# AGENDA

## NHS OVERVIEW AND SCRUTINY COMMITTEE

**Friday, 12th January, 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 - 10 November 2006

3. Commissioning Homeopathy - West Kent Primary Care Trust

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)

   a) Maidstone & Tunbridge Wells NHS Trust and West Kent PCT

   *Rose Gibb, Chief Executive of Maidstone & Tunbridge Wells NHS Trust and Steve Phoenix, Chief Executive of West Kent PCT will make a formal presentation to the Committee. (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 will be in attendance for the item).*

   **Break 11:30-11:45 am**

   b) Kent Air Ambulance

   *Mr David Philpott, Chief Executive of Kent Air Ambulance will be in attendance for this item.*

**Lunch 12:15-1:00 pm**

c) Views of County Councillors who represent an electoral division in the catchment area for the Maidstone & Tunbridge Wells NHS Trust.

d) Dr C Thom, consultant Geriatrics and Dr M South, former consultant Vascular and General with Maidstone & Tunbridge Wells NHS Trust, Dr T Hulse, Paediatrician and a GP representative of the British Medical Association will be in attendance for this item.

**Break - 2:30-2:45 pm**

e) Views of Maidstone Borough Council, Tonbridge & Malling Borough Council; Tunbridge Wells Borough Council; East Sussex County Council and Kent County Council

f) Other Stakeholders views on consultation

g) Conclusion on Maidstone & Tunbridge Wells NHS Trust consultation

5. Medway NHS Trust - Foundation Status application

## 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

**4 January 2007**

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

**KENT COUNTY COUNCIL**

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# NHS OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the NHS Overview and Scrutiny Committee held at Sessions House, County Hall, Maidstone on Friday 10 November 2006.

PRESENT: Mr A R Chell (Chairman), Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr M J Angell, Mr A D Crowther, Mr D Daley, Mr W Newman (substitute for Ms A Harrison), Mr C Hibberd, Mr D Hirst, Mr G Horne, Mrs E D Rowbotham, Mr R Pascoe (substitute for Mrs P A V Stockell), Mr R Tolputt, Mrs E M Tweed and Councillor Dr B Pollington (District Council representative for South and West Kent health economy area).

OTHER MEMBERS PRESENT: Mr B Bassam, Mr G Gibbens, Mr J F London; Councillor Mrs J Etheridge, Councillor D Wildey, Councillor G Juby, Medway Council; Councillor M Warner, Councillor P Germain, Maidstone Borough Council.

ALSO PRESENT: Councillor R Appadoo, Mr J A Reece (Patient and Public Involvement Forum representatives), Ms M Rolfe, Ms S Eksteen (Kent and Medway Networks Ltd), Mr T Barrett (Maidstone Borough Council), Ms L Dell (Medway Council), Mr D Yates (Maidstone & Tunbridge Wells NHS Trust).

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

**UNRESTRICTED ITEMS**

**42. Membership**

The Committee noted that Mr D Daley had replaced Mrs M Featherstone on the Committee.

**43. Minutes – 22 September 2006**

RESOLVED:-

That the Minutes of the meeting held on 22 September 2006 are correctly recorded and that they be signed by the Chairman ***(resolved)***

Mrs Angell asked the following questions, arising from the minutes:

- What was KCC's role in services for learning disabilities given that the Partnership Trust had said local government was leading on this?
- The Drugs and Alcohol Action Team had been rated “Fair", along with 71% of services – what ratings had the rest got (better or worse)?
- What progress had been made with Choose and Book in Kent and Medway?

The secretariat undertook to let Mrs Angell have full answers to these questions.

**44. NHS Health organisations reconfiguration - Outcomes**

*(Ann Sutton, Chief Executive of Eastern & Coastal Kent Primary Care Trust and Steve Phoenix, Chief Executive of West Kent Primary Care Trust were in attendance for this item.)*

(Mr M Angell declared an interest in this item as a non-executive director of the Kent & Medway NHS & Social Care Partnership Trust Board but remained at the meeting. Mr M Fittock challenged Mr Angell's membership on the Committee as in his view this involved a conflict of interest.)

(1) The Chairman welcomed Ann Sutton, Chief Executive of Eastern & Coastal Kent Primary Care Trust and Steve Phoenix, Chief Executive of West Kent Primary Care Trust to the meeting and invited them to explain how the new PCTs were getting on in being established during this transitionary period.

*Eastern & Coastal Kent Primary Care Trust*

(2) Ann Sutton started by saying that she had been the Chief Executive of the new PCT since the 1st October; it was a new organisation and meant a new set of challenges. The new Eastern & Coastal Kent PCT covered six Borough and District Council areas. The headquarters for the PCT were in Chestfield, Whitstable.

(3) A Joint Director of Public Health was due to be appointed the following week. This was a joint appointment between the two Primary Care Trusts and the County Council.

(4) The siting of the headquarters in Chestfield meant that it was co-located with Adult Services. Six non-executive directors were appointed. A director of Citizen Engagement and Commissioning had just been appointed, namely Lynne Selman, formerly of Maidstone Weald PCT.

(5) The PCT was currently preparing a strong commissioning plan taking into account the issues of health inequalities.

(6) There would be small bases for the PCT in each of the six Borough and District Council areas with an executive member and a non-executive director linked to each.

(7) In answer to a question from Mr Angell about who was taking the lead commissioning role for the Primary Care Trusts in respect of mental health, Ann confirmed that this was Medway PCT. In answer to a question about the provision of sexual health from the East Kent Hospitals NHS Trust, Ann responded that this would be integrated across the Primary Care Trusts. Four thousand staff were involved in the sexual health service, with 3,600 directly providing the service. This would not be a rapid process of divesting but it was important that there were considered options for the future.

(8) Both Mr Crowther and Mr Horne expressed concerns over the issues surrounding Community Hospitals. Ann Sutton confirmed that the future of Community Hospitals would form part of the *Creating an NHS Fit for the Future* review. It was important that there was the right balance between the services available in the

community and those that would be provided in people's own homes. It was not just about beds in the Community Hospitals but it was important that there was a good environment and good health care integration between health, residential homes and nursing homes. Mr Horne expressed his deep concerns for the residents of West Kent regarding their Community Hospitals. There was lack of clarity, and money was a particular issue in view of the deficits in the NHS. Ann acknowledged that financial deficits from the old PCTs presented difficulties but the Primary Care Trust had to break even by the end of this financial year.

(9) Mr Tolputt welcomed the idea of co-location with Social Services and asked for a list of the directors and non-executive directors so far appointed as well as a structure chart. Mrs Angell indicated that she was delighted to hear of the appointment for Director of Citizen Engagement and asked for further details around the eight directors who had been appointed.

(10) In answer to questions around the total income for the Eastern & Coastal Kent PCT, Ann Sutton responded that this was £900 million and that £3.6 million savings had to be identified by the end of March 2008. There would be no redundancies of staff at this stage.

(11) In answer to a question from Mr Chell relating to Public Health, Mr Phoenix confirmed that the interviews with Kent County Council for a new director of Public Health were to be held the following week.

(12) The issues around resources for Public Health remained but it was important to work with partners looking at the whole issue of Public Health including social service, police and health.

(13) It was also important to recognise that even within healthy and wealthy populations there were pockets of deprivation which needed to be addressed.

*West Kent Primary Care Trust*

(14) Steve Phoenix introduced himself and said that he too had been in post since the 1st October 2006. He was new to Kent and, unlike East Kent, West Kent were not so far advanced with the establishment of their structure. They were still working on a locality structure.

(15) He referred to a number of workstreams which were key for the future. These included:-

Finance – the financial situation for the new Primary Care Trust has got considerably worse. In addition to the Turnaround Plan deficit, of which the NHS Overview and Scrutiny Committee were aware as reported to them in the summer, of £9.6 million in the new Primary Care Trust area for West Kent there was a potential deficit of £19 million at the year end for the former Dartford, Gravesham and Swanley PCT area. He was pleased to report that the Primary Care Trust had appointed a Director of Public Engagement and Social Marketing, Julia Ross. Julia will be liaising with the Patient and Public Involvement Forums and the NHS Overview and Scrutiny Committee around community engagement and Member

concerns. Several Members expressed their concerns at the larger deficit than expected. They felt that the PCT was not fit for the purpose. At the current time, the PCT was still trying to configure itself. Concerns were expressed as to why the former Maidstone Weald and South West Kent PCTs areas should be burdened with the additional financial burden of problems arising from the former Dartford, Gravesham and Swanley PCT. Mr Daley was very concerned about a reference by Mr Phoenix to looking at the United States insurance system as a model, as Mr Daley saw this as a preliminary to privatisation and the break-up of the National Health Service. Mr Phoenix responded that the United States health insurance schemes were relating to the public and he felt that in the US it was done considerably better than in the UK both in terms of its citizens and patients. However, he wanted to make it clear that he was not suggesting that this is what would be done but he felt that there were benefits to such an approach, around disease prevention and health promotion.

(16) Regarding the restructuring of the Primary Care Trust, he wanted to make it clear that this was not affecting the frontline staff. Mr Horne raised a series of questions having expressed his concern that the Primary Care Trust had been set up from the 1st October and he felt that his local community were extremely worried about a number of issues. The issues related to:-

- Work with GPs and practices on commissioning; and
- The lack of dentists within the Tonbridge area.

(17) Mr Phoenix acknowledged that dentistry was a problem. He saw that there were three distinct areas where there was room for improvement. These were:-

a) practice-based commissioning and system modernisation, including Choose and Book. He saw this as a small programme over six to eight weeks, but the Primary Care Trust was still behind. He felt that the preliminary work he had seen was encouraging.
b) With regard to dentistry, some practices had opted out of NHS provision and this was generating a problem.
c) There were also issues around the standard and calibre of the primary-care premises for both dentistry and medicine. It was important that the focus was on the total estate for primary and community provision, rather than on individual practices.

**45. Creating an NHS Fit for the Future**

*(Rebecca Sparks, Director of Development & Partnership, South East Coast Strategic Health Authority; Ann Sutton, Chief Executive of Eastern and Coastal Kent PCT; Steve Phoenix, Chief Executive of West Kent PCT; Louise Parker, Deputy Chief Executive and Director of Service Development of Medway PCT were in attendance for this item.)*

(1) A copy of the PowerPoint presentation made by the three Primary Care Trust representatives to the Committee is attached as Appendix 1. During the discussion which followed the presentation, the following issues and questions emerged:

(2) Currently the three Primary Care Trusts were in the discussion phase of *Creating an NHS Fit for the Future* and the PCTs were currently developing their commissioning plans. During this discussion phase the PCTs were keen to hear from the public. There were a number of other consultations and pieces of work currently underway across Kent and Medway which would feed into *Creating an NHS Fit for the Future*, including the current consultation on emergency surgery and emergency orthopaedic care surgery for the Maidstone and Tunbridge Wells NHS Trust and the future of health services for Dover. *Creating an NHS Fit for the Future* was all about implementing *Our Health, Our Care, Our Say*.

(3) The Primary Care Trusts acknowledged that they were living beyond their means. If the Primary Care Trusts and the Acute Hospital Trusts across Kent and Medway did not take action now there would be trouble. They needed to work together to manage in a planned way. People should only be in hospital if they really needed to be there.

(4) The Committee were informed that the services needed to be clinically appropriate. The challenge for the Primary Care Trusts was how to explain the change to the public so that they understood that what was being proposed was for the better.

(5) In answer to a question relating to the Minor Injuries Unit at the Woodlands Centre at Darent Valley Hospital, Mr Phoenix said that the co-location of this with A&E at the Hospital would make for a much better service.

(6) Mr Hibberd said he supported the principal of having consultation but he wondered whether the elderly would understand it. Mr Phoenix responded that the understanding of the public was always a challenge. He then spoke of the deliberative events which were being organised, where the public could have their say.

(7) In answer to a question about the Kent and Medway Ambulance Service, now combined with that in Surrey and Sussex, Ann Sutton responded that it would have been appropriate for the Ambulance Service to be with PCT colleagues to answer questions around the discussion phase. It was appropriate that there needed to be proper links into the Primary Care Trusts for the Ambulance Service.

(8) A question was then raised by Mr Fittock about repatriating services from London back into Kent because of the number of people who travelled, particularly from West Kent, to London for services.

(9) He spoke about Maidstone becoming a centre of excellence for cancer.

(10) Louise Parker responded that Medway NHS Trust were about to apply for Foundation Trust status and were looking at providing and repatriating services locally. Steve Phoenix acknowledged that this was a good question and that if, for example, people could be treated for cancer locally in Maidstone rather than going to London, this had to be a positive step forward. Rebecca Sparks indicated that she had recently attended a meeting in south west London regarding their plans. It was important that locally the Committee kept abreast of developments for *Creating an NHS Fit for the Future* in London.

(11) Mr Angell then raised concerns about how the questions accompanying consultation papers for recent consultations had been phrased. If this was an attempt to hear from the public in a genuine way then in his opinion he felt that the questions were too leading. Rebecca Sparks responded that the discussion document on *Creating an NHS Fit for the Future* had been produced in-house between the Primary Care Trusts and the Strategic Health Authority. It had been compiled building on the work in Surrey and Sussex when they undertook their discussion phase. Unfortunately, the discussion document had omitted the date when stakeholders and the public needed to submit their views which was Friday 22 December 2006.

(12) Rebecca Sparks also advised the Committee that MORI had been commissioned to do some baseline research around the co-design events and the deliberative event.

(13) Asked about the lack of specialist staff and equipment locally for some hospital procedures, Mr Phoenix responded that it was not good to spread specialist expertise too thinly and wherever possible the desire was to seek repatriation of services locally to Kent. As technology and practice procedures changed it should be possible to get specialist services more locally. However, the Committee noted that this was a very fluid and changing environment.

(14) Mrs Rowbotham articulated her experience in terms of preventative healthcare. She felt that there were fewer hospital beds, nurses were being de-skilled at the real cost of being a professional nurse and there was a lack of monitoring. Mr Phoenix responded that he felt that the analysis of Mrs Rowbotham was totally wrong. It was about getting the right people in the right place at the right time and, in short, it was about using the skills of people most appropriately so that healthcare assistants could support specialist nurses. He questioned whether beds were as important as the people providing services.

(15) Mr Daly expressed his concerns about the delivery of services in a community setting: if you wanted specialty services then you were required to go into hospital but it was important that you needed a number of qualified staff spread across the area. Mr Phoenix responded that it was often commented on about the inability to provide the care in the community that could be provided. He said that it was a vicious circle – there was no money for community care so people then went into hospital and when they were fit and well there was no money for community care. What needed to happen was for this vicious circle to be broken and for a plan and necessary investment to be made.

(16) Mr Daley then responded that the task for Mr Phoenix in the short term was to deal with his deficit.

(17) Asked by the Chairman about whether the options would be costed in the consultation, Mr Phoenix responded that by the time the consultation started the options would have been costed. Mr Phoenix responded that the short term challenge for him was indeed to overcome the deficits but in the medium to long term, part of the solution had to be investment to achieve greater care in the community. Mr Fittock then said that the Committee had heard a lot about the clinical drivers for the proposed changes but he asked about some of the system-reform drivers, including Choose and Book, Foundation

Trust status, Primary Care Trust commissioning. These did not seem to be reflected in the consultation documents and he asked why not. In response, Rebecca Sparks said this was a preliminary discussion document, a scene-setting phase, where the three Primary Care Trusts were seeking preliminary thoughts. She said there would be some social research undertaken to get a baseline for the Primary Care Trusts about what the local population would like however the PCTs were also trying to reach people who do not normally get the opportunity to be involved.

(18) What Mr Fittock described was absolutely right, there was a whole range of drivers but it was felt that these were too technical for inclusion in the discussion document. The Primary Care Trusts would have to take account of system reform in their commissioning plans.

(19) In answer to some questions from Mr Warner of Maidstone Borough Council about GPs and whether facilities will be in place first for services in the community as well as the impact of the cutbacks in Dartford, Mr Phoenix responded that the GPs were fully involved in Practice-Based Commissioning and he felt that, by the time that proposals went out to formal consultation, proposals for services in the community would be entirely clear.

(20) With regard to the cutbacks in the Dartford, Gravesham and Swanley area Mr Phoenix indicated that there was currently a recruitment freeze due to the financial problems. Asked whether Mr Phoenix envisaged having to bring people in from outside to provide services in the community, Mr Phoenix responded that he did not expect this to occur as he felt people would be enthusiastic about the opportunity to provide services in a primary-care setting. Rebecca Sparks acknowledged that the discussion document did not contain the date for comments to be made, which was an error, and all copies were having a sticker attached to them stating that the date was 22 December 2006. Ms Sparks then went on to explain about the continued implementation of Patient Choice, which was becoming wider and wider. She, therefore, said that there needed to be an ongoing dialogue with local authorities re the criteria for where people are treated and who paid. Louise Parker added that there needed to be a truly integrated core service.

(21) In answer to a question relating to the consultation phase and options for Kent and Medway vis-à-vis what was going on in Surrey and Sussex, Rebecca Sparks indicated that the options for Surrey and Sussex had not been completed yet. However, she noted that there were linkages across the various counties that needed to be addressed.

(22) She added that she did not anticipate the consultation in Kent and Medway being done jointly with Surrey and Sussex. She said, whilst it would not be ruled out, it was unlikely and the intention was to keep the slippage to a minimum. Mr Reece asked whether this discussion document was a typical National Health Service document with nice words. He said that the public did not want to read long documents and he felt that the question that needed to be asked was which treatments would people travel for. He also added that he felt that Choose and Book influenced what services were provided where. In answer to these questions, Rebecca Sparks said that they were trying to start the debate about services and the way that consultation documents are written and could be improved. She was open to suggestions about how it could be done better. With regard to Choose and Book, Mr Phoenix said that this in itself would not influence where

services went, there were other factors such as Patient Choice, Payment by Results, the reputation of individual hospitals and clinicians within those hospitals.

(23) Mr Gibbens said that he felt that it was important that feedback was widely achieved on these proposals. There was a real need to reach those areas across the County where people are disadvantaged.

(24) He also expressed concern that there were so many different ways in which Accident & Emergency, Emergency Centres, Minor Injury Units and Trauma Centres were described. There was a real need to reassure the public what these services were and to define them appropriately. Ms Sparks responded that it is a real challenge to reach people and, yes, the terminology was key.

RESOLVED that the Committee:-

- i) wished to see further information regarding the dates and times of the co-design events and the deliberative event;
- ii) were encouraged and noted that there was some independent engagement of the public through MORI – but this did not go far enough;
- iii) noted that there was a real need to ensure that the outcomes on the options which would be consulted upon resulted in improved health outcomes for Kent residents and a reduction in health inequalities; and
- iv) noted the need to describe and clarify the terminology around Accident & Emergency, Trauma Centres, Minor Injury Units, etc.

**46. West Kent Primary Care Trust – Turnaround Plan and Review of Community Hospitals relating to the former South West Kent and Maidstone Weald Primary Care Trust areas.**

(1) Mr Phoenix informed the Committee that the formal Turnaround Plan for Maidstone Weald and South West Kent PCTs was introduced earlier on in the year to overcome a deficit of £9.6 million for the financial year 2005–2006. This had been approved by the respective Boards and Professional Executive Committees (PECs), the Strategic Health Authority and the Department of Health. The Turnaround Team was managed by an interim director who had private sector experience.

(2) Dartford, Gravesham and Swanley Primary Care Trust had a deficit for 2006 of £2.75 million, but they had not entered into a formal Turnaround Plan – which had been a mistake. By August this year, it had been evident that the situation in Dartford, Gravesham and Swanley had deteriorated considerably and, therefore, PricewaterhouseCoopers would be reporting to the West Kent PCT Board on Thursday 16 November 2006. Support was currently being sought from the Strategic Health Authority to bridge the gap.

(3) He added that there were nine workstreams within the Maidstone Weald and South West Kent PCT Turnaround Plan which would now need to be extended to cover Dartford, Gravesham and Swanley as well. It would become a much more expensive and comprehensive Turnaround Plan. The Chairman asked where the overspend had occurred and Mr Phoenix responded that the pressures were:-

a) commissioning from the acute hospital trust;
b) no provision for the Private Finance Initiative (PFI) for Gravesham Community Hospital; and
c) overspending on prescribing.

(4) Mr Tolputt reminded the Committee of the need for Maidstone & Tunbridge Wells NHS Trust to be bailed out by the NHS Bank and so he asked whether the funding allocation had been wrong in the first place, as most of the deficit seemed to be accruing in West Kent. Mr Phoenix responded that there was no evidence to suggest that the funding was wrong but there was evidence to demonstrate that money had been spent by people when they did not have the money in the first place.

(5) Mr Angell asked why the deficit in Dartford, Gravesham and Swanley should affect other areas of West Kent which he considered was grossly unfair. He added that Maidstone and Tunbridge Wells NHS Trust also has financial problems; there were issues around the status of the Homeopathic Hospital in Tunbridge Wells, the health visitor services review, etc. Mr Phoenix responded that he would be looking to target savings in the north of the West Kent PCT area. However, the Department of Health would see the situation as a West Kent Primary Care Trust area problem and, therefore, other parts of the Primary Care Trust geographical area would not be immune from the savings required.

(6) Mr Horne then spoke of issues relating to his area. He asked that the figures for the overspends be written down and made available to the Committee, including how the tariff for individual treatments operated. He added that he was also concerned about physiotherapy delivery and the lack of dentists in the Tonbridge area. Mr Phoenix responded that lessons were to be learnt from the Turnaround Team that had been operating in the former Maidstone Weald and South West Kent areas for operation in the north of the West Kent PCT area.

(7) He confirmed that it would be necessary for the South East Coast Strategic Health Authority to look at tariffs and coding for procedures across the South East Coast Strategic Health Authority area. He said that in the new Payment by Results system they would not want to be disadvantaged by perverse incentives. He felt that the issues around Payment by Results were being wrestled with nationally. Mr Fittock said that there needed to be an equality of funding, an equality of services across Kent and that there needed to be adequate planning between Social Services and health provision. He asked what the percentage of the deficit was relative to the overall expenditure and received a response that it was 2% of the budget. Mr Fittock added that they were trying to avoid hospital admissions yet were making cuts in community hospitals too. Mr Phoenix said that the Turnaround Plan was a public document and he was confident that the Primary Care Trusts were making savings. The PricewaterhouseCoopers report had only just been delivered and there would be a need to look at a more comprehensive plan by the end of this month including the year end target. It would not be possible to recover the entire financial deficit within this year so, therefore, the plan would need to run until March 2008; but with minimising the year’s overspend because of RAB (Resource Accounting & Budgeting). Mr Hibberd asked about the numbers who use the health service: some people did use it and others did not at all. Mr Phoenix responded that there were national figures available. He added that hospitals were the least used element of the National

Health Service. Over-85s were a particularly costly section of the population in terms of use of healthcare.

(8) Mrs Angell then asked a series of questions around the discussion document which indicated that 4–5% of hospital admissions could be avoided, which would lead to a 30% reduction in acute hospital beds. However, she referred to the review of Community Hospitals carried out by Tribal and asked questions about how it was intended to provide for communities in West Kent outside the Community Hospitals. Finally, she asked how £700,000 of the allocation for dental services could be retained rather than being spent on that area of provision. Mr Phoenix responded that dentistry was an area of priority. Asked how he was managing vacancies, Mr Phoenix responded that it was better not to employ someone in the first place rather than having to make someone redundant.

RESOLVED:-

That the information provided concerning the Turnaround plan be noted.

**47. Homeopathic Hospital, Tunbridge Wells**

(1) Mr Phoenix informed the Committee that there had been a reduction in referrals to the Homeopathic Hospital as part of the Turnaround Plan. This would save fifty to sixty thousand pounds by being excluded from the service and from the scrutiny of individual applications.

(2) He informed the Committee that he had revised that decision and was now not assuming any savings. Referrals were being examined by treatment panel and not held up. Mr Coe, Chairman of the Campaign to Save the Homeopathic Hospital (CaSHH), his group and others had challenged whether what was being applied was a proper process. Mr Phoenix indicated that he had some sympathy with that and therefore he had asked GP and public health colleagues to work up a proper paper for consideration in the new year. He was also making arrangements to discuss the issues with Maidstone & Tunbridge Wells NHS Trust consultants and other interested stakeholders. If, as a result, the outcomes did lead towards a substantial change then formal consultation on the proposals would take place in the early part of 2007. Mr Coe was in attendance at the meeting and addressed the Committee. Having listened to Mr Phoenix carefully Mr Coe indicated that he had said some new things since they had last met the previous week and that he was not sure what they meant. To look at saving money was one way of looking at the NHS but he challenged what was happening to the patients.

(3) He informed the Committee of how he had become involved and how he had ended up being referred to the Tunbridge Wells Homeopathic Hospital. He referred to a letter that had been sent to General Practitioners where it was not made clear who had made the decision and why and on what basis. He indicated that the group were appealing to the Information Commissioner to use the Freedom of Information Act. He said that there was no evidence that any money would be saved and there was a caseload at the hospital of 1,000 patients. It was of interest to the Maidstone and Tunbridge Wells NHS Trust who he said were prepared to promote the service because it made a surplus and helped with their financial situation. He also referred the Committee

to the Tunbridge Wells Orthopaedics Hospital building being endowment for future generations and he impressed on the Committee the duty to preserve it.

(4) Mr Fittock indicated that, unfortunately, Ms Harrison was unable to be present at the meeting but that she wanted the Committee to be aware that she was a great supporter of the Hospital.

(5) Likewise, Ms Rowbotham said that she supported homeopathy and she said she would also be a supporter of the Campaign.

(6) Mr Horne then asked Mr Phoenix whether the decision which had been taken was illegal. In response Mr Phoenix said he did not think it was illegal but that he felt it had not been handled in the best way and he wanted to ensure that all the issues were covered.

(7) Mr Coe added it was for the courts to decide. The group were considering a challenge under the Human Rights Act.

(8) Mr Daley asked why not also promote alternative services if hospital services are being reduced.

RESOLVED:-

That Mr Coe be thanked for his attendance at the Committee and for articulating the concerns of the Campaign to Save Tunbridge Wells Hospital so eloquently and it be noted that the West Kent Primary Care Trust were to review the whole issue surrounding the Tunbridge Wells Homeopathic Hospital as indicated by Mr Phoenix, Chief Executive of the PCT (sub paragraph 2 above refers).

**48. Community Hospitals**

(1) Mr Phoenix set out the review of the Community Hospitals, a piece of work which had been commissioned in the summer and was being driven forward by a steering group. The steering group included a range of stakeholders. Mr Phoenix said he had kept away from the piece of work because he was satisfied that it was moving along fine in his view. A number of options were being considered.

(2) He made it clear that this review of Community Hospitals was around the former South West Kent and Maidstone Weald Primary Care Trust areas and did not include the facilities within Dartford, Gravesham and Swanley PCT.

(3) As the Committee were aware he reaffirmed that the commissioning plans must be factored in by December/January and this would be done. He said that he had a completely open mind and that the proposals forthcoming from the review would need to support the whole health system and economy across the West Kent PCT area. Asked about the commissioning plans, Mr Phoenix said there was a variety of scenarios being worked on here around caring for people in their own home, GPs doing more work, the Community Hospitals and nursing homes. He said that it would be January/February before the proper synthesis was available.

(4) Mr Horne said that it was a very worrying and disturbing situation that was really contentious locally with the review of four Community Hospitals in Sevenoaks, Tonbridge, Edenbridge and Hawkhurst. He sought confirmation that at the time of the meeting there were no plans to close any of these four hospitals. He raised this concern because of a bid for funding which he understood had been made to allow the continuance of the Community Hospital in Sevenoaks only. He said that it was important to have respite and hospice facilities closer to people's homes. People locally felt that decisions had already been made.

(5) He raised concerns relating to tariff-unbundling and the impact of this on cottage hospitals. He spoke to the number of empty beds and people bed-blocking in acute hospitals and how all of this was going to be delivered in view of the deficit that Mr Phoenix had informed the Committee about earlier. If the services were removed Mr Horne questioned whether this was legal and how services would be provided.

(6) In reply to Mr Horne, Mr Phoenix said that he could not speak for the former Primary Care Trusts but he could confirm that no decisions on the future of the four Community Hospitals had yet been made. On being pressed by Mr Horne about why he understood a bid had already been made for funding for Sevenoaks Community Hospital only, Mr Phoenix responded that this might have occurred because of the timescales for making such bids – he promised to check this. He added that, as far as he was concerned, this was a genuinely open process and he had a completely open mind.

(7) Asked by Mr Angell about the cuts in administrative costs, how and what this involved, and the impact of the Community Hospitals review potentially on Social Services and nursing home bed spaces, Mr Phoenix responded that he was looking to make £2–2.5 million of administrative savings; 40 posts had already gone and more would disappear prior to Christmas. He was not indicating that administrative staff were less valuable than clinical staff, though.

(8) He confirmed that, as Mr Angell had said, communication with local Members was key. He added that Social Services were involved in the review of Community Hospitals and Jan Bumstead served on the steering group.

(9) Asked how much it was costing to employ the external consultants, Tribal, to undertake background research and work, Mr Phoenix said that he envisaged that this would be in the region of £30–50,000.

RESOLVED:-

That Mr Phoenix's commitment to having an open mind about the four Community Hospitals in the former Maidstone Weald and South West Kent Primary Care Trust areas and the fact that at this time no decision had been taken around the future of these Community Hospitals be welcomed and that the Committee continue to be fully appraised of the review and its proposed outcomes.

**49. Review of health visiting services**

(1) Mr Phoenix explained that the PCT expected to save an annual sum of £700,000 as a result of its review of health visiting services. The service would in future

be focused particularly on children aged under four and their families. It was still the intention to allow universal access to the service, but it would be provided in a different way, being targeted at those most in need.

(2) The review was underway and involved the distribution of a stakeholder questionnaire, as well as one-to-one discussions with service-users. Priority areas of working had been identified and over 900 replies had been received from service-users. A reference group, made up of 18 health-visitor team members, had been formed to develop a service model.

(3) Reforms to health-visiting services in other parts of the country had been used for benchmarking purposes. A 28-day formal discussion phase would start on 13 November.

(4) The "core values" that would be adhered to were:

a. a child-centred approach;
b. targeting of services at the most vulnerable;
c. allowing referral to the service by other health professionals at any time.

(5) The service would be stratified as follows:

a. Low need (assessed by nursery nurses);
b. Medium need (assessed by community staff nurses);
c. High need (assessed by fully qualified health visitors).

(6) A stakeholder workshop was to be held on 23 November; this would look at benchmarking data in order to ensure a robust review. The various strands of work in the review would be reported on in January and February.

(7) Mr Phoenix stated that the review was bound to result in there being fewer health visitors. Numbers had already been reduced by means of not filling vacancies.

(8) Sarah Carpenter, Regional Officer for Amicus / Community Practitioners' and Health Visitors' Association, addressed the committee on behalf of the union's health-visiting members employed by West Kent PCT. Ms Carpenter explained that the health visitors whom she represented were strongly opposed to the proposals that the PCT had brought forward.

(9) Health visitors were often the only interface some families might have with a healthcare professional. They worked using a preventative model of healthcare, and their interventions could halt a deterioration of the potential physical and psycho-social consequences of a wide range of conditions.

(10) Given that the issues addressed by health visitors affected all parts of society, the universality of health visiting was critical to the delivery of a safe service – yet this was threatened by the current review.

(11) The aim of the review was to save 33% of the current health visiting budget, i.e. £700,000. If this were simply a proposal to deliver a more effective health visiting service, Ms Carpenter's members would have no objection – but it was not such a

proposal. The review proposed to reduce health visiting staffing numbers overall by 10.09 whole-time-equivalents. This was made up of a reduction in health visitor numbers from 57.09 whole-time-equivalents to 42 (with over a quarter of skilled, qualified staff being lost to the service) and an increase from 11.5 whole-time-equivalents to 16.5 of lower-qualified and lower-paid staff.

(12) A substantial number of health visitors had already left the PCT (mainly due to retirement) and not been replaced. In the Maidstone area alone, eight health visitors had left in the last 12 months. This meant that the service was already hugely stretched, before these further cuts had been implemented.

(13) Under the proposals, the burden of providing the service would fall on the less-qualified staff and the caseloads for the remaining fully-qualified staff would be above nationally recommended levels.

(14) No commitment had been given to assessing the vulnerability of families more than once – such an approach would not capture the full extent of need for services. The quality of the service would be compromised in respect of many areas of need, including:

a. child protection;
b. child development (including speech, language and hearing problems);
c. breastfeeding;
d. domestic violence;
e. postnatal depression;
f. teenage pregnancy and contraception.

This would be a false economy, as it would result in increased demand for other services, as well as worse health outcomes.

(15) The preventive role of the health-visiting service was being undermined, to statements from the government on the importance of the service.

(16) Finally, Ms Carpenter pointed out that the Department of Health would be conducting a national review of health-visiting, beginning in December, with a report expected in April. Her members felt that the review of services in West Kent should be postponed until the results of the national review were known.

(17) Mrs Angell asked about the impact of the proposals on screening young children for hearing and vision problems. She asked how the PCT's proposals related to trends in births – were there now fewer babies being born in West Kent? She also asked why the West Kent review was going ahead prior to the national review of health visiting.

(18) Mr Phoenix said that there was a national screening programme for hearing problems, but no equivalent programme relating to vision – he agreed that the work of health visitors in this respect was important. He said that the West Kent review had begun before the announcement of the national review, and it was well underway. Mr Phoenix was pressed by Mrs Angell as to whether the PCT's plans were driven by diminishing need for services, due to fewer children being born, or the imperative to save money. Mr Phoenix said that the review had been set in motion by financial considerations – but the

PCT had seized the opportunity to define a different model of care, which was universal but targeted, based on models already in use elsewhere.

(19) Mr Horne asked whether the proposals would give the right skill mix. Mr Phoenix said there would still be qualified staff, but they would be qualified in different ways. The right skills would be available in the right places. Ms Carpenter said there was a level of vagueness about which services would be delivered by which members of staff. She thought people would be asked to do jobs for which they were not properly qualified. Mr Phoenix said he did not believe this would be the case. He emphasised that the PCT had to find £10 million of savings, and this could not be done without making changes. However, there was no intention to increase risk or make the service worse. He wished the financial situation were different, but he had to deal with it.

(20) Cllr Warner said he felt that money was being taken away from a “soft target” and questioned whether the consequences had been thought through. Mr Phoenix said a risk assessment had been carried out. Also, the PCT’s Professional Executive Committee had agreed the planned service model, with some caveats. Cllr Warner asked for the risk model used to be shared with the committee.

(21) Mr Fittock asked about possible effects of the proposals on Children’s Trusts and Children’s Centres. Mr Phoenix explained that the Children’s Trust was a commissioning body, not a providing one, and was a partnership between KCC and the PCTs.

(22) Mr Daley asked about the costs occasioned by the apparently constant change that was going on in the NHS. Mr Phoenix agreed that the NHS was changing into a very different form to the one it had previously had, with choice and a growing plurality of providers in both health and social care. There was a feeling of constant revolution and this would continue to be so for some time to come.

(23) Mrs Rowbotham said she thought the proposals regarding health visiting should be put on hold, pending the outcome of the national review, in case more government funding was forthcoming.

(24) Mr Crowther said he thought too much was being made of the deficit in the NHS, which only constituted a small proportion of the budget. Mr Phoenix said the overall NHS deficit was equivalent to 2% of the budget. Nevertheless, the Department of Health thought this was a big sum; and PCTs had a duty to live within their budgets.

(25) Mrs Angell pressed Mr Phoenix to provide figures on the birth rate in West Kent. Mr Phoenix promised he would obtain this data for the committee.

(26) Mrs Angell thought the PCT’s proposals would not be cost effective, as they would simply lead to problems being identified later rather than sooner.

(27) Mr Phoenix promised that the PCT Board meeting on 16 November would consider whether the review of health visiting services needed to be delayed pending the outcome of the national review. As regard the risks attached to the proposals, he did not share the views put forward on this, having taken professional guidance.

(28) Mr Angell asked about the possibility that more domiciliary visits by other healthcare professionals and voluntary organisations would be needed to fill the gaps caused by the proposed changes to health visiting services. Mr Phoenix said that GPs were among those who had looked at the proposals. He explained that the review only covered health-visiting services, not services to children as such. As regards the concerns that had been expressed about whether families would have their risk status assessed more than once, Mr Phoenix said he did not know how far the review group had looked into this but he would try and make sure it had been addressed.

RESOLVED:-

That West Kent PCT be strongly urged to await the outcome of the national review of health visiting before making any final decisions about changes to the service provided in the south of West Kent.

**Appendix 1**

# Creating an NHS Fit for the Future

'More personalised care closer to home'

creating an NHS *fit for the future*

## Introduction

- Why healthcare needs to change
- Planning for the future
- What's happening locally
- Working with patients and partners to shape the future

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## Why healthcare needs to change

- Moved from treating infectious disease to managing long term, chronic conditions
- Better drugs, new technology, more effective therapies and improved surgical techniques
- All help improve quality of life and extend life expectancy and;
- Reduce time spent in hospital

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## Why healthcare needs to change

– Treat more people, more quickly
– Previously a 2 year wait, now within 6 months and soon, start to finish in 18 weeks
– Access could be easier and;
– We're living beyond our means

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# Planning for the future

- We want new ideas about providing care
- Prevention and promotion
  - A health service, not a sickness service
- Urgent and emergency care
  - Right care, right place

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## New ways of planning care

- Community settings and people's homes
- Local care centres
- Local general hospitals
- Major acute hospitals
- Critical care hospitals

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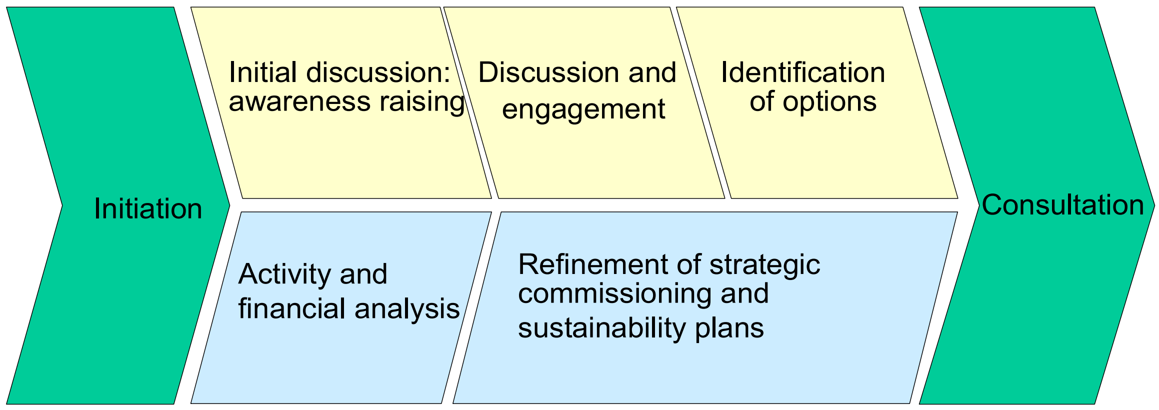
## The process




creating an NHS fit for the future

## Kent and Medway timeline

NHS
South East Coast

| Establish PPI and clinical reference groups | Sept '06 |
|---|---|
| Briefing undertaken with key stakeholders (MPs, Local Authorities, LSPs, Staff, NHS Boards, Deanery, PPI, local groups) | Sept-Nov '06 |
| Discuss engagement proposals with OSCs | Oct / Nov '06 |
| Discussion pamphlet circulated | 31st Oct '06 |
| Social research commissioned | 31st Oct '06 |
| External company identified to analyse responses to discussion pamphlet and consultation document | 31st Oct '06 |
| Local engagement and discussion | Oct-Dec 06 |
| PCT Boards consider consultation process (e.g. single K&M consultation document, joint decision making process) | Dec '06 |
| Deliberative event | Nov '06 |
| Co-design events | Dec '06 |
| Consultation document prepared | Early Jan '07 |
| Consultation starts | Early 07 |
| Decisions taken on consultation outcomes | Jun '07 |

# Local focus

- Improving access to specialist community services
- Improving access to diagnostic services
- Improving the care for people with chronic diseases e.g. diabetes
- Integration of health and social care services
- Provide more care in community settings to avoid emergency admissions / reduce the stay in hospital
- Improving the health of the local population and seeking to prevent ill-health

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# Who we are involving

- NHS Trusts and PCTs
- Kent & Medway MPs
- Kent & Medway Health & Overview Scrutiny Committees
- South East Coast Ambulance Trust
- PCPI/PPIF
- Citizens Panels
- Voluntary and charitable organisations
- Independent providers (ISTCs etc)
- Strategic partners (dentists, optometrists, etc)
- Local authorities (including district councils and their Chief Executives)
- The Universities of Kent, Christchurch and Greenwich
- Kent Health Protection Unit
- The Medical Deanery
- Local Medical Committee
- Local Dental Committee
- Local Pharmaceutical Committee
- Local Optical Committee
- Editors and local media

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# Eastern & Coastal Kent PCT

NHS
South East Coast

| Project Plan | |
|---|---|
| Establish local steering group | Aug 06 |
| Establish Communications Sub Group | Sep 06 |
| Staff awareness via newsletters, intranet and internet sites | Sep–Dec 06 |
| Local clinical engagement and discussion | Sep–Dec 06 |
| Local engagement and discussion | Oct–Dec 06 |
| Discussion pamphlet circulated | Oct 06 |
| Deliberative event | Nov 06 |
| Active Lives events | Nov 06 |
| Co-design events x 3 | Dec 06 |
| PCT Board Meetings | Dec & Jan 07 |
| Consultation starts | Early 07 |

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# Medway PCT

| Project Plan | |
|---|---|
| Establish local steering group | Oct 06 |
| Staff awareness via newsletters, intranet and internet sites | Sep–Dec 06 |
| Local clinical engagement and discussion | Oct-Dec 06 |
| Local engagement and discussion | Oct–Dec 06 |
| Discussion pamphlet circulated | Nov 06 |
| Deliberative event | Nov/Dec 06 |
| Co-design events x 1 | Dec 06 |
| PCT Board Meetings | Dec & Jan 07 |
| Consultation starts | Early 07 |

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# West Kent PCT

| Project Plan | |
|---|---|
| Establish local steering group | Aug 06 |
| Staff awareness via newsletters, websites and staff forums | Sep - Dec 06 |
| Local community engagement and discussion with voluntary and statutory sector | Oct-Nov 06 |
| Discussion document circulated | Nov 06 |
| Discussions with LMC and practice based commissioning groups | Nov 06 |
| Deliberative event | Nov 06 |
| Active Lives events | Nov 06 |
| Co Design Event at Tonbridge and Gravesend | Dec 06 |
| PCT Board and PEC meetings | Dec & Jan 07 |
| Consultation starts | Early 07 |

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# West Kent PCT Cont/d…

- Health Visitors Review
- Orthopaedic/Trauma
- Community Hospital Review
- Gravesend Community Hospital PFI
- Darent Valley PFI
- Homeopathic Services

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# Discussion Pamphlet

**List of questions posed on the discussion pamphlet:**

Q1. What support would make the biggest difference to you (or people you know) with long term conditions to avoid a crisis due to a deterioration in their health?

Q2. We know people with certain conditions, such as cancer, get better results when they see a qualified specialist – would you be prepared to travel 10, 15, 20 or more miles for this?

Q3. Does it matter if your nearest acute hospital does not provide every specialist service?

Q4. If we invest in providing more services in community settings, treating people effectively and safely in clinics and at home, then we are unlikely to need as many large hospitals in the future. What is your view about that?

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# Discussion Pamphlet

**List of questions posed on the discussion pamphlet:**

Q5. How do you feel about more services being provided in the local community, such as outpatient appointments, therapy services etc, so that people do not have to travel so far for this kind of service?

Q6. If we expand services in the community for those who need support to regain their independence after a period of illness or treatment, particularly the elderly, we will need to invest less in hospital services and more in community services. What do you think about this?

Q7. One of the biggest frustrations we have heard from patients and the public is the lack of co-ordination between services, which results in being seen by different professionals and causes more travel. To improve the sharing of information between health and social care partners we may be able to locate some services in the same buildings. What do you think?

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# Shaping the Future

- The NHS, patients, carers and partners working together
- We need your views to shape proposals fit for the future
- Formal consultation if major changes are proposed

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# Staying involved

- Response form with the discussion document
- Website: www.kentmedwayfitforthefuture.nhs.uk
- Email: fitforthefuture@kentmedway.nhs.uk
- Post: Freepost, Fit for the Future, MA1339
- Local events

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Directorate of Civic Engagement

**Draft – v2**

**Commissioning Homeopathy Review Process**

***January 2007***

**Introduction**

In 2006 the combined deficits of South West Kent & Maidstone Weald PCTs led them into formal turnaround. The nature of turnaround is such that every possible area of saving – both efficiency improvements and the review of service provision – must be considered. A Turnaround Director with considerable experience was appointed, in line with national policy and directive.

The Turnaround Plan identified a number of service areas for review, of which one was homeopathy. The PCT initially proposed to direct all referrals for homeopathic services through the Individual Treatments Panel so that each case could be considered on the basis of need before the referral went ahead. This proposal, however, caused concern amongst some stakeholders and it was therefore agreed to conduct a review of the demand for homeopathy services and the cost benefit of such treatments being provided within NHS funds.

This short paper describes the PCT's proposed process to conduct the review, taking into account the views of key stakeholders.

**Principles**

The specific issues related to homeopathy as a form of 'alternative' medicine makes the review particularly sensitive. Polarised opinion is formed on both sides of the debate, both as to the efficacy and effectiveness of treatments and the use of NHS funding for providing them. It is therefore imperative that key stakeholders agree some underpinning principles for the review before it goes ahead. These will include principles relating to:

- Conducting the review;
- Evaluating the evidence base;
- Engaging stakeholders, and;
- Criteria for decision-making.

The stakeholders at the outset of the review will agree to a set of core principles. There are a number of underlying basic principles that the PCT is committed to:

- Fulfilling its statutory obligation to work within budget, which may require difficult decisions being taken about purchasing priorities at times;
- An objective and transparent process for decision making, engaging the public and key stakeholders in coming to priority decisions;
- The pursuit and performance of evidence based clinical practise;
- The provision of patient choice in line with national policy.

**Stakeholders**

For the purposes of this review key stakeholders who will be fully engaged in the process will comprise:

- Kent County Council Health Overview & Scrutiny Committee (HOSC)
- West Kent Patient & Public Involvement Forum (PPIF)
- Maidstone & Tunbridge Wells NHS Trust (homeopathic hospital management & clinicians)
- West Kent PCT Professional Executive Committee (PEC)
- West Kent Practice-Based Commissioners
- South East Coast Strategic Health Authority (SHA)

Additional members of the public, patients and interest groups will be invited to a stakeholder event and their views will be fed into the process before the final decision is taken.

The final decision rests with the PCT Board.

**Review Process**

It is proposed that the review be conducted in four stages:

1. A review of existing activity and spend on homeopathic services;
2. An external review and evaluation of the evidence for homeopathy;
3. A discussion phase, where both reviews are shared and discussed amongst the stakeholders, options presented and developed and decision making criteria are agreed in conjunction with the PCT Board;
4. The decision-making process, where the PCT Board will apply, weight and score agreed criteria.

The PCT's Director of Civic Engagement will lead the process.

**Next Steps**

Over the next couple of weeks the PCT Director of Civic Engagement will convene a meeting with the key stakeholders to discuss, amend and finalise the process.

At the same time it will be assumed that a review of demand, supply and costs and the underlying evidence base are essential foundations of any process and will be set in motion with immediate effect.

Julia Ross
*Director of Civic Engagement*
January 2007

# NHS Overview and Scrutiny Briefing Note

**Maidstone and Tunbridge Wells NHS Trust consultation: *A new direction for surgical and orthopaedic care***

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

4 January 2007

**The Trust's proposals**

Previous consultations have had the outcome of retaining full Accident and Emergency (A&E) provision at both Maidstone Hospital, and the Kent and Sussex (K&S) Hospital in Tunbridge Wells – both of which are run by the Maidstone and Tunbridge Wells (MTW) NHS Trust.

In recent months, MTW Trust has developed proposals to:

- centralise emergency orthopaedic surgery and emergency general surgery at the K&S, creating a single specialist trauma centre for the Maidstone and Tunbridge Wells area;
- centralise all complex pre-planned inpatient surgery at Maidstone Hospital, creating a specialist centre for complex surgical care for Maidstone and Tunbridge Wells;
- redesign the medical admissions pathway at Maidstone Hospital to allow admission directly into a specialist unit, rather than through A&E.

Since October, the Trust has, jointly with West Kent Primary Care Trust, been running a major public consultation on the first two of these proposals.

MTW Trust's plans would mean the A&E department at Maidstone Hospital losing its capacity to deal with some "blue-light" emergencies – but medical emergencies (e.g. heart attacks and strokes), which make up the bulk of blue-light cases, would continue to be dealt with at the hospital.

Patients requiring emergency surgical and orthopaedic operations would be taken by ambulance to the A&E departments at the acute hospitals in Dartford, Medway, Ashford or Tunbridge Wells, as appropriate. (The Trust's consultation document says this involves about 12 cases per day, or 2,500 per annum – although 12 per day would actually give a figure of 4,380 per annum.) It is argued that, since similar alternative blue-light A&E provision is not easily accessible from Tunbridge Wells, Maidstone's A&E department is the logical candidate for downgrading in response to the need to concentrate emergency general surgery and emergency orthopaedics on a single site within the Trust.

Conversely, around 20 patients per week who are currently undergoing complex planned inpatient surgery at the K&S would, under the proposals, instead be treated at Maidstone Hospital. This arrangement would build on the hub of specialist surgical services for cancer that is being developed at Maidstone as part of the Kent Oncology Centre.
The Trust states that "no change" is not an option and that, if its proposals are not implemented, one of the following more drastic solutions may have to be adopted:

- running one of the A&E services for less than 24 hours per day;
- closing one of the A&E services entirely.

## Reasons for change

*Clinical*

The Trust is justifying this proposed reconfiguration by arguing that its current A&E arrangements are not as safe or as effective as they could and should be, since they involve trying to run parallel services on two sites with insufficient staff. The Trust states that, in consequence:

- patients (including some of the sickest general-surgery patients) are waiting too long for emergency surgery – up to two days in some cases;
- patients are not being seen by a consultant every day – instead being seen by junior staff, who are still in training;
- orthopaedic patients have to wait for senior orthopaedic staff to be called from home at night.

The Trust says that increased ambulance journey-times will not be detrimental to clinical outcomes, on account of the enhanced skills and modern equipment that paramedic teams now have.

The Trust further argues that the present situation leads to adverse consequences for planned (elective) surgery patients, with operations being cancelled at short notice as surgeons try to juggle competing priorities.

The following considerations are also relevant:

- The Department of Health has recently argued that more centralised emergency services are better able to use new medical techniques and technology, and are, therefore, safer and clinically more effective. The same argument has also been put forward by the Institute for Public Policy Research, which is closely aligned to the government.
- In order to maintain their skills at an adequate level, surgeons need to see a certain number of cases of different types over a given period – and this dictates a certain optimal catchment population for services. For this reason, MTW Trust does not have the option of simply taking on more surgeons, even if it could afford to do so.
- The following measures will both significantly change surgeons' working patterns, thereby creating further staffing issues in the future:
    - the European Working Time Directive;
    - the "Modernising Medical Careers" programme.

In addition, the Trust states that the changes will lead to:

- fewer cancelled operations, due to the separation of emergency and planned surgery;
- reduced risk of hospital-acquired infection, as elective-surgery patients will not be mixed with unscreened emergency patients;
- improved use of staff, through an improved working environment in which staff can make better use of existing skills and develop new ones;
- reduced length of stay for patients.

The Trust says that the consultants working in the specialties concerned are, on clinical grounds, entirely supportive of the proposals.

*Financial*

MTW Trust's financial situation forms a significant part of the backdrop to these proposals:

- The Trust is attempting to realise savings to avoid a projected shortfall of £16.7m during 2006–7 (although savings from the current proposals would not be realised until 2007–8).
- The Trust has a carried-forward accumulated deficit of £16.9m.
- The Trust's finance strategy further envisages reducing its cost-base by £35m over the next four years.

*"System reform"*

The Trust is trying to achieve financial (and clinical) sustainability in the context of a radically changing NHS. "System reform" (Patient Choice; Payment by Results; competition between a plurality of providers, including the private and voluntary / non-profit sectors), which is refashioning the NHS as a market, is putting increasing pressure on NHS acute Trusts.

At the same time, there is a strong drive in the NHS (underpinned by Practice-based Commissioning and the strategic commissioning intentions of Primary Care Trusts) to treat patients in primary-care settings rather than in acute hospitals, wherever possible.

All of these developments point to a significant change in the way that acute hospital services will be configured in future.

*"Fit for the Future"*

A far-reaching review of health services across Kent and Medway is currently being undertaken by the three local Primary Care Trusts under the heading "Fit for the Future". This review is intended to reconfigure the NHS in Kent and Medway in light of the radical and overarching changes in the NHS summarised above. It has been left unclear how exactly MTW Trust's reconfiguration proposals relate to this review. However, they might be seen as an attempt to pre-empt "Fit for the Future" (proposals from which are currently due for publication in the next few months).

**Objections to the proposals**

MTW Trust's plans have met with strong local opposition from a range of individuals and bodies, including the Maidstone Division of the British Medical Association (whose members have voted overwhelmingly against the proposals) and members of Maidstone Borough Council. In December, a rally was held in Maidstone against the proposals, attracting some 2,500 people. The local press has also been balloting local people, urging opposition to the Trust's plans.
The following points have been raised by objectors:

- It has been suggested that MTW Trust's consultation document gives a somewhat skewed presentation of the issues, particularly in stating that existing arrangements

are actually not safe for patients.

- The Trust's questionnaire has been accused of containing leading questions, designed to elicit the responses that the Trust wants.

- The assertion that rejection of the current proposals may lead to even more drastic options being adopted is seen by some as a form of blackmail.

- It has been argued that the measures are primarily motivated by financial, rather than clinical, considerations – with the purported clinical case resting on a number of somewhat debatable claims and assumptions, and an inflexible interpretation of general principles about clinical best practice.

- The removal of these aspects of blue-light A&E capacity from Maidstone Hospital is seen as putting patients at risk. The time taken in transporting patients to hospital still matters – even allowing for how well-equipped and well-trained paramedics now are – and ambulances will have to travel significant additional distances (and along a poor road connection, in respect of the journey between Maidstone and Tunbridge Wells).

- It is pointed out that – without additional resources – increased journey-times and more time spent by paramedics stabilising patients, will put the ambulance service (as well as the charitably-funded Kent Air Ambulance) under greater strain. If their resources are overstretched, it could take longer for ambulances to reach patients than is currently the case.

- Attention has been drawn to the fact that the K&S, unlike Maidstone Hospital, does not have a helipad and is, therefore, unable to take patients who have been transported by air ambulance.

- The poor road and public-transport connections between Maidstone and Tunbridge Wells, it is argued, will mean considerable inconvenience for some patients, as well as for the relatives and friends of patients who wish to visit them. The Trust concedes this point, but says that patients will be sent from the K&S to Maidstone Hospital as soon as possible, and that any inconvenience is heavily outweighed by the clinical benefits of change.

- It has been noted that the K&S is housed in a Victorian building in a town-centre location, access to which is inhibited by traffic congestion – whereas Maidstone Hospital is a much more modern building and located away from the town centre.

- It has been queried whether the A&E departments in Dartford, Medway, Ashford and Tunbridge Wells will be able to cope with the displaced work from Maidstone. This may be a particular issue in the longer term, with both the Thames Gateway and Ashford being designated by the government as Growth Areas, and Maidstone having now been awarded New Growth Point status.
- It is pointed out that the benefits of separating emergency and elective surgery do not depend on the two services being provided at separate locations ("a wall would suffice!", runs the argument).

- Concern has been expressed by clinicians about the impact of the proposals on the

viability of Maidstone Hospital as a centre for postgraduate medical training. If the hospital has an inadequate range of specialties, it will risk losing its accreditation for training from the Royal Colleges.

- Broader concerns about the future of Maidstone Hospital have also been raised. MTW Trust clearly believes that the hospital has a long-term future – albeit more as a provider of specialist care for patients from a wide geographical catchment area (within the emerging national NHS "market"), than as a general hospital for the local community. However, there are fears that the hospital's existence could be in doubt in the longer term, with this partial downgrading of A&E seen as marking the start of a process of decline. It is claimed that there are well-advanced plans to withdraw all doctors from A&E, reducing it to the status of a minor injuries and minor illness unit.

- It has been suggested by some opponents that the real reason behind the proposed changes is a plan by the Trust to move services from Maidstone Hospital to the K&S, in order to strengthen the case for government approval of the planned new hospital at Pembury (which is intended to replace both the K&S and the existing hospital at Pembury). This has been denied by the Trust.

**Suggested areas of questioning**

Members may wish to explore the following themes with witnesses:

- to what extent the Trust's proposals are based on clinical considerations, and how far they are being driven by financial and other imperatives;

- whether, and how, the proposals will deliver services for patients that are better and safer than those currently being provided;

- the reasons for the strong opposition to the plans among clinicians (GPs and consultants alike) – and why it is that clinicians in the hospital specialties actually affected are apparently not opposed;

- whether the knock-on effects of the proposals for other A&E departments – as well as for the ambulance service and the Kent Air Ambulance – will adversely affect those services in the absence of additional resources.

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# A new direction for surgical and orthopaedic care

# Kent County Council

## Overview & Scrutiny

### 12th January 2007

# The Proposals

To create a specialist centre for trauma and a specialist centre for complex and cancer surgery by:

- Centralising all inpatient emergency orthopaedic surgery and emergency general surgery operations at K&S, supporting day case and 23 hour care.
- Centralising complex inpatient elective surgery at Maidstone Hospital, supporting complex cancer surgery, day case and 23 hour care

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# Why change (1)

- To improve standard of care
- To ensure patients see right specialist, every time
- To support training, with good supervision and sustain development of specialist skills e.g. stomach surgery
- To create safe, modern trauma services covered by specialists 24 hours a day
- To cancel fewer operations
- To reduce risk of infection of elective patients in particular

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# Why change (2)

- To better use staff skills
- To reduced length of stay in hospital
- To improve mortality and complication rates
- To save more lives of patients presenting with complicated surgical conditions
- To increase ability to manage complex cancer & surgery and bring new skills locally e.g keyhole surgery, pelvic surgery

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# Mr Paul Skinner – Orthopaedic consultant

- Half day trauma lists – 50% delayed > 24 hours
- All day orthopaedic lists – 16% cancelled – no beds
- Competition for beds and time – emergency vs. elective
- Superficial wound infection rate 2001 – 2006:

| | Maidstone | T. Wells | National |
|---|---|---|---|
| Trauma hip fracture: | 6.0%* | 2.9% | 4.3% |

* No dedicated trauma theatre

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# Why change - Orthopaedics

## Workforce effect of EWTD

| T&O MTW | Jan 04 | Jan 07 | Jan 09 |
|---|---|---|---|
| Consultants | 10.5 | 11.5 | ? |
| Registrars | 10 | 16 | 20 |
| Juniors | 10 | 16 | 20 |
| **Total** | **30.5** | **43.5** | **40+** |

- Doubling number of junior doctors every 5 years
- Additional £800k cost 2007, ? £1.2m by 2009
- 50% posts in 2007 not recognised by Royal College and Deanery
- Not good for training or modernising Medical careers

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# The current proposal

- All day consultant trauma lists, 12 per week including weekends
- Day case, outpatients & electives – no change

| Advantages | Disadvantages |
|---|---|
| Consultant provided service<br>80% admissions unaffected<br>Better trauma service<br>Electives and emergencies separated<br>No new build required | Small number of ambulance patients no longer going to Maidstone<br>Travel for relatives |

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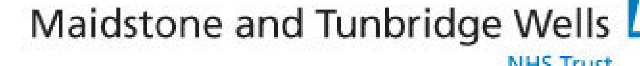

# Orthopaedics – what does it look like

| Maidstone | K&S/Pembury |
|---|---|
| A&E<br>Fracture and orthopaedic clinics<br>Day cases<br>Elective surgery (until PFI)<br>Hospital at night cover<br>80% patients no change | A&E<br>Fracture and orthopaedic clinics<br>Day cases<br>Elective surgery<br>**Trauma all day lists**<br>Resident trauma team |

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# Orthopaedics - improvements

- Better care for patients
- Less delays to operations
- Fewer cancellations
- Better training for junior doctors
- Provision of trauma standards

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# Mr Philip Bentley – Consultant Surgeon

- Need to separate elective and emergency
- Supported by Royal Colleges and other bodies
- Quality related to outcomes and volume of activity
- Sub specialisation
- GP access to urgent surgical opinion – daily slots

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# Objectives of change

- Deliver consultant led care
- Safe services for critically ill and injured patients
- Sustain local services through:
  - Outpatient clinics
  - Day cases (up to 80% of the work)
  - Emergency clinics
  - Fracture clinics
- Sustain modern emergency medicine on both sites
- Sustain cancer centre at Maidstone
- Improved outcomes & save more lives

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# Risk to patients if changes are not made

- Trauma service is not sustainable
- Patients will wait longer for their operations
- Greater risk of infection and poor outcomes
- May not be seen by a senior surgeon on daily basis
- Recuperation and recovery will be slower
- Surgery is not sustainable
- Mortality rate will not improve
- Complications will not decrease
- Sickest & most complex patients will remain a clinical governance risk

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# Emerging issues and themes:

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# "No Clinical Ownership"

- 3 years debate
- Meetings with external facilitation of directorate teams, with medical director and CEO, through Dean of medical education
- Options agreed at Multi-organisational workshop in Hop farm
- Clinically led  Planning & Implementation Group

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# “A&E is closing”

A&Es continue to change

- Direct admissions into specialist units
- More care delivered by specialist nurses
- Integration of GPs into A&E from emergency care centre

- Admission avoidance with PCTs
- Bulk of ‘blue light’ emergencies e.g. medicine, remain with full ITU etc
- Some 55,000 attendances will continue to be treated at Maidstone emergency care centre

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# "Maidstone Hospital is being downgraded"

- £70m of investment in Maidstone over 3 years
- Specialist doctors in diabetes, heart and lung medicine
- Cardiac cath lab in 2007
- Acute Stroke unit under development
- Pathology development
- Major tertiary centre not simply a local hospital, providing cancer care for 1.7m
- Single Trust with 2 viable hospitals

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# “Proposals are not safe”

- ‘’Emergency medicine requires rapid access to high-quality surgical advice, but not necessarily on-site surgery’’. National Leadership Network – **this will be the case with onsite inpatient surgery and day case surgery**
- British Association for Emergency Medicine and the College of Emergency Medicine recommend that emergency departments of greater than 40,000 attendances must have immediate access to key supporting services such as general surgery – **this will be the case complex surgery is on site**
- IPPR research says by-passing local hospitals to get to the right hospital with right specialists will save 1000s of lives

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# “Too far to travel”

Ambulance Service view is clear:

- Benefits of receiving right treatment outweighs additional journey times
- Maidstone population has 3 hospitals within a reasonable travel time offering emergency services

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# Not listening in consultation to alternative proposals

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# Alternative proposal 1

Provide emergency surgery at both hospitals

Why this will not work:

- Does not ensure safe services without large investment
- Requires an additional 3 consultants at both hospitals
  - Clinically not feasible – fewer patients seen per doctor reduces critical mass and skills
  - Training will worsen as not enough exposure to surgery and too many to supervise
  - Financially not sustainable
- Continue to mix emergency and elective patients: Infection risk continues
- Undermines tertiary cancer work

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# Alternative proposal 2

Reverse the option – electives at K&S and emergencies at Maidstone

Why this will not work:

- Undermines specialist cancer services at Maidstone, these would probably have to cease
- Leaves a large population without access to alternative emergency surgery and orthopaedics
- Places very large pressure onto ambulance services and costs to mitigate this pressure
- No urgent care network to support K&S

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# "Not enough public involvement in the planning"

- Engagement goes back to Acute Services Review in 1999
- Planning & engagement has worked through:
  - 2004/05 - Shaping your local health services – creating specialist centres
  - 2005/06 - Better services for Women & Children
  - 2005/06 - Orthopaedic Centralisation
  - 2006/07 - A new direction for surgical & orthopaedic care

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# "This is financially driven and all about the PFI"

- These proposals are about clinical safety and improving health for patients
- £70m investment in Maidstone, with continued annual plans for next 10 years
- Maidstone A&E could have closed in 2004/05 with threatened withdrawal of recognition by Royal College
- MTW is made more cost effective by the full closure of Maidstone services – so we would close services/hospitals if finances were the driver
- The highly profitable work from K&S would transfer if the options were successful

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# "Does an emergency care network exist?"

- Local health economy works in a series of networks e.g..
  - Obstetrics, Special care baby units, cancer, vascular
- Urgent Care Network works in a similar way comprising of 4 Kent and Medway hospitals
- West Kent Emergency Planning Network is held as a beacon of excellence
- Networks do not require minuted meetings to exist

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# "Opposition from Maidstone BMA and M.A.S.H."

- What did the BMA say and who did they ask?
- Advice is contradiction of BMA chair who stated separation of elective and emergency care is the way forward
- Maidstone BMA support full A&E service for self referral & blue light ambulance cases with possible exceptions of major trauma and some overnight services :
- Maidstone ''opposers'' support:
    - Full 24/7 service for walk-in patients – GPs responsible out of hours
    - Accept blue lights 18 hours a day
    - Ambulance service would not bring trauma cases to Maidstone
    - Orthopaedics and trauma should be centralised in Tunbridge Wells

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# "So what is the clinical evidence"

- Vascular services centralised to improve patient care where clinical expertise is based (Vascular Society)
- Cardiac care, stroke, SCBU centralisation – all supported by international evidence (i.e. Paper by R Boyle)
- Emergency access including trauma centralisation – all supported by international evidence (i.e. Paper by G Alberti)
- Worldwide and U.K research demonstrate better outcomes for patients in specialist units

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# "How can safe emergency medicine be delivered?"

- Access for urgent surgical opinion through senior surgeons in clinic during the day and via Hospital at Night (as now)
- All key support services retained
  - Critical care (ITU)
  - Imaging
  - Pathology
  - Access to surgical opinion

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# “How does it fit with Fit For Future?”

- Consistent with ‘Fit for the Future’ planning assumptions e.g best care possible, modern standards
- FFF would need to consider these options if these were not currently being consulted on
- FFF is a financial model and focuses on cost reduction – consultation is a clinical model and offers safe services with least change

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# "Delay decision – what would happen?"

- Patients would be denied right of improved care and lower mortality rates
- Reassessment of clinical risk would have to be undertaken to ascertain how long services could be safely supported
- Risk mitigation options would have to be considered including possible closure of some services

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# Summary

- These proposals represent the least change required to ensure good clinical modern services
- These proposals decrease infection and complications for patients
- These proposals work with other acute hospitals
- These proposals provide safe emergency services at both sites, supporting the bulk of emergency care - acute medicine
- Support good training for doctors, and a response to the reduction in doctors
- Make best use of skilled staff e.g doctors and nurses
- These proposals offer a Trust with excellent specialist and general hospital care, from two quality hospitals meeting modern day standards
- These proposals improve our ability to save lives

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# Next steps

- Complete the consultation feedback
- Collate a full and balanced report
- Undertake decision by West Kent PCT Board
  - in public on 22nd February
- Confirm outcome with the public
- Implement any change – as decided

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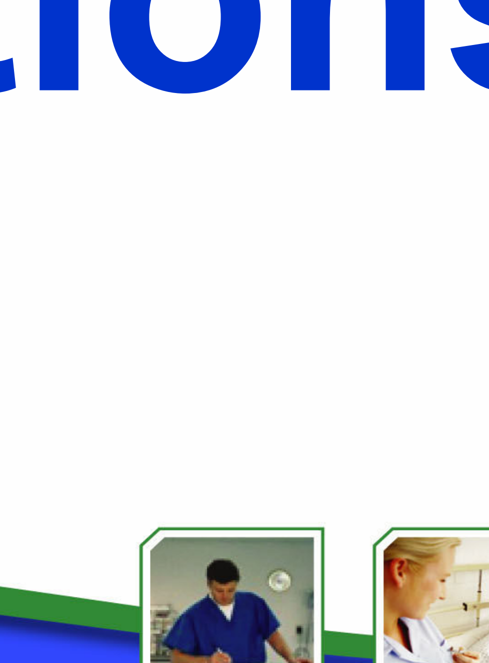

# Questions

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**Item 5**

By: Overview and Scrutiny Manager

To: NHS Overview and Scrutiny Committee – Friday 12 January 2007

Subject: Medway NHS Trust – Application for Foundation Trust status

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Summary: To seek delegated authority to the Overview and Scrutiny Manager to liaise with Medway NHS Trust

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(1) Medway NHS Trust are the only Trust in Kent and Medway currently seeking Foundation Trust status.

(2) The Trust are very keen to give a presentation to the NHS Overview and Scrutiny Committee on their Foundation Trust status bid. The Trust is on a truncated timetable with the consultation concluding on 2 February 2007.

(3) Recognising that residents in the Swale Borough Council area provides a third of all the Trust's patients. The Trust are keen to ensure that the County Council's NHS Overview and Scrutiny Committee are properly involved in a consultation.

(4) The agenda for today's meeting did not allow sufficient time for this presentation to take place. I am therefore seeking delegated authority in consultation with the Chairman, Vice Chairman and Liberal Democrat Spokesman of this Committee together with Members who represent an electoral division for Swale and Maidstone to convene a meeting at which the Trust can make its presentation to this Group. To meet the Trust's timetable this meeting needs to take place before the end of January. Suggested dates are:-

Monday 22 January, any time between 2 pm and 4 pm
Wednesday 24 January, 3 – 4 pm
Friday 26 January, any time between 2 pm and 5 pm
Monday 29 January, any time between noon and 4 pm

(5) The outcome of this discussion will be reported to the Committee's next meeting on 9 February 2007.

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Background Information: *Nil*

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