

By: Overview and Scrutiny Manager  
To: NHS Overview and Scrutiny Committee – Friday 9 February 2007  
Subject: NHS Overview and Scrutiny Committee –Work Programme Update

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

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## **Introduction**

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

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

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

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

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

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

### **Meeting – Friday, 9 March 2007**

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

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

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

### **Health Care Commission Core Standards**

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

#### **Recommendation**

5. The Committee are asked to:-

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

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

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Background Information: *Nil*

### **Reasons based on the written and verbal evidence that the NHS Overview and Scrutiny Committee has received for rejecting the proposals for orthopaedic surgery and emergency care within the Maidstone and Tunbridge Wells NHS Trust**

1. The committee feels that the Trust's consultation document gives a skewed presentation of this matter, failing to acknowledge the true balance of costs and benefits involved in both the proposals and the alternative options. The committee believes that the issue is rather less straightforward and clear-cut than is apparent from the account given by the Trust.

We note also the factual inaccuracy in the report as regards the number of cases that would be affected by the proposals. The report states that this figure is 12 per day and that this amounts to 2,500 per year; however, 12 cases per day would actually give an annual figure of 4,380.<sup>1</sup>

2. The Trust has stated that clinical evidence clearly shows the optimal minimum catchment population for an acute hospital with full A&E capacity to be 500,000. Services operated with a smaller catchment population than this, it is claimed, will inevitably be clinically substandard, as the throughput of patients will be inadequate to guarantee the case-mix needed to maintain consultants' clinical skills at an appropriate level. Consequently, it is argued, the MTW Trust – which has a catchment population of 500,000 – can only have one acute hospital with full A&E capacity.

However, the committee is aware that the evidence base for these claims appears to be less strong than has been asserted – as indicated by two published systematic reviews.<sup>2</sup>

The views of the Royal College of Surgeons and the Institute for Public Policy Research have been cited by the Trust in support of its proposals. But we note that recent publications by both these bodies accept that a catchment population as low as 300,000 is realistic, achievable and clinically acceptable.<sup>3</sup>

At the NHS OSC meeting on 12 January, the committee heard from Dr Thom, representing the Maidstone Division of the British Medical Association, that a catchment population of 250,000 was entirely workable and viable.

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<sup>1</sup> *A new direction for surgical and orthopaedic care*, p. 7.

<sup>2</sup> Ferguson *et al.*, "Concentration and Choice in the Provision of Hospital Services", 8<sup>th</sup> Report of the NHS Centre for Reviews and Dissemination, University of York (1997); Halm, Lee and Chassin, "Is Volume Related to Outcome in Health Care? A Systematic Review and Methodological Critique of the Literature", *Annals of Internal Medicine*, 137, 511–520 (2002).

<sup>3</sup> RCSEng, *Delivering High-quality Surgical Services for the Future* (March 2006), p. 28; ippr, *Hospital reconfiguration: ippr briefing* (September 2006).

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

3. The committee does not accept that configuring local health services is simply a matter of crudely applying a universal “one-size-fits-all” template. Full account must be taken of any detrimental consequences of centralisation, as well as anticipated benefits. In doing so, a range of local factors needs to be taken into consideration, including:
  - population distribution;
  - facilities available in surrounding areas;
  - future population growth; and
  - transport connections.

We note that the NHS National Leadership Network report *Strengthening Local Services: The Future of the Acute Hospital*, which has been cited in support of the Trust’s proposals, acknowledges the need for local flexibility in applying the preferred service model to local circumstances. The illustrative scenarios provided in Appendix 2 of the report include one relating to a District General Hospital covering a rural area and a medium-sized town. This shows Acute Medicine, General Surgery and Trauma & Orthopaedics all provided on one site in support of a 24-hour A&E department.<sup>4</sup>

4. The Trust argues that the quality of modern paramedical services means that journey-times to hospital can be lengthened without adversely affecting clinical outcomes for emergency patients. However, the committee notes that – even allowing for how well-equipped and well-trained paramedics now are – the time taken in transporting emergency patients to hospital still matters.

The committee notes that, under the current proposals, ambulances will have to travel significant additional distances (and along a poor road connection, in respect of the journey between Maidstone and Tunbridge Wells). We are concerned that this will lengthen journey times to an extent that will, in some cases, compromise clinical outcomes – even as far as causing a higher mortality rate.

5. The committee has not been reassured that proper account has been taken of how far, under the proposals, the resources of the ambulance service will be put under greater strain – due to increased journey-times and more time being spent by paramedics stabilising patients. If the ambulance service’s resources were to be overstretched, it could take longer for ambulances to reach patients than is currently the case.

The committee was not given a cast-iron reassurance that sufficient compensating additional resources will be made available to the ambulance service if the Trust’s proposals are implemented.

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<sup>4</sup> NHS National Leadership Network Local Hospitals Project, *Strengthening Local Services: The Future of the Acute Hospital – Reference and Resource Report* (March 2006), pp. 58–9.

6. The committee noted the evidence given at the meeting on 12 January by Mr David Philpott, Chief Executive of the Kent Air Ambulance Trust. Mr Philpott stated that, while his organisation agreed in principle with the reconfiguration of A&E services, it could not support the current proposals.

The Air Ambulance Trust felt that the proposals failed to take account of the “big picture” of services across Kent and Medway, and the need for the appropriate supporting infrastructure to be in place before such changes could occur. Mr Philpott noted that the Kent and Sussex Hospital, unlike Maidstone Hospital, does not have a helipad. He explained that, as well as preventing the Air Ambulance bringing emergency patients in, this would also prevent emergency cases being taken on to specialist services elsewhere (as the service had done at Maidstone in respect of some 37 cases in recent years, thereby undoubtedly saving a number lives).

7. The committee was informed by the Trust on 12 January that the “Fit for the Future” review of health services across Kent and Medway was primarily concerned with financial issues. Therefore, it was argued, it was appropriate for the Trust to address this particular reconfiguration issue before the completion of “Fit for the Future”.

However, this account of “Fit for the Future” clearly runs counter to statements made to the committee by representatives of the South East Coast Strategic Health Authority and of the local Primary Care Trusts. They have clearly stated that “Fit for the Future” is concerned with much broader issues than purely financial ones, and involves considering how health services across Kent and Medway – and, to an extent, beyond – will fit together. Confirmation that this is the case came in the meeting from Mr Philpott, of the Air Ambulance Trust, who directly contradicted the evidence given by the Trust to the meeting about “Fit for the Future”.

The committee finds itself bound to agree with the view, expressed by Mr Philpott, that the reconfiguration of A&E services within MTW Trust must be wholly subsumed into “Fit for the Future”. The Trust, however, insists that reconfiguration must be dealt with as a discrete matter apart from, and prior to, this overarching review. It is suspected that the Trust is actually trying to influence the outcome of “Fit for the Future” by rushing through a pre-emptive decision on the reconfiguration of A&E services within the Trust.

8. The committee has not been convincingly reassured that the A&E departments in Dartford, Medway, Ashford and Tunbridge Wells will all be able to cope adequately with the emergency caseload that will be displaced from Maidstone as a result of these proposals – given that there are no plans to allocate additional compensating resources.

We are particularly concerned that this may become a significant issue in the longer term, with both the Thames Gateway and Ashford being designated by the government as Growth Areas. Further, Maidstone itself has now been awarded New Growth Point status (meaning the construction of a further 10,000 houses in the area – as already noted above).

9. The committee accepts the clinical benefits attached to the separation of emergency and elective surgery – and notes that the wish to achieve this separation is apparently a significant factor in the support that the Trust’s surgeons are giving to these proposals.

However, we do not accept that the only way this can be accomplished is by providing the two services at separate locations, as the Trust maintains. We note that emergency and elective orthopaedics have already been successfully split within one location, at Maidstone.

We further note that the Trust’s proposals will actually achieve an imperfect separation of emergency and elective patients at Maidstone. The plans do not allow for elective general surgery beds to be ringfenced at Maidstone – meaning it is highly likely that some general surgery beds will end up being used by unscreened emergency medical patients.

We would ask the Trust to reconsider the possibility of achieving the separation of emergency and elective surgery while retaining both at the Maidstone site.

10. The committee notes that medical consultants at Maidstone Hospital have argued, through the local BMA division, that the removal of emergency surgery from the hospital will compromise the quality of clinical outcomes. They state that it is not uncommon for some patients to be admitted to A&E with symptoms indicating the need for medical intervention, but subsequently turn out to need surgical intervention. If the Trust’s proposals are implemented, such patients will need to be treated elsewhere, leading, it is argued, to poorer outcomes – including a higher mortality rate.

11. The Trust has clearly stated that its plans do not involve the removal from the A&E department at Maidstone of emergency medicine – which accounts for the bulk of “blue-light” admissions.

However, the committee heard at its meeting from consultants in emergency medicine at Maidstone Hospital that they feared the future of their specialty would be jeopardised. This, it was argued, was due to the anticipated consequences of removing emergency surgery, which is closely linked to emergency medicine.

The committee notes that, while the Trust gave reassurances about the future of emergency medicine at Maidstone, it was stated that detailed plans to allow this still had yet to be formulated. The committee would expect such plans to be in place, and to be acceptable to the clinicians involved, as an important precondition of proceeding to the proposed reconfiguration.

12. The committee notes the apparent willingness of the BMA representatives at the meeting on 12 January to consider a compromise, involving the centralisation of emergency orthopaedic surgery at the Kent and Sussex Hospital, with emergency general surgery continuing to be provided at both Maidstone Hospital and the K&S.

The Trust stated at the meeting that such a compromise would be unacceptable on clinical grounds. The committee would want to know in detail why this is the case and to be reassured that the Trust has explored this option fully before rejecting it.

13. The Trust has accepted that the poor road and public-transport connections between Maidstone and Tunbridge Wells will mean considerable inconvenience for some patients, as well as for the relatives and friends of patients who wish to visit them, if the proposed changes go ahead. However, the Trust maintains that any inconvenience thereby caused is heavily outweighed by the clinical benefits of change.

The committee would contend that, since the purported clinical benefits of the proposals are clearly open to doubt, the inconvenience the proposals would cause to patients and the public can less easily be dismissed in weighing up the costs and benefits attached to options for change.

14. The committee notes that, as was apparent at the meeting on 12 January, there is clearly a sharp division in clinical opinion within the Trust (and beyond) on these proposals. Whilst the surgeons seem strongly in support of the changes, their physician colleagues (both medical consultants and general practitioners) are clearly overwhelmingly opposed.

The Trust appears to take the view that it has achieved adequate clinical engagement as the surgeons are supporting the proposals – and that, whilst the opposition of other clinicians is unfortunate, it is not possible to please everyone all the time. The committee takes the view that, whilst it is clearly unrealistic to expect complete unanimity among clinicians, the clear split between surgeons and physicians on these proposals greatly weakens the claim that there is proper clinical engagement.

The medical consultants argued on 12 January that, while the surgeons had been involved in formulating the proposals, the physicians had not – they were simply presented with a *fait accompli*. We are concerned that these proposals do appear to have been developed without reference to clinicians in a specialty on which they are bound to have a significant impact.

The views of GPs in Maidstone have also clearly not been taken into account in framing the proposals. These views were expressed on 12 January by the BMA's Dr Debbie Taylor, who stated starkly that "people will die" as a result of longer ambulance journey times if the proposals are implemented.

The committee believes that the Trust's claim to have adequate clinical engagement in respect of its proposals is not tenable. We would want to see evidence that the Trust has achieved full clinical engagement, involving physicians as well as surgeons, and primary-care practitioners as well as consultants.