KENT COUNTY COUNCIL

NHS OVERVIEW AND SCRUTINY COMMITTEE

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

PRESENT: Mr A R Chell (Chairman), Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr R B Burgess (Substitute for Mr M J Angell), Mr A D Crowther, Mrs V J Dagger (Substitute for Mr G A Horne MBE), Mr D S Daley, Ms A Harrison, Mr C Hibberd, Mr D A Hirst, Mr J F London (Substitute for Mr J Curwood), Mr M J Northey (Substitute for Mrs E M Tweed), Mrs E D Rowbotham, Mrs P A V 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 Paul Wickenden, Overview, Scrutiny and Localism Manager and Dr David Turner, HOSC Research Officer.

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 Care 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 & Tunbridge Wells NHS Trust - a new direction for surgical and orthopaedic care (proposal to remove some emergency services from Maidstone Hospital A&E)
(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.

British Medical Association – Maidstone

Dr Chris Thom – Consultant in Elderly Care

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

(74) 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.

(75) 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.

(76) 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.

(77) 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.

(78) 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.

(79) 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.

(80) 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.

(81) 250,000 was an appropriate catchment population for an Accident and Emergency Department – and the local population was expanding.

(82) 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.

(83) 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.

(84) 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.

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

Dr Marie South – Consultant vascular and general surgeon

(86) 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.

(87) 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

(88) 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.

(89) 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.

(90) 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).

(91) 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.

(92) 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.

(93) 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.

(94) 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.

(95) 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.

(96) 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.

(97) 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?

(98) 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.

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

(100) 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.

(101) 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

(102) 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.

(103) 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

(104) 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.

(105) 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

(106) 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.

(107) 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.

(108) 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.

(109) 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.

(110) 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.

(111) 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

(112) 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.

(113) 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'

(114) 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.

(115) 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.

(116) 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.

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

(118) 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.

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

(120) 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.

(121) 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.

(122) 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.

(123) 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.

(124) 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.

(125) 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.'

(126) 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.

(127) Mr Northey seconded the motion.

Carried 7 votes to 6

(128) 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.