:-

that the Minutes of the meeting held on 9 March 20007 were correctly recorded and that they be signed by the Chairman.

22. MATTER ARISING – 'A New Direction for Emergency and Orthopaedic Care' – Maidstone & Tunbridge Wells NHS Trust

(1) The Overview and Scrutiny Manager updated the Committee on the ongoing negotiations the spokesmen of the Committee and he were continuing to hold with representatives of the West Kent Primary Care Trust, members of the Maidstone Branch of the British Medical Association and correspondence with the Chief Executive of the Maidstone and Tunbridge wells NHS Trust.

(2) He tabled and circulated:-

- the spokesmen's letter to the Chairman and Chief Executive of the West Kent Primary Care Trust dated 9 March (copied to the Chief Executive and Chairman of the Maidstone and Tunbridge Wells NHS Trust) and a response to this letter from the Chief Executive of the Maidstone and Tunbridge Wells NHS Trust dated 13 March 2007;

- a letter from the spokesmen of the Committee to the Chairman of the West Kent Primary Care Trust Board dated 14 March 2007 expressing concern that the ongoing dialogue with this Committee had not been reflected in the report which was to be considered by the West Kent Primary Care Trust Board on 15 March 2007 when a decision would be taken; and

- a copy of the West Kent Primary Care Trust Board report on this issue which was before the Board on 15 March 2007.

(3) The Overview and Scrutiny Manager informed the Committee that he had attended the West Kent PCT Board meeting on 15 March 20007. The correspondence set out in sub paragraph (2) above had not been referred to when the report was introduced and there was no recognition of the ongoing dialogue with the Committee.

(4) He added that no formal vote had been taken on the Primary Care Trust Board's approval of the recommendations set out in paragraph 39 of the PCT Board report.

(5) The Overview and Scrutiny Manager reminded the Committee that referral of an issue to the Secretary of State should only take place once all opportunities to achieve a local resolution had been exhausted.

(6) Several Members of the Committee expressed their extreme concern over the references to the NHS Overview and Scrutiny Committee by the Leader of the County Council when he had been interviewed on Radio Kent earlier that morning, especially when negotiations to seek a resolution were at such a delicate stage.

(7) Mr Angell moved, seconded by Mr Daley that the negotiations with the West Kent Primary Care Trust, Maidstone and Tunbridge Wells NHS Trust and representatives of the Maidstone Branch of the British Medial Association should continue. In moving this proposal he suggested that it might be worthwhile extending the negotiations to a wider grouping of County Councillors.

(8) Mr Hibberd made an alternative suggestion that a full detailed report should be prepared for the Committee's next meeting on Friday 11 May.

(9) The Committee agreed, without taking a vote, that:-

(a) the spokesmen of the Committee and Overview and Scrutiny Manager should continue the negotiations; and

(b) a detailed report should be made to the Committee at its meeting on Friday 11 May 2007, at which a decision on the way forward would be taken.

Chairman _____

Date _____

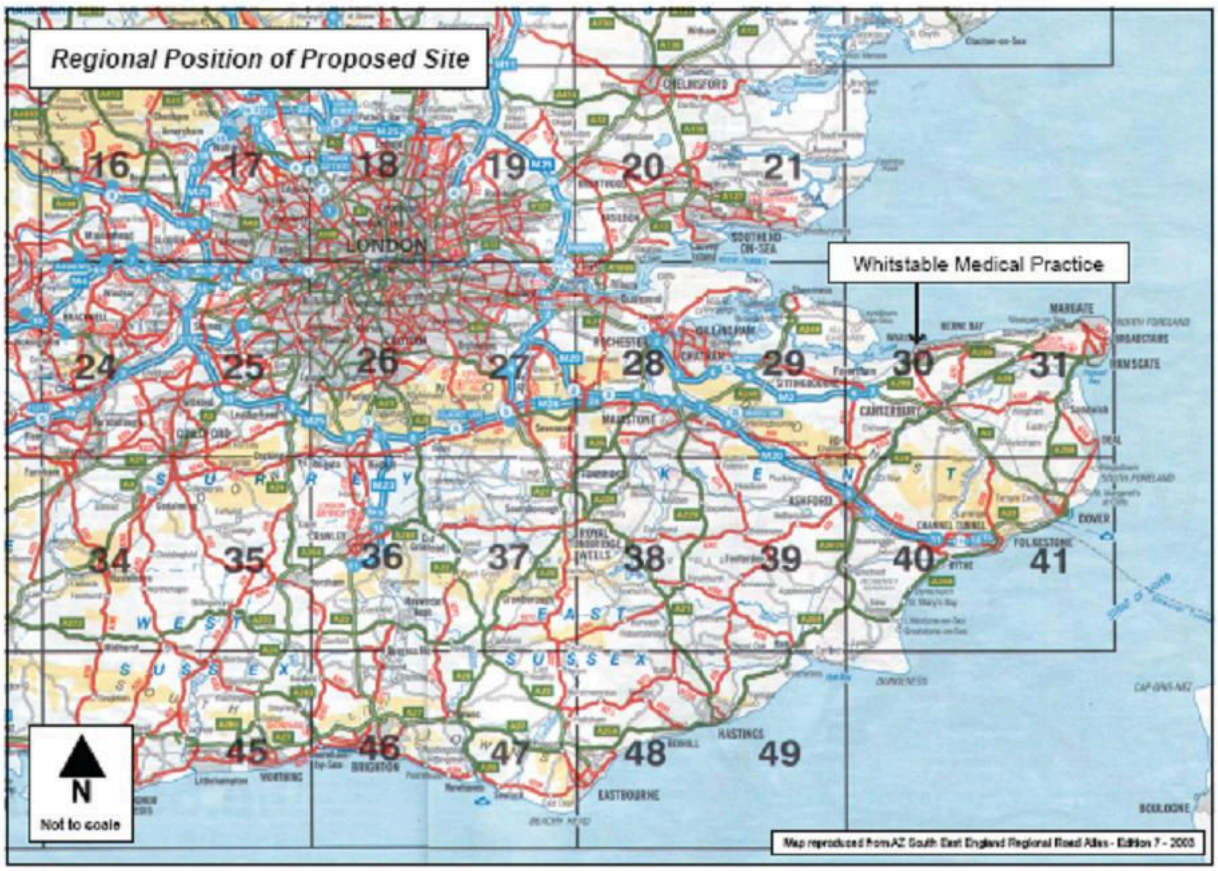
Appendix 1

A Proposal for the Modernisation of Health Services in Whitstable

Dr J M Ribchester
Executive Partner
Whitstable Medical Practice

Presentation to Kent County Council
NHS Overview and Scrutiny Committee

23 March 2007



Whitstable

Whitstable

STRATEGIC FIT

- Government Policy
- National Priorities
- Local Priorities and High Risk Areas for the PCT
- Whitstable Medical Practice PBC Practice Commissioning Plan

GOVERNMENT POLICY 1

Our Health, Our Care, Our Say

"This will allow the acquisition of patient services from a broader range of providers within the NHS, voluntary and the private sector."

"To meet the clear public preference for as much treatment at home or near home as possible."

"Services will be integrated, built round the use of individuals and not service providers, promoting independence and choice."

GOVERNMENT POLICY 2

Our Health, Our Care, Our Community

It "*calls on PCTs to demonstrate an ambitious shift in resources … and to encourage local initiatives in community services over the next five years.*"

It "*calls on PCTs to do this in conjunction with … GP Practices who are developing Practice Based Commissioning as well as providers from the NHS, local government and independent sector.*"

NATIONAL PRIORITIES

- Improving the health of the population
- Supporting people with long term conditions
- Access to services
- Patient/User experience
- Achieving financial balance
- Implementing reform
- Six key service priorities

LOCAL PRIORITIES AND HIGH RISK AREAS FOR THE PCT

- ✓ Orthopaedics
- ✓ Gastroenterology
- ✓ Cardiology
- ✓ General Surgery
- ✓ Ophthalmology
- ✓ Dermatology

WMP PBC PRACTICE COMMISSIONING PLAN

- Urgent need to develop a third site at the west end of Whitstable.
- Requirement to engage with Practice Based Commissioning and other White Paper directives.
- A wish to be involved in redevelopment of health care facilities at Whitstable & Tankerton Hospital.
- Practice credo of striving to provide the best possible quality of health services within the available budget.

A PROPOSAL FOR THE MODERNISATION OF HEALTH SERVICES IN WHITSTABLE

Phase 1

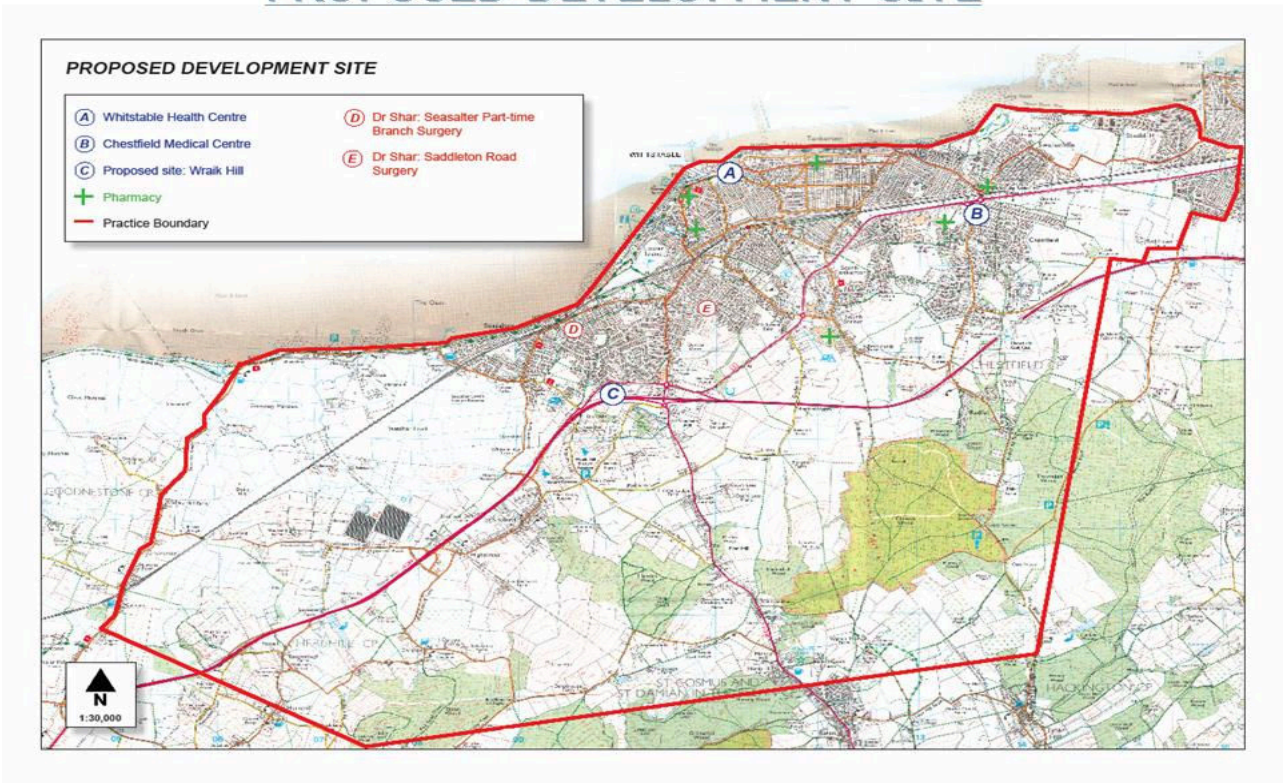
- An Additional Site for Provision of Full GP Services
- Co-location of a Community Pharmacy
- Co-location of a Polyclinic to Provide Surgical Out-Patients, Day Case Operating Theatre and Diagnostic Facilities
- Co-location of an Ambulance Response Base

Phase 2

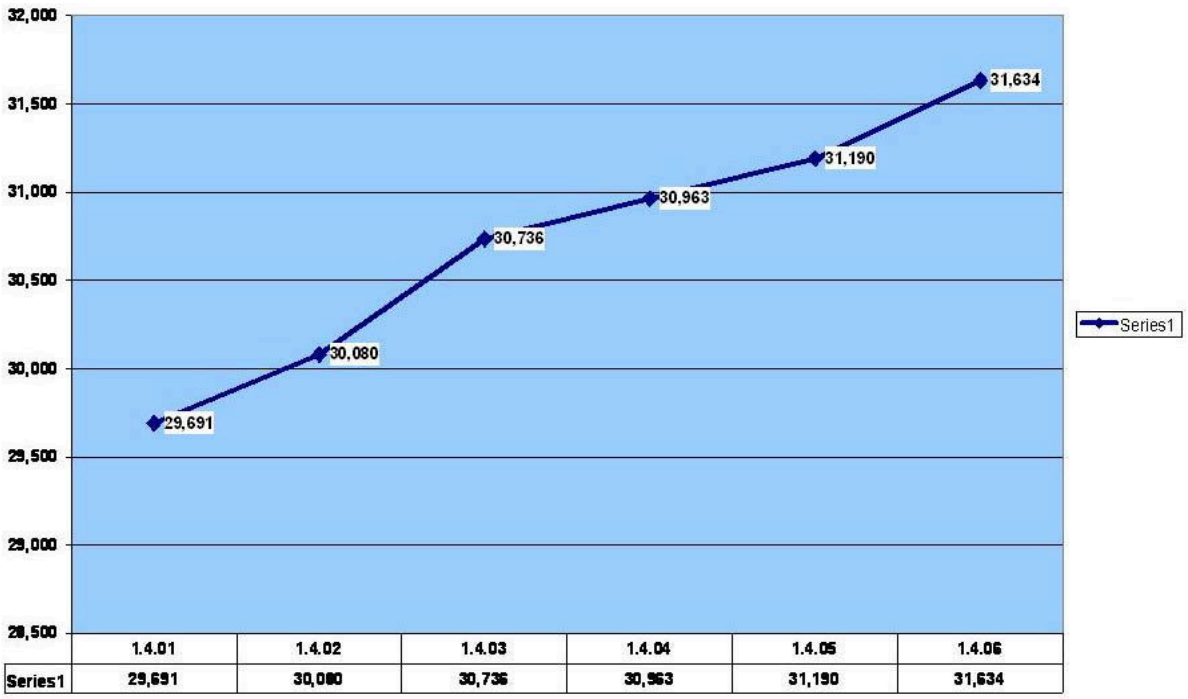
- Redevelopment of Services at Whitstable and Tankerton Hospital, most notably Holden Ward

THE CASE FOR CHANGE

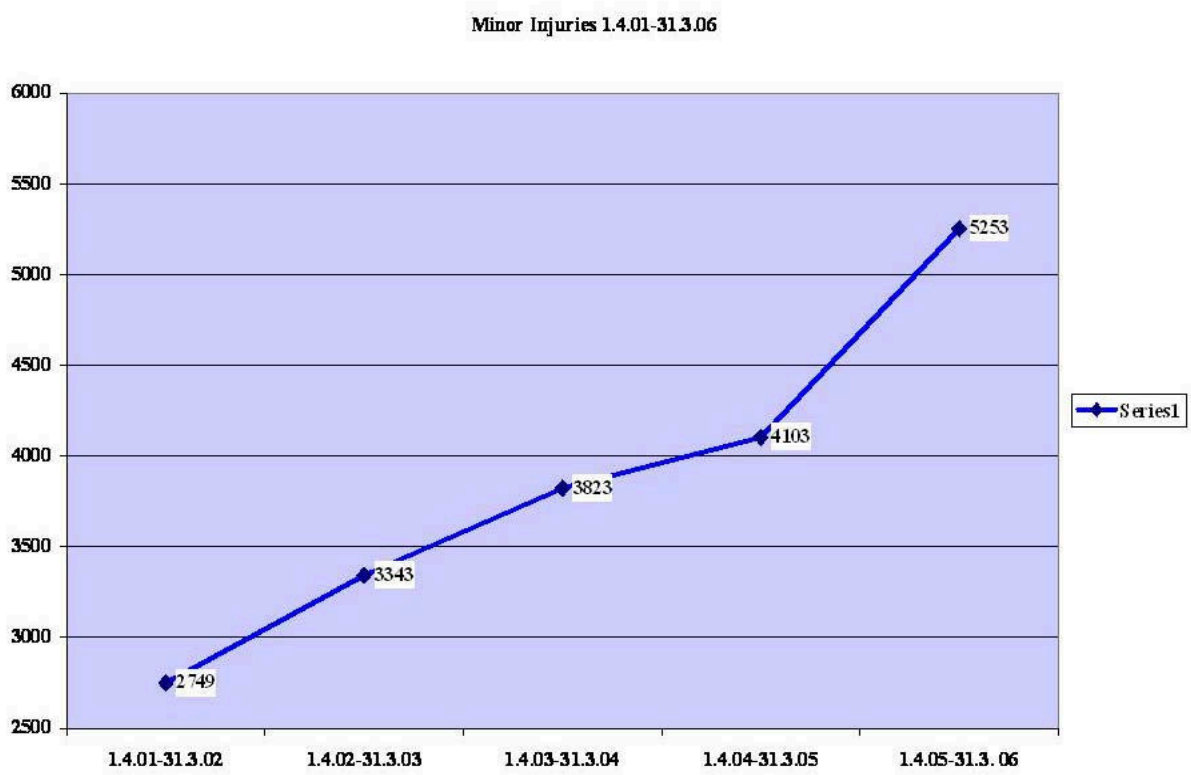
PROPOSED DEVELOPMENT SITE



WHITSTABLE MEDICAL PRACTICE LIST SIZE



	1.4.01	1.4.02	1.4.03	1.4.04	1.4.05	1.4.06
Series1	29,691	30,080	30,736	30,963	31,190	31,634



CURRENT CONFIGURATION OF GP SERVICES

WHITSTABLE HEALTH CENTRE

11 General Practitioners, full general medical and Practice nurse facilities
Minor Injury Unit
Nurse-led Minor Illness Service
Training and Research
Overcrowded and no dedicated space for MIU.

CHESTFIELD MEDICAL CENTRE

6 General Practitioners, full general medical and Practice nurse services
Nurse-led Minor Illness Service
Training and Research
Surgery in Primary Care Service
Full to capacity.

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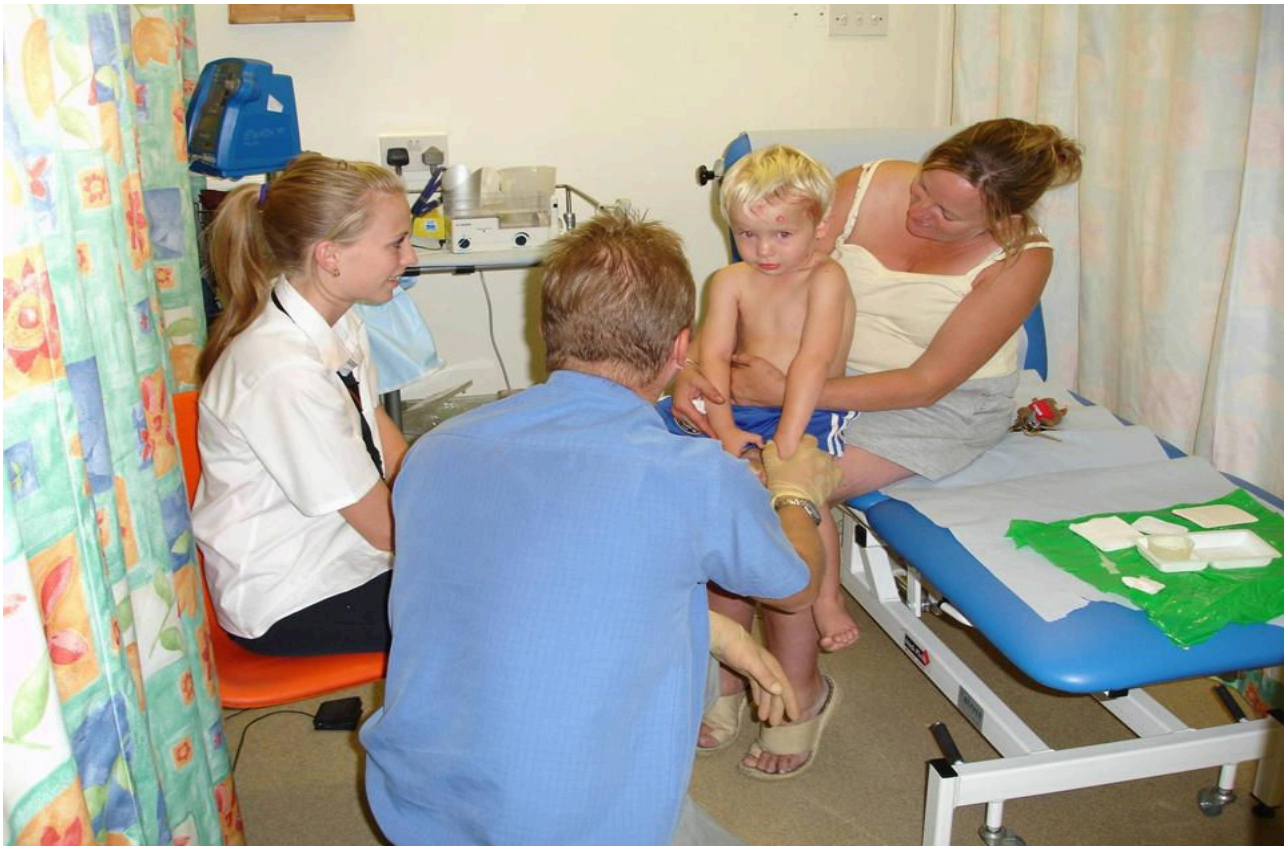


Proposed Modernisation of Local Health Services
Phase 1

Whitstable Health Centre

Number of General Practitioners reduced to 6, full general medical and Practice nurse facilities
Minor Injury Unit housed in dedicated space.
Nurse-led Minor Illness Service
Training and Research
New space for PBC In-house Clinics, Social Services, Mental Health facilities, Voluntary Agencies and Patient Groups.

Chestfield Medical Centre – Unchanged

6 General Practitioners, full general medical and Practice nurse services
Nurse-led Minor Illness Service
Training and Research
Surgery in Primary Care Service

New Combined GP Surgery, Community Pharmacy and Polyclinic at Wraik Hill

6 General Practitioners, full general medical and Practice nurse services
Integral Community Pharmacy
Ambulance Response Base

Polyclinic:

Surgical Out-patient Department:
General Surgery
Urology
Orthopaedics
ENT
Ophthalmology
Anaesthetics & Pain Management
Gynaecology

Diagnostics:
Radiology/Ultrasound
Pathology Laboratory
Docking station - visiting MRI & CT units

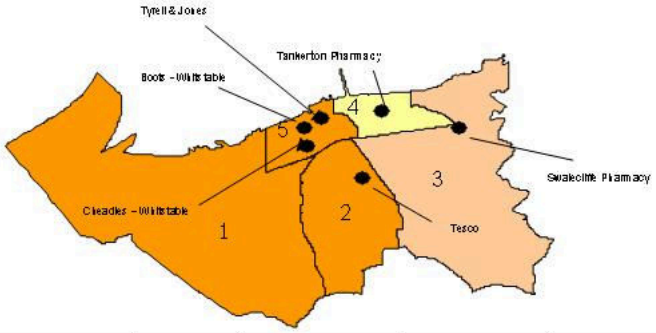
Operating Theatre Department
1 Day Case operating theatre with all associated rooms/facilities for general anaesthetic surgery
CSSD Department

Patient Choice

- To remain registered with their current GP.
- To change to a GP working from the Medical Centre nearest to their home.
- To be referred to the Polyclinic, or any available hospital provider they wish.

INTEGRATED COMMUNITY PHARMACY AT WRAIK HILL

- PCT pharmacy needs assessment. Possible gap in Seasalter – no pharmacy, large elderly population
- On-site access to prescriptions and other medication to patients attending this building
- Nearest pharmacies (2, both 1.3 miles away)



	Ward Name	Pop	% Aged 50+	K&M Rank	No. of Pharmacies	No. of practice premises
1	Seasalter	7,108	48%	112	0	0
2	Gorrell	6,045	36%	103	1	1
3	Chestfield and Swalecliffe	8,145	48%	167	1	1
4	Tankerton	4,706	51%	240	1	0
5	Harbour	5,853	29%	89	3	1
	Whitstable	**31,857**	**42%**	**149**	**6**	**3**

Whitstable has the oldest population in the PCT. It is served by six pharmacies – about one for every 5,500 people. Half the pharmacies are in Harbour ward, which has the youngest population (but contains the town centre). A possible gap exists in Seasalter, which has a large elderly population but no pharmacy.

THE POLYCLINIC

The Polyclinic will provide an NHS:

- Range of surgical outpatient consulting rooms
- Day surgery operating theatre suite
- Range of on-site diagnostics – likely to include x-ray and ultrasound, also some pathology
- Docking facility for CT and MRI scanning

This unit is designed to complement Phase 2, the redevelopment of Whitstable and Tankerton Hospital.

Centres of Clinical Excellence - CCE

- A partnership of clinicians, healthcare professionals and business people.
- Involved in developing new and better ways of delivering healthcare, as described in the NHS White Papers.
- Everyone in CCE, be they a surgeon or a cleaner, is a partner.
- Local East Kent Consultants will work at Wraik Hill

CONSULTANT AND GP INVOLVEMENT IN DEVELOPING CLINICAL CARE PATHWAYS

CLINICAL CARE PATHWAYS

A team of consultants and GPs are jointly developing care pathways in:

1. Gynaecology
2. Orthopaedics
3. ENT
4. Ophthalmology
5. General Surgery
6. Urology

BENEFITS

- New, clinically safe care pathways provide evidence-based care at less cost to the NHS.
- Less referrals to outpatient department, by appropriate use of care pathways involving GPs with special interests.
- One stop, consultant-led OPD clinics where possible, so less follow up appointments.

REVENUE CONSEQUENCES TO EKHT

- EKHT annual budget circa £300 million
- Proposed Polyclinic revenue £1.5 million
- Therefore an estimated 0.5% loss of revenue to EKHT

AMBULANCE RESPONSE BASE

- Currently no Ambulance base in Whitstable
- Local Ambulances all based in adjacent locations – Faversham, Herne Bay, Canterbury
- Difficulty in meeting response times.

SUPPORT FOR A MEDICAL CENTRE AT WRAIK HILL

- Canterbury City Council Community Developments Survey
- Members of WMP Practice Users Group
- The Friends of Whitstable Hospital and Healthcare – registered charity
- Local CCC Councillors
- Patricia Hewitt's Office
- Julian Brazier MP
- The Post-Graduate Deanery for Kent, Surrey and Sussex

BENEFITS TO THE PROPOSAL

- Provision of a local General Practice and Community Pharmacy for a local population who currently have neither.
- A Polyclinic to provide surgical outpatient, day surgery and diagnostic facilities. Shorter waiting lists, less cost and more local. Available to all GPs and patients under Choose & Book. Should release some pressure on local hospitals, and help achieve the 18 week referral to treatment target.
- Allow dedicated space for the Whitstable Minor Injury Unit.
- Allow space for additional PBC services to population – also room for mental health, counselling, social services, housing and voluntary organisations.
- Improve Ambulance response times.
- Improve and modernise patient services at Whitstable and Tankerton Hospital.

RISK ANALYSIS

There are many consequences of the PCT not approving this project:

- A ward of 7000 patients continue to have no full-time General Practice, nor a Community Pharmacy.
- Increasingly cramped accommodation for local GP and other services.
- Ongoing inappropriate accommodation of patients at Whitstable and Tankerton Hospital.
- Constraints to the implementation of the advantages of Practice Based Commissioning.
- Patient access to healthcare continues to be difficult.
- Risks to meeting waiting targets, and the 18 week Pioneer Project.
- Difficulty meeting Ambulance response times in Whitstable.
- Less choice of provider.
- A missed opportunity of circa £5 million investment from the independent sector in healthcare in Whitstable.

CONCLUSION

- The proposal provides a sustainable solution to the provision of healthcare in Whitstable
- It incorporates many additional benefits to patients
- It will be revenue neutral to the PCT and save money on clinical activity via PBC budget savings
- This can be reinvested in patient care.

Appendix 2

NHS
Overview & Scrutiny Committee

Friday 23 March 2007
The Guildhall, Canterbury

An update in respect of the Dover Project & East Kent Neuro-rehabilitation services

Eastern and Coastal Kent NHS
Primary Care Trust

The Dover Project – background (1)

- A public consultation initiative for Dover town residents in respect of11 areas health and social care services in Dover
- Consultation exercise focussed on possible alternative models of care for all 11 service areas as well as a 'no change option'
- Consultees were asked to choose their preferred options and also to share any other issues they felt were important when considering service re-design

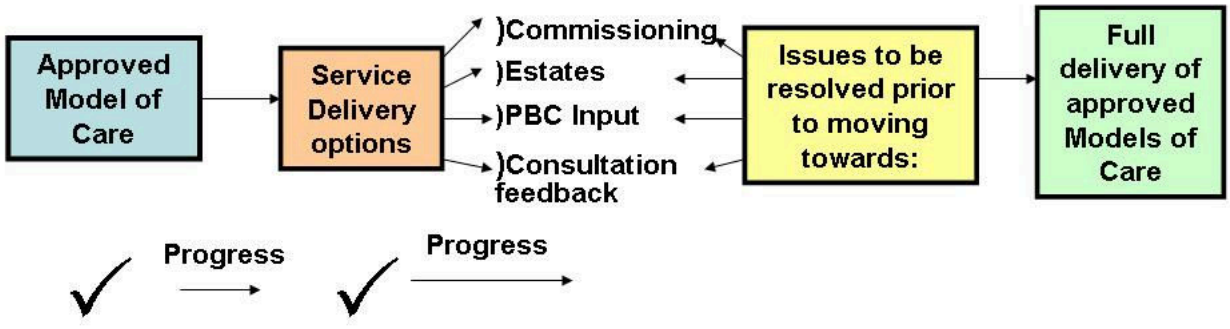
Eastern and Coastal Kent NHS
Primary Care Trust

The Dover Project – background (2)

- Outcome was a favoured 'model of care' for all of the 11 service areas.
- The PCT's commitment is to continue to provide all the services that were part of the consultation for Dover residents according to the agreed model of care.
- This will involve a re-design of how the services are provided
- The approved Models of Care have now been considered alongside other issues (such as location) and there are now emerging service delivery options for the 11 service areas.

Eastern and Coastal Kent NHS Primary Care Trust

Implementation of approved Models of Care



Eastern and Coastal Kent NHS Primary Care Trust

Key Issues - Commissioning

- The Fit For the Future programme
- The Dover Project is an FFF initiative as it is about improving health and social care services by making services more accessible through providing them closer to home and wherever possible in a primary care setting
- The PCT's Commissioning Strategy is a key component to implementing FFF and therefore also provides the strategic direction to develop the Dover Project Models of Care

Eastern and Coastal Kent NHS
Primary Care Trust

Key Issues - Practice Based Commissioning (PBC)

- PBC gives GPs the power to manage their own funding budgets.
- The Dover and Aylesham PBC consortium has formed and is increasingly involved in the development of the service delivery options
- This ensures that the local GPs are proactively managing the interests of their patients.
- As well as ensuring the ongoing provision of existing services they will consider the provision of additional services shifting provision from acute to primary care

Eastern and Coastal Kent NHS
Primary Care Trust

Key Issues - Estates Issues

- Services are currently delivered through a variety of locations. These are:

- Dover Health Centre
- Buckland Hospital
- Pharmacies
- GPs practices
- Dental Practices

- All of these locations have strengths and weaknesses when considering developing services for the future and in the context of meeting the Government White Paper's main objective to provide high quality services in accessible locations

Eastern and Coastal Kent NHS Primary Care Trust

Key Issues - Estates Issues

- There are also particular pressures around:

- Ensuring that interdependent services are co-located e.g. minor injuries and x-ray facilities.
- GP practices wishing to provide additional services having space to do so
- Identifying community based intermediate care beds
- Plugging gaps in provision e.g. children's services in the community
- Ensuring that the quality of the estate is 'fit for purpose' to deliver essential services

Eastern and Coastal Kent NHS Primary Care Trust

Key Issues - Estates Issues

- Solutions in respect of estate issues can not be developed solely through the PCT and the Hospitals Trust
- There is a need to work in partnership with the local district council, KCC and other strategic partners to identify and secure suitable locations to deliver the approved Models of Care
- This partnership activity is critical and early discussions have taken place with Dover Pride in respect of the Mid Town regeneration plans for the area around the Dover Health Centre and the PCT responding to Dover District Council's options for growth as detailed in their Local Development Framework

Eastern and Coastal Kent NHS
Primary Care Trust

Consultation feedback

- A number of issues were raised during the consultation process which respondents felt were important to take into account when developing service delivery options for the Models of Care
- Transport – improving access and frequency needs to be developed with a range of partners. The PCT has contributed to Dover District Council's Transportation Strategy to ensure that the concerns raised through the Dover Project are taken into account when developing future transport plans.
- Accessibility and condition of buildings – This is being considered as part of the estates issues

Eastern and Coastal Kent NHS
Primary Care Trust

Consultation feedback cont./

- Opening hours – being considered as part of the development of service delivery options.
- Location of services – part of the estates solutions overview.
- Strong support for the preservation of Buckland Hospital – being considered as part of the overall estates provision which currently deliver health and social care services in Dover.

Eastern and Coastal Kent NHS
Primary Care Trust

Conclusion

- The commissioning framework for delivering the approved Models of Care through FFF and the local PBC cluster has been established.
- However, there are still a number of complex estates issues which need to be resolved before full implementation of the approved Models of care can be achieved.

Eastern and Coastal Kent NHS
Primary Care Trust

Any questions?

Eastern and Coastal Kent NHS
Primary Care Trust

East Kent Neuro-Rehabilitation service - update

- The service is currently based at the Buckland Hospital which was identified as a temporary expedient when the neuro-rehabilitation unit was set up in 2001.
- Following advice from this committee a focussed discussion (not a full public consultation) with patients, carers, support organisations, staff and clinicians is taking place and views in respect of the existing service are being sought.
- This process has been overseen by a Neuro-rehabilitation working group which comprises, patients, carers, clinicians, social services, PCT and Hospital Trust representation.

Eastern and Coastal Kent NHS
Primary Care Trust

East Kent Neuro-rehabilitation services - the discussion process

- 13th November – a discussion with neuro-rehabilitation staff at Buckland Hospital
- 18th January – a workshop of key stakeholders including patients, carers, staff, clinicians, community and voluntary organisations to develop the consultation document
- At this workshop the attendees identified their priorities for the service which were included in the consultation document

Eastern and Coastal Kent NHS
Primary Care Trust

East Kent Neuro-rehabilitation services - the consultation document

- 1200 documents have been sent specifically to past and current neuro-rehabilitation patients, staff, supporting voluntary and community organisations.
- The document includes a description of how the service works and identifies the key components of the treatment pathway.
- There is also a section which details the key priorities which were identified at the stakeholder workshop in January.
- The questions for the consultee focus on their experience of the service and also seeks their views about how they would feel if, in order to improve the service the unit is moved from Dover to a different location in east Kent.

Eastern and Coastal Kent NHS
Primary Care Trust

East Kent Neuro-Rehabilitation - timescales and responses received to date

- This focussed consultation process began on the 14th of February and will end on the 30th of March.
- 1200 consultation documents have been sent
- 203 responses received to date – 16.9%
- Not all respondents have replied to all 4 questions.

Eastern and Coastal Kent NHS Primary Care Trust

East Kent Neuro-Rehabilitation – analysis of responses received

Question 1. During your treatment did you and your carer clearly understand your own treatment pathway and who was responsible for your care?

- Yes - 97 - 53% respondent to Qu.1
- Mostly - 58 - 32% "
- No - 27 - 15% "

Eastern and Coastal Kent NHS Primary Care Trust

East Kent Neuro-Rehabilitation – analysis of responses received

Question 2. During your treatment did you and your carer feel that your handover from one component on the treatment pathway to another was well planned and clearly explained to you?

- Yes - 80 - 44.3% respondents to Qu. 2
- Mostly - 60 - 33.3% "
- No - 40 - 22.3% "

Eastern and Coastal Kent NHS Primary Care Trust

East Kent Neuro-Rehabilitation – analysis of responses received

Question 3. If you are now cared for in the community, either at home or in a permanent place of residence, do you have sufficient support for your needs and are you confident about who to contact for further advice when you need it?

- Yes - 83 - 50.5% of respondents to Qu. 3
- Mostly - 51 - 30.5% "
- No - 31 - 19% "

Eastern and Coastal Kent NHS Primary Care Trust

East Kent Neuro-Rehabilitation – analysis of responses received

Question 4. The neuro-rehabilitation unit, currently based in Dover, provides an east Kent wide service. If, in order to improve the service, the unit needs to be moved from Dover to a different location in east Kent how would you feel about this?

- Don't mind if it moves - 102 – 57% of respondents to Qu. 4
- Would not like to see it move - 77 – 43% "

Eastern and Coastal Kent NHS Primary Care Trust

Any questions?

Eastern and Coastal Kent NHS Primary Care Trust

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Item 3

By: Overview and Scrutiny Manager

To: NHS Overview and Scrutiny Committee – Friday 11 May 2007

Subject: A New Direction for Orthopaedic and Emergency Care – Maidstone & Tunbridge Wells NHS Trust

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Background

(1) Maidstone and Tunbridge Wells NHS Trust (hereafter "the Trust") plans to centralise all emergency orthopaedic surgery and emergency general surgery at the Kent and Sussex Hospital in Tunbridge Wells, and all complex planned inpatient surgery at Maidstone Hospital. The Trust's proposals were set out in the document *A new direction for surgical and orthopaedic care*, around which a formal public consultation was conducted between October 2006 and January 2007.

(2) On 12 January 2007, the NHS Overview and Scrutiny Committee considered the Trust's proposals and rejected them on the grounds that:

- *the proposals are not in the interests of health services in Kent, particularly for those persons who look towards the hospitals within the Maidstone and Tunbridge Wells NHS Trust for their healthcare*; and
- *the Committee believes these proposals would more appropriately be considered as an integral part of the much wider 'Fit for the Future' review*.

(3) Since that meeting, the committee's three party spokesmen have been negotiating with the Trust and with the West Kent Primary Care Trust (PCT), which (as the main NHS body commissioning services from the Trust) is responsible for deciding whether the reconfiguration can proceed.

Proposed reconfiguration

(1) Set out below is a comparison of the current configuration of services and the one that would apply were the reconfiguration to go ahead:

Service	Type	Current configuration	Proposed configuration
General Surgery	Planned	Both Sites	Maidstone only
	Emergency	Both Sites	Tunbridge Wells only
	Day cases	Both Sites	Both Sites
	Outpatients	Both Sites	Both Sites
Orthopaedics	Planned	Both Sites	Maidstone only
	Emergency	Both Sites	Tunbridge Wells only
	Day cases	Both Sites	Both Sites
	Outpatients	Both Sites	Both Sites

(2) It is stated by the PCT that the proposed changes are likely to have the following impact on patient flows among the population that looks to the Maidstone and Tunbridge Wells NHS Trust for its hospital services:[1]

Type of patient	Change at Maidstone Hospital (per week)	Change at Tunbridge Wells (per week)	Change at other hospital locations (per week)	Total patients affected (per week)
Surgical and Orthopaedic planned patients	+ 20	- 20	None	20
Surgical and Orthopaedic emergency patients	- 84	+ 49	+ 21 Ashford + 7 Medway + 7 Dartford/ Bromley	84
All other services	Nil	Nil	Nil	
Net change	**- 64**	**+ 29**	**+ 35**	**104**

Reasons for change put forward by the Maidstone and Tunbridge Wells NHS Trust

(1) The Trust states that current arrangements are not as safe or as effective as they could and should be, since they involve:

- trying to run parallel services on two sites with insufficient staff and too-small catchment populations – a situation that cannot be addressed by simply taking on more staff (for clinical, financial and practical reasons);
- lack of separation between elective and emergency surgery – leading to too many cancellations of elective surgery at short notice and an unacceptably high risk of hospital-acquired infection (due to mixing elective-surgery patients with unscreened emergency patients);
- inadequate use and development of staff skills;
- greater lengths of stay for patients than is necessary.

(2) The Trust states that its proposals will produce safer and better services, with significantly improved clinical outcomes, by successfully addressing all of the issues set out above.

[1] A different set of figures was given by the Trust to the NHS OSC meeting on 12 January 2007.

West Kent Primary Care Trust Board meeting

(1) At its meeting on 15 March 2007, the PCT agreed the Trust's proposals, subject to the following provisos:

a. *That implementation of the proposals are delayed until the publication of the Fit for the Future consultation document, to ensure that there is no contradiction between these proposals and those that may emanate from Fit for the Future review.*

b. *That clear staffing arrangements are established to ensure that medical staffing, including Consultant level, within the [Accident and Emergency] department at Maidstone hospital is appropriate, as deemed by external review.*

c. *That clear staffing arrangements and protocols are established to ensure that access to surgical advice for medical emergencies at Maidstone hospital is appropriate, as deemed by external review.*

d. *That protocols are established to ensure that minor orthopaedic cases can continue to be dealt with at Maidstone hospital. (E.g. simple breaks)*

e. *That agreement is finalised between [the Trust] and the PCT regarding the development of new medical services at Maidstone hospital including the catheterisation laboratory and dedicated stroke unit. Further work will follow to consider the establishment of a pain clinic.*

f. *That [the Trust] continues to work with the relevant transport and other authorities to examine the issues of travel and access for relatives.*

Letter from the Chief Executive of the Maidstone and Tunbridge Wells NHS Trust

(1) The Chief Executives of the PCT and the Trust have stated that the PCT Board decision must be seen in the context of the following reassurances given to the committee's three party spokesmen in correspondence from the Chief Executive of the Trust (dated 13 March 2007):

1. The Status and staffing of the A&E Department at Maidstone

We can confirm that the A&E Department at Maidstone will be staffed by Medical Staff and the proposal is as per the [Maidstone British Medical Association] recommendation that this is undertaken by A&E specialist staff for between 12 and 15 hours per day with acute general physicians supporting services out-of-hours. I can confirm that the A&E medical staff will continue under A&E Consultant leadership and that both Maidstone and Kent & Sussex A&Es will continue under single Clinical Directorship.

I enclose for your information copies of correspondence to staff that have raised these concerns to demonstrate the commitment.

2. Acute general surgical provision at Maidstone

I can confirm that the greatest proportion of surgeons with sub-specialist interest will be based at Maidstone. They will provide an emergency on-call rota and this emergency on-call rota will support the totality of services at the Maidstone site. This will ensure unlimited access to a surgical opinion and the full range of sub-specialist expertise.

With respect to emergency surgery I can confirm that any elective patient who has had surgery on that site who deteriorates will, if it is clinically appropriate, have any further emergency surgery on that site.

Additionally, in the rare circumstance that anyone should present into A&E with a clinical emergency which it is believed cannot be stabilised and transferred, then naturally those patients would also receive surgery at Maidstone.

3. Provision for orthopaedic trauma at Maidstone

Elective orthopaedics (until 2010), day case orthopaedics, outpatients and fracture services will continue on the Maidstone site. This will enable the full provision of urgent orthopaedic opinion to be made available. The service model as proposed always envisaged that in the event a patient with an orthopaedic injury should arrive at Maidstone A&E, we would stabilise, treat and transfer that patient, and this we regard as our duty of care. It must be noted that we continue with this duty of care for any and every patient who presents at either Kent & Sussex or Maidstone A&E services irrespective of service reconfiguration. You may be aware that we already undertake this duty of care, for example, for emergency vascular patients at both our hospital sites where we stabilise, treat and transfer those very critical emergency patients. We do not envisage that there will be any change to our ability to do this for either surgical patients or orthopaedic patients in either the current or proposed service model.

Ongoing representations

(1) The committee's three party spokesmen have also negotiated with and received ongoing representations from some key stakeholders, most notably:

(a) The Leader of the County Council, who called upon this committee to meet in April to determine whether the matter should be referred to the Secretary of State
(b) Maidstone Borough Council's External Scrutiny Committee
(c) The Maidstone Division of the British Medical Association
(d) Maidstone and Tunbridge Wells NHS Trust
(e) West Kent PCT

(2) A chronology of events and correspondence is attached to this report as Appendix I. A summary of correspondence exchanged with NHS colleagues in late April 2007 is attached as Appendix II.

Conclusions and recommendations

(1) At the NHS OSC meeting on 11 May 2007, the committee's three party spokesmen will table a document detailing the results of further correspondence with the Chief Executives of Maidstone and Tunbridge Wells NHS Trust, West Kent PCT and the South East Coast Ambulance Service NHS Trust, and setting out the spokesmen's conclusions and recommendations.

(2) It will then be for the committee to decide, in light of all the information before it, whether it wishes to withdraw its rejection of the reconfiguration or to exercise its statutory power to refer the reconfiguration proposals to the Secretary of State for Health.

(3) A note regarding the statutory role and responsibilities of the committee is attached as Appendix III.

Alan Chell	Mark Fittock	Dan Daley
Chairman	Vice Chairman	Liberal Democrat spokesman

Appendix I
Chronology

13 June 2006	Maidstone and Tunbridge Wells NHS Trust Management Board holds a meeting for clinicians on "Strategy, Policy and Modernisation" at The Hop Farm Country Park
15 June 2006	Rose Gibb (Chief Executive of Maidstone and Tunbridge Wells NHS Trust) meets NHS OSC spokesmen to outline possible changes to the Trust's clinical strategy
28 June 2006	Trust Board members meet to discuss emerging themes for change in the Trust's clinical strategy
19 July 2006	Joint meeting of the Trust Board and West Kent Primary Care Trust Board discusses Maidstone and Tunbridge Wells Trust's proposed clinical strategy
20 July 2006	NHS OSC hears a presentation from Rose Gibb (Chief Executive of Maidstone and Tunbridge Wells NHS Trust) on the proposed clinical strategy
25 July 2006	Trust Board agrees the proposed clinical strategy
9 October 2006	Joint Trust / Primary Care Trust consultation around *A new direction for surgical and orthopaedic care* begins
12 October 2006	Consultation meeting held in Tonbridge
16 October 2006	Consultation meeting held in Tunbridge Wells
23 October 2006	Consultation meeting held in Sevenoaks
24 October 2006	Consultation meeting held in Maidstone
30 October 2006	Consultation meeting held in Maidstone
7 November 2006	Consultation meeting held in Crowborough
20 November 2006	Consultation meeting held in Maidstone
23 November 2006	Consultation meeting held in Larkfield
30 November 2006	Trust holds an "Option Workshop" on the proposed changes, attended by a range of stakeholders
21 December 2006	Leader of Kent County Council, Paul Carter, writes to Rose Gibb (Chief Executive of Maidstone and Tunbridge Wells NHS Trust), stating that the council is unable to support the proposals on the grounds that: they pre-empt the "Fit for the Future" review of health services across Kent and Medway; new services should be introduced

	and shown to be effective before existing provision is decommissioned; and it has not been made clear how any financial savings will be reinvested in patient care
8 January 2007	Joint Trust / Primary Care Trust consultation ends
12 January 2007	NHS OSC considers the proposals and rejects them (the approved minutes of the meeting are attached as Document A)
26 January 2007	NHS OSC spokesmen meet informally with Steve Phoenix (Chief Executive of West Kent Primary Care Trust) and give him a document outlining 14 reasons for the committee's rejection of the proposals (attached as Document B)
29 January 2007	NHS OSC spokesmen write to Steve Phoenix (Chief Executive of West Kent Primary Care Trust) welcoming commitments given at the meeting on 26 January to explore certain issues further and requesting the opportunity to address the Primary Care Trust Board when it discusses this issue
5 February 2007	Rose Gibb (Chief Executive of Maidstone and Tunbridge Wells NHS Trust) writes to Paul Wickenden (Overview and Scrutiny Manager, Kent County Council), responding to the 14-point document (see attached Document C)
26 February 2007	Rose Gibb (Chief Executive of Maidstone and Tunbridge Wells NHS Trust) writes to Paul Wickenden, summarising her discussions with representatives of the Maidstone Division of the British Medical Association (letter attached as Document D)
27 February 2007	NHS OSC spokesmen meet informally with Steve Phoenix (Chief Executive of West Kent Primary Care Trust)
8 March 2007	NHS OSC spokesmen meet informally with representatives of the Maidstone Division of the BMA
9 March 2007	NHS OSC spokesmen write to Steve Phoenix (Chief Executive of West Kent Primary Care Trust) and David Griffiths (Chairman of West Kent Primary Care Trust) – with the correspondence copied to Rose Gibb (Chief Executive of Maidstone and Tunbridge Wells NHS Trust) and James Lee (Chairman of Maidstone and Tunbridge Wells NHS Trust) – seeking certain clarifications and assurances (letter attached as Document E)
12 March 2007	Maidstone Division of the BMA launches a document entitled *Surgical and orthopaedic care: the right direction*,

	which contains its response to the Trust's proposals and suggests alternative arrangements
13 March 2007	Rose Gibb (Chief Executive of Maidstone and Tunbridge Wells NHS Trust) writes to the NHS OSC spokesmen, giving clarifications and assurances in response to the points raised in their letter of 9 March (letter attached as Document F)
14 March 2007	NHS OSC spokesmen write to David Griffiths (Chairman of West Kent Primary Care Trust Board), expressing disappointment that the Board paper does not refer to: their 14 reasons for rejecting the proposals; the ongoing dialogue they have had with the Primary Care Trust to try and resolve the issue; or their letters of 9 March (letter attached as Document G)
15 March 2007	West Kent Primary Care Trust Board agrees the proposals – with certain conditions (Board paper attached as Document H)
12 April 2007	NHS OSC spokesmen meet informally with Rose Gibb (Chief Executive of Maidstone and Tunbridge Wells NHS Trust), Steve Phoenix (Chief Executive of West Kent PCT) and Dr Roger Hart (Honorary Secretary of the Maidstone Division of the BMA)
24 April 2007	NHS OSC spokesmen write to Rose Gibb (Chief Executive of Maidstone and Tunbridge Wells NHS Trust), Steve Phoenix (Chief Executive of West Kent Primary Care Trust) and Paul Barratt (General Manager for South East Coast Ambulance Service), seeking certain reassurances before the committee meeting on 11 May (see attached Document I)
27 April 2007	Steve Phoenix (Chief Executive of West Kent Primary Care Trust) and Geraint Davies (Director of Corporate Affairs and Service Development, South East Coast Ambulance Service NHS Trust) respond to the NHS OSC spokesmen (letters attached as Documents J and K)
30 April 2007	Rose Gibb (Chief Executive of Maidstone and Tunbridge Wells NHS Trust) responds to the NHS OSC spokesmen (letter attached as Document L)

Appendix II
Summary of correspondence, April 2007[2]

1) Fit for the Future		
Points raised by NHS OSC spokesmen	**NHS response**	**Comments**

The actual outcome of the Fit for the Future consultation should be awaited before the proposed changes to MTW services are implemented.	• "The overall approach [of FFTF], along with some specific initiatives, will be described in a consultation document to be produced in the summer along with our colleagues in Eastern & Coastal Kent and Medway PCTs. However, given the nature of the Fit for the Future programme it is likely that formal public consultation will take place in phases relating to specific elements over a period of time. For this reason the recommendation was to wait until the consultation document is produced to ensure the proposed changes fit with the overarching principles and direction of travel described in Fit for the Future." (PCT; Trust)
	• "This will be further tested through the PCT Board's review of Maidstone & Tunbridge Wells' (MTW) detailed implementation plans." (PCT; Trust)
	• "[T]hese changes are about improving patient safety and access to the best possible care. We need to ensure that the changes are consistent with the wider strategic model, but we do not want to delay vital benefits to our
		• This response falls short of what was sought by the NHS OSC spokesmen.
		• The response could be said to indicate that:
		  ○ the consultation over FFTF will actually be a foregone conclusion; or
		  ○ FFTF will be essentially irrelevant to emergency services.
		• It remains unclear to what extent FFTF will actually be the subject of consultation and what the exact timetable for any consultation will be.

[2] NHS OSC spokesmen's letter dated 24 April 2007; West Kent Primary Care Trust letter dated 27 April 2007; South East Coast Ambulance Service NHS Trust letter dated 27 April 2007; Maidstone and Tunbridge Wells NHS Trust letter dated 30 April 2007.

	population." (Trust)	
2) Modelling for future services		
Points raised by NHS OSC spokesmen	**NHS response**	**Comments**
The PCT Board paper understates anticipated population growth in Maidstone.	• "The PCT have asked Meradin Peachey, Joint Director of Public Health for Kent County Council and Kent PCTs, to work with the HOSC to understand the discrepancies between the figures you quote and those that formed part of their Board paper, and to finalise a single set we all agree. If a miscalculation was made in the Board paper then this will be acknowledged and the PCT team will review the implications on the proposed changes." (Trust) • If there has been a miscalculation, it "would only alter projections over a 10 -15-year period [by] 5 – 10,000. While this may be important for, say family doctor services, where the optimum population for specialist surgery is 500,000 plus the implications are not material." (PCT) • "[T]he known demographic statistics have been factored into the planning models … The outputs of this model have been quality assured and checked by the Department of Health at a number of Gateway reviews and the modelling has been confirmed as robust." (Trust) • "MTW did provide a ready reckoner to demonstrate the ad hoc impacts of new homes	• There seems a reluctance to accept that there is an error. • It is stated that, even if there is an error, it is not of sufficient magnitude to make any difference to the proposals, since they are predicated on a massive optimal catchment population of half-a-million.

	(10,000) on the acute hospital service. This assumed 3 people per home with a demographic distribution consistent with the existing population. This was a less sophisticated model as it assumed that all the resultant population would go to Maidstone hospital for their care. Reality would be different to that, especially in relation to emergencies. Nonetheless, it shows a relative small impact on hospital care and not sufficient to undermine the changes." (Trust)	
3) Continued medical staffing of Maidstone A&E department		
Points raised by NHS OSC spokesmen	**NHS response**	**Comments**
• Maidstone A&E department must continue to be staffed by A&E consultants throughout normal working hours (9am to 5pm). • There must be continued A&E medical staffing (both middle-grades, i.e. Specialist Registrars and Staff Grades / Associate Specialists; and junior trainees, i.e. Foundation Year 2 trainees, under supervision) for a minimum of 17 hours per day (8am to 1am). • There must be, within the Maidstone Hospital site plan, dedicated space in which to continue delivering the "majors" side of the department. • Full resuscitation teams must be maintained at Maidstone Hospital. • The "majors" and "minors" sides of the	• "[T]his will be provided in a safe and appropriate manner." (PCT) • "[T]he PCT Board charged managers and doctors at MTW with producing detailed implementation plans, which will be subject to the external scrutiny of a panel of independent clinicians in both emergency surgery and emergency medicine. The PCT Board will only give the go ahead to any changes once they have the assurance of these experts that the arrangements are clinically safe, meet standards of good practice and are sustainable." (PCT; Trust) • "[T]he Maidstone A&E department will be led by an A&E consultant … the staffing and operational details will be determined by clinical	• The undertakings that were requested have been given regarding: o dedicated space for "majors"; o full resuscitation teams; and o the integration of "majors" and "minors". • The detailed guarantees that were requested regarding levels of medical staffing have not been given (these details are to be determined by the proposed external review). • It is stated that the service will be staffed by A&E specialists for 15 hours per day – not 17, as stipulated by the spokesmen. However, this does represent a shift from the position in the Trust's letter to the OSC spokesmen dated 13 March 2007, in which it was stated that A&E

department must continue to be run together as a single, integrated whole.	professionals and subject to external review. The intended arrangements are for a 15 hour service with the exact opening conforming to peak activity times." (Trust) • "[T]here will continue to be dedicated space for 'majors' …" (Trust) • "[T]he department will function as a single, integrated unit …" (Trust) • "[T]here will continue to be full resuscitation teams at Maidstone". (Trust)	specialist staff would be on duty "for between 12 and 15 hours per day".
4) Acute general surgical provision at Maidstone Hospital		
Points raised by NHS OSC spokesmen	**NHS response**	**Comments**
As a minimum, the following must continue to be available at Maidstone: • when needed in an emergency, a general surgical opinion from a consultant or middle-grade doctor (Specialist Registrar or Staff Grade / Associate Specialist), in person, on any patient in A&E or a ward, 24 hours per day, seven days per week; • the capacity to undertake emergency surgery on-site at any time of day or night, in the rare event of that being necessary; • on-site assessment of patients referred to the hospital or presenting to A&E with possible surgical problems (most of whom will not require emergency surgery), for a minimum of 17 hours per day (8am to Midnight), seven days per week; • the capacity for emergency general	• "[T]his will be provided in a safe and appropriate manner." (PCT) • "A general surgical opinion will be available 24 hours a day at Maidstone. During normal working hours this will be provided by the on-site team and out of hours by a combination of direct telephone advice and the potential use of telemedicine, for example PACS [Picture Archiving and Communication Systems – a networked digital imaging system]." (Trust) • "There will, in addition, be a surgical on call team to support Maidstone hospital and overall this is an improvement to the current service. This is entirely consistent with best practice and national clinical evidence and has been recently ratified by the clinical case for change	• Reassurance has been given in respect of the availability of services. • Reassurance has not been given as regards the detail of staffing arrangements (these details are to be determined by the proposed external review).

surgery 24 hours per day, seven days per week in the case of clinical emergencies presenting at A&E where the patient cannot be stabilised and transferred safely. To make this possible, a middle-grade surgeon (Specialist Registrar or Staff Grade / Associate Specialist) must be present in the hospital for a minimum of 17 hours per day, and readily available on call the rest of the time.	outlined by Professor Sir Ara Darzi [the Department of Health's National Advisor on Surgery] in his report, 'Saws and scalpels to lasers and robots – advances in surgery'." (Trust) • "MTW will continue to have the ability to undertake emergency surgery at Maidstone in line with reviews and recommendations [from] the [N]ation[al] CEPOD [Confidential Enquiry into Patient Outcome and Death] enquiry." (Trust)	
5) Provision for orthopaedic trauma at Maidstone Hospital		
Points raised by NHS OSC spokesmen	**NHS response**	**Comments**
We expect that the following types of orthopaedic trauma presenting at Maidstone A&E will continue to be dealt with at Maidstone according to the protocols indicated: • minor trauma not requiring surgery or an in-patient stay – to be dealt with usually in A&E by A&E staff, but with occasional orthopaedic input; • trauma requiring surgical intervention but not an in-patient stay (e.g. reduction under anaesthetic) – to be dealt with as a day-case, usually by the orthopaedic team; • trauma not requiring surgery but needing an in-patient stay (e.g. a frail elderly patient with a pelvic fracture) – to be dealt with by admission to Maidstone, usually under the care of physicians, with orthopaedic input when necessary.	• "[T]his will be provided in a safe and appropriate manner." (PCT) • "Minor trauma will continue to be seen and treated in the A&E department." (Trust) • "Trauma requiring day case treatment will be seen locally, as now, with patients having operations booked. However, if the treatment requires urgent surgical intervention the patient will need to be transferred to the trauma centre at Kent and Sussex hospital to be seen by the skilled specialist team, or to another centre of the patient's choice." (Trust) • "Trauma requiring an inpatient stay, but without surgery, would be admitted locally; normally under the care of the physicians. Orthopaedic or surgical input would then be available." (Trust)	• Reassurance has been given in respect of the protocols for dealing with various types of trauma case. • Reassurance has not been given as regards the details of staffing arrangements (these details are to be determined by the proposed external review).

We would only expect cases of trauma requiring both surgery and an in-patient stay to entail transfer to the trauma centre in Tunbridge Wells (or another appropriate hospital). Even in these cases, we would expect Maidstone A&E to have the capacity to receive them, should they present at Maidstone, in order to stabilise them so they can be transferred elsewhere as appropriate. Where a local patient presents with an uncertain need for surgery (e.g. in the case of a possible hip fracture following a fall), we would expect this to be dealt with by assessment and diagnostic imaging in Maidstone. This should then be followed by management in accordance with whichever protocol (as outlined above) is appropriate. In order to deliver the above model of care, we would expect a middle-grade (Specialist Registrar or Staff Grade / Associate Specialist) orthopaedic surgeon to be present in the hospital, or immediately available, for a minimum of 17 hours per day.	• "The Maidstone A&E department will be capable of receiving, stabilising and transferring trauma cases and those patients with uncertain need for surgery. This builds on the current ability to diagnose, treat and transfer patients who need more specialist care such as vascular surgery and neurological trauma." (Trust)	
6) External reviews		
Points raised by NHS OSC spokesmen	**NHS response**	**Comments**
Regarding the external reviews in respect of provision for acute general surgery and orthopaedic trauma, we require to know: • who will comprise the review panel? • when will the review be completed? • will the outcome of the review be considered by the PCT Board before any changes to services are implemented?	• "The panel is yet to be convened but … in addition to the external clinical experts it will include, representatives from the PCT PEC, the ambulance service and public health. The panel will be chaired by Dr James Thallon, the PEC [PCT-appointed Professional Executive Committee] chair, and supported by Jenny Thomas, Director of	• It appears that the external reviews will actually be internally led. • There is some confusion about the timetable for the reviews. • The Trust states that the Royal Colleges will be involved; the PCT does not.

	Strategy for the PCT … the review will be complete by the summer and the panel will report to the [July, according to the Trust; September, according to the PCT] meeting of the PCT Board." (PCT; Trust) • "[T]he PCT Board charged MTW with producing detailed implementation plans, which will be subject to the external scrutiny of independent national clinical experts in both emergency surgery and emergency medicine, as well as the relevant Royal Colleges." (Trust) • "[T]he PCT would be delighted for a nominated member of the HOSC to observe the panel if it would help assure you of the efficacy and robustness of the process." (Trust)	
7) Ambulance service		
Points raised by NHS OSC spokesmen	**NHS response**	**Comments**
We take the view that, where Maidstone is the closest hospital, or the one that can be reached most quickly, ambulances should be able to take patients there – except in cases where the patient has a need for particularly specialised care. Ambulance staff must not be placed in the very difficult position of being required to bypass Maidstone where it is the nearest or most accessible hospital and the patient's life is at stake. We need to know the clear and detailed protocols agreed with the Ambulance Service and that additional Ambulance vehicles and crews will be available in the periods when any additional travelling time is required.	• "The ambulance service … will take patients to the most appropriate hospital with the correct facilities. They do this now and national evidence clearly shows that patient care is improved and lives are saved by taking patients to hospital with the right specialists, even if this means by-passing the nearest hospital." (PCT; Trust) • "[T]he right level of vehicles and crews, with the right skills, will be in place to ensure a safe and appropriate level of service … the investment will be agreed as part of the	• Arguably, this response does not address the issue of ambulance crews having to bypass Maidstone Hospital in cases where clinical outcome could be compromised by a longer journey to another hospital. On the other hand, the assurances given about the ability of Maidstone A&E to stabilize patients where necessary could be seen as answering this point. • The information about the use of a consultancy firm is new and something of a surprise. The NHS OSC should surely have been

We also seek reassurances that there will be sufficient numbers of adequately trained paramedics to ensure the safety of patients, given the increased travel-to-hospital times that will be entailed in a significant number of cases by the proposed changes.	service level agreement for this year" (Trust; SECAmb) • "MTW commissioned Operational Research in Health Ltd (ORH), an independent research organisation, to undertake a study of the possible impact on the ambulance service" (SECAmb)	informed about this research and the data that it yielded regarding the level of resources that is required.
8) Repatriation of Maidstone patients		
Points raised by NHS OSC spokesmen	**NHS response**	**Comments**
We require reassurance that, in cases where Maidstone patients receive emergency general surgery or emergency orthopaedic surgery at Tunbridge Wells, or another location, those patients will be repatriated to Maidstone Hospital for any postoperative care that they may require.	• "[W]here it is appropriate and clinically safe to do so, and the patient prefers it, they will be repatriated to Maidstone Hospital for the rehabilitative care they require" (PCT; Trust) • "[W]e would aim to transfer patients back to their own homes if that is better for them and their visitors." (Trust)	This reiterates assurances given previously.
9) Anticipated changes to patient flows		
Points raised by NHS OSC spokesmen	**NHS response**	**Comments**
The PCT Board paper contains figures regarding patient flows that are different to those given to NHS OSC by Rose Gibb.	• "[T]he reason for the change is that MTW had not taken account in their calculations of the differences between day case and planned care, which works on a 5-day-week basis, and emergency care, which works on a 7-dayweek basis" (PCT; Trust)	• The NHS OSC was clearly given figures that hugely underestimated the number of Maidstone patients that would have to make the difficult journey to Tunbridge Wells. • The Trust and the PCT seem to have slightly different explanations of how this occurred; both are somewhat opaque. • This is apparently not regarded as a material error, presumably given that the PCT Board made its decision based on the correct figures.

Appendix III
Statutory role and responsibilities of the committee

(1) Under Section 244 of the National Health Service Act 2006, local authority NHS Overview and Scrutiny Committees (OSCs) "review and scrutinise", in accordance with regulations, matters relating to the NHS in their authority's area.

(2) Regulation 4(1) of the Local Authority (Overview and Scrutiny Committee Health Scrutiny Functions) Regulations 2002 (SI2002 No. 3048) stipulates that:

> *… [W]here a local NHS body has under consideration any proposal for a substantial development of the health service in the area of a local authority, or for a substantial variation in the provision of such service, it shall consult the OSC of that authority.*

(3) Under Regulation 3(1), an OSC

> *may make reports and recommendations to local NHS bodies and to its local authority on any matter reviewed or scrutinised by it.*

(4) Under Regulation 4(5), an OSC may refer an issue, in writing, to the Secretary of State for Health if it is not satisfied with:

- the content of the consultation;
- the time allowed for consultation;
- the reasons given for not carrying out a consultation.

(5) The Secretary of State may then require the NHS Body concerned to carry out such (further) consultation with the OSC as she considers appropriate.

(6) Under Regulation 4(7), an OSC may refer an issue, in writing, to the Secretary of State if the OSC believes that the proposed change to services

> *would not be in the interests of the health service in the area of the committee's local authority.*

(7) The power of referral to the Secretary of State is not to be used lightly, and should only be resorted to in situations where the OSC has grave concerns and all avenues for resolving the issue at local level have been comprehensively exhausted.

(8) Where a referral has been made to the Secretary of State, she is under no obligation to heed the views of the OSC concerned. The Secretary of State may send the referral on to the local NHS (i.e. the Strategic Health Authority) for local resolution.

(9) Alternatively, she may refer the matter on to the Independent Reconfiguration Panel (IRP). The IRP is a non-departmental public body that can advise the

Secretary of State on proposed reconfigurations or other significant service changes within the NHS. The IRP too is not obliged to heed the views of the OSC in these cases.

(10) After receiving a referral, the IRP will carry out an initial gathering of written evidence and undertake to report to the Secretary of State within eight weeks of receipt of evidence. The Secretary of State will then consider the IRP's report.

KENT COUNTY COUNCIL

NHS OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the NHS Overview and Scrutiny Committee held at Sessions House, County Hall, Maidstone on Friday, 12 January 2007.

PRESENT: Mr A Chell, (Chairman), Mrs C Angell, Mr R Burgess (substitute for Mr M Angell), Mr A Crowther, Mrs V Dagger (substitute for Mr G Horne), Mr D Daley, Mr M Fittock, Ms A Harrison, Mr C Hibberd, Mr D Hirst, Mr J London (substitute for Mr J Curwood), Mr M Northey (substitute for Mrs E Tweed), Mrs E Rowbotham, Mrs P Stockell and Mr R Tolputt.

OTHER MEMBERS PRESENT: Mr N Chard, Mrs M Featherstone, Mr G Gibbens, Mr A King; Councillor Mrs Diane Phillips, East Sussex County Council; Councillor Mervyn Warner and Councillor Paddy Germain, Maidstone Borough Council.

ALSO PRESENT: Councillor R Appadoo, Mr D Herbert and Mr J A Reece (Patient and Public Involvement Forum representatives); Darren Yates, Maidstone & Tunbridge Wells NHS Trust; Louise Smith, Angela Taylor and Richard Ash, Maidstone Borough Council; Mark Raymond, Tonbridge & Malling Borough Council; Claire Lee, East Sussex County Council; Mr M Cayzer, Wateringbury Parish Council; Roger Hart and Dr Debbie Taylor, Maidstone BMA; Angela Cole and Paul Francis, Kent Messenger; Jenna Pudelek, Kent & Sussex Courier and Denis Fowle, Downs Mail; Kevin Miller, Heather Morsley, Hazel Saunders, Sarah Waters and Iris Warner, members of the public.

IN ATTENDANCE: Mr P D Wickenden, Overview and Scrutiny Manager and Dr D Turner, Research Officer to the NHS Overview & Scrutiny.

UNRESTRICTED ITEMS

1. Minutes – 10 November 2006
(Item 2)

RESOLVED that the Minutes of the meeting held on the 10 November 2006 are correctly recorded and that they be signed by the Chairman.

2. Matters Arising
Review of Health Visiting Services (Minute 49 of 2006 refers).

(1) Mrs Angell asked Mr Phoenix whether the Health Visitors Review had been delayed to await the national review, as suggested by the Committee at its meeting on 10 November 2006. Mr Phoenix responded that he had considered the NHS Overview and Scrutiny Committee's views but he had decided not to wait for the national review, as it had only just started and was not due to be completed until March 2007.

(2) Mr Phoenix informed the Committee that the Health Visitors model being proposed in West Kent had impressed the Department of Health and,

anecdotally, the Secretary of State. He informed the Committee that it was likely that the national review would be influenced by what was going on in West Kent. If the national review had an outcome of different conclusions, these would be would be taken into account in the West Kent model. However, Mr Phoenix was anticipating that the national review would reach conclusions similar to the proposed model for West Kent.

(3) West Kent Primary Care Trust's Health Visitors Review consultation had finished at the end of December 2006. One change resulting from the consultation would be an increase in the number of health visitors by around five whole-time-equivalents compared to the original proposal.

(4) The West Kent Primary Care Trust Board would meet on 25 January 2007. Mr Phoenix anticipated that this, and other recommendations arising from the review, would be endorsed at that meeting. To delay the review until the outcome of the national review was known would have put the Health Visiting Service into limbo.

West Kent Primary Care Trust

(5) Mr Tolputt asked whether the Committee could have a structure chart and a list of Directors appointed to the West Kent Primary Care Trust. Mr Phoenix said that not all appointments had been made. Appointments were still being made to the remaining Director posts. However, all non-executive Directors had been appointed. This information would be made available to the Committee.

3. Commissioning Homeopathy – West Kent Primary Trust
(Item 3)

The Chairman indicated that, following a recent meeting with colleagues from the West Kent Primary Care Trust, it had been agreed that proposals for the commissioning of homeopathy in West Kent should be the subject of an item at the Committee's next meeting on 9 February 2007.

4. Maidstone and Tunbridge Wells NHS Trust – A New Direction for Surgical and Orthopaedic Care
(Item 4)
Rose Gibb, Chief Executive of Maidstone & Tunbridge Wells NHS Trust and Steve Phoenix, Chief Executive of West Kent PCT, Dr Jeremy Mayhew, Medical Director and Paul Barratt, General Manager (South) from South East Coast Ambulance Service and Paul Skinner, Clinical Director – Orthopaedics and Philip Bentley, Clinical Director – Surgery from Maidstone & Tunbridge Wells NHS Trust were in attendance for the item, along with surgeon, physician and nursing colleagues from the Trust.

(1) The Committee had before them a briefing note setting out the Trust's proposals for changes to surgical and orthopaedic care, and the reasons for the proposals – together with objections, representations and views received from: County Councillors whose constituents looked to the Maidstone and

Tunbridge Wells NHS Trust for their hospital services; the County Council; East Sussex County Council; Borough and District Council colleagues; Parish Councils; and other stakeholders.

(2) Attached as an Appendix to these Minutes is a copy of the presentation made by the Chief Executive of West Kent Primary Care Trust, the Chief Executive and colleagues of Maidstone and Tunbridge Wells NHS Trust.

(3) By way of introduction, Mr Phoenix made it clear to the Committee that the presentation they were about to receive was being clinically led – because that was appropriate and was how the consultation had been handled by the acute Trust and the Primary Care Trust.

(4) He indicated that the West Kent Primary Care Trust Board would consider all responses to the consultation and make a decision at its meeting on 22 February 2007.

(5) Rose Gibb, Chief Executive of Maidstone and Tunbridge Wells NHS Trust – accompanied by a team including clinicians and representatives of the South East Coast Ambulance Service – made a presentation to the Committee on the Trust's proposals.

(6) Ms Gibb indicated that the issues being addressed in the Trust's proposals for change to surgical and orthopaedic care were extremely complex and were highly emotive. She did not underestimate how difficult it was to set aside emotion and personal opinion. The proposals before the Committee were all about providing health services which were clinically safe and meeting national standards.

(7) Ms Gibb reminded the Committee that the proposals were to create a specialist centre for complex and cancer surgery by:-

(a) centralising all inpatient emergency orthopaedic surgery and emergency general surgery operations at the Kent and Sussex Hospital, Tunbridge Wells, supporting day-care and 23-hour care; and
(b) centralising complex inpatient elective surgery at Maidstone Hospital, supporting complex cancer surgery, day-care and 23-hour care.

(8) Ms Gibb said the reasons why change was necessary were as follows:-

(a) to improve standards of care;
(b) to ensure patients saw the right specialist every time;
(c) to support training with good supervision and sustained development of specialist skills, e.g. stomach surgery;
(d) to create safe modern trauma services, covered by specialists 24-hours-a-day;
(e) to cancel fewer operations;
(f) to reduce risk of cross-infection, among elective patients in particular;
(g) to better use staff skills;
(h) to reduce length of stay in hospital;
(i) to improve mortality and complication rates;

(j) to save more lives of patients who presented with complicated surgical conditions;
(k) to increase the ability to manage complex, cancer and surgery; and
(l) to bring in new skills locally, e.g. keyhole surgery and pelvic surgery.

Mr Paul Skinner – Clinical Director (Orthopaedics)

(9) Mr Skinner informed the Committee that the proposals put forward by the Trust would, in his opinion, improve services – in terms of number of operations cancelled, infection control, mortality rates and a reduction in complications arising from an operation.

(10) Maidstone Hospital had a dedicated trauma theatre, which gave excellent outcomes in terms of infection control. He said that there was a need to have a 'tower-block' structure rather than a 'pyramid structure', with a lot of junior doctors at the bottom. This had been recognised in the government's 'Modernising Medical Careers' programme.

(11) Mr Skinner said that 80% of admissions for elective surgery in orthopaedics would be unaffected by the proposed changes.

Mr Philip Bentley – Clinical Director (Emergency Surgery)

(12) Mr Bentley explained to the Committee the difference between planned care and emergency admissions. Planned surgical cases were pre-assessed and booked in advance on a list, which could be run efficiently. With emergency care, by contrast, there was a need to assess and diagnose the patient on admission to hospital; and numbers of cases could not be known in advance, and might vary significantly.

(13) Mr Bentley informed the Committee that the Royal Colleges and a number of other bodies supported the proposals to separate elective and emergency surgical care.

(14) Mr Bentley said that one of the drivers for change was 'sub-specialisation'. He added that Primary Care Trusts, who were the purchasers of the services, would not buy services where the outcomes for patients were poor.

(15) He further added that it had been suggested that the changes being proposed by the Maidstone and Tunbridge Wells NHS Trust would reduce the surgical presence at the Maidstone Hospital. He said this was not true. On the contrary, there would be more surgeons at Maidstone. Nine or 10 of these surgeons would not be on call for emergencies, but would be dealing with planned elective surgery lists and 'outpatient' sessions. The outcome would be more consultant-led care. He added that a few patients would have to move from Tunbridge Wells to Maidstone for elective surgery. There would be emergency clinics still provided both at Maidstone and Tunbridge Wells.

(16) Turning to the optimum catchment populations he said for emergency surgery, this was 500,000. For emergency medicine the recommended level of catchment population was 250,000 residents. Reconfiguration of some the services for the Trust was inevitable. Doing nothing at all was not an option.

(17) Trauma services would be improved if they were centralised. He said if this was not achieved then Primary Care Trusts would not want to purchase substandard services. Without streamlined 'cold surgery', the Trust would be under threat from the purchasers of services. To have general wards with beds occupied by unselected patients, due to a mix of planned and unplanned patients, was not safe, as it increased the risk of cross-infection.

Ms Rose Gibb – Chief Executive of the Maidstone & Tunbridge Wells NHS Trust

(18) In response to the perception that there was no clinical ownership for the proposals, Ms Gibb informed the Committee that there had been facilitated meetings and workshops across Maidstone and Tunbridge Wells NHS Trust about the proposed changes. She refuted the claim that the consultation had not been clinically led. She went on to say that not 100% of clinicians wanted change at this time – but that did not mean that there was no clinical ownership. It was unlikely that 100% agreement would ever be achieved and it was also inevitable that people would be passionate about these changes.

(19) In answer to concerns that the Accident and Emergency Department at Maidstone Hospital was closing, Ms Gibb said that this was not true. This was a misconception – one that was even held by some 'senior individuals' across the county. What was being proposed was a refinement to Accident and Emergency services. There would be:-

- direct admissions into specialist units;
- more care delivered by specialist nurses;
- integration of General Practitioners (GPs) into Accident and Emergency through the Emergency Care Centre.

(20) Ms Gibb made it clear that medical emergencies would continue to be treated at Maidstone. Some 55,000 attendances a year would continue to be treated at the Maidstone Emergency Care Centre. It was not true that Maidstone Hospital was being downgraded: in fact, £70 million of investment had been put into Maidstone Hospital over the last three years.

(21) Maidstone Hospital was a major tertiary centre, not simply a local hospital – it was providing cancer care for a catchment population of 1.7 million people. There were specialist doctors in diabetes, heart and lung medicine. A cardiac catheter lab would be established in 2007 and the acute stroke unit was under development.

(22) Responding to the claim that the proposals put forward by the Trust were not safe, Ms Gibb said that the British Association for Emergency Medicine and the College of Emergency Medicine recommended that emergency departments with attendances greater than 40,000 per year must have immediate access to key supporting services such as general surgery. If the proposals were to go ahead, this would be the case and complex surgery would still be available on the Maidstone site.

(23) Ms Gibb said that, with regard to the perception that patients would have to travel 'too far', the South East Coast Ambulance Service was clear that the

benefit of patients receiving the right treatment outweighed additional journey time. The population of Maidstone had three hospitals within a reasonable travel time offering emergency services (namely the Medway Maritime, William Harvey and Darent Valley hospitals).

(24) Ms Gibb indicated that the option of providing emergency surgery at both hospitals would not work, because it would require additional consultants – three at each hospital. This was clinically not feasible, because too few patients would be seen by each doctor, meaning the 'critical mass' of patients necessary to maintain optimum skill levels would not be achieved. Training would worsen, as not enough exposure to surgery would be available for trainees. The proposal was financially unviable. Infection control would be put at risk if the Trust were to continue mixing emergency and elective patients. Finally, the proposal would undermine tertiary cancer work at Maidstone.

(25) The second alternative proposal was the reverse of the preferred option – with elective patients being treated at the Kent and Sussex Hospital, and emergency cases at Maidstone Hospital. Ms Gibb said that this proposal would not work because it undermined specialist cancer services at Maidstone, meaning that these would probably have to cease. It would also leave a large population in Tunbridge Wells without good access to alternative emergency surgery and orthopaedics – there being no urgent care network that was easily accessible by the catchment population of the Kent and Sussex. This would place very great pressure on the ambulance service and there would be costs associated with mitigating this pressure.

(26) Ms Gibb then responded to the allegation that there had been a lack of public involvement in planning for the proposed changes. She identified the various consultations that had taken place over the last three to four years. She added that Maidstone and Tunbridge Wells NHS Trust had been involved in engaging the public on a number of issues since 1999. She it was impossible to get 190 consultants to agree to the proposed changes, never mind a population of 500,000 residents.

(27) In answer to the perception of some that the proposals were financially driven and all about the Private Finance Initiative (PFI) for a new Pembury Hospital, Ms Gibb insisted that the proposals were about clinical safety and improving health for patients. £70m had been invested in Maidstone Hospital with continued annual plans for the next ten years. Ms Gibb added that the easy option would have been for Maidstone Accident and Emergency Department to have been closed in 2004/05, when the Royal Colleges had threatened the withdrawal of training recognition.

(28) Turning to the opposition from the Maidstone Division of the British Medical Association and MASH (Maidstone Action to Save our Hospital), Ms Gibb said that even these opponents recognised that what currently existed had to change. She said that MASH were only a few people. The BMA were talking about the Accident and Emergency Department only being open 18 hours per day; and they had accepted the need to centralise orthopaedics and trauma in Tunbridge Wells.

(29) Reference was made to the international clinical evidence for centralisation of services put forward by:-

- Prof Roger Boyle (National Clinical Director for Heart Disease and Stroke);
- Prof George Alberti (National Clinical Director for Emergency Care).

(30) In answer to questions relating to perceptions about how emergency medicine could continue to be delivered safely, Ms Gibb informed the Committee that surgical opinions from senior surgeons would be available in-clinic during the day and via the 'Hospital at Night' scheme. All key support services were to be retained, including:-

- critical care;
- imaging;
- pathology; and
- access to surgical opinion.

(31) Ms Gibb said, in conclusion, that the proposals being put forward by the Trust were consistent with its future planning, meaning the best care possible and modern standards. She added that the 'Fit for the Future' review was based on a financial model and focused on cost-reduction. This consultation had been about a clinical service which offered a safe service with the least amount of change.

(32) If the decision were delayed, patients would be denied the right to proper care, and lower mortality rates. A reassessment of clinical risk would have to be undertaken to ascertain how long services could be safety supported – and risk-mitigation options would have to be considered, including the possible closure of some services.

(33) In summary, Ms Gibb said that the proposals being put forward by the Trust represented the least change of services necessary to ensure good modern clinical services. The proposals would:-

- decrease the risk of infection and complications for patients; and
- ensure that the Trust would be working with other Acute Trusts

(34) The proposals would also:-

- support training for doctors; and
- make best use of the skills of staff, including doctors and nurses.

(35) The proposals offered Maidstone and Tunbridge Wells NHS Trust the opportunity to provide excellent specialist and general hospital care from two quality hospitals meeting modern day standards, and would improve the Trust's ability to save lives.

Questions

(36) Mr Daley said he presumed that the two clinicians from whom the committee had heard were from Tunbridge Wells. He asked why so many clinicians were

arguing passionately that the Trust had got its proposals wrong. He stated that it felt like Maidstone was always losing out. He referred specifically to the loss of the chronic pain clinic, which he would like to see returned to Maidstone.

(37) In answer, Ms Gibb said that the chronic pain unit was a separate issue. She admitted the two Clinical Directions were based at the Kent and Sussex Hospital, but stated that 100% of emergency surgery and orthopaedic consultants (including those at Maidstone) were in favour of the proposed changes. It was important to separate anecdotal views and opinions from hard evidence.

(38) Dr Simon Bailey, a consultant general surgeon, then addressed the Committee. He said that he had only recently been appointed to the Trust and he had been attracted to Maidstone because of the proposal to create a specialist unit. He added that he was frustrated at the slow pace of change. He said that he could not guarantee patients operations would take place until the morning of the operation because of the lack of preparation from emergency care.

(39) He said that the system was a 'mish-mash' based on the NHS model of 1948 – which he said was for 1948, not the present day. The NHS now had to move to a system of specialisation.

(40) Dr Bailey's views were echoed by a fellow surgeon from the Trust, who told the committee that there was currently competition for operating theatres between elective and emergency work. Centralisation would allow all-day trauma lists, reducing mortality rates and length of hospital stay. He accepted that certain groups of patients would have to travel for longer, but it would be worth it because of the improved quality of service.

(41) Ms Gibb said it was important that the Committee listened to the experts who had to deliver the service.

(42) Mr Northey then referred to the 500,000 catchment population to which the Trust had referred. This catchment population might be appropriate for a few specialist areas of medicine, but it was not for the majority of cases. He felt that this was a case of 'the tail wagging the dog', with the general public paying the price.

(43) Mr Northey also asked whether there was enough cover to go round for all the various 'sub-specialisms'.

(44) Mr Bentley responded that the Royal College of Surgeons had laid down how expert each type of surgeon needed to be. General surgeons were required to be 'emergency safe', but did not, for instance, need the detailed knowledge possessed by Dr Bailey and his colleagues in respect of cancer. In the case of colon cancer, a general surgeon could deal with a distended abdomen – but it would need a specialist surgeon to deal with the underlying condition. As regards the matter of catchment populations, Mr Bentley said that there were a number of specialisms where the optimum catchment population was even larger than 500,000 – it could be as large as 2–3 million people. What was

important was the safety of the patient. The Trust's proposals were about patients, not the convenience of consultants. In his own case, Mr Bentley would find himself having to commute from Tunbridge Wells to Maidstone under the Trust's proposals.

(45) Mr Fittock made clear his position, and that of his party colleagues, regarding the recent Kent County Council press release and the letter written by the Leader of the Council on 21 December 2006. He wanted to make it clear that his Group were disassociating themselves from those two items.

(46) He then went on to ask a range of questions relating to the in-house separation of emergency and elective care:-

- How many people would be affected if the proposals relating to 'blue-light' services set out in the Trust Consultation were to go ahead?
- Would other adjoining Trusts' Accident and Emergency Departments be able to cope with additional demand displaced from Maidstone?
- What about the poor transport links between Tunbridge Wells and Maidstone?

He thought there was a contradiction between what the Trust had told the committee about 'Fit for the Future' and what he had heard from other NHS colleagues. The Trust were saying that 'Fit for the Future' was being driven by finance – yet NHS colleagues who were involved in the review were saying that it was categorically not primarily about finance.

(47) Rose Gibb responded to Mr Fittock that the consultancy firm McKinsey had produced a model for 'Fit for the Future' which was a financial planning tool, intended to show the financial limits within which services would have to operate.

(48) Regarding numbers affected by the proposals, Ms Gibb said that around 60,000 people presented to Maidstone Hospital Accident and Emergency Department every year. If the proposals as set out in the Trust Consultation document were to go ahead, 5,000 of those people (about 12 per day) would be affected. Very few of these would need to go to Tunbridge Wells; the rest would divide up as follows:

- Medway Maritime – four or five;
- William Harvey – four;
- Darent Valley – two.

(49) Paul Barratt from the South East Coast Ambulance Trust indicated that the Trust were wholly supportive of the proposals. In responding to the claim that patients would be at risk of dying before reaching hospital, Mr Barratt said similar comments had been made when similar changes were proposed in East Kent. Yet, this had not happened when the changes were implemented. Mr Barratt said that there would be no journey times above 30 minutes. He expressed the view that extended journey times would be worth it if it meant getting the patient to the most appropriate hospital. He said that, in most cases, the time difference involved would actually be negligible. Regarding

whether it was possible to separate elective and emergency surgery merely by separating patient flows (without centralising each service at a different location), Dr Bailey said it was necessary to have an adequate volume of patients in order to achieve separation. He joked that it would be possible to have all services located in a single hospital located at, say, Paddock Wood. That would allow sufficient volume of patients to permit separate flows without separate locations – but, of course, it would not be acceptable to people. Ms Gibb said that the financial savings attached to the proposals would be no more then £2 million, and that out of this would come payments to the Ambulance Trust to cover additional transport costs. The source of the savings would be the removal of staff from non-training grades and the avoidance of the need for extra investment on account of the European Working Time Directive.

(50) Mr Tolputt asked about the number of ambulance staff that would need to be on standby. He also asked about the potential impact of Operation Stack on the need for ambulance cover. Mr Barratt responded that the reconfiguration of services in East Kent had, contrary to what people had claimed, led to the need for the 'vast number' of just two extra ambulances. He said the ambulance service was also freeing up capacity, as fewer ambulances were now being sent up to London. He accepted that Operation Stack was a concern – but it was not a major issue. Very few road-traffic accident casualties on the M20 now went to Maidstone Hospital; most went to Ashford. He emphasised that the majority of medical emergencies, e.g. heart attacks, strokes, etc., would still be going to Maidstone. And he underlined that the proposals were not financially driven. He reiterated that the anticipated savings were around non-training posts.

(51) Asked whether the Accident and Emergency Unit at Maidstone Hospital would remain fully clinically staffed or would just have emergency nurses, Rose Gibb responded that this was a misunderstanding. The Accident and Emergency Department was not closing. The situation was that the majority of cases at Maidstone A&E presented as walk-in patients, and they were treated by nursing staff. This was the situation in all hospitals. Only a minority of cases were true emergencies – and these were mostly medical emergencies, which would remain at Maidstone Hospital. Of the 25,000 blue-light patients presenting annually at the Accident and Emergency Unit at Maidstone Hospital, the majority were medical patients and these would stay at Maidstone. Around 5,000 patients per year required emergency surgery, and these cases would go elsewhere. What the Trust was saying was that the Kent and Sussex, and Maidstone hospitals did not have adequate infrastructures for 24-hour modern services. And even if she had the 16 surgeons necessary to run services on both sites, there would not be enough work for them to do, which would be a waste of money.

Kent Air Ambulance

(52) Mr David Philpott, Chief Executive of the Kent Air Ambulance, was then invited to address the Committee. He informed the Committee that he had no difference of opinion on clinical arguments with the Trust. He accepted that reconfiguration on the lines set out by the Trust was national policy. He added that he had worked closely with Professor George Alberti and it was his view

that the intention was that trauma hospitals would be based around a 500,000 population, whether we liked it not. The Kent Air Ambulance was a non-political organisation and independent of the National Health Service. Having said all this, the Air Ambulance Trust did have issues with the current proposals. He disagreed with Rose Gibb about 'Fit for the Future' – it was not about finance, it was about having a big vision for the NHS in Kent and Medway, and such a vision was lacking in these proposals. The Kent and Sussex Hospital did not have a helipad – unlike Maidstone Hospital, to which a total of 92 cases had been airlifted by the Air Ambulance. Not only could the Air Ambulance not take cases to the Kent and Sussex, it could not airlift cases out. In recent years, 37 cases had been airlifted from Maidstone Hospital to specialist services elsewhere, and lives had thereby been saved. He added that he felt that the proposals were a good idea, but in the wrong place and the wrong time; and the infrastructure was wrong.

(53) Mrs Stockell indicated her support for Mr Philpott's comments and asked whether the proposals would undermine the Kent Air Ambulance's position. Mr Philpott responded that they would not. He had met the Secretary of State a couple of months ago and, in his view, Air Ambulance Services would increasingly be the solution to the problem of transporting emergency cases. They were supplementary to the National Health Service, but the need for them would increase.

(54) Mrs Rowbotham expressed the view that 'downgrading' was an inappropriate word; she accepted the need for reconfiguration in some form. What she wanted to know was whether there were enough helipads. Mr Philpott responded that he felt that Health Trusts tended to think in 'silos', neglecting issues such as helipads, and that the system forced people to think that way. John Tickner, Operations Manager for the Air Ambulance Trust, emphasised that the Air Ambulance was a very small part of ambulance provision, only dealing with between 200 and 300 cases per year. In the last six months, 60 cases had been taken to Maidstone Hospital which now would all have to go elsewhere.

(55) Dr Ramzi Freij, a medical consultant employed by the Air Ambulance, explained that he was one of four consultants working for them. Kent had the most heavily consultant-led Air Ambulance Service in the country. A few cases, the most serious ones, needed stabilisation at the roadside; and the consultants were able to do this.

(56) Mr Hibberd referred to the impossibility of landing at the Kent and Sussex Hospital; he said that helicopters could land on oil rigs in the North Sea, so why not in Tunbridge Wells? He asked how close to the hospital the Air Ambulance would need to land in order to be effective. Mr Philpott responded that the Air Ambulance could land in fields adjacent to hospitals – but this would a require land ambulance then to transfer the patient to hospital. He added that the Kent Air Ambulance did try to land near to the Kent and Sussex in this way, but it was not ideal. Mr Tickner added that they had been known to land at a sports field south of Tunbridge Wells – however that added 10 minutes to the journey time to the Kent and Sussex Hospital.

(57) Mr Tickner then went on to refer to the Darent Valley Hospital. Although it was a very good hospital, the helipad was half-a-mile away from the Accident and Emergency Unit. As a consequence, they tended to overfly that hospital.

(58) Ms Gibb added that the majority of hospitals in the UK did not have a helipad. She said that the new Pembury Hospital would have a helipad. With regard to Maidstone Hospital, she added that it was only an extra two minutes to fly from Maidstone to the Medway Maritime Hospital, which had a helipad. She added that a number of patients were relocated from Maidstone to Medway for vascular surgery in any case.

(59) Mr Crowther responded that he was ashamed to hear there were still hospitals that did not have a helipad.

(60) Mr London sought information about the dimensions for a helipad and whether the helicopters could operate at night. Mr Philpott answered that Kent Air Ambulance were advocating the idea of night-time flights to move intensive-treatment patients. The Air Ambulance had a lit base at Marden and so could fly at night if lit helipads were available at hospitals. Mr Philpott said that helipads required little space and they were relatively inexpensive to build (around £4,000). He wished that NHS colleagues would consult with the Air Ambulance Trust before making decisions about the availability of helipads.

(61) Mr Daley commented that the Kent Air Ambulance was not the service of first response. He thought that they were really saying the reconfiguration should wait until the new PFI hospital opened at Pembury. He asked whether flight paths were also an issue, as well as the availability of helipads. Mr Philpott answered that the Air Ambulance had no view on the centralisation of elective surgery, but they did accept the general trend towards specialisation in the NHS. He said that the Air Ambulance certainly was a service of first response. They screened every emergency call in the South East of England (1,500 per day) and they self-deployed, without waiting to be called. He went on to say that paramedics did a lot now but added that the doctors were pre-hospital care specialists with a lot of training.

(62) Mr Daley's point about flight paths was valid, Mr Philpott conceded.

(63) Following lunch, local County Members were given the opportunity to address the Committee about their views on the Maidstone and Tunbridge Wells NHS Trust's proposals.

(64) Mr A J King, Member for Tunbridge Wells Rural and Deputy Leader for the County Council, said that the transport connections between Maidstone and Tunbridge Wells were not fit for the purpose. He said that Kent County Council was opposed to the Trust's proposals because it was their view that services for the public should be available in both Maidstone and Tunbridge Wells. He added that they understood the pressures on NHS Managers. He said that he had been a Health Authority Chairman for two years and a Trust Chairman for six years. He added that he recognised that there were diktats coming from Whitehall, putting NHS managers in a more difficult position than that faced by local government. Mr King was keen to extend the hand of

friendship to people in the NHS and said that it was important that there was a dialogue which was fit for the twenty-first century.

(65) Mrs M Featherstone, Member for Maidstone North East, indicated that she had received several comments from her constituents. She added that the publicity in the local newspapers had not helped and proposals being put forward by the Trust were not well understood and the public were left with the impression that all blue-light services in Maidstone would cease. As a consequence, this would result in delays in getting patients to hospital which could potentially add to travel-time and cost for people visiting their family and friends in hospital.

(66) Mrs Featherstone mentioned the growth in population in Ashford and the Thames Gateway – and indicated that Maidstone was also a growth area.

(67) She went on to say that a lot of staff who worked in the Maidstone Hospital lived within her electoral division. They had told her about reconfiguration in Epsom, which had meant patients had died on the way to hospital because of over-long journey times. While she acknowledged that car ownership was high, she informed the Committee that not everyone drove and, therefore, a two-hour visit to the Kent and Sussex Hospital would take four hours by public transport. The taxi fare to do this journey would cost in excess of £20.

(68) Mrs Featherstone said that she had been told by a member of staff working at Maidstone Hospital that there were three major accidents dealt with at Maidstone Accident and Emergency Department every week. She spoke about the proximity of Maidstone to the M20.

(69) Finally, she added that the population of Maidstone was set to grow for the next 10 or 20 years and that the public would expect a hospital with all services to be available in Maidstone.

(70) Mr London, Member for Sevenoaks Central, spoke about the difficulty of access from Sevenoaks to local hospitals. Dartford could only be reached via London on public transport. He added that all the focus so far at the meeting had been on clinical services and only once had there been mention of visitors. He concluded that the constituents within his electoral division were bemused by all the consultations and new organisations in the NHS.

(71) Mrs Stockell, Member for Maidstone Rural West, said that she represented an electoral division which had 13 Parish Councils over a very large rural area and that journey times across the electoral division were horrendous. Maidstone currently had a population of 140,000 people and this was expected to grow in the next ten years to 150,000 people.

(72) Mrs Dagger, Member for Malling West, said that within the Tonbridge and Malling area residents had easier access to health services. A major concern was Pembury Hospital, which was accessed by the A228 Colts Hill which could easily become blocked. Kent County Council had been pressing the Government for funding for years to upgrade this road.

5. British Medical Association – Maidstone

Dr Chris Thom – Consultant in Elderly Care

(1) Dr Thom said that he had spent just under 12 years at Maidstone Hospital.

(2) He informed the Committee of a survey which had been undertaken involving all members of the Maidstone Division of the British Medical Association. A total of 156 replies had been received; 95% of the respondents had agreed that:

- full A&E services should continue to be provided at both Maidstone and Tunbridge Wells;
- Maidstone Hospital should continue to provide a full unselected medical and general surgical 'take';
- no services should be transferred from Maidstone before the Private Finance Initiative had been agreed;
- consultants at Maidstone should be fully involved in deliberations on service configuration.

He added that the totality of physicians at Maidstone Hospital, as well as some of the surgeons, were opposed to the Trust proposals.

(3) Dr Thom informed the Committee that he was a physician who admitted many patients with medical conditions which didn't need emergency surgery to Maidstone Hospital. However, he said that one could not always tell what sort of support and services were going to be needed. He said that out of recent 30 medical admissions at Maidstone Hospital, three had needed emergency surgery. One patient had presented with heart pain but this had turned out to be an abdominal emergency. A second patient had presented with a lower-limb infection and had turned out to require a life-saving amputation (and it would not have been safe to move the patient). The third patient had needed to be taken to a London hospital for emergency heart surgery.

(4) Dr Thom informed the Committee that for his surgical colleagues the proposals as put forward by the Trust did have benefits – but there were disadvantages as well. He added that a countywide GI Unit was being developed and that these proposed changes by the Trust would not fit with the way many people saw this developing. Dr Thom said that training must follow services. The out-of-hours service was given by postgraduate trainees; if the proposals were to go forward, he said, there would be reduction in the quality of training. He acknowledged that medical emergencies were staying at Maidstone – but there was no plan worked out for this.

(5) Turning to the national context, Dr Thom referred to the recent document from the Institute for Public Policy Research, which had sought to justify reconfiguration to achieve large catchment populations. The report admitted that this was driven by political imperatives – and he had to agree with that. He indicated that 250,000 was the current average catchment population for local hospitals; only Medway Maritime Hospital had a catchment population above 300,000.

(6) There was a drive to reduce the number of Accident and Emergency Departments by one-third. He said that this would be good for a few cases but not for the bulk of patients, who he said would be disadvantaged.

(7) Dr Thom stated that a catchment population of 100,000 people was too small but in his view 500,000 was too big. What was required was a population somewhere in between. He advocated that a 250,000 population was workable to sustain two viable hospitals. He recognised that it would not be possible to provide all services at both hospitals but there would be a network. He said that the current proposals did not start from the hospital as a whole. He referred the Committee to the NHS National Leadership Network document 'Strengthening Local Services', which had been cited early on in the consultation. This actually stated that a substantial majority of hospitals with smaller catchment populations would continue to provide emergency general surgery. He added that he did accept, as a postgraduate tutor, the need for the Trust to modernise.

(8) The Committee then heard from Dr Debbie Taylor, a General Practitioner in Maidstone since 1990. Dr Taylor said that in 1986 she gone to work at Maidstone Hospital as a House Officer. She had seen the hospital grow since opening in 1983. She said that local people needed local services. Maidstone was much larger than Tunbridge Wells and she emphasised that the links between Maidstone and Tunbridge Wells were very poor. She said that it would take longer to get to an Accident and Emergency Department at Dartford, Medway or Ashford – and people would die as a consequence.

(9) 250,000 was an appropriate catchment population for an Accident and Emergency Department – and the local population was expanding.

(10) Ms Taylor said that all general practitioners (GPs) in the Maidstone area were opposed to the changes. She went on to say that those people who were on low incomes or lived in a deprived area would not be able to afford to travel to Tunbridge Wells. She reaffirmed her view that the road links were extremely poor. Tunbridge Wells Hospital also lacked a helipad.

(11) Ms Taylor stated that there was often talk about the "golden hour" in respect of getting emergency cases to hospital, but often it was a "golden half-hour". This time could easily be lost where there were poor road links. She informed the Committee about how the Trust's proposals would impact on general practitioner training. She said that it was the GP's role to deal with uncertainty: patients did not come to their GP with a label. They needed to refer patients for an opinion at the hospital, and she was concerned that not all these patients would actually go to Tunbridge Wells.

(12) Dr Taylor said Ms Gibb had assured her there would be a surgical opinion available at Maidstone – but it could still be difficult to contact a surgeon if they were involved in a clinic.

(13) A copy of a note expressing Ms Taylor's views was tabled at the meeting.

Dr Marie South – Consultant vascular and general surgeon

(14) Dr Marie South explained that she had recently moved from Maidstone and Tunbridge Wells NHS Trust, after 25 years' service, to work at Medway Maritime Hospital. She informed the Committee that there were sub-specialities within general surgery where it was valuable to concentrate services on one site, e.g. the vascular speciality, for which a regional specialist centre had been created at the Medway Maritime Hospital. Dr South added that there were similar arguments for surgery involving the upper gastrointestinal tract. However, this did not apply to all specialties. She stated that having a purely elective surgical centre at Maidstone was not necessary or desirable; there were surgical emergencies, such as abscesses and appendicitis, that could and should continue to be dealt with at Maidstone. Ms Harrison noted that it was the Royal College of Surgeons that decided appropriate levels of training – if the assumption were made that money was no object, would the Royal College continue to recognise Maidstone Hospital as a training centre? She said that Sheppey's Accident and Emergency Department had been shut by the Royal College, although Sheppey was a deprived area and miles from anywhere. Ms Harrison went on to ask whether all blue-light cases currently went to Maidstone. She asked were the proposals put forward by the Trust were clinically detrimental to the population of Maidstone. In answer, Dr Thom said that in his view, yes the proposals were overall detrimental – but that was not to say that the situation should stay unchanged. He said that almost all blue lights currently went to Maidstone. He said that there was no short-term threat to training and that the proposals would not affect this – but they did complicate matters.

(15) Dr South said emergency surgery was a vital part of trainees' surgical experience, so the proposals would limit the number of trainees allocated to the Maidstone site.

Dr Akbar Soorma – Consultant in Accident and Emergency Medicine

(16) Dr Soorma responded that the closure of the Sheppey Accident and Emergency Unit had happened before the Postgraduate Medical Education and Training Board (PMETB) had been established. This organisation, rather than the Royal Colleges, now had the final say on the training of all surgeons, physicians and anaesthetists.

(17) Mr Fittock then asked a range of questions of health colleagues including:-

(a) whether members of the British Medical Association in Tunbridge Wells had been consulted, or whether the consultation had been limited only to members of the Maidstone Division;

(b) what they thought of the model for emergency care now in operation at the Kent and Canterbury Hospital – there had been a lot of opposition to this, but it seemed to be working quite well now;

(c) how it was that Ms Gibb was able to state that the British Medical Association's national policy was actually in support of the model proposed for her Trust;

(d) what they thought about the risk of cross-infection if the model of mixed elective and emergency services continued; and

(e) whether they thought it was acceptable for patients from, for instance, Swanley to have to travel a long distance to Maidstone Hospital to access the Kent centre of excellence for cancer, which was at Maidstone.

(18) Dr Thom responded that it was the Maidstone Division of the British Medical Association that was objecting to the Trust's proposals. There had been no similar consultation exercise in Tunbridge Wells. He added that he did not regard the emergency care service at the Kent and Canterbury Hospital as a satisfactory clinical model – although he accepted that it worked well most of the time. He noted that there was a vascular unit at the Kent and Canterbury Hospital, meaning that they had emergency surgery available to a somewhat greater extent than was proposed for the Maidstone site. He said that Foundation Year 1 trainees now had to spend two months at Canterbury and two months at Ashford – this was bad for the trainees and bad for the service (due to the extent of turnover it entailed).

(19) He said that the national policy of the British Medical Association that had been referred to by Ms Gibb was that of support for the separation of emergency and elective care.

(20) With regard to infection control, he could accept this as justification for the proposals, if they really were going to guarantee proper separation of elective and emergency surgery. However, the proposals would only achieve an imperfect separation at Maidstone, due the lack of ringfencing for elective general surgery beds. The benefits of the proposals were in reality less than they would seem; and they were outweighed by the disadvantages of what was proposed.

(21) Dr Thom concluded that Maidstone Hospital should remain a centre of emergency care supported by emergency surgery. He went on to say that, whilst he had argued against the centralisation of trauma and orthopaedics, he thought this could be done with less damage than would be caused by centralising emergency surgery. A compromise would be to centralise only emergency orthopaedics; a lot of work would need to be undertaken with the ambulance service on this, but it could be done. This compromise position would still not be perfect and would still attract a great deal of opposition. There would be a cost involved and it would be less convenient for general surgery colleagues.

(22) Dr Hulse added that one of the problems with the consultation document was the lack of balance in presenting the risks associated with the possible solutions. He said there would be winners and losers for each of the possible solutions – but this had not been acknowledged in the document, which had been slanted towards the Trust's favoured option.

(23) Mr Hibberd said that the Committee was getting into the details of medical training and he said he did not feel best placed to decide on this. He wondered whether the Committee could get an expert to advise it on these matters.

(24) Mrs Angell asked what consultation had taken place within the Trust on the proposed changes. In reply, Dr Hulse referred to a clinical meeting at the Hop Farm in Beltring last June to decide new policy for the Trust. Dr Hulse said that, in his opinion, the event had been poorly structured, with clinicians confined to discussing only issues directly related to their own specialties. The proposals for emergency services had been arrived at solely within the surgical and orthopaedic directorate, and there had been no consultation with other specialties. The Trust's physicians were unanimously opposed to the proposals.

(25) Mr Daley said that there was no possibility of getting an entirely objective and independent opinion on this issue. The Committee could not call for expert advice, as Mr Hibberd had suggested; they had to make a judgement on what they had heard. The public had got a one-sided impression from the local press, whose coverage had been quite emotive. He wanted to take the emotion out. He had some misgivings about the East Kent model for emergency care; but largely it had worked. There were also the underlying financial issues: was it really possible to run full Accident and Emergency services at both Maidstone and Tunbridge Wells within the financial constraints?

(26) Dr Soorma said he had been a consultant in Accident and Emergency Medicine for the past 10 years; and he was grateful for the Trust's support regarding staffing levels. He said that the new Pembury PFI hospital would be wonderful for surgical and orthopaedic colleagues, allowing them to work less demanding rotas. He was proposing that, until the new Pembury Hospital opened, services at the Accident and Emergency department at Maidstone should be maintained as they were currently, but not on a 24-hour basis. Only a dozen patients usually attended at night, so there was no need to provide a full service overnight. He noted that, at the Hop Farm meeting, it had actually been proposed not to provide emergency orthopaedics at night at Maidstone; he had been surprised when surgical colleagues had then produced the proposal to remove emergency orthopaedics and emergency surgery from Maidstone entirely.

(27) A letter from Dr Soorma was tabled and circulated at the meeting.

(28) In conclusion, Dr Thom said no-one was saying 'carry on as we are'; but he re-emphasised that the proposals as currently put forward by the Trust had not been adequately thought out and put together. He said hospitals much smaller than Maidstone were providing a fuller emergency service than that proposed by the Trust. This view was endorsed by Dr Hulse, who said he was not opposed to change but that the details had just not been worked out properly.

(29) Mr Crowther offered the view that he could support the Trust's proposals if the two hospitals were in the same town – but they were too far apart. The proposals would make it very difficult to visit patients. He said he was inclined to say that the Trust should go away, sort out a compromise and then come back to the Committee.

East Sussex County Council

(30) Councillor Mrs Phillips of East Sussex County Council attended the meeting to express the views of constituents in that part of East Sussex which looked towards the Kent and Sussex Hospital for their hospital services.

(31) Councillor Phillips said that if there were any proposal to remove emergency care from the Kent and Sussex Hospital, this would adversely effect the rural population to the south.

Tonbridge and Malling Borough Council

(32) Mark Raymond, Corporate Services Manager, Tonbridge and Malling Borough Council, also attended the meeting. Mr Raymond said Tonbridge and Malling Borough Council were generally supportive of the arguments for the reorganisation of services. However, they did have concerns, particularly over transport – both in terms of patients and visitors.

(33) Mr Raymond also spoke of the scope for delivering services in the community through community hospitals or in other community settings. There needed to be a link between these proposals, 'Fit for the Future' and the current community hospitals review in West Kent.

Maidstone Borough Council

(34) Councillor Paddy Germain, Chairman of Maidstone Borough Council's external Scrutiny Committee addressed the Committee. He informed the Committee that Maidstone Borough Council's External Scrutiny Committee had done an exhaustive review of the proposals being put forward by Maidstone and Tunbridge Wells NHS Trust. He said there was a very large majority of Maidstone residents who opposed the Trust's proposals. It was the Scrutiny Committee's view that the Trust had not respected public opinion. He said there was a liberal and inconsistent use of medical terminology within the consultation document which only led to the confusion of lay people.

(35) The External Scrutiny Committee found that the Trust's consultation document was blatantly leading. He said he was impressed with the idea of trying to get people cared for closer to their homes but he questioned how people could be sure that this would work.

(36) Councillor Germain added that he had been unable to find a GP who was enthusiastic about treating more people in the community. He said there was very little chance of getting a community hospital in Maidstone. He acknowledged that the proposals before the Committee were supposed to be clinically-led but he had found it hard to find leading clinicians in Maidstone who supported the proposals.

(37) The draft report of the External Scrutiny Committee had been sent to the Trust and an initial response had been received. The Trust had pointed out that the Committee's report contained a number of errors. The Committee had met on Monday 8 January 2007 when it had unanimously endorsed the report, with some minor amendments.

(38) He went on to say Ms Gibb had not convinced Maidstone Borough Council's External Scrutiny Committee, the residents of Maidstone or the Maidstone Division of the British Medical Association.

(39) In conclusion, Councillor Germain said that Maidstone was suffering because of the lack of services and he felt that part of the reason was the need to further the PFI Hospital at Pembury. He added that 10,000 new houses were due to be built in Maidstone. He, therefore, asked the NHS Overview and Scrutiny Committee to reject the proposals because he said that if the Committee agreed them, further changes would be brought forward.

Mr G Gibbens – Cabinet Member for Public Health, Kent County Council

(40) Mr Gibbens informed the Committee that he was the County Council Cabinet Member with the portfolio for Public Health. He said that in attending the meeting he in no way sought to influence the NHS Overview and Scrutiny Committee.

(41) Kent County Council had responded to the Consultation on 21 December 2006. A copy of that letter was before the Committee. He reiterated the views expressed in that letter that these proposals should not go ahead until the broader picture of 'Fit for the Future' was known.

Mr Dennis Fowle – Editor of the 'Downs Mail'

(42) Mr Fowle addressed the Committee and spoke of all the letters which had been received by the 'Downs Mail'. Copies of these letters were made available to the Committee for its inspection. He referred the Committee to the protest rally in Mote Park rally prior to Christmas which had been attended by approximately 2,500 people. Several other petitions had also been received. Reference was also made to the 2,000 forms filled in and returned to the 'Kent Messenger' in support of its campaign against the proposals.

(43) Turning to specific concerns, he spoke of issues of safety that would arise if the proposals were to go ahead. He respected the skills of paramedics, but he was concerned that clinical outcomes would be jeopardised if the 'golden hour' were to be lost in excessive journey times. Tunbridge Wells was an old hospital; it was a long way from Maidstone; and it was not properly staffed all day. He said he felt the Trust had a poor safety record and referred to the recent 20 deaths from Clostridium difficile. He added that nurses were seriously overworked and he criticised the Trust for underspending by £2 million on its nursing budget in the current year. He referred the Committee to the attempt made by the Trust to shift Women's and Children's Services to Pembury, which had been withdrawn by the Trust. He said that the Committee had heard about the Trust's £70m investment in Maidstone Hospital – yet core services were still being downgraded, for example Accident and Emergency, maternity, paediatrics and the chronic pain unit.

(44) Mr Fowle said that Maidstone distrusted the Trust. He cast doubt on the figures that the Trust had produced regarding numbers of patients that would be affected by the proposals. He said that the Trust Board was loaded with representatives from Tunbridge Wells, to the detriment of Maidstone.

(45) He said that he had often been moved to tears by the letters he had received from members of the public.

(46) In reaching its conclusions on this matter the NHS Overview and Scrutiny Committee took into account the views of the Maidstone and Tunbridge Wells NHS Trust and West Kent Primary Care Trust, as well as other stakeholder views, including those of: the Kent Air Ambulance Trust; representatives of East Sussex County Council; Maidstone Borough Council; Tonbridge and Malling Borough Council; several Parish Councils; Patient and Public Involvement Fora; and representatives of the Maidstone Division of the British Medical Association. Account was also taken of the weight of public opinion on this issue, particularly in the Maidstone area.

(47) The Committee was reminded of its statutory powers, including, as a last resort, referral to the Secretary of State for Health.

(48) After a short adjournment, to allow a discussion between the Chairman and Vice Chairman of the Committee and the Liberal Democrat spokesman, the Chairman invited the Chief Executive of the Maidstone and Tunbridge Wells NHS Trust, Ms Rose Gibb, to say whether the Trust was prepared to amend its proposals in the light of the opposition that had been expressed and alternative options that had been put forward.

(49) Ms Gibb said that the Trust had previously compromised regarding the reconfiguration of trauma and orthopaedics – but this had produced a service that was not working well for patients. The status quo could not be allowed to continue. Ms Gibb noted that concerns had been expressed by consultants in emergency medicine at Maidstone that their specialty would suffer as a result of the relocation of emergency surgery away from the hospital. She said that details regarding the future of emergency medicine were still being worked on – but she did not believe that people would see the Accident and Emergency department at Maidstone without a medical presence. She maintained that the level of surgical support to medicine at Maidstone would actually increase.

(50) Mr James Lee, Chairman of the Trust Board, said that the possible compromise mentioned by the BMA representatives – centralising emergency orthopaedics at the Kent and Sussex Hospital while keeping emergency surgery at Maidstone – made no sense. The linkages between general surgery and orthopaedic surgery were far stronger than those between emergency medicine and emergency general surgery.

(51) Ms Gibb added that worldwide clinical evidence supported the Trust's proposals; those who were opposed needed to consider this and set aside their passion for their particular town. She recognised the Committee's concern regarding how these proposals would relate to the strategic review of health services across Kent and Medway known as 'Fit for the Future'. She assured the Committee that the proposals would not be implemented until the outcome of 'Fit for the Future' was known – and if this turned out to be at odds with the proposals, they would be revised accordingly. Ms Gibb urged the Committee to endorse the Trust's proposals on the basis of that assurance.

(52) Mr Fittock said that he was happy to go along with what Ms Gibb had suggested – provided it was clear that the eight surgeons currently working in the Accident and Emergency department at Maidstone would continue to do so, pending the outcome of 'Fit for the Future'. He added that the Trust had to demonstrate that they were listening to the public.

(53) Mr Daley concurred with what Mr Fittock had said. He felt that an appropriate response would be as the Leader of the County Council had written in his letter to the Trust dated 21 December 2006:-

> 'Whilst we broadly support the overall objectives of the NHS in Kent to improve the standards of healthcare to the population within a sustainable financial framework we maintain that any reconfigurations of this nature should be discussed with the more comprehensive proposals that will emerge from the wider Fit for the Future review process.'

(54) Mrs Stockell said that she could not agree with Mr Fittock and Mr Daley. Maidstone was the county town, it had a growing population and it needed a full Accident and Emergency Service. It was not appropriate for the Committee to be asked to agree in principle to the proposed changes on the basis proposed. In concluding, Mrs Stockell moved that the proposals as set out in the consultation document 'A new direction for surgical and orthopaedic care' be rejected on the grounds that:

a) they were not in the interests of health services in Kent, particularly for those persons who looked towards the hospitals within the Maidstone and Tunbridge Wells NHS Trust for their healthcare; and

b) they would more appropriately be considered as an integral part of the much wider 'Fit for the Future' review.

(55) Mr Northey seconded the motion.

Carried 7 votes to 6

(56) RESOLVED that:-

(a) the NHS Overview and Scrutiny Committee reject the proposals contained in the West Kent Primary Care Trust and Maidstone and Tunbridge Wells NHS Trust document 'A new direction for surgical and orthopaedic care', on the grounds that: the proposals are not in the interests of health services in Kent, particularly for those persons who look towards the hospitals within the Maidstone and Tunbridge Wells NHS Trust for their healthcare; and

(b) the Committee believes these proposals would more appropriately be considered as an integral part of the much wider 'Fit for the Future' review.

Reasons based on the written and verbal evidence that the NHS Overview and Scrutiny Committee has received for rejecting the proposals for orthopaedic surgery and emergency care within the Maidstone and Tunbridge Wells NHS Trust

1. The committee feels that the Trust's consultation document gives a skewed presentation of this matter, failing to acknowledge the true balance of costs and benefits involved in both the proposals and the alternative options. The committee believes that the issue is rather less straightforward and clear-cut than is apparent from the account given by the Trust.

   We note also the factual inaccuracy in the report as regards the number of cases that would be affected by the proposals. The report states that this figure is 12 per day and that this amounts to 2,500 per year; however, 12 cases per day would actually give an annual figure of 4,380.[3]

2. The Trust has stated that clinical evidence clearly shows the optimal minimum catchment population for an acute hospital with full A&E capacity to be 500,000. Services operated with a smaller catchment population than this, it is claimed, will inevitably be clinically substandard, as the throughput of patients will be inadequate to guarantee the case-mix needed to maintain consultants' clinical skills at an appropriate level. Consequently, it is argued, the MTW Trust – which has a catchment population of 500,000 – can only have one acute hospital with full A&E capacity.

   However, the committee is aware that the evidence base for these claims appears to be less strong than has been asserted – as indicated by two published systematic reviews.[4]

   The views of the Royal College of Surgeons and the Institute for Public Policy Research have been cited by the Trust in support of its proposals. But we note that recent publications by both these bodies accept that a catchment population as low as 300,000 is realistic, achievable and clinically acceptable.[5]

   At the NHS OSC meeting on 12 January, the committee heard from Dr Thom, representing the Maidstone Division of the British Medical Association, that a catchment population of 250,000 was entirely workable and viable.

   The committee notes that the current catchment population for Maidstone Hospital is around 250,000 – and that a further 10,000 houses are to be built in the area.

3. The committee does not accept that configuring local health services is simply a matter of crudely applying a universal "one-size-fits-all" template. Full account

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[3] *A new direction for surgical and orthopaedic care*, p. 7.

[4] Fergusson *et al.*, "Concentration and Choice in the Provision of Hospital Services", 8th Report of the NHS Centre for Reviews and Dissemination, University of York (1997); Halm, Lee and Chassin, "Is Volume Related to Outcome in Health Care? A Systematic Review and Methodological Critique of the Literature", *Annals of Internal Medicine*, 137, 511–520 (2002).

[5] RCSEng, *Delivering High-quality Surgical Services for the Future* (March 2006), p. 28; ippr, *Hospital reconfiguration: ippr briefing* (September 2006).

must be taken of any detrimental consequences of centralisation, as well as anticipated benefits. In doing so, a range of local factors needs to be taken into consideration, including:

- population distribution;
- facilities available in surrounding areas;
- future population growth; and
- transport connections.

We note that the NHS National Leadership Network report *Strengthening Local Services: The Future of the Acute Hospital*, which has been cited in support of the Trust's proposals, acknowledges the need for local flexibility in applying the preferred service model to local circumstances. The illustrative scenarios provided in Appendix 2 of the report include one relating to a District General Hospital covering a rural area and a medium-sized town. This shows Acute Medicine, General Surgery and Trauma & Orthopaedics all provided on one site in support of a 24-hour A&E department.[6]

4. The Trust argues that the quality of modern paramedical services means that journey-times to hospital can be lengthened without adversely affecting clinical outcomes for emergency patients. However, the committee notes that – even allowing for how well-equipped and well-trained paramedics now are – the time taken in transporting emergency patients to hospital still matters.

   The committee notes that, under the current proposals, ambulances will have to travel significant additional distances (and along a poor road connection, in respect of the journey between Maidstone and Tunbridge Wells). We are concerned that this will lengthen journey times to an extent that will, in some cases, compromise clinical outcomes – even as far as causing a higher mortality rate.

5. The committee has not been reassured that proper account has been taken of how far, under the proposals, the resources of the ambulance service will be put under greater strain – due to increased journey-times and more time being spent by paramedics stabilising patients. If the ambulance service's resources were to be overstretched, it could take longer for ambulances to reach patients than is currently the case.

   The committee was not given a cast-iron reassurance that sufficient compensating additional resources will be made available to the ambulance service if the Trust's proposals are implemented.

6. The committee noted the evidence given at the meeting on 12 January by Mr David Philpott, Chief Executive of the Kent Air Ambulance Trust. Mr Philpott stated that, while his organisation agreed in principle with the reconfiguration of A&E services, it could not support the current proposals.

   The Air Ambulance Trust felt that the proposals failed to take account of the "big picture" of services across Kent and Medway, and the need for the

[6] NHS National Leadership Network Local Hospitals Project, *Strengthening Local Services: The Future of the Acute Hospital – Reference and Resource Report* (March 2006), pp. 58–9.

appropriate supporting infrastructure to be in place before such changes could occur. Mr Philpott noted that the Kent and Sussex Hospital, unlike Maidstone Hospital, does not have a helipad. He explained that, as well as preventing the Air Ambulance bringing emergency patients in, this would also prevent emergency cases being taken on to specialist services elsewhere (as the service had done at Maidstone in respect of some 37 cases in recent years, thereby undoubtedly saving a number lives).

7. The committee was informed by the Trust on 12 January that the "Fit for the Future" review of health services across Kent and Medway was primarily concerned with financial issues. Therefore, it was argued, it was appropriate for the Trust to address this particular reconfiguration issue before the completion of "Fit for the Future".

   However, this account of "Fit for the Future" clearly runs counter to statements made to the committee by representatives of the South East Coast Strategic Health Authority and of the local Primary Care Trusts. They have clearly stated that "Fit for the Future" is concerned with much broader issues than purely financial ones, and involves considering how health services across Kent and Medway – and, to an extent, beyond – will fit together. Confirmation that this is the case came in the meeting from Mr Philpott, of the Air Ambulance Trust, who directly contradicted the evidence given by the Trust to the meeting about "Fit for the Future".

   The committee finds itself bound to agree with the view, expressed by Mr Philpott, that the reconfiguration of A&E services within MTW Trust must be wholly subsumed into "Fit for the Future". The Trust, however, insists that reconfiguration must be dealt with as a discrete matter apart from, and prior to, this overarching review. It is suspected that the Trust is actually trying to influence the outcome of "Fit for the Future" by rushing through a pre-emptive decision on the reconfiguration of A&E services within the Trust.

8. The committee has not been convincingly reassured that the A&E departments in Dartford, Medway, Ashford and Tunbridge Wells will all be able to cope adequately with the emergency caseload that will be displaced from Maidstone as a result of these proposals – given that there are no plans to allocate additional compensating resources.

   We are particularly concerned that this may become a significant issue in the longer term, with both the Thames Gateway and Ashford being designated by the government as Growth Areas. Further, Maidstone itself has now been awarded New Growth Point status (meaning the construction of a further 10,000 houses in the area – as already noted above).

9. The committee accepts the clinical benefits attached to the separation of emergency and elective surgery – and notes that the wish to achieve this separation is apparently a significant factor in the support that the Trust's surgeons are giving to these proposals.

   However, we do not accept that the only way this can be accomplished is by providing the two services at separate locations, as the Trust maintains. We

note that emergency and elective orthopaedics have already been successfully split within one location, at Maidstone.

We further note that the Trust's proposals will actually achieve an imperfect separation of emergency and elective patients at Maidstone. The plans do not allow for elective general surgery beds to be ring-fenced at Maidstone – meaning it is highly likely that some general surgery beds will end up being used by unscreened emergency medical patients.

We would ask the Trust to reconsider the possibility of achieving the separation of emergency and elective surgery while retaining both at the Maidstone site.

10. The committee notes that medical consultants at Maidstone Hospital have argued, through the local BMA division, that the removal of emergency surgery from the hospital will compromise the quality of clinical outcomes. They state that it is not uncommon for some patients to be admitted to A&E with symptoms indicating the need for medical intervention, but subsequently turn out to need surgical intervention. If the Trust's proposals are implemented, such patients will need to be treated elsewhere, leading, it is argued, to poorer outcomes – including a higher mortality rate.

11. The Trust has clearly stated that its plans do not involve the removal from the A&E department at Maidstone of emergency medicine – which accounts for the bulk of "blue-light" admissions.

    However, the committee heard at its meeting from consultants in emergency medicine at Maidstone Hospital that they feared the future of their specialty would be jeopardised. This, it was argued, was due to the anticipated consequences of removing emergency surgery, which is closely linked to emergency medicine.

    The committee notes that, while the Trust gave reassurances about the future of emergency medicine at Maidstone, it was stated that detailed plans to allow this still had yet to be formulated. The committee would expect such plans to be in place, and to be acceptable to the clinicians involved, as an important precondition of proceeding to the proposed reconfiguration.

12. The committee notes the apparent willingness of the BMA representatives at the meeting on 12 January to consider a compromise, involving the centralisation of emergency orthopaedic surgery at the Kent and Sussex Hospital, with emergency general surgery continuing to be provided at both Maidstone Hospital and the K&S.

    The Trust stated at the meeting that such a compromise would be unacceptable on clinical grounds. The committee would want to know in detail why this is the case and to be reassured that the Trust has explored this option fully before rejecting it.

13. The Trust has accepted that the poor road and public-transport connections between Maidstone and Tunbridge Wells will mean considerable inconvenience for some patients, as well as for the relatives and friends of patients who wish to visit them, if the proposed changes go ahead. However,

the Trust maintains that any inconvenience thereby caused is heavily outweighed by the clinical benefits of change.

The committee would contend that, since the purported clinical benefits of the proposals are clearly open to doubt, the inconvenience the proposals would cause to patients and the public can less easily be dismissed in weighing up the costs and benefits attached to options for change.

14. The committee notes that, as was apparent at the meeting on 12 January, there is clearly a sharp division in clinical opinion within the Trust (and beyond) on these proposals. Whilst the surgeons seem strongly in support of the changes, their physician colleagues (both medical consultants and general practitioners) are clearly overwhelmingly opposed.

The Trust appears to take the view that it has achieved adequate clinical engagement as the surgeons are supporting the proposals – and that, whilst the opposition of other clinicians is unfortunate, it is not possible to please everyone all the time. The committee takes the view that, whilst it is clearly unrealistic to expect complete unanimity among clinicians, the clear split between surgeons and physicians on these proposals greatly weakens the claim that there is proper clinical engagement.

The medical consultants argued on 12 January that, while the surgeons had been involved in formulating the proposals, the physicians had not – they were simply presented with a *fait accompli*. We are concerned that these proposals do appear to have been developed without reference to clinicians in a specialty on which they are bound to have a significant impact.

The views of GPs in Maidstone have also clearly not been taken into account in framing the proposals. These views were expressed on 12 January by the BMA's Dr Debbie Taylor, who stated starkly that "people will die" as a result of longer ambulance journey times if the proposals are implemented.

The committee believes that the Trust's claim to have adequate clinical engagement in respect of its proposals is not tenable. We would want to see evidence that the Trust has achieved full clinical engagement, involving physicians as well as surgeons, and primary-care practitioners as well as consultants.

Maidstone and Tunbridge Wells NHS
NHS Trust

Chief Executive and Chairman's Office
Maidstone Hospital
Hermitage Lane
Maidstone
Kent ME16 9QQ

Tel: 01622 – 226417
Fax: 01622 226416

5 February 2007

Mr Paul Wickenden
Overview and Scrutiny Manager
Kent County Council
Sessions House
County Hall
Maidstone
Kent ME14 1XQ

Dear Paul

Re: Response to KCC OSC reasons for rejecting proposals for orthopaedic surgery and emergency care within MTW NHS Trust.

Thank you for your letter setting out the reasons based on the evidence, written and verbal, as it was received by the NHS Overview and Scrutiny Committee for rejecting the proposals from MTW and West Kent PCT.

For absolute clarity the proposals are not about all emergency care at MTW, the proposals may affect some 5,000 out of 110,000 emergency patients seen and treated by MTW per year. The proposals relate to very specific services, orthopaedic trauma and emergency and planned surgery.

In general terms I would like to separate the issues of evidence and fact from anecdote and 'feel'. The clinical evidence against the proposals considered by the OSC must be subject to scrutiny. Clarity on the OSC process undertaken for this, given the 15 minutes taken to arrive at a decision, needs to be clearly understood. The list supporting the OSC minutes shows a wide range of items, some not related to consultation i.e. chronic pain services; some of which may have emerged through lack of understanding of the issues as I am mindful that only some 20% of the original cabinet members were at the OSC meeting and members also repeatedly advised that they felt they required independent medical advice to enable them to navigate the issues. Information and news was heard from a variety of individuals and organisations, much of which was not supported by clinical evidence and there was no opportunity for MTW to respond to issues or for the OSC to review clinical evidence or scrutinise any previous clinical evidence. Many of the points on the detailed list were never asked of MTW. Previously OSC has held its scrutiny process in a different way which seemed to provide members with greater opportunity for scrutiny and understanding of clinical evidence. It may be helpful for us to reconsider how to undertake this differently for the future.

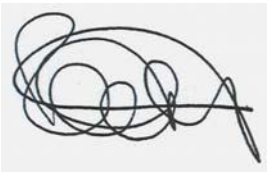
In particular, the reasons for rejection do not appear to correlate with the fact that there has been an effective and successful reconfiguration of services in East Kent, approved by KCG OSC, predicated on the same clinical principles of critical mass.

I have responded to your reasons for rejection point by point, this is set out on the attached. I recognise the merit of aligning the approval of these proposals with those of the 'Fit For Future' work as I voiced at the OSC meeting and I concede to the numerical error in the misrepresentation of 2,500 patients being affected (this was in fact the number modelled to divert to the Kent & Sussex Hospital). I am also well aware of the concerns regarding the inconvenience to carers and relatives of patients which we have never sought to conceal. It is vital that the OSC view is based upon the clinical evidence and we need to ensure you have the relevant information. These proposals have never been about saving costs, they are about securing the future viability of services but even if it were the case that these proposals would cost more, it would still be in the best interests of patients based upon the clinical evidence which consistently shows that:

- Improved clinical outcomes outweigh inconvenience for relatives and carers
- Outcomes are improved as a direct consequence of enabling sub-specialisation on both hospital sites
- The whole of Kent would benefit from having a new level 2 trauma service at K&S.

I hope the attached helps clarify the OSC points.

Yours sincerely



Rose Gibb
Chief Executive

Enc

Maidstone & Tunbridge Wells NHS Trust

Response to KCC OSC reasons for rejecting proposals for orthopaedic surgery and emergency care within MTW NHS Trust.

1. *The Committee feels the consultation document is not a balanced document for the proposed options and alternative proposals and fails to acknowledge the true balance of costs and benefits.*

Firstly this consultation and the drivers for change are not and never have been founded upon a need to save money. The fact that the proposals suggest a possible £2m saving in a full year is incidental and the amount is not material relative to the significance of clinical change and upheaval that is being proposed. Indeed there are options to address the need for change that save more money and if that was the key driver, proposals may be far more radical and far less palatable as indicated on page 7 of the document.

Beyond this, the basis for the view that the document is not balanced needs to be clarified. The need for change, the impact on surgical, orthopaedic, A&E and ambulance services and the benefits to patients are all set out in factual terms supported by questions and answers deliberately included to provoke challenge to the proposals with a view to bringing balance.

The document recognises that there are other options, these are expanded upon, described and assessed for impact and benefits from a clinical outcome perspective within a context of financial and clinical sustainability.

OSC needs to demonstrate where it sees imbalance and skewed presentation of facts within the document.

The factual inaccuracy in quoting 2,500 patients as being affected a year together with 12 patients per day clearly does not add up. 12 patients a day is the key number for those affected and this was reflected in later correspondence and at public meetings. 2,500 is the expected number within that who would be affected by being diverted to the Kent and Sussex hospital. It is important to remember that the figure of 12 patients a day is an estimate of attendances for assessment, not necessarily for admissions.

2. *Evidence that the optimal minimum catchment population for an acute hospital with full A&E capacity is interpreted to be 'less strong than has been asserted' and actually in a range from 500,000 down to 250,000.*

Firstly these proposals are not about changing A&E services at Maidstone Hospital nor the Kent and Sussex Hospital in Tunbridge Wells. The Trust has and will continue to support A&E services at Maidstone with the full range of 7 support services as recommended by the British Association for Emergency Medicine

i. Critical Care and 24 hour anaesthetic cover
ii. Acute general medicine
iii. Orthopaedics
iv. Paediatrics
v. General Surgery

vi. Imaging (X-ray/CT/Ultrasound)
vii. Laboratory Services including blood bank

[Ref. BAEM – "Securing Local Services": attached]

The BAEM expands on this in clearly stating "The College of Emergency Medicine and the British Association for Emergency Medicine strongly believe that in order to provide a safe service an Emergency Department requires 24 hour support by doctors skilled in level 3 critical care". Maidstone Hospital will continue to provide the 'must have' critical care / ITU services under these proposals.

Regardless of the above, on a point of accuracy, close scrutiny of the actual evidence submitted by the Trust (from the Royal College of Surgeons and the IPPR) shows 500,000 to be the optimal and preferred catchment population; 300,000 is described as a minimum acceptable catchment population recognising financial constraints may prevent optimal service design being implemented. The Trust would suggest that 'optimal' which is being proposed is preferred to 'minimum acceptable'. To suggest that 250,000 is entirely viable and workable is not supported by any national evidence.

The impact of an additional 10,000 homes in the Maidstone area has been modelled in detail and compared to existing population distribution maps *[See Map attached].* This has shown a potential need for 5 additional elective and 6 emergency beds across both hospitals to accommodate 270 additional emergency patients and 226 additional orthopaedic patients. This has been shared with external stakeholders and was part of the information pack at the stakeholder event inn November 2006.

The Trusts Clinical Strategy *[attached]* details plans for services across a catchment population of 500,000 it identifies core services and is predicated on 2 viable A&E Departments seeing at least 40,000 attendances per annum.

3. *It is suggested that the proposals are attempting to apply a one-size-fits-all template and that full account of detrimental consequences of centralisation have not been taken into account nor consideration of local factors including:*
   i. Population distribution
   ii. Facilities available in surrounding areas
   iii. Future Population growth
   iv. Transport connections

Without doubt, the Trust is not attempting to apply a strict "one size fit all" template. It is true that the Trusts position is not unique and therefore it is entirely appropriate to apply evidenced based models of best practice patient care that have been proven to work elsewhere. These have been tailored to offer a localised solution taking into consideration exactly the sort of local factors mentioned above plus the Trusts role as a tertiary care centre and the uniqueness of its services and geographical distribution of hospital sites. I would reiterate that MTW is one Trust. Significant local factors considered were the 'fixed points' agreed before considering any proposals which are:

- Must maintain 2 viable A&E Departments with at least 40,000 attendances per annum.
- Must sustain an unselected Medical 'take' at both hospitals

- Must ensure Maidstone hospital continues to be a tertiary centre for Oncology, co located with oncology surgery services
- Must recognise that Maidstone hospital is a surgical oncological resection centre serving a catchment population of 1.2m people.

- Other key factors considered were:
- The existing emergency care network in Kent and Medway
- The continuance of 23 hour surgery and provision of diagnostics at both hospitals

With regard to the specific local factors singled out by the Committee, Population distribution maps were overlaid with journey time maps; for example, this was the critical evidence that determined the 'reversal' option which would see emergency services centralised at Maidstone could not be the preferred option because of the disproportionately larger population that would be left with over 30 minutes journey time to a hospital with orthopaedic trauma and emergency surgery services. Journey time maps and population distribution maps are attached again for your reference. ***[See Population Distribution Map from point 2 above plus travel time distribution maps attached that were part of the information pack for the consultation workshop held in November]]***

Facilities available within the surrounding areas have been assessed and again the fact that facilities exist within the network of hospitals, Ashford, Medway, Dartford, Maidstone and the Kent and Sussex is a fundamental enabling fact to support the proposals.

Future population growth including the projected additional 10,000 homes in the Maidstone area has been extensively modelled as part of the Trust's long term planning for the PFI hospital at Pembury and this has been reconciled to growth projections undertaken as part of the Fit For Future work. In both instances, there is clear need for two vibrant acute hospitals, one each in Maidstone and Tunbridge Wells, however when set against the increasing ability to provide more healthcare services in non-acute settings more locally for patients, including emergency treatment, growth does not negate the need for change.

Transport connections were considered in detail in terms of modelling journey times to and from different hospitals and also from districts of residence to different hospitals as part of assessing the options in these proposals and also as part of the Fit For Future modelling. Consistently the relatively good connections from Maidstone supported the preferred options where the need for change must be met. It is a fact that road links between Maidstone and Tunbridge Wells are not the best; the Trust has never suggested otherwise and has been quite open on this point at public meetings. However, early results from an independent report on patient and ambulance travel analysis indicates an additional journey time of 11 minutes on average for the 12 diverted patients per day under the preferred options. This impact on travel times must be viewed consistently with those changes affected as a result of the earlier reconfigurations of urology and clinical haematology services as previously approved by the OSC. In the case of urology services, patients from Tunbridge Wells were affected in the reverse of these current proposals and in that case patients were required to travel to Maidstone themselves compared to relatives and carers or patients being transported by ambulance.

The OSC has previously supported changes to vascular services that led to increases in travel time of up to an hour in order to provide specialist care in the optimum way.

On this point it must be clearly understood that as a major tertiary care centre the Trust serves a very significant population, not just Maidstone.

4. *Extra journey time for patients risks compromising clinical outcomes ~ even as far as causing a higher mortality rate*

This is not supported by ambulance service evidence, specialist services experience or experience from national or local service reconfigurations as in East Kent. The Committee should substantiate the evidence upon which it has based this conclusion and advise as to why journey times would be considered more critical under these proposals than previous reconfigurations which the Committee has approved.

Clinical evidence points to the contrary on this point; patients with the most life threatening injuries and conditions, for example vascular and head injuries are routinely transferred across the County and beyond to get to most appropriate point of care to ensure the best possible clinical outcome. Roger Boyle, the National Director for Heart Disease was quoted by Sir George Alberti, the National Director for Emergency Access "long ambulance journeys do not lead to more deaths" **[Ref. Emergency Access – Clinical Case for Change: Report by Sir George Alberti, the National Director for Emergency Access]**

5. *No cast iron assurance that Ambulance service will be given sufficient extra resources as required*

At the time of the Trusts presentation to the Committee, findings from an independent report into the impact of travel times for patients and ambulances were not available; therefore no detailed robust assessment of resources could be described. Regardless of this both the Trust and West Kent Primary Care Trust made an unequivocal declaration in public that they shall ensure that Ambulance Service has the funding and resources that it requires under these proposals, it is entirely within their gift to ensure this. This commitment is recognised and accepted by Paul Sutton, Chief Executive Officer of South East Coast Ambulance Service NHS Trust. I am inclined to question the evidence relied upon by the Committee that tells it there is no commitment from Health Service partner organisations to ensure the ambulance service is not compromised.

Paul Sutton has confirmed in writing that his service "is able to support the clinically preferred options for the following reasons:

- A larger critical mass of staff, with 24 hour consultant led services will offer the safest care for patients
- Patients who receive definitive care at dedicated centres of excellence will ultimately receive better quality care
- Although patients may experience an increase in travel time as a result of the changes, it is our view that the impact will be mitigated if it means that the hospital they are taken to is able to deal with their problem straight away".

I would like to draw the Committee's attention to the fact that the ambulance service have been instrumental in this consultation, attending and speaking at stakeholder events, service planning meetings and public consultation events.

Paul Sutton identifies in his letter a lead time of six months to bring into operation any additional resources required by the ambulance service to address the impact of the proposals. I can confirm that such a lead time would be within any implementation timeframe if the proposals were to be agreed. *[Paul Sutton Letter of 5th January 2007 Attached]*

Early findings from the independent travel analysis (subject to ratification), suggest an average increased journey time of 11 minutes per patient; for the ambulance service to maintain its ability to respond to emergency calls within national target times, a vehicle needs to be available for an additional 4 hours per day. This is a maximum estimate using the most prudent vehicle utilisation rates and before considering off setting factors such as the continuing repatriation of specialist services from London hospitals to Kent hospitals, including Maidstone, which reduce the frequency ambulances are required to travel into London. The Trust, West Kent PCT and South East Coast Ambulance Service will continue to work together to ensure responsiveness of emergency services are unaffected.

6. *Not considered objections by Air Ambulance – lack of infrastructure inhibits their work*

It is important to note that the Air Ambulance service agree in principle with the proposals, most significantly that the best care for a patient is not necessarily the nearest care. The contribution of the Kent Air Ambulance is without question and it is recognised nationally (Sir George Alberti's report) that there is likely to be increased reliance over on air ambulances if the move towards increasing specialist care centres develops.

There is no ability to install a helipad at the Kent and Sussex hospital however there is one in the design for the proposed PFI hospital at Pembury. In the interim however, the flight time from above Maidstone hospital to Medway Maritime hospital, the County's only level 1 trauma centre, is believed to be some 2 minutes, in many events this time may be shorter still given that pick ups are from accident sites not from the hospital. It is agreed by all that the best outcomes are from specialist treatment given when a patient is taken direct to a treatment centre, with such a short flight time this must be preferred to the possibility of patients being flown to the Kent & Sussex hospital for example, only to then be transferred by road to a specialist centre to receive the treatment they need.

It should be remembered that the ambulances are still the first line response vehicles for accident and emergency; there is no evidence that suggests A&E services must be supported by air ambulance access.

7. *Rushing through changes ahead of & apart from FFF, Trust is suspected of trying to influence the outcome of "Fit For Future" by rushing through a pre-emptive decision on the reconfiguring A&E services*

The Trust accepts the Committees view that these proposals are delayed in order to be considered in context with proposals arising from 'Fit For Future' and that the Committee may wish to announce the outcomes of its decision in June therefore.

These plans have not however been rushed, nor are they an attempt to influence the outcome of 'Fit For Future'. The need for change has meant options and potential plans have been developed since 1999 and have formed a core component of the trust's clinical strategy which has been through numerous versions and clinical reviews to ensure clinically & financially viable & sustainable services. The Trust clinical strategy is underpinned by directorate service level strategies which have been developed by lead clinicians.

In 2005 the KCC OSC specifically advised that these options proposed should be considered.

To note, Fit For Future is a review of services led by West Kent Primary Care Trust, as is this consultation. The primary aim of the review was to look at and test different models of service provision and service distribution to ensure financial sustainability within the local health economy. The Trust and the PCT have worked very closely together to model potential scenarios for change ensuring a consistency of objectives in service redesign with 'Fit For Future' and these proposals. There is no evidence to suggest these proposals are inconsistent with the principles of 'Fit For Future'.

8. *Not convincingly reassured that other Trust's A&E departments can take displaced activity*

It is worth reiterating that this is in the order of 12 patients or less a day. 65% of these patients (approx. 2,850 per annum), are expected to go to the Kent & Sussex hospital which we will be developing to accommodate extra activity as part of developing it as a specialist trauma centre. 35% (approx. 1,530 per annum) would go to Medway Maritime hospital (less than 2 pts per day on average) & Ashford (less than 2.5 pts per day on average). This would not constitute a step change in activity they could not accommodate; activity currently fluctuates well beyond these ranges on a daily basis without compromising patient care.

'Payment by Results', the national funding mechanism for the NHS, will ensure those providers are paid for the treatment they provide ensuring services and capacity can be invested in as required.

9. *No evidence that separation of elective from NEL cannot be done on same site and that proposals include an imperfect separation of elective and emergency services patients at Maidstone.*

The Trust needs to understand what the Committee understands to be an imperfect separation of patients within the proposals.

With regard to existing arrangements to separate elective from emergency patients at Maidstone, there is a very significant difference between the improvements that can be offered to patients from the current 12 bedded unit, too often occupied by emergency medical admissions compared to multiple ring fenced 28 bedded elective wards, the two scenarios are not comparable. It is only with that scale of separation that the full benefits to patients may be seen:

	Incidence	Impact of Specialist Centre
Cancelled operations	1,000 a year	could reduce by 90%
Litigation cases arising from missed diagnosis or poor surgery	29 over the past 3 years	could reduce to almost zero
Hospital acquired infections (MRSA & C.Diff) – Elective Patients	105 over 12 months	could reduce to almost zero
Complaints	165 over 12 months	could reduce by 50%

To achieve such separation on one site would require a new build, and it would require an additional 8 consultants, 4 at each hospital plus junior medical teams and support which is simply not an option financially and clinically there is insufficient work to support this level of workforce. This would also run into difficulties with clinical issues arising from doctors not seeing enough patients, a point accepted by the Committee.

The evidence to support the need to separate elective from emergency surgery underpins the operating list guidance and criteria for improved mortality rates in the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports. *[See summary reports sheet attached]*

10. *Removal of emergency surgery from Maidstone hospital will compromise the quality of clinical outcomes for medical patients admitted who then require surgical intervention; patients will need to be treated elsewhere, leading to ~ higher mortality rates.*

Emergency medicine will benefit from improved direct access to specialist units (medical assessment units) rather then to the traditional A&E environment (as is the case for Obstetric emergencies).

Maidstone hospital will be supported by the full range of sub specialised surgeons available 24 hours a day 7 days a week; there will be continuing GP support, a full 'Hospital at Night', emergency urology and ITU. It is hoped that this will be further enhanced with a county wide 24 hour urology service at Maidstone.

It is worth noting the BAEM paper 'Securing Local Services' which quotes "a significant minority (of surgical admissions) will require an (emergency surgery) operation". This supports the view that the need is for a surgical opinion, which the proposals will ensure is available. A recent audit at the Trust found that 20% of patients had not been seen by a consultant within 24 hours of admission; a further number had not been seen within 3 days of admission. The proposals for support to emergency medicine would significantly improve on current services.

Again it is not clear how the Committee can evidence that these proposals will lead to poorer clinical outcomes and higher mortality rates when actual evidence to the contrary can be seen from the experiences at East Kent Hospitals and from national evidence to be found through the following sources:

Institute for Public Policy Research

www.ippr.org

Department of Health Publications
www.dh.gov.uk/publications

Royal College of Surgeons
www.rcseng.ac.uk

British Association for Emergency Medicine
www.emergencymed.org.uk/BAEM/

College of Emergency Medicine
www.emergencymed.org.uk/cem/

British Orthopaedic Association – (Ref. for Trauma Care Standards)
www.boa.ac.uk

11. *The Trust has not produced detailed plans that show that emergency medicine at Maidstone is assured & wholly beyond doubt.*

At no time has the Trust been asked to produce detailed plans to this effect. I would refer you to the Trusts clinical strategy which is predicated on two vibrant hospitals, both with acute medicine, acute stroke units and 2 cardiac angiography units. This is evidenced by the investment in the establishment of cardiac catheterisation labs at both sites and stroke units at both sites, a strategy led by and signed off by Dr Thom and Dr Reynolds of MTW. In January of 2007, the design drawings for the Maidstone Cath Lab were signed off by the medical consultants, it is now expected to be operational from 2008 and the Trust has received confirmation of the necessary capital funding from the Strategic Health Authority.

Assuring the future of any service at any particular location "wholly and beyond doubt" is at best improbable. Increasing plurality of provision among providers of NHS healthcare services, together with new drug and therapeutic technologies allowing more care to be delivered by the primary care sector for example will continue to make traditional physical boundaries of service location harder to sustain. For the avoidance of doubt the Trust has no other plans for medical services within the Trust.

The Trust will be happy to present its detailed implementation plans if and when proposals are accepted. We will do this in the summer prior to changes being made.

12. *The Committee requires assurance that proper consideration has been given to the option of centralising Orthopaedics at Tunbridge Wells but retaining emergency surgery at both hospitals.*

This option has been considered in detail and was rejected for a number of reasons, fundamental when considering the need for change. Importantly the Trust has never claimed this option to be "unacceptable on clinical grounds", primarily the Trust simply does not have enough surgeons for both which means it is unable to deliver the requisite sub-specialisation now required for the best surgical outcomes. To afford more surgeons would then lead to the situation of doctors 'de-skilling' through

not seeing enough patients. Critically whilst this solution addresses the issues for orthopaedics, it does not solve the issues facing surgical services, namely:

- Emergency patients not seeing senior surgeons in an emergency
- More doctors will be needed in the future as European Working Time Directives reduce the number of hours they can work, but even if they are available, bigger teams of specialists will not see enough patients individually to maintain their skills
- Longer emergency responses are resulting in patients potentially needing longer in hospital to recuperate
- Patients not always assessed and having their care planned out by a senior surgeon
- Patients having their pre-booked operations cancelled on the day of surgery due to emergencies taking precedence
- Pre-booked patients screened for infections finding themselves on a ward next to emergency surgical patients who have not been screened, raising the risk of cross infection.
- Long delays to take emergency patients to theatres

The fact that the case for centralising orthopaedic trauma is accepted by the Committee compels the Committee to accept the case for centralising emergency surgery. The BAEMS state that the need for specialist emergency surgery, often for the most sick patients is more evident than that for orthopaedics. If surgery were to be retained at both sites and emergency and elective care separated at both sites we revisit the position that such separation requires new build capacity the Trust does not have and which it does not need if separation of services can be delivered within the proposals put forward.

As previously mentioned, the proposal to centralise emergency surgery at the Kent & Sussex hospital rather than Maidstone was the preferred option based upon geography and travel time impacts together with the impact on oncology services at Maidstone and the associated specialist elective oncology surgery that is undertaken there.

13. *Insufficient weighting has been given to inconvenience for patients – given that the "purported clinical benefits of the proposed changes are open to doubt"*

I would categorically disagree that clinical benefits are open to doubt. The clinical evidence base, 100% of surgical and orthopaedic clinicians in their field, the Royal College of Surgeons, the British Association of Emergency Medicine, the Institute of Public Policy & Research and international evidence all support the proposed changes on the grounds that they deliver clinical benefits to the patient population served by the Trust.

The Trust recognises the inconvenience to relatives and their carers, the Trust has never sought to conceal this or down play it. However for patients, the evidence does support improved outcomes and the ambulance service and the air ambulance service have supported the principle that extended journey times are outweighed by the clinical benefits of being treated in a specialist centre, a practice that is routinely undertaken for some of the sickest patients in the county. Sir George Alberti, National Director for Emergency Access captures the essence of this in his quote "We will have to continue to ensure that the ambulance services can all offer 'hospital

on the move' support to patients". I would suggest that being in the care of trained paramedics being conveyed to a specialist centre that may be on average 11 minutes further drive time away would not be considered an inconvenience.

In recognising the potential inconvenience to relatives and carers, the trust is looking at the possibility of extending its voluntary car service for those with insufficient funds.

14. Failed to secure adequate clinical engagement esp. physicians & GPs – "medical consultants & GPs are clearly overwhelmingly opposed"

The Trust has actively sought to engage with clinicians, consultant physicians and GPs amongst other key stakeholders from the outset of this process. Events held internally & externally dating back to 1999. An example of the level of engagement is shown attached with a record of the Trust Management Board meeting held at the Hop Farm in June together with a list of attendees plus minutes of a meeting of the Trust's Consultant Committee at which key clinicians were present. In addition I have attached a letter that was sent to all Consultant staff within the Trust which invited 1:1 meetings or group meetings with me to discuss the proposals. *[See Attached]*

A key piece of evidence to substantiate this is the Trusts Clinical Strategy which is built upon directorate level strategies for the component services offered by the Trust. These Directorate strategies were developed and signed off by the clinical directors and lead clinicians themselves, the best example of this is the Stroke Strategy, which was clinically led and ultimately shaped and signed off by Drs Thom and Reynolds.

It is worth noting that as an 'opposer' to the proposals / the preferred option, Dr Thom had issue solely with the need to ensure appropriate surgical support for medical patients, he does not disagree with the need for change. Similarly Dr Soorma does not dispute the need for change, the option that he put forward to reduce A&E services at Maidstone to just 12 hours a day was rejected as that cessation of services for 12 hours would lead to a run down of all emergency services at Maidstone hospital.

The Trust has not "shut out and sidelined" consultant physicians and GPs. All have been communicated with and actively pursued for engagement and their comment. Invites, written & verbal, happened to be rarely taken up by these groups even with a months notice of meetings arranged at mutual convenience.

I would request that the Committee shares the evidence of the "overwhelming opposition" from the whole population area that the Trust serves.

Much of the evidence detailed above as 'attached' was included in the consultation workshop packs for the November event. For completeness I have also enclosed the balance of those packs which includes the option assessment criteria and results for example. *[Attached]*

Chief Executive and Chairman's Office
Maidstone Hospital
Hermitage Lane
Maidstone
Kent ME16 9QQ

Tel: 01622 – 226417
Fax: 01622 226416
26 February 2007

Paul Wickenden
Overview and Scrutiny Manager
Overview and Scrutiny Committee
Kent County Council
Sessions House
County Hall
Maidstone
Kent
ME14 1XQ

Dear Paul

I am aware that the Overview and Scrutiny Committee is reviewing once again its position on the consultation and wishes to determine whether there has been any further debate, discussion and movement.

Since the Overview and Scrutiny Committee meeting I have met with Messrs Thom, Hulse and Soorma. All are in agreement that the need for change is evident. There are two main concerns that emerge:

1. The guarantee of support to Emergency Medicine on the Maidstone site; and
2. the staffing structure within A&E services on the Maidstone site; although all recognise that this point was never a subject to consultation, but it is in some ways linked to the support that can be given to acute medical services.

I attach for your information a copy of a letter concerning the agreed way forward and I am writing to formally advise the Overview and Scrutiny Committee of the way forward which I believe satisfies the above issues.

1. There is recognition that the greatest consolidation of surgical expertise will remain on the Maidstone site if service reconfiguration is successful. This is because at any given time eight consultants will be based on the Maidstone site in surgery undertaking elective surgery, emergency surgical clinics and day surgery, and providing an on-call that supports the Maidstone site. I believe we all recognise that this is a significant increase in expertise on the Maidstone site from the current arrangements and through protocols and the order of those protocols we will ensure timely surgical opinion to medical inpatients occurs. I believe all recognise all believe this would be an appropriate way forward.

2. A&E staffing. We recognise that there is a group of patients who will present to A&E who will require medical assessment beyond those who are referred by GPs. I have agreed to personally intervene to review the staffing structure and ensure the presence of medical support for a minimum of 12 and up to 18 hours of appropriate specialists in A&E. This would support the medical assessment unit which will be staffed by physicians and ensure appropriate assessment of patients presenting to A&E who may not have previously been assessed by a GP and who require inpatient admission.

The details of the above clearly need to be worked through and this will take some weeks and I am committed to presenting those details prior to implementation of service reconfiguration should West Kent PCT Board support the proposal.

I think it is also important for the Overview and Scrutiny Committee to understand that if service reconfiguration proposals move forward this allows:

1. the reorganisation of our estate to deal with very significant patient safety and privacy and dignity issues enabling us to develop single sexed environments where nightingale wards exist;
2. the removal of beds in cramped conditions;
3. the development of an acute stroke unit, in the first instance at Kent & Sussex followed by Maidstone;
4. the development of high dependency facilities at both hospital sites; and
5. greatly improving our infection control capability.

I enclose for your information a Board paper demonstrating the range of moves across departments that we will be able to make if service reconfiguration is successful.

I hope the attached is helpful in the Overview and Scrutiny Committee considering the wider implications of these plans for patient safety at a variety of levels.

Yours sincerely

For and on behalf of
Rose Gibb
Chief Executive

Cc: Steve Phoenix
CEO
West Kent PCT

Chris Thom
Consultant
MTW

Mr Steve Phoenix
Chief Executive
West Kent Primary Care Trust
Wharf House
Medway Wharf Road
Tonbridge
Kent TN9 1RE

Members' Suite
Sessions House
County Hall
Maidstone
ME14 1XQ
Tel 01622 694434
Fax 01622 694212
Email: members.desk@kent.gov.uk

9 March 2007

Dear Steve

A NEW DIRECTION FOR SURGICAL AND ORTHOPAEDIC CARE

We refer to our letters dated 29 January and 2 February, in which we set out and discussed with you the reasons for the County Council NHS Overview and Scrutiny Committee rejecting the consultation proposals in "A new Direction for Surgical and Orthopaedic Care" at its meeting on 12 January 2007. We have been in dialogue with the Primary Care Trust and representatives of the Maidstone Division of the British Medical Association.

As the political group spokesmen for the NHS Overview and Scrutiny Committee, we are writing to express the view of the Committee (agreed when it met today). We welcome the ongoing dialogue and the emerging compromise on this issue. However, the Committee is not yet sufficiently satisfied to withdraw its rejection of the proposals. On behalf of the Committee, we would seek further written clarification from the West Kent Primary Care Trust, and the Maidstone and Tunbridge Wells NHS Trust regarding the following issues:-

(1) The status and staffing of the A&E Department at Maidstone – we seek assurances that the department will continue to be staffed by specialist emergency-medicine doctors under A&E consultant leadership.

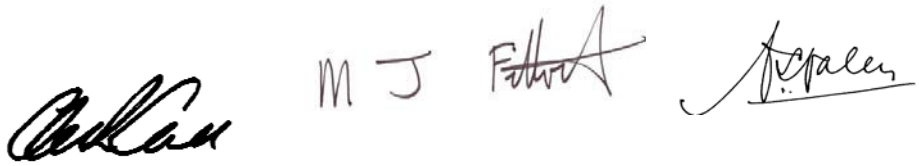
(2) Acute general surgery provision at Maidstone – we seek assurances that emergency medicine will be supported by unlimited access to a surgical opinion; and that at least some emergency general surgery provision will continue.

(3) Provision for orthopaedic trauma at Maidstone – we seek assurances that an urgent orthopaedic opinion will be available; and that there will be the capacity to receive orthopaedic trauma cases requiring in-patient care in order to stabilise them so they can be transferred elsewhere as appropriate.

We would ask that the contents of this letter be drawn to the attention of the West Kent Primary Care Trust Board when it meets on Thursday 15 March.

We await the outcome of the PCT Board's deliberations with interest and look forward to continuing the dialogue.

Yours sincerely



Alan Chell **Mark Fittock** **Dan Daley**
Chairman **Vice Chairman** **Liberal Democrat Spokesman**

NHS Overview and Scrutiny Committee

Cc: Rose Gibb

James Lee

Maidstone and Tunbridge Wells NHS
NHS Trust

Chief Executive and Chairman's Office
Maidstone Hospital
Hermitage Lane
Maidstone
Kent ME16 9QQ

Tel: 01622 – 226417
Fax: 01622 226416

13 March 2007

Alan Chell, Chairman
Mark Fittock, Vice Chairman
Dan Daley, Liberal Democrat Spokesman
NHS Overview and Scrutiny Committee
Kent County Council
Members' Suite
Sessions House
County Hall
Maidstone
Kent ME14 1XQ

Dear Alan, Mark and Dan

A New Direction for Surgical & Orthopaedic Care

Thank you very much for a copy of your letter of 9 March to David Griffiths, Chairman, West Kent Primary Care Trust.

I am responding to the points in your letter seeking clarification and assurance on three key issues. I confirm the assurance as follows:

1. *The Status and staffing of the A&E Department at Maidstone – we seek assurances that the department will continue to be staffed by specialist emergency-medicine doctors under A&E consultant leadership.*

   We can confirm that the A&E Department at Maidstone will be staffed by Medical Staff and the proposal is as per the BMA recommendation that this is undertaken by A&E specialist staff for between 12 and 15 hours per day with acute general physicians supporting services out-of-hours. I can confirm that the A&E medical staff will continue under A&E Consultant leadership and that both Maidstone and Kent & Sussex A&Es will continue under single Clinical Directorship.

   I enclose for your information copies of correspondence to staff that have raised these concerns to demonstrate the commitment.

2. *Acute general surgical provision at Maidstone – we seek assurances that emergency medicine will be supported by unlimited access to a surgical opinion; and that at least some emergency general surgery provision will continue.*

   I can confirm that the greatest proportion of surgeons with sub-specialist interest will be based at Maidstone. They will provide an emergency on-call rota and this emergency on-call rota will support the totality of services at the Maidstone site. This will ensure unlimited access to a surgical opinion and the full range of sub-specialist expertise.

With respect to emergency surgery I can confirm that any elective patient who has had surgery on that site who deteriorates will, if it is clinically appropriate, have any further emergency surgery on that site.

Additionally, in the rare circumstance that anyone should present into A&E with a clinical emergency which it is believed cannot be stabilised and transferred, then naturally those patients would also receive surgery at Maidstone.

3. *Provision for orthopaedic trauma at Maidstone – we seek assurances that an urgent orthopaedic opinion will be available; and that there will be the capacity to receive orthopaedic trauma cases requiring in-patient care in order to stabilise them so they can be transferred elsewhere as appropriate.*

   Elective orthopaedics (until 2010), day case orthopaedics, outpatients and fracture services will continue on the Maidstone site. This will enable the full provision of urgent orthopaedic opinion to be made available. The service model as proposed always envisaged that in the event a patient with an orthopaedic injury should arrive at Maidstone A&E, we would stabilise, treat and transfer that patient, and this we regard as our duty of care. It must be noted that we continue with this duty of care for any and every patient who presents at either Kent & Sussex or Maidstone A&E services irrespective of service reconfiguration. You may be aware that we already undertake this duty of care, for example, for emergency vascular patients at both our hospital sites where we stabilise, treat and transfer those very critical emergency patients. We do not envisage that there will be any change to our ability to do this for either surgical patients or orthopaedic patients in either the current or proposed service model.

As I have already said I am very happy to meet with you again with clinical colleagues who could help you to understand these pathways. It is important that we understand that these changes, if agreed, will continue to support the bulk of the current workload in A&E services, i.e., some 55,000 of the current 60,000 who attend with the ability to treat, stabilise and transfer anyone else who presents irrespective of whether we have those specialist services available or not in either of the hospitals at Maidstone or Kent & Sussex.

Yours sincerely

Rose Gibb
Chief Executive

Cc: Paul Wickenden
KCC Overview & Scrutiny Committee

David Griffiths
Chairman
West Kent PCT

Steve Phoenix
Chief Executive
West Kent PCT

James Lee
Chairman
Maidstone & Tunbridge Wells NHS Trust

A copy of this letter was also sent to Mr David Griffiths the Chairman of West Kent PCT

David Griffiths
Chairman
West Kent PCT
Wharf House
Medway Wharf Road
Tonbridge
TN9 1RE

Members' Suite
Sessions House
County Hall
Maidstone
ME14 1XQ
Tel 01622 694434

14 March 2007

Dear David,

Thank you for sending us a copy of the report on the reconfiguration proposals put forward by the Maidstone and Tunbridge Wells NHS Trust which the County Council's NHS Overview and Scrutiny Committee has objected to. We were disappointed to read that the 14 reasons for rejecting the proposals were not referred to in the report or the ongoing dialogue we have had with Steve to achieve a local resolution.

Equally we were disappointed that our letter to you dated 9 March 2007 has not been specifically referred to in the report. We appreciate that in introducing the report for the Board's consideration the NHS Overview and Scrutiny Committee's views and the ongoing process to seek a formal resolution might be referred to including the assurances we have received from Rose set out in her letter dated 13 March 2007.

Finally we noted one of the recommendations is to undertake further work on the establishment of a pain clinic. For Maidstone this would be the re-instatement of a pain clinic. We believe a pain clinic is essential and would seek the Board's assurance that this will be provided.

Yours sincerely

Alan Chell **Mark Fittock** **Dan Daley**
Chairman **Vice Chairman** **Liberal Democrat Spokesman**
NHS Overview and Scrutiny Committee

West Kent NHS
Primary Care Trust

Report on the outcome of the consultation on "A New Direction for Surgical and Orthopaedic Care"

Executive Summary

1. West Kent PCT (The PCT) and Maidstone & Tunbridge Wells (MTW) NHS Trust, consulted with the public on the proposed reconfiguration of Orthopaedic and General Surgical services between the Maidstone Hospital and Kent & Sussex Hospital during the period from the 9th October to 8th January 2007. This paper sets out:

    a. The strategic context
    b. The case for change
    c. The proposal for change
    d. The evidence in support of the proposal
    e. The process of consultation
    f. The outcomes of consultation
    g. The themes emerging from the consultation
    h. Conclusions
    i. Recommendations to the Trust Board

2. Nomenclature relating to clinical services, which has been used within this paper, has been explained in Appendix 1.

The strategic context

3. Hospital services across Maidstone and Tunbridge Wells have evolved over time. Proposals to modernise clinical services have been subject to a series of consultation exercises. These latest proposals represent a further stage in a continuum of development of services agreed between the PCT and the Trust that provide:

    a. Ambulatory care as close to home as possible, including in non-hospital care settings
    b. High cost or low volume care organised using a "hub and spoke" model, to ensure critical mass at the hub and local access at the spokes(s)
    c. Specialist services consolidated in single centres of excellence

The case for change

4. MTW trust has two main objectives:

    a. **To improve clinical safety** by
        - Saving more lives of patients presenting with complicated surgical conditions. Using litigation cases as a proxy measure of this, there have been 17 orthopaedic and 12 general surgical cases of missed diagnosis or

poor surgery in the previous 3 years which is thought could be reduced to almost zero, if the changes were to be implemented.

- Cancelling fewer operations. Currently, mixed scheduling of emergency and planned patients exists on the same theatre list. Planned patients are often cancelled (292 orthopaedic patients and 471 general surgical patients in the past 3 years) because a more serious emergency case unexpectedly arrives. It is thought that this could be reduced by up to 90% if the changes were to be implemented.
- Reducing the risk of infection. By segregating planned patients from emergency patients, the likelihood of contracting an infection is lowered. Hospital Acquired Infections (MRSA and C.Diff) have in the past 12 months run at 48 cases in orthopaedics and 57 cases in general surgery. It is thought that this could be reduced to almost zero for planned cases if the changes were to be implemented.
- Ensuring the patient sees the right specialist at the right time, in the right place, every time. At present there is inadequate, less than 24-hour consultant cover in both surgery and orthopaedics at both Maidstone and Kent & Sussex hospitals. This will be addressed if these changes were to be implemented.
- Reducing complaints. In the past 9 months, 76 complaints relating to orthopaedics and 48 complaints relating to general surgical have been received. It is estimated that this could be reduced by 50% if the changes were to be implemented.

b. **To assure clinical sustainability**, by

- Creating safe, modern trauma services covered by specialists 24 hours a day, serving a sufficiently large population to satisfy national critical mass standard requirements if the changes were to be implemented.
- Supporting training with good supervision and sustain the development of specialist skills, such as in the performance of surgery on the stomach.
- Increasing the ability to manage complex cancer and complex surgery and bring new skills locally e.g. minimally invasive (or keyhole) & pelvic surgery
- Strengthening clinical networks in services that are critically allied or complex, such as in Upper GI surgery and in complex cancer surgery.

The proposal for change

5. Leading up to the generation of the options was a clinically led, two-year clinical engagement process, designed to frame a safe and effective clinical strategy.

6. This led to MTW holding a significant consultation event held with its clinical, managerial and service staff at the Hop Farm in June 2006. Participants included surgeons, physicians, A&E staff, nurses and managers. Staff considered 20 scenarios for service reconfiguration in 5 work streams for Orthopaedics, Surgery, Medicine, A&E and Women & Children's' services. A clinically preferred option for surgery and orthopaedics emerged from this event, and when the consultation exercise began on the 15th October, the consultation document presented seven options for change, 4 relating to general surgery (of which Option 1 was the clinically preferred option) and 3 relating to orthopaedics (of which Option 6 was the clinically preferred option). See Table 1.

7. On the 30th November 2006, during the consultation period, a Local Health Community LHC "Option Evaluation Workshop" was held at East Malling Research Centre. The options were expanded by one to include an additional option requested by a member of the public at an earlier meeting. This was the reversal of the clinically preferred options with all emergency orthopaedics and surgery at Maidstone, and planned orthopaedics and surgery at Kent & Sussex. Participants agreed a set of criteria for evaluating the options and then scored all 7 options against these. This confirmed that the preferred options for surgery (Option 1) and orthopaedics (Option 6), generated at the Hop farm event were considered to be the preferred options for the LHC.

Table 1: Options for reconfiguration of surgical and orthopaedic service between Maidstone and Kent & Sussex Hospitals

Maidstone = M, Kent & Sussex = K&S

Service	**Type**	**Currently At**	**Options for Change**							
			1**	**2**	**3**	**4**	**5**	**6****	**7**	**8**
General Surgery	Planned	Both Sites	M only	M only	M only	K&S only				K&S only
	Emergency	Both Sites	K&S only	M: daytime only K&S	M only	K&S only				M only
	Day cases	Both Sites	No change	No change	K&S only	M only				No change
	Outpatients	Both Sites	No change	No change	No change	No change				
Ortho-paedics	Planned	Both Sites					K&S only	~~K&S~~ M only	K&S only	M only
	Emergency	Both Sites					M only	K&S only	K&S And M on a 12 hr A&E model	M only
	Day cases	Both Sites					No change	No change	No change	No change
	Outpatients	Both Sites								
***Score against criteria			***534	353	288	255	449	***534	369	357

** = MTW Trust's preferred option, which was agreed as the Local Health Community's preferred option

*** = criteria for scoring:

Improved patient experience and outcome
Reduction of clinical risk
Improvement of patient safety
Reduction in the likelihood of a cancelled operation
Preferred impact on staff
Deliverability
Improved access
Impact on other health and social care organisations
Affordability

8. The net effect of the preferred options would be:

Maidstone	Kent and Sussex
• Maidstone would remain as a site dealing with all types of A&E patients, **except** general surgical and orthopaedic patients brought in by ambulance. • Maidstone would deal with **ALL** planned inpatient and day case procedures performed by the Trust. • Patients who self-referred to Maidstone would be seen, treated and if required, transferred to Kent & Sussex, William Harvey, Medway, Darent Valley hospitals. • General surgery and orthopaedic outpatients would continue.	• Kent and Sussex would deal with **ALL** types of A&E patients. (note: except paediatric medical patients, as exists now). • Kent and Sussex would deal with planned inpatient and day case procedures performed by the Trust **except** planned inpatient general surgery and orthopaedics. • General surgery and orthopaedic outpatients would continue.

9. These changes are expected to deliver the following benefits

   a. To provide full 24/7 presence of on-site surgical teams that can assure clinical safety.
   b. Achieve shorter emergency response times because of on-site senior surgical presence
   c. Provide dedicated theatres, wards and surgical staff for elective operations that would not need to be cancelled because of competition with emergency needs
   d. Help to reduce the risk of cross infection by separating emergency and elective patients
   e. Have the minimum impact on other services at Maidstone Hospital and could be supported through the emergency network of Medway, Darent Valley, William Harvey and Kent & Sussex Hospitals
   f. Support the changes to the reducing numbers of doctors in training
   g. Create a specialist emergency surgical centre
   h. Provide surgeons with a critical mass of patients to keep up their skills, develop new ones and sub-specialise.
   i. Best meet the needs of the population served.

10. This is expected to change patient flows as follows:

Type of patient	Change at Maidstone – per week	Change at Kent & Sussex – per week	Change at Other hospitals – per week	Total Per week
Surgical and Orthopaedic planned patients	+ 20	-20	none	20
Surgical and Orthopaedic emergency patients	-84	+ 49	+ 21 Ashford + 7 ~~William Harvey~~ Medway + 7 to Darent Valley or Bromley	84
All other services	No change	No change	No change	-
All other services	No change	No change	No change	-
Weekly Net change	**- 64**	**+29**	**+ 35**	**104**
Daily Net change	**- 9**	**+4**	**+ 5**	

11. The creation of a specialist surgical centre and trauma centre are consistent with the PFI. The costs of achieving this reconfiguration will be delivered within the MTW financial envelope and capital programme. Under a joint agreement, potential costs associated with the changes that might affect the South East Coast Ambulance service, which are considered to be negligible, will be funded by the annual uplift to the contract. It is thought that the changes will avoid payment of £2m, which would otherwise have been required to fund the unsustainable and clinically unsafe double-running of services on two sites.

The evidence supporting the proposals

12. Common conclusions of relevance in support of this reconfiguration proposal are listed below.

13. In support of a clinical service model that maintains general medical services associated with A&E departments that have different levels of :

    a. **access to short-stay in patient** beds to diagnose, assess and treat undifferentiated patients (a patient who arrives at an A&E department, without having been seen by a clinically qualified referrer) on a short stay basis,
    b. and **access to urgent opinion**, in the British Association for Emergency Medicine BAEM, “The Way Ahead” 2005, the president of the Association acknowledged the essential relationship between practitioners of emergency medicine, acute medicine, and support from other specialties:

"Emergency Medical practitioners have a specific role in the initial assessment and management of the undifferentiated patient……where many patients will present with less typical symptoms which require a period of focused investigation in the emergency department or clinical decision unit/observation area after which many of these patients can be safely discharged home…..For those hospitals with new patient attendances of greater than 40,000 per annum, the principles for Emergency Departments are….immediate access to intensive care, anaesthetics, acute medicine, general surgery and orthopaedic trauma….""

14. To counteract ay notion of downgrading of hospital sites caused by reconfiguration of specialist services, in March 2006, the Report of the National Leadership Network Local Hospitals Project (whose aim is to set out a sustainable future vision for all hospitals) stressed the importance of *every* hospital having to be an active member of multi-hospital networks, with local innovation providing sustainable solutions and that different local circumstances would increasingly result in different service configurations. This would imply that no matter what changes were proposed, both Maidstone and the Kent & Sussex hospitals would still be seen as "an active member of multi-hospital networks"

15. To endorse the suggestion that the separation of planned and emergency surgery as being a more efficient and effective model for the delivery of care, the March 2006 consultation document from the Royal College of Surgeons of England Reconfiguration Working Party "Delivering High-quality Surgical Services for the Future" said:

"Elective inpatient surgery is often better carried out independently of emergency provision in order to minimise disruption to both services."

16. In regard of reconfiguration to achieve essential critical mass, this same report said;

"*The preferred catchment population size, as recommended in previous reports, for an acute general hospital providing the full range of facilities, specialist staff and expertise for both elective and emergency medical and surgical care would be 450,000 – 500,000. It is estimated that hospitals of this size count for less than 10% of acute hospitals in England. This size of hospital would produce very large numbers of medical admissions each day and they are likely to be located a significant distance away from patient's homes, family and social services contacts. It is unlikely that there is going to be a significant shift to this size of hospital in the short to medium term. The majority of acute hospitals currently have and are likely to continue to have a catchment population of approximately 300,000. Some rural populations do not even reach this population mass and yet are still required to provide as full a range of services as possible. Such units have a particularly difficult task in providing services that are local, safe, and cost effective. There needs to be , in the first instance strategically planned re-organisation so that, where feasible , smaller hospitals are able to merge to achieve a catchment population of at least 300,000."*

17. In support of the desire to co-locate specialist services and assure clinical safety, in September 2006, an interim paper in the Future Hospital project was published by the Institute for Public Policy Research IPPR, "Hospital Reconfiguration: ippr briefing" which made the following points:

"Acute care, like Accident and Emergency (A&E) and specialist surgery, needs to be concentrated in fewer locations so that doctors with the right skills, experience and equipment are available to treat the sickest patients safely…..(This) paper does not argue for concentration of all hospital services onto fewer larger sites. The primary objective for concentrating specialist services is to facilitate the safe performance of surgery. This is of course an important objective and one that has not been adequately communicated by political , management or clinical leaders. However using hospital to population ratios is only one way of illustrating the problem, rather than the blueprint for reconfiguration"

18. In making the clinical case for reconfiguration and mitigating the need for additional travel times, Professor Sir George Alberti the National Director for Emergency Access published a report " Emergency Access: clinical case for change" December 2006, and said:

" In a range of very serious emergencies, from strokes and heart attacks to aortic aneurysms, it may be better for patients to bypass the nearest local hospitals and be taken by highly-trained paramedics straight to specialist centres with the equipment, knowledge and experience - gained through treating many similar patients needed to save lives"

THE PROCESS OF CONSULTATION

19. The PCT and MTW agreed to launch a public consultation exercise on proposed changes to the location of some orthopaedic and surgical services between the Maidstone and Kent & Sussex at Tunbridge Wells Hospital sites. The consultation period began on Monday 9th October and ran for 12 weeks until 8th January 2007.

20. Due to the transition to the new West Kent PCT responses to the consultation were collated by MTW. To assure independence of analysis the PCT conducted a meta-review of both the process of the consultation and the analysis of feedback received. See appendix 2.

21. During the consultation period a number of engagement strategies were adopted, including:

- Distribution of 3,937 consultation documents with feedback questionnaire – 134 completed questionnaires were returned
- Additionally the consultation document was available on the Trust's website.
- Public meetings – c. 300 participants attended, >66% from the Maidstone area
- Presentations were made at 11 local groups, including local council meetings, patient representative groups, Local Medical Committee, BMA and other interest groups – C. 300 participants
- Discussions with staff in both open meetings and specifically with medical and therapy staff
- Regular meetings with the Kent County Council Health Overview and Scrutiny Committee (HOSC)

THE OUTCOMES OF CONSULTATION

22. The analysis of the outcome of consultation has been attached at Appendix 2.

23. Formal responses were received from:

- Kent County Council HOSC
- Maidstone division of the BMA
- Patient & Public Involvement Forum – South West Kent & Maidstone Localities
- Maidstone Borough Council External Scrutiny Committee
- Tonbridge & Malling Borough Council
- 12 parish councils
- Maidstone Department of Medicine plus 1 A&E consultant
- All orthopaedic surgeons
- All general surgeons

24. 99 letters of feedback and 9 petitions with a total of 9,779 signatures from members of the general public were received.

25. Following the closure of the consultation process, Kent County Council HOSC met on 12th January to consider their final response. The Committee received a number of presentations, both from MTW, West Kent PCT and a range of clinical representatives opposed to the changes. This resulted in a split decision, which was swung in favour of a 'No' by the Chairman's casting vote.

26. The HOSC meeting highlighted concern in three main areas:

a. That inadequate attention had been paid to the provision of surgical support for physicians managing acutely ill medical patients at Maidstone Hospital, once the changes were implemented. Pathways for specific high-risk conditions (such as a GI bleed) should be described under the proposed new system, to assure clinical safety.
b. That a compromise solution (made by a Maidstone A&E consultant) on the opening times of the Maidstone A&E could be further explored, which would mitigate concern on the safe management of A&E, should emergency surgery be relocated to the Kent & Sussex Hospital
c. That the timing of the changes was considered, such that best fit with Fit for the Future strategic plans could be confirmed.

27. The Maidstone Division of the BMA submitted a paper highlighting their objections. These included:

a. Reduced speed of access to emergency care for the people of Maidstone and environs
b. A dispute about MTW's claims to improve safety and quality of care because:

- Maidstone A&E would not have doctors in the department.
- Some patients presenting as medical cases would turn out to require surgical advice or intervention, adding potentially dangerous delays in access (e.g. GI bleeds).

- Longer ambulance journeys from Maidstone to Tunbridge Wells would lead to dangerous delays in treatment.
- Elderly patients in more distant hospitals would face difficulty and delay in discharge, with a minimum of 1 day being added to their length of stay. This would lead to higher complication rates.
- Emergency medical patients would continue to be unpredictable and therefore require admission to elective surgical beds so that there would be no reduction in cross-infection risk or increased guarantee that patients booked for elective surgery would not be cancelled.
- Foundation Year 1 doctors would not be able to spend long enough at each site, reducing the quality of their training and their ability to provide safe and effective care.

c. The countywide upper GI unit in Maidstone would not be able to provide specialist care for emergency as well as elective cases, thus undermining plans for specialist surgical centres.
d. Some patients who currently receive emergency surgery at Maidstone would be taken to hospitals other than the Kent & Sussex, thus reducing the overall level of emergency activity and making it difficult for surgeons to retain their skills.
e. The narrowing range of specialties at Maidstone would reduce its effectiveness as a teaching and training centre and therefore its ability to attract the highest calibre trainees.

28. The Maidstone Division of the BMA subsequently produced an alternative proposal, which they published as "surgical and orthopaedic care: *the right direction*" in February 2007.

29. Maidstone Borough Council's External Scrutiny Committee submitted a paper rejecting the proposals. Their objections included:
    a. In the committee's view a fully functioning urgent care network was not in place
    b. Increased journey times by ambulance would put lives at risk
    c. The changes would adversely affect postgraduate training at Maidstone Hospital
    d. The changes had been managerially and financially rather than clinically led
    e. Greater journey times would impact on those most vulnerable in the borough
    f. The consultation document was not balanced
    g. The consultation should not take place at the same time as a review of all health services in the County was being conducted
    h. Public and patients had not been sufficiently involved in the development of the proposals.

30. Signed letters have now been received by the PCT **from all of** the orthopaedic and general surgeons in MTW **in support of the proposed changes.**

The themes emerging from the consultation

31. Details of written responses are available in Appendix 3. Five overarching themes emerge, however:

    a. **A&E 'closure'/downgrading of Maidstone Hospital** – people generally and some physicians and GPs particularly are concerned about the level of

medical cover proposed for Maidstone A&E. In addition people feel that this change in service may represent the start of a general 'downgrading' of Maidstone Hospital.

b. **Patient safety** – people generally and some physicians and GPs specifically are concerned that the increase in ambulance journey times and reduced service in Maidstone will cause fatalities.
c. **Travel** – People are concerned about access to the Kent & Sussex Hospital. Specific concerns include poor transport links, extended journey times and car parking issues.
d. **Population Change** - Impact of the size of the current population and planned population changes – people are concerned that this has not been taken into account in modelling the proposed changes.
e. **Consultation process and strategic fit** – people are concerned that the process of consultation was flawed and that the timeframe is at odds with the Fit for the Future Programme.

Conclusions

32. Since consultation closed, the Senior Management Team (SMT) of the PCT has been concerned to examine and investigate issues that had arisen both by its own examination of the proposals and those raised in consultation. These have been described against each of the five themes emerging from the consultation.

33. **A&E 'closure'/downgrading of Maidstone Hospital**

- The SMT believe that concerns about the downgrading of the hospital or the closure of A&E are not substantiated by the facts. There are currently 60,000 attendances at Maidstone A&E and 55,000 will continue to attend.

- The Professional Executive Committee (PEC) of the PCT has reviewed in full the concerns of the BMA as set out in its report, and has considered the topic at two of its meetings, including rigorous debate at the last of these, held on 6th March 2007. It is now entirely satisfied that the issues of concern have been or will be addressed, however it will continue to meet with the BMA to assure them of progress.

- The SMT has reviewed the concerns of the Maidstone division of the British Medical Association (BMA), set out in its report, and believes that the issues of medical staffing in A&E, surgical opinion to A&E and other matters will be accommodated within implementation plans. Furthermore, the SMT believes that if these plans are clearly articulated and successfully implemented, then that should reassure the BMA and the public, about the maintenance of the A&E at Maidstone Hospital.

- The SMT believes that concerns expressed by senior A&E and medical consultants about the medical rotas in the A&E department and access to surgical advice have been dealt with. This will be covered in more detail in the recommendations.

34. **Patient safety**

- The SMT believes that the present situation in Orthopaedics and Surgery is sub optimal. Although not currently unsafe, the present arrangements do not represent best practice and are not in the best interests of patients. In that context the preferred proposals consulted upon, represent a significant improvement in patient safety and are consistent with national and professional recommendations.

- Crucially for the SMT, these proposals have the full backing of all Orthopaedic and Surgical clinicians who are the senior body charged with delivering a safe service for patients.

- Although concerns have been expressed about increased travel time for urgent conditions, it is clear that these proposals are consistent with national guidance on best practise. (See evidence, point 18) This states that improvements in mortality and morbidity justify incurring a slightly longer travel time.

- The SMT will work with the South East Coast Ambulance NHS Trust to ensure that patient pathways and protocols are in place to ensure that the right patients are transported to the right location first time. This process should replicate the successful approach that has already been taken in East Kent in similar circumstances of service reconfiguration.

35. **Travel**

- An extra twelve emergency patients per day and an extra four planned patients per weekday will need to travel to Maidstone Hospital. It is clear that this will result a number of patients' relatives having longer journeys than currently (although for others they will be shorter). This is an issue for strategic service modelling across West Kent and the SMT are convening a working party to explore the issues associated with travel and access for all parts of the patch. This group will have representatives of all key agencies, including Kent County Council Highways Agency, borough councils, voluntary sector and NHS partners.

36. **Population Change**

- The most up-to-date predictions of population growth have been included in the Fit For the Future Programme modelling. This includes an estimate of 10,000 growth in the Maidstone population. Alternative service provision in the community and primary care will also be considered in the Fit for the Future planning process.

37. **Consultation process and strategic fit**. The SMT has reviewed this under the areas of clinical and public involvement and in respect of the Fit for the Future Programme.

a. Clinical involvement.

- Although an extensive range of options were considered by MTW and its clinicians in the pre-consultation phase, the SMT believes that these could have been made more explicit as part of the consultation process. The SMT considers that the consultation exercise has resulted in a range of issues being raised and is satisfied that these have now been addressed.

- The SMT has received signed letters from all of the Orthopaedic and Surgical consultants giving full support to the preferred options. The SMT believes that this is a significant factor in its approach to the outcome of consultation and should be a major determinant in the final decision of the Board.

- The SMT is satisfied from the evidence that a wide range of clinical opinion was sought in the construction of the final proposal and its subsequent development through the consultation process.

b. Public involvement.

- While there has been extensive public engagement throughout the consultation, the SMT believes that improvements could have been made to the way in which patients and the public were involved in the pre-consultation phase. There is nevertheless no evidence that this would have

materially affected options for consultation. However the SMT assures the Board that it will work with MTW, other NHS providers, Overview and Scrutiny Committees and patients' fora to strengthen patient involvement in future consultation exercises.

c. Finance/PFI

- The SMT does not believe these proposals have been driven by finance or issues associated with the potential new hospital at Pembury. On the contrary, it seems that these proposals were designed to address genuine clinical concerns about patient safety and the quality and standard of patient care.

Recommendations

38. In reviewing these proposals the SMT has been mindful of the huge public interest generated by this consultation. The issue has cased a massive amount of passion and concern. The challenge for the PCT Board is a difficult one and requires a mature judgement on the balance between proposals that appear to genuinely meet the need to improve patient safety and the quality of care and that have the full support of the clinicians providing the service alongside the deeply felt concerns of the population at large and some other clinicians that the proposals are either inappropriate for "social " reasons or have flaws in the level of clinical analysis.

39. The original proposals, which were consulted upon, did not adequately describe the critical relationships that would need to be in place to make them successful. The SMT would therefore not be able to support them. The process of consultation has highlighted a number of areas requiring adaptation of the original proposals and in the light of this, the SMT recommends that the Board support an amended set that would impose conditions on approval of the consultation. These conditions are as follows:

a. That implementation of the proposals are delayed until the publication of the Fit for the Future consultation document, to ensure that there is no contradiction between these proposals and those that may emanate from Fit for the Future review.
b. That clear staffing arrangements are established to ensure that medical staffing, including Consultant level, within the A&E department at Maidstone hospital is appropriate, as deemed by external review.
c. That clear staffing arrangements and protocols are established to ensure that access to surgical advice for medical emergencies at Maidstone hospital is appropriate, as deemed by external review.
d. That protocols are established to ensure that minor orthopaedic cases can continue to be dealt with at Maidstone hospital. (E.g. simple breaks)
e. That agreement is finalised between MTW and the PCT regarding the development of new medical services at Maidstone hospital including the catheterisation laboratory and dedicated stroke unit. Further work will follow to consider the establishment of a pain clinic.
f. That MTW continues to work with the relevant transport and other authorities to examine the issues of travel and access for relatives.

40. The Board is therefore asked to approve Options 1 and 6, subject to the conditions being met.

41. The Board is asked to support the work with MTW, other NHS providers, Overview and Scrutiny Committees and patients' fora to strengthen patient involvement in future consultation exercises.

Jenny Thomas
Director of Strategy and Corporate Affairs
12th March 2007

APPENDIX 1

COMMON NOMENCLATURE USED WITHIN THE PAPER

Complex or Specialist that is needing to be performed by clinicians with expert experience or qualification, with support staff and equipment which may need to be co-located in fewer places than more general treatments would otherwise require. The title is applied to patients and clinicians (according to their particular specialty) and hospitals. All consultants have a requirement to provide "safe" emergency care, however in order to practise in a sub-specialty, they need to work on a minimum number of cases per annum to retain this. Hence a general surgeon can stabilise a patient in an emergency situation, but if they found a problem in the lower gut tract, would have to refer to a Lower GI surgeon for that procedure. Each sub-specialty is ascribed a minimum population size from which a minimum number of cases is likely to arise, for them to achieve this practise level.

Day case & 23 hour Care the patient needs to be in a bed or a chair for periods up to 23 hours of care

Elective OR Planned care that is, the patient and clinician elects or can choose when to have the relevant procedure. (e.g. a hip replacement)

Emergency that is, the patient and the clinician need to perform the procedure immediately, to stabilise the problem, although this may not extend to the full procedure, which may be carried out at another time, after the patient has been stabilised.

Inpatient the patient needs to be in a bed for over 24 hours care

Medical care is delivered by **physicians** and their teams, for medical patients and requires **conservative** treatment, usually using medication (drugs) and more recently **minimally invasive** treatment, if a diagnostic camera wielded by a radiologist is guided through the blood vessels, to perform this treatment.

Surgical and medical Care is then further sub-divided by the part of the body to which it applies, and in this case, **Orthopaedics** relates to bony and aligned soft tissue and **general surgery** relates to problems of the organs and soft tissue.

Surgical care is delivered by **surgeons** and their teams, to surgical patients and requires **invasive** intervention in an operating theatre with intensive care support provided by anaesthetists.

A **Trauma** Centre is a status afforded to a hospital on the basis of having specific facilities that are nationally recognised for specific emergency conditions. These exist at different levels, which can be broadly summarised as follows;

Level 1	basic
Level 2	intermediate
Level 3	senior

APPENDIX 2

ANALYSIS OF THE CONSULTATION

Summary of Feedback on Public Consultation into Proposed Changes to Emergency Surgery and Emergency Orthopaedic Services

The consultation period officially ran from 5th October 2006 to 8th January 2007 inclusive. However, engagement with many stakeholder groups commenced prior to this period and this summary includes letters and feedback received both before and after the official period of consultation. These have been taken into account in the analysis.

In total, 3,937 copies of the document were sent out, distributed as follows:

2,500 to GPs
11 to Practice Based Commissioners
29 to requests by phone/e-mail, etc
450 to libraries
213 to Parish Councils and Special Interest Groups
173 to Trust Consultants
21 to League of Friends for all 3 hospitals, MPs and Borough/County Councils (Appendix 1)
15 to Stakeholder Group (comprising key partners in other Trusts, scrutiny committees, PPI) (Appendix 2)
25 to other Acute Trusts, PCTs and the SHA for the South East Coast Region (Appendix 3)
500 to signers of previous KM petition

Copies were also e-mailed to all staff, made available in all public areas and wards and on the Trust intranet. It was e-mailed to Voluntary Action West Kent for distribution to their PPI members across the region and also placed on the Kent & Medway website.

The Trust and PCT also undertook a series of public meetings. Initially 6 meetings were arranged, with an additional 2 meetings being added at different times of the day by public request. In total, approximately 306 people attended these meetings and discussed the issues with members of Trust, including consultants, PCT and ambulance service representatives. Three biggest meetings were:

Church Farm Hall, Larkfield	120+
Invicta Grammar School, Maidstone	69
Maplesden Noakes School, Maidstone	67

In addition, representatives from the Trust attended 2 Parish Council meetings which approximately 80 members (70 at Wateringbury) of the public attended. They also attended meetings with and/or gave presentations to the following (approximate no. of attendees in brackets):

Tonbridge & Malling Borough Council – Parish Partnership (30)

Tonbridge Forum (30)
NHS Retirement Fellowship (60)
North Larkfield Group for the Protection of the Environment (12)
Tonbridge Wells Access Group (inc. representatives from Kent-wide disabled groups)
Tonbridge & Malling Borough Council – Health Policy Board (35)
Maidstone GPs (10)
Local Medical Committee (6)
Maidstone Division of the British Medical Association (13)

The vast majority of issues raised at all the above meetings parallels those concerns/comments made by members of the public in letters/feedback forms received by the Trust and will be summarised later in this document.

Internally, as well as discussing at Open Staff Meetings and directorate level meetings, presentations were given to the following:

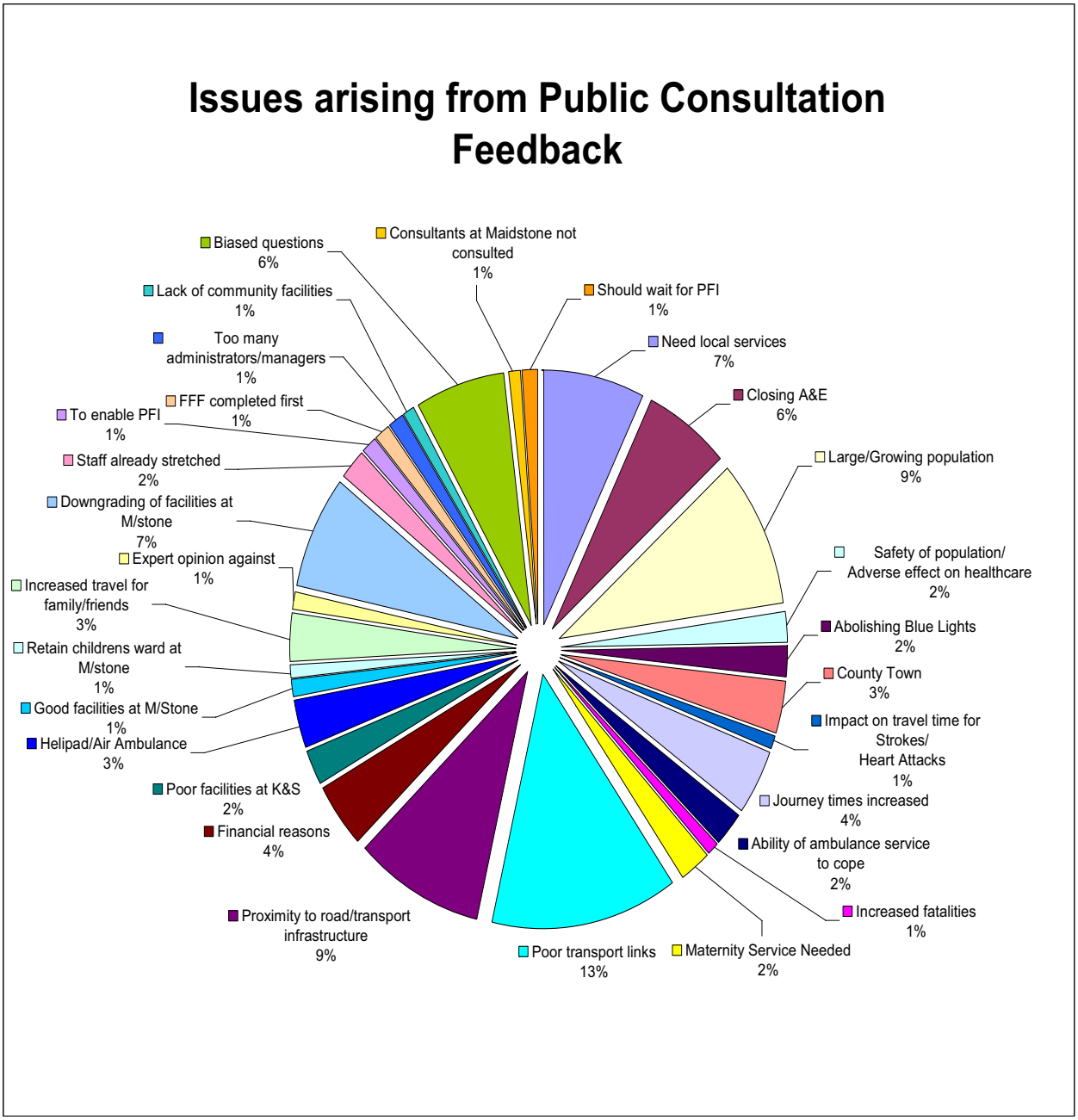
Therapy Departments at Maidstone (19) and Kent & Sussex (12)
Doctors at Maidstone (60)

Responses Received

The Trust received a total of 233 responses (99 letters and 134 forms), not including the formal responses from the Overview & Scrutiny Committees of Maidstone Borough and Kent County Councils. The majority of the responses were from Maidstone residents (71%).

Of the 52 issues identified in the feedback, the pie chart on the next page shows the main topics of comment. Key themes include: Transport -
Closing A&E
Downgrading services at Maidstone
Large/Growing Population

Most of the early letters received prior to the consultation period thought that A&E was being closed (66%).



Options for Emergency Surgery/Orthopaedics

Of those who expressed a preference for Surgery, 63% voted for Option 1, the clinically preferred option.

Of those who expressed a preference for Orthopaedics, 62% voted for Option 2, the clinically preferred option.

This was borne out in the results of the workshop held on 30th November, when the clinically preferred options came top when scored against the criteria, which had been agreed earlier in the day (see table below). The options scored included the additional option requested by a member of the public at an earlier meeting, which was the reverse of the clinically preferred option with all emergency orthopaedics at Maidstone and elective inpatients at K&S.

Options *(Clinically preferred option in bold)*	**Total Score**
Elective inpatients at Maidstone, emergency surgery at K&S, day cases at both	**534**
Elective inpatients and daytime emergency surgery at Maidstone, emergency surgery at K&S, day cases at both	353
All elective inpatient and emergency surgery at Maidstone, day cases at K&S	288
All elective inpatient and emergency surgery at K&S, day cases at Maidstone	255
All emergency orthopaedics at Maidstone and elective inpatients at K&S	449
All elective inpatient and emergency orthopaedics at K&S, day cases at both	**534**
Elective inpatient orthopaedics at K&S, emergencies retained on both, with Maidstone running a 12 hour A&E model	369
Emergency surgery and emergency orthopaedics at Maidstone, elective inpatient surgery at K&S, elective inpatient orthopaedics at Maidstone, day cases at both	357

Petitions and Rallies

1) The campaigns by the Kent Messenger and Downsmail calling on Maidstone & Tunbridge Wells NHS Trust to "stop reducing services at Maidstone Hospital. We call for maternity services, the children's ward and the chronic pain unit to be retained at Maidstone Hospital. We oppose reductions in Accident and Emergency services, including ambulance blue light orthopaedics and surgery." generated the following response:

   Kent Messenger 3,582 signatures and 71 letters

   The KM summarised the concerns as follows:

- The longer travel times from Maidstone to Pembury and Tunbridge Wells, both by ambulance and mothers in labour; by car for visitors, and by public transport, if there is any.
- Maidstone Hospital is only around 20 years old and has newer, more modern facilities easily accessible from the M20, in contrast to the Kent and Sussex Hospital at Tunbridge Wells.
- The forecasts for population growth in the Maidstone borough over the next 10 years are far higher than the expected growth in the Tunbridge Wells area.
- That high profile, senior consultants, have publicly opposed the planned changed.
- That there has not been enough consultation within the wider population.
- Lack of emergency medical cover left on the Maidstone site, if trauma and general surgery move to Tunbridge Wells.
- That the other A&E departments – Medway, Dartford and Ashford will be overstretched because they will not have any extra staffing or funds for the extra estimated 12 "blue light" patients a day which would have gone to Maidstone's A&E.

- There is a helipad at Maidstone Hospital, but no such facility at the Kent and Sussex Hospital
- That Maidstone, as the County Town, should have appropriate medical services.

Downsmail 1,302 signatures and 142 letters

The forms (approximately 1200) were analysed by the Downsmail with the following results:

Threat to the Maidstone A&E service	99.63%
Losing blue-light services	80.12%
Losing maternity department	90.24%
Losing children's ward	92.24%
Losing chronic pain unit	80.61%

The media were using the consultation to generate public debate about previously consulted and agreed service changes egg, Women & Children's, as well as other service changes egg. Chronic Pain Unit.

2) The rally held in Mote Park on 2 December was attended by approximately 2,500 to 3,000 people.

A number of speakers addressed the crowd, including some MTW consultants. The broad themes linked with those raised by the joint KM and Downsmail petition.

3) Additionally, the Trust has received 8 other petitions, totally 8,477 signatures, which opposed:

"Many departments are due to close including the Accident and Emergency department, the Maternity Unit and many others – Please sign this petition to show your support for your local hospital and in turn **Help Save Lives**." (3,406 signatures)

"Say No to Cutbacks" – Save the Maidstone Hospital's Emergency Surgery, Orthopaedics & Trauma (445 signatures)

"We the undersigned **OPPOSE** the proposal to close our 'blue light' Accident and Emergency service and the transfer of our emergency orthopaedic and maternity services from the Maidstone Hospital to Tunbridge Wells. We also **OPPOSE** the plans to close beds and operating theatres at the Maidstone Hospital." (3,191/126 signatures)

"I/We object to the proposed changes at Maidstone Hospital.
They are:-

1. Acute Surgery and Emergency Orthopaedics moved to Kent & Sussex Hospital, Tunbridge Wells.
2. Downgrading of Maidstone Hospital Accident & Emergency Department
3. Bed closures at Maidstone Hospital.)" (254 signatures)

"We call on Maidstone and Tunbridge NHS Trust to stop reducing services at Maidstone Hospital. We call for maternity services, the children's ward and the

chronic pain unit to be retained at Maidstone Hospital. We opposed reductions in Accident and Emergency services, including ambulance blue light orthopaedics and surgery." (434 signatures)

"We the undersigned oppose the reduction in services and eventual closure of the Accident and Emergency Centre at the Maidstone Hospital" (621 signatures)

"We, the undersigned members of Larkfield Active Retirement Association are strongly against the proposed changes of Maidstone & Tunbridge Wells NHS Trust to move services away from Maidstone, on the grounds of distance and inaccessibility of Kent & Sussex Hospital from our area." (154 signatures)

Responses from stakeholders

The following responses have been received:

Other Acute Trusts/PCTs/Ambulance Services

Responses in favour of the proposals received from East Sussex PCT, Medway NHS Trust and the South East Coast Ambulance NHS Trust. A request for modelling information from East Kent Hospitals NHS Trust was responded to, but no formal response has been received.

Kent Air Ambulance, whilst not responding formally to the Trust, agreed to the principles at the Kent County Council OSC meeting on 12 January 2007.

Key Stakeholders

Responses in favour of the proposals received from Chairman of the MTW PPI Forum and the Chair of South West Kent PPI Locality Group.

Maidstone Borough Council OSC and Kent County OSC have stated that they are against the proposed changes. A letter of support was received from Tonbridge & Malling Borough Council prior to the start of consultation and nothing has been received from Tunbridge Wells Borough Council.

12 Parish Councils have responded as follows:

Boughton Monchelsea	Against
Bredhurst	For
Chart Sutton	Against
Downswood	Against
East Malling & Larkfield	Against
Lenham	Against
Loose	Against (comments only from one member)
Rother	For
Ryarsh	Against
Wateringbury	Against before start of consultation – nothing further received.
West Malling	Against before start of consultation – nothing further received.

Wrotham	In favour of specialist centres, opposed to loss of A&E at Maidstone and queries about obstetric services.

The Maidstone division of the BMA wrote with the response of a vote on the following:

1. That Maidstone Hospital should continue to be the provider of a great majority of emergency secondary care to the nearly quarter million residents of Maidstone and its surrounding districts including:
   a. A full A&E service for self-referral and blue-light ambulance cases (with the possible exceptions of major trauma and some overnight services).
   b. A full unselected medical and general surgical 'take'.

2. That services should not be transferred from Maidstone to Tunbridge Wells (particularly Pembury Hospital) before the new PFI hospital has been agreed by government.

3. That consultants based in Maidstone should be fully involved in deliberations on service configuration.

Internal

Letters with a wide-ranging list of concerns have been received from both an A&E consultant and the Department of Medicine based in Maidstone. A letter has been written to representatives of the various groups concerned and a way forward has been agreed.

Letters in support have been received from all Tunbridge Wells General Surgeons &Orthopaedic Surgeons and all of Maidstone's General Surgeons Orthopaedic Surgeons.

Kent County Council's NHS Overview and Scrutiny Committee voted at its meeting on 12 January 2007 to reject the proposals by Maidstone and Tunbridge Wells NHS Trust to change services available at the Accident and Emergency department of Maidstone Hospital. The decision was based on a detailed set of arguments against the proposals.

Since that meeting, the Board of West Kent Primary Care Trust has voted, at its meeting on 15 March 2007 to accept the Trust's proposals – although with a number of conditions being stipulated.

The NHS OSC will meet again on 11 May 2007 to decide whether or not to exercise its statutory power to refer this matter to the Secretary of State for Health. Following useful discussions with both MTW Trust and the PCT, the three party spokesmen on NHS OSC now wish, ahead of the meeting in May, to seek further detailed clarification and guarantees from the Trust and the PCT regarding the issues set out below.

In particular, we seek confirmation that the services available at Maidstone A&E department will, following reconfiguration, not fall below the minimum level set out below.

Fit for the Future

The paper agreed by the PCT Board on 15 March 2007 includes the following recommendation at para. 39(a):-

> *That implementation of the proposals are delayed until the publication of the Fit for the Future consultation document, to ensure that there is no contradiction between these proposals and those that may emanate from Fit for the Future review.*

We take the view that no service changes should be implemented until the actual *outcome* of the consultation around Fit for the Future is known.

Modelling for future services

The PCT Board paper refers, at para. 36, to modelling for future services (through the Fit for the Future project) being based on "the most up-to-date predictions of population growth", which includes "an estimate of 10,000 growth in the Maidstone population" (it is not stated over what time period this growth is expected to occur).

However, it is planned that Maidstone district will, as a designated "Growth Point", receive an additional 10,080 homes over the 20-year period to 2026. On the basis of the latest (2004-based) projected average household size in the South East Region for 2006 of 2.33, this would equate to a population increase of 23,486 (average household size in the South East in 2026 is projected to be 2.14 by 2026 – but that would still mean a population increase of 21,571). It should also be noted that the latest (2004-based) sub-national population projections (which are based on observed trends and do not take account of government policy on Growth

Areas/Growth Points) forecast that Maidstone district will have a population of 166,800 in 2026 – an increase of 20,600 on the forecast figure for 2007.

We would appreciate acknowledgement of this miscalculation in the Board paper and its implications for the evaluation of the proposed changes.

Continued medical staffing of Maidstone A&E department

Rose Gibb's letter to us of 13 March 2007 states:-

> *We can confirm that the A&E Department at Maidstone will be staffed by Medical Staff and the proposal is as per the BMA recommendation that this is undertaken by A&E specialist staff for between 12 and 15 hours per day with acute general physicians supporting services out-of-hours. I can confirm that the A&E medical staff will continue under A&E Consultant leadership and that both Maidstone and Kent & Sussex A&Es will continue under single Clinical Directorship.*

The paper agreed by the PCT Board includes the following recommendation at para. 39(b):-

> *That clear staffing arrangements are established to ensure that medical staffing, including Consultant level, within the A&E department at Maidstone hospital is appropriate, as deemed by external review.*

We have concluded that the following are the necessary minimum preconditions for the continuation of a medically-staffed A&E department in Maidstone:-

- The department must continue to be staffed by A&E consultants throughout normal working hours (9am to 5pm).
- There must be continued A&E medical staffing (both middle-grades, i.e. Specialist Registrars and Staff Grades/Associate Specialists; and junior trainees, i.e. Foundation Year 2 trainees, under supervision) for a minimum of 17 hours per day (8am to 1am).
- There must be, within the Maidstone Hospital site plan, dedicated space in which to continue delivering the "majors" side of the department.
- Full resuscitation teams must be maintained at Maidstone Hospital.
- The "majors" and "minors" sides of the department must continue to be run together as a single, integrated whole.

Acute general surgical provision at Maidstone Hospital

Rose Gibb's letter to us of 13 March 2007 states:-

> *I can confirm that the greatest proportion of surgeons with sub-specialist interest will be based at Maidstone. They will provide an emergency on-call rota and this emergency on-call rota will support the totality of services at the Maidstone site. This will ensure unlimited access to a surgical opinion and the full range of sub-specialist expertise.*

With respect to emergency surgery I can confirm that any elective patient who has had surgery on that site who deteriorates will, if it is clinically appropriate, have any further emergency surgery on that site.

Additionally, in the rare circumstance that anyone should present into A&E with a clinical emergency which it is believed cannot be stabilised and transferred, then naturally those patients would also receive surgery at Maidstone.

The paper agreed by the PCT Board includes the following recommendation at para. 39(c):-

That clear staffing arrangements and protocols are established to ensure that access to surgical advice for medical emergencies at Maidstone hospital is appropriate, as deemed by external review.

As a minimum, the following must continue to be available at Maidstone:-

- when needed in an emergency, a general surgical opinion from a consultant or middle-grade doctor (Specialist Registrar or Staff Grade/Associate Specialist), in person, on any patient in A&E or a ward, 24 hours per day, seven days per week;
- the capacity to undertake emergency surgery on-site at any time of day or night, in the rare event of that being necessary;
- on-site assessment of patients referred to the hospital or presenting to A&E with possible surgical problems (most of whom will not require emergency surgery), for a minimum of 17 hours per day (8am to Midnight), seven days per week;
- the capacity for emergency general surgery 24 hours per day, seven days per week in the case of clinical emergencies presenting at A&E where the patient cannot be stabilised and transferred safely.

To make this possible, a middle-grade surgeon (Specialist Registrar or Staff Grade/Associate Specialist) must be present in the hospital for a minimum of 17 hours per day, and readily available on call the rest of the time.

Provision for orthopaedic trauma at Maidstone Hospital

Rose Gibb's letter to us of 13 March 2007 states:-

Elective orthopaedics (until 2010), day case orthopaedics, outpatients and fracture services will continue on the Maidstone site. This will enable the full provision of urgent orthopaedic opinion to be made available. The service model as proposed always envisaged that in the event a patient with an orthopaedic injury should arrive at Maidstone A&E, we would stabilise, treat and transfer that patient, and this we regard as our duty of care. It must be noted that we continue with this duty of care for any and every patient who presents at either Kent & Sussex or Maidstone A&E services irrespective of service reconfiguration. You may be aware that we already undertake this duty of care, for example, for emergency vascular patients at both our hospital sites where we stabilise, treat and transfer those very critical emergency

patients. We do not envisage that there will be any change to our ability to do this for either surgical patients or orthopaedic patients in either the current or proposed service model.

The paper agreed by the PCT Board includes the following recommendation at para. 39(d):-

That protocols are established to ensure that minor orthopaedic cases can continue to be dealt with at Maidstone hospital. (E.g. simple breaks)

We expect that the following types of orthopaedic trauma presenting at Maidstone A&E will continue to be dealt with at Maidstone according to the protocols indicated:-

- minor trauma not requiring surgery or an in-patient stay – to be dealt with usually in A&E by A&E staff, but with occasional orthopaedic input;
- trauma requiring surgical intervention but not an in-patient stay (e.g. reduction under anaesthetic) – to be dealt with as a day-case, usually by the orthopaedic team;
- trauma not requiring surgery but needing an in-patient stay (e.g. a frail elderly patient with a pelvic fracture) – to be dealt with by admission to Maidstone, usually under the care of physicians, with orthopaedic input when necessary.

We would only expect cases of trauma requiring both surgery and an in-patient stay to entail transfer to the trauma centre in Tunbridge Wells (or another appropriate hospital). Even in these cases, we would expect Maidstone A&E to have the capacity to receive them, should they present at Maidstone, in order to stabilise them so they can be transferred elsewhere as appropriate.

Where a local patient presents with an uncertain need for surgery (e.g. in the case of a possible hip fracture following a fall), we would expect this to be dealt with by assessment and diagnostic imaging in Maidstone. This should then be followed by management in accordance with whichever protocol (as outlined above) is appropriate.

In order to deliver the above model of care, we would expect a middle-grade (Specialist Registrar or Staff Grade/Associate Specialist) orthopaedic surgeon to be present in the hospital, or immediately available, for a minimum of 17 hours per day.

External reviews

Regarding the external reviews in respect of provision for acute general surgery and orthopaedic trauma, we require to know:-

- who will comprise the review panel?
- when will the review be completed?
- will the outcome of the review be considered by the PCT Board before any changes to services are implemented?

Ambulance service

We take the view that, where Maidstone is the closest hospital, or the one that can be reached most quickly, ambulances should be able to take patients there – except in cases where the patient has a need for particularly specialised care. Ambulance staff must not be placed in the very difficult position of being required to bypass Maidstone where it is the nearest or most accessible hospital and the patient's life is at stake.
We need to know the clear and detailed protocols agreed with the Ambulance Service and that additional Ambulance vehicles and crews will be available in the periods when any additional travelling time is required.

We also seek reassurances that there will be sufficient numbers of adequately trained paramedics to ensure the safety of patients, given the increased travel-to-hospital times that will be entailed in a significant number of cases by the proposed changes.

Repatriation of Maidstone patients

We require reassurance that, in cases where Maidstone patients receive emergency general surgery or emergency orthopaedic surgery at Tunbridge Wells, or another location, those patients will be repatriated to Maidstone Hospital for any postoperative care that they may require.

Anticipated changes to patient flows

At the NHS OSC meeting on 12 January 2007, Rose Gibb gave the committee numbers of patients that were expected to be diverted from Maidstone A&E to other hospitals under the Trust's proposals (recorded at para. 48 of the minutes).

We note that the PCT Board paper contains (at para. 10) a somewhat different set of figures regarding anticipated changes to patient flows, as shown in the following table:-

Hospital	Patients per week	
	Rose Gibb (12/1/07)*	PCT Board paper (15/3/07)
Kent and Sussex	7–14	49
Medway Maritime	28–35	7
William Harvey	28	21
Darent Valley	14	7**
TOTAL	**84**	**84**

* Patients per day multiplied by seven
** Also includes Bromley Hospitals NHS Trust

We would appreciate some clarification on these discrepancies and any implications they have regarding the feasibility of the proposed changes.

24 April 2007

West Kent NHS
Primary Care Trust
Wharf House
Medway Wharf Road
Tonbridge
Kent
TN9 1RE
Telephone: 01732 375200
Fax: 01732 359046
Email: steve.phoenix@westkentpct.nhs.uk
27th April 2007
SP/cg/275

Alan Chell, Chairman
Mark Fittock, Vice Chairman
Dan Daley, Liberal Democrat Spokesman
NHS Overview & Scrutiny Committee
Kent County Council, Sessions House
County Hall, Maidstone, ME14 1XQ

Dear Alan, Mark & Dan

A New Direction for Orthopaedic and Emergency Care

Thank you for your letter and request for further clarification regarding a number of issues related to the above. I will seek to respond to your concerns in the order you raised them.

1. Fit for the Future – I agree, and indeed the PCT Board took the view that it is important any proposed service changes fit with the principles of Fit for the Future, which is an improvement programme designed to ensure clinically and financially sustainable services are in place across Kent & Medway. Our overall approach, along with some specific initiatives, will be described in a consultation document to be produced in the summer along with our colleagues in Eastern & Coastal Kent and Medway PCTs. However, given the nature of the Fit for the Future programme it is likely that formal public consultation will take place in phases relating to specific elements over a period of time. For this reason the recommendation was to wait until the consultation document is produced to ensure the proposed changes fit with the overarching principles and direction of travel described in Fit for the Future. This will be further tested through the PCT Board's review of Maidstone & Tunbridge Wells' (MTW) detailed implementation plans.

2. Modelling for future services – If a miscalculation was made in our Board paper then I will be happy to acknowledge it. However the potential difference, between household and population estimate increases in Maidstone would only alter projections over a 10 -15-year period of 5 – 10,000. While this may be important for, say family doctor services, where the optimum population for specialist surgery is 500,000 plus the implications are not material.

3. Medical staffing, acute general surgical provision and provision for orthopaedic trauma at Maidstone Hospital – I can confirm this will be provided in a safe and appropriate manner. As you are aware, the PCT Board charged managers and doctors at MTW with producing detailed implementation plans, which will be subject to the external scrutiny of a panel of independent clinicians in both emergency

surgery and emergency medicine. The PCT Board will only give the go ahead to any changes once they have the assurance of these experts that the arrangements are clinically safe, meet standards of good practice and are sustainable.

4. External review panel – The panel is yet to be convened but I anticipate that in addition to the external clinical advisors it will include, representatives from our own PEC, the ambulance service and public health. The panel will be chaired by Dr James Thallon, our PEC chair, and supported by Jenny Thomas, Director of Strategy for the PCT. We are expecting that the review will be complete by the autumn and the panel will report to the September meeting of the PCT Board.

5. Ambulance service – It is not a new phenomenon for ambulance crews to make judgements about where to take a patient, and to bypass one hospital to get to a more appropriate one depending on the need of the patient. For example this would be true in the case of a major burn, where the hospital of choice would be the Queen Victoria in East Grinstead, even if the patient were picked up in Maidstone. The ambulance service have already confirmed their support for the proposals.

6. Repatriation of Maidstone patients – I can assure the HOSC that where it is appropriate and clinically safe to do so, and the patient prefers it, they will be repatriated to Maidstone Hospital for the postoperative care they require.

7. Anticipated changes to patient flows – I apologise for the confusion caused by the different numbers quoted. As you know, my team conducted a thorough interrogation of the MTW case and process in order to be in a position to assure our Board and make recommendations. It was during this scrutiny process that the changes arose. In summary the reason for the change is that MTW had not taken account in their calculations of the differences between day case and planned care, which works on a 5-day-week basis, and emergency care, which works on a 7-day-week basis. If you would like further explanation I'd be happy to ask Jenny Thomas to meet or speak to you directly on this point.

I hope these points of clarification are helpful, but if you require more information or further explanation, please do not hesitate to get in touch with me.

Finally, let me assure you that as a PCT we are committed to ensuring the best possible care of the highest standards is provided for all the people of West Kent and we are determined to get these changes right in the best interests of the patients we serve.

Yours sincerely

Steve Phoenix
Chief Executive

South East Coast Ambulance Service NHS
NHS Trust

Reply To: Heath Road,
Coxheath,
Maidstone,
Kent,
ME17 4BG
Tel: 01622 747010

April 27 2007

Alan Chell Mark Fittock Dan Daley

Chairman Vice Chairman Liberal Democrat Spokesman

NHS Overview and Scrutiny Committee

Dear Sirs

Re: A New Direction for Orthopaedic and Emergency Care

Further to your letter to Paul Barratt dated April 2007; it has been forwarded to me to respond to as I am the Director with responsibility for Fit for the Future and other service developments across South East Coast Ambulance Service.

As you may be aware, South East Coast Ambulance Service (SECAmb) was fully involved in the public consultation surrounding the proposed changes to emergency surgery and orthopaedic provision at Maidstone General Hospital (MGH). In January 2007, Paul Sutton, Chief Executive of SECAmb formally responded to the public consultation process, supporting the clinically preferred proposal. However, this support was given subject to ensuring the right resources are made available to ensure that the current standards of ambulance provision are not affected by the proposed changes.

Since July 2006, representatives of Maidstone Tunbridge Wells NHS Trust (MTW) and SECAmb have been working together to consider how the impact of the proposed changes could be identified and fully understood by both parties. As a result, MTW commissioned Operational Research in Health Ltd (ORH), an independent research organisation, to undertake a study of the possible impact on the ambulance service.

As a result of the study I am pleased to advise that we are currently in positive discussions with West Kent Primary Care Trust to ensure that the necessary resources are identified and implemented in time for any changes that may occur.

I hope that this provides you with the necessary assurances you are looking for; please do not hesitate to contact me should you need any further information or clarification.

With kind regards

Geraint Davies
Director of Corporate Affairs and Service Development

Cc:

Bob Deans, Director of Commissioning, West Kent PCT
Frank Sims, Director of Corporate Affairs, Maidstone Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS
NHS Trust

Chief Executive and Chairman's Office
Maidstone Hospital
Hermitage Lane
Maidstone
Kent ME16 9QQ

Tel: 01622 – 226412
Fax: 01622 226416

30 April 2007

Alan Chell, Chairman
Mark Fittock, Vice Chairman
Dan Daley, Liberal Democrat Spokesman
NHS Overview & Scrutiny Committee
Kent County Council
Sessions House
Maidstone

Dear Alan, Mark & Dan

A NEW DIRECTION FOR ORTHOPAEDIC AND EMERGENCY CARE

Thank you for your letter and request for further clarification regarding a number of issues related to the above. I believe you sent a similar letter to Steve Phoenix and that he has replied directly. I will respond to your concerns in the order you raised them.

1. Fit for the Future – MTW agree, and indeed the PCT Board took the view that it is important any proposed service changes fit with the principles of Fit for the Future, which is an improvement programme designed to ensure clinically and financially sustainable services are in place across Kent & Medway.

   The overall approach, along with some specific initiatives, will be described in a consultation document to be produced in the summer along with our colleagues in Eastern & Coastal Kent and Medway PCTs. However, given the nature of the Fit for the Future programme it is likely that formal public consultation will take place in phases relating to specific elements over a period of time.

For this reason the recommendation was to wait until the consultation document is produced to ensure the proposed changes fit with the overarching principles and direction of travel described in Fit for the Future. This will be further tested through the PCT Board's review of Maidstone & Tunbridge Wells' (MTW) detailed implementation plans.

I would also emphasise the point that these changes are about improving patient safety and access to the best possible care. We need to ensure that the changes are consistent with the wider strategic model, but we do not want to delay vital benefits to our population.

2. Modelling for future services – The PCT have asked Meradin Peachey, Joint Director of Public Health for Kent County Council and Kent PCTs, to work with the HOSC to understand the discrepancies between the figures you quote and those that formed part of their Board paper, and to finalise a single set we all agree. If a miscalculation was made in the Board paper then this will be acknowledged and the PCT team will review the implications on the proposed changes.

I can confirm, as I have done consistently during the consultation, that the known demographic statistics have been factored into the planning models. The model was constructed for the new hospital build and took account of the entire MTW catchment population, not just Pembury. The outputs of this model have been quality assured and checked by the Department of Health at a number of Gateway reviews and the modelling has been confirmed as robust.

In addition, MTW did provide a ready reckoner to demonstrate the ad hoc impacts of new homes (10,000) on the acute hospital service. This assumed 3 people per home with a demographic distribution consistent with the existing population. This was a less sophisticated model as it assumed that all the resultant population would go to Maidstone hospital for their care. Reality would be different to that, especially in relation to emergencies. Nonetheless, it shows a relative small impact on hospital care and not sufficient to undermine the changes.

Medical staffing, acute general surgical provision and provision for orthopaedic trauma at Maidstone Hospital – Thank you for clarifying your views on this. You make a number of statements and requests about the model of care and about the need to be able to cope with certain categories of patients. It is worth stating clearly that clinical priorities will continue to be assessed at the roadside by the ambulance service and by the clinical teams at hospital.

I have confirmed that the Maidstone A&E department will be led by an A&E consultant and that the staffing and operational details will be determined by clinical professionals and subject to external review. The intended arrangements are for a 15 hour service with the exact opening conforming to peak activity times. The A&E will of course be open 24 hours a day.

As you are aware, the PCT Board charged MTW with producing detailed implementation plans, which will be subject to the external scrutiny of independent national clinical experts in both emergency surgery and

emergency medicine, as well as the relevant Royal Colleges. The PCT Board will only give the go ahead to any changes once they have the assurance of these experts that the staffing model is clinically safe, meets standards of good practice and is sustainable.

I would also like to address a number of your specific points:

- I can confirm that that there will continue to be dedicated space for 'majors' and that the department will function as a single, integrated unit and there will continue to be full resuscitation teams at Maidstone. The service will regularly be reviewed, as is the case for all clinical care, to ensure that it is run in line with best clinical practice.
- A general surgical opinion will be available 24 hours a day at Maidstone. During normal working hours this will be provided by the on-site team and out of hours by a combination of direct telephone advice and the potential use of telemedicine, for example PACS. There will, in addition, be a surgical on call team to support Maidstone hospital and overall this is an improvement to the current service. This is entirely consistent with best practice and national clinical evidence and has been recently ratified by the clinical case for change outlined by Professor Sir Ara Darzi in his report, ''S*aws and scalpels to lasers and robots – advances in surgery''*.
- MTW will continue to have the ability to undertake emergency surgery at Maidstone in line with reviews and recommendations form the nation CEPOD enquiry.
- Minor trauma will continue to be seen and treated in the A&E department.
- Trauma requiring day case treatment will be seen locally, as now, with patients having operations booked. However, if the treatment requires urgent surgical intervention the patient will need to be transferred to the trauma centre at Kent and Sussex hospital to be seen by the skilled specialist team, or to another centre of the patient's choice.
- Trauma requiring an inpatient stay, but without surgery, would be admitted locally; normally under the care of the physicians. Orthopaedic or surgical input would then be available.
- The Maidstone A&E department will be capable of receiving, stabilising and transferring trauma cases and those patients with uncertain need for surgery. This builds on the current ability to diagnose, treat and transfer patients who need more specialist care such as vascular surgery and neurological trauma.

3. Expert review panel – The panel is yet to be convened but I anticipate that in addition to the external clinical experts it will include, representatives from the PCT PEC, the ambulance service and public health. The panel will be chaired by Dr James Thallon, the PEC chair, and supported by Jenny Thomas, Director of Strategy for the PCT. I expect the review will be complete by the summer and the panel will report to the July meeting of the PCT Board. I am sure that the PCT would be delighted for a nominated member of the HOSC to observe the panel if it would help assure you of the efficacy and robustness of the process.

4. Ambulance service – The ambulance service are very clear. That they will take patients to the most appropriate hospital with the correct facilities. They do this now and national evidence clearly shows that patient care is improved and lives are saved by taking patients to hospital with the right specialists, even if this means by-passing the nearest hospital.

   The PCT and MTW have been working closely with South East Coast Ambulance service to understand the implications of any changes for their teams and we can assure you that that the right level of vehicles and crews, with the right skills, will be in place to ensure a safe and appropriate level of service; this will be agreed through our commissioning process. We will be happy to ask the Ambulance Service to come and meet with the HOSC to discuss these issues in more detail if that would be helpful.

   I can confirm that a meeting between the 3 commissioning leads has already taken place and the investment will be agreed as part of the service level agreement for this year.

5. Repatriation of Maidstone patients – I can assure the HOSC that where it is appropriate and clinically safe to do so, and the patient prefers it, they will be repatriated to Maidstone Hospital for the rehabilitative care they require. Indeed, we would aim to transfer patients back to their own homes if that is better for them and their visitors.

6. Anticipated changes to patient flows – I apologise for the confusion caused by the different numbers quoted. As you know, the PCT conducted a thorough interrogation of the proposed model of care and of the process in order to be in a position to assure the PCT Board and make recommendations. It was during this scrutiny process that the changes arose. In summary the reason for the change is that MTW had quoted figures relating to emergency flows and not quoted the elective activity. This was in relation to the debate about emergency transfers. The total volumes of patients were known and consistent and were presented in total at the PCT Board. If you would like further explanation I suggest that it would be helpful to meet with Jenny Thomas who produced the presentation for PCT Board.

I hope these points of clarification are helpful, but if you require more information or further explanation, please do not hesitate to get in touch with me.

Finally, let me assure you that as a Trust and local health community we are committed to ensuring the best possible care of the highest standards is provided for all the people of West Kent and we are determined to get these changes right in the best interests of the patients we serve.

Yours sincerely,

Rose Gibb
Chief Executive

Steve Phoenix
Chief Executive
West Kent Primary Care Trust
Wharf House
Medway Wharf Road
Tonbridge
TN9 1RE

Members' Suite
Sessions House
County Hall
Maidstone
Kent ME14 1XQ
Tel: 01622 694434
Fax: 01622 694212
Email: members.desk@kent.gov.uk
8 May 2007

Dear Steve

A New Direction for Orthopaedic and Emergency Care

Thank you for your letter of 27 April, replying to ours of 24 April.

In view of your letter, and correspondence received from Rose Gibb and Geraint Davies, we are now minded to recommend at the NHS Overview and Scrutiny Committee meeting on 11 May that the committee endorse the decision taken by the PCT Board on 15 March regarding *A New Direction for Orthopaedic and Emergency Care*. However, this is subject to the following provisos:

1) We are strongly of the view that the panel for the planned external review cannot be chaired by someone from within the PCT if it is to be genuinely external. Consequently, Dr Thallon is not acceptable to us as the chair of the panel.

2) We would be more comfortable to know that there is representation from the local British Medical Association on the external review panel.

3) We reserve the right to reopen this issue in the event that the outcome of the external review turns out to be significantly detrimental to the provision of local health services.

4) We require clarification as to why the Trust intends that Maidstone A&E department will be staffed by A&E specialists for 15 hours per day rather than 16 hours or more.

5) We require to see the detailed results of the study undertaken by Operational Research in Health Ltd at the behest of the Trust regarding the level of resources that the ambulance service will need if the proposed changes are implemented.

We would be grateful for your responses to these points. We are also writing in the same terms to Rose Gibb; and our letter to you is being copied to Geraint Davies. Once we are in receipt of your responses, we will decide what final conclusions and recommendations we wish to put before the NHS Overview and Scrutiny Committee on 11 May. Accordingly, a prompt reply would be very much appreciated.

Regards

Yours sincerely

Alan Chell	**Mark Fittock**	**Dan Daley**
Chairman	**Vice Chairman**	**Liberal Democrat Spokesman**

NHS Overview and Scrutiny Committee

Cc: Geraint Davies (Director of Corporate Affairs and Service Development, South East Coast Ambulance Service NHS Trust)

Geraint Davies
Director of Corporate Affairs and Service Development
South East Coast Ambulance Service
Kent Office
Heath Road
Coxheath
Maidstone ME17 4BG

Members' Suite
Sessions House
County Hall
Maidstone
Kent ME14 1XQ
Tel: 01622 694434
Fax: 01622 694212
Email: members.desk@kent.gov.uk
8 May 2007

Dear Mr Davies

A New Direction for Orthopaedic and Emergency Care

Thank you for your letter of 27 April, replying to correspondence from us.

Enclosed is further correspondence that we have sent to Steve Phoenix (we have also written in the same terms to Rose Gibb). We would like to draw your attention to the fifth of the numbered points in our letter, regarding the study undertaken by Operational Research in Health Ltd.

Yours sincerely

Alan Chell	**Mark Fittock**	**Dan Daley**
Chairman	**Vice Chairman**	**Liberal Democrat Spokesman**

NHS Overview and Scrutiny Committee

Rose Gibb
Chief Executive
Maidstone & Tunbridge Wells NHS Trust
Maidstone Hospital
Hermitage Lane
Maidstone
ME16 9QQ

Members' Suite
Sessions House
County Hall
Maidstone
Kent ME14 1XQ
Tel: 01622 694434
Fax: 01622 694212
Email: members.desk@kent.gov.uk
8 May 2007

Dear Rose

A New Direction for Orthopaedic and Emergency Care

Thank you for your letter of 30 April, replying to ours of 24 April.

In view of your letter, and correspondence received from Steve Phoenix and Geraint Davies, we are now minded to recommend at the NHS Overview and Scrutiny Committee meeting on 11 May that the committee endorse the decision taken by the PCT Board on 15 March regarding *A New Direction for Orthopaedic and Emergency Care*. However, this is subject to the following provisos:

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We would be grateful for your responses to these points. We are also writing in the same terms to Steve Phoenix (with a copy sent to Geraint Davies). Once we are in receipt of your responses, we will decide what final conclusions and recommendations we wish to put before the NHS Overview and Scrutiny Committee on 11 May. Accordingly, a prompt reply would be very much appreciated.

Regards

Yours sincerely

Alan Chell **Mark Fittock** **Dan Daley**

Chairman **Vice Chairman** **Liberal Democrat Spokesman**

NHS Overview and Scrutiny Committee

Maidstone and Tunbridge Wells NHS
NHS Trust

Overview & Scrutiny Committee
11th May 2007

Update on Pembury Redevelopment

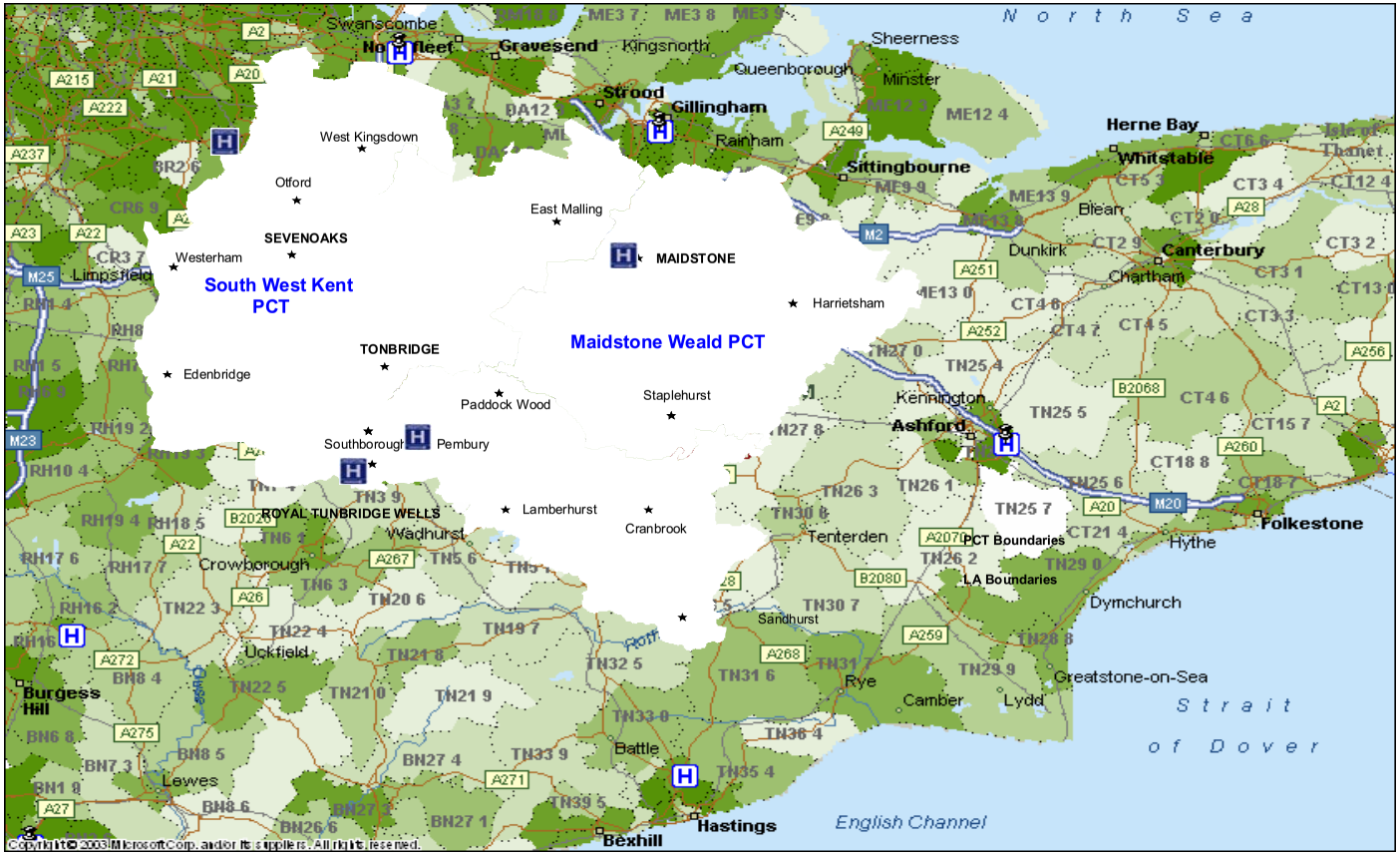
Trust Attendees

Rose Gibb	Chief Executive
Bernard Place	Commissioning & Healthcare Director
Laurence Bunnett	PFI Project Director

Acute Hospital Proposals

Strategic Context

Strategic Context – 1
Geographic location



Strategic Context – 2 Context

- Population
  - Resident 465,500,Wards 27, 4 local boroughs
  - Geographic range of 30 x 30 miles
- Provision of all forms of acute hospital and emergency services
- Provision and specialist services for:
  - Cardiology, complex surgery, foetal and maternal medicine
- Provision of specialist services to West Kent population for:
  - Ophthalmology, children's endocrinology and gastroenterology
- Provider of tertiary services in cancer and complex surgery for:
  - 2.3 million across the county of Kent & Medway up to & including Hastings & Eastbourne
  - Geographic range of 46 x 61 miles, and 72 wards

Strategic Context – 3
Trust response

- Ambulatory care and care close to patients' home
- High cost or low volume care, centralised using a hub and spoke model
- Provider of specialist and complex rehabilitation on acute hospital sites
- Day case, one-stop specialist and complex ambulatory services at both sites
- Elective & emergency patient flows, separated, ring fenced elective facilities
- Services to link smoothly between acute, primary, community and social care
- Can be the provider of non acute hospital based specialist or complex services off acute sites

Strategic Context – 4
Pembury Redevelopment

- Consolidates Kent and Sussex and Pembury services
- Enables consolidation of Trust obstetric and paediatric services
- Enables final bed stock efficiencies, eradicating duplicate working and rotas
- Provides modern estate and equipment replacing old building stock
- Backlog maintenance £60m eradicated

Strategic Context – 5
Trust service profile

Critical Care Centre Tunbridge Wells	SERVICES	Local Hospital and Tertiary Centre Maidstone
✓	Specialist OPD	✓
✓	Diagnostics	✓
✓	Medical	✓
✓	Surgery	Day case ISTC + Elective IP's
✓	Trauma & Orth	Day case ISTC
✓	Obstetrics	Midwife Unit
✓	Paediatrics	Ambulatory care
Day case	Oncology	✓
Day case	Cancer Surgery	✓
Day case	Urology	✓
Level 2 trauma	A&E	Level 3

Pembury Redevelopment – 1 Statistics

- Approx. 65,000 sqm
- Approx. £290m public sector (£241m ex. VAT at outturn prices)
- Beds: 512 (100% single room approach)
- Theatres: 8 major + 2 obs
- Outpatient rooms: 37
- Hard Fm by ProjCo, Soft Fm by Trust or Trust party

Pembury Redevelopment – 2 (PFI) Procurement Process

- Strategic Outline Case (SOC)
- Outline Business Case (OBC)
- Tender/Selection process – PITN/FITN
- DOH PFI Review
- Post FITN Process
- Provisional Preferred Bidder
- Appointment Business Case completion
- Pref'd Bidder & Planning application submission
- Completion of design & contractual negotiations
- Final Business Case (FBC) completion
- Contract sign (Financial Close) & Construction Start

Pembury Redevelopment – 3
PFI Review Overview

- Review implemented Nationally
- Tests and requirements:
  - Care closer to home agenda (sustainability)
  - Project deliverability (build-ability)
  - Introduced 15% metric (affordability)
  - Introduced ABC requirement

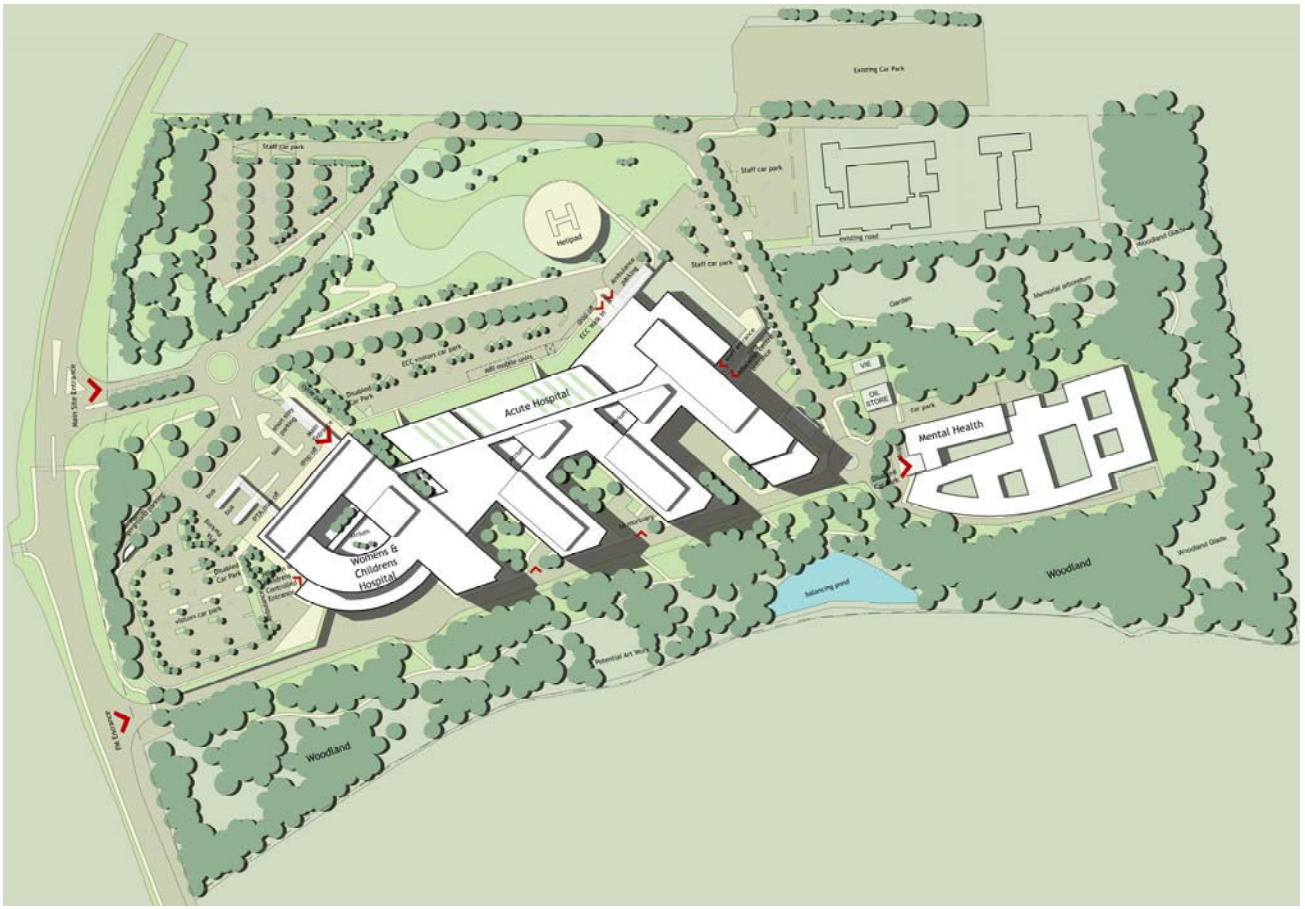
Pembury Redevelopment – 3 Care Model Principles - 1

- Patient Safety Design
  - Infection control
  - Falls
  - Medication errors
  - Sleep and rest
- Therapeutic Environment
  - Light
  - Ambient acoustics
  - Views
  - Colour

Pembury Redevelopment – 4 Care Model Principles - 2

- Patient and Family centred care
  - Patient preference
  - Privacy and dignity
  - Involvement of carers
- Care close to patient
  - Near patient data entry
  - Distributed nursing stations
  - Rehab by bed
  - Rehab embedded in ward
  - Minimum intra-hospital moves
- Maximised ‘purposeful nursing care’
  - 30% direct care to 60% direct care
  - Walking distances
  - ‘Vocera’ technology

Pembury Redevelopment – 5
Site design



Pembury Redevelopment – 6 Room design proposals

Figure 2: The therapeutic environment (acute bedroom shown)

Traffic & Transport Issues – 1

- Car Parking
  - 1200 Spaces in outline plan
    - Acute
    - MHU
  - In dialogue with planners (full plan)
  - New Traffic Impact Assessment required
  - Travel Plan

Traffic & Transport Issues – 2 Highway Infrastructure

- Dialogue with Highways Agency (A21)
- New DoT (Dept of Transport) Circular
  - Transport Impact Assessment
  - Travel plan
- Trust commitment to access

Programme update

- ABC
  - Issued to SHA and DH
  - Approval end June/mid-July
  - Pref'd bidder appointment post sign-off
- Design development
  - Work in progress with Provisional Pref'd bidder
  - Planning application under preparation
- Contract preparation
  - Legal & commercial terms for contract nr completion
- Development works
  - Enabling works in progress (lower site clear, asbestos removal)
  - Contract sign and major work start early 2008

End

Thank you

Question and answer session

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Item 6

By: Overview and Scrutiny Manager

To: NHS Overview and Scrutiny Committee – Friday 11 May 2007

Subject: NHS Overview and Scrutiny Committee – Work Programme and update on Committee activity.

Introduction

1. I set out in this paper various strands of activity that are being planned or are currently underway relating to the NHS Overview and Scrutiny Committee.

Future meetings and Work Programme

2. Set out below are the items already planned for future meetings of the Committee:-

Friday 8 June Council Chamber, Sessions House, County Hall, Maidstone	• StourCare Out of Hours service • Public Health Strategy for Kent • Fit for the Future update • Pharmacy • Infection control
Friday 20 July	• Mental Health Service Provision across Kent and Medway • Fit for the Future update • LINks update • Chronic Pain Clinics
Friday 7 September	• Fit for the Future • Primary Care Trust prospectuses • Update on *A new direction for Surgery and Emergency Orthopaedic Care update* (Maidstone and Tunbridge Wells NHS Trust)
Friday 12 October Council Chamber, Sessions House, County Hall, Maidstone	• Preventative healthcare – Steve Phoenix
Friday 9 November, Council Chamber, Sessions House, County Hall, Maidstone	• Dentistry • Audiology • LINks update
Friday 14 December Council Chamber, Sessions House, County Hall, Maidstone	

Homeopathy Review

3. Members will recall that a colleague from the West Kent Primary Care Trust attended on 9 February to advise the Committee about the Review of Homeopathy Services currently being developed. The consultation document for this review is attached as Appendix 1.

Fit for the Future

4. (1) The Committee will continue to receive regular updates on the Fit for the Future proposals for Kent and Medway.

(2) Arrangements are being made for colleagues from the three Primary Care Trusts across Kent and Medway to bring all Members of the County Council up to speed on the current proposals for Fit for the Future.

(3) The Committee will be aware that over recent months health colleagues have made it clear that it may not be necessary to consult on the Fit for the Future proposals.

(4) Colleagues from the Eastern & Coastal Kent Primary Care Trust met with the Chairman, Vice Chairman and Liberal Democrat Spokesman of this Committee on 20 April 2007. At this meeting they drew attention to the development of the PCT's Commissioning Strategy and the ongoing workstreams for the development of service change. They indicated that they did not envisage in every case that formal consultation would be necessary. The workstreams that they referred to were:-

a) elective services (including Integrated Clinical Assessment and Treatment Service – ICATS);
b) urgent care;
c) adult mental health;
d) children and young people;
e) *Choosing Health*;
f) maternity services; and
g) National Service Frameworks Local Improvement Teams (for cancer, coronary heart disease and older people).

"Health Showcase"

5. (1) Members will be aware that at a meeting earlier on in the year I was asked whether it might be possible to organise an event relating to Patient Pathways.

(2) At that meeting I suggested that this would be an appropriate event for all Members of the County Council. I have mentioned this to colleagues in the Primary Care Trusts in Kent, and there is a willingness to organise a "Health showcase" where all Members of the County Council can increase their understanding and knowledge of a whole range of Health Service issues.

(3) Members will be aware that the special Council meeting on 24 July 2007 is to be dedicated to health issues. I am exploring whether an event such as I have described above will be possible as a complement to this County Council meeting, when most Members of the Council will be present.

(4) Increasing our knowledge of the complexity of the Health Service, which is subject to so much change, is an ongoing process that needs continual updating.

Presentation by the Chief Executive of the South East Coast Ambulance Service NHS Trust

6. (1) On 25 April 2007 a group of NHS OSC members visited the ambulance control centre at Coxheath and heard a presentation by the Chief Executive of the South East Coast Ambulance Service NHS Trust, Paul Sutton, on his vision for future services.

(2) Those who attended were very impressed by what Mr Sutton had to say and expressed the wish for him to have the opportunity to give the presentation to the rest of the Committee, as well as other members of the County Council.

NHS Overview and Scrutiny Committee Protocols

7. (1) Members will recall that you have raised with me on several occasions the issue of devolving some of the powers of the Committee to a more local level.

(2) Underpinning this are the NHS Overview and Scrutiny Committee Protocols, signed up to by all the local authorities across Kent, which were agreed and incorporated in each of the authorities' constitutions when the Committee was established in November 2001. There is a clear need for the protocols to be re-examined. I am, therefore, convening a steering group comprising Borough and District Council colleagues, Patient and Public Involvement Forum colleagues and representatives of the Health Service to look at the protocols and make recommendations for their amendment to a Member steering group prior to each Council being invited to adopt the protocols for inclusion in their Council's Constitution. The current protocols are attached as Appendix 2.

(3) A number of Borough and District Councils across the county are now very keen to engage in health scrutiny through their own scrutiny arrangements and several already do so. I am keen to encourage this activity. For example, following the last meeting of the Committee in Canterbury when a discussion took place on the development of the Polyclinic at Whitstable I met with colleagues from Canterbury City Council about the possibility of their Health Scrutiny Panel looking at this in greater detail. Canterbury CC have indicated that they would be very willing to look at the issues surrounding the development of the Polyclinic through their Health Scrutiny Panel.

Integrated Clinical Assessment and Treatment Service (ICATS)

8. (1) One of the emerging issues for the development of health care services being available in the community is the development of an Integrated Clinical Assessment and Treatment Service (ICATS).

(2) At the meeting with Eastern & Coastal Kent PCT colleagues on 20 April 2007 the spokesmen were told of an ICATS which has been piloted and is operational in Ashford.

(3) Health colleagues indicated that they would be very happy to host a visit from Members of the Committee and local Members.

(4) The Committee are asked to indicate whether they would wish to have a visit organised to this service.

Development of a LINk

9. (1) Members will recall that the Local Government and Public Involvement in Health Bill contains proposals regarding the establishment of Local Involvement Networks (LINks), on the basis of one for each authority with social services responsibilities, to replace the Patient and Public Involvement Forums.

(2) The Chairman and I have been engaging colleagues from some of the "early adopter" authorities for LINks, as well as other councils, to see how they are planning to embrace this planned new arrangement. It is fair to say that, even amongst the early adopters, there is little enthusiasm for the proposal – especially in the absence of any real detail (which is expected in regulations once the legislation has been passed).

(3) More recently, on 20 April 2007, the Commons Select Committee on Health produced a report on Patient and Public Involvement in Health which was highly critical of the government's plans to replace PPIFs with LINks. A copy of the Executive Summary of the Select Committee's report is attached as Appendix 3.

Recommendation:-

that the contents of the report be noted.

Paul Wickenden
Overview and Scrutiny Manager
Ext 4002
paul.wickenden@kent.gov.uk

Appendix 1

Should the NHS pay for homeopathy?

HAVE YOUR SAY

Public consultation

West Kent NHS
Primary Care Trust

1 Setting the scene

1.1 West Kent PCT

West Kent Primary Care Trust (PCT) ensures that health services are provided for all 674,000 residents in the Dartford, Gravesham, Swanley, Sevenoaks, Tonbridge, Tunbridge Wells, and Maidstone and Weald areas.

Figure 1: West Kent PCT area

The PCT has a budget of £747 million per year, and works with about 400 family doctors, 110 dentists, 104 pharmacists, 6 community hospitals, and 3 larger hospitals. About £200,000 is spent each year on homeopathy.

As part of a wider review of all services and spending, West Kent PCT is considering whether the NHS should fund homeopathy offered by doctors who have a postgraduate qualification in complementary therapy (integrative practitioners). This consultation document sets out the reasons for the review and some suggested ways forward. The PCT Board would like to hear your views to help guide decision-making.

1.2 This consultation

This consultation is about the referrals GPs (family doctors) make to specialist doctors for homeopathy. Section 1.3 describes what we mean by homeopathy. We're focussing on homeopathy because there is ongoing debate about whether homeopathy provides a cost-effective, value for money service and the PCT has a responsibility to ensure that resources are used well. Services such as acupuncture will continue to receive funding from the NHS and are not the subject of this consultation.

The purpose of this consultation is not to question whether homeopathy is effective – only whether it should be funded by the NHS

The answer to this question may not be clear cut. It is possible that homeopathy could be funded to support people with some conditions but not others. West Kent PCT is reviewing a wide range of perspectives to help address this question.

The review is taking place in the context of a healthcare system that is trying to regain financial control. Difficult decisions have to be made about relative priorities for funding. The PCT has to commission services within the resources available, so if homeopathy is funded some other services may receive less funding or no funding. The consultation will help the PCT understand the importance of homeopathy to local people, compared to other priorities.

1.3 What is homeopathy?

In England, a significant number of people use complementary therapies such as homeopathy to supplement or in some cases to replace conventional healthcare. Surveys conducted in the late 1990s found that up to one in four adults may have visited a complementary medicine practitioner or purchased over-the-counter complementary therapies in the past year.

As well as being available for private purchase, some complementary therapies are available through the NHS in some places. In West Kent, GPs can refer local people to hospitals that specialise in complementary therapies such as homeopathy.

Homeopathy is based on the principle that 'like should be cured with like' and that a substance which causes certain symptoms might be able to resolve similar symptoms. For example, for hay fever a highly diluted remedy made of onion is often used. In undiluted form this may cause hay fever-like symptoms in healthy people.

Doctors who provide homeopathy often work with people with long-term conditions and those with illnesses that do not have a firm diagnosis. Initially, these doctors have a long consultation with people to understand their problems and the impact on their lives. They then match people's symptoms to individualised remedies and adjust doses over time.

On average, someone receiving homeopathy paid for by the NHS will attend an initial consultation and about three follow up appointments. Those with long-term conditions receive more follow up appointments.

1.4 Cost of services

Every year, West Kent PCT funds about 2800 homeopathy appointments for around 750 people. Three quarters of these are follow up visits for people receiving ongoing care.

The majority of homeopathy consultations paid for by West Kent PCT take place at Tunbridge Wells Homeopathic Hospital, by doctors trained in both complementary and conventional medicine. This is one of five NHS homeopathic hospitals in England.

In the year ending December 2006, West Kent PCT paid £192,682 for homeopathy appointments. This equates to a cost of about £250 per person receiving homeopathy per year. PCT audit data suggests that people who receive homeopathy are often receiving other specialist services for their condition as well, so the PCT may be 'paying twice' for their care.

To put this in context, for illustrative purposes, the total amount spent on homeopathy equates to about 1500 appointments with pain specialists, 2300 appointments with dermatologists, or 1300 appointments with arthritis specialists.

Any change would not affect people currently receiving homeopathy.

The PCT will continue to fund homeopathy for everyone currently receiving it. But we'd like your views about whether the NHS should pay for new referrals from now on.

2 Do we need to change?

2.1 Potential benefits

In preparing for this consultation, West Kent PCT has examined the benefits and costs to the NHS of homeopathy.

This section describes feedback about the benefits of homeopathy and examines where homeopathy fits in with other PCT priorities.

We know that some people experience important benefits from homeopathy. The question is should it be a priority for NHS funding?

As part of the review process, the PCT has spoken to some service users and doctors and commissioned a review of research about the effects and cost effectiveness of homeopathy. More information will be compiled throughout the consultation.

What do people using the service say?

Last year, West Kent PCT paid for about 750 people to receive homeopathy.

Feedback from more than 5500 people attending Tunbridge Wells Homeopathic Hospital over a 7.5 year period suggests that three quarters believe they get some relief from their symptoms. Half think they are 'moderately better' or 'much better.'

"I am 55 years old. I asked my GP to send me for homeopathy because I had very itchy skin. Dermatitis medicines didn't seem to help. I've visited the Homeopathic Hospital every month for the past four months. My skin feels much better now and I'm looking forward to getting into shorts this summer." [Service user]

But not everyone has the same positive experiences. To find out whether homeopathy has clinical benefits for a wide number of people, at the beginning of 2007 West Kent PCT commissioned an independent review of up to date research that met the highest quality standards for evidence-based medicine.

What does the research say?

The review examined published studies of large numbers of people in order to put feedback from individuals into context. It included 39 reports compiling all of the major research about homeopathy plus randomised trials that compared outcomes for people who received homeopathy versus those who did not. The review found that, although there were some positive trends, there was not enough evidence about homeopathy for people with conditions such as asthma, depression, back pain, or arthritis, and there was very little information about cost-effectiveness. This is true for many other treatments offered by the NHS too.

Homeopathy was not associated with many side effects, but most studies found no 'clear cut' evidence that homeopathy improved people's symptoms.

There is no clear evidence to support or to recommend against homeopathy.

Some scientists think that people might feel better when receiving homeopathy because they are getting care and attention – it is not the homeopathic medicine that is making a difference, but the fact that people think it might help. This is called a 'placebo effect.' Overall, homeopathy remains unproven.

What do homeopathic doctors say?

Doctors offering homeopathy in West Kent say that it is important to keep funding the service because it supports people who may not be able to get help from other types of medicine, especially those with long-term health problems. They say that homeopathy is very popular with some patients.

Doctors offering homeopathy also say that it does not cost a great deal of money to provide the service. The main cost is for the practitioner's time.

These specialists suggest that people who receive homeopathy might not use as many conventional medicines or appointments if they feel better after receiving homeopathy and that the NHS may save money by avoiding side effects from conventional medicines. The PCT is compiling information from GP records and other audit data to investigate these claims.

"People often ask for homeopathy because they have a condition where there is no effective conventional treatment or where other medicines have side effects. Side effects cost the NHS a lot of money. Homeopathy has few side effects and is thought to be more natural, because it stimulates people's own healing mechanisms." [Dr Helmut Roniger, Tunbridge Wells Homeopathic Hospital]

What do other doctors say?

Some doctors question whether the NHS should pay for homeopathy. A letter to The Times earlier this year from a number of medical academics questioned the legitimacy of PCTs continuing to fund homeopathy. A leading Professor of Complementary Medicine in the UK signed this letter too.

Some GPs in West Kent say that the NHS should not continue to fund all homeopathy because it remains an unproven therapy, and because the PCT must pay for treatments that make the best use of the limited amount of money it has.

"We all share an absolute duty to spend NHS money in both a clinically and cost effective manner. For historical reasons there has been a permissive endorsement of homeopathy across the NHS despite widespread recognition that the theoretical basis in science is implausible. The motto of the Royal College of General Practitioners is "science with compassion." In this case we must insist on the science. We must not have one without the other." [Dr James Thallon, GP]

2.2 PCT priorities

It is important to think about homeopathy in the context of the PCT's other priorities. West Kent PCT is undertaking a review of **all** services to make sure that the things we fund meet health priorities and people's needs now and in the future. Homeopathy is not being 'singled out' for review – a wide range of services are being considered.

"West Kent PCT is going through a process of financial turnaround. We are looking carefully at all services and seeing how they fit in with local and national strategic plans. We need to make some tough decisions about what we will and will not continue to fund. We can't keep funding everything, and so we have to make some choices about what is best for the majority of people in West Kent."
[David Newcombe, West Kent PCT Financial Turnaround Director]

West Kent PCT wants to fund services that the largest number of people can benefit from. Homeopathy is used by a relatively small number of people each year (755 people in 2006), but those people do generally feel that homeopathy helps them.

The PCT's priority is to offer services based on the needs of local people. We want to invest in providing more care close to people's own homes; paying for services to support people with long-term conditions such as arthritis, asthma, depression, and heart disease; and increasing access to services for those who need them most.

The PCT is questioning whether homeopathy should be a priority for funding for many reasons, including:

- Many PCTs don't routinely refer people for homeopathy. In the past few years 53 PCTs have taken steps to reduce NHS funding for homeopathy.
- The NHS has a finite amount of funding and cannot fund everything that people think might make them feel better. The NHS needs to fund the most efficacious services for the majority of people.
- Homeopathy remains an unproven discipline and there is limited evidence about cost effectiveness. This is true of some other health services too.
- Most people who use homeopathy request to do so. It is not generally 'prescribed' for clinical purposes.
- Like some other specialist services, homeopathy is only accessed by a small subset of people. This may be because not everyone knows about it, but the PCT needs to consider the wellbeing of the wider population.
- People who use homeopathy also tend to be using conventional services. This might be because conventional medicine is not working for them, but often there is a double use of services, rather than homeopathy substituting for conventional care.
- Any change will not affect people currently receiving homeopathy. Decisions will only be made about whether to fund new referrals. Current services will not be 'cut off.'

3 How could we change?

3.1 Options

West Kent PCT has developed three possible options for a way forward. These options were developed in consultation with user representatives, stakeholders from Tunbridge Wells Homeopathic Hospital, and GPs.

Option 1: Homeopathy funded following decision by Independent Panel

GPs who want to refer someone for homeopathy would send a request to an Independent Panel. The Panel would decide whether or not the treatment will be funded by the NHS. The criteria the Panel use to make decisions would be developed in discussion with GPs and the doctors providing homeopathy. The Panel would be made up of the Director and Assistant Director of Nursing, a Consultant in Public Health, a GP, and a Pharmacy / prescribing lead, amongst others, and would meet regularly to consider a range of treatments.

Option 2: Fixed number of homeopathy visits funded

GPs would refer people for homeopathy directly, as they do now. The NHS would fund both an initial consultation for homeopathy and a fixed number of follow up visits. Further treatment for the same condition would need approval from an Independent Panel. The exact number of visits funded would be decided following consultation with GPs and the doctors providing homeopathy. However, at this stage it is suggested that one initial consultation and three follow up appointments might be considered. This is the average number of visits per person per year that the PCT currently funds.

Option 3: No homeopathy funded by the NHS

The NHS would not fund any referrals for homeopathy. The rationale would be that there is insufficient evidence that homeopathy provides good value for money or is a high priority compared to other services that require NHS funding.

We would like to hear about any other options you think of

3.2 Impacts

The PCT has begun to consider the impacts of each option and will continue to compile information about this during the consultation period. Table 1 summarises some of the key information available so far.

Table 1: Initial information about key impacts of each option

Option	Impact on referrals	Impact on costs	Impact on other treatments
Option 1: **Decision about NHS funding of each individual case by an Independent Panel**	It is difficult to estimate the impact of Option 1 on referrals, because the decision making criteria have yet to be developed. If the Independent Panel approved treatment only for conditions where there are some positive research trends, referrals may reduce by half to two thirds.	The exact cost reduction would depend on the number of referrals funded. If the Independent Panel approved funding for half of all possible new referrals from GPs, there would be a saving of about £50,000 per year.	The Independent Panel already meets to discuss other treatments. There would be some additional costs for staff time. If some funding for homeopathy is withdrawn, people might use other specialist services instead. However, many people receiving homeopathy also receive conventional specialist care at the same time, so extra costs from people using more conventional care may be limited to £10,000 per year.
Option 2: **NHS funds fixed number of homeopathy visits**	If the NHS funded a fixed number of visits for all conditions, there would be little impact on first referrals. Follow up appointments may be reduced by half to one third.	The exact cost reduction would depend on the number of follow up visits funded. If the NHS funded one consultation and 2-3 follow ups the saving would be about £50,000 each year.	As above, extra costs from people using more conventional care may be limited to about £10,000 per year. The Independent Panel already meets to discuss other treatments. Under this option there few additional costs for staff time.
Option 3: **NHS does not fund homeopathy**	Under Option 3, no referrals for homeopathy would be funded by the NHS.	This option would save the NHS about £200,000 per year on consultation costs.	It is estimated that the costs of people using extra conventional care instead of homeopathy may amount to up to £20,000 per year. The majority of people may already be receiving homeopathy and other care simultaneously.

The PCT believes that funding homeopathy does not necessarily fit with national or local strategic priorities, where there is an emphasis on funding the best care for the greatest number of people in locations close to home. Given that so many services need NHS funding, and there is only a finite amount of money available, the PCT is questioning whether continuing to pay for homeopathy is a priority in the long term.

The decision about whether and how to change must be based on the health needs of people living throughout West Kent. A number of organisations provide homeopathy services in West Kent, including the Royal London Homeopathic Hospital and Tunbridge Wells Homeopathic Hospital. It is homeopathy referrals that are under review, not any specific hospital.

The consultation is about whether the NHS should pay organisations to provide homeopathy treatment.

The consultation is not about whether Tunbridge Wells Homeopathic Hospital should remain open, but about whether the NHS should pay for any homoeopathy that might be available there. However, because the NHS pays Tunbridge Wells Homeopathic Hospital for many homeopathy services in the area and because we recognise the institution's importance to some local people, this section briefly examines the impacts of change upon the Hospital.

The Hospital is owned by the local NHS mental health trust. It provides a wide range of services in addition to homeopathy. Homeopathy is not its only form of business, but is an important part.

About half of referrals to the Homeopathic Hospital come from West Kent, 35% come from Bromley, and 15% come from other sources. If West Kent PCT provided less or no referrals to the homeopathy service, the Hospital would need to review its service provision. It would still continue to receive the half of referrals from outside West Kent, and this may impact on where NHS homeopathy services are based.

West Kent PCT is not suggesting that homeopathy should not be available to people who find it helpful. The question is whether it should be a priority to receive NHS funding, given all the other spending priorities. If the NHS did not pay for treatments like homeopathy, they would continue to be available privately.

If there were changes to the service, this could impact on the roles of three part time clerical and nursing staff and two complementary medical practitioners, but this would be up to their employer, not the PCT. Specialist doctors may continue at the Hospital or consider private practice.

Any changes would not impact on people currently receiving homeopathy, because only new referrals would be affected.

It is also unlikely that there would be significant impacts on GPs and hospitals. People who receive homeopathy are usually already getting care from their GPs or other hospitals too, so if homeopathy was limited they would not all suddenly need to use a greater number of conventional services.

4 How will we make decisions?

4.1 Making decisions

The PCT Board will select which option to move forward with. The Board will use criteria to help them weigh up the pros and cons of each option. These may include:

Clinical effectiveness
Will Option 1, Option 2, or Option 3 allow the PCT to deliver the most effective services?

Impact on other parts of the system
Does Option 1, Option 2, or Option 3 best help us avoid pressure on other services?

Population needs
Does Option 1, Option 2, or Option 3 best meet the whole population's needs now and in the future?

Practicality
Is Option 1, Option 2, or Option 3 most achievable and easy to put into place?

Public demand
Does Option 1, Option 2, or Option 3 best fit in with public perceptions and feedback?

Value for money
Does Option 1, Option 2, or Option 3 provide the most affordable and sustainable service given the PCT's financial pressures?

We would like your feedback about the criteria the Board will use to make decisions

You could suggest other factors the Board should consider when making decisions too.

4.2 Next steps

There are three parts to this consultation: public meetings, meetings with other stakeholders, and analysis of written feedback.

1. Public meetings

The PCT will host five public meetings at:

1. Tuesday 8th May; 1.45-4.45pm
   Board Room 2, Preston Hall,
   Aylesford, Maidstone
2. Friday 11th May; 1.45-4.45pm
   Gravesham Community Hospital
3. Wednesday 16th May; 1.45-4.45pm
   The Camden Centre, Market Square,
   Tunbridge Wells
4. Wednesday 16th May; 6-9pm
   The Camden Centre, Market Square,
   Tunbridge Wells
5. Monday 21st May; 6-9pm
   The Camden Centre, Market Square,
   Tunbridge Wells

These meetings will include presentations about the reasons changes are being considered and discussions about the pros and cons of each option. Feedback from meetings will be considered when the Board makes its decision.

Everyone is welcome at the public meetings. To receive documents for the public meetings, contact 01732 375288 or jonathan.barnes@swkentpct.nhs.uk

2. Meetings with staff and key groups

The PCT team will be available to speak at a range of groups and will make visits to organisations and voluntary groups that work with people with the conditions most commonly referred for homeopathy treatment.

If you would like West Kent PCT to make a presentation or come to discuss the issues with a group you're involved with, contact 01732 375288 or jonathan.barnes@swkentpct.nhs.uk

3. Written feedback

Members of the public, staff, and other stakeholders are invited to complete the consultation feedback form, or to write a letter expressing their views. The feedback form is overleaf.

The consultation is not a 'vote' and the option with the greatest support will not necessarily be selected.

It is more important for the PCT Board to weigh up the pros and cons of each approach – and that is why the reasons that people support or oppose each option will be carefully considered.

The PCT Board are very interested in how you think they should make the decision, which is why we are asking for feedback about the criteria that will be used to judge each option.

The deadline for receiving feedback forms and letters is 2 July 2007.

After this, all feedback from forms, letters, and meetings will be collated into a report that will be made available to the PCT Board as part of their decision making process. The Board hope to make a decision at the Board meeting on 26 July 2007.

5 Have your say

If you would like to give us your views, please tear out this form, fill it in, and post it back by 2 July 2007. The freepost address is at the end of the form.

Making decisions

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. I understand the reasons that change might be needed	☐	☐	☐	☐
I agree with the reasons for change described	☐	☐	☐	☐
I believe homeopathy should be a priority for the NHS	☐	☐	☐	☐
I believe the NHS should pay for some homeopathy	☐	☐	☐	☐

2. Please tell us how important these factors should be when making decisions about the pros and cons of each option

	Very important	Of some importance	Of little importance	Not important
Clinical effectiveness (will the option give effective care?)	☐	☐	☐	☐
Impact on other services (will there be pressure elsewhere?)	☐	☐	☐	☐
Population needs (does the option meet people's needs?)	☐	☐	☐	☐
Practicality (is the option easy to put in place?)	☐	☐	☐	☐
Public demand (does the option fit in with public feedback?)	☐	☐	☐	☐
Value for money (is the option affordable and sustainable?)	☐	☐	☐	☐

3. Are there any other criteria that we should consider when making decisions?

Options

4. We have outlined three possible options for change. The option with the highest number of 'votes' will not necessarily be selected. It is more important for us to know the reasons for your views.

	Strongly Agree	Agree	Disagree	Strongly Disagree
I support Option 1: Decision by an Independent Panel	☐	☐	☐	☐
I support Option 2: Fixed number of homeopathy visits funded	☐	☐	☐	☐
I support Option 3: No homeopathy funded by the NHS	☐	☐	☐	☐

Should the NHS pay for homeopathy?

5. Please tell us what you think are the best and worst points about each option:

	Main advantages	Main problems
Option 1: Decision by an Independent Panel		
Option 2: Fixed number of visits funded		
Option 3: No homeopathy funded by the NHS		

6. Do you have any other comments about the options or how they will affect you? Or would you like to suggest another option?

Please attach a separate page if needed.

About you

Finally, we would like to know a little about you. This will help us make sure we have feedback from a wide range of people.

7. Which area do you live in or closest to?

- Dartford ☐
- Gravesham ☐
- Swanley ☐
- Sevenoaks ☐
- Tonbridge ☐
- Tunbridge Wells ☐
- Maidstone and Weald ☐

8. Tick if you have used NHS homeopathy before ☐
9. Tick if you have paid for homeopathy before ☐

10. Are you ...

- a member of the public / service user ☐
- a PPI Forum or Citizen's Panel member ☐
- a member of NHS clinical staff ☐
- a non clinical NHS staff member ☐
- a Councillor or other elected official ☐
- a voluntary sector organisation ☐
- a health organisation ☐
- other- please write in: ☐

_____

Thank you for your views. Please post to FREEPOST RRJX JYUR UYAC, West Kent PCT, Wharf House, Medway Wharf Road, Tonbridge TN9 1RE. We need your response by 2 July 2007.

West Kent Primary Care Trust

Wharf House
Medway Wharf Road
Tonbridge
Kent TN9 1RE

01732 375200

www.westkentpct.nhs.uk

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Appendix 2

Annex B: Protocol for National Health Service Overview and Scrutiny

5B.1 These protocols are agreed within a context that assumes organisationally:-

- the bringing into force of the Health and Social Care Act 2001
- the continued development of partnership working, especially between Social Services and NHS bodies
- the continued existence at District/Borough level of local overview and scrutiny committees concerned with NHS matters
- the continued existence of Community Health Councils or representative organisations operating at sub-county level
- a partnership approach working with not against NHS bodies in the county

5B.2 The protocols are based on the principles that:-

- Overview and Scrutiny should focus on supporting the improvement of health services to Kent residents.
- Overview and Scrutiny should minimise the additional administrative burdens on local authorities or NHS bodies.
- Overview and Scrutiny agendas need to be developed jointly by the local authorities and the NHS bodies.
- Overview and Scrutiny needs to operate at different levels within Kent.

Structures

5B.3 Overview and Scrutiny structures will comprise:-

Community Health Councils

To continue as now until replaced by new patient bodies but with more support from local authorities and integration into the Overview and Scrutiny system to pave the way for their successor bodies:-

- Dialogue focused on service providers (acute trusts and PCT provider units)

District Council Overview and Scrutiny Committees

To look at local service issues:-

- Local co-ordination (or joint committees) to ensure cross-district issues dealt with jointly

- Local KCC Members and CHC representatives to have rights of participation

- Focused on PCTs

KCC Health Service Scrutiny Committee

To look at broad and wide area issues, including from the viewpoint of the County Council's Social Service responsibilities:-

- An emphasis on working through themed (topic) reviews conducted by Select Committees (smaller ad hoc groups) including District and Patient members.

- DC and CHC representatives to have rights of participation.

- Service reconfigurations to be looked at through Select Committees (ad hoc time limited sub-committees including DC and CHC participation) reporting to the KCC Health Service Scrutiny Committee to consider reference to the national Reconfiguration Panel (when the legislation is brought into force).

- Focused on Health Authorities.

Medway Overview and Scrutiny Committee

To combine both levels of operation within the Medway area but LINked into the co-ordinated system.

Co-ordination

5B.4 Overview and Scrutiny activity at local and Kent level needs free exchange of information and protocols for co-ordination of work and resolution of conflicts. To facilitate this there will be:-

- a regular meeting of Committee Chairmen and NHS representatives to agree a programme of work across the county and Medway.

- a similar officer forum to support and advise the Chairmen on the work programme and co-ordinate requests for NHS officers to provide papers, information or attend committee meetings.

5B.5 The KCC Committee membership allows for DC and CHC membership:-

- a permanent representation of three District/Borough Members nominated by KALA and two CHC representatives nominated by the CHCs on a non-voting basis.

- a right for the Chairmen of each District/Borough Overview and Scrutiny Committee (or another relevant Member) and each CHC to attend and speak at the KCC Committee (or send a representative) on a matter particularly affecting that area.

- appointment of members of relevant District Overview and Scrutiny Committees and CHCs to individual topic reviews (agreed through the Chairmen's meeting).

5B.6 District Committees will allow local KCC Members and CHC representatives to attend and speak at the Committee.

5B.7 KCC and DC members on CHCs will be briefed by and feed back to their appointing Councils.

Review Planning

5B.8 Overview and Scrutiny will take the form of a programme of reviews. Each review should be preceded by a Review Plan discussed within the officer forum and agreed with the relevant NHS bodies. Any disagreement should be considered by the relevant Overview and Scrutiny Committee after the NHS representative has attended the Committee to express the NHS view and answer member questions.

5B.9 The Review Plan should:-

- set the terms of reference for the review including the general nature of the expected outcome.

- set an approximate timetable of meetings and a reporting date.

- state the officers supporting the review within the local authority, the NHS and the CHCs and estimate the time commitment required of them.

- state the main witnesses and information sources expected to be involved.

Review Administration

5B.10 The arrangements for meetings of Overview and Scrutiny Committees shall ensure that:-

- Dates for witnesses to attend Committee meetings are agreed with witnesses as far in advance as possible.

- NHS Chief Executives and other local authorities' Chief Executives arrange for appropriate officers chosen by them to attend to give evidence on the identified topics (subject to any provision to be made in statutory regulations).

- Advance notice is given of the areas to be covered in questioning.

- Information is wherever possible distributed to the Committee in writing before the witness attends.

Meeting Protocols

5B.11 All Overview and Scrutiny Committees should incorporate in their Procedure Rules or otherwise ensure that:-

- Committee Members should endeavour not to request detailed information from officers of the NHS or another local authority at meetings of the Committee, unless they have given prior notice through the Clerk. If, in the course of question and answer at a meeting of Committee, it becomes apparent that further information would be useful, the officer being questioned may be required to submit it in writing to members of the Committee through the Clerk.

- In the course of questioning at meetings, officers of the NHS or another local authority may decline to give information or respond to questions on the ground that it is more appropriate that the question be directed to a more senior officer or Member.

- Officers of the NHS or another local authority may decline to answer questions in an open session of the Committee on the grounds that the answer might disclose information which would be exempt or confidential as defined in the Access to Information Act 1985. In that event, the Committee may resolve the exclude the media and public in order that the question may be answered in private session.

- Committees may not criticise or adversely comment on any individual officer of another local authority or of an NHS body by name.

Reporting

5B.12 All local authorities should ensure that:-

- A record is made of the main statements of witnesses appearing before the Committee and agreed with those witnesses prior to publication or use by the Committee (Committee meetings may be electronically recorded).

- Drafts of Committee reports and recommendations should be made available for comment by the relevant NHS body (or local authority) whose operations might be commented on and any adverse comments or concerns reported to the Committee before the final report is published.

- The Chief Executive of any NHS body and/or the Chief Officer of any other local authority involved with the review is given advance notice of the date of publication of the report and consulted on the text of any accompanying press release.

- Reports should include an agreed timetable for any NHS body and/or other local authority involved to publish a response to the report's recommendations once confirmed by the appropriate Overview and Scrutiny Committee.

Service Reconfigurations

5B.13 NHS bodies remain responsible for public and other consultation on service reconfiguration proposals.

5B.14 The intention to carry out a consultation will be discussed in the officer forum.

5B.15 The KCC Health Service Scrutiny Committee will consult District/Borough Councils and CHCs for the areas affected by each proposal on whether to:-

- consider the matter at a full meeting of the Committee.
- set up a KCC Select Committee to consider the proposal.
- request a District/Borough Overview and Scrutiny Committee to consider the proposal.

5B.16 If a Select Committee is established or a District/Borough Overview and Scrutiny Committee requested to carry out a review:-

- paragraphs 8-12 above shall apply to its work programme and proceedings.

- the Review Plan shall as far as possible be integrated with the NHS body's consultation programme.

- consideration shall be given to:-

  - including one or more members of District/Borough Councils on the Select Committee or KCC members on the District/Borough Overview and Scrutiny Committee.
  - including CHC members on the Committee.
  - other arrangements for ensuring all local authorities and CHCs may express their views and seek information on the proposal.

- the review report shall be submitted to the KCC Health Services Scrutiny Committee who will consider the recommendations together with any response by the NHS body and decide whether to refer the proposal to the Reconfiguration Panel.

Appendix 3

House of Commons Health Committee

Patient and Public Involvement in the NHS
Third Report of Session 2006–07

Patient and public involvement describes a wide range of activities and has a variety of purposes. Patient involvement and public involvement are distinct and are achieved in different ways. The conflation of these distinct terms and the confusion about the purpose of involvement has led to muddled initiatives and uncertainty about what should be done to achieve effective patient and public involvement. Nevertheless, patient and public involvement has the potential to play a key role in both NHS and Social Care services by bringing about service improvement and improving public confidence. Given the lack of local accountability in the NHS, often referred to as the 'democratic deficit', there remains a role for independent patient and public involvement structures.

The first formal structures to represent the public's interest in the NHS were Community Health Councils (CHCs), which were in created in 1974. CHCs were in place for almost 30 years, but in recent years there has been a flurry of changes. CHCs were abolished at the end of 2003. Their role was taken over by a number of organisations, including Overview and Scrutiny Committees (OSCs—the remit of which was extended to cover healthcare), Patient Advice and Liaison Service (PALS), Independent Complaints Advocacy Service (ICAS) and Patient and Public Involvement Forums (PPIfs). PPIfs were supported by the Commission for Patient and Public Involvement in Health (CPPIH). Our predecessor Committee warned at the time of the consequences of these changes. In July 2004, less than six months after PPIfs had begun operating, the Department announced the abolition of CPPIH. At the time it said that PPIfs would remain, but. in July 2006 the abolition of PPIfs was also announced. They are to be replaced by Local Involvement Networks (LINks). No precise date has yet been set for the abolition of PPIfs or CPPIH.

The Department argued that LINks would provide better value for money and be better able to take into account the changing nature of the NHS, such as the increasing role of the private sector. The other reasons given for the abolition of PPIfs are the same as those given when CHCs were abolished: there is a wide variation in performance and they are not representative of the community, failing to attract young people and ethnic minorities. We are not convinced that PPIfs should be abolished. We do not see why PPIfs could not have been allowed to evolve. The abolition of PPIfs seems to have been driven by the need to abolish CPPIH rather than a real need to start again. Merging the existing PPIfs to form LINks would have been much less disruptive for volunteers and would have reduced the risk of significant numbers of them leaving. As most Forum Support Organisations already support several forums they could have been allowed to evolve into Hosts, keeping their experienced staff. Once again the Department has embarked on structural reform with inadequate consideration of the disruption it causes.

The Local Government and Public Involvement in Health Bill establishes LINks. It sets out the main remit, rights and duties of the organisation, but provides very little detail. Most of this is to be set out in regulations once the Bill has received Royal

Assent, although the Department did send the Committee a number of draft consultation documents. Worryingly, a number of projects known as 'early adopters', which seek explore how LINks would operate, were established in December 2006, after the Bill was introduced, implying that the establishment of LINks was not an evidence-based decision.

The Department's concept of LINks seems to have changed. It looks as if the model was originally for a network which would act as little more than a conduit to enable health service organisations to contact a wide range of communities. Subsequently, the Department's concept for LINks has taken the form of a 'PPIf plus model', which would involve volunteers undertaking a similar range of activities to those done by PPIfs.

There was widespread concern about the proposals to set up LINKs. It is unclear how far they are to be similar to PPIfs, how far a more nebulous network. Witnesses feared that the Department could end up with the worst elements of both models. There is a real danger that LINks will end up trying to do too much, that there will be confusion about what they should do and that volunteers will be lost as a result.

In addition, a number of outstanding issues are unresolved. At present, LINKs are not accountable; for example, it is unclear who would call a dysfunctional LINk to account. The organisations which will provide LINks with support are to be known as Hosts. The Government intends to permit a large number of organisations to undertake the role of a Host, including voluntary sector organisations which provide social care; this could create a conflict of interest since the organisations would be providing as well as scrutinising social care services.

While we do not believe that it was necessary to abolish PPIfs and establish LINKs and while we have concerns about the Department's proposals, we consider that LINks could be effective. We make a number of recommendations to improve their effectiveness. The Department should:-

- Clarify what LINks should do and ensure they prioritise. LINKs will have neither the funds nor the number of volunteers to do all that the Minister suggested they might like to do. The Department is keen not to be prescriptive; it is right not to specify how LINks should work, but must issue guidance about what they should do. This guidance should be tailored to what is achievable within their budget and should encourage LINks not to duplicate work, including research, done by other organisations
- Ensure that the 'early adopter' projects operate with 1) a Host organisation to see how this works in practice and 2) the same budget that a LINk will have to see what can be achieved with these funds
- Clarify how LINKs will be made accountable
- Clarify how conflicts of interest arising from social care providers acting as Hosts are to be resolved
- Take steps to ensure that existing volunteers are not lost in the transition from PPIfs to LINks since there are a limited number of people prepared to make a substantial commitment to patient and public involvement and many of those are members of PPIfs.

Section 11 of the Health and Social Care Act 2001 provides for extensive public consultation and involvement in the case of changes to services. Its accompanying guidance, entitled *Strengthening Accountability* gives good advice on how NHS bodies should go about consulting and involving the public. In theory an excellent system is in place. However, in practice there is much disquiet: people feel that they are consulted after decisions have been made. There has also been criticism of NHS organisations' refusal to consult about major changes and of the Department of Health vigorous support of these decisions. The Bill proposes changes to Section 11 consultation.

We fear that the Bill will weaken Section 11. The change of definition it proposes may lead to confusion and could lead to more court cases when the Act is tested. We are not convinced that this change is needed. We conclude that there is no need to change the law or the guidance, which is sufficient. The problem lies with the NHS organisations, often under pressure from deficits.

The Department should encourage NHS bodies to undertake consultation in accordance with Section 11 and the associated guidance. When undertaking consultations all NHS bodies must follow the best practice that already exists in parts of the NHS; in particular, they must be clear about what can and cannot be changed, ensure that they consult early enough in the process that plans can be changed and recognise that even the best designed and run consultation will not result in public agreement. Consultations in which a large proportion of the public reject plans which go ahead anyway must not continue to happen.

A major problem with large consultations has been the readiness of the Secretary of State to intervene, often after a full consultation has been undertaken. This is threatening to undermine public confidence in the consultation process. We recommend that she refer all cases to the Independent Reconfiguration Panel before intervening.

Throughout the inquiry we heard that what matters is not patient and public involvement structures but effective involvement of patients and the public. Structures and procedures, whether LINks, CHCs, PPIfs or Section 11, will have little effect if the heath service is not prepared to listen and make changes as a result of what they learn. Indeed the existence of separate structures for patient and public involvement has tended to reinforce the NHS' tokenistic approach. Effective patient and public involvement is about changing outcomes, about the NHS and social care providers putting patients and the public at the heart of what they do.

Many NHS and social care organisations have done patient and public involvement well. The existence of good practice shows that there is no reason why the NHS and social care providers cannot all effectively involve patients and the public.

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