AGENDA

NHS OVERVIEW AND SCRUTINY COMMITTEE

Friday, 9th March, 2007, at 10.00 am	Ask for:	**Paul Wickenden**
Woodville Halls, Gravesend DA12 1DD	Telephone:	**01622 694486**

Tea/Coffee will be available 30 minutes before the meeting outside the Chamber

Membership (15)

Conservative (10): Mr A R Chell (Chairman), Mr M J Angell, Mr A D Crowther, Mr J Curwood, Mr D A Hirst, Mrs S V Hohler, Mr G A Horne MBE, Mrs P A V Stockell, 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 - 12 January and 9 February 2007 (Pages 1 - 66)

3. Dentistry (Pages 67 - 74)

Bill Millar, Assistant Director of Primary Care, West Kent Primary Care Trust and Jayne Macdonald, Head of Primary Care – Dentistry, Eastern & Coastal Kent Primary Care Trust will be in attendance for this item.

Break 11:30-11:45 am

4. Provision of Clinics at Gravesend Community Hospital and Darent Valley Hospital (Pages 75 - 86)

Mark Devlin, Chief Executive, Dartford & Gravesham NHS Trust and Karen Jeffries, Deputy Director of Provider Services, West Kent PCT will be in attendance for this item.

5. Audiology Services (Pages 87 - 100)

John Beadle, Patient and Public Involvement Fora representative, Mark Devlin, Chief Executive, Dartford and Gravesham NHS Trust, Alex Willoughby, Head of Audiology, Medway NHS Trust and Ingrid Coburn, Commissioning Manager - Audiology, Eastern & Coastal Kent PCT will be in attendance for this item.

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

1 March 2007

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

KENT COUNTY COUNCIL

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.

Chairman ________________________________

Date ______________________

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 9 February 2007.

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

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

ALSO PRESENT: Mr J Reece, South East Coast Ambulance Patient and Public Involvement; Mr D Easton, East Kent Hospitals Patient and Public Involvement; Mrs C Swann, Kent and Medway NHS & Social Care Patient and Public Involvement; Mr R Knibbs, Kent and Medway NHS & Social Care Partnership Trust; Ms A Neal, East Kent Hospitals NHS Trust; Ms M Cleator, UNISON Invicta Health and Keep Our NHS Public; Mr G Manners, Downs Mail and Mr J Ogden, Kent County Council's Standards Committee.

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

UNRESTRICTED ITEMS

Non-pecuniary interest

Mr Angell declared a non-pecuniary interest as a non-executive director of the Kent & Medway NHS & Social Care Partnership Trust.

6. Minutes – 12 January 2007

The Overview and Scrutiny Manager reported that the Minutes of the January meeting were still being prepared and he apologised to the Committee that they were not available for this meeting to consider and approve. They would be presented to the meeting of the Committee on 9 March 2007.

7. Medway NHS Trust – application for Foundation Trust Status
(Item 3 – Mr A Horne, Chief Executive of Medway NHS Trust was in attendance for this item)

(1) Mr A Horne, Chief Executive of Medway NHS Trust made a presentation to the Committee on the Trust's proposed application for Foundation Trust Status. A copy of Mr Horne's presentation is attached as Appendix 1. The Committee were reminded that they had authorised the Overview and Scrutiny Manager, in consultation with the Chairman, Vice Chairman and Liberal

Democrat Spokesman of the Committee, to arrange a meeting and invite colleagues who represented an electoral division in Maidstone Borough Council and Swale Borough Council areas to meet with Mr Horne and other Trust colleagues regarding their application for Foundation Trust Status. This meeting had taken place on Monday 22 January 2007 and a copy of the note of that meeting was attached to the report.

(2) At the conclusion of his presentation, Mr Horne responded to a range of questions.

Emergency Care

a) In response to a question about taking on more emergency care and the capacity of the Trust to do so, Mr Horne said that the Medway NHS Trust was already taking a number of vascular emergency cases from Maidstone and Pembury hospitals. He added that, after April 2007, the Trust would also be taking vascular emergencies from Darent Valley Hospital at Dartford. He was confident that Medway NHS Trust could deal with, and had the capacity to deal with, transfers from neighbouring Trusts.

Flexibility and Freedoms of Foundation Trusts

b) Asked about the benefits of Foundation Trust Status and the role of 'Monitor', Mr Horne responded that if Foundation Trust Status was achieved it would enable the Trust to operate within a more flexible framework. Foundation Trusts also had freedom to borrow money from a wider range of lenders, in addition to the NHS bank. Monitor had been established approximately three years ago and was the body set up to assess and accredit Foundation Trusts, primarily from a financial point of view. It was a regulatory body – as such, it was similar to the Healthcare Commission, which was responsible for looking at quality standards across NHS Trusts.

Consultation Process

c) Asked how widely the consultation had been undertaken and the percentage of responses received, Mr Horne acknowledged that, whilst the consultation document had not been sent to London Boroughs, it had been widely distributed amongst the catchment area for the Medway NHS Trust – including the western part of Swale and the Isle of Sheppey. He did not have with him detailed figures regarding the rate of responses to the consultation, but would make them available to the Committee.

Car Parking and Transportation

d) Mr Horne said that the car parking at the Medway Maritime Hospital was not privatised. The car parks were run by the Trust and there were

no plans to change the charges for car parking. The Trust was continuing to look at environmental strategies, including the promotion of walking and car sharing, as well as considering the safety aspects of the issue. Mr Horne said that the Trust was continuing to invest in encouraging more people to become volunteer drivers.

Foundation Trust – Governing Bodies

e) In answer to a question about how many representatives local authorities would have on the Governing Body, Mr Horne said that he envisaged there would be one representative drawn from Medway Council and one from Kent County Council. He hoped that the representative from Kent would be drawn from the Swale area, as patients from here looked towards the Medway NHS Trust for their acute hospital services.

Patient Choice

f) Mr Horne said he recognised that the Patient Choice agenda was extremely important. His Trust was having to compete with a range of providers, including the Will Adams Independent Sector Treatment Centre at Gillingham. To ensure that the hospital retained its top hospital status, he said the Trust would have to ensure that it undertook marketing strategies to encourage patients to use the services the Trust was offering.

Facilities for Voluntary Groups and Audiology Services

g) Mr Horne stated that the Trust provided some facilities for voluntary and independent groups – but it needed to be recognised that this was an equal partnership. He said that he was not fully briefed about the Trust's relationship with the hearing charity Hi Kent, but he would follow up on specific points raised by Mrs Angell about this and get back to her.

RESOLVED that the NHS Overview and Scrutiny Committee:-

- support the Medway NHS Trust's application for Foundation Trust Status;

- request the Medway NHS Trust periodically to report back to the Committee on the progress being made towards Foundation Trust Status.

8. Fit for the Future – Draft Commissioning Plans

(Item 4 – Rebecca Sparks, Director Development and Partnerships, South East Coastal Strategic Health Authority; Steve Phoenix, Chief Executive, West Kent Primary Care Trust; Lynne Selman, Director of Communications and Dr Roger Pinnock, GP and Professional Executive Committee (PEC) member, Dr Robert Stewart, Medical Director, Eastern & Coastal Kent Primary Care Trust; Colette Glasson, Director of Communications, Heidi Shute, Community

Cardiology Manager and Marion Dinwoodie, Chief Executive, Medway Primary Care Trust were in attendance for this item)

(1) The Committee had among their papers a briefing note on commissioning. It was recognised that there was not a concise definition of commissioning, since this term actually referred to a range of activities that had changed over time and were continuing to change as a result of major NHS reforms. The briefing note referred to: the original NHS model; the internal market; commissioning and the new NHS; Payment by Results; patient choice; practice-based commissioning; the mixed economy of providers; the role of Foundation Trusts; expectations as regards PCTs undertaking commissioning and how that sat with practice-based commissioning and patient choice; how commissioning related to the reconfiguration of services; how commissioners could ensure access to services and tackle health inequalities.

(2) Health colleagues then made a presentation to the Committee, which is attached as Appendix 2 to this set of minutes.

Dental, Palliative and Respite Care

(3) Following the presentation, Mr Godfrey Horne indicated that he liked the idea of the best care being available in the best place for the best value because he felt that it added meaning for the public and it was easier to understand. He then asked a series of questions relating to how commissioning plans would improve services such as dental care, palliative care and respite care, recognising that there needed to be an holistic approach across the core agencies for delivering some of these services. Mr Phoenix responded that there was an agreement between the Primary Care Trusts and local authorities that neither would take decisions that would impinge on, and place additional financial burdens on, the other side. From a West Kent perspective, he said that there would be a review undertaken shortly on palliative care. He acknowledged that dental-care provision was an issue across many parts of Kent and this was something that the Primary Care Trusts needed to tackle collectively. However, that work had not yet started. Marion Dinwoodie said that, in Medway, the Primary Care Trust ran the Wisdom Hospice; she actually had a surplus of hospice beds, because care in the community was working so well.

Patient Choice vis-à-vis Planned Hospital Care

(4) Mr Phoenix said that there was clearly a possibility that Patient Choice would not deliver everything that was hoped. He added that there might or might not be tensions between Choice and practice-based commissioning. He said it was intended there would be a national set of standards, but the care pathways and the services offered would end up looking different in different areas. He said that devolution often led to diversity. “Postcode lotteries” were seen as bad – but local involvement and local freedoms were regarded as good things; there was a tension here. The national tariff meant that price would be standardised within the NHS market, so there could not be

competition on price between providers. Choice of provider was currently still limited – but the policy was to allow the patient unlimited choice of provider, including within the private sector. He acknowledged that the different facets of current health policy did not necessarily fit together very well and that they did, in some respects, tend to 'rub up against each other'.

(5) Dr Pinnock added that Choice was inevitably affected by patients' ability to access different providers, but there was a stipulation that transport should not be a barrier to Patient Choice – transport should be provided where the patient was not able to travel independently. He agreed there was a tension between Choice and practice-based commissioning. There would need to be negotiation between the GP and the patient – if the GP explained to the patient what the best service was, the patient would choose that one. Ms Dinwoodie said that the choice presented to patients should be a choice between health services of the highest quality. Medway PCT had actually withdrawn a provider from their Choice menu because of concerns about quality.

Best Practice

(6) Ms Harrison asked why, given that there were a number of good ideas in the NHS that could be copied, were not all Trusts across Kent good already? She emphasised the need to treat patients holistically to achieve the best outcomes. She also expressed concerns about NHS Direct tending to err on the side of advising callers to attend their nearest Accident and Emergency Department, thereby placing unnecessary pressure on the service. She also felt there was a need to educate the public about what truly constituted an emergency, to ensure services were used appropriately.

(7) Ms Harrison also raised concerns relating to: the shifting of services from acute hospitals into the community; the fact that Swale had for a long time been receiving a funding allocation below that stipulated by the weighted capitation formula; and the lack of GPs available, particularly on the Isle of Sheppey.

(8) Dr Stewart said that there was already a great deal of co-operation and sharing of good practice; and there were several examples across the county where health colleagues were involved in national pilots. As regards 'under-doctored' areas, he said that problems in this regard in Shepway and Swale were being addressed.

(9) Ms Sparks responded that there was much work already underway around cross-fertilisation and sharing of best practice to improve services. She referred specifically to: the Institute of Innovation (formerly the NHS Modernisation Agency); the 'Improvement Cabinet', 'Improvement Academy' and 'Clinical Champions' established by the former Kent & Medway Strategic Health Authority; and the annual 'Best of Health' awards, hosted by the South East Coast Strategic Health Authority. Regarding appropriate use of emergency services, Dr Pinnock suggested that many years of attempting to educate the public about this had not dissuaded some sections of the

population from continuing to use A&E services as a substitute for primary care. He thought that the NHS should recognise this and address it by co-locating primary-care services with A&E departments. Ms Dinwoodie said that new services had to be signposted for the public when they were commissioned, to encourage people to use them – one way this was being done was through the insertion in the Yellow Pages telephone directory of a guide to local health services.

Emergency Care provided in a Primary Care setting, Mental Health, Inter-relationship between health services Provision and Deprivation

(10) Mr Phoenix said that there were a number of emergency-care models operating across Kent. For example, at the Darent Valley Hospital in Dartford, a new model of care had started on 2 January, with a nurse-led urgent care unit; this was already taking over 30% of the work away from the Accident & Emergency Centre. A similar arrangement would be used at the new Pembury Hospital. In Gravesend, there was a Minor Injuries Unit at the Gravesham Hospital.

(11) £83 million was being spent annually on mental health – which represented approximately 11% of the budget. Mr Phoenix said that, overwhelmingly, mental-health patients were being seen in primary care. He would like to see the balance of the service shifted more towards prevention of mental illness.

(12) Mr Phoenix indicated that he would like to come back to the Committee at some stage to talk about preventive services in general and how they could be provided differently. He said that general practice was a better approach to healthcare provision than the alternatives found in other health systems. In the United States and France, secondary care could be accessed directly without going through a primary-care 'gatekeeper', and this worked less well than the system in the United Kingdom. Dr Stewart added that the interrelationship between health and deprivation was being taken very seriously. He said that hospital was not the only option for providing healthcare – intermediate care was very important. Marion Dinwoodie added that 'top-slicing' and 'ring-fencing' of monies in PCT budgets presented challenges as regards delivering services. It was vital to have Service Level Agreements with acute providers that worked. PCTs were still ploughing money into acute care and they needed to make it clear to acute providers exactly what work they were being expected to do for that money. At the same time, primary care needed to be re-engineered to reduce the number of patients being treated in the acute sector.

Patient Choice

(13) Mrs Tweed asked what would happen to the William Harvey Hospital if too many patients chose to go to, for instance, the Medway Maritime Hospital instead. Marion Dinwoodie responded that the William Harvey would still have plenty of work, especially given the planned growth in Ashford's population;

she had no doubt that people would continue to choose it. The important thing was to re-engineer systems, map out patient pathways and plan for the future.

Neurology Services in East Kent

(14) Dr Stewart said there was no plan to take neurology provision away from East Kent; the intention was simply for a few specialist cases to be dealt with at the Medway Maritime Hospital.

Fit for the Future

(15) Concern was expressed at the lack of a joined-up message coming from all the NHS bodies that were caught up in the ‘Fit for the Future’ review. Ms Sparks said the key messages had all been set out in the public discussion document relating to Fit for the Future. The key drivers for Fit for the Future were those set out in the national health-policy framework. There was a project board for Fit for the Future in Kent and Medway, which comprised representatives from the Primary Care Trusts, Acute Trusts, Patient and Public Involvement Forums and local-authority Social Services. In addition, there was a steering group in each Primary Care Trust, in which acute Trusts and PPIFs were involved.

Choose & Book/Independent Sector Treatment Centre

(16) Dr Pinnock said that a major challenge of the current funding system was that of unbundling the tariff – i.e. dividing the tariff up where a spell of acute care was dealt with partly by an acute provider and partly in primary care. A question was asked about Independent Sector Treatment Centres receiving guaranteed full payment of their contract for five years, regardless of how much work they actually did – and how they were able to pick and choose which patients they would treat. Mr Phoenix said that PCTs were obliged to pay ISTCs in accordance with contracts that had been negotiated by the Department of Health centrally. Mr Phoenix said that he was enthusiastic to re-negotiate the terms of the contract with the ISTC that had opened in Maidstone. Ms Dinwoodie said that the Will Adams ISTC in Gillingham was receiving a guaranteed income of £4 million a year from Medway PCT, and Eastern and Coastal Kent PCT under the terms of the ISTC’s contract. The Centre was currently operating at 78% of capacity, and the fixed payment contract was a very strong incentive for her PCT to try and make as much use of the Centre as possible. She said that the Department of Health would be working on the issues of case-mix and pre-assessment of patients by ISTCs, in order to try and prevent the Centres from “cream-skimming” by excluding those patients they were reluctant to accept.

Choose & Book/Single-handed Surgeries/IT

(17) Mrs Angell asked: about recruitment and retention of primary-care staff; about the high proportion of single-handed GP practices in Medway; how doctors could find the time during consultations to use the Choose & Book system; and

whether the Minor Injuries Unit at Gravesham Community Hospital was being removed to the Darent Valley Hospital. Mr Phoenix responded that ‘Agenda for Change’ had addressed recruitment and retention in the NHS; and work was being done on the primary-care workforce. Marion Dinwoodie confirmed that 37 out of 64 GPs in the Medway Towns were single-handed practitioners. She said practice-based commissioning was energising GPs and encouraging them to work together. Mrs Angell also asked whether limitations in information technology were preventing people accessing a national Choice menu. Mr Phoenix said that there was currently a restricted choice of provider, but there would in due course be full choice of any provider, anywhere in the country – the extent of the choice on offer was a matter of national policy and had nothing to do with IT issues.

Accountability of Foundation Trusts/Competence of Primary Care Trusts to commission

(18) In response to several questions from Mr Daley, Mr Phoenix said that the establishment of Foundation Trusts within the NHS was a national policy. Foundation Trusts were within the ‘NHS family’ but were legally distinct entities and not owned by the Secretary of State for Health, as ordinary Trusts were. Monitor had been set up by the government to hold Foundation Trusts to account financially. With regard to the claim that PCTs lacked the capability to commission effectively, Mr Phoenix said that was a matter of opinion. The former structure of PCTs had not been considered appropriate – hence the new PCTs had been created. He did not think that PCTs would be done away with in the next two or three years. They would continue to be commissioning bodies, although they might take on new forms in future. What happened would depend on the success of practice-based commissioning. It was possible that there would be no change in the NHS for another four or five years – although such a period of stability was not something he had ever seen before in his 27 years in the NHS.

RESOLVED that the Primary Care Trusts be thanked for their presentations on their Commissioning Plans

9. Commissioning Homeopathy – West Kent Primary Care Trust
(Item 5 – Julia Ross, Director of Civic Engagement West Kent Primary Care Trust was in attendance for this item)

(1) The Committee had before them the proposals (tabled at the meeting) for a review process around Commissioning Homeopathy. The Committee noted that, in 2006, the South West Kent and Maidstone Weald PCTs had undertaken a formal turnaround process. The nature of turnaround was such that every possible area of savings – both efficiency improvements and the review of service provision – had to be considered.

(2) The Turnaround Plan had identified a number of service areas for review – of which one was homeopathy. The Primary Care Trusts had initially proposed to direct all referrals for homeopathic therapy through a Treatment Panel, so

that each case could be considered on the basis of clinical need before the referral went ahead. This proposal, however, had caused concern among some stakeholders and it had, therefore, been agreed to conduct a review of the demand for homeopathic services and the cost-benefit of such treatment. The Committee noted that the Tunbridge Wells Homeopathic Hospital was one of only five such hospitals run by the NHS.

(3) Mrs Ross stated that the review was not about closing the Homeopathic Hospital, it was about reviewing and establishing the demand for homeopathic services and whether the cost-benefit of such treatments was appropriate for provision from NHS funds. The review process would include four distinct stages:-

1. a review of existing activity and spending on homeopathic services;

2. an external review and evaluation of the evidence for homeopathy;

3. a discussion phase, where both reviews were shared and discussed amongst the stakeholders, options presented and developed, and decision-making criteria agreed in conjunction with the PCT Board; and

4. the decision-making process, where the PCT Board would apply weight, and score by the agreed criteria.

(4) The Committee noted that a reference group of key stakeholders had been established and that Paul Wickenden was the representative for the NHS Overview and Scrutiny Committee on this reference group. The first meeting of the reference group was to take place on 13th February 2007.

(5) Mrs Ross said that the review might come up with a range of options. She hoped that a decision by the PCT Board would be taken in April. The issues around the homeopathy review were particularly sensitive. There were polarised opinions as to both the effectiveness of treatments and the use of NHS funding for providing the service.

(7) The Committee noted that there were 400 referrals to the Homeopathic Hospital from West Kent PCT each year. This was a very small part of the commissioning done by the PCT, but it was important that the PCT looked at every service that it commissioned.

(8) The Committee noted that the reference group included individuals who came from both sides of the debate on homeopathy, in order to ensure balance.

RESOLVED that the position be noted

10. NHS Overview and Scrutiny Committee – Work Programme Update
(Item 6 – report by Paul Wickenden, Overview and Scrutiny Manager)

(1) The Overview and Scrutiny Manager reported on the potential work programme for the next two meetings of the Committee, based on approaches made to the Chairman and Spokesmen of the Committee or direct to him.

Maidstone & Tunbridge Wells NHS Trust – a new direction for surgical and orthopaedic care

(2) Following the decision of the Committee on 12 January 2007, all the evidence had been re-examined and a meeting had taken place with the Chairman, Vice Chairman and Liberal Democrat Spokesman of the Committee to agree the reasons underlying the Committee's decision. The Committee were invited to endorse the action which had been taken retrospectively by the Overview and Scrutiny Manager, with the approval of the Chairman, Vice Chairman and Liberal Democrat Spokesman of the Committee.

(3) The reasons for opposing the proposals, as agreed by the Chairman, Vice Chairman and Liberal Democrat Spokesman, had been sent to Mr Phoenix, Chief Executive of West Kent Primary Care Trust and Ms Gibb, Chief Executive of Maidstone & Tunbridge Wells NHS Trust (see Appendix 1).

(4) Members were reminded that the Committee had the power to refer matters to the Secretary of State for Health on grounds of inadequate consultation, or on the basis that what was proposed was not in the interests of health services in Kent. However, this right of referral was only to be exercised as a last resort, once all avenues of possibility to resolve the matter locally been exhausted.

Meeting – 9 March 2007

(5) Issues emerging for potential inclusion on the NHS Overview and Scrutiny Committee's agenda for the meeting on 9 March 2007 were:-

- services provided for residents of north west Kent at the Gravesham Community Hospital, and the removal of some of these to the Darent Valley Hospital; and

- Audiology Services, which the Committee had discussed at its meeting in January 2006 and agreed to review in a year's time.

(6) Other concerns had been raised relating to cancer services at the Kent and Canterbury Hospital and the proposed development of a polyclinic at Whitstable. The Committee were asked to consider whether they would want to hold one meeting split between two locations – with the first half in north west Kent and the second half in east Kent.

(7) The Committee concluded that it would be far more appropriate to have two separate meetings, one each to deal with the east Kent issues and the north west Kent ones.

Healthcare Commission Core Standards

(8) The Committee considered whether it wished to make a submission in the spring for the Healthcare Commission's annual healthcheck. Each NHS Body was required to submit its self-assessment to the Healthcare Commission by 1 May 2007.

(9) Three types of body had the opportunity to add a commentary to these self-assessments against the Healthcare Commission Core Standards, namely NHS Overview and Scrutiny Committees, Patient and Public Involvement Fora and Strategic Health Authorities.

(10) The Committee agreed that it would be useful to collate throughout the year evidence that it might wish to submit to the Healthcare Commission, so that compiling a submission in the spring was not too onerous a task. The Committee noted that a new set of Healthcare Commission Core Standards was being piloted in 2007 and would be introduced in 2008.

(11) Considerable discussion took place around the idea of "enhanced two-tier working" between county councils and borough/district councils. Other aspects of the Local Government and Public Involvement in Health Bill (which was currently before Parliament) were also discussed, including Community Calls for Action. The Committee agreed that it would be useful to look at the structure of the NHS Overview and Scrutiny Committee, with a view to the Committee operating in future more at a strategic level, while devolving more local issues to borough/district authorities and other partners. The Committee noted that protocols had already been agreed by the Kent Association of Local Authorities in 2001 regarding the delegation of more local-level issues to committees or joint committees of borough/district councils.

(12) It was noted that, under provisions contained in the Bill, the County Council would also acquire the responsibility to establish a Local Involvement Network (LINk), which would replace the Patient and Public Involvement Fora in the county. It was already planned to abolish the Commission for Patient and Public Involvement in Health.

(13) Consideration was also given to the possibility of organising an event for all Members of the County Council to explain the concept of Patient Pathways for accessing health services.

(14) The Committee asked that the provision of mental-health services should also be an item for a discussion at a future meeting.

RESOLVED that:-

a) the action taken by the Overview and Scrutiny Manager, in consultation with the Chairman, Vice Chairman and Liberal Democrat Spokesman, in taking forward the dialogue with health colleagues following the decision of the

Committee on Maidstone & Tunbridge Wells NHS Trust's consultation on 'A new direction for surgical and orthopaedic care', be agreed;

b) the Work Programme and venues for the next two meetings of the Committee be as set out in the sub-paragraphs above;

c) the Overview and Scrutiny Manager should continue to work with all stakeholders in looking at the possible devolution of health overview and scrutiny in the key issues to a more local level; and

d) the Overview and Scrutiny Manager should investigate making arrangements for a seminar for all Members of the County Council on Patient Pathways for accessing health services.

Appendix 1

The journey to Foundation Trust status for The Medway NHS Trust

By Andrew Horne, Chief Executive

National drivers

To deliver a patient led NHS there is a commitment to prepare all NHS Trusts for Foundation Trust status by April 2008.

- Health and Social Care Act 2003
- Commissioning a patient led service 2005
- Choice / Practice Based Commissioners
- Payment by results
- Secondary to Primary care shift

The Medway NHS Trust NHS
your first choice

What is an NHS Foundation Trust?

- A new organisation – only the 3rd across KSS
- A clear direction
- A commercial business – customers first
- Quality, responsiveness and access
- Affordability & Value for Money
- Modernisation and innovation
- Transparency and accountability
- Risk management

The Medway NHS Trust NHS
your first choice

Strategic vision

- A major district general hospital (supporting local DGHs)
- Joined up hospital and community services
- Acute emergency services to a wider population
- Some planned work to other locations
- Chronic conditions to primary care
- More diagnostic workup in primary care
- A changing workforce (MMC, EWTD, etc)
- Capital investment

The Medway NHS Trust NHS
your first choice

How will we be structured?

The Medway NHS Trust NHS
your first choice

Membership of the Medway NHS Foundation Trust

Council of Governors

Board of Directors (Trust Board)

37

The Medway NHS Trust NHS
your first choice

Membership Groups

Two groups have been proposed:

PUBLIC & PATIENT GROUP

- Medway
- Swale
- Rest of Kent and beyond

STAFF GROUP

- Open to all equally across the Trust

The Medway NHS Trust NHS
your first choice

Stakeholder members

From partners such as:

- Primary care groups
- Local authorities
- Local Universities
- Business &voluntary groups

Council of Governors

• Staff Governors	5
• Stakeholder Governors	
PCTs	3
Local authorities	2
Partners	3
• Total staff and stakeholders	13
• Patient & Public Governors	14

- Chaired by Chairman of Board

What are the benefits of becoming a member?

The Medway NHS Trust NHS
your
first choice

- Helping the services to improve through discussing experiences
- Being consulted on proposed changes to services
- Receiving updates and information about the Hospital
- Opportunity to become a Governor
- Electing Governors

The Medway NHS Trust NHS
your
first choice

What do we need to do to become a Foundation Trust from where we are today?

40

The Medway NHS Trust NHS

your first choice

The application – process/assessment

- **Phase 1** starts 6th Nov 2006
  - Consultation
  - DH development phase
- **Phase 2**
  - Historical due diligence
- **Phase 3** ends 1st July 2007
  - Monitor assessment

The Medway NHS Trust NHS

your first choice

In Conclusion

History

- A 100 years of caring at Medway Hospital
- Built on dedication, quality and service

Strategy

- Support from our local community
- Respected clinical services

Our success will be based on

- Listening to our patients, our public, our members
- Being "Your First Choice" for local people
- Knowing that status quo is not an option

The Medway NHS Trust NHS
your first choice

- Do you support NHS FT status?
- Do you agree with our future plans?
- Do you agree with the minimum age of 14?
- Do you agree with the geographical split
- How should we communicate?
- Do you agree with partner Governor proposals?
- Do you agree with the overall number of Governors?
- Do you agree with the transitional arrangements ?
- Any other comments?

The Medway NHS Trust NHS
your first choice

Thank you for attending.

Appendix 2

NHS
South East Coast

Kent and Medway NHS

PCT Commissioning Plans

NHS
South East Coast

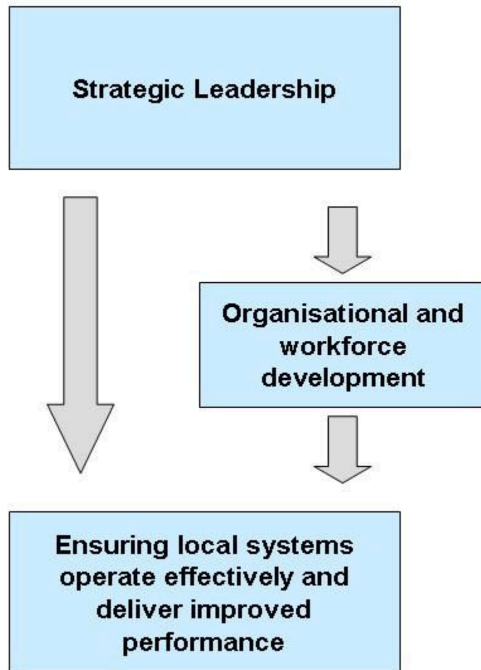
What we will cover...

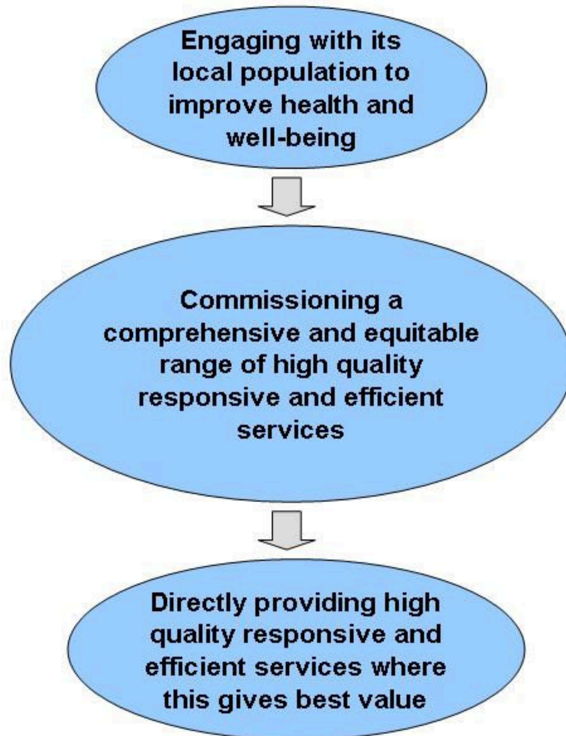
1. Roles and responsibilities
2. National policy context
3. The commissioning cycle
4. What commissioning needs to take account of…
5. West Kent PCT / East Kent PCT / Medway PCT:
   - i. Vision
   - ii. Profiling future demand
   - iii. Commissioning initiatives
   - iv. Fit for the Future engagement timeline
6. Questions and Answers

NHS South East Coast

SHA role

PCT role





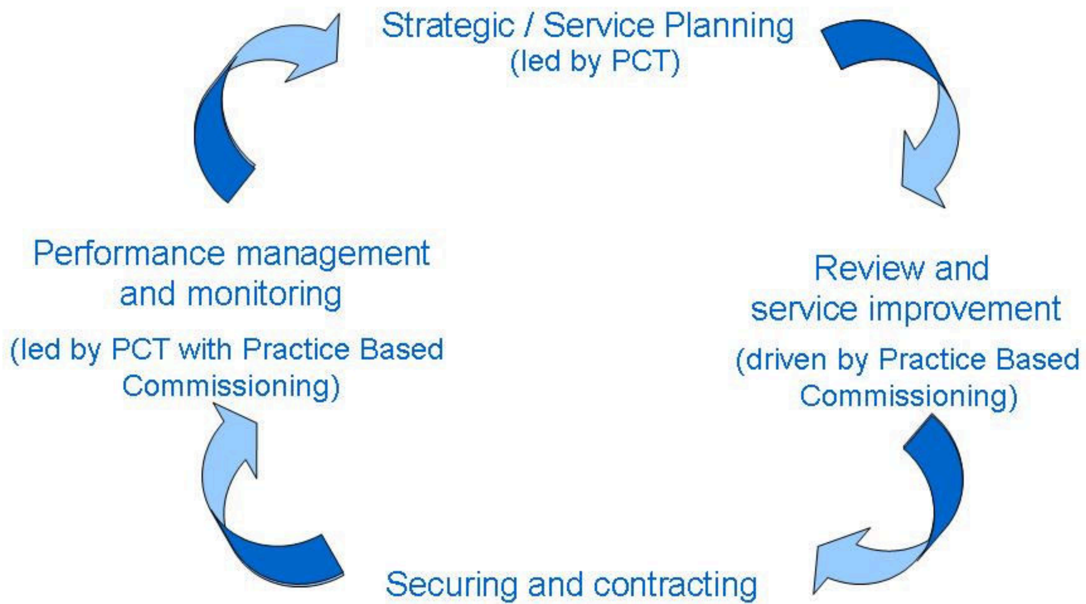
Source: DH Guidance May 2006

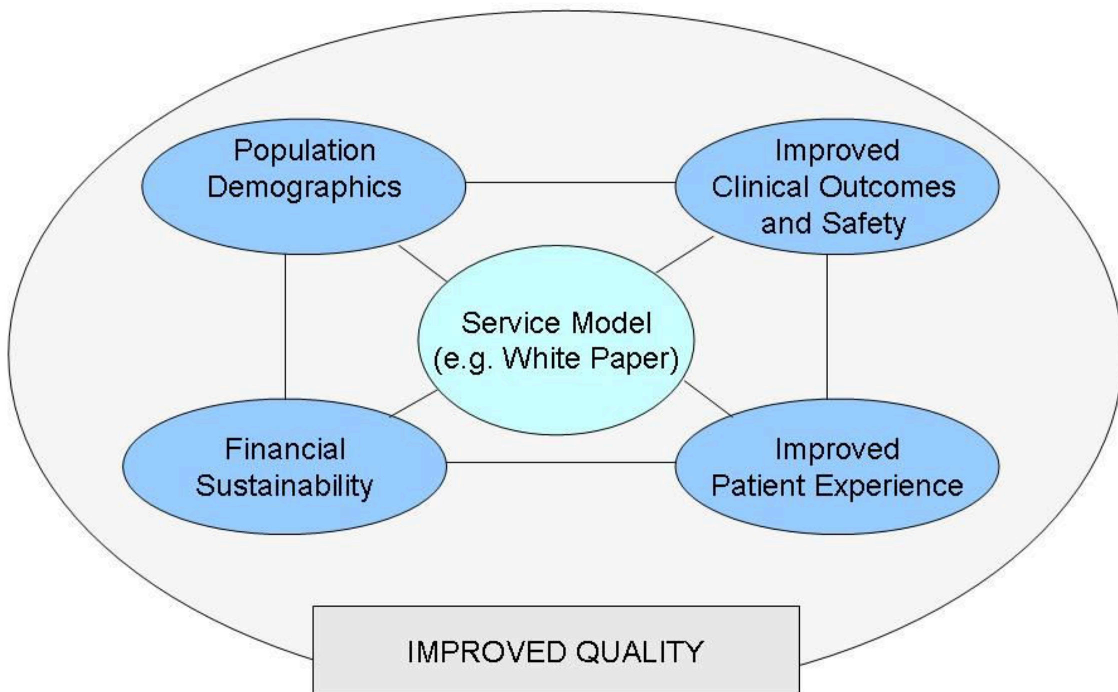
NHS South East Coast

National Policy: three key policy drivers

❑ ***Choice***	not only with respect to choice of provider but also patients wanting to take responsibility for their own care
❑ ***Diversity***	variety of providers for people to choose from, including the development of Foundation Trusts
❑ ***Payment By Results***	standardised pay structure and further adoption of national tariff

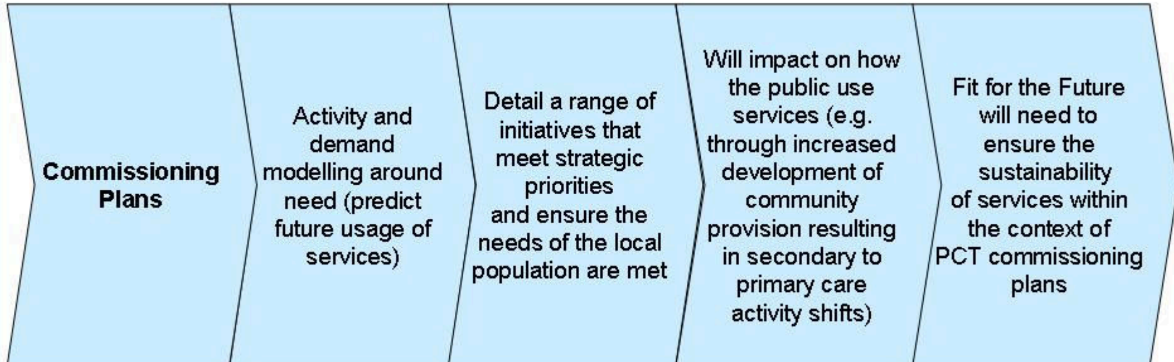
N.B. Delivered through clinical leadership, e.g. practice based commissioning


The Commissioning Cycle: The Local Delivery Plan
NHS
South East Coast
Strategic / Service Planning
(led by PCT)
Review and
service improvement
(driven by Practice Based
Commissioning)
Securing and contracting
Performance management
and monitoring
(led by PCT with Practice Based
Commissioning)


Commissioning needs to take account of….
NHS
South East Coast
Population
Demographics
Improved
Clinical Outcomes
and Safety
Service Model
(e.g. White Paper)
Financial
Sustainability
Improved
Patient Experience
IMPROVED QUALITY

Commissioning Plans: Fit for the Future

NHS South East Coast



West Kent PCT: Overarching vision

NHS South East Coast

- In 2007 the Trust will adopt a new strategic plan 'Best care, Best place, Best value', this will set out our priorities over the next five years.
- BEST CARE We will provide and commission services which hold the full confidence of local people and which will earn us a reputation for excellence. Skilled motivated and friendly staff will deliver high standards of clinical care.
- BEST PLACE We aim to provide our local communities with fast, convenient and local access to as wide a range of services as possible working with the local authority.
- BEST VALUE:The commissioning decisions that we take to achieve these priorities will ensure that we do so within the resources available to the Trust.

West Kent PCT: Profiling future demand

NHS South East Coast

❑ Age related demographics	- The expected activity in 2008 has been adjusted by a weighting derived from expected changes in age group cohorts of the population
❑ Non-age related demographics	- Weights were applied to specific disease groups. The weighting was derived from morbidity projections identified in the general household survey
❑ Other factors	- This included information from current plans. For example cancer and cardiology networks and technical predictions

West Kent PCT: Commissioning Initiatives

NHS South East Coast

- **INITIATIVE 1** – Elective Management: £1.360m

  Examples: Introduction of Clinical Assessment Services in Orthopaedics, rheumatology, Dermatology, Ophthalmology; Reprovision of minor surgical procedures in Primary Care Settings; Changes in Care Pathways to make them faster and less convoluted.

- **INITIATIVE 2** – Non Elective Management: £2.568m

  Examples: Improving the emergency pathway into care, as in the Maidstone Urgent Care centre reducing waiting times, reducing short stay admissions and ensuring patients receive treatment centred around their home , rather than the hospital

- **INITIATIVE 3** – Benchmarking: £888k

  Examples: Improving performance in New : Follow Up appointment ratios to National best practise averages, and gaining the economies of scale that moving into a new PFI building will release, or using this as an opportunity to improve Care Pathways to make them faster and less convoluted.

- **INITIATIVE 4** – Outpatient Management: £717k

  Examples: ensuring that referrals between Consultants add value to the quality of the diagnosis and treatment decision, ensuring that the need to be seen in an outpatient setting is the best place to receive care.

NHS South East Coast

West Kent PCT: Clinical example of a commissioning initiative

The Plan: To perform minor general surgical procedures (on conditions such as the removal of non-malignant moles) that can be provided quickly and safely, with minimal inconvenience to the patient, in a GP's surgery, instead of a hospital

The Gain: 165 first outpatient appointments, 107 follow up appointments and 132 minor surgical procedures re-provided in GP surgeries and gain a Return on Investment of 130-150% (up to £167K)

Reality: Service now offered by a GP who also has a FRCS qualification in Borough Green Surgery, which is being extended to other areas depending on the skills of local GPs.

NHS South East Coast

West Kent PCT: Fit for the Future engagement

- November – December 2006
  - 4000 discussion documents distributed
  - Presentations to 98 stakeholder groups across West Kent
  - Co-design events x2 – 83 participants in total
  - Clinical workshop – 40+ participants
- January – March 2007
  - Locality based stakeholder workshops x5 – 400+ participants
  - Establish Patient Reference Group to support development of consultation options & document
  - Social research & deliberative event (24/03)
  - Clinical workshop – 40+ participants
- March onwards
  - Detailed development of consultation document with stakeholders

NHS South East Coast

Eastern & Coastal Kent PCT: Strategic Vision

The PCT will work with clinicians, our different communities,

and other key partners to reduce ill health and to deliver high quality health services as close to home as possible

NHS South East Coast

Eastern & Coastal Kent PCT: Strategic Vision

We will commission

- Accessible, high quality primary care
- Integrated community services that reduce avoidable unscheduled admissions.
- Routine elective care more efficiently and closer to people's homes
- Safe and effective secondary and specialised care.

We will invest in measures

- To reduce health inequality, and
- Promote independence

NHS South East Coast

Eastern & Coastal Kent PCT : Context

Health Status and Trends

Population Trends

6% overall population growth by 2010; 16% by 2020

18% population is age 65+ (v Eng & W 16%); rise of 42% in numbers of residents aged 65+ by 2020

Health Inequality

17% live in 20% most deprived wards (-43.3% national average)

Within ECK 57% difference in CHD mortality rates between most and least deprived 20%; (+29.3%)

teenage pregnancy; (+3.3%)

NHS South East Coast

Eastern & Coastal Kent PCT:

Health Status and Trends (continued)

Significant Mortality/Disease Pressures

Cancer <75s (+2.7%)

Accidents all age 18+ (+15.4%)

Mental Health (+9.2%)

Diabetes (+4.1%)

COPD (+2.9%)

Hypertension (+6.8%)

NHS South East Coast

Eastern & Coastal Kent PCT : Context (continued)

National Policy/Targets e.g.

- Deliver 18 week target
- Deliver Choose and Book
- Sexual Health access target

Settings of Care e.g.

- Reduce unscheduled care demand and avoidable admissions
- Delivery MH in-patient redesign
- Government White Paper – more routine care closer to home
- Infrastructure improvement and rationalisation

Finances e.g.

- Deliver community service efficiency/financial surplus to reinvest in prevention as per LAA, choosing health, self care and inc independence in older people
- Work in partnership to deliver clinical/productivity improvements in secondary care.

NHS South East Coast

Eastern & Coastal Kent PCT: Commissioning Initiatives

Integrated Commissioning Programmes

"Choosing Health"

- including Local Area Agreement Targets, national Sexual Health Targets targets and reducing health inequality gap in CHD.

Mental Health

- continued programme of in-patient redesign and specific focus on Older Peoples' Community Mental Health Services.

Children and Young People

- integrated commissioning across health and local government against key policy areas, including Child & Adolescent Mental Health; continuation of targeted programmes in communities of need.

NHS South East Coast

Eastern & Coastal Kent PCT:
Commissioning Initiatives (continued)

Elective Care

Significant changes to elective pathways, more routine care delivered in primary & community settings; focus on best practice in delivery of care. Delivery 18 week from GP referral to treatment.

Urgent Care

Demonstration site – whole system approach to include prevention and supported self-care, emergency responses in community; triage in A&E; and effective discharge arrangements for those who are admitted.

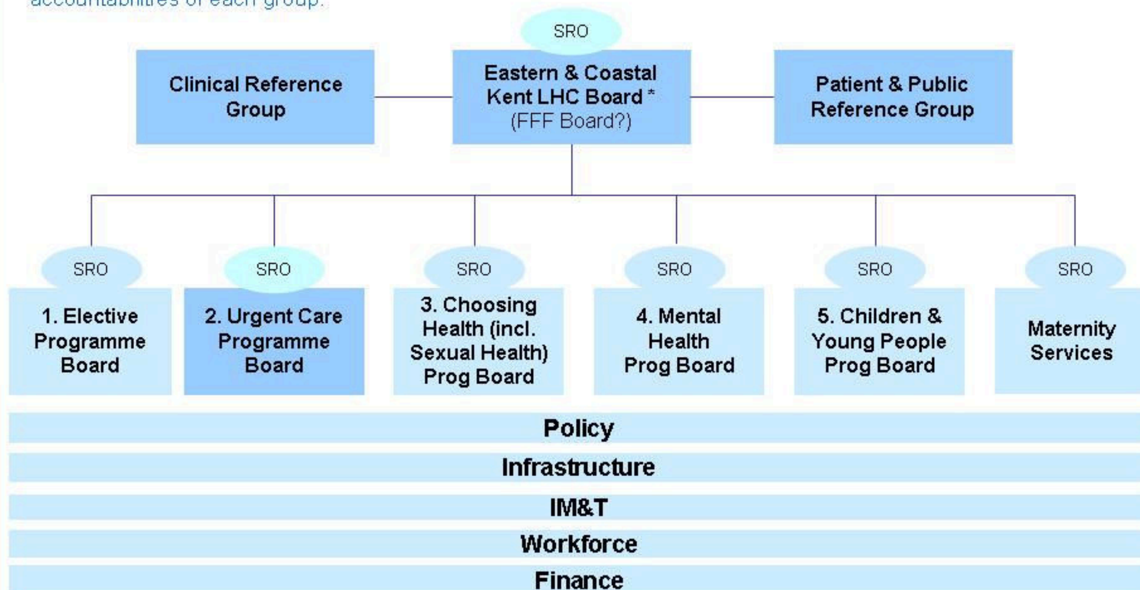
Community Infrastructure

Services, IT solutions and facilities to deliver care closer to patients.

NHS South East Coast

Eastern & Coastal Kent Local Health Community:
Proposed Overall Programme Structure

The proposed overall structure of the programme for transforming services across Eastern & Coastal Kent Local Health Community is set out below. Subsequent pages outline the specific roles, functions, responsibilities and accountabilities of each group.



* Note: representatives on the LHC Board will provide the link back to Organisation Management Boards, e.g. SHA, Trusts, KCC, etc

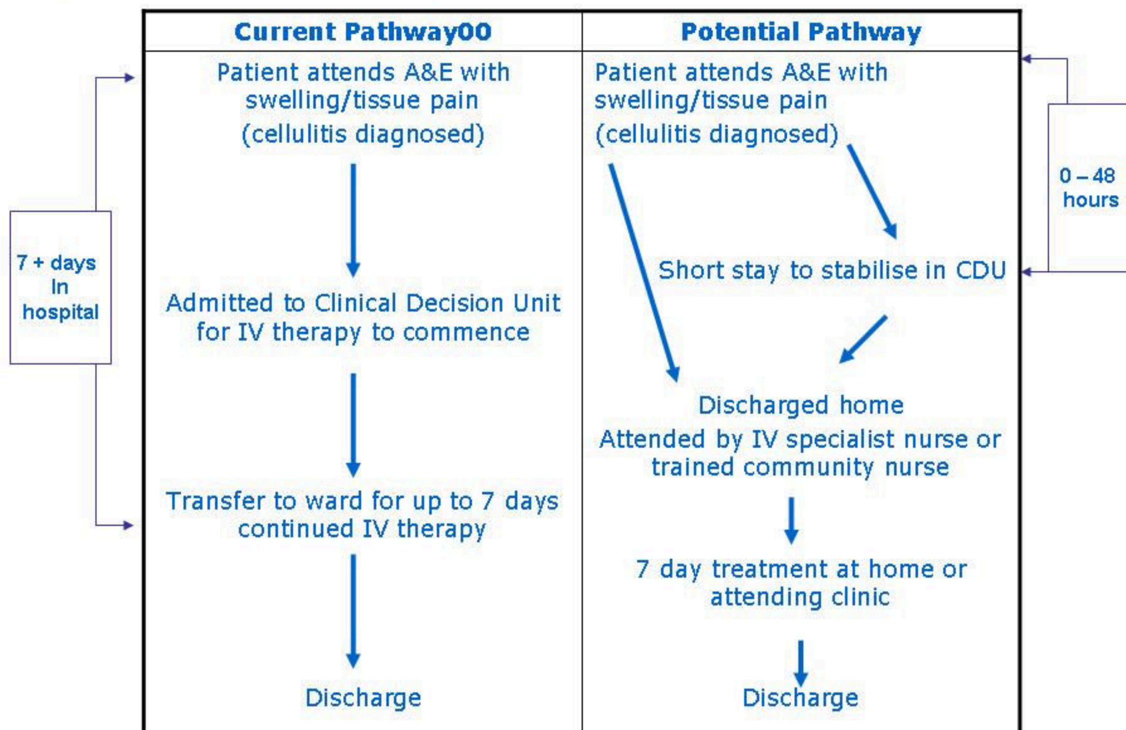
NHS South East Coast

Eastern & Coastal Kent PCT: Urgent Care Exemplar

- Selected for national programme which offers high profile opportunity to influence policy.
- Programme to deliver step changes across health and social care to support better urgent care outcomes for all stakeholders.
- Joint working groups to deliver change.
- Demonstrate clear benefits e.g. palliative care patients.
- Outcomes to include improved patient experience, improved public confidence in services, better value for money/better use of facilities, effective use of workforce and skills.

NHS South East Coast

Eastern & Coastal Kent PCT :
Urgent Care Case Study – Intravenous Antibiotics



NHS South East Coast

Eastern & Coastal Kent PCT:
Commissioning and Public Engagement Timeline

See also detailed timeline in handouts

Oct-Dec 06:

- 6000 discussion documents issued – 900+ returned
- Stakeholder discussion events x 3 locations
- Co-design events x 3 locations
- Ongoing presentations to PPIF; staff groups; vol/com groups etc.

Jan-March 07

- presentation to c100 staff at EK Hospitals Trust
- Stakeholder half-day event – exploring themes from discussion/co-design
- MORI-led research and deliberative event
- On-going development of "virtual panel" and meetings with stakeholders.

April onwards

- Development of consultation document/process (if required) with stakeholders

NHS South East Coast

Medway PCT: Overarching vision

Making Medway a good place to live, work and thrive by:

Improving the health of the population and reducing health inequalities *

Commissioning local, responsive access to health and social care in a value-for-money delivery system of high quality providers which include:

- well-developed extended primary care services
- robust health and social care trust
- acute care in foundation trusts
- increased provision by private and third tier sectors

* Public Health Annual Report published 2006

Medway PCT: Profiling future demand

NHS South East Coast

- Public health needs
- Historical under investment in health services in Medway
- Commissioning 'preventative' health services rather than reactive 'illness' services
- Improved access to primary and community services
- Health audits will continue to profile the needs of the population in Medway
- Need for emergency in-patient capacity will reduce as care pathways for long-term conditions continue to develop
- Up to 75 per cent of people treated in A&E could be treated in improved primary care settings

Medway PCT: Commissioning initiatives

NHS South East Coast

- Planned care changes
- Unscheduled care changes
- Trauma and Orthopaedic – clinical assessment
- Chronic disease management
- Practice-based commissioning
- Emergency care pathways for children

NHS South East Coast

Medway Kent PCT:
Clinical example of a commissioning initiatives

A patient journey
Heidi Shute – Community Cardiology Manager

NHS South East Coast

Medway PCT:
Clinical example of a commissioning initiatives

NHS
South East Coast

Medway PCT:
Clinical example of a commissioning initiatives

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Clinical example of a commissioning initiatives

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Medway PCT:
Clinical example of a commissioning initiatives

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Medway PCT:
Clinical example of a commissioning initiatives

In Summary

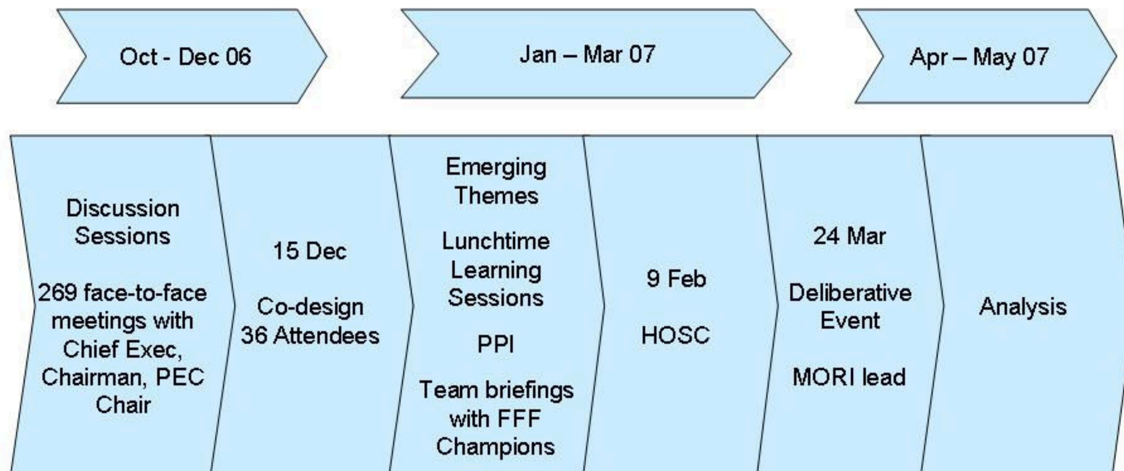
- Heart care moving from hospital to community
- Rehabilitation service available for all heart attack/heart surgery (234→850)
- Community diagnostics (2,500 per year)
- Heart Failure (209 new referrals)   Saved admissions March-Dec 06 =28 Medway, 7 Swale
- Cost saving Medway= £70,000

NHS South East Coast

Medway PCT:
Clinical example of a commissioning initiatives

NHS South East Coast

Medway PCT:
Fit for the Future engagement timeline



Appendix 3

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.[1]

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.[2]

   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.[3]

   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.

[1] *A new direction for surgical and orthopaedic care*, p. 7.
[2] Ferguson *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).
[3] RCSEng, *Delivering High-quality Surgical Services for the Future* (March 2006), p. 28; ippr, *Hospital reconfiguration: ippr briefing* (September 2006).

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 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.[4]

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.

[4] 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.

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 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 ringfenced 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.

Chairman ____________________________

Date ________________________

NHS Overview and Scrutiny Briefing Note

Dentistry

1 March 2007

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Background

Ever since the inception of the National Health Service in 1948, General Dental Practitioners (GDPs – "High Street" or "Family" dentists, providing primary-care NHS dental services) have been independent, self-employed contractors. As such, GDPs have always been free to provide as much, or as little, private dentistry as they wish, alongside their NHS commitment. And they have always had to pay for their own premises, staff, equipment and materials out of their practice incomes (NHS and private). Dentists working in the NHS do, though, receive NHS pensions.

From 1948 until the introduction of the 2006 dental contract, an NHS dental contract was available to any dentist who wanted one; and dentists were free to provide NHS dentistry wherever they wished to.

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

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

There has always been (and continues to be) universal entitlement to NHS dental treatment – i.e. anyone who needs it is entitled to access it. For the first three years of the NHS, dentistry was available to NHS patients free at the point of use. However, in 1951 patient charges were introduced (primarily as a means of limiting demand) and they have remained ever since, in one form or another (with exemptions from charges for children and for adults falling into certain low-income categories).

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

Subsequently, dentists felt themselves to be chronically underpaid for NHS practice,

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

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

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

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

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

The new dental contract (2006)

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

This meant that, for the first time, Primary Care Trusts (PCTs) were responsible for contracting locally with dentists to provide services, as part of PCTs' "commissioning" role. And remuneration of dentists was no longer based on the "item of service" principle – dentists began to be paid per *course* of treatment provided; and they were required to hit a target, expressed in "Units of Dental Activity".

At the same time, the old complex system of patient charges was replaced by simple charge-bands covering courses of treatment (priced as follows from 1 April 2006):

- Band 1: Diagnosis, treatment planning and maintenance – also urgent and Out of Hours treatment (£15.50)
- Band 2: Diagnosis, etc. *and* simple treatment (£42.40)
- Band 3: Diagnosis, etc. *and* simple treatment *and / or* complex treatment / provision of appliances (£189.00)

Any further treatment required at the same charge-level within two months was now free of charge. Replacements for lost or damaged appliances were now subject to a charge of 30% of the Band 3 charge (£56.70).

This new patient-charge regime meant that the maximum patient charge for a course of

treatment was now £189.00 (the previous upper limit had been £384.00). However, the cost of a simple check-up, with no further treatment, effectively rose from £5.84 to £15.50.

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

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

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

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

The new contract was available to all dentists who were already practising within the NHS, provided they signed up before 1 April 2006. Dentists who signed before that date were also guaranteed the same yearly gross fees as they earned during a 12-month "reference period" (2004–5) for the next three years. PCT dental allocations are ring-fenced during that time. At the end of this initial three-year transitional period, PCTs will assume full responsibility for commissioning dental services in their area, using money from a (now non-ring-fenced) budget for this purpose. The intention is that PCTs will structure services according to local need, directing dentists towards areas where access problems exist, as part of their commissioning function.

Issues around the new contract

The Department of Health (DoH) argued that the new contract freed dentists from the "treadmill" style of working associated with the "fee per item" system and encouraged a more preventive approach. Dentists' representatives, however, argued that remuneration through Units of Dental Activity was merely another form of "treadmill", since it was target-driven.

The overwhelming majority of NHS dentists did sign up to the new contract. However, a significant minority of around 10% of them did not sign, thereby withdrawing from the NHS. The DoH insisted that the vast bulk of routine NHS dental provision had been secured through the new contract, with service levels, measured in Units of Dental Activity, being successfully maintained. Those dentists refusing contracts were, it was claimed, mostly those who had been providing only minimal NHS services. And PCTs were confident that they could make good any shortfall in provision through other dentists expanding their NHS commitment and through the commissioning of new services.

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

contract.

The DoH maintains that more NHS dentistry is now being commissioned than ever before. However, there remains a widespread perception (endorsed by dentists' representatives) that access to NHS dentistry has not improved since the introduction of the new contract – and may actually have worsened.

It has recently been reported that PCTs are experiencing financial problems in respect of dental services, due to revenue receipts from dental patient charges being (for several reasons) lower than was forecast when the new contracts were issued in 2006.

Given that dental allocations are ring-fenced for the first three years of the new contract, funds earmarked for primary-care dental provision cannot be diverted by PCTs in order to address financial problems. However, it is feared that this could happen once ring-fencing ends.

It is noteworthy that, in the turnaround plan agreed by South West Kent and Maidstone Weald PCTs in July 2006, it was stated that £700,000 remained from the PCTs' 2006–7 dental allocation and that "delays in providing alternative arrangements for more NHS dentistry" would "result in a one off saving". It is questionable whether unspent ring-fenced dental allocations can actually be retained in this way by PCTs – or whether they should instead be passed back to the Strategic Health Authority.

Possible themes for questions:

- Whether the new dental contract has permitted the commissioning of adequate:

    - access to NHS dental care for all those who need it, in all areas;
    - Out of Hours dental services;
    - specialist dental services (particularly orthodontics).

- The possible effect on service provision of contractual disputes that remains outstanding, if these cannot be satisfactorily resolved.

- Whether the reported shortfalls in dental patient charge revenue will affect service provision.

- Whether significant gaps in services will open up at the end of the three-year transition period, when significant numbers of dentists may wish to withdraw from the contract; and when ring-fencing of PCT dental allocations will come to an end.

- Whether PCTs are able adequately to fulfil their commissioning role in terms of:

    - accurately gauging local need for services; and
    - directing provision towards areas or communities that are underserved.

Number of dentists (General Dental Practitioners) on open NHS contracts in Kent & Medway as at 30 September 2006 (including orthodontists)

Primary Care Trust	Total number of dentists (performers) on open NHS contracts	Population per dentist
Ashford PCT	68	1,606
Canterbury and Coastal PCT	68	2,452
Dartford, Gravesham and Swanley PCT	87	2,567
East Kent Coastal PCT	57	4,106
Maidstone Weald PCT	94	2,544
Medway PCT	362	725
South West Kent PCT	111	1,624
Shepway PCT	46	2,119
Swale PCT	41	2,383

Sources:
The Information Centre for health and social care
NHS Business Services Authority

Units of Dental Activity commissioned by Primary Care Trusts in Kent & Medway, as at 30 November 2006

	UDAs commissioned			UDAs re-commissioned		
Primary Care Trust	and provided	but not yet provided	Total	and provided	but not yet provided	Total
Eastern and Coastal Kent PCT	929,990	33,664	963,654	39,187	6,232	45,419
Medway Teaching PCT	419,401	8,750	428,151	5,176	-	5,176
West Kent PCT	739,278	8,576	747,854	22,832	265	23,097

Source: Department of Health

Disputed dental contracts in Primary Care Trusts in Kent & Medway, as at 30 November 2006

	Total initially in dispute		Unresolved		Resolved - outcome accepted		Resolved - outcome not accepted	
Primary Care Trust	Contracts	UDAs	Contracts	UDAs	Contracts	UDAs	Contracts	UDAs
Eastern and Coastal Kent PCT	51	488.593	32	294,591	18	177,227	1	16,755
Medway Teaching PCT	19	138,916	1	453	18	138,462	-	-
West Kent PCT	44	376,667	8	85,256	36	291,411	-	-

Source: Department of Health

KLDC Kent Local Dental Committee

The Kent Local Dental Committee (KLDC) is grateful to Paul Wickenden and the KCC NHS Overview & Scrutiny Committee for the opportunity of advising how General Dental Practitioners (GDPs) in Kent have reported problems they have experienced since the introduction in April 2006 of the new GDS (General Dental Services) and PDS (Personal Dental Services) contract(s).

The KLDC is unable to offer information on difficulties encountered by GDPs in specific areas of Kent. This information is more accurately held by the PCTs in direct contract with the practitioner(s). However the following back ground information will be of use to members of the Committee.

The new contract came in April 2006. The new contract was supposed to allow dentists to spend more time with their patients, focussing on preventive dentistry and to not incentivise dentists to be paid more for doing more interventive treatments. It was also supposed to be based on their previous activity in the reference year October 2004 to September 2005, such that provided the dentist did the same amount of treatments they would be paid the same amount of money in 12 equal monthly instalments.

The only choice the dentists had with the new contract was to either sign it or not. They did not have a choice about the content of the contract and so were not able to negotiate variations within it. Given this "done deal" most dentists signed - but in 'dispute'. Most of the disputes were rejected by the DoH as the grounds for dispute were non-negotiable and as a consequence the dentists had to accept the contracts as they stood. These disputes were listed as "resolved" by the PCTs in giving feedback to the DoH but many dentists have been left feeling unhappy with the contract.

When the dentists were sent their individual contracts a significant number of dentists were required to carry out more activity represented by 'Units of Dental Activity' (UDAs) than they had in fact carried out in their reference year. Some experienced as much as a 30% increase in their workload for the same funding. The reality is that these practitioners are working just as hard as before (if not harder) and effectively are being asked to do more work to earn the same money as before.

Now that we are drawing near to the end of the first year (April 06 to March 07), most dentists are short of their required targets although some have achieved them and others achieved their targets quite some time ago. This latter category included dentists whose reference year was atypical of their normal activity (e.g. they had time off for illness or pregnancy in the test period). Where dentists had asked for higher funding with their new contracts because the reference year was atypical, few were able to obtain this because the PCT had no additional funds available. These dentists reached their targets easily. Most dentists look as though they are likely to be falling short of their targets. If they are more than 4% short of their 'target' the PCTs are preparing prompt action to either withhold future funding proportional to the shortfall or require dentists to repay money that they have been given.

The new contract did not allow dentists to spend more time with their patients as it is still an output driven contract whereby dental activity is still measured by items of treatment. The nature of the contract means that superficially (and politically) it may appear that more courses of treatment are being provided than under the previous dental contract. The reality is that although more 'courses' of treatment may be being provided, less actual treatment is being provided on each course of treatment than before. It seems very unlikely therefore that the perceived increase in treatment provision is a reality.

Although we have no data as yet, it is likely that any PCT claw-backs and a lack of sensitivity in these subsequent negotiations will precipitate further withdrawals of dentists from continuing to provide NHS care to patients in Kent. This is a real risk that must not be under estimated. A lack of sensitivity will prompt withdrawal from the NHS by many practitioners who have tried out the new system in good faith and will feel betrayed by the PCT if they feel the PCT is merely on a book balancing exercise with no real regard for the practitioners and the patients they are looking after.

We feel that relating UDAs as the target by which all judgements are made and against which financial sanctions may be applied is iniquitous and merely produces resentment in practitioners and is unhelpful to patients - especially given the fact that there is no accurate reliable data being produced by the Business Services Authority (BSA). It would be a shame to threaten dentists who are practising good ethical dentistry centred on patient care.

The KLDC is happy to answer any questions the NHS Overview & Scrutiny Committee may have over any issue affecting Performers working within NHS dentistry in Kent.

Julian M Unter
as Secretary to Kent Local Dental Committee kldc@unter.co.uk 8 March 2007

Chairman	Vice Chairman	Secretary	Treasurer
Timothy Hogan	Ian Hammond	Julian M Unter	Huw M Winstone
Dental Surgery	Dental Surgery	Rainham Dental Surgery	Dental Practice
117 Old Tovil Road	52 London Road	15 High Street	Meadow Lane
Maidstone	Canterbury	Rainham	New Ash Green
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NHS Overview and Scrutiny Briefing Note

Provision of Clinics at Gravesend Community Hospital and Darent Valley Hospital

✉ David.Turner@kent.gov.uk
☎ **(01622) 694196**

2 March 2007

Members are referred to the attached correspondence and press reports on this matter.

Possible themes for questions:

- Whether adequate alternative services in Gravesham are being commissioned by West Kent PCT to replace those outpatient clinics that have been removed from Gravesham Community Hospital by the Trust. (Failure to commission such alternative services would presumably entail service-users from Gravesham having to travel on a regular basis to the Darent Valley Hospital at Dartford.)

- Whether these changes to services are related to the long-term high fixed overhead costs of the two Private Finance Initiative hospitals within this health economy. (Darent Valley Hospital costs the acute Trust £20 million a year – one-fifth of the Trust's turnover; Gravesham Community Hospital costs the PCT £3 million a year; both these PFI contracts will run for three decades.)

- Why the PCT has made a heavy long-term financial commitment to a community hospital in Gravesham when it appears that the intention is now to commission from GP providers services that have hitherto been provided at the community hospital.

- Whether the community hospital will prove to be a growing financial liability for the local health economy if the trend continues of withdrawing services from it – and what the possible consequences of this are.

The attached appendices are as follows:-

Appendix 1	21.04.06	Press release detailing outpatients services at the new Gravesend Hospital
Appendix 2	05.06.06	Letter from Dartford, Gravesham & Swanley PCT and Dartford & Gravesham NHS Trust re Proposals for Future Services at Gravesham Community Hospital (GCH)
Appendix 3	04.10.06	Gravesend Express article
Appendix 4	06.10.06	Gravesend KM Extra article
Appendix 5	15.11.06	Letter from KCC to Chief Executive of Dartford & Gravesham NHS Trust re changes to services at Darent Valley Hospital (DVH) and GCH
Appendix 6	21.11.06	Response from Chief Executive of Dartford & Gravesham NHS Trust to Appendix 5

Dartford, Gravesham and Swanley NHS
Primary Care Trust

Media Statement

21st April 2006

Outpatient services at the new Gravesham Community Hospital

The new, leading-edge health and social care centre, based in Bath Street, Gravesend is a partnership project which comprises the PCT's new Gravesham Community Hospital and Kent County Council Social Services' residential and nursing care home and day centre, known as Gravesham Place. Grosvenor House Group will manage the new facility and employ the support staff.

Liz Cracknell, Deputy Chief Executive of Dartford, Gravesham and Swanley Primary Care Trust (PCT) said:

"The services the PCT is directly providing in its new hospital include a minor injuries unit, the out of hours service, and intermediate care services for patients with chronic progressive neurological disorders.

"The majority of outpatient services are provided by NHS Trusts other than Darent Valley Hospital (Dartford & Gravesham NHS Trust).

"It has been agreed with Darent Valley Hospital that they will be relocating a small number of outpatient services back to Dartford. However, this gives the PCT an opportunity to expand its provision of a comprehensive range of local community-based services in order that its new facility in Gravesend will be used to its full potential. We will be implementing these plans over the next few weeks. As a result of these plans more patients than ever will be accessing services at Gravesham Community Hospital."

Mark Devlin, Chief Executive of Dartford and Gravesham NHS Trust, said:

"Following detailed discussions with the PCT we have now agreed to the reconfiguration of services. With the new PCT-run Gravesham Community Hospital now complete both organisations need to ensure that the services delivered locally continue to be of the highest quality and are as efficient as possible."

Further media enquiries:

Please contact Anita Brunger, communications manager (Tues - Fri) or Quentin Williamson, communications officer (Mon - Thurs) on 01322 622303, or email: anita.brunger@dgspct.nhs.uk or Quentin.Williamson@dgspct.nhs.uk

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Dartford and Gravesham NHS
NHS Trust
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5 June 2006

To All Neighbouring NHS Trust
Local Borough Councils
KCC Overview & Scrutiny Committee
Patients Forum
Local MPs
GPs
Kent Social Services
Voluntary Sector Partners

Dear Colleague

Re: Proposals for Future Services at Gravesham Community Hospital (GCH)

Introduction

You may be aware that the new Gravesham Community Hospital (GCH) opened in April. This state of the art facility has given us the opportunity to review how many services are provided, and ensure that as many of our local population as possible are able to benefit from the superb new hospital.

At the same time, given the financial challenges facing both the PCT and the Acute Trust, with the fixed costs associated with the Private Finance Initiative (PFI) contract for the Darent Valley Hospital, (DVH) as well as the PFI for GCH, it is important that both of these assets are used as intensively as possible, and deliver the objectives set out in the new White Paper “Our Health Our Care Our Say.”

We have therefore worked together to develop new services for several groups of patients, with the innovation of Clinical Assessment Services based at GCH.

Current Services

The current configuration of services at GCH follows a historical pattern, which has not been reviewed in many years.

The Acute Trust provides the following services on the GCH site:

- Rheumatology clinics
- Orthopaedic clinics
- Dietetic clinics
- Diabetes clinics
- Anticoagulation clinics

- Retinal Screening

Medway PCT provides the following services:

- Speech Therapy
- Community Dentistry
- Podiatry
- Podiatric Surgeon

Medway Acute Trust provides the following services:

- ENT clinics
- Audiology

Fawkham Manor provides the following service:

- Ultrasound

Queen Mary's Sidcup provides the following service:

- Ophthalmology clinics

The following table summarises the services currently provided at Gravesham Community Hospital:

Monday		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
AM	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM,**
Child Behaviour	Ret Screen	Ret Screen	Ret Screen	Dietician	Ret Screen	Ret Screen	Fracture Clinic	Rheumatology	Ret Screen
Rheumatology	School Nurse	Rheumatology	Dietician	Audiology	Neonatal Hearing	Rheumatology	Dietician	Orthoptist	BCH Clinic
Audiology	Urology Nurse	Diabetes Nurse	Diabetes Nurse	ENT	Tissue Viability	Omerod	Rheumatology	Psychiatry	Audiology
ENT	Neonatal BCG	Omerod	BCG Clinics	Cardiac Nurse	Dr Manahi Psychiatry	Orthoptist	Eyes	Retinal Screen	Fracture Clinics
Orthoptist	Orthopaedic	Eyes	Omerod	Anti coagulation	Fracture Clinic	Dr Khalid Psychiatry	Omerod	Podiatry	ENT
School Nurse	Fracture Clinic	Orthoptist	Fracture Clinic	Ultra Sound	Podiatry	Ultra Sound	Orthoptist	Dental	Mr Mason Podiatric Surgeon
Orthopaedic	Podiatry	Orthopaedic	Diabetologist	Podiatry	Dental	Podiatry	Orthopaedics	SLT	Podiatry
Podiatry	Dental	Podiatry	Podiatry	Dental	SLT	Dental	Ultra Sound	MIU	Dental
Dental	SLT	Dental	Dental	SLT	Mr Mason Podiatric Surgeon	SLT	Podiatry	Phlebotomy (GP Refs)	SLT
SLT	Mr Mason Podiatric Surgeon	SLT	SLT		MIU	Mr Mason Podiatric Surgeon	Dental		MIU
Eyes	MIU	MIU	MIU	MIU		MIU	SLT		
MIU		Phlebotomy (GP refs)		Phlebotomy (GP refs)		Phlebotomy (GP refs)	MIU		
Phlebotomy (GP refs)									

DGSPCT	
DVH	
Maidstone Weald PCT	
Medway Acute	
Queen Marys	
Fawkham Manor	
Medway PCT	
K& M NHS & Social Care Partnership Trust	

Out of hours service evenings and weekends

It is worth noting that 50% of patients that attend current clinics are from Dartford.

Future Services at GCH

As a health economy we will be building on these existing clinics in order to extend services and maximise the number of patients able to access local services at GCH. This will be done by working with a wide range of Providers.

We are in the process of opening an orthopaedic clinical assessment service run by GP Specialists and Specialist Physiotherapists. This service will provide a first line assessment of patients with musculo-skeletal problems (back pain, for example).

In order to provide space for the Orthopaedic Clinical Assessment Service (CAS) at GCH, the consultant orthopaedic surgeons will undertake all their clinics at DVH, and the specialist GP/Physio service will be based at GCH.

Based on experience elsewhere, we estimate that 50% of patients with this type of problem will be seen in the community and not need to attend DVH at all.

Secondly, Gravesend patients attending DVH A&E who subsequently need to attend a fracture clinic will be referred back to GCH to receive their onward care there. We estimate this to be 1100 additional patients who will benefit from the new facilities.

Additionally, a Dermatology CAS (currently based at Swanley) will be extended to include the residents of Gravesend and based at GCH. We estimate that additional patients will benefit from this service of whom only a small percentage will then be subsequently referred to Medway Hospital.

The ENT service at GCH is also being extended to benefit more patients in receiving their care locally.

From September a service for cataract removal will be provided at GCH enabling locals residents, who previously would have travelled to Queen Mary's Sidcup for removal of their cataracts, to receive their treatment at GCH.

We are developing an option appraisal to establish the viability of a comprehensive children's centre based at GCH, which will include services from a range of providers.

We are also planning to extend the range of Clinical Assessment Services to enable even more patients to benefit from these facilities.

Staff Issues

The immediate moves described above enables a small number of DVH Trust staff, such as clinic nurses and physiotherapists to move to DVH as part of a larger team. However, they will be immediately replaced by PCT staff (GP specialists and physios) in order to maintain a comprehensive service to local residents. These will then be joined over the next few weeks by staff running the dermatology clinics, extended fracture clinics and the cataract removal service.

Conclusion

We would be happy to meet to discuss these proposals further and to receive your views during June.

Yours sincerely

Elizabeth Cracknell
Director of Commissioning
Dartford, Gravesham and Swanley Primary Care Trust

Mark Devlin
Chief Executive
Dartford & Gravesham NHS Trust

Gravesend Express
4 October 2006

Patients' fury at three-hour trip to clinic

Blood unit's move from community hospital sparks protests

By Ed Riley

Angry patients face a three-hour trip to a blood-thinning clinic, which has moved to another borough.

The anti-coagulant clinic is now based at Darent Valley Hospital in Darenth Wood Road, Dartford, following transfer from the Community Hospital in New Road, Gravesend.

In August, the Express revealed the plan to transfer the clinic from the multi-million pound centre, which opened just a few months ago, prompting anger from readers. Rose Ellis, 30, of Grangeways Close, Northfleet, attends the clinic every six weeks to receive treatment for a heart condition she has suffered from since she was born.

She said: "I would like to know how those in charge of this ridiculous decision can spend millions of pounds on a new so-called 'community hospital' and then close vital services within months of opening and fail to serve the community."

Miss Ellis is a member of Grown-up Congenital Heart Patient Association, which campaigns to make the lives of people with heart problems easier.

She added: "Many people with my condition are unable to drive and this is true of all the elderly patients who attend the clinic. Why should they be forced to make a difficult journey on public transport, often having to change buses halfway?

"I am one of the lucky ones because I can drive, but the petrol costs are going to be high and I will have to spend a whole morning getting to the hospital, whereas before I could receive my treatment in a couple of hours.

"My grandfather is 87, and he attends the clinic. He just isn't capable of making the journey. I don't know what he is going to do."

A Dartford, Gravesham and Swanley Primary Care Trust spokesman said: "Following a review of services and subsequent consultation period it has been agreed that the anti-coagulant clinic will be moved. The PCT, meanwhile, is working in collaboration with GP practices to develop ant[i-]coagulant services within surgeries as this will improve accessibility for the patients who use this service."

Appendix 4

Gravesend KM Extra
6 October 2006

Plans to move specialist clinic

Health chiefs are contemplating moving Gravesend's diabetic clinic from its home in Gravesham hospital over to Darent Valley Hospital.

The twice-monthly clinic which runs from the health and social care centre in Bath Street could be based at the Darenth Wood Road hospital from as early as next month.

The move is thought to be a mutual agreement between Darent Valley bosses at Dartford and Gravesham NHS Trust and Dartford, Gravesham and Swanley Primary Care Trust which runs the Bath Street facility.

Information

There are 8,080 diabetic patients across Dartford, Gravesham and Swanley, but it is unclear as to how many use the clinic on any one day.

The clinic is for sufferers undergoing their twice-yearly check, those who need further advice about their treatment and the insulin they're taking or others seeking diet information.

Darent Valley Hospital, which already runs another series of clinics at the hospital, is charged a rental fee by the PCT to run their Tuesday clinic from Bath Street.

And so moving it back to Darent Valley would save the cash-strapped hospital money.

Dartford, Gravesham and Swanley PCT said the clinic's move was part of a "wider configuration of services" but was unable to explain what other services could be affected by this review and who might fill the gap left by the diabetic clinic.

Diabetic patient Simon Clarke from Chiltern Road in Northfleet received a letter explaining the proposed changes. He said when the Bath Street hospital was built users were assured all services would remain unchanged.

Mr Clarke said: "They assured us all the facilities that were provided before would remain and now they are going back on it."

It is anticipated a firm decision will be made by the end of the month, and if given the go-ahead the clinic will move the seven miles and run out of Darent Valley from mid-October.

Appendix 5

Mark Devlin
Chief Executive
Dartford & Gravesham NHS Trust
Darent Valley Hospital
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Dartford DA2 8DA

Direct Dial/Ext: (01622) 694486
Fax: (01622) 694383
Email: paul.wickenden@kent.gov.uk
Ask for:
Your Ref:
Our Ref:
Date: 15 November 2006

Dear Mark

Darent Valley Hospital and Gravesham Community Hospital

Several of our Members have raised concerns regarding changes to services at the Darent Valley Hospital and Gravesham Community Hospital, and I wondered if you could please clarify the situation for us.

At its meeting on 9 June 2006, the NHS Overview and Scrutiny Committee heard evidence from you and Liz Cracknell, from Dartford, Gravesham and Swanley PCT, about services at GCH. The Committee was informed that, while the PCT was responsible for GCH, a number of services available at that location were actually provided by the acute Trust. These were listed as follows:

- Rheumatology clinic
- Orthopaedic clinic
- Dietetics clinic
- Diabetes clinic
- Anticoagulant clinic
- Retinal Screening

The Committee was told that there was to be some rearranging of orthopaedic services at GCH; but no indication was given of any other planned changes to services.

We have recently become aware of local press reports regarding the removal of the anticoagulant clinic to DVH (*Gravesend Express*, 4/10/2006) and a proposal to move the diabetes clinic as well (*Gravesend KM Extra*, 6/10/2006). We do not appear to have been notified by the Trust or the PCT regarding this. Concern has been expressed at these changes and I would be grateful if you could explain them and the reasoning behind them.

In August, we were informed by DGS PCT that, as of 2 January 2007, they would be taking over the running and managing of the Minor Injuries service provided at DVH and would also be providing a primary care service there. On the basis that this did not entail any material change in the actual service provided, it was agreed that this matter did not need to go before NHS OSC.

In October, we received further correspondence from the new West Kent PCT notifying us that the Minor Injuries and primary care service (to be known as the Emergency Care Centre) would be provided by the PCT from the Woodlands Centre at DVH (where it would be co-located with the GP Out of Hours service), rather than in the MIU footprint within the A&E Department at DVH.

When I circulated this recent correspondence to Members, it became apparent that a number of them were under the impression that the Minor Injuries service currently provided at GCH was to be withdrawn and relocated to DVH. It may be that some confusion has arisen here with the withdrawal by the Trust of certain outpatient services from GCH. I would be grateful if you could please clarify the situation for us.

Yours sincerely

Paul Wickenden
Overview and Scrutiny Manager
Democratic Services

Cc: All Members who represent a Gravesham and Dartford electoral Division
Alan Chell, Chairman, NHS Overview and Scrutiny Committee
Mark Fittock, Vice Chairman, NHS Overview and Scrutiny Committee
Dan Daley, Liberal Democrat Spokesman, NHS Overview and Scrutiny Committee
Graham Gibbens, Cabinet Member for Public Health

Appendix 6

Dartford and Gravesham NHS
NHS Trust

Mark Devlin
Chief Executive

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21st November 2006

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

Dear Paul

Thank you for your letter of the 15th November regarding services at Gravesham Community Hospital. As you say, the West Kent PCT are responsible for this facility, however, this Trust provides some outpatient services there.

I believe I did state at the meeting on the 9th June that issues would need to be kept under review and that there were ongoing discussions about the balance of hospital and community services. We have corresponded with all the patients who attend clinics at Gravesham in an effort to understand their requirements. Some clinics have transferred directly as we discussed at the meeting, whilst others have changed as a direct result changing patterns of care and the impact of the White Paper “Our Health, Our Care, Our Say”, in which you know the Government signals a shift of care out of hospital into the community.

The Anticoagulant clinic is a classic example of this, where it has long been considered unnecessary to travel to hospital for blood tests and that these services should be provided within GP Practices. This is part of the rationale for cessation of the Anticoagulant clinic at Gravesham Community Hospital. Similarly the PCT is encouraging a much greater emphasis on diabetic care supported by GPs and primary care Nurse Practioners rather than being hospital led. We are, therefore, trying to re-profile our hospital provided services accordingly.

I think you have recently had a presentation from Steve Phoenix, the new West Kent PCT Chief Executive, on the Fit for the Future programme. The thinking underlying this project is that very significant shifts of patient activity will occur in the next 2-3 years out of hospitals and closer to patients’ homes.

In the context of these changes, the only service that Dartford and Gravesham NHS Trust is continuing to provide at Gravesham Community Hospital is the Retinal Screening clinic. The remainder of the clinic services there will be provided either by the PCT itself or commissioned by the PCT from other Acute providers. The Clinical Assessment Service we discussed is now up and running in place of the Orthopaedic and Rheumatology Clinics.

On the point of the Minor Injuries Unit, the development at Darent Valley Hospital is new and does not involve the transfer of any services from Gravesham Community Hospital. It is my understanding that PCT staff will rotate between the two units.

I hope these comments clarify the situation.

Yours sincerely

Mark Devlin
Chief Executive

Cc: Steve Phoenix, CEO, West Kent PCT

NHS Overview and Scrutiny Briefing Note

Audiology
7 March 2007

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☎ **(01622) 694196**

Background

In 2004, some 213,900 people in England were registered with their local Social Services department as deaf or hard-of-hearing. But it is estimated that 7.5 million (around a fifth of the population) in England actually suffer from deafness or are hard-of-hearing. A substantial majority of people with hearing loss obtain their hearing rehabilitation through the National Health Service. Significant numbers also suffer from tinnitus ("noise" in the ear) and balance disorder; and almost all are treated by the NHS.

Two million people in the UK have been fitted with hearing aids, although it is estimated that only about 1.4 million of these use them regularly. It is believed that a further four million people might benefit from having a hearing aid (some estimates put this figure as high as five to six million). The NHS provides at least 2.6 million adult hearing-aid appointments per year, including 500,000 hearing-aid fittings.

There are 164 NHS Audiology services in England, mostly provided by acute Trusts in a hospital setting; a few are provided by Primary Care Trusts (PCTs). The audiology services undertake:

- hearing screening of new-born children;
- diagnostic testing of new-born children;
- work with hearing-impaired children;
- children's hearing testing;
- diagnostic work relating to the audio-vestibular (balance) system;
- balance rehabilitation;
- hearing therapy;
- counselling for tinnitus;
- support for Ear, Nose and Throat (ENT) and Audiological Medicine services;
- work with adults with age-related hearing loss.

The work of NHS audiology services is commissioned by PCTs through block contracts, audiology not currently being subject to the Payment by Results system.

Modernising NHS Audiology services

During 2000–5, the provision of all adult hearing-rehabilitation services within the NHS was transformed by the Modernising Hearing Aid Services (MHAS) project, which was a UK-wide government initiative, managed in partnership with the Royal National Institute for the Deaf (RNID).

The two key components of MHAS were: the implementation of an improved rehabilitative process; and the provision of digital hearing aids (as recommended by the National Institute for Health and Clinical Excellence), which had previously only been available privately, often at high cost. Digital devices have programmable "intelligent" amplification

that is considerably better than analogue technology.

The NHS Purchasing and Supply Agency (PSA) was able to get significant discounts on digital hearing aids by large-scale bulk purchasing – apparently securing the lowest unit cost achieved by any purchaser of hearing aids in the world. (So long as hearing aids are bulk-purchased in this way their provision counts as a capital transaction and is, therefore, excluded from Payment by Results.) Roll-out of digital hearing-aids in the NHS Audiology service was completed in 2005.

Between 2003 and 2006, NHS Audiology services for children were also successfully modernised.

The modernised audiology service was complemented by “Hearing Direct”, a telephone follow-up and triage service provided by NHS Direct.

Waiting times

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

The most recent returns from the Department of Health (DoH) on waits for diagnostic tests, for December 2006, show 170,033 people in England waiting for an audiology test – 113,474 had waited more than 13 weeks; and 84,374 had waited more than 26 weeks. The average expected wait for an audiology assessment was 17.6 weeks. The average expected wait in the South East Coast Strategic Health Authority (SHA) area was the worst in the country – 45 weeks.

The DoH does not collect data on waiting times for hearing-aid fittings. However, the British Society of Hearing Aid Audiologists conducts an annual survey on this topic. In 2006, the survey found that the average wait in England for an NHS hearing aid, for someone seeking their first device, had risen for the third year in a row to 45–48 weeks.

There were huge variations across the country, with patients waiting on average 73–74 weeks in the South East, which had the worst waiting times. Four hospitals in England (one of which was the Kent and Canterbury Hospital) had waiting times of 117 weeks (i.e. two years and three months), the longest waits in the UK. Users wanting to upgrade their hearing aids from analogue to digital had to wait on average 68 to 72 weeks. At one hospital in England, the wait was 260 weeks (i.e. five years), and at another five hospitals there were waits of over 200 weeks (i.e. nearly four years).

The Public Private Partnership

Between 2003 and 2005, the DoH, through the NHS PSA, negotiated a national framework contract with two major private-sector suppliers for patients to receive their NHS hearing

aids through the private sector, by way of a three-episode patient journey (assessment, fitting and follow up). This was known as the Public Private Partnership (PPP). It was facilitated by local NHS Audiology services, which also undertook clinical governance monitoring of the scheme. Patients on the NHS waiting list were invited to take part, and at least 68,600 people received hearing aids in this way during 2004–6.

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

The end of ring-fenced funding

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

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

National waiting-time target

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

Audiology appeared to represent a significant problem for the NHS in meeting the 18-week target – two-thirds of the total number of patients waiting more than 26 weeks for diagnostic tests are waiting for audiological assessment.

However, in May 2006, the DoH announced that referral by GPs direct to NHS Audiology Services fell outside the 18-week pathway. Only those cases involving referral to an ENT consultant were deemed relevant to the 18-week pathway. (The DoH states that 50% of audiology referrals, and 20% of adult hearing-loss referrals, are to ENT consultants; audiologists' representatives seem to put the latter figure at 10%.) The DoH also indicated that direct-referral audiology patients should not be re-routed to the ENT service in order to get around the bottle-neck in the audiology service and get onto the 18-week pathway.

It has been argued that the exclusion of audiology from the 18-week pathway has meant that financial support for NHS Audiology capacity has been further undermined – as resources in local health economies have been shifted to other services where there are mandatory targets to hit.

Interim diagnostic targets

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

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

Although hearing-aid fitting falls outside the 18-week pathway, referral for hearing tests *is* within these interim targets for diagnostic assessment. It appears that, consequently, the NHS in a number of areas is assessing all patients on the hearing-aid waiting list in order to hit the interim diagnostic targets – regardless of whether there is any realistic prospect of the patient receiving appropriate rehabilitation (including the fitting of a hearing aid). Consequently, by the time the local audiology service is able to provide rehabilitation, the hearing test will be out-of-date and will, therefore, have to be repeated. Thus, the national target may be hit – but resources are actually wasted.

Second-wave Independent Sector Treatment Centres

Episodes of audiology care (three-stage patient pathways) are being included in contracts for the second wave of centrally-procured Independent Sector Treatment Centres (ISTCs), procurement of which by the DoH began in 2006.

Audiologists' representatives have expressed alarm at the lack of involvement of the NHS Audiology service itself in making arrangements for the delivery of audiology by ISTCs. The following issues have been raised:

Type of hearing aid

Concern has been expressed about lack of information concerning the type of hearing aid to be used by the ISTCs. There are issues around quality, repair and maintenance of devices, and whether use of unfamiliar devices will impair seamless follow-up by NHS Audiology service staff.

Cases requiring a specialist opinion

Up to half of patients referred from primary care to NHS Audiology services potentially require onward referral to an ENT specialist. NHS audiologists often manage these cases under local clinical governance arrangements agreed with ENT colleagues. It is unclear what provision will be made in ISTCs to cover this situation and whether patients will complete the three stages of the patient journey (assessment, fitting of the hearing aid and follow-up) whilst waiting for a medical opinion.

Patients with complex needs

Many patients with complex needs are currently identified by NHS audiologists and referred on. Rehabilitation of hearing loss can be a complex and sometimes lengthy process. Patients may need information and advice on assistive listening devices or, for the most severely affected, bone-anchored hearing aids and cochlear implants. Rehabilitation also encompasses communication skills training, and counselling to help patients improve their quality of life. Many patients require more than one follow-up visit after a hearing-aid fitting – sometimes several. It is not apparent that the ISTC contracts will include provision for meeting the needs of such patients by employing the specialist (graduate) audiologists who deal with these cases in NHS Audiology services. And there seems to be no clarity yet regarding pathways and funding mechanisms for ISTCs to refer

these cases on to appropriate services.

Continuity of care

It is still unclear whether, under the terms of the ISTC contracts, the patient will return to local NHS Audiology services after the three-stage patient journey. It is not known whether the patient will stay with the ISTC for the life of the hearing aid, or whether the local NHS Audiology service will be commissioned to provide maintenance, repair, replacement of lost hearing aids, etc. If NHS Audiology services are to undertake such extra activity, they will need the resources to do so. There is also the question of whether additional referrals from primary care will be required for such continuing care.

Clinical governance

It is unclear whether the ISTC contracts will be covered by the same clinical governance arrangements as applied to the PPP scheme, allowing for monitoring of standards, as well as senior clinical involvement.

Sharing of patient records

If the patient is to have the option of returning to their local NHS Audiology service, there will need to be full and quick access to their patient records, to maintain standards of care. It is unclear whether ISTCs will be required to give such access.

Patient selection

There is some doubt as to the mechanism whereby audiology patients will be sent to an ISTC (whether this will be done through Patient Choice; whether those on waiting lists will be seen first).

Staffing

Questions have been raised about how ISTC-delivered audiology is to be staffed. Given that rules on "additionality" are apparently to be relaxed for second-wave ISTCs, there are concerns about possible poaching of staff from NHS services.

The extent of ISTC procurement

In July 2006, the government announced that 300,000 three-stage audiology patient pathways per year were being centrally procured from the independent sector, to come on-stream from early 2007.

There has been concern that independent-sector procurement on such a massive scale might actually lead to the creation of over-capacity (large waiting lists and unmet need notwithstanding) – and undermine NHS services.

The future of NHS Audiology services

In theory, independent sector-provided audiology is purely additional to that provided by NHS Audiology services. However, commissioners have no choice about whether to use ISTCs, or the volume of work for which they are contracted, since ISTC contracts are

centrally procured by the DoH. (In theory, arrangements are signed off by PCTs; in practice, there seems to be no real local involvement in setting ISTC contracts.) There could thus be a significant incentive for commissioners to treat ISTCs as their core providers and the (non-ring-fenced) NHS Audiology services as additional.

On this basis, a significant shift from NHS providers to ISTCs could occur irrespective of any considerations about the value-for-money or quality of the two types of provider (as has been seen, in other contexts, with first-wave ISTCs).

Audiologists' representatives have expressed fears that the very existence of the core NHS Audiology service could be threatened, jeopardising the range of services that they provide in addition to the routine fitting of hearing aids (and which ISTCs will not provide).

The National Audiology Action Plan / *Improving Access to Audiology Services in England*

In May 2006, it was announced that there would be a National Audiology Action Plan. The government stated that this would address concerns about the future coherence and comprehensiveness of audiology services in the NHS.

Professional organisations, patient groups and voluntary-sector agencies all expressed disappointment at not being directly involved in the DoH Expert Working Group that compiled the Action Plan. Concern was also expressed that fundamental decisions (not least regarding independent-sector procurement) had apparently already been taken by the DoH.

On 6 March 2007, the DoH published *Improving Access to Audiology Services in England*. This appears to be the promised National Audiology Action Plan.

The document states that delivery of improved audiology services is down to "local health systems" using "the health reform mechanisms of better commissioning and pathway redesign, choice and competition, information and incentives". Each PCT, as the local commissioning body, is expected to set out in its forthcoming first "Prospectus" the strategic direction for local audiology services.

The DoH, according to the document, estimates that, nationally, around 300,000 extra adult hearing-aid complete pathways "would be needed between April 2007 and December 2008, on top of existing levels of NHS provision, to make a maximum wait of 18 weeks from referral to treatment possible for *all* audiology referrals …" This "capacity gap" will be filled partly through "greater efficiency in existing services where possible" and partly through commissioning new capacity.

The document states that 42,000 additional audiology patient pathways a year have already been centrally procured as part of "the Phase 2 IS [Independent Sector] diagnostics procurement", to come on-stream from April 2007. Further independent-sector provision has been prepared through "a Phase 2 IS elective audiology procurement", apparently to come on-stream by April 2008 – but "the amount to be procured [is] dependent on the outcome of the current planning process". It is unclear how this relates to the government announcement in 2006 that ISTC provision of up to 300,000 audiology pathways a year was being procured (see above).

The DoH plans to produce a number of aids to commissioning, including model care-pathways and model protocols for referral, the document states.

The document underlines the requirement to meet the national interim targets on diagnostic waits and says it is “good practice” for the hearing aid to be fitted “soon after or at the same time as the initial assessment”. This is clearly in response to concerns about the tendency of national targets to produce “perverse incentives” to prioritise diagnosis without prioritising treatment (see above).

In respect of Patient Choice, the document says that patients should already be offered a choice of provider for audiology referrals to ENT consultants; and consideration is to be given to allowing a choice of provider for patients referred direct to audiology services. In the meantime, Version 4.0 of the Choose and Book system, due for release in 2007, will enable booking of direct-referral audiology appointments.

The document also states that the DoH will develop benchmark costs for audiology and consider introducing a standard national tariff for audiology services. In the meantime, PCTs can “develop prices [apparently meaning local tariffs] that support choice and efficiency, rather than block contracts”. (However, in the absence of Payment by Results arrangements, block contracts will presumably continue to apply to audiology; and ISTC prices will presumably be agreed by the DoH, not at local level by PCTs, given that ISTCs are centrally procured.)

Health Select Committee Enquiry

The House of Commons Health Select Committee recently conducted a short enquiry into audiology services in England, and its report is expected soon.

Waiting times for audiology services in Kent and Medway, by hospital (2004-6)

	Weeks to first appointment			Weeks from first appointment to fitting			Total wait in weeks			
Hospital	**2004**	**2005**	**2006**	**2004**	**2005**	**2006**	**2004**	**2005**	**2006**	**Analogue to digital**
Darent Valley Hospital, Dartford	6 to 7		Now Medway Maritime	32		Now Medway Maritime	38 to 39	NA	NA	NA
Kent and Canterbury Hospital, Canterbury	8	NK	13	52	104	104	60	104+	117	104
Kent and Sussex Hospital, Tunbridge Wells	104	52	52	52	NK	13	130	52+	65	52
Maidstone Hospital	8 to 13	13	22	8	21	34	16 to 21	34	56	52
Medway Maritime Hospital, Gillingham	4	4	4 to 6	15	NK	13 to 17	21	NK	17 to 23	104 to 156
Queen Elizabeth the Queen Mother Hospital, Margate	52	52	52		54	3 to 4	NK	106	55 to 56	52 to 78
Royal Victoria Hospital, Folkestone (now at William Harvey Hospital, Ashford)		26	11		78	78	NK	104	89	78

Source: British Society of Hearing Aid Audiologists annual surveys

People registered as deaf or hard-of-hearing in Kent and Medway, by category of disability and age (as at 31 March 2004)

		People registered as deaf, by age					People registered as hard-of-hearing, by age				
Local authority	**All people registered as deaf or hard-of-hearing**	All Ages [1]	0-17	18-64	65-74	75 or Over	All Ages [1]	0-17	18-64	65-74	75 or Over
Kent CC	7,225	2,920	240	1,155	300	1,225	4,305	75	550	530	3,145
Medway UA	1,070	445	55	240	45	105	625	10	135	120	360

1 "All ages" total includes some cases where the age was not known; therefore, the age groups may not add to the total.

Source: Triennial returns on form SSDA 910, submitted to the Department of Health by councils with Social Services responsibilities

Numbers waiting for audiology assessments, and assessments carried out, in Kent and Medway, by provider and commissioner (December 2006)

Provider	Total Waiting	Number waiting 13+ Weeks	Number waiting 26+ Weeks	Number waiting 52+ weeks	Tests carried out during the month: Planned tests [1]	Unscheduled tests [2]	Waiting list tests (excluding planned waits)
East Kent Hospitals NHS Trust	2,257	1,917	1,525	658		699	201
Medway NHS Trust	635	521	457	352	245	414	107
Maidstone and Tunbridge Wells NHS Trust	1,393	748	371		18	748	54
West Kent PCT	181	41	1				50

Commissioner	Total Waiting	Number waiting 13+ Weeks	Number waiting 26+ Weeks	Number waiting 52+ weeks	Tests carried out during the month: Planned tests [1]	Unscheduled tests [2]	Waiting list tests (excluding planned waits)
Eastern and Coastal Kent PCT	2,595	2,151	1,710	800	32	760	219
Medway PCT	359	319	287	214	146	153	57
West Kent PCT	1,559	796	381	1	86	954	139

1 Planned tests are those that are carried out as part of a treatment plan and must, for clinical reasons, be carried out at a specific time or repeated at a specific frequency (and hence involve planned waiting).
2 Unscheduled tests are those that are carried out on Accident and Emergency patients or following an emergency admission.

Source: Monthly returns on form DM01, submitted to the Department of Health by commissioners

EAST KENT HOSPITALS NHS TRUST
AUDIOLOGY DEPARTMENT
DIGITAL HEARING AID SERVICE

POSITION STATEMENT – JANUARY 2007

1. Service Provision:-

The East Kent Audiology Department provides a Digital Hearing Aid service at:-

- Kent and Canterbury Hospital;
- William Harvey Hospital, Ashford;
- Queen Elizabeth the Queen Mother Hospital, Margate and;
- Royal Victoria Hospital, Folkestone.

Since April 2006 – additional initiatives have been introduced to create additional capacity through restructuring of timetables and resources at:

- Whitstable and Tankerton Hospital;
- Queen Victoria Hospital – Herne Bay;
- Faversham Hospital;
- Victoria Hospital – Deal;
- Bethesda Medical Centre in Cliftonville.
- Garlinge Surgery – Westbrook
- Broadstairs Health Centre

It is anticipated that the service will be expanded to cover other satellite sites throughout East Kent.

2. The priority categories are:-

- Patients who have a War Pension for hearing loss;
- Registered blind patients and partially sighted patients;
- Patients in full time education;
- Patients in paid/voluntary employment where the ability to work is affected by the hearing loss;
- Principal carer of child/children;
- Principal carer of disabled family member.

Any patient who falls into the above will be prioritised as 'urgent' and will be seen within 5-6 weeks. All other patients will be prioritised as 'routine' and a hearing aid provided at the earliest opportunity; current waiting time is 83 weeks (January 2007).

3. Patient Journey:-

The following details the journey for a new patient, existing patient and patients requiring aid repairs – also detailed are the waits for each.

New Patient:-

- ❖ Referral made by GP to ENT (may be redirected to Audiology if appropriate) or Audiology.

(GP's will refer a patient to ENT rather than direct to Audiology if the clinical decision made by the GP, based on the symptoms presented by the patient, do not determine that the patient necessarily requires a hearing aid. Otherwise patients are referred direct to Audiology).

- Referral received by ENT and patient given appointment – to be **seen within 11 weeks of referral**;

  or

- Referral received by Audiology and patient given appointment to be seen **within either 5-6 weeks or 18 months depending on category where they will be:**
  - screened to see if an aid is needed or not and pre-fitted for aid. Appointment takes 30 minutes.

- **2-3 weeks later** – patient invited for fitment of hearing aid. Appointment takes 45 minutes ;

- **As appropriate** – further care (battery supply, repair, reassessment etc) is given (life long).

<u>Existing Patient (patient needing reassessment, i.e., they feel their hearing has deteriorated):-</u>

- Patient is sent a questionnaire to prioritise their treatment;

- **5-6 weeks or 18 months depending on category ie priority/routine** – patient invited for fitment of replacement hearing aid. Appointment takes 45 minutes;

- **As appropriate** – further care (battery supply, repairs, further reassessment etc) is given (life long).

<u>Patient requiring repair to aid:-</u>

- Patient contacts Audiology Department and drops aid in for repair – aids turned around within 2-3 working days however if there is a need for a technician to see the patient (e.g. to take an ear impression) there is a 2-3 week wait.

EAST KENT AUDIOLOGY SERVICE

60 187

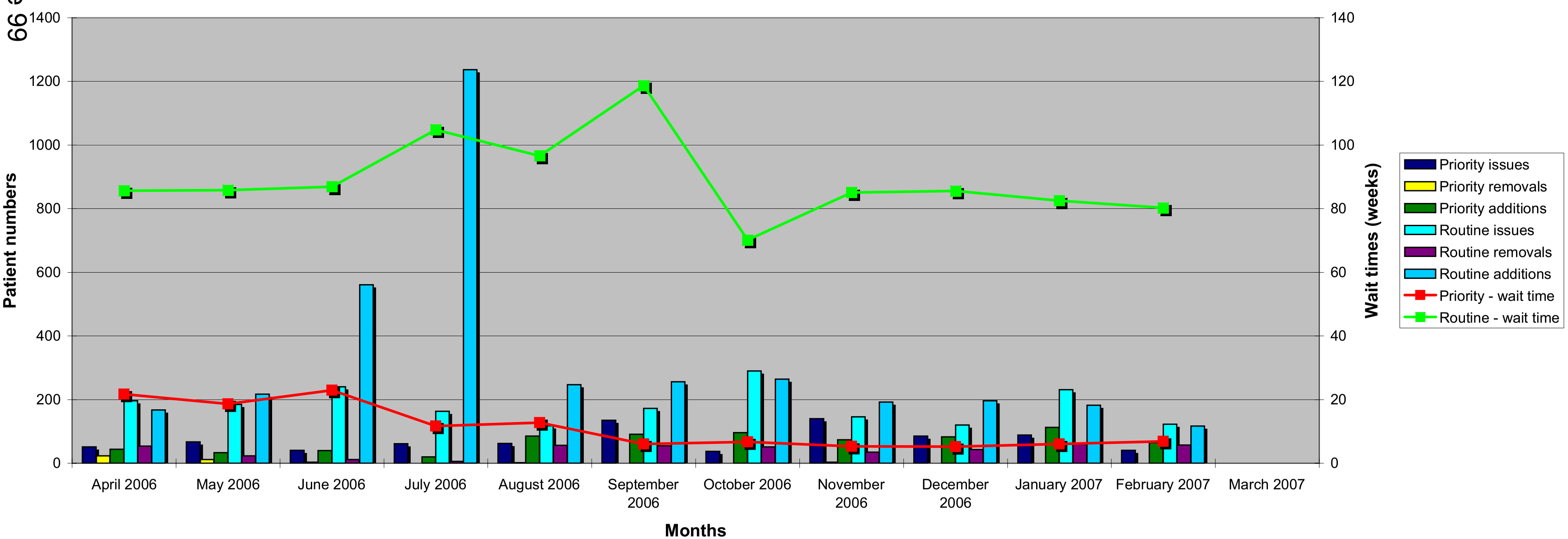
Hearing Aid service: Operational performance 2006/2007

Month end	Priority Issues	Priority Removals	Priority Additions	Priority Totals	Bilateral issues	Routine Issues	Routine Removals	Routine Additions	Routine Totals	Bilateral issues	Waiting Lists Priority	Waiting Lists Routine	Waiting Lists Total	Waiting times (wks) Priority	Waiting times (wks) Routine	Hearing Aid Repairs
March 2006											355	3936	4291	35	104	
April 2006	51	23	44	-30	18	196	54	167	-83	72	325	3853	4178	22	86	223
May 2006	67	12	33	-46	25	185	23	217	9	76	279	3862	4141	19	86	195
June 2006	41	3	40	-4	23	240	12	561	309	58	275	4171	4446	23	87	209
July 2006	61	0	20	-41	26	163	6	1237	1068	69	234	5239	5473	12	105	279
August 2006	62	2	85	21	19	118	56	247	73	40	255	5312	5567	13	97	144
September 2006	135	0	91	-44	15	172	55	256	29	82	211	5341	5552	6	119	136
October 2006	37	0	96	59	27	290	51	264	-77	89	270	5264	5534	7	70	153
November 2006	140	3	74	-69	60	146	35	192	11	50	201	5275	5476	5	85	175
December 2006	85	0	83	-2	42	120	43	196	33	33	199	5308	5507	5	86	196
January 2007	89	0	113	24	30	231	60	182	-109	80	223	5199	5422	6	83	162
February 2007	41	0	65	24	28	123	57	117	-63	67	247	5136	5383	7	80	185
March 2007				0					0		247	5136	5383			
Totals:	**809**	**43**	**744**	**-108**	**313**	**1984**	**452**	**3636**	**1200**	**716**						**2057**
Average bilateral fittings					*39%*					*36%*						

Note 1: Removals from lists through validation and did not attends (waiting list amalgamation completed May 06)

117

Note 2: June and July - additions to routine list increased due to amalgamation of direct access waiting list patients (completed July 06)



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