

NHS Overview and Scrutiny Committee

Select Committee Topic Review

***‘Modernising Hospital Services
in East Kent’***

VOLUMES 1 & 2

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Select Committee - Modernising Hospital Services in East Kent

Chapter	Page
1. INTRODUCTION	2
2. SELECT COMMITTEE TERMS OF REFERENCE	2
3. TOMORROW'S HEALTHCARE	3
4. KEY ISSUES	3
5. OVERVIEW OF PROPOSALS	4
6. REVIEW PROCESS	8
7. CASE FOR FURTHER CHANGE	8
8. POPULATION IN EAST Kent	12
9. ACCESSIBILITY AND TRANSPORT	14
10.ACCESSIBILITY OF EMERGENCY SERVICES	16
11.ACCIDENT AND EMERGENCY SERVICES	17
12.CANCER SERVICES	19
13.GENERAL MEDICINE	21
14.ELECTIVE SURGERY	22
15.WOMEN'S HEALTH SERVICES	23
16.BED CAPACITY	24
17.PRIVATE FINANCE INITIATIVE	27
18.PREFERRED OPTION	28
19.RECOMMENDATIONS	29
20.BACKGROUND DOCUMENTS	32
Appendix 1 – copy of the Secretary of State's letter of 1998	34
Appendix 2 – Summary of the review process	37

1. INTRODUCTION

The Health and Social Care Act 2001 makes statutory provision for local authorities with social services responsibilities to extend their scrutiny and overview functions to cover the National Health Service. The Department of Health are currently consulting upon the arrangements for NHS Overview and Scrutiny Committees and set out the following aims:

- First, to ensure that people's needs and wishes for health and health related services that meet the needs of all the population have been identified towards achieving local health improvements.
- Second, to scrutinise whether services provided that impact on health of local inhabitants are accessible to, and can be accessed by, all parts of the local community.
- And last, to scrutinise whether the outcomes of intervention are equally good for all groups and sections of the local population.

Kent County Council established a Pilot NHS Overview and Scrutiny Committee in 2001, in advance of the regulations being published and coming into force. District and Borough Councils in Kent have also chosen to establish Overview and Scrutiny Committees as such protocols for local authority scrutiny of the NHS in Kent have been developed and were agreed by the Kent Association of Local Authorities.

This is the report of the first Select Committee established by Kent County Council's NHS Overview and Scrutiny Committee, which was set up to consider the East Kent Health Authority's reconfiguration proposals 'Modernising Hospital Services in East Kent'.

2. SELECT COMMITTEE TERMS OF REFERENCE

The Select Committee is made up of seven Kent County Council Members, one District/Borough Council representative and one Community Health Council representative. The Terms of Reference proposed for this topic review are outlined below:

- (a) To prepare a strategic Kent County Council response to the East Kent Health Authority's consultation 'Modernising Hospital Services in East Kent' bearing in mind the County Council's statutory responsibilities for social care, transport and the social economic and environmental well-being of Kent;
- (b) To examine the Options proposed by the East Kent Hospitals NHS Trust and to consider them in the wider Kent context;
- (c) To take evidence from stakeholders including relevant voluntary and community groups;
- (d) To report its recommendations to Kent County Council's Cabinet and the County Council, and to the East Kent Hospitals NHS Trust and the East Kent Health Authority.

3. TOMORROW'S HEALTHCARE

In 1998 the East Kent Health Authority consulted upon the configuration of acute hospital services, the proposals in Tomorrow's Health Care were subsequently agreed by the Secretary of State. This decision confirmed that acute inpatient services would be transferred from Kent and Canterbury and focused at Ashford and Margate, however, the Secretary of State made a number of stipulations, which are outlined in his letter attached as Appendix 1. The Health Authority have clearly established that this decision will not be revisited and that only comments on the Options being consulted upon can be recorded.

Four proposals are being consulted upon, all of which focus acute services, to varying degrees, at Ashford and Margate. Only one of the Options being proposed (Option A) reflects what was agreed in 1998. The configuration of services is being consulted upon again due to the East Kent Health Authority's concerns that changes since 1998, such as the development of clinical governance and the NHS Plan, reduce the sustainability of the Option agreed in 1998. Similarly as the proposals will be funded by a Private Finance Initiative (PFI) it is necessary that all Options are re-appraised in order to comply with PFI requirements.

Hazel Blears, in the adjournment debate of the 30 October 2001, also clearly expressed the need to reconsider the configuration of services agreed in 1998.

"The chosen Option for reconfiguring acute services, which was endorsed by my right hon. Friend, was right at the time that it was taken. However, we are three years on and we have seen the introduction of a whole agenda for clinical governance. We must therefore reconsider whether that configuration would still be able to meet present day needs."

4. KEY ISSUES

The proposed reconfiguration centres on the three main hospitals in East Kent:-

- The Kent and Canterbury Hospital, Canterbury (K&C)
- The Queen Elizabeth The Queen Mother Hospital, Margate (QEQM)
- The William Harvey Hospital, Ashford (WHH)

Many feel passionately that three hospitals with full acute services must be retained in East Kent, yet others feel equally strongly that change is essential to improve the quality of hospital services. During the review the Select Committee has heard the views of a wide range of groups including health professionals and the public and the strength of public opinion has been evident throughout the process.

Those within the catchment population for the Kent and Canterbury Hospital have argued vociferously for a three hospital solution, widely known to be Option E. Similarly the public meetings arranged by the East Kent Hospitals NHS Trust have clearly illustrated that many of those within the catchments of The William Harvey and The Queen Elizabeth Queen Mother Hospitals are in support of change along the lines of the Options proposed. However, the views which have been expressed cannot be neatly divided on geographical lines and it is apparent that no consensus has emerged.

The key issues which have been identified during the review process of hearings, public meetings and the gathering of background information are detailed below. The full findings and evidence collated during the process are available upon request. These are also expanded upon in section 6 'The Case for Further Change'.

1. The closure of the Accident & Emergency Unit at the Kent and Canterbury.
2. The accessibility of emergency services.
3. The accessibility to services for patients and visitors, particularly the implications for the elderly and those reliant on public transport.
4. The future of Cancer Services in East Kent as part of the Kent Cancer Network.
5. The safety of providing a 'Low Risk' midwifery led maternity service.
6. The concern that specialist services will be polarised rather than centralised.
7. The dangers of spreading services too thinly.
8. The need to significantly improve services at all of the four hospitals in East Kent.
9. The need to significantly improve the fabric of all four hospitals in East Kent.
10. The long term viability of the Options proposed.
11. Whether the increased bed capacity will be sufficient to improve services.
12. The accuracy of East Kent Health Authority's interpretation of the Office for National Statistics population forecasts.
13. Canterbury is perceived to be the natural centre of East Kent, therefore a more appropriate site for the provision of full acute and specialist services.
14. That the perceived geographical remoteness of the Queen Elizabeth Queen Mother will affect its long term sustainability.
15. That the proposals will not support recruitment and retention to the three hospitals.
16. That the project is unaffordable and that the PFI will lead to staff and/or bed cuts as has happened elsewhere in the country.

5. OVERVIEW OF PROPOSALS

The East Kent Health Authority and East Kent Hospitals NHS Trust are consulting about the right mix of services to be provided at the Kent & Canterbury Hospital and the effect of those choices on services and patients across East Kent.

Under all of the Options all three main East Kent hospitals, The William Harvey in Ashford, The Queen Elizabeth Queen Mother in Margate and The Kent and Canterbury will remain. However, in line with the 1998 decision acute services including accident and emergency will be focused at Ashford and Margate. This will require some consultants to work at more than one hospital in the way that many already do now, but consultants will only be on-call at one hospital at a time which is not currently the case. The proposals will be funded via a Private Finance Initiative which will enable the hospitals to be developed and enlarged, overall the number of beds will increase by at least 175. The Buckland Hospital in Dover (BHD) and Arundel Unit for mental health patients at The William Harvey Hospital will also be developed under all of the Options.

The core services outlined below will all remain at The Kent and Canterbury hospital, and in addition to these services the four Options being proposed offer various combinations of medicine, elective surgery, medicine and elective surgery or none of these at The Kent and Canterbury Hospital. The core services to be provided at The Kent and Canterbury under all of the Options are:-

- 24 hour nurse-led minor injuries unit
- Day surgery
- Outpatient paediatrics
- Service for older people, community assessment and intermediate care
- Day care hospital
- Outpatient clinics
- Midwifery led- low risk maternity
- Cancer services (part of the Kent Cancer Network)

The additional services which would be provided under each of the Options proposed are outlined in the table below.

On the mix of the following services to be provided at Kent & Canterbury	Option A	Option B	Option C	Option D
Medical emergency admissions via GPs and a medical assessment unit.	Y	N	Y	N
Care of older people including acute rehabilitation.	Y	N	Y	N
Coronary Care Unit	Y	N	Y	N
Critical Care Unit	Y	Y	Y	N
Planned inpatient surgery - hip/knee replacement, urology and breast surgery	N	Y	Y	N
Beds at K&C	170	158	272	46
Beds at WHH	741	763	725	781
Beds at QEQM	784	774	698	868
Beds at Buckland	100	100	100	100
Totals	1795	1795	1795	1795

The table below clearly illustrates that the Options offer varying levels of accessibility but also that most patients currently receiving treatment at the Kent and Canterbury will be able to continue to access the majority of treatment there. This can be explained by the fact that so many treatments are now provided on an outpatient or day case basis. Essentially the proposals focus on centralising specialist acute

services, which generally require inpatient care and often very specific expertise and technology.

Number of Patients who will still attend Kent & Canterbury Hospital

Level of Change	A	B	C	D
% of current A&E attenders who will still be treated at K&C	65	58	65	58
% of current planned procedures and operations which would be done at K&C	52	52	67	31
Overall % of Canterbury patients who would still go to K&C for the services they get there now	87	85	89	83

Under each of the Options being proposed the precise spread of services differs, the details of the changes to services being proposed under each of the Options are summarised below.

General Medicine:- Full services are currently provided at the WHH, QEQM and K&C with day patient services offered at the BHD. Under Options B and D full services would only be provided at the QEQM and WHH with day patient services at K&C and BHD. Under Options A and C additional a GP emergency service, elective service and day service would also be provided at the K&C.

General Surgery:- Full services are currently provided at the WHH, QEQM and K&C and elective and day services offered at BHD. Under Options A and D full general surgical services would only be provided at the WHH and QEQM. Under Options B and C some low risk elective surgery would be centralised at the K&C for all East Kent residents. Some concerns have been expressed by physicians regarding medicine being provided without the on site support of surgery.

Renal Medicine:- Currently renal medicine is provided at the K&C for all East Kent residents under all of the Options this would move to the QEQM.

Vascular Surgery:- Currently this is provided at WHH, QEQM and the K&C under all of the Options this service would be centralised at the QEQM. It is widely regarded that vascular surgery requires a population of 600,000 in order to be viable, and also that renal medicine should be provided from the same location.

Dermatology:- Currently this is provided at the WHH and QEQM with day services at K&C and BHD. Under Options A, B and C this service would be centralised at the K&C with day services provided at the WHH, QEQM and BHD. Under Option D this service would be provided at the WHH and QEQM with day services.

Rheumatology:- Currently this is provided at WHH and QEQM with day services at K&C and BHD. Under each of the Options this service would be centralised at the K&C with day services provided at the WHH, QEQM and BHD. Under Option D this service would be provided at the WHH and QEQM with day services.

Urology:- Currently this service is provided at WHH, K&C and QEQM with day and elective services provided at the K&C. Under Options B and C this service would be provided at K&C with A&E urology services at the WHH and QEQM, under Options A

and D this service would be centralised at the QEQM with A&E services provided at the WHH.

ENT, Ophthalmology and Oral Surgery:- Currently this service is centralised at the WHH with day services offered at K&C and QEQM there will be no change to the configuration of this service under any of the Options.

Services for Older People:- Currently full services are provided at WHH, QEQM and K&C with day hospital and day services provided at BHD. Under Options B and D this service will only be provided at the WHH and QEQM with day hospital and day services provided at K&C and BHD. Under Options A and C some additional services will be provided at the K&C; GP emergency services and acute rehabilitation.

Trauma and Orthopaedics:- Full services are currently provided at WHH and QEQM, emergency, GP services and day services provided at the K&C and elective and day services at the BHD. Under Options A and D full services will only be provided at the WHH and QEQM with day services at the K&C and BHD. Under Options B and D elective services will also be provided.

Obstetrics and Gynaecology:- Full services are currently provided at WHH, K&C and QEQM and a day and low risk maternity service provided at BHD. Under all Options full services will only be provided at WHH and QEQM with day and low risk maternity services offered at K&C and BHD.

Paediatrics:- Currently full services are provided at WHH, QEQM and K&C with the Neonatal Intensive Care Unit centralised at K&C. Under all Options full services would be provided at WHH and QEQM with the Neonatal Intensive Care Unit centralised at WHH, and a day and ambulatory care service provided at K&C and BHD.

Accident & Emergency:- Full services are currently provided at the WHH, QEQM and K&C and a Minor Injury Service at BHD. Under all of the Options full Accident & Emergency services will be centralised at WHH and QEQM with Minor Injury Services being provided at the K&C and BHD.

Cancer Care:- Currently inpatient and day service chemotherapy and radiotherapy and chemotherapy for rare tumours are provided at the K&C, with inpatient and day service chemotherapy also being provided at the WHH and QEQM. Under all Options inpatient radiotherapy, inpatient and chemotherapy for rare tumours would all move from the K&C to Maidstone Hospital.

Cardiology:- Full services are currently provided at WHH, QEQM and K&C. Under Options B and D full services would only be provided at WHH and QEQM, Options A and C offer all cardiology services except emergencies.

Neurology:- Full services are currently provided at WHH, QEQM and K&C under all Options this service would be centralised at WHH.

Critical Care:- Intensive Care and High Dependency units are currently provided at WHH and QEQM and Intensive Care at K&C. Under Options A, B and C the

Intensive Care Unit at K&C would be replaced by a High Dependency Unit, but under Option D no critical care facilities would be provided at the K&C.

It is important to note that some of the specialisms as laid out in the East Kent Health Authority's consultation document may be subject to change. As national frameworks for services continue to develop and regional and Kent wide reviews of services take place further change to the location of some of the major specialisms such as renal medicine may occur.

The centralisation of specialisms across East Kent would focus on inpatient care such as major surgery, with the majority of care continuing to be delivered locally on an outpatient basis. However, it is clear that the accessibility of some specialist inpatient services will be significantly reduced for residents in East Kent.

6. REVIEW PROCESS

The review has been designed to be as inclusive as possible and has involved a range of key organisations and individuals from across the whole health economy, including the East Kent Health Authority, East Kent NHS Trust, East Kent Community Trust, Primary Care Groups/Trusts, Kent Ambulance Trust, Community Health Councils, Social Services, the Local Medical Committee, local GPs and consultants. The reconfiguration only focuses on acute services, however, the interdependencies between the various aspects of health care from prevention to treatment ensure that any alteration to services must be considered in the wider context of healthcare.

The review process has involved six hearings where information and views have been sought from a range of bodies, such as health partners, pressure groups, the public and Kent County Council officers from Social Services and Strategic Planning. Written evidence has also been submitted to the Select Committee by members of the public, Community Health Councils, Members of Parliament, Members of the County Council, District/Borough Councils, voluntary organisations, consultants, GPs and professional bodies such as the Royal Colleges. In addition members of the Select Committee attended all of the public consultation meetings arranged by the East Kent Health Authority, in order to hear the views of the public of East Kent. Details of the hearings and correspondence are attached as Appendix 2.

7. CASE FOR FURTHER CHANGE

The East Kent Health Authority's proposals to modernise acute hospital services in East Kent are aimed at improving patient care and the quality of these critical services.

Over recent years dramatic changes have taken place in medicine and surgery, one of the most notable trends is the increase in the levels of day surgery. Many patients undergoing operations to treat hernias or remove cataracts will go home on the same day, and the stay in hospital for patients undergoing keyhole gall bladder surgery has been reduced from five to seven days to within 48 hours. Consequently many procedures which were once regarded as complex are now fairly routine and can be delivered locally. However, significant medical advancements have led to the

development of more specialist treatments, which need to be centralised around the right experts and technology. As new, more effective treatments rapidly emerge and become increasingly complex practitioners, in order to offer the best possible care, must work in an environment where their skills, knowledge and capacity to master new treatments is fully supported.

The Health Authority state four main reasons to explain the need for the change, these are:-

Sub-specialisation:- As medicine and surgery become more sophisticated and change with such rapidity it has become increasingly important for practitioners in all disciplines to develop expertise in a relatively confined area of medical practice. This is in order that individual practitioners can see enough patients in their speciality to keep their skills up to date and offer patients the highest quality of care available.

The Joint Consultants Committee indicated that the “ideal” catchment population for most specialities is between 450,000 - 500,000 as this enables practitioners to treat a wide enough range of conditions to remain expert. Most professional bodies are in broad consensus with this estimate although it is recognised that the population base can be lower or conversely must be higher for some specialities. For instance, vascular surgery requires a population of 600,000, surgery between 450,000 - 500,000, and as physicians training is more general and there is a higher incidence of the diseases they treat the threshold can be lower.

The arguments for sub-specialisation are based on research evidence which suggests that some patients have better health outcomes if they are treated by doctors who are ‘experts’ in their particular specialism. The Royal College of Surgeons emphasised the importance of sub-specialisation in their document ‘The Surgical Workforce in the NHS’,

“The increased trend towards specialisation within all branches of surgery has developed expertise and improved outcomes.”

Similarly the Vascular Surgical Society of Great Britain & Ireland stated in ‘The Provision of Vascular Services’ stated that,

“There is evidence that patients are better cared for by a specialist vascular team than by those without a specialist interest. Specialist vascular surgeons achieve superior clinical outcomes in general and specifically in the management of aortic aneurysm, limb ischaemia and carotid artery disease.”

Specialist Teams:- The benefits of specialist teams is that expertise can be shared, skills enhanced, best practice identified and implemented and duplication of effort minimised all of which result in better patient care. The development of specialist teams also ensures specialist medical cover can be provided 24 hours a day, 7 days a week. Therefore ensuring a more equitable and consistent service can be delivered, where it is the norm to be treated by the appropriate expert. The National Confidential Enquiry into Peri-Operative Deaths (NCEPOD) has analysed the causes of avoidable post operative deaths for over ten years and emphasises the need for greater involvement of multidisciplinary teams to improve patient care. NCEPOD data from 1994/5 suggests that one third of patients admitted as vascular emergencies are currently treated by surgeons with no vascular interest, clearly this

fails to ensure that patients can be treated by the experts who will offer them the best health outcomes.

'Clinical Governance: Quality in the new NHS' highlighted the need for both multi-disciplinary and multi-agency working in order to improve services. This view is also being asserted by professional organisations such as the Royal College of Surgeons, who stated in 'The Surgical Workforce in the NHS' that;

"The evolution and culture of team working in surgery is essential for the future. The days of the isolated surgeon as regards attitude, behaviour or indeed in single-handed practice must end."

Currently the East Kent Hospitals NHS Trust operates a number of specialist teams within rheumatology, dermatology, cardiology, gastro-enterology, urology and breast surgery, however, as these teams are spread across three sites they are not large enough to provide cover 24 hours, 7 days a week. Under the proposals larger specialist teams could be developed across the key specialities to ensure full cover. Such specialist teams would normally include a range of medical practitioners; consultants, junior doctors, nurse practitioners and nurses to ensure the most sophisticated and effective care can be provided. Furthermore specialist teams are linked to other clinical adjacencies or include members of others specialisms in their teams, for instance, the effective treatment of vascular conditions includes skilled interventional radiologists.

Staff Shortages:- National shortages in healthcare professionals such as doctors, nurses, therapists and scientists are placing added pressures on acute hospitals. This is further exacerbated by the fact that in order to comply with the New Deal and Working Hours Directive, the Trust will need to increase its number of staff. Staff shortages exist at all levels in East Kent and it is argued that centralisation of services will enable staff to be managed more effectively and to form specialist teams. The East Kent Hospitals NHS Trust have confirmed that none of the proposals will lead to staff redundancies. It has also been suggested by the Trust that the opportunities to develop or take forward high quality specialist services will act as a significant incentive in recruiting staff.

In December 2001 vacancy levels at the Trust according to post were 9.6% for nurses, 0% for Junior Doctors and 3.9% for consultants. Although these staff shortages are a national problem it is widely regarded that the instability since the 1998 consultation 'Tomorrow's Healthcare' has exacerbated recruitment problems. It is clear that the future of East Kent Hospitals must be decided and stability restored to ensure that service improvements can be developed and maintained.

It was also suggested to the Select Committee that The Queen Elizabeth Queen Mother Hospital in Margate faced particular recruitment difficulties. However, there is no evidence to suggest that this is the case. The table on the next page clearly demonstrates that vacancy levels are not site specific and vary according to speciality. The information provided in the table should be used as a guide only, as it is calculated by comparing Funded Establishment Figures and Staff in Post data which are not in a compatible form.

Staff Vacancies by Hospital and Directorate

Directorate	Vacancies		
	KC	QEQM	WHH
A&E	25% (7wte)	15% (5wte)	13% (4wte)
Anaesthetics	20% (24wte)	8% (10wte)	17% (28wte)
Gen. Medicine	16% (23wte)	18% (25wte)	11% (18wte)
Gen. Surgery	11% (4wte)	14% (7wte)	22% (8wte)
Healthy Care of Older People	13% (12wte)	20% (11wte)	25% (8wte)
Women's Health	21% (17wte)	15% (12wte)	19% (14wte)
Trauma & Orthopaedics	18% (5wte)	21% (10wte)	27% (14wte)
Critical Care	18% (7wte)	6% (2wte)	20% (10wte)
Theatres	37% (21wte)	13% (6wte)	22% (14wte)
Pathology	10% (6wte)	24% (7wte)	-
Radiology	13% (11wte)	31% (12wte)	15% (6wte)
Therapies	-	18% (11wte)	15% (11wte)
Outpatients	2wte	3wte	-

- *Some vacancies in Health Care of Older People also exist at Bucklands (17%) and the Royal Victoria (22%), Bucklands also has 30% vacancies in Theatre.*

It has been argued that increases in junior doctors and nurses being pursued by the government will alleviate the existing staff shortages but this will take time to achieve. Furthermore the high levels of medical staff reaching retirement age will mean that national increases in the number of doctors and nurses may not have the fullest possible impact in East Kent. Alternative ways of resolving recruitment problems must be explored by the Trust, for instance, in some areas such as elective surgery more innovative methods of providing medical cover could be adopted. Such as through links with private hospitals, the use of staff grade doctors, nurse practitioners and GP specialists.

A significant increase in the number of staff would not in itself remove the need for change. As although larger teams could be established to provide more appropriate cover across three sites, none of the individual practitioners would see enough cases to maintain their skills and expertise to a 'specialist' level.

Junior Doctors:- The Postgraduate Deanery is responsible for the commissioning and quality of medical education, whilst the content and standards are set by the relevant Royal Colleges and General Medical Council. Currently the East Kent Hospitals NHS Trust is accredited to deliver junior doctor training and no serious threats are being made to withdraw junior doctors from East Kent's Hospitals.

However, increasingly junior doctor requirements emphasise the importance of sub-specialisation and team working. The Trust must also comply with the 'New Deal' regulations for junior doctors and the European Working Time Directive, which will reduce junior doctor working hours to 56 hours a week by 2003 and to 48 hours a week by 2009 respectively. Consequently junior doctors will need to see a wider range of cases in a shorter period of time. The British Medical Association (BMA) lobbied vociferously for this reduction in hours and improved training for junior doctors.

In March 2001 the East Kent Hospitals NHS Trust return indicated that only 43% of its junior doctor posts were New Deal compliant. The Trust have estimated that under the current service structure complying with both the New Deal and Working Time Directive would require an additional 108 specialist registrars, 320 Senior House Officers/House Officers and 53 staff grades.

In a letter to the Select Committee the Deanery explained that,

“Our general principle is that the service arrangements should be optimised for the benefit of patients and public, and systems of education should respond and adapt to those as best as can be engineered. An effect of planning issues which is often underestimated is that of reducing hours of work of junior doctors to civilised levels..... The implications of this are that most acute services will have to be maintained by junior doctors working in shift arrangements, and will in effect reduce the available workforce that provide 24 hour cover, 7 days a week. These considerations are obviously highly relevant in dealing with the problem of maintaining full acute services in several sites.”

The drivers for change are similar to those expressed in 1998. Since that time local and national changes have led to a need to re-evaluate the proposals agreed in 1998. The trend towards sub-specialisation and team working clearly illustrates how health outcomes of patients can be improved. However, although staff shortages, reductions in working hours and changes to junior doctor training must be recognised as significant local and national problems, they should not in themselves drive service reconfigurations. Hospital services must be organised on the basis of delivering quality services to meet the needs of patients.

RECOMMENDATIONS

- Patient needs and service improvements are the only appropriate drivers for change, and must be pursued within a context of scarce resources.
- The future of East Kent hospitals must be decided, stability restored and recruitment efforts stepped up.
- Innovative use of Staff Grade Doctors, Nurse Practitioners, GP Specialists and Junior Doctors should be explored.

8. POPULATION IN EAST KENT

Kent County Council have estimated the population of the East Kent Health Authority area in 2000 using official Mid Year Estimates for Districts apportioned to ward level, this gives 618,400 people in 2000, which is slightly higher than East Kent Health Authority's figures of 614,576. This slight variation can be explained by the different methodologies used to work out population estimates.

Kent County Council and Medway Council are about to consult the public on Options for the scale and distribution of housing development throughout Kent as part of the Kent and Medway Structure Plan Review.

A report to Kent County Council’s Cabinet in December 2001 includes three Options. These options are outlined on below:-

- Option 1: 5,000 dwellings per annum in Kent as a whole 2001-16
- Option 2: 5,700 dwellings per annum in Kent as a whole 2001-16
- Option 3: 4,300 dwellings per annum in Kent as a whole 2001-16

Option 1 provides the mid range and on the basis of this and assuming the dwelling rate is carried forward to 2021, the result would be a growth rate of 2.92% leading to a forecast population in East Kent of 636,700 by 2011 increasing to 648,500 by 2021. This is a rate of change similar to that produced by York University for the East Kent Health Authority.

However, the above estimates do not include the full impact of possible long term development at Ashford which is being considered in a joint KCC-Ashford study as required by Regional Planning Guidance for the South East Region (RPG9) of 2001. No decision has been made on major growth at Ashford and will not be made until the results of the current study are known and there is a review of Regional Planning Guidance. Such growth could create additional demands for health services at Ashford but might be offset by lower growth than that in Option 1 in other Districts.

RECOMMENDATION

- To ensure that the health needs resulting from any additional population increases can be met the acute bed capacity must be kept under constant review.

The explanation of populations serving individual hospitals in the consultation document ‘Modernising Hospital Services in East Kent’ provides a confusing view of the number of people accessing each of the hospitals. Hospital catchment populations can only provide a crude indication of the population size served by hospitals. As patient choice means individuals will not always attend the hospital which is physically nearest but for instance the one which they perceive to offer the best care or is the easiest to reach by public transport. The table below indicates that the various populations served by each of the hospitals are fairly equally divided, especially when it is taken into account that those in the locality of the Buckland Hospital in Dover must access acute services at the other three acute hospital sites.

Estimated Catchment Populations for Hospitals in East Kent

Hospital	2000	2000	2011	2011	2021	2021
	all ages	over 65	all ages	over 65	all ages	over 65
QEQM	135,382	29,580	137,093	27,052	138,417	30,540
BHD	102,503	19,024	102,519	19,999	102,020	23,730
KC	174,449	32,895	175,674	36,355	174,107	44,239
WHH	206,310	36,041	221,434	39,031	233,941	47,666
Total	618,644	97,788	636,720	102,505	648,485	122,816

- *These populations are calculated by Kent County Council on the basis of boundaries provided by the East Kent Hospitals Trust.*

Thanet is Kent County Council’s most deprived District and is the 60th most deprived Local Authority District in England. Pockets of deprivation exist throughout East Kent and 35 of the most deprived wards in the Kent County Council area are located in

East Kent (Thanet, Shepway, Dover, Canterbury and Ashford, in decreasing order of prevalence). The link between deprivation and poor health is widely recognised and consequently it is important that health services are organised in such a way that reflect the needs of the most deprived populations. It has been suggested on the basis of mortality and morbidity ratios that this link cannot be demonstrated in Thanet. However, the link between health and deprivation is based on a wider range of factors such as the incidence of heart disease. The table below clearly illustrates the prevalence of health deprivation in Thanet and Shepway.

Health Deprivation and Disability Domain - Ten most deprived wards, DETR

Ward	District	IMD 2000 Score	National Rank	KCC Rank
Pier	Thanet	1.9	168	1
St. Mary in the Marsh	Shepway	1.43	535	2
Folkestone Central	Shepway	1.37	617	3
Ethelbert	Thanet	1.32	677	4
Shepway West	Maidstone	1.28	743	5
Cliftonville	Thanet	1.22	820	6
Sheerness West	Swale	1.18	877	7
Westgate-On-Sea	Thanet	1.14	953	8
Castle	Dover	1.12	984	9
Joyce Green	Dartford	1.07	1083	10

9. ACCESSIBILITY AND TRANSPORT

The Select Committee unanimously support the concept of ‘local services for local people’ but recognise that accessibility and the quality of care need to be carefully balanced in order to ensure patient safety.

It is indisputable that the current service model offers the best access to hospital services. However, it must also be emphasised that under all of the Options the majority of residents within the catchment area of The Kent and Canterbury hospital will continue to be treated there, this has been estimated at between 83% and 89%.

There is only the very slightest difference in terms of accessibility between a combination of Ashford and Margate or Canterbury and Ashford. The detailed analysis conducted by the East Kent Hospitals NHS Trust illustrates that in non-flowing traffic the Option of Ashford and Margate would advantage approximately 8% more of the population. The Department of Geography of Canterbury Christ Church College confirmed the slight advantage of this Option but stressed that a two hospital system would lead to a significant reduction in accessibility. Other factors which were taken into consideration in 1998 and are still relevant today in agreeing the Ashford and Margate combination, are the rate of population growth in Ashford and the high levels of deprivation in Thanet.

However, it is apparent that the rural nature of much of East Kent combined with the current transport infrastructure will ensure that hospital services cannot easily be accessed from all points within East Kent. An issue which will be important for all residents of East Kent. If the proposed changes are implemented all East Kent residents could, for instance, be required to travel to Canterbury for specialist

dermatology services, Margate for renal medicine and Ashford for neurology. Although this would only effect the minority of patients, those being treated on an inpatients basis in some specialities, the reduction in accessibility for these patients would be significant. The absence of reasonable public transport links across some parts of East Kent (for instance New Romney to Margate), would make improvements to the transport arrangements to hospitals for patients and visitors essential.

The East Kent Hospitals NHS Trust have established a Health Partnership Transport Board, which brings together representatives from the Health Authority, East Kent Hospitals NHS Trust, Kent Ambulance Service, Kent County Council, District/Borough Councils, voluntary services, Stagecoach and the Government Office of the South East. This inclusive approach is enabling hospitals to become more accessible. A Patient Transport Service (PTS) is established and between August and October 2001 transported 29,114 patients, in exceptional circumstances this service is extended to visitors. A voluntary car scheme operates across all three hospitals and complements the work of the PTS, between August and October 2001 19,409 patients were transported under this scheme. Two 'Health Hopper' buses are now in place which provide sustainable transport between each of the hospitals. Kent County Council has also recently supported a 'Dial-a-Ride' in Deal and services such as these help to ensure public transport is available to those in less accessible areas. In addition work is being undertaken to develop a comprehensive bus timetable which more clearly supports public access to East Kent hospitals.

Significant improvements are still required to ensure that patients and equally importantly their visitors can, both in terms of time and cost, have reasonable access to hospital services. The principle that individuals will travel further to access specialist services to ensure the best health outcomes, is only practicable where patients and their visitors can reasonably access those services. Currently unless you are a car owner the hospitals in East Kent are not equally accessible to all, and further travel distances to hospital services would in particular disadvantage a number of groups such as the elderly, disabled, single parents and those on lower incomes.

RECOMMENDATIONS

- Local services must be provided for local people, where ever they can be provided safely and to a high quality. Hospital services must only be centralised when it is clear that this will improve the quality of health outcomes.
- The transport arrangements for patients and visitors must be developed and implemented, within the framework of the Health Partnership Transport Board, to meet the additional transport needs of the final Option selected.
- The County Council should continue to support the East Kent Hospitals NHS Trust in developing the public transport infrastructure in East Kent, through its involvement in the Health Partnership Transport Board.
- Moving people to hospital in a sustainable way should be a high priority of Kent County Council and be embodied in the Local Transport Plan.

- The East Kent Hospitals Trust in developing hospital services must ensure that the access to hospital sites and parking is improved.

10. ACCESSIBILITY OF EMERGENCY SERVICES

A number of serious concerns have been repeatedly expressed to the Select Committee that the longer journey times to acute hospitals will effect patients chances of survival. It has been similarly suggested that an acute accident and emergency service will not be accessible from all parts of East Kent within 30 minutes.

The role of the ambulance service has changed dramatically over recent years. Paramedics now have a significantly wider role in providing pre-hospital treatment and can administer basic life support including cardiac monitoring and defibrillation. The role of paramedics will continue to grow, for instance the NHS Plan sets out a clear agenda to ensure paramedics are trained to administer 'clot busting' thrombolytic drugs. The early delivery of this treatment can significantly improve the survival rates of heart attack victims. Telemedicine links between ambulances and Accident and Emergency departments are also being developed.

New satellite tracking systems ensure that the closest available ambulance can be quickly identified and dispatched to ensure the fastest possible response times. In addition a range of services are provided to ensure patients can be quickly reached and treated, such as double crewed ambulances with paramedic facilities and single responders. Plans are also being investigated to extend the 'Community Responders' scheme, whereby volunteers are trained by Kent Ambulance Service and complement the work of paramedics particularly in rural areas. Similarly initiatives such as 'Heart Start' are leading to the installation of defibrillation equipment at strategic local points, to ensure that in the future treatment can be administered even more rapidly. National targets to respond to 75% of life threatening calls within 8 minutes and 95% of other emergency calls within 19 minutes are close to being achieved in East Kent, with the year to December 2001 standing at 71.1% and 95.9% respectively. The NHS Plan requires that these standards are met by the end of 2002.

It is widely recognised that there is a 'golden hour' in which emergency patients should be treated. It is from this concept that the 30 minute blue light travel time has been arrived at. The East Kent Hospitals NHS Trust have argued that provided patients can be reached within 8 minutes, stabilised and treated in hospital within one hour, that their health outcomes should not be adversely affected by the longer journey times created by the Options being proposed. However, it is clear that journey time is important in ensuring positive health outcomes and there is a clear consensus that in a very small minority of cases that the length of journey time will be a significant factor. However, both the quality of pre-hospital and hospital care are critical in ensuring patients have the best possible health outcomes. Consequently it would be inappropriate to look at this issue purely from the basis of the impact of extended journey times.

The Kent Ambulance Service have worked with a firm of consultants to establish that from all parts of East Kent an Accident and Emergency department can be reached within 30 minutes. It is important to note that this includes Accident and Emergency Departments at Ashford, Margate, Maidstone and in Medway. However, in order to

continue to deliver this service within national response targets, additional resources will be necessary. The Ambulance Trust has estimated that Options A and C will require an additional £470,000 per year recurring and that Options B and D will need £550,000 per year recurring. The East Kent Health Authority has promised that this funding will be made available and that this will be a commitment that the Primary Care Trusts are duty bound to honour once they assume their commissioning role.

RECOMMENDATIONS

- The provision of safe emergency care under the proposals will be dependent on the expansion of the Kent Ambulance Service. It is critical that this expansion is adequately funded, monitored and developments clearly communicated to the public.
- The training of paramedics in the use of thrombolytic drugs must take place before any of the Options are implemented. In addition, telemedicine links with Accident and Emergency departments must be installed in all emergency ambulances.

11. ACCIDENT AND EMERGENCY SERVICES

It is clear that Accident and Emergency services must be improved. It is regrettable that this is to be achieved through the closure of any Accident and Emergency departments in East Kent. If as a result of changes in local or national circumstances it becomes feasible to retain any additional services at the Kent and Canterbury, without impacting on the quality of services at all three sites, then this must be pursued. The importance of local accessibility to services cannot be over-estimated.

The Secretary of State in 1998 agreed that full acute Accident and Emergency services would be centralised on two hospital sites at Ashford and Margate, with 70% (reduced to between 58% and 65% in the proposed Options) of current emergency patients continuing to be treated at the Kent and Canterbury.

There has been enormous opposition to the proposal to close the full accident and emergency unit, particularly but not exclusively in the area served by the Kent and Canterbury Hospital. However, there is no clear consensus on this matter and some East Kent residents and medical practitioners are convinced that change is necessary in order to improve the quality of hospital services. There has been an absolute consensus that conditions in Accident and Emergency are unacceptable and must be improved, the contention revolves around how this should be done. The President of the Royal College of Physicians offered his view of the situation to the Select Committee:

“It does not seem feasible or reasonable to attempt to maintain full acute and other services on all three sites. This should not be interpreted as downgrading services on any of the sites. The proposal to place full 24-hour services for acute medical and surgical emergencies at Ashford and Margate seems reasonable. It is essential that a nurse/GP-led service for emergencies be established at Kent and Canterbury. This could deal with approximately 60% of cases.”

The problems facing Accident and Emergency in East Kent are national ones. Over the last 10 years the number of emergency admissions to hospitals has increased by 20% and the trend towards sub-specialisation, advancements in technology, staff shortages and reductions in working hours are making it increasingly difficult to deliver high quality services on traditional patterns.

The Minor Injuries Unit will continue to provide many of the services which are currently provided by the Accident and Emergency department at The Kent and Canterbury Hospital, and will be available 24 hours a day, 7 days a week. It is estimated that, depending on the Option chosen, between 58% and 65% of current Accident and Emergency patients will continue to be treated at the Kent and Canterbury Hospital. The title 'Minor Injuries Unit' in many ways disguises the full extent of services offered by these facilities. Minor Injury Units can stitch cuts, treat burns and scalds, remove sharp things from under the skin and objects from ears, throats and noses, treat bites, abscesses, strains and sprains, set simple fractures and deal with conditions such as asthma, hypoglycaemia and some head injuries. The unit will be nurse led but managed by a consultant and will be staffed with both nurses and nurse practitioners. Tele-medicine link ups with the acute Accident and Emergency departments will ensure consultant advice can be easily accessed when necessary and Options A, B and C will provide varying levels of access to on-site consultant support.

Accident and Emergency departments act as a gateway to a hospital for emergency inpatient admissions but the safe and effective provision of emergency treatment is wholly dependent on the specialist services behind the department. Such as general medicine, general surgery, services for older people, trauma and orthopaedics, obstetrics and gynaecology, paediatrics, cardiology, critical care, pathology, diagnostics and a pharmacy. Consequently the performance of Accident and Emergency is intrinsically linked to the performance of other parts of the hospital. The inability to provide specialist cover 24 hours a day, 7 days a week ensures that acute emergency patients do not have consistent access to the practitioners who can treat them most effectively. Also the failure to provide 24 hour diagnostic or pharmaceutical services and a shortage of beds in both the acute hospital and wider private and voluntary nursing care sectors, culminate to ensure that currently Accident and Emergency departments cannot offer the best possible care to patients. In addition the British Association for Accident and Emergency Medicine (BAEM) and Faculty of Accident and Emergency Medicine (FAEM) recommend in 'Workforce Planning in Accident and Emergency Medicine 2001 - 2011' significant increases in the 'shop floor' consultant presence in Accident and Emergency departments to improve the quality of care patients receive. In a climate where medical staff are difficult to recruit, working hours are being reduced and services must serve larger populations in order to meet the needs of sub-specialisation it is becoming increasingly difficult for small Accident and Emergency departments to provide the standards of care patients are entitled to.

Patterns of emergency health care are changing across the country. Developments such as NHS Direct, improved access to GPs, Minor Injury Units, Primary Care Emergency Centres together with the greater utilisation of nurse practitioners and paramedics are leading to a step change in emergency care. Increasingly this means that patients with minor injuries or illnesses can be treated more quickly, locally and as effectively outside of an acute hospital setting. The current consultation has only looked in detail at acute services but emergency care must

begin to be planned in a wider context, in partnership with the primary sector, Kent Ambulance Services, Social Services and voluntary and private organisations. Furthermore greater emphasis must be placed on prevention and models of care need to be designed around a holistic approach which recognises the importance of both prevention and treatment.

RECOMMENDATIONS

- The current conditions in Accident and Emergency are unacceptable and must be addressed immediately. Investment must be made in the interim as improvements cannot wait until the implementation of the Private Finance Initiative.
- Emergency care should be planned for in the wider context in partnership with Primary Care, Kent Ambulance Services, Social Services, private and voluntary organisations. To ensure the appropriate types of care can be provided as efficiently and locally as possible.
- That greater emphasis is placed on prevention and the role of Primary Care and Social Services in intervening to prevent avoidable hospital admissions.

12. CANCER SERVICES

The Kent Cancer Network is managed by the Maidstone and Tunbridge Wells Hospital Trust. Maidstone Hospital and the Kent and Canterbury Hospital jointly form the Kent Oncology Centre, which is essentially a non-surgical cancer centre serving Kent. The centre was developed following a detailed review of cancer services in Kent by Dr. Jill Bullimore.

The Secretary of State in his letter of March 1999 clarified that,

“the decision I announced in December on service changes in East Kent was final. The retention of specialist cancer services at Kent and Canterbury Hospitals was part of the decision. Specialist cancer services at Canterbury, therefore, have a firm future.”

The current organisation of cancer services in East Kent is highlighted in the table below and under all of the proposals inpatient chemotherapy and radiotherapy and chemotherapy for rare tumours will be withdrawn from the Kent and Canterbury and centralised at Maidstone. The proposals for cancer care are being driven by the National Cancer Plan, which emphasises the need to improve cancer treatment in Britain and bring it in line with the more successful outcomes on the continent and in North America. In addition the national shortage of oncologists is making it extremely difficult to maintain services.

Current Organisation of Cancer Services across East Kent

Cancer Care Services	WHH	BHD	K&C	QEQM
Inpatient Chemotherapy	Yes	No	Yes	Yes
Day service Chemotherapy	Yes	No	Yes	Yes
Chemotherapy for Rare Tumours	No	No	Yes	No
Outpatient Radiotherapy	No	No	Yes	No
Inpatient Radiotherapy	No	No	Yes	No
Cancer Surgery	Yes	No	Yes	Yes

The East Kent Hospitals NHS Trust and Kent Cancer Network have repeatedly confirmed that cancer services will remain at The Kent and Canterbury under all of the Options. Public concern revolves around the extent of services which will be provided at The Kent and Canterbury and their long term viability if acute services are removed. It is clear that the four Options differ in their ability to offer comprehensive cancer services at the Kent and Canterbury site, it is clearly stated in the consultation document that Options A and C will provide the critical support services to ensure the provision of more comprehensive oncology services. This view was confirmed by the Royal College of Radiologists in their letter to the Select Committee,

“Although critical care would be available under Option B, the appropriate staffing cover for cancer emergencies would be extremely difficult to provide without Medicine being present. Options B and D would downgrade Kent and Canterbury to being a cancer unit with a radiotherapy facility that would have to be run as an ‘outpost’ of Maidstone.”

It is estimated that the centralisation of inpatient services at Maidstone will only affect about 20% of East Kent cancer patients, the remaining 80% of patients would continue to be treated as day attenders at the Kent and Canterbury. The East Kent Hospitals NHS Trust argue that the investment in cancer services at The Kent and Canterbury, such as the installation of a new £1 million linear accelerator for radiotherapy treatment, demonstrates the commitment to cancer care at this site.

Currently patients travel to London and beyond to access specialist care for some rare cancers and it is clear that on some occasions this is absolutely necessary if patients are to have the best chances of survival. However, it is equally apparent that very sick patients being treated for cancer benefit from being able to access services as locally as possible, provided that the optimum care is available.

Although the commitment of the East Kent Hospitals NHS Trust to retain cancer services at The Kent and Canterbury is clear, it is less apparent what level of services could be retained in the medium to long term. The situation is made yet more uncertain as a result of the recruitment difficulties in this speciality. The East Kent Hospitals NHS Trust are committed to continuing an open dialogue with oncologists to develop innovative ways in securing cancer services at The Kent and Canterbury, such as brokering a partnership with the Chaucer Hospital to ensure that some inpatient care for cancer patients could be provided.

RECOMMENDATIONS

- The retention of full cancer services at the Kent and Canterbury is strongly advocated. Hospital services must only be centralised when it is clear that this will improve the quality of health outcomes, as set out in the National Cancer Plan.
- The future of cancer services in Kent must be driven by patients needs and not as a consequence of change to acute services in East Kent.
- The Kent Cancer Network and East Kent Hospitals Trust must continue to explore ways, such as partnership arrangements with the Chaucer Hospital, to ensure that comprehensive cancer services can be retained at the Kent and Canterbury Hospital.

13. GENERAL MEDICINE

The General Medicine which would be provided at the Kent and Canterbury under Options A and C includes the following services;

- Medical Emergency Admissions via GPs and a medical assessment unit.
- Care of older people including acute rehabilitation.
- Coronary Care Unit.
- Critical Care Unit.

Essentially it is the provision of these services at The Kent and Canterbury which formed the option agreed by the Secretary of State in 1998. The reason for this second consultation is in part due to the East Kent Hospitals NHS Trust's concerns about providing general medicine in the absence of 24 hour surgical cover on a site which accepts medical emergencies, and the sustainability of providing general medicine on three sites.

The services provided within general medicine are dependent on each other. For instance, medical emergency admissions cannot be accepted unless a coronary care and critical care unit is available, and similarly acute rehabilitation of the elderly can only be provided on a site where medical emergency cases are admitted. The Trust have clearly stated that they believe all Options are workable, however, have expressed some serious concerns about the long term sustainability of general medicine being provided on three sites. This is in part due to the need to sub-specialise although it is recognised that within general medicine the more regular incidence of cases ensures that practitioners can serve smaller populations than in other specialities. However, staff shortages which will be exacerbated by the reduction in doctor's working hours resulting from the European Working Time Directive, mean that it is becoming increasingly difficult to deliver medicine on three sites. Professor Alberti, President of the Royal College of Physicians, summed up many of the key issues in his letter to the Select Committee;

"I personally would place more emphasis on the need for high-quality services which require a critical mass of appropriate specialists. In medicine we can adapt the training needs somewhat but you cannot make up for the deficiencies in cover that

ensue from having too few consultants in specialities. Ideally for all the major specialities East Kent needs five consultants for it to provide both 24-hour cover, development of sub-specialities, and the ability to provide outreach programmes.”

Women’s Health is an example within South East Kent of how services have been successfully restructured. Full Obstetrics and Gynaecology Services were rationalised from two to one unit several years ago, a full service is now provided at the William Harvey and a Midwifery Led Maternity Centre at the Buckland Hospital Dover. The new structure offers a genuine choice to women about how they want to give birth, has enabled a emergency clinic to be established and consultant outreach ante-natal clinics to be developed across the locality, making services more locally accessible and increasing attendance rates.

The provision of local services is of great importance particularly in treating the elderly. The elderly in East Kent make up 19% of the local population which is considerably higher than the national average of 15.5%, in the Canterbury area where the access to services is likely to have the greatest impact there is a significant elderly population. It is estimated that the catchment population for The Kent and Canterbury includes 32,895 people over 65 years of age, which is predicted to rise to 36,355 by 2011. As the elderly population tend to require more access to healthcare and are often the least able to access care, it is extremely important that their health needs are carefully considered in any reorganisation of health services. Services for older people are provided in all Options but acute rehabilitation is only available under Options A and C, therefore Options B and D could lead to elderly patients being isolated from their visitors in large and daunting hospitals. Furthermore under all of the Options the centralisation of specialist services will significantly reduce the access to services for some patients and visitors.

RECOMMENDATIONS

- Greater emphasis should be placed on the development of local services through the development of further consultant outreach clinics.
- The high demand for healthcare services amongst the elderly and the particular access difficulties must be fully recognised and healthcare for the elderly delivered as locally as possible.

14. ELECTIVE SURGERY

The East Kent Hospitals NHS Trust have expressed concern about medical emergencies being admitted to a site where there is no surgical presence. In the interests of safety the Select Committee would support the view that where unselected medical emergencies are admitted that surgical cover should be available on site.

Planned inpatient surgery for hip/knee replacements, urology and breast surgery are offered in Options B and C. The benefit of focusing such surgery at the Kent and Canterbury would be that planned surgery would be separated from emergency admissions, which would have the effect of reducing the number of cancelled

operations. However, in Option C where some medical emergencies would be admitted operations would not be protected, although clearly the disruption would be far less than that resulting from a full Accident and Emergency Unit. There is also some suggestion that the plans for inpatient surgery outlined in Options B and C could be expanded, to further reduce the number of cancelled operations and improve patient care. It is important to note that the surgical facilities at The Kent and Canterbury have recently been expanded and upgraded.

Professor Darzi reviewed elective surgery at Kidderminster following the reconfiguration of hospital services in that area and recommended that,

“The selection of suitable procedures for Kidderminster should be done on a severity rather than sub-speciality basis. The key issue would be to ensure that only patients who represented an acceptable clinical risk were accepted...The clinical risk threshold should be set high, reflecting the very high importance which must be given to patient safety, but accepting that rare adverse events will occur, and ensuring good arrangements are in place to deal with them.”

It is possible that services at The Kent and Canterbury could be extended by adopting the approach outlined above and by increasing the level of elective surgery requiring an overnight stay.

<p>RECOMMENDATIONS</p> <ul style="list-style-type: none">• Cover from both medicine and surgery should be available if medical emergency admissions are accepted.• That the possibility of offering additional levels of low risk elective surgery at the Kent and Canterbury be explored.
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15. WOMEN’S HEALTH SERVICES

A midwifery led, low risk maternity unit is to be provided at the Kent and Canterbury Hospital under all of the Options. However, a number of witnesses appearing before the Select Committee have expressed a belief that there is “no such thing as a low risk pregnancy” and consequently that this proposal should be reconsidered.

There is no evidence to suggest that births in midwifery led centres have different outcomes to consultant led centres. Excellent ante-natal care and the screening and selection of patients is of critical importance, as are the protocols and transfer arrangements of women and babies to an acute environment. The Midwifery Led Maternity Centre at The Buckland Hospital Dover has been recognised by the Department of Health as a National Beacon Site and offers women a genuine choice about where they would like to give birth. These centres have a range of facilities and telemedicine links with obstetrics consultants to ensure immediate care can be administered to stabilise patients in an emergency. In the event of complications arising the midwife would also accompany patients being transferred to an acute setting. It is intended that the unit at The Kent and Canterbury would be modelled on the centre at The Buckland Hospital.

New transfer arrangements for neo-natal intensive care are being developed across Kent, Surrey and Sussex, which if implemented would improve the emergency transfer facilities for new born babies in need of acute care.

RECOMMENDATIONS

- In establishing the Midwifery Led Maternity Centre the experience of the Buckland centre must be fully utilised.
- That the neo-natal transfer arrangements being developed for Kent, Surrey and Sussex must be implemented to ensure that modern specialist transfer arrangements are in place to support the proposals in East Kent.

16. BED CAPACITY

In total 95 acute beds have been introduced in East Kent since 1996/7 and all of the proposed Options seek to increase the number of beds by 175. The movement and increase of beds is complex and has evolved to meet changing service needs, the main changes are outlined below.

In June 2001 Nunnery Fields Hospital closed (93 beds) and the services moved to The Kent and Canterbury Hospital. At the same time the patient flow for GP emergency admissions moved from The Kent and Canterbury Hospital to The Queen Elizabeth Queen Mother Hospital. Consequently 11 additional beds were provided at The Kent and Canterbury and 86 at The Queen Elizabeth Queen Mother Hospital. In July 2000, acute medicine moved from The Buckland Hospital to The William Harvey, with the reduction of 43 beds at The Buckland and the increase of 54 beds at The William Harvey. In 2000 a Rotary Suite was also provided at The William Harvey Hospital creating an additional 29 beds.

Acute, Community and Mental Health Bed Numbers in East Kent from 1996 to 2002

Hospital	1996/7	2000	2001	2002	A	B	C	D
Queen Elizabeth Queen Mother	402	427	499	499	791	782	705	876
William Harvey	441	467	521	521	705	726	689	744
Kent & Canterbury	370	416	427	435	170	158	272	46
Buckland Hospital	165	144	101	101	100	100	100	100
Nunnery Fields	91	93	0	0	0	0	0	0
Royal Victoria, Folkestone	78	57	57	22	22	22	22	22
Rotary Suite	0	29	29	29	29	29	29	29

Acute Total	1547	1633	1634	1642	1817	1817	1817	1817
Victoria Hospital, Deal	40	36	36	36	36	36	36	36
Queen Victoria, Herne Bay	34	34	34	34	34	34	34	34
Whitstable & Tankerton	48	48	48	48	48	48	48	48
Faversham	33	33	33	33	33	33	33	33
West View	19	21	21	21	21	21	21	21
Victoria House	12	12	12	12	12	12	12	12
Thanet Intermediate Care	0	0	0	0	0	0	0	0

Non Acute Total	186	184						
Mental Health, QEQM	59	59	59	59	59	59	59	59
Mental Health, Arundel	72	79	79	79	79	79	79	79
St. Martin's	111	121	121	121	121	121	121	121
Mental Health Total	242	259						

Health Economy Total	1975	2076	2077	2085	2260	2260	2260	2260
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**Excludes 5 extra beds at Buckland Hospital Dover funded from winter monies as of January 2002, which will close in March 2002.*

However, many questions have been raised about whether the increase in beds proposed will be sufficient. The East Kent Hospitals Trust have expressed the need to keep these figures under review in order to meet any changes in demand. This is an approach the Select Committee must strongly endorse. It is not sufficiently clear that an increase of 175 beds will be enough to alleviate the capacity problems currently being faced, which must be fully addressed through any changes. Prior to the current consultation the development of Hotel or Rotary Suite beds at The Kent and Canterbury Hospital were discussed. As the level of day surgery is expected to increase from 70% to 85% over the next 10 years, the development of such beds should be pursued.

The focus on acute bed numbers is in many ways artificial as it is the capacity across the whole health economy which is most relevant. For instance the provision, of adequate capacity in intermediate care and nursing care homes would help to resolve 'bed blocking' by ensuring that patient discharges are not delayed by a lack of availability elsewhere in the health sector. A Kent County Council Select Committee Review of Nursing Care identified that in the five years to September 2001, there has been a reduction of nursing home beds from 2189 beds to 1408 beds in East Kent. This Select Committee highlighted the links between delayed discharges and the reduction in nursing care homes but also recognised that the problem of delayed discharge is due to a number of reasons not exclusively in Social Care. Similarly expansions in bed numbers are planned in other sectors of the health economy. For example, a dual registered nursing home and day care centre is to be developed at Westview Community Hospital. In order to ensure the bed capacity of East Kent can be effectively developed it is critical that is done collaboratively with the East Kent Hospitals NHS Trust, Community Trust, Primary Care Trusts, Social Services, private and voluntary organisations and District/Borough Councils all working in partnership to achieve this.

The National Beds Inquiry promotes an active policy to increase the number of beds with a view to providing more responsive emergency and specialist care and avoiding premature discharge. The need to develop Intermediate Care services, to prevent avoidable hospital admissions and to facilitate the transition from hospital to home is similarly emphasised. It is clear that the issue of bed capacity must be looked at and planned for in a wider context to ensure that the right beds are available in the right place at the right time. Similarly through collaborative working more innovative cost effective approaches could be developed such as in the provision of continuing care beds.

In implementing the proposed changes to East Kent hospitals it will be critical that capacity is carefully planned for across the whole health sector, to ensure that increases in capacity are as effective as possible and to avoid investment in one area of health diverting resources and limiting progress elsewhere.

RECOMMENDATIONS

- The current shortage of acute beds must be addressed by these proposals. If 175 additional beds do not prove to be enough it is critical that further beds are provided.
- To ensure the health needs resulting from any additional population growth can be met the acute bed capacity must be kept under review.

- The provision of beds should be planned across the whole health sector to ensure the right numbers of beds of the right type can be provided in the right place. This should be done in partnership between the East Kent Hospital Trust, Community Trust, Primary Care Trusts, Social Services, private and voluntary organisations and District/Borough Councils.

17. PRIVATE FINANCE INITIATIVE

The Private Finance Initiative is the only funding stream currently available to the NHS in developing projects of this scale. In the Strategic Outline Case the cost of the proposals were estimated at £102 million but the East Kent Hospitals NHS Trust have indicated this will be higher, in order to deliver the additional 175 beds and to meet new standards for hospital accommodation, such as increasing the number of single rooms.

Many individuals have expressed grave concerns about the Private Finance Initiative and the possible implications for health care in East Kent. The consultation is not about the mechanism of funding, however, the Select Committee must state the need for the project to be affordable and to learn from the mistakes of early schemes which elsewhere in Kent and nationally have led to bed and staff reductions. Improvements have been made to the Private Finance Initiative process but it must be emphasised that this process must be carefully managed to ensure that the mechanism of funding does not undermine in anyway the improvements which need to be made within the acute hospitals.

As a major capital project is planned in West Kent it is also extremely important that the health economy can afford both of these projects. Furthermore that these acute developments do not inadvertently lead to money being diverted from Primary Care.

Land disposal at the Kent and Canterbury Site has been estimated at £10 million, however this has not been included in the economic appraisal as agreement will need to be reached with the Regional Office about the most appropriate use for this capital receipt. Under all of the Options a significant portion of the Kent and Canterbury site could be released, however, it would be strongly advised that priority is given to the consideration of the development of other health services on this site prior to it being disposed.

RECOMMENDATIONS

- That the Private Finance Initiative is taken forward in a way which is affordable to the whole health economy.
- That any land released at the Kent and Canterbury must be considered firstly for the development of additional health services.

18. PREFERRED OPTION

The long term sustainability of Options A, B and C has been questioned by the East Kent Health Authority and East Kent Hospitals NHS Trust. As these Options would continue to spread many services thinly across three sites. Consequently the Options being proposed pose a question regarding the appropriate balance between the accessibility of services and the quality of services.

The importance of local accessibility to services cannot be over-estimated. The rural nature of many parts of East Kent, the poor transport infrastructure, combined with the high levels of deprivation and increasingly elderly population make it critical that services are provided as locally as possible. The Select Committee would impress upon both the East Kent Hospitals NHS Trust and the East Kent Health Authority to recognise the importance of accessibility and the need to provide local services for local people. It is equally clear that some services because of their highly specialist nature must be centralised in order to utilise new technology, provide around the clock specialist cover and to ensure practitioners see sufficient numbers of rare conditions to remain expert. In these instances services must be organised to offer patients the best available healthcare.

The Select Committee requests that in developing the final proposals the East Kent Hospitals NHS Trust keeps an open mind. If, as a result of changes in local or national circumstances, it becomes feasible to retain any additional services at The Kent and Canterbury Hospital, without impacting the quality of services at all three sites, then this must be pursued. The importance of local accessibility to services cannot be over-estimated.

It has been stated by the East Kent Hospitals NHS Trust that all the Options are workable. However, the Select Committee cannot unanimously agree upon an option, it is strongly felt by some members that the only acceptable Option is C and by others that only Option D will be viable in the long term.

Option C, is supported by five members and one non-voting member of the committee. This Option would retain the most services locally within Canterbury ensuring services are more accessible. Furthermore the more even spread of specialities between the three hospitals would improve the level of access to services and to each of the hospital sites. On the basis of patient safety it is felt by the whole Committee that where medical emergency admissions are accepted both general medicine and surgery should be available on site. It is also strongly felt that the concentration of Accident and Emergency at two sites may increase the disruption to elective surgery. As such the provision of low risk elective surgery at The Kent and Canterbury is felt to be particularly important, and is an area which the Select Committee believes could possibly be extended. This would also ensure that the recently upgraded and expanded surgical facilities at The Kent and Canterbury could be fully utilised. Importantly, Option C would also enable the most comprehensive cancer services to be retained at the Kent and Canterbury.

Option D, is supported by two members and one non-voting member of the committee. On the basis that the other Options will continue to spread services too thinly and as a result it is believed it will be unsustainable in the long term. As the other Options will minimise the effects of sub-specialisation and team working it is felt that this would not ensure the best quality services for the residents of East Kent.

Also very importantly, that the stability which must be restored to East Kent Hospitals would not be achieved unless a sustainable Option is selected. However, it was also felt that in order to resolve the problems of elective surgery being cancelled as a result of emergency admissions, that the possibility of low risk elective surgery being centralised at the Kent and Canterbury should be explored.

The divergence within the Select Committee in respect to the options clearly reflects the complexity of the issues leading towards this configuration.

19. RECOMMENDATIONS

The NHS Overview and Scrutiny Select Committee on completion of the Topic Review ‘Modernising Hospital Services in East Kent’ have not unanimously agreed upon a preferred Option. This is on the basis of differing opinions on the long term viability of each of the Options. Five members and one non-voting member agreed that Option C offers the most beneficial configuration of services, whilst two members and one non-voting member agreed that only Option D would be viable in the long term.

However, the Select Committee unanimously agree that if as a result of changes in local or national circumstances, it becomes feasible to retain further services of a high quality at the Kent and Canterbury then this must be pursued. It is similarly felt that the chosen Option must balance the quality of services with the needs of patients in relation to access to services. The 27 recommendations below have been unanimously agreed and it is hoped they are given the strongest consideration:-

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| <p>PROVISION OF SERVICES:-</p> <ul style="list-style-type: none">• Patient needs and service improvements are the only appropriate drivers for change, and must be pursued within a context of scarce resources.• Local services must be provided for local people, where ever this can be done safely and to a high quality. Hospital services must only be centralised when it is clear that this will improve the quality of health outcomes.• Greater emphasis should be placed on the development of local services through increasing the number of consultant outreach clinics.• The high demand for healthcare services amongst the elderly and the particular access difficulties must be fully recognised and healthcare for the elderly delivered as locally as possible.• Greater emphasis should be placed on prevention and the role of Primary Care and Social Services in intervening to prevent avoidable hospital admissions. |
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ACCESS TO SERVICES:-

- The transport arrangements for patients and visitors must be developed and implemented, within the framework of the Health Partnership Transport Board, to meet the additional transport needs of the final Option selected.
- The County Council should continue to support the East Kent Hospitals NHS Trust in developing the public transport infrastructure in East Kent, through its involvement in the Health Partnership Transport Board.
- Moving people to hospital in a sustainable way should be a high priority of Kent County Council and be embodied in the Local Transport Plan.
- The East Kent Hospitals NHS Trust in developing hospital services must ensure that the access to hospital sites and parking is improved.

ACCIDENT AND EMERGENCY:-

- The current conditions in Accident and Emergency are unacceptable and must be addressed immediately. Investment must be made in the interim as improvements cannot wait until the implementation of the Private Finance Initiative.
- Emergency care should be planned for in the wider context in partnership with Primary Care, Ambulance Services, Social Services, private and voluntary organisations. To ensure the appropriate types of care can be provided as efficiently and locally as possible.
- The provision of safe emergency care under the proposals will be dependent on the expansion of the Kent Ambulance Service. It is critical that this expansion is adequately funded, monitored and clearly communicated to the public.
- The training of paramedics in the use of thrombolytic drugs must take place before any of the Options are implemented. In addition, telemedicine links with Accident and Emergency must be installed in all emergency ambulances.

CANCER SERVICES:-

- The retention of full cancer services at The Kent and Canterbury is strongly advocated. Hospital services must only be centralised when it is clear that this will improve the quality of health outcomes, as set out in the National Cancer Plan.
- The future of cancer services in Kent must be driven by patients needs and not as a consequence of change to acute services in East Kent.
- The Kent Cancer Network and East Kent Hospitals NHS Trust must continue to explore ways, such as partnership arrangements with the Chaucer Hospital, to ensure that comprehensive cancer services can be retained at The Kent and Canterbury Hospital.

MEDICINE AND SURGERY:-

- Cover from both medicine and surgery should be available if medical emergency admissions are accepted.
- The possibility of offering additional levels of low risk elective surgery at The Kent and Canterbury should be explored.
- In establishing the Midwifery Led Maternity Centre the experience of The Buckland centre must be fully utilised.
- The neo-natal transfer arrangements being developed for Kent, Surrey and Sussex must be implemented to ensure that modern specialist transfer arrangements are in place to support the proposals in East Kent.

RECRUITMENT AND RETENTION:-

- The future of East Kent hospitals must be decided, stability restored and recruitment efforts stepped up.
- Innovative use of Staff Grade Doctors, Nurse Practitioners, GP Specialists and Junior Doctors should be explored.

BED CAPACITY:-

- To ensure that the health needs resulting from any additional population increases can be met the acute bed capacity must be kept under constant review.
- The current shortage of acute beds must be addressed by these proposals. If 175 additional beds do not prove to be enough it is critical that further beds are provided.
- The provision of beds should be planned across the whole health sector to ensure the right numbers of beds of the right type can be provided in the right place. This should be done in partnership between the East Kent Hospitals NHS Trust, Community Trust, Primary Care Trusts, Social Services, private and voluntary organisations and District/Borough Councils.

FINANCE:-

- The Private Finance Initiative should be taken forward in a way which is affordable to the whole health economy.
- Any land released at The Kent and Canterbury must be considered firstly for the development of additional health services.

BACKGROUND DOCUMENTS

Author	Title
East Kent Health Authority	Modernising Hospital Services in East Kent 2001 Moving Forward: A Strategic Outline Case for Modernising Hospital Services in East Kent 2001 Tomorrow's Health Care 1998 The Future of Hospital Services in East Kent 1998 Minutes of the East Kent Health Authority Meeting 29 June 1998
Deloittee & Touche	East Kent Health Authority Tomorrow's Healthcare Economic and Social Impact 1998
East and West Kent Health Authorities	Report of the Renal Medicine Group 1999
York Health Economic Consortium	Capacity Modelling Update 2 - Final Report
East Kent Hospitals Trust	Minutes of Clinical Policy Board Meeting held on Friday 18 th January 2002
Royal College of Surgeons	The Surgical Workforce in the New NHS 2001
Department of Health	A Health Service of all the talents - developing the NHS workforce 2000 The NHS Plan - A Plan for Investment, A Plan for Reform 2000 Reforming Emergency Care 2001 Reforming Emergency Care: Practical Steps 2001 Accident and Emergency Modernisation Programme: Interim Report to Ministers 1999 Building a Safer NHS for Patients 2001 National Service Framework for Coronary Heart Disease 1998 The NHS Plan 2000 National Beds Inquiry 2000

	The NHS Cancer Plan 2000
	Shifting the Balance of Power: The Next Steps 2001
Kent County Council	Deprivation in Kent October 2000
NHS Executive	Workforce Development in the NHS South East Region 2000
	NHS Emergency Pressures - Making Progress 2001
	Quality and Performance in the NHS: High Level Performance Indicators 1999
	Clinical Governance: Quality in the new NHS 1999
	Modernisation of Pathology Services – Circular 1999
	Public Private Partnerships in the National Health Service: The Private Finance Initiative
The Nuffield Trust	Local Medical Emergency Units 2001
Audit Commission	By Accident or Design 1996
	Accident and Emergency 2001
Joint Consultants Committee	Organisation of Acute General Hospital Services 1999
Professor A. Darzi	Independent Review of Elective Surgery at Kidderminster 2001
British Association of Emergency Medicine	Workforce Planning in A&E Medicine 2001 – 2010
Department of Geography Canterbury Christ Church College	Access, Deprivation and Hospitals in East Kent 1998
Expert Advisory Group on Cancer	A Policy Framework for Commissioning Cancer Services 1995
Dr. J. Bullimore	A Cancer Centre for Kent 1996
Vascular Surgical Society of Great Britain and Ireland	The Provision of Vascular Services 1998
George Monbiot	Captive State: The Corporate Takeover of Britain 2001

Letter from the Secretary of State, December 1998



The full text of the letter from the Secretary of State for Health to the Chairman of East Kent Health Authority

December 1998

Dear Mrs Hawkes,

I have considered the outcome of East Kent Health Authority's consultation on the future of hospital services in the light of objections from Canterbury and Thanet and South East Kent Community Health Councils.

Briefly my decision is to endorse the Health Authority's proposals, subject to a number of conditions:

- a) The proposals for Kent and Canterbury Hospital and A&E and local emergency services across East Kent are not satisfactory and must be improved.
- b) The proposals for haemophilia services and renal medicine are not satisfactory and must be improved.

Therefore an East Kent-wide approach to A&E and local emergency services is needed together with a Kent-wide approach to haemophilia services and renal medicine.

So, in accepting the proposals, I have asked East Kent Health Authority to:

- a) Guarantee that on-site consultant anaesthetic, surgical and medical cover will be provided at the Kent and Canterbury Hospital during the day and that on call cover in these specialities out of hours and at weekends is properly available.
- b) Ensure that there is an East Kent-wide approach to A&E and local emergency services, with co-ordinated policies and common protocols across all hospitals.
- c) Include in its plan for an East Kent-wide accident and emergency service for consultant leadership of local emergency centres. The consultants will be in charge of overseeing clinical governance and establishing, with other specialists and primary care professionals, new clinical protocols. There will be a designated consultant to develop and lead the Canterbury Emergency Centre. In addition, he or she will be responsible for the training and development of staff and support of the

nurse-provided services at Canterbury. There will be a clear job description to ensure that a substantial proportion of consultant time will be spent at Canterbury. It is anticipated that as many as 70% of the patients currently treated in the existing Canterbury A&E Department will continue to be treated locally. Over time, with the advances in telecommunications and with the support of the new East Kent-wide service, significantly more patients should be treated in Canterbury than originally planned.

- d) Guarantee that the consultant medical cover for the coronary care unit at Kent and Canterbury Hospital includes a physician with an interest in coronary care.
- e) Carry out with West Kent Health Authority a joint analysis of the impact of possible future patient referral patterns on the viability of the renal unit, if transferred to Margate.
- f) Agree with West Kent Health Authority on a model of care for renal services.
- g) Carry out a joint review, with West Kent Health Authority, of haemophilia services for the population served by the Canterbury Centre, involving service providers, service users and independent expert advisers.

My intention in coming to these decisions is to provide top quality services in every part of East Kent and to promote co-operative working between all these NHS institutions and individuals responsible for providing treatment and care for the people in the area. In particular it should mean better A&E services than those originally proposed.

I share the widespread concern about bed numbers. As a result of my decision, Kent and Canterbury Hospital will have 232 beds compared with the 65 beds originally proposed. Overall, some 85% of the patients who would today expect to go to Kent and Canterbury Hospital should continue to be treated there. I have asked the Health Authority to monitor carefully the impact on services during the period of transition. I welcome their commitment as part of these proposals to invest an extra £3.1 million a year in primary care, community care and transport.

The history of these proposals suggests that an amalgamation of the three trusts concerned could well assist the development of policies designed to meet the needs of the people of East Kent as a whole. This would not mean an amalgamation of hospitals, but an amalgamation of managements. This could reduce spending on bureaucracy and remove the organisational barriers which have proved inimical to co-operation. I have asked the South East Regional Office of the NHS Executive to initiate consultation on a proposal to merge the Kent and Canterbury Hospital Trust, Thanet Healthcare Trust and South Kent Hospitals Trust into a new East Kent Hospitals Trust by April 1999.

I believe that the decision I have reached, after long and careful consideration of the cases put by all those involved, represents the best way forward for the services in East Kent. Whatever the outcome of the consultation on Trust merger, I now expect

everyone involved in the NHS in East Kent to put their backs into the new arrangements to raise the standards of treatment and care so that everyone in East Kent receives a first class service.

FRANK DOBSON

Select Committee 'Modernising Hospital Services in East Kent'

SUMMARY OF THE REVIEW PROCESS

Hearings

The Select Committee held 6 hearings between December 2001 and February 2002, which were held in public and formally recorded. Transcripts of the evidence provided to the Committee are available upon request.

The organisations and individuals represented at each of the hearings are listed below:-

Hearing One - 17th December 2001

- East Kent Health Authority: Mr Outhwaite (Chief Executive)
- East Kent Hospitals NHS Trust: Mr Hermitage (Chairman), Mr Astley (Director) and Mrs Cracknell (PFI Director)
- Canterbury and Thanet Community Health Council: Mr Peppiatt (Chairman), Mrs Binfield (Vice Chairman), Mrs Bently (Vice Chairman) and Mr Williamson (Chief Officer).
- South East Kent Community Health Council: Mr Watkins (Co-opted Member & former Chairman), Mrs Howkins (Chief Officer).
- East Kent Hospitals NHS Trust: Mrs Sidwell (Director of Nursing)
- East Kent Hospitals NHS Trust: Mr Murphy (Human Resources Director)

Hearing Two - 7th January 2002

- Concern for Healthcare in East Kent (CHEK): Mr Short, (Chairman)
- Maidstone & Tunbridge Wells Hospital Trust: Professor James (Director of Kent Cancer Network).
- East Kent NHS Hospitals Trust: Dr Padley (Medical Director), Mr Davis (Clinical Director Obstetrics & Gynaecology), Ms Watkins (Director of Midwifery), Dr Sturgess (Clinical Director for Care of the Elderly), Dr Bull (Coronary Care) and Dr Leak (Director of Medical Education)
- Primary Care Groups: Mr Jones (Ashford Chief Executive) and Mr Williams (Canterbury Chief Executive).
- Kent County Council: Peter Gilroy (Strategic Director Social Services).
- East Kent Local Medical Committee: Dr Calver (Chairman)

Hearing 3 - 11th January 2002

- Kent Ambulance Service: Mr Burgess (Director of Operations)
- East Kent Community Trust: Mr Parr (Chief Executive)
- Gravesend & Dartford Primary Care Trust: Mrs Stanwick (Chief Executive)
- Mr Graham, Former Chairman of Save Canterbury Hospital
- East Kent Hospitals NHS Trust: Mr Jones (Director of Facilities)
- Kent County Council: Dr Jefford (County Transport Operations Manager)

Hearing 4 - 30th January 2002

- Dr Taylor, MP for Wyre Forest

(This was not a public meeting, 6 Members of the Select Committee met Dr. Taylor in London and formal minutes of the meeting were taken).

Hearing 5 - 4th February 2002

- Dr Ribchester, local GP

Hearing 6 - 7th February 2002

- Dr Coltart, Consultant Oncologist, Kent & Canterbury Hospital
- Mr Collins, Consultant General and Endocrine Surgeon, Kent and Canterbury Hospital
- East Kent Health Authority: Dr Sandro Limentani (Director of Public Health) and Jacqui Stewart (Director of Development and Performance).
- East Kent Hospitals NHS Trust: Mr Hermitage (Chairman), Mr Astley (Director) and Mrs Cracknell (PFI Director), Dr Padley (Medical Director), Dr Marie Beckett (A&E Consultant).

Evidence Gathering

The Select Committee wrote to a wide range of groups to request their views about the proposals being consulted upon by the East Kent Health Authority and East Kent Hospitals NHS trust. These included 135 local voluntary organisations, the Royal Colleges, The Postgraduate Deanery, the South East Regional Office, Members of Parliament, County Councillors and District/Borough Councils. In addition, requests were made via the press for members of the public to write to the Select Committee. A wide range of responses were received and a number of local GPs and consultants wrote to the Committee as members of the public to share their views.

In addition Members of the Select Committee observed at the public meetings held by the East Kent Hospitals NHS Trust. The attendance at these meetings is detailed below.

Deal	Mr Ford, Mrs Birkett, Mr Kenworthy, Mrs Hopkins.
Dover	Dr Robinson, Mrs Hopkins.
Faversham	Dr Robinson, Mr Gibbens, Mrs Hopkins.
Herne Bay	Dr Robinson, Mrs Hopkins
Canterbury	Dr Robinson, Mr Vye, Mr Ford, Mr Gibbens, Mr Wale, Mrs Hopkins.
Ashford	Dr Robinson, Mr Ford, Mr Kenworthy, Mrs Hopkins
Whitstable	Mr Gibbens, Mr Vye, Mr Ford, Mr Kenworthy.
Ramsgate	Mr Poole, Mr Ford.
Margate	Dr Robinson, Mr Ford, Mrs Hopkins.
Folkestone	Mr Ford
New Romney	Dr Robinson, Mr Ford, Mr Kenworthy, Mrs Hopkins