KENT COUNTY COUNCIL

NHS OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the NHS Overview and Scrutiny Committee held in the Darent Room at Sessions House, County Hall, Maidstone on Friday 11 May 2007.

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

OTHER MEMBERS PRESENT: Mr G Gibbens, Mr R Parry, Mrs E M Tweed.

OBSERVERS: Mr P Gilroy, Chief Executive, Mr R Pullen, Department for Communities and Local Government, Mr E George, Legislature of St Helena, Ms E Eggington, Foreign and Commonwealth Office, Ms J Knight, Assistant Director of Citizen Engagement and Communication, Eastern & Coastal Kent PCT, Mr F Sims, Mr P G Bentley, Mr P W Skinner, Mr J Webb, Maidstone & Tunbridge Wells NHS Trust, Ms A Cole, Kent Messenger, Mrs C Swann, Mr J Reece, Patient and Public Involvement Fora representatives, Mr J A Ogden, Chairman, KCC Standards Committee, Ms E Burns, Corporate Communications, Cllr M Warner, Cllr P Germain and Ms K Harwood, Maidstone Borough Council, Dr C Thom and Dr R Hart, Maidstone BMA.

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

UNRESTRICTED ITEMS

23. Minutes

RESOLVED that, subject to the following amendments:-

a) “Mrs F Witherdew” to read “Mrs F Witherden”; and

b) Mr Julian Brazier, MP to be shown present as an observer;

the Minutes of the meeting held on 23 March 2007 were correctly recorded and that they be signed by the Chairman.

Other Matters raised relating to the Minutes

(1) The Overview and Scrutiny Manager responded to Mr Crowther that he had been recorded as attending the visit to the Kent & Canterbury Hospital in the afternoon but as he had not attended the formal meeting of the Committee in the morning he had not been recorded in the Minutes as being present.

(2) In response to a question from Mr Hibberd about the appropriateness of recording Mr Shortt's comments in the body of the Minutes, the Overview and Scrutiny Manager explained that the Committee had been responding to a range of issues raised by Mr Shortt on behalf of Concern for Health in East Kent (CHEK).

(3) Ms Gibb, Chief Executive of the Maidstone and Tunbridge Wells NHS Trust, clarified, in respect of Minute 17 (4), that there were oncologists working across the whole of Kent and Medway; and that the point being made in her comments recorded at Minute 17 (6) was regarding the importance of having the right staff working with the right linear accelerator.

24. Maidstone & Tunbridge Wells NHS Trust – a new direction for orthopaedic and emergency care

(Ms R Gibb, Chief Executive, Maidstone & Tunbridge Wells NHS Trust and Mr S Phoenix, Chief Executive of West Kent PCT were in attendance for this item)

(1) Mr Phoenix and Ms Gibb were accompanied by some consultants from Maidstone & Tunbridge Wells NHS Trust, Mr J Webb, Clinical Director – Emergency Services and Critical Care, Mr P Skinner, Clinical Director – Orthopaedics and Mr P Bentley, Clinical Director – Surgery.

(2) Mr Angell raised a number of questions with Ms Gibb relating to:-

a) whether the calculations regarding the proposed reconfiguration took into account fully the growth in population, the ageing of the population and the growing number of overweight people;

b) what guarantee could be given as to whether the proposed reconfiguration would actually happen; and

c) whether she could guarantee that there would continue to be a quality Accident & Emergency (A&E) department at Maidstone.

(3) Ms Gibb responded that the Maidstone & Tunbridge Wells NHS Trust had given due consideration to all the demographic factors. She said that the anticipated population growth was sufficient to affect primary care but not great enough to affect planning for hospital services.

(4) She said that the changes could be concluded by December 2007/January 2008 if the NHS Overview and Scrutiny Committee agreed them. The Trust had the necessary finances and project infrastructure ready. It was imperative that the core of services must be sustainable and appropriate, otherwise the Trust would be unable to guarantee the quality and range of services. Finally, Ms Gibb concluded in response to Mr Angell's questions that they did not know how health policy and technology would change in the future but what was clear was that we could anticipate continual change.

(5) Mr Skinner, Clinical Director – Orthopaedics, added that all orthopaedic surgeons believed in the separation of elective and emergency orthopaedic care and a concentration of elective surgery at one location.

(6) It was important that there was a dedicated surgical team who could operate on emergency cases without distractions. Mr Webb, Clinical Director – Emergency Services and Critical Care, informed the Committee of an A&E middle-grade vacancy where recently there had been just one suitable applicant.

(7) He said that the Trust were very supportive, both practically and financially. Mr Webb informed the Committee that he had two Specialist Registrars based solely at Maidstone and four middle-grade staff at Maidstone and Tunbridge Wells. The nurse-provider service had been expanded at both locations. F1 and F2 staff (i.e. Housemen) were on duty overnight in A&E. He said that a 24-hour middle-grade rota at the Kent & Sussex Hospital, Tunbridge Wells would be a significant advancement. He said that the model being proposed of an integrated physician/general practitioner/nurse practitioner team with junior doctor support at Maidstone would also be a step forward. Mr Phoenix referred the Committee to the West Kent Primary Care Trust Board decision of 15 March 2007, which had attached conditions to the proposed reconfiguration. Significant checks and balances had been put in place to ensure the maximum confidence of clinicians.

(8) The Chairman then referred to the ongoing negotiations that had taken place between the spokesmen of the NHS Overview and Scrutiny Committee and the Chief Executives of both Maidstone & Tunbridge Wells NHS Trust and West Kent Primary Care Trust, and members of the Maidstone Division of the British Medical Association (BMA). Mr Phoenix referred to the most recent letter from the Committee spokesmen and said that a reply was in the post.

(9) As regards the spokesmen's stipulation that there should be an independent chairman for the external review panel that had been referred to in the conditions agreed by the PCT Board, Mr Phoenix said that he was happy to see one of the three independent members of the panel as the chairman. Regarding the involvement of the BMA in the panel, Mr Phoenix said they were a trade union and, therefore, including them on the panel would stop it being external and impartial, as they were an internal stakeholder. However, Mr Phoenix added that he was happy to actively involve the Honorary Secretary of the BMA in the process, while keeping the BMA's views external to the process. Regarding the NHS Overview and Scrutiny Committee reserving the right to re-open the issue, he said that this was a constitutional matter which would need to be considered. Regarding the request for clarification as to why the Trust intended that Maidstone A&E department would be staffed by A&E specialists for 15 hours per day, rather than 16 hours or more, Mr Phoenix said that 15 hours per day was the existing extent of cover. Mr Phoenix then referred to the Committee spokesmen's request to see the document detailing the changes to Ambulance Service resources that would be necessary if the proposed reconfiguration were to go ahead. Mr Phoenix said that it had been agreed to make this document available to the Committee.

(10) Responding to a further question about the chairing of the external review panel, Mr Phoenix confirmed he had accepted that an external clinician would chair the panel. A question was asked as to whether there would continue to be a 24-hour A&E

service in Maidstone. A further question was asked about the distance between Maidstone and Tunbridge Wells with reference to what was commonly known as "the magic hour", referring to the time during which it was critical that an emergency patient receive treatment. Mr Webb said that the doors of the A&E department at Maidstone would be open 24 hours a day. He added that what used to be done in hospital within "the golden hour" was now being done by ambulance crews.

(11) He went on to refer to some of the major specialties, such as brain, burns and cardiothoracic services that had already been centralised. This meant that Maidstone Hospital already routinely transferred all sorts of emergencies. As a specific example, he referred to the instance of a leaking aneurysm. In the past, this would have been dealt with by a general surgeon at a district general hospital. Now, however, it was undertaken by a specialist vascular surgeon. Increasing specialisation was the direction in which medicine in general was headed.

(12) Mrs Stockell returned to the issue of staffing of A&E and how it was dependent on the external review agreed by the PCT Board. She asked whether the NHS Overview and Scrutiny Committee would get the opportunity to come back to the matter when the outcome of that external review was known.

(13) She also asked about the growth of population, which the Trust was acknowledging it had failed to take full account of. Mrs Stockell further asked whether A&E at Tunbridge Wells would also be open 24 hours a day.

(14) Mr Phoenix responded that A&E at Tunbridge Wells would be a 24-hour service. In response to an interjection by Mrs Stockell, Mr Phoenix confirmed that trauma services would be concentrated at Tunbridge Wells. Responding to the point raised about population growth, Mr Phoenix said that Maidstone would be experiencing an increase of 10,000 in the number of households over the next ten years.

(15) He said that 500,000 was now considered the optimal catchment population for acute services. A 10,000 to 20,000 increase in the population would not require a material alteration in the shape of the service. An increase in patient volume on that scale could be accommodated without configuring acute services differently.

(16) He went on to add that work on projected population changes had already been undertaken in planning for the Private Finance Initiative (PFI) at Pembury. He said that population forecasting was not an exact science. The PCT was planning to invest more in primary and community care to take account of population changes.

(17) In response to Mrs Stockell's point about revisiting the issue once the external review panel had completed its task, Mr Phoenix said that, in his view, the Committee was not best placed to review operational staffing matters. He added that it was for the PCT to performance-manage the outcomes of the external review panel, but he would be happy to report the outcomes back to the NHS Overview and Scrutiny Committee.

(18) Mr Fittock said that he did not want to revisit all the issues which the spokesmen of the Committee had addressed with Mr Phoenix and Ms Gibb already through the negotiations. Appendix 2 to the report before the Committee represented the spokesmen's understanding of the current position with regard to these

negotiations. However, he went on to say that he would welcome the NHS Overview and Scrutiny Committee Chairman, Mr Chell, being an observer on the external review panel. Mr Fittock said the Committee spokesmen had "moved the goalposts" somewhat by stipulating that specialist cover must be present at Maidstone A&E department for a minimum of 17 hours per day.

(19) With regard to the spokesmen's concerns around Fit for the Future, he felt that the Trust and the PCT had covered this. This left the questions relating to the Ambulance Service and he understood that the Ambulance Service had responded.

(20) The Overview and Scrutiny Manager then read to the Committee a message from Geraint Davies, of the South East Coast Ambulance Trust, a copy of which is attached as Appendix 1 to these minutes.

(21) Mr Phoenix responded that he did not have a problem with Appendix 2 to the report. He said that this was an accurate reflection of the negotiations which had taken place between the spokesmen of the NHS Overview and Scrutiny Committee and the Trust and PCT.

(22) He added that he had no problem with a representative of the NHS Overview and Scrutiny Committee observing the external review panel. Ms Gibb said that the comments on Appendix 2 to the NHS Overview and Scrutiny Committee's report were from the Committee's perspective. She added that the assurances that the spokesmen had sought on behalf of the Committee had been given by the Trust and PCT.

(23) In response to Mr Fittock's question about specialist cover in Maidstone A&E, she said that 15 hours would actually represent an increase on the current situation. She added that the external review panel would not itself determine the levels of staffing but that it would determine whether the proposals about this put forward by the Trust were appropriate and safe.

(24) Mr Vye said that he understood the arguments being made about getting patients to specialists who were equipped to provide the best outcome. However, he added that time-to-surgery was still an important consideration. He sought confirmation that there would still be the capacity to deal with some emergency surgery cases at Maidstone Hospital, where necessary; and also that it would be possible to stabilise patients before transferring them, where necessary. He asked how these situations would be handled during those parts of the day when relevant specialist cover was not being provided, given that such cover was not going to be available on a 24-hour-a-day basis. Ms Gibb responded that they did not at the current time have a proper 24-hour service – people often had to wait for a specialist. She listed again the specialist services that the Trust did not provide, such as dealing with head injuries. She added that if a patient needed immediate surgery and no surgeon was on site, then the patient would be stabilised while a surgeon was sought and a theatre opened.

(25) Mr Bentley, Clinical Director – Surgery, informed the Committee that Maidstone would have the best specialist major surgery centre in the area. He said that two new specialist consultants had recently been appointed who were "utterly brilliant" and patients would flood in. He added that the on-call surgeons at Maidstone

would not be the same surgeons who were on-call at the Kent & Sussex Hospital, Tunbridge Wells. If necessary, surgeons would be called in to Maidstone and patients would be stabilised and then treated; but often it was actually dangerous to treat patients straightaway. He said that stabilisation of a patient could take four, six and sometimes 10 hours. He reassured the Committee that patients at Maidstone would be properly covered. Mr Horne said that the proposals before the Committee had turned out to be very contentious. Mr Phoenix had said that the Committee was not well placed to know about operational matters. However, Mr Horne said, the Committee was well placed to represent the views of the public – and they were very worried. He said that the Trust's role was to reassure the public that the proposed service changes were in their best interests.

(26) If the service to be provided at the Maidstone Hospital A&E department was only for 15 hours then people would feel that the service was being reduced. Mr Horne also expressed concern that these proposals had been put forward before the Fit for the Future consultation process had been concluded. He said that he needed to be convinced that the Trust and PCT were looking at improving services not reducing them. He said that the medical profession had also voiced doubts and concerns. Ms Gibb responded that change was never easy and was always painful. To demonstrate the point, she referred to the consultation some years ago on the provision of vascular services across Kent and Medway when there had been a huge outcry at what people had seen as a loss of services. People had said that the service would fall apart and that, as a result, patients would die. However, the reality was that this had not happened; the outcome had been better services, and patients had been convinced. Hearts and minds would change, she said, when people saw the service in operation. Ms Gibb said that she was still hearing confusion from Members present at the meeting. For example, she said, specialist staff were not available now 24 hours a day – or even 15 hours a day. Changes could be seen as a reduction in services, but if you saw the right specialist at the right time, the outcome was better; and UK and international evidence showed that. Mr Phoenix added that, having spent nearly 30 years in the National Health Service, he saw many buildings that were still the same, but what went on in them had changed beyond recognition. He said that during the last five to 10 years the pace and scope of change had been much greater than before. He emphasised that clinical testimony was very important. He referred the Committee to the fact that the PCT had had signed letters from all the surgeons in the Trust supporting these proposals. Mr Hirst said that change was very difficult and that the Committee was caught between the electorate and reality. He said that the electorate was living in the past, with a lack of comprehension of the consequences of not changing. He said that County Councillors were "going with the flow" and following the electorate. He said that they had been through all of this in Canterbury and they now had a service there that was far better than they had had before. Was the Committee going to go through this with every Trust? What would it do to the NHS if elected Members blocked every necessary change? Ms Gibb responded that it was not possible to ignore the factors that were driving change and that similar changes were taking place up and down the country. If the Committee were to support the changes there would be a sound service.

(27) Ms Gibb referred to the work of Professor Sir Ara Darzi, which showed that some services would have to change even more. A "critical mass" catchment population of 500,000 people was vital to delivering good-quality health outcomes. Across England, and Scotland too, there was the same process of change, leading to

centralisation. Mr Hibberd said that he was surprised by the amount of public protest by the medical profession. He had been informed that the BMA still had reservations. He asked the Trust and PCT representatives whether they were satisfied that medical staff were behind them. Ms Gibb said that it was not always possible to get 100% staff support – but 100% of the surgeons were in favour. Some concerns were being expressed by physicians, which had also been the case in respect of the changes in Canterbury. She said it was not unique for clinicians to oppose proposals; this had also occurred in Maidstone & Tunbridge Wells NHS Trust in 1999 and when the vascular review had been undertaken. It was actually rare to get what had been achieved in the present case, namely 100% agreement from the surgeons.

(28) Ms Harrison said that at the last meeting of the Committee there had been a lot of myths; for instance, some people had believed that the hospital was closing. She had thought that the Committee had nailed those myths. There was a need to spell out in words of one syllable what was proposed. The Committee could have done a lot to help public understanding. Trust staff were saying that fewer people would die as a result of the changes. Unless the Trust was telling the Committee a pack of lies, the proposals would actually improve services. Yet the newspapers were reporting that the hospital was closing. Ms Harrison found similar misleading perceptions about NHS services in the area that she represented.

(29) Ms Gibb responded that they had had a clear and consistent message to give and she did not know how it could have been said in simpler terms. The confusion perhaps arose in these matters when people started negotiating.

(30) Mrs Rowbotham spoke about provision for the repatriation of patients to Maidstone if the proposals were implemented. The general public were concerned about bus services not running in the evenings. Would people find themselves stranded? Mr Phoenix responded that the Trust already dealt with travel difficulties now according to people's circumstances. He said that south west Kent had a level of car ownership that was amongst the highest in the county. He also informed the Committee that the changes being proposed would not be affected by car-parking charges.

(31) Mrs Loveday, Chairman of the Patient and Public Involvement Forum for the Maidstone & Tunbridge Wells NHS Trust, said that a Trust representative had attended one of their meetings to explain the proposed change. She felt that there were considerable benefits in the proposals being put forward by the Trust as regards dealing with the issues of cross-infection and mixed-sex wards. She said she felt people that were currently opposing the change would come round to supporting it when it was in place.

(32) Mr Germain, Chairman of Maidstone Borough Council's external scrutiny panel, was then invited to comment. He said that he would not deal with the technical matters as he did not fully understand them – and he suspected that most people present did not either. He said that he agreed with Mr Horne that the Trust had not convinced people that their county-town hospital was not being downgraded. He said that, when consulted, the people of Maidstone rejected the proposals; so he questioned what the point of consultation actually was. Mr Phoenix made it clear to the Committee that it was the PCT that had responsibility for the consultation

process and not the Trust. He said that they had had to put in place a comprehensive process of consultation, which they had done; he was sure that, with the benefit of hindsight, they could they have done things better. He said that it had been West Kent PCT Board's responsibility then to take a decision, in the light of responses received, in the best interest of patients. A lot of the comments that had been received had been predicated on wrong assumptions. The decision had had to be made on the quality, rather than the weight, of opinion expressed.

(33) The PCT Board believed that the proposals would be more convenient and safer than current arrangements, reducing cross-infection and mortality. Twenty-four-hour A&E cover at the Kent & Sussex Hospital, Tunbridge Wells would be an improvement on the current situation. Mr Phoenix acknowledged that a lot of people were frightened and misunderstood the proposals. He acknowledged that the easiest thing that the Trust could have done would have been to take the path of least resistance; but he could not in all conscience have done so.

(34) Dr Thom, representing the Maidstone Division of the BMA, then addressed the Committee. He said that the NHS Overview and Scrutiny Committee had played an enormously helpful role in counterbalancing the corporate management view. The issue was to balance the need for centralisation against the need for local services. This was a national issue.

(35) From the BMA's perspective, the missing ingredient in the proposals had been a clear idea of what was needed for a viable emergency hospital. There had now been considerable improvement in the way the proposals were elaborated. However, Dr Thom pointed out that there remained some areas of concern:-

a) medical staffing in A&E – if staffing levels were maintained, then rotas could be sorted out to allow A&E to be staffed adequately;

b) general medical training;

c) provision for surgical assessments to be carried out at Maidstone when necessary.

(36) Dr Roger Hart, Honorary Secretary of the Maidstone Division of the BMA, said that he was very impressed with the conditions that the PCT Board had imposed on the Trust's proposals. These conditions had taken into account a lot of the questions raised by Maidstone BMA. However, what was missing was the detail. He insisted that the planned external review must be genuinely external and he made a suggestion that it should be for the College of Emergency Medicine to appoint the chairman of the review panel. Dr Hart wished to state that 44% of BMA members in Maidstone had voted in their ballot on the reconfiguration, although the Trust and PCT had tried to dismiss this vote as unrepresentative. He also wished to state that Maidstone A&E was clearly being downgraded from a Level II Trauma Centre to a Level III centre. This was indicated by the fact that the helipad at Maidstone Hospital would no longer be used. Mr Phoenix replied that the PCT seemed to have been "damned with faint praise" for actually moving the matter on. The BMA did appear to be saying that the conditions agreed by the PCT Board had in fact addressed their concerns. As regards the helipad, he said that the use of the Air Ambulance was actually a rare event; and the helipad at Maidstone would still be

used for transfers of patients. There were informal arrangements to land the Air Ambulance at the back of the Kent & Sussex Hospital, Tunbridge Wells, although he accepted that this was not the same as having a helipad. He reaffirmed that the external review panel must be genuinely external. Ms Gibb said that there had been dialogue, which was what consultation was about. The Trust had listened, and modified and changed its position during the consultation. There were still concerns about the details, but the Trust needed to have a decision so they could move on and deal with those details.

(37) Mr Marsh informed the Committee that he was a substitute at the meeting but he had had 22 hours to study the papers. He said that the issue was not about politics but about people. He said it was not about getting a message across but about care. He said it was condescending to say that people did not understand. The Trust and PCT ignored the people of Kent at their peril. He felt it was also condescending to say that the Committee could not understand the details. Members could certainly represent the people of Kent. For the Committee to respond after the external review, he thought, would be “shutting the stable door after the horse had bolted”.

(38) Mrs Tweed talked about the underestimation of the projected population growth in Maidstone and the additional pressure that that could place on A&E services at the William Harvey Hospital, Ashford.

(39) Mrs Stockell said it was wrong to say that people did not understand the issue. The BMA were experts and they were opposed too. She also asked about journey-to-hospital times, and accused the Trust and PCT of using “woolly and weasely” words that were not very convincing. She stated that Maidstone Hospital was being downgraded and that was a fact. Mr Phoenix responded that his comments about Members not understanding had actually been a response to comments that Members themselves had made about their difficulty in understanding technical matters. He said that Mr Marsh had twisted some of his words and he would leave it at that. Ms Gibb added that she recognised that people had a passion for bricks and mortar. Mrs Stockell responded to that comment by saying the issue was not about bricks and mortar but about services. Ms Gibb replied that the Trust had invested heavily in Maidstone Hospital. Downgrading of Maidstone Hospital had been talked about on several occasions and she once again referred to the review of vascular services, which had not led to a downgrading of the service but rather the creation of a centre of excellence. Comments in the press to the effect that A&E was closing or that Maidstone Hospital was closing were not accurate or true. That was, however, what people had written in and protested about. Mrs Stockell asked again about travel-to-hospital journey times. Ms Gibb answered that the Ambulance Service did not think there was a problem. Blue-light ambulances could get through quickly – and certainly more quickly than a car could. She pointed out that a lot of people would need to travel from Tunbridge Wells to Maidstone for elective surgery in future under the proposals, so the change would not be all in one direction.

(40) The Chairman, Mr Chell, informed the Committee that a lot of progress had been made. In his view, the proposals now before the Committee, having been amended through negotiation with the Trust and PCT, were now close to being acceptable – subject to clarification of some minor details and to the conditions that had been

imposed on the Trust by the PCT Board. He moved that, on this basis, the proposed reconfiguration proposals be accepted, subject to clarification of minor details and the outcome of the external review. This was seconded by Mr Fittock. The matter was put to the vote, with five votes for the motion, eight votes against and two abstentions.

(41) Mr Fittock then asked that the Overview and Scrutiny Manager record the way that Members had voted.

For:-	Mr M J Fittock, Mrs C Angell, Ms A Harrison, Mrs E D Rowbotham, Mr M J Vye.
Against:-	Mr M J Angell, Mr A D Crowther, Mr C Hibberd, Mr G A Horne, Mr R A Marsh, Mr M Northey, Mrs P A V Stockell, Mr R Tolputt.
Abstain:-	Mr A R Chell, Mr D A Hirst.

(42) Mr Fittock then said that he felt it was unconstitutional not to have debated the motion before voting. Mr Wild advised the Committee that, a vote having been taken, the item of business was now closed and the Committee should move on. Mrs Stockell moved, seconded by Mr Northey, that, the negotiations having been exhausted without a satisfactory outcome, the proposed reconfiguration and the decision of the West Kent Primary Care Trust Board should, therefore, be referred to the Secretary of State for decision. In debating the motion, Mr Fittock said that the Committee spokesmen had set out for the Trust and PCT a number of reasons for opposing the reconfiguration. The Committee's three spokesmen had worked hard to pursue these objections and other issues, which had all been dealt with satisfactorily. Mr Northey said that he did not like the separation of clinical and human factors, as regards it being more difficult for patients to receive visitors by virtue of being in hospital further away from home. Patient visits were part of the healing process. It was not true that people did not understand. People knew when something was being taken from them. He said that Maidstone was the county town of a major county of England. He referred to the reconfiguration of services in Canterbury, which he said had left the local population with a feeling that they had no longer got what they once had. Mr Hirst asked why the Kent & Canterbury Hospital had ended up with such a huge deficit. He said it all went back to what was being talked about here. There had been a protracted fight, but no extra money had been forthcoming from the Secretary of State. In this instance too, the Secretary of State would not bail them out. All that was happening was that the inevitable was being delayed. There was only so much money, and everything had to be balanced. He felt it was not appropriate to transfer the responsibilities of the NHS Overview and Scrutiny Committee to central government and that matters should be resolved locally. Mr Vye said that referral would delay bringing into being services that would save lives. The Committee needed to move on. There was not a huge number of the highest qualified surgeons in the country. The service was not sustainable on two sites. He said that the issue of Maidstone's county-town status was not relevant and the issue of visitors for patients was a separate matter. Ms Harrison said that Members had clearly not read the papers before them and they were just being political. Members did not want to take a decision that would be unpopular. She said that the proposals were about "need" not "want". Her constituents wanted 24-hour A&E facilities, but the clinical need was not there. The

Committee was being told that this was an improvement of services. Members had made their minds up two-and-a-half hours ago – if not months ago. If Members of the majority party wanted to make the Committee political, then Opposition Members would do the same. She said that the proposals were in the best interests of Maidstone, Tunbridge Wells and Kent – but not, it seemed, the Conservative Party.

(43) Mr Hibberd said that the Committee had not reached an agreement, so referral was the best way to get out of this tangle. Mrs Stockell said that she was sorry about Ms Harrison's comments; Ms Harrison did not represent people in Maidstone as she (Mrs Stockell) did. What was before the Committee was better than before, but it was still full of "maybes". She said the experts had said that the hospital was being downgraded from Level II to Level III. There had been some improvement in the proposals, but they were being told to "take it or leave it", which she found to be antagonistic. Mr Angell said that the Committee had reached a defining moment in its life. Referral to the Secretary of State was a last resort. The Committee had had good relations with the Trust and PCT, and meetings had always been cordial and cooperative. However, the reasons given for the changes were weak. Mrs Angell said that saving lives was not a "fundamentally flawed" reason for change. She referred to one of the other items on the agenda, where reference was made to the protocols for the operation of overview and scrutiny of the NHS across Kent; there was talk about approaching things on a partnership basis and working with NHS bodies, not against them. The attitude of some Members on this issue was not in that spirit. Mrs Rowbotham said that the issue was to achieve proper care in the proper place. She wondered if opening hours could be extended during school holidays. As regards the high level of car ownership, which had been referred to, she was concerned about the environmental impact of any policy that caused people to use their cars more.

(44) The Chairman then put to the vote the motion proposed by Mrs Stockell, and seconded by Mr Northey, that the proposed reconfiguration and the decision of the West Kent Primary Care Trust Board be referred to the Secretary of State. The vote was taken and the result was eight votes for, five against and two abstentions. Mr Fittock then asked that the way Members had voted be recorded.

For:- Mr M J Angell, Mr A D Crowther, Mr C Hibberd, Mr G A Horne, Mr R A Marsh, Mr M Northey, Mrs P A V Stockell, Mr R Tolputt.

Against:- Mr M J Fittock, Mrs C Angell, Ms A Harrison, Mrs E D Rowbotham, Mr M J Vye.

Abstain:- Mr A R Chell, Mr D A Hirst.

RESOLVED:-

that the proposed reconfiguration and the decision of the West Kent Primary Care Trust Board be referred to the Secretary of State.

25. Business Plan for the Private Finance Initiative (PFI) – Pembury
(Ms R Gibb, Chief Executive, Bernard Place, Commissioning and Healthcare Director and Laurence Bunnett, PFI Director, Maidstone & Tunbridge Wells NHS Trust and Mr S Phoenix, Chief Executive of West Kent PCT were in attendance for this item)

(1) The Committee received a presentation on the Business Plan for the Private Finance Initiative (PFI) at Pembury, which is attached as Appendix 2 to these Minutes.

(2) Mr Horne said that the new Pembury Hospital was required as quickly as possible. He had specific questions around the renal unit, the diabetes unit, rehabilitation and continuing life care for people with long-term conditions. He also mentioned concerns relating to the A21 in respect of dualling the carriageway, which he saw as a big issue for the PFI project. Mr Phoenix said that the West Kent PCT was discussing with Guys and St. Thomas' NHS Foundation Trust in London the positioning of the renal unit in a new location, which need not be at an acute hospital site. He referred to the West Kent PCT Board report that was being prepared for the Board's meeting on 24 May 2007, relating to the Community Hospitals review, which would mention the renal unit.

(3) Mr Phoenix also said that diabetes services did not have to be at an acute hospital site either. Mr Place said that some intense short-stay rehabilitation would be at the new hospital but the rest did not necessarily have to be provided at the hospital. Mr Bunnett said that upgrading the A21 was not a critical precondition of the hospital getting built, but there could be a helpful congruence of these two issues. He said that issues around the A228 would also not be an obstacle to the project going ahead. The Trust were working on the question of traffic profile.

(4) Mr Phoenix said, in response to the question about long-term care, that this would not be provided in acute hospitals. Once again, he referred the Committee to the proposals on Community Hospitals – although these were not necessarily the best place either for people who needed care but not medical care; they were better looked after at home or in "more homely settings".

(5) Members asked a series of questions about the source of funding for the PFI; whether the building would be environmentally sustainable; and ensuring that car-parking would not be a "cash cow". Ms Gibb responded that the construction project would not be publicly funded but, as a PFI project, would use wholly private finance. Sustainability and environmental issues would be looked at. The government's review of the project had stated that health issues needed to be reflected in the plan. Local labour would be used where relevant and appropriate, but the project would be in competition for local labour with the 2012 Olympics. Ms Gibb confirmed that cancer patients who had to attend the hospital on a regular basis for treatment would receive a car-parking pass. In answer to a question around the funding of the PFI and whether Value Added Tax would be payable, Mr Bunnett confirmed that VAT was not applicable in the case of a PFI project. If the hospital were to be built under traditional public-sector procurement arrangements, then VAT would be payable.

(6) Mr Vye asked some questions around mental-health provision and said that co-location of these services at the acute hospital site would be a good idea. Mr Phoenix confirmed that the PCT was looking into this with mental-health colleagues as regards bed availability. However, he said it was unlikely that the PFI project would include a dedicated mental-health unit. Mr Phoenix informed the Committee that in West Kent there was a lack of mental-health beds in a community setting. He said that also they were not making the best use of what beds they already had. Therefore, it was not appropriate to be including a mental-health building in the plans for the new PFI project. The Trust representatives responded to questions relating to the provision of individual rooms for all patients within the PFI project. Regarding how the hospital was to be paid for, Mr Phoenix confirmed that this would be through annual payments by the Trust to the PFI company from funds supplied by commissioning PCTs for services provided (which was, of course, taxpayers' money).

(7) The Committee noted that the travel plan would address the road issues. Mr Horne returned to the dualling of the A21 and improvements required for the A228. He said that the A21 was a trunk road and so not a County Council responsibility. However, the matter should still be raised with KCC's Highways department. He said it was important that both patients and doctors had decent road connections. The Committee noted that work on the PFI project would start early in 2008.

26. Fit for the Future update

(Mr S Phoenix, Chief Executive of West Kent PCT was in attendance for this item)

(1) Mr Phoenix informed the Committee that the PCTs in Kent were working towards a consultation document being available by July for the whole of Kent and Medway. This would incorporate the feedback and responses from local "co-design" meetings. The consultation document would deal with forecasting the future financial position across Kent and Medway up to 2015–6. Fit for the Future had been initially predicated on the assumption that there would be a severe financial crisis if nothing happened, but this was no longer the case. The emphasis would now be on the need for more care to be provided in the community. This was about the type, levels and settings of care in the community. He said that it would not be possible to have a once-and-for-all consultation, as things were changing all the time. For instance, he expected very soon to have revised guidelines on stroke-handling. The new standards would require every hospital to do things differently. There would be a network model and not every hospital would do everything. Fit for the Future was unlikely to propose major infrastructure changes. Mr Phoenix offered to come to the July meeting of the NHS Overview and Scrutiny Committee for a preliminary conversation about Fit for the Future.

(2) The Chairman asked whether there would be a common approach to Fit for the Future across the whole of Kent and Medway. Mr Phoenix responded that there would be a single document, localised to particular areas. Mr Horne referred to a 16,000-signature petition relating to the Tonbridge Community Hospital, as well as to similar campaigning in other areas. He asked Mr Phoenix whether Fit for the Future would cover the future of the Community Hospitals. Regarding the renal unit, he asked how this would be paid for. Mr Phoenix responded that Fit for the

Future would reflect proposals on the future of the Community Hospitals that would be in a separate report, which was going before the West Kent PCT Board on 24 May 2007. He said that it would have something exciting and positive to say. With respect to the renal unit, he said that the PCT was already paying Guy's and St. Thomas' Trust, as a specialist provider, for the use of this service. The question was only one of how the service was to be provided in future.

(3) Asked a question about the capital implications of providing care closer to home, Mr Phoenix said that there would be some capital implications but not many. He said that, with the new hospital at Pembury, the county would have the most up-to-date hospital stock in the country. Pembury Hospital would be very new; Darent Valley Hospital was new; Gravesham Community Hospital was new; and Maidstone Hospital was relatively new in NHS terms – and parts of it were very new.

(4) RESOLVED that:-

the position be noted.

27. NHS Overview and Scrutiny Committee – Work Programme and Update on Committee Activity

(1) The Overview and Scrutiny Manager submitted a report updating the Committee on the future work programme and a number of other issues.

(2) Asked about the establishment of a Local Involvement Network (LINk), the Overview and Scrutiny Manager said that reports would be made to the Committee in July and November on the proposal to establish a LINk.

(3) The Overview and Scrutiny Manager made reference to a visit by some Members to the Kent headquarters of the South East Coast Ambulance Service, which had been excellent. He asked if the Committee would welcome a repeat visit. He also asked whether Members would like to visit the Integrated Clinical Assessment and Treatment Service being operated as a pilot in Ashford. The Committee agreed that both these proposed visits would be useful.

(4) Mr Horne raised the issues of: the lack of NHS dentists in Tonbridge; and the future of Tonbridge Cottage Hospital. The Overview and Scrutiny Manager said that, with regard to the Community Hospitals, Fit for the Future was a standing item on the NHS Overview and Scrutiny Committee's agenda and the Committee could maintain a watching brief on this issue under that heading. He also reminded the Committee that its Members and all those who represented an electoral division in West Kent had been invited to a stakeholder meeting about the review of Community Hospitals in West Kent on the afternoon of 17 May at Tonbridge.

(5) Questions were then asked about the homeopathy review being undertaken by West Kent PCT. The Overview and Scrutiny Manager reported that the consultation document was included in the papers before the Committee for their information. The consultation finished on 2 July and a report would be submitted to the West Kent PCT Board on 26 July. He indicated that if Members had any

comments that they wished to make they should make these direct to the PCT. In response to comments from one of the Members of the Committee that there was too much business on the NHS Overview and Scrutiny Committee agendas and that some of the items before them could be tackled informally, the Overview and Scrutiny Manager referred the Committee to the protocols for the operation of NHS Overview and Scrutiny across Kent. These protocols were currently being revisited by a steering group including health, Patient and Public Involvement Forum, and Borough and District authority colleagues. Consideration would be given to delegating some of the work of the NHS Overview and Scrutiny Committee to Boroughs and Districts, which had always been the intention within the existing protocols. He referred the Committee to the issue of the proposed Whitstable Polyclinic, which had been tackled at the last meeting of the Committee, held in Canterbury on 23 March. There was a clear willingness on the part of Canterbury City Council to take forward the overview and scrutiny of this issue.

Appendix 1

The following points were relayed in a telephone call on 10 May 2007 by Geraint Davies, Director of Corporate Affairs & Service Development for the South East Coast Ambulance Service:

- The Ambulance Trust has been actively involved in discussions with both the hospital Trust and the PCT about the MTW reconfiguration plans.

- The additional capital and revenue resources that the Ambulance Trust requires in order to cope with reconfiguration have been clearly identified. They need one extra ambulance vehicle and crew.

- The consultants that were involved in identifying the additional resource requirements, Operational Research in Health (ORH) Ltd, are recognised as leaders in the field of identifying the ambulance-resource implications of hospital reconfigurations.

- The Ambulance Trust will be happy to share ORH's report with the NHS OSC. It's not a confidential document.

Appendix 2

Maidstone and Tunbridge Wells NHS
NHS Trust

Overview & Scrutiny Committee 11th May 2007

Update on Pembury Redevelopment

1

Trust Attendees

Rose Gibb	Chief Executive
Bernard Place	Commissioning & Healthcare Director
Laurence Bunnett	PFI Project Director

2

Acute Hospital Proposals

Strategic Context

3

Strategic Context – 1
Geographic location

4

Strategic Context – 2 Context

- Population
  - Resident 465,500,Wards 27, 4 local boroughs
  - Geographic range of 30 x 30 miles
- Provision of all forms of acute hospital and emergency services
- Provision and specialist services for:
  - Cardiology, complex surgery, foetal and maternal medicine
- Provision of specialist services to West Kent population for:
  - Ophthalmology, children's endocrinology and gastroenterology
- Provider of tertiary services in cancer and complex surgery for:
  - 2.3 million across the county of Kent & Medway up to & including Hastings & Eastbourne
  - Geographic range of 46 x 61 miles, and 72 wards

5

Strategic Context – 3 Trust response

- Ambulatory care and care close to patients' home
- High cost or low volume care, centralised using a hub and spoke model
- Provider of specialist and complex rehabilitation on acute hospital sites
- Day case, one-stop specialist and complex ambulatory services at both sites
- Elective & emergency patient flows, separated, ring fenced elective facilities
- Services to link smoothly between acute, primary, community and social care
- Can be the provider of non acute hospital based specialist or complex services off acute sites

6

Strategic Context – 4
Pembury Redevelopment

- Consolidates Kent and Sussex and Pembury services
- Enables consolidation of Trust obstetric and paediatric services
- Enables final bed stock efficiencies, eradicating duplicate working and rotas
- Provides modern estate and equipment replacing old building stock
- Backlog maintenance £60m eradicated

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Strategic Context – 5
Trust service profile

Critical Care Centre, Tunbridge Wells	SERVICES	Local Hospital and Tertiary Centre, Maidstone
✓	Specialist OPD	✓
✓	Diagnostics	✓
✓	Medical	✓
✓	Surgery	Day case ISTC + Elective IP's
✓	Trauma & Orth	Day case ISTC
✓	Obstetrics	Midwife Unit
✓	Paediatrics	Ambulatory care
Day case	Oncology	✓
Day case	Cancer Surgery	✓
Day case	Urology	✓
Level 2 trauma	A&E	Level 3

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Pembury Redevelopment – 1 Statistics

- Approx. 65,000 sqm
- Approx. £290m public sector (£241m ex. VAT at outturn prices)
- Beds: 512 (100% single room approach)
- Theatres: 8 major + 2 obs
- Outpatient rooms: 37
- Hard Fm by ProjCo, Soft Fm by Trust or Trust party

9

Pembury Redevelopment – 2 (PFI) Procurement Process

- Strategic Outline Case (SOC)
- Outline Business Case (OBC)
- Tender/Selection process – PITN/FITN
- DOH PFI Review
- Post FITN Process
- Provisional Preferred Bidder
- Appointment Business Case completion
- Pref'd Bidder & Planning application submission
- Completion of design & contractual negotiations
- Final Business Case (FBC) completion
- Contract sign (Financial Close) & Construction Start

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Pembury Redevelopment – 3 PFI Review Overview

- Review implemented Nationally
- Tests and requirements:
  - Care closer to home agenda (sustainability)
  - Project deliverability (build-ability)
  - Introduced 15% metric (affordability)
  - Introduced ABC requirement

11

Pembury Redevelopment – 3 Care Model Principles - 1

- Patient Safety Design
  - Infection control
  - Falls
  - Medication errors
  - Sleep and rest
- Therapeutic Environment
  - Light
  - Ambient acoustics
  - Views
  - Colour

12

Pembury Redevelopment – 4
Care Model Principles - 2

- Patient and Family centred care
  - Patient preference
  - Privacy and dignity
  - Involvement of carers
- Care close to patient
  - Near patient data entry
  - Distributed nursing stations
  - Rehab by bed
  - Rehab embedded in ward
  - Minimum intra-hospital moves
- Maximised 'purposeful nursing care'
  - 30% direct care to 60% direct care
  - Walking distances
  - 'Vocera' technology

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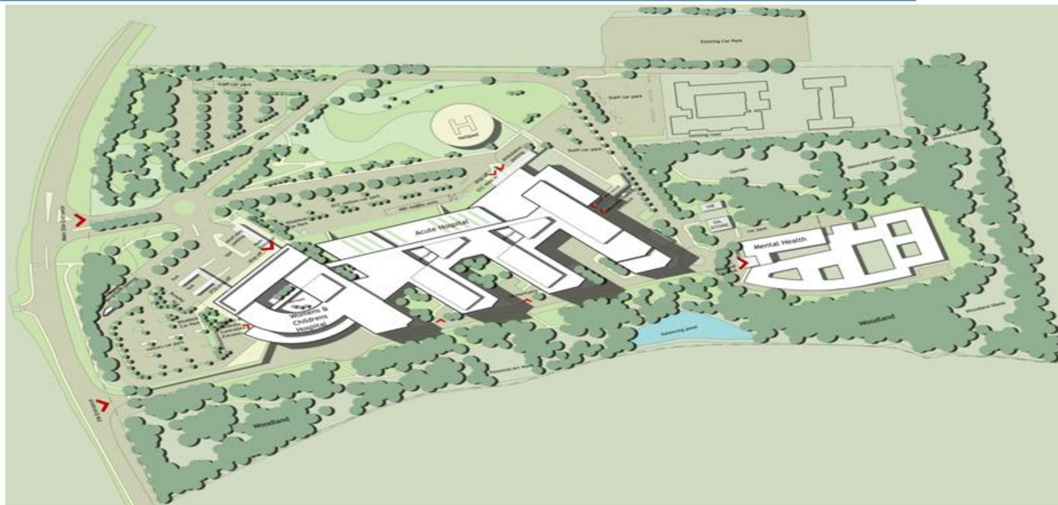
Pembury Redevelopment – 5
Site design



14

Pembury Redevelopment – 6
Room design proposals

Figure 2 The therapeutic environment (acute bedroom shown)

15

Traffic & Transport Issues – 1

- Car Parking
  - 1200 Spaces in outline plan
    - Acute
    - MHU
  - In dialogue with planners (full plan)
  - New Traffic Impact Assessment required
  - Travel Plan

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Traffic & Transport Issues – 2
Highway Infrastructure

- Dialogue with Highways Agency (A21)
- New DoT (Dept of Transport) Circular
  - Transport Impact Assessment
  - Travel plan
- Trust commitment to access

17

Programme update

- ABC
  - Issued to SHA and DH
  - Approval end June/mid-July
  - Pref'd bidder appointment post sign-off
- Design development
  - Work in progress with Provisional Pref'd bidder
  - Planning application under preparation
- Contract preparation
  - Legal & commercial terms for contract nr completion
- Development works
  - Enabling works in progress (lower site clear, asbestos removal)
  - Contract sign and major work start early 2008

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