AGENDA

NHS OVERVIEW AND SCRUTINY COMMITTEE

Friday, 9th February, 2007, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Paul Wickenden**

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 2007 (to follow)

3. Medway NHS Trust - Application for Foundation Trust Status (Pages 1 - 12)

   Mr A Horne, Medway NHS Trust will be in attendance for this item.

4. Fit for the Future - Draft Commissioning Plans (Pages 13 - 20)

   Rebecca Sparks, Director Development and Partnerships; Michael Ridgwell, East Kent Primary Care Trust; Steve Phoenix, Chief Executive Officer and James Thallon, GP and Professional Executive Committee member for West Kent Primary Care Trust;
   Lynne Selman, Director of Communications and Roger Pinnock, GP and Professional Executive Committee member for Eastern & Coastal Kent Primary Care Trust; Colette Glasson, Director of Communications, Heidi Shute, Community Cardiology Manager and Marion Dinwoodie, Chief Executive Officer for Medway Primary Care Trust

Break 11:15-11:30 pm

Fit for the Future - Draft Commissioning Plans (cont'd)

5. Commissioning Homeopathy - West Kent Primary Care Trust

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

6. NHS Overview and Scrutiny Committee - Work Programme Update (Pages 21 - 28)

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 February 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.

By: Overview and Scrutiny Manager

To: NHS Overview and Scrutiny Committee – 9 February 2007

Subject: **Medway NHS Trust – Application for Foundation Trust Status**

Summary: The Committee will be invited to agree a response to Medway NHS Trust's consultation on applying for Foundation Trust Status.

Introduction

1. (1) At the Committee's meeting on 12 January 2007 I was authorised by the Committee in conjunction with the Chairman, Vice Chairman and the Liberal Democratic Spokesman of the Committee to invite colleagues who represent an electoral division in Maidstone and Swale Borough Council areas, to meet with Mr A Horne, Chief Executive of the Medway NHS Trust and other colleagues, regarding their application for Foundation Trust status.

(2) The Committee were keen to ensure that colleagues who represent an electoral division in both Maidstone Borough and Swale Borough Council area should be invited to attend this meeting.

Meeting – Monday, 22 January 2007

2. (1) The meeting with Mr Horne and colleagues took place on Monday, 22 January. A copy of the note taken at that meeting is attached as Appendix 2.

(2) Printed with the papers for this meeting is a briefing note on Foundation Trust Status (Appendix 1).

(3) At the meeting or 22 January 2007 Mr Horne was asked whether the views of the NHS Overview and Scrutiny Committee could be made known to the Trust following the meeting of the Committee on 9 February 2007. Mr Horne said that this would be possible.

(4) Mr Horne has very kindly agreed to attend the meeting for 30 minutes to answer Members questions. Once again Members from Maidstone and Swale electoral divisions have been invited to attend this meeting.

Recommendation

3. The Committee are invited to agree a formal response to Medway NHS Trust consultation on applying for Foundation Trust Status.

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Background Information: *Nil*

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NHS Overview and Scrutiny Briefing Note

Foundation Trust status

✉ David.Turner@kent.gov.uk
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1 February 2007

What is Foundation Trust status?

The Department of Health (DoH) states that "The introduction of NHS Foundation Trusts represents a profound change in the history of the NHS and the way in which hospital services are managed and provided".

Foundation Trusts (FTs) were established under the Health and Social Care (Community Health and Standards) Act 2003 as "independent public benefit corporations" – this is a new type of organisation, which exists within the public sector to provide public services on a non-profit basis, but with unprecedented commercial and managerial freedoms. The government states that the model for these corporations is the "mutualism" and "social ownership" of co-operatives, "social enterprises" and the voluntary sector.

FTs are part of the NHS, and their "principal purpose" is to provide NHS treatment free at the point of use; but they are able to act in ways that are not open to the rest of the NHS. FTs are free to:

- borrow from the private sector;
- retain any financial surpluses that they generate;
- retain all moneys from the sale of NHS land and other assets;
- exercise a greater degree of flexibility than other Trusts in setting pay and benefits for staff;
- provide paid-for healthcare services, in order to generate additional income;
- form joint ventures with the private sector.

FTs are also free from the control of the Secretary of State for Health, and are not subject to performance-management by their local Strategic Health Authority.

Each FT is run by a Board of Directors, which works with an elected Council of Governors, representing "key stakeholders". Some Governors are elected by Trust "Members" – self-selecting volunteers drawn from among local residents, patients and staff. There must be a "staff constituency" and a "public constituency" for elections; there may also be a "patients' constituency". Other Governors are appointed to represent local partner organisations (Primary Care Trusts, local authorities and others). Governors play an advisory, guardianship and strategic role; they are not involved in the day-to-day running of the FT and so do not deal with matters such as budget-setting and performance-management.

Governors directly appoint the non-executive directors of FTs, including the Chair, but cannot mandate or recall them. The DoH states that "The executive directors are appointed by a committee consisting of the Chair, the other non-executive directors and the chief executive". The Chief Executive is appointed by the non-executive directors, subject to approval by the Governors.

A regulatory body, the Office of the Independent Regulator (known as "Monitor"), which has the status of an independent corporate body, grants authorisation for Trusts to become FTs and ensures that they comply with their terms of authorisation.

Access to FT status is based on the principle of "earned autonomy" – only Trusts that perform well (as evaluated by the Healthcare Commission) are permitted to apply for FT status. Trusts must show a financial surplus before they are permitted to become FTs.

The government is committed to seeing all hospital Trusts in a position to apply for Foundation status by 2008 (a target that all Strategic Health Authorities must seek to fulfil). There appears to be an intention for all NHS Trusts to become FTs eventually (along with the service-delivery arms of PCTs – which are to become "Community Foundation Trusts").

As NHS Bodies, FTs remain subject to local authority NHS Overview and Scrutiny Committees – but matters relating to FTs cannot be referred by OSCs to the Secretary of State; instead, the power of referral is to "Monitor".

What are the arguments in favour of Foundation Trust status?
FTs are a major (and politically controversial) plank of the government's NHS reforms. The key arguments in favour of FT status are as follows:

- FTs are a key expression of the government's commitment to the decentralisation of public services and the creation of a patient-led NHS. FTs are intended to allow the devolution of decision-making to local level, making Trusts more responsive and accountable to their patients and communities.
- By becoming more autonomous, flexible and locally accountable, FTs are better able to tackle health inequalities.
- FTs are able to offer additional financial incentives to staff, so as to address the problem of recruitment and retention in areas that have a high cost of living or are unattractive to work in.
- FTs have greater financial freedom than other Trusts, incentivising innovation and entrepreneurialism, leading to the improvement of services.
- FTs support the Patient Choice agenda by increasing the plurality and diversity of providers within the NHS.

FTs are subject to a set of legal safeguards, designed to ensure that they do not damage the cohesion and continuity of the NHS:

- local ownership and control, through "Members" and Councils of Governors, representing patients, staff and other stakeholders in the community;
- legal incorporation as non-profit "independent public benefit corporations", with "Members" (rather than shareholders who draw dividends) and provision of free NHS care as FTs' "principal purpose";
- a "lock" on NHS assets (designated "protected property" may not be sold to generate a surplus), preventing any "asset stripping";
- controls on borrowing by FTs from private sources;
- a "cap" on income from private patients, ensuring that FTs cannot shift the balance of their activities away from their "principal purpose" of providing NHS care;

- a ban on charging NHS patients for care (in accordance with primary NHS legislation);
- protection of staff under nationally negotiated agreements on terms and conditions of employment;
- regulation by "Monitor", which ensures that FTs abide by the terms of their authorisation;
- continued applicability of national NHS standards, performance ratings and systems of inspection (enforced by the Healthcare Commission and other regulatory bodies).

What are the arguments against Foundation Trust status?

FT status is opposed by a number of stakeholders (including several major trade unions within the NHS) on the basis that:

- FTs will lead to the creation of a two-tier NHS, widening health inequalities and geographical disparities in healthcare. FTs are able to poach staff from other Trusts (by "topping up" national terms and conditions of employment) and have access to sources of funding not open to other Trusts (private-sector borrowing, sale of assets, commercial income-generation). The resulting "uneven playing field" is even more damaging in the context of Payment by Results.
- FTs are not genuinely accountable to their local communities. Governors have only limited powers. Not all Governors are elected and those that are elected, are elected by "Members", who are a small group of self-selecting individuals and are not accountable to the wider community. Only a small minority of "Members" may actually be involved in elections (in some cases, e.g. University College London Hospitals NHS Foundation Trust, Governors have been elected with votes in single figures).
- FTs are primarily "market actors", pursuing surpluses within the emerging NHS "market", rather than ensuring provision of the services that their local population needs. FTs can choose, on the basis of commercial considerations, which services they will provide – this runs counter to the core NHS principle of needs-based planning of services.
- FTs have scope to shift the balance of their activities towards providing paid-for private healthcare. The "cap" on income from providing private healthcare: allows for private work to grow in line with overall growth in income; does not cover all commercial income; and does not cover income generated in joint ventures with commercial partners or through subsidiaries and spin-off companies. Moorfields Eye Hospital NHS Foundation Trust is controversially using its ability to borrow more freely in order to set up a clinic in Dubai, in the United Arab Emirates, providing paid-for services under, as the Chief Executive puts it, "the widely recognised Moorfields brand name".
- The "lock" on NHS assets is not absolute. If a service is contracted to an outside provider, the NHS estate thereby freed up can be "unlocked" and disposed of, with the proceeds staying entirely within the FT.
- FTs have a commercial incentive to charge patients for an enhanced NHS service. The possibility of such charging within the NHS is shown by the "Jentle Midwifery" premium NHS service (offering continuity of care from a designated midwife), now being provided for a £4,000 fee by Queen Charlotte's and Chelsea Hospital (which is actually not a FT hospital). There is also an incentive to charge privately for procedures that can be re-classified as "cosmetic" and thereby removed from the scope of NHS provision. This is illustrated by the case of the

Foundation Skin Clinic, set up by the Harrogate and District NHS Foundation Trust, which charges for services previously available as free NHS care. FTs further have an incentive to maximise revenue from charging NHS patients for facilities such as parking and telephone facilities.

- "Monitor" is essentially a market regulator, concerned primarily about FTs' financial viability, rather than their provision of services. It is not bound to ensure the continuation of a comprehensive, free and universal NHS.
- Handing more power to certain privileged acute Trusts, through FT status, cuts across the empowerment of the Primary Care sector, which the government has stated as a key strategic aim for the NHS.

Becoming a Foundation Trust

Preliminary Stage: A Trust wishing to apply for FT status must first prepare:

- a service development strategy (showing it is financially viable in the long term);
- a draft constitution (detailing governance arrangements, including the recruitment of "Members" and Governors);
- a long-term vision (including a Human Resources strategy).

This will involve consultation with staff and the public. The Trust must then apply to the Secretary of State for permission to proceed with its FT status application. Success at this stage is no guarantee of success at the next stage.

Preparatory Stage: Once the Secretary of State has approved the application for FT status, the Trust must draw up a detailed business plan and compile further information for submission to "Monitor".

If "Monitor" grants authorisation (effectively a licence to operate as a FT), the Trust enacts its constitution in "shadow" form before finally "going live" as a FT. Annual reports must be submitted to "Monitor", and the Trust must continue to show compliance with the terms of its authorisation.

Appendix 2

Note of informal meeting with Medway NHS Trust re application for Foundation Trust status
22 January 2007

Present:

Medway NHS Trust
Andy Horne (Chief Executive)
Jacqueline Geoghegan (Director of Nursing and Operations)
Amanda Bedford (Head of Corporate Affairs)

KCC NHS OSC members
Alan Chell (Chairman)
Dan Daley (Liberal Democrat spokesman)
Adrian Crowther

KCC officers
David Turner (NHS Research Officer)
Paul Wickenden (Overview and Scrutiny Manager)

Mr Horne explained that the Trust's consultation on its Foundation Trust status application was due to finish on 2 February – however, it would not be a problem if NHS OSC were to respond a little after that date (following the committee's meeting on 9 February).

Mr Horne noted that a year previously the Dartford and Gravesham NHS Trust had also been consulting about applying for Foundation Trust status – but had not proceeded with its application. This showed that not all applications went ahead: around 50% of them were stopped at, or before, one of the two hurdles that had to be cleared – namely approval by the Secretary of State for Health and approval by "Monitor".

However, it was intended that all Trusts would become Foundation Trusts eventually, so a halted application only affected *when* a Trust became a FT, not *whether* it did so.

Mr Horne said that applications were usually halted by financial issues, often relating to large, expensive PFI projects (Trusts had to make a surplus before they were allowed to proceed to FT status). There were also sometimes issues relating to the quality of services provided, since quality criteria also had to be met before a Trust could become a FT.

Mr Horne said that the government had originally required all Trusts to become FTs by 2008. It was now saying only that every Trust must be in a position to apply for FT status by 2008. Questioned about the possibility of FTs taking over Trusts that failed to become FTs, he admitted that this had been proposed in one case – where Heart of England NHS Foundation Trust was bidding to take over Good Hope Hospital NHS Trust, in Birmingham. However, he thought this was an exceptional case, as Good

Hope Hospital Trust was very small – and, in any case, he thought it had still not yet been decided what was to happen in that case.[1]

Mr Horne denied that there was any rush to meet a government deadline: "it's not a race, it's about getting it right". He said the issue of reconfiguration of services was very relevant to achieving FT status, and that this was all part of a clinically-driven process to achieve better services.

It was noted that the Trust aimed to achieve a modest surplus of £69,000 in 2006–7. Mr Horne was asked what would happen if the Trust were to fail to achieve a surplus in future as a result of competition with other providers in the emerging NHS market. He said that, as a FT, the Trust's emphasis would be on managing its business better – which would include planning for loss of income as a result of the intended shift towards primary care within the NHS. Medway PCT was already investing in primary care, for instance by taking on community matrons. If the Trust ended up losing services as a result, it would be able to reduce its cost base by knocking down some of the 100-year-old buildings at the hospital that were no longer suitable for medical use, and by reducing its number of nursing staff through natural wastage. He said that, if the Trust were to get into a deficit in the millions as a FT, he and other members of senior management would be dismissed.

Mr Horne was asked about Medway Trust's relationship to the Maidstone and Tunbridge Wells Trust and whether the two were in competition. He explained that there was cooperation in some areas (such as cancer care) and competition in others, particularly areas of planned care such as orthopaedics, urology and ENT. Medway would never seek to compete with the specialist cancer care that MTW provided as a tertiary specialist provider.

The Trust representatives were asked what effect "Fit for the Future", and the associated PCT commissioning plans, would have on the Trust. Ms Geoghegan replied that a lot of the Trust's business plan depended on "Fit for the Future" and they would need to be flexible. Asked whether it was wise to apply for FT status ahead of "Fit for the Future", Mr Horne replied that there would always be uncertainty in the NHS – but they would manage if they were flexible.

Mr Horne spoke about the plans for Membership arrangements under FT status. He explained that there would be two types of Members: Staff Members (all members of staff would be automatically enrolled); and Public Members (who would be recruited from the general public). The Trust aimed to get between 7,000 and 8,000 recruits out of a catchment population in Medway and Swale of some 370,000 (as well as the wider North Kent population, for which the Trust provided some specialist services). Mr Horne said that the Trust would probably change its mind about the proposed minimum age limit of 14 (following representations received in the consultation) and change this to age 16. The Trust would still engage younger people through organisations such as the local Youth Parliament.

Mr Horne was asked about services provided by the Trust outside Medway Maritime Hospital. He said that the Trust provided some medical cover for intermediate care at St Bart's Hospital in Chatham. Asked generally about how intermediate care was provided, Ms Geoghegan explained that this was an issue between Trusts and PCTs

[1] The takeover is set to go ahead, subject to public consultation – http://www.heartofengland.nhs.uk/publicconsultation/goahead.asp

everywhere. Mr Horne added that it was possible Medway PCT would be putting a polyclinic at the Rochester end of the Medway Towns (to be built under Local Improvement Finance Trust arrangements) and that diagnostic work could be shifted into this setting.

Mr Horne went on to explain about proposed arrangements for Governors under FT status. There would be three types of Governors: Staff; Public; and Stakeholder (representing Medway Council, KCC, local universities, the Hospital League of Friends, etc.). Mr Horne said that the Governors "appoint the Board [of Directors] and can sack it".[2]

Mr Horne explained that LINks would also play a part in patient and public involvement in the work of the Trust as a FT.

Mr Horne was asked about the Trust's financial situation and whether good financial performance in future might actually result in reduced income. He explained that the Trust was now operating substantially under the Payment by Results system, which was based on a national tariff derived from average costs. If the hospital could attract more patients it would receive more income.

Mr Horne was asked about the Trust's current financial situation and how that would impact on its FT status application. The most recent financial report presented to the Board indicated a likely deficit of £1.5m at the end of 2006–7 – yet the Trust was aiming to achieve a surplus (of £69,000), and apparently needed to do so in order to achieve FT status.

Mr Horne said that "Monitor" was able to live with short-term financial instability in a FT if its underlying finances were sound. Some FTs had been allowed to run up modest deficits. He thought that Medway Trust's FT status application could still go through even if the Trust ended 2006–7 with a small deficit. In any case, they still had 10 weeks to go before the end of the financial year and could yet achieve the planned surplus. Mr Horne said that Medway Trust was clearly in a better financial position than Dartford and Gravesham Trust, whose finances were significantly weakened by their PFI costs.

Asked about the role of the Strategic Health Authority in the Trust's FT plans, Mr Horne said that FTs, unlike ordinary Trusts, were not performance-managed by SHAs – but, as a FT, Medway Trust would be "good partners" with the SHA.

Mr Horne was asked about stakeholder involvement in the FT status application. He explained that the Trust's consultation booklet had been widely distributed locally and a series of public meetings had been held. He admitted, though, that attendance at the meetings had been "poor" – with numbers between a dozen and 30. The Trust would be working to encourage local people to join up as members, but he admitted public engagement "is a challenge". The problem was that the public tended to see the change to FT status as merely a technical, administrative matter that wasn't relevant to the actual delivery of services.

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[2] In fact, Governors can only directly appoint the non-executive directors of FTs, including the Chair, and cannot mandate or recall them. The DoH states that "The executive directors are appointed by a committee consisting of the Chair, the other non-executive directors and the chief executive". The Chief Executive is appointed by the non-executive directors, subject to approval by the Governors – http://www.dh.gov.uk/assetRoot/04/13/02/32/04130232.pdf

Mr Horne was asked about the relationship between acute and community services. He said that the shift to community services proposed in the *Our Health, Our Care, Our Say* White Paper was based on European and American models (in particular a model developed in California),[3] that were possibly not replicable in the UK. A significant number of older people in the UK lived alone and it was not practical for them to receive medical care at home.

However, Mr Horne said that his Trust's expertise was at the acute end of the medical spectrum, and it ought to concentrate on providing acute services. The PCTs wanted to support people living with chronic conditions, and that was appropriate.

It was noted that PCTs appeared to be cutting back on health visitors and district nurses; and Social Care in Kent and Medway did not have the staff to cope with large numbers of ill people being cared for in the community.

Ms Geoghegan said that the Trust would tend to agree with those statements. But work was being done to develop the NHS workforce to accommodate the shift to community provision. This was apparent from the documents *Modernising Nursing Careers* and *From Hospital to Home*. The Chief Nursing Officer was leading on this, which indicated that it was a clinically-led initiative.

The matter was raised of whether the Trust was consulting on the principle of becoming a FT or simply on the arrangements for doing so. Dartford and Gravesham Trust had indicated in their consultation that question of whether the Trust became a FT was not up for discussion, as it was government policy for all Trusts to become FTs. Mr Horne said he hoped that the Trust could convince the local community that FT status was a good idea.

Asked about opposition to the principle of FT status, he said that the main concern expressed had been in relation to privatisation – but the Trust did not believe that FT status was related to privatisation. Some groups and trade unions were concerned, but he stated there had been "no direct opposition" and "no large groups are actively opposed". Two members of the Staff Side (from UNISON and the BMA) actually sat on the FT Steering Group. He thought that the trade unions' concerns were "really around PFI".

Mr Horne was asked about the potential impact on the Trust of competition between providers in the NHS, driven by Patient Choice. He said that the Trust was focusing more on emergency services and those acute services where Choice did not apply (for instance, urgent referrals by GPs). Choice did mean that providers were obliged to consider the quality of their service – even down to whether receptionists were welcoming and friendly to patients.

Mr Horne was further asked about the possibility of new private providers (such as the new hospital planned at Maidstone) entering the NHS "market" and "cherry-picking" work under the Free Choice arrangements from 2008, thereby taking income from NHS providers under Payment by Results. He noted that the Will Adams Independent Sector Treatment Centre in Gillingham had actually found it very difficult to get patients to choose them rather than Medway Maritime Hospital. He thought this

[3] The California model was developed by the company Kaiser Permanente.

was because the ISTC was a new provider and patients preferred to stay with their local NHS hospital, with which they had an established relationship.

It was pointed out that Medway PCT appeared to be blaming local GPs for the low uptake of the services at the ISTC – it had been suggested that many GPs were not informing patients about the options available to them and were not using Choose and Book.

Mr Horne said he was sure there were "lots of reasons" why the ISTC was underused. He talked to local GPs and they had their explanations as to why so few patients were using the Treatment Centre. He said that he wished the Trust had all the advantages that had been given to the ISTC – including guaranteed payment regardless of how many patients were treated.

The Trust representatives were asked about the possible impact on Medway's A&E department of the proposals to remove emergency surgery and emergency orthopaedics from Maidstone Hospital. Ms Geoghegan said that just 12 patients per day would be going by ambulance to somewhere other than Maidstone under the proposals – and not all of those 12 would be going to Medway. Mr Horne said that the Trust was not anticipating the need for any extra beds in consequence of this: "if anything, our bed needs are diminishing".

Mr Horne was asked whether, as a FT, Medway Trust would be "kicking patients out more quickly", due to commercial pressures. Mr Horne said that the Trust could not just do that – they would continue to work with partners to ensure that patients were discharged appropriately and at the right time. It should be borne in mind that patients themselves did not want to stay in hospital longer than was necessary, not least because of concerns about hospital-acquired infections.

The question was raised of whether London hospitals would suffer as a result of losing patients from Kent if more specialist tertiary services were to be developed in the county. Mr Horne said that new specialties were developing in the London teaching hospitals that would take the place of specialties that shifted to providers in outlying areas.

It was put to Mr Horne that the Trust actually had a large "captive market" for its services in the Medway Towns – on this basis, did he think that FT status would help to bring stability to the Trust?

Mr Horne noted that the unprecedented recent growth in NHS spending would end in 2008; thereafter, growth would return to normal levels – there might even be cuts in the future. Therefore, attempts were currently being made to get the NHS in robust shape for the future. He had been in the NHS for 32 years, and he knew it was quite possible that a future government could change it all again.

Mr Horne was asked what he thought of the suggestion that the NHS was effectively turning into an insurance system. He said that he could not see that. There had been a review of NHS funding a few years ago[4] and he had not heard any recent discussion about the possibility of introducing a new method of funding. The issue now was how to manage the extra money that had been put into the NHS.

[4] This was the Wanless review (published in 2002), which recommended that the NHS should continue to be tax-funded.

The matter was raised of “overperformance”, which had been an issue in the Medway Trust in early 2006, with some clinical activity being suspended due to the inability of commissioning PCTs to pay for any further work until the new financial year. Mr Horne said that this was PCT-driven – they too had to live within their means. It was pointed out that Medway PCT again appeared to be struggling to stay out of deficit in the current financial year. Mr Horne agreed that there would be challenges before the end of the financial year.

NHS Overview and Scrutiny Briefing Note

Commissioning in the NHS

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1 February 2007

Defining "commissioning"

The term "commissioning" is now widely used within the NHS and it is recognised that it refers to something crucially important. However, it is difficult to give a concise definition of commissioning, since it actually covers a range of activities that have changed over time – and are continuing to change as a result of major NHS reforms.

Put at its simplest, commissioning can be said to consist of purchasing health services through contracts with suppliers. But commissioning is more than just administering a set of contractual arrangements – it amounts to a continuing process that involves:

- planning services (identifying need; determining priorities; managing suppliers; budgeting);
- purchasing services (determining how services are to be provided; identifying providers; managing contracts);
- monitoring services (confirming delivery; controlling quantity and quality; ensuring patient satisfaction).

The original NHS model

Historically, the purchasing of services within the NHS was chiefly about buying aspects of primary care from independent contractors – General Medical Practitioners, General Dental Practitioners, pharmacists and opticians. These groups were initially made up of self-employed professionals in very small-scale businesses. NHS pharmacy and optical services have come increasingly to be provided by corporate High Street chains; but General Medical Practice and General Dental Practice have remained, up to now, largely "cottage industries", with very little provision of NHS services by corporate (shareholder-owned) organisations. GPs in particular have been very closely tied in to the NHS, despite their independent contractor status – especially after their contractual arrangements were revised in the 1960s.

Within secondary care, services were overwhelmingly provided "in-house" by NHS suppliers – the hospital sector having largely been, in effect, nationalised when the NHS was established in 1948. However, there has always been some purchasing of secondary care from private-sector providers at the margins, to supplement NHS capacity.

The "internal market"

The NHS reforms of the early 1990s brought about for the first time a "purchaser–provider split" within the NHS. Hospitals were put under the control of NHS Trusts, which acted as "providers" of acute services, functioning independently of District

Health Authorities (DHAs). Trusts' services were "purchased" through contractual arrangements with the DHAs and some GPs (fundholders – who were able to control NHS budgets in respect of their patients).

The "market" element of these arrangements was, though, somewhat watered down. This model of commissioning in practice amounted to, as one health-policy academic has put it, "monogamy, rather than polygamy … with most purchasers and providers locked into permanent relationships in which each partner sought to modify the other".[1] Providers were guaranteed financial stability by the fact that purchasing of health services took place through "block" contracts – with volumes of work defined and paid for in advance by purchasers.

Following the change of government in 1997, GP fundholding was ended (in 2000); but the purchaser–provider split was effectively retained, albeit with new purchasing bodies – Primary Care Groups, which mostly became freestanding Primary Care Trusts (PCTs) in 2002.

Commissioning and the New NHS

The far-reaching reforms that are currently being implemented in the NHS mean that commissioning is again changing, and is becoming even more central to the way that the NHS operates. The key reforms that are impacting on commissioning are as follows:

- ***Payment by Results (PbR)***

Block contracts for services from acute hospitals have substantially been replaced by "cost and volume" contracts. Under these, Trusts are paid for each "spell" of care actually provided, according to a fixed national "tariff", based on average costs across NHS providers. (There is some adjustment in the tariff to allow for unavoidable differences in costs between regions – using the Market Forces Factor.)

It is intended that the scope of PbR will be extended to cover as much of hospital care as possible (including emergency care) and other areas, such as mental health.

By its very nature, the national tariff disadvantages those Trusts with above-average costs and favours those with below-average costs.

Under PbR, "underperformance" (lack of patient referrals or insufficient patient throughput) can financially destabilise a Trust. Conversely, "overperformance" (treatment of more patients than are specified in a contract) can financially destabilise a PCT that lacks funds to pay for all the treatment undertaken.

To ensure that Trusts are adequately compensated for handling more difficult and costly cases, "Healthcare Resource Groups" (HRGs) are used to classify together cases that are clinically similar. However, the limited number of HRGs means that they can only approximately reflect actual case-mixes. There are also concerns about how spells of care are allocated to HRGs –

[1] Rudolf Klein, *The New Politics of the* NHS (fifth edition, 2006), p. 163.

providers will have an incentive to "upcode" (*i.e.* overstate the complexity of a case) or even to "overtreat" (provide more care than is clinically necessary) in order to boost their income.

Another issue associated with PbR is that of "tariff unbundling". This arises where a PCT and a Trust have to agree how to split a tariff payment in respect of a spell of care that is divided between the Trust and primary care. This situation usually happens where a patient is discharged after hospital treatment into some form of "stepdown" care, because he or she is not yet fully recovered.

- ***Patient Choice***

From 1 January 2006, all patients needing planned hospital care should have been offered a choice of four or more providers (usually including at least one private-sector provider) from a local (Primary Care Trust) menu, where clinically appropriate, at the point of referral.

In addition to the four or more local-menu options, since 31 May 2006 patients have been able to choose from a national menu encompassing the "Extended Choice Network". The Network includes all NHS Foundation Trusts, all centrally-accredited Independent Sector Treatment Centres (ISTCs; see below, under "'Mixed economy' of providers") and other centrally-procured Independent Sector providers.

Under "Free Choice", which will be introduced in 2008, NHS patients will be able to choose any healthcare provider (NHS, private or voluntary-sector/charity/not-for-profit/"Third Sector") that meets appropriate standards (certified by the Healthcare Commission) and is prepared to provide care at the NHS tariff rate. The plan is apparently for the PCT in the area where each provider is located to contract for services on behalf of all the other PCTs whose patients choose to use the provider's services.

The DoH is working on next steps in the implementation of Patient Choice and options on future policy. Among issues that may be considered are the possible extension of Choice to hitherto excluded areas (such as mental health and maternity services) and the consideration of other "choice points" along the "patient pathway" (*e.g.* consultant-to-consultant referrals and referrals into tertiary services). The application of Choice to primary care is apparently also under consideration by the DoH.

- ***Practice-based Commissioning (PbC)***

GPs are now able to take responsibility for the budgets in respect of their patients, under a system that is similar (although not identical) to GP fundholding. Commissioning is effectively devolved from the PCT to the GP practice. Where GPs are able to make savings in commissioning services for their patients, the money saved can be reinvested back into their practice.

Involvement in PbC is voluntary – since GPs are independent contractors, they cannot be obliged to participate. However, the government expects and intends that all GPs will wish to take up the opportunities presented by PbC.

- ***"Mixed economy" of providers***

The government is seeking to break what it calls the "monopoly" position of in-house NHS service-providers and bring about "contestability" of services by creating a "plurality" of providers. In consequence, NHS clinical services are increasingly being provided by non-NHS (for-profit and, to a lesser extent, non-profit) providers.

Private providers have already been centrally procured in significant numbers by the Department of Health (DoH). These have mostly been in the form of ISTCs, from which PCTs have been obliged to buy services on terms that are substantially different to those under which NHS providers must operate. ISTCs are able to choose which patients they wish to treat; they are paid significantly above the national tariff; and they are not bound by PbR – they are guaranteed the full value of their five-year contract, regardless of how many patients they actually treat. A second wave of ISTCs is planned (including Integrated Clinical Assessment and Treatment Services), and central commissioning of these by the DoH is well underway.

PCTs are now required to commission acute services locally from private providers, in order to facilitate Patient Choice; and to pay any providers from the Extended Choice Network that patients choose to use. From 2008, PCTs will have to pay whichever providers (NHS, for-profit or non-profit – anywhere in England) are chosen by patients under the Free Choice policy.

In 2005, the government retreated from plans to oblige PCTs to divest themselves of their role as a provider of services and become purely commissioning bodies. But there is still clearly an expectation on the part of the DoH that PCTs should attempt to contract out the provision of clinical services where possible. And PCTs are expected to achieve a clear organisational separation between their commissioning function and their service-provider function.

PCTs are also clearly being encouraged by the DoH to put General Medical Services out to tender and to consider using Alternative Provider Medical Services contracts in order to engage for-profit corporations in place of both traditional GPs and GPs who are salaried PCT employees.

- ***Foundation Trusts***

Foundation Trusts (FTs) are NHS Trusts that have been granted a form of "earned autonomy", giving them a number of major freedoms that ordinary Trusts do not possess. The government expects all acute Trusts to be in a position to apply for FT status by 2008. In addition, all in-house NHS providers in primary care are expected, once they have separated organisationally from their PCT's commissioning arm, to become "Community Foundation Trusts".

Contracts between PCTs and FTs are legally binding – unlike contracts between PCTs and ordinary Trusts, which are only "Service Level Agreements" between NHS Bodies and, as such, are not enforceable in law.

FTs are also unlike other Trusts in not being accountable to the Secretary of State or their local Strategic Health Authority. FTs are subject to a body called "Monitor" (effectively a market regulator concerned primarily with FTs' financial health) and have their own distinctive governance arrangements, which are intended to make them accountable to their local communities. FTs arguably have much greater freedom than ordinary Trusts to adjust what services they provide in response to the pressure of competition within the NHS "quasi-market".

Commissioning in the future

A number of problems and issues in respect of commissioning can be seen arising out of the operation of the reforms listed above:

- ***Are PCTs fit to undertake commissioning?***

It is widely recognised that commissioning is an underdeveloped function within PCTs – which have tended to lack the skills and expertise necessary to discharge this role adequately. One response to this on the part of the government has been to indicate that such skills and expertise can be bought in from the private sector (possibly from the same corporations that are also taking over GP practices and providing other clinical services for the NHS). The government has, however, denied that it intends to outsource PCTs' commissioning function completely.

One PCT (Hillingdon, in London) is currently considering outsourcing of this kind on a major scale.

- ***How does PCT commissioning fit with Practice-based Commissioning?***

PbC appears to mean that PCTs are being expected effectively to devolve their commissioning role to GP practices – although PCTs still hold all moneys (GP commissioners only have "indicative budgets") and contracts with providers.

This raises issues about whether the whole commissioning function can, or should, be devolved in this way. If only some aspects of commissioning are to be devolved, which are they, and how could this be achieved? If all commissioning is eventually to be done by GP practices, will PCTs then become redundant organisations?

It has been suggested that "strategic commissioning" (meaning high-level, longer-term functions such as market-management, reconfiguration of services, public health and assessment of health needs) can only sit with PCTs. However, this has been disputed by Prof Julian Le Grand, the chief architect of the government's health reforms, who has argued that it smacks too much of old-fashioned "central planning". He argues that the functions placed under the heading of "strategic commissioning" can be dealt with by GP commissioners or (in the case of market-management) regulatory bodies,

such as Monitor and the Healthcare Commission.

- ***How does commissioning fit with Patient Choice?***

There does seem to be a tension, if not a contradiction, between the idea of commissioning (whether done by PCTs or GP commissioners) and the expanding frontier of Patient Choice.

If the scope of Choice develops as the government apparently intends it to, the role of commissioners in the NHS seems to become one of issuing patients with virtual "vouchers" to "spend" in the "quasi-market" of competing providers. Choice then seems to become a kind of "individual commissioning", with commissioners playing the role of demand-managers, attempting to counterbalance powerful providers (chiefly NHS FTs and corporate private providers).

It has been argued that commissioning GPs, as "gatekeepers" regulating access to services, are well placed to fulfil the role of demand-managers. The elaboration of patient pathways (outlines of how different conditions are to be dealt with) by commissioners is also relevant to the task of managing demand. Questions do arise here about whether it is appropriate to mix the financial and economic issue of managing demand with the essentially *clinical* tasks of gatekeeping healthcare services and mapping out optimum patient pathways.

- ***How does commissioning relate to reconfiguration of services?***

The government has made it clear that it is determined to see specialist acute services centralised, and a substantial number of other services pushed out of the acute sector and into primary care. There are a number of issues concerning how these policies relate to the various strands of system reform in the NHS.

As noted above, it has been argued that reconfiguration of services is a part of the "strategic commissioning" role that PCTs need to play. However, Prof Le Grand has argued that reconfiguration could be allowed to take place in the NHS "quasi-market" through investment decisions taken by providers, acting in response to market forces – just as happens in "conventional markets".

- ***How will commissioners ensure access to services and tackle health inequalities?***

Concern has been expressed that the move to a "quasi-market" in the NHS will compound health inequalities by undermining universal and comprehensive access to healthcare on the basis of need – which is actually the chief goal of the NHS. This could occur as a result of some sections of society (who are usually those most in need of healthcare) being less able or willing to exercise Patient Choice. At the same time, there could be "cherry-picking" or "cream-skimming" by providers, i.e. catering for those who are cheapest, easiest and most profitable to treat (who are those least in need of healthcare).

The DoH, however, believes that good commissioning practice will enable PCTs to guarantee equitable access to services on the basis of clinical need, in spite of countervailing forces that might emerge from the various strands of NHS reform.

The government says that it intends to ensure there is “voice” as well as “choice” within the new NHS. Communities are supposed to be able to articulate their needs, and criticisms of how the NHS is meeting them, through: the community governance arrangements of FTs; the planned new patient-and-public-involvement mechanism of Local Involvement Networks (LINks); and Health Overview and Scrutiny Committees (HOSCs). Both LINks and HOSCs, the government intends, will be focused much more in future on scrutiny of commissioning than on scrutiny of service provision.

The DoH has suggested that rigorous management of contracts can minimise “cherry-picking” and “cream-skimming” by providers. And where there are gaps in provision, PCTs, as commissioners, might be able to use various forms of incentive to induce providers to cater for populations that are underserved. These may include the PCT:

- paying a supplement to the tariff, to cover set-up or development costs;
- providing guarantees within the contract, for instance regarding minimum income;
- reducing the capital investment required from the provider, for instance by supplying facilities.

These are, of course, reminiscent of the enhanced terms that the DoH has itself given ISTCs, in order to “pump-prime” independent-sector provision.

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Item 6

By: Overview and Scrutiny Manager

To: NHS Overview and Scrutiny Committee – Friday 9 February 2007

Subject: NHS Overview and Scrutiny Committee –Work Programme Update

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Summary: To note the work in developing the work programme for forthcoming meetings of the NHS Overview and Scrutiny Committee

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Introduction

1. This report sets out a potential work programme for the next two meetings of the Committee based on approaches made to the Chairman and Spokesman of the Committee or direct approaches to myself.

Maidstone and Tunbridge Wells NHS Trust - A New Direction for Surgical and Orthopaedic Care

2. (1) Following the decision of the Committee on 12 January 2007, all the evidence has been re-examined and I arranged a meeting with the Chairman and Spokesman of the Committee to agree the reasons in support of the Committee decision. The reasons for the decision are attached as an Appendix to this report. The Committee are asked to endorse the action I have taken in accordance with the Chairman, Vice Chairman and Liberal Democrat spokesman of this Committee retrospectively.

(2) The reasons have been sent to Steve Phoenix Chief Executive of West Kent Primary Care Trust, Rose Gibb Chief Executive of Maidstone and Tunbridge Wells NHS Trust.

(3) The Committee will recall that I advised the Committee at its meeting on 12 January 2007, that the Committee does have the power to refer matters which are not in the interests of health services in Kent to the Secretary of State for Health, but only as a last resort once all local avenues of resolution and potential agreement have been exhausted.

(4) The Chairman and Spokesman of the Committee met with Steve Phoenix on Friday, 26 January 2007 to start the dialogue on a potential local resolution. The Committee will be updated on the negotiations orally at the meeting.

Meeting – Friday, 9 March 2007

3. (1) Issues emerging for potential inclusion on the NHS Overview and Scrutiny Committee agenda for the meeting on 9 March 2007 are services for Gravesham residents provided at the Gravesend Community and Darent Valley Hospitals. The Committee did agree at its meeting in January 2006 that would wish

to monitor audiology services in a years time Other concerns have also been raised relating the cancer services at the Kent and Canterbury Hospital and the proposed polyclinic at Whitstable.

(2) I have also been approached by health colleagues who are leading on the Dover Project who would like to update the Committee on progress with that Project. I would like to explore whether it would be possible to have the morning session, somewhere in East Kent and then transfer to a venue in the Gravesend area. This would take the meeting to the areas/communities affected by these various health proposals.

Health Care Commission Core Standards

4. I am now engaging each of the health trusts in Kent to ascertain what their timetable is for agreeing their self assessment against the Health Care Commission Core Standards. The Committee will recall that Health Overview and Scrutiny Committees have a role, if they wish to exercise the role in submitting commentaries as part of the self assessment process to the Health Care Commission. The Committee are asked whether they wish to participate in this process on this occasion.

Recommendation

5. The Committee are asked to:-

(a) agree the action I have taken in consultation with the Chairman, Vice Chairman and Liberal Democrat Spokesman of this Committee in taking forward the dialogue with Health Trust colleagues following the decision of the Committee on Maidstone and Tunbridge Wells NHS Trust consultation on - A New Direction for Surgical and Orthopaedic Care; and

(b) agree the Work Programme and venues for the next two meetings of the Committee.

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Background Information: *Nil*

Appendix

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.

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[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).

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

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

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