

*IRP*

*Independent Reconfiguration Panel*

*ADVICE ON NHS SERVICE CHANGE  
IN EAST KENT*

Submitted to the Secretary of State for Health

12 June 2003



*Independent Reconfiguration Panel*

*“Our aim will be to make sure that decisions about local services are made at local level – by the people directly affected by those decisions.”*

Dr Peter Barrett, Chair, Independent Reconfiguration Panel

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## **EXECUTIVE SUMMARY**

The NHS Plan published in July 2000, set out a challenging programme of reform to provide the best possible services for patients. As the NHS considers how best to implement the necessary change, many trusts and health authorities are considering changes in the way services are organised. Inevitably, such changes sometimes arouse considerable local, and in some cases national interest. The Independent Reconfiguration Panel (IRP) offers advice to the Secretary of State for Health on contested proposals for NHS reconfigurations and service changes in England.

The Independent Reconfiguration Panel was asked to examine proposals for changes to the provision of health services in East Kent.

Our advice to the Secretary of State for Health is that:

- The three main acute hospitals should work interdependently, each contributing to the provision of specialist services where it is feasible to provide such services only on one or two of those hospital sites.
- The health community of East Kent, including the Acute, Community and Ambulance Trusts, PCTs, Social Services and the Strategic Health Authority, must continue to follow an inclusive process of involvement. The OSC, CHCs and all stakeholders, including patients and the public, must be fully involved in the development of services for the whole of East Kent.
- There is now little support for the proposals for change as set out in the decision of 25 March 2002 [by the East Kent Health Authority].
- The interim proposals represent the speediest and most efficient means of proceeding in the interest of the people of East Kent.
- The health community should work with the NHS Modernisation Agency in the development of the interim options. They should seek to develop robust clinical

networks across the whole health community, demonstrate the benefit to patients' through appropriate pathways, and take account of the needs of staff.

- A health community transformation team, led by the four PCTs, should ensure that all health services that do not need to be provided on hospital sites should be located in local settings.
- The development of a Local Emergency Centre at the Kent and Canterbury Hospital, linked to appropriate resources and training for the ambulance service, is an appropriate way to proceed.
- The Private Finance Initiative, which has been suspended, should be abandoned. Any new PFI initiative, to address key estate renewal issues, should only be considered once the Trust has reached a position of greater financial stability.
- Improvement and rationalisation of the estate should be addressed in an integrated way with the implementation of the interim proposals. A longer-term strategy will be required to meet all estate renewal requirements.
- Consideration should be given to the potential benefits of a plurality of partners in developing elective services.
- The National Cancer Plan should continue to be implemented through the Kent Cancer Network.
- The Kent County Council, in collaboration with the health community, should continue their progress in addressing the problems of transport in East Kent.
- In implementing the interim proposals, the health community should ensure full engagement with the OSC, CHCs and all stakeholders, including patients and the public, so that solutions that best meet the needs of the local population can be reached in the swiftest possible manner.

- All healthcare professionals in training in East Kent should receive their clinical experience according to the new shape of local health services as they are re-developed.

## OUR REMIT

### *What was asked of us*

- 1.1. The Independent Reconfiguration Panel's general terms of reference are included in Appendix One.
- 1.2. On 11 April 2003, Hazel Blears, Parliamentary Under Secretary of State for Public Health, wrote to the IRP Chair, Dr Peter Barrett, asking the Panel to examine proposals for changes to the provision of health services in East Kent. Hazel Blears' letter, which sets out the specific terms of reference, and Peter Barrett's reply to that letter, are included in Appendix Two.
- 1.3. The Panel was asked to consider:
  - a) *Whether it is of the opinion that the proposals for change set out in the decision of 25 March 2002 [by the East Kent Health Authority] will ensure the provision of safe, effective and accessible health services for the people of East Kent. And if not, why not;*
  - b) *Any other observations the Panel may wish to make in relation to the proposals for change; and*
  - c) *In the light of a) and b) above, the Panel's advice as to how to proceed in the speediest and most efficient manner in the interests of local people.*

*and to submit its recommendations by 12 June 2003.*
- 1.4. The deadline set was a demanding one. However, as Hazel Blears states in her letter, the local health community is currently operating under considerable pressure and the people of East Kent are in urgent need of action to improve the delivery of local health services.
- 1.5. For these reasons, the Panel agreed to accept the requested deadline.

- 1.6. In formulating our advice to the Secretary of State for Health, we have specifically commented on the proposals included in the East Kent Health Authority's decision of 25 March 2002, and on interim proposals that have subsequently evolved from the East Kent Hospitals Trust since that decision was made. Our comments on those two sets of proposals have framed our response to part c) of our commission – how to proceed in the speediest and most efficient manner in the interests of local people.
- 1.7. We have commented only briefly on the process of consultation undertaken. This is for two reasons. First, a judicial review conducted in November 2002 considered this issue in detail. Secondly, while clearly there are lessons to be learned from the past, we are conscious of the need to move forward. Our advice has been developed on that basis.



## **OUR PROCESS**

### ***How we approached the task***

- 2.1. The Panel Secretariat asked the Kent and Medway Strategic Health Authority (SHA) and the East Kent Hospitals Trust (EKHT) to obtain all relevant documentation, and to arrange site visits, meetings and interviews with interested parties. The Panel wishes to record its thanks to all those in the Authority and the Trust who assisted with this. We also wish to thank all those who gave up their valuable time to present evidence to the Panel, and to everyone who wrote to us offering their views.
- 2.2. As part of the process for compiling evidence, the SHA in conjunction with the Trust, completed a standard information template compiled by the Panel. The completed template can be accessed through the IRP website ([www.doh.gov.uk/irp](http://www.doh.gov.uk/irp)).
- 2.3. Nick Naftalin, Mark Santer and Malcolm Stamp were selected to lead the consideration of the proposals although in practice the Chair and all members of the Panel were closely involved.
- 2.4. Panel members visited East Kent on two occasions. Peter Barrett, Nick Naftalin, Ray Powles, and Mark Santer visited the Kent and Canterbury Hospital, Canterbury on the morning of 20 May 2003. Peter Barrett and Mark Santer then went on to visit the William Harvey Hospital, Ashford in the afternoon. On the morning of 27 May 2003, Malcolm Stamp and Sanjay Chadha visited the Buckland Hospital, Dover. Nick Naftalin and Lise Llewellyn visited the Sturry Surgery, a primary care facility near Canterbury. The two groups then visited the Queen Elizabeth the Queen Mother Hospital in Margate in the afternoon. The IRP Chief Executive, Tony Shaw, and Secretary, Martin Houghton accompanied Members on the visits.
- 2.5. Despite the present uncertainties in East Kent, the Panel was most impressed with the professionalism and dedication of the staff they met. The deep

concern of patients and their carers for their health services was evident throughout.

- 2.6. Prior to our visits, as part of our inclusive process, invitations were extended to all interested parties to meet Panel Members either during the visits or separately. A list of people we met or held telephone conversations with during the course of our work is included in Appendix Three.
- 2.7. Interested parties were also offered the opportunity to submit written evidence to the Panel. A list of all evidence submitted is contained in Appendix Four. The Panel considers that the documentation received provides a fair representation of the views from all sides of the debate.
- 2.8. The Panel reviewed a draft report on 6 June 2003 for submission to the Secretary of State. The advice contained in this report was finalised and agreed at that meeting.
- 2.9. Throughout our consideration of this complex case, our primary aim has been to reflect the needs of patients, the public and staff and to consider how services can be optimally configured to suit best the needs of the greatest number of people in East Kent.
- 2.10. The advice contained in this report represents the unanimous view of the Chair and eight members of the IRP.

## THE CONTEXT

### *A short history*

- 3.1. The Panel's role is to offer advice to the Secretary of State for Health on proposals for service change in East Kent. Whatever course of action is ultimately decided upon will inevitably involve some difficult decisions. The diverse geography and population of East Kent was very much reflected in the evidence, both written and oral, that was presented to us. However, people on all sides of the debate were agreed on two issues. First, that maintaining the status quo is not an option. Secondly, that an early decision is needed to put an end to the impasse.
- 3.2. There is a long and complex history attached to the configuration of health services in East Kent. The process began in the early 1990's with a series of service reviews. These identified inequalities in healthcare delivery together with a lack of responsiveness to healthcare needs particularly in the provision of services for the elderly and the deprived.
- 3.3. This led to the publication in 1997 by the East Kent Health Authority of *Tomorrow's Healthcare*, a service review to consider solutions to the problems identified. *Tomorrow's Healthcare* concluded that it was not possible to retain major and complex services on all three main hospital sites in the long term.
- 3.4. A public consultation was held in 1998, after which revised proposals were published in a further consultation document *The Future of Hospital Services in East Kent* (also known as *A Better Balance*). The Health Authority's preferred option within these proposals was for the continuation of acute medicine (without surgical support) and retention of a core of local services in Canterbury whilst centralising specialist services at Ashford and Margate. Following objections by the Canterbury and Thanet Community Health Council (CHC) and the South East Kent CHC, the matter was referred to the then Secretary of State for Health, Frank Dobson. On 22 December 1998, the

Secretary of State broadly endorsed the proposals, although he also imposed a number of conditions.

- 3.5. One of the conditions imposed was that the NHS Trusts involved should merge to take forward the proposals. In April 1999 the East Kent Hospitals Trust was formed from a merger of the Kent and Canterbury Hospitals NHS Trust, the South Kent Hospitals NHS Trust, and Thanet Healthcare NHS Trust.
- 3.6. During the course of 2000 and 2001 it became evident that the new Trust faced an extremely difficult task in implementing the chosen option. Concern grew about the sustainability of the proposals contained in *A Better Balance* as a long-term solution.
- 3.7. After further work, formal public consultation on four options for service development was undertaken between 5 December 2001 and 28 February 2002. These are outlined in the consultation document *Modernising Hospital Services in East Kent*. Following the consultation, the East Kent Hospitals Trust Board met on 18 March 2002 to consider comments received on the proposals and to make recommendations to the East Kent Health Authority. The Board recommended that the future configuration of acute services in East Kent should follow a combination of options C and D as outlined in the consultation document and that further work be undertaken to consider renal and vascular services.
- 3.8. In brief, these proposals recommended that:
- Acute medicine should be provided on two sites - William Harvey Hospital (WHH), Ashford, and the Queen Elizabeth the Queen Mother Hospital (QEQM), Margate.
  - Elective medicine should be provided on three sites – the WHH, the QEQM and the Kent and Canterbury Hospital (KCH)

- Other elective services should be provided on three sites – the WHH, the QEQM and the KCH
- KCH should have a diagnostic and treatment centre (DTC).

3.9. This recommendation was broadly supported by the East Kent Health Authority at its Board meeting on 25 March 2002, though the Authority asked for further work to be undertaken on renal and vascular services. The newly established Kent and Medway Strategic Health Authority also gave its support at a meeting on 18 April 2002 subject to further work.

3.10. In April 2002, two local community health councils (CHC) – the Canterbury and Thanet CHC and the South East Kent CHC – formally objected to the proposals and, in accordance with the CHC Regulations 1996, asked that the matter be referred to the Secretary of State for Health. The Canterbury and Thanet CHC objected on the grounds of clinical viability, safety and sustainability. The South East Kent CHC objected on the grounds of inadequate bed capacity proposals and inadequate consultation.

3.11. In September 2002, Mrs Maureen Smith, a member of a local campaigning group, Concern for Health in East Kent (CHEK), sought and became the claimant for a judicial review of events.

3.12. The hearing was held on 12 – 15 November 2002. The judge, The Hon. Mr Justice Silber, delivered his opinion on 4 December 2002. He concluded that the process had been properly conducted and did not uphold any of the grounds for objection.

3.13. However, since the decision of 25 March 2002 was made, various factors emerged that directly influenced the environment in which the decision was taken. These factors included:

- The introduction of new organisational arrangements within the healthcare system. In particular, the developing role of primary care trusts as primary

commissioners of local healthcare and the establishment of strategic health authorities as strategic developers of healthcare within health communities

- Re-assessment of the East Kent Hospital Trust's financial situation, including the re-appraisal of the proposed private finance initiative
- Recognition of the continued opposition to the preferred option by sections of the local population
- Ongoing service sustainability issues, including concerns expressed by Royal Colleges
- The publication of new policy guidance by the Department of Health:
  - i. Keeping the NHS local – A New Direction of Travel*
  - ii. Strengthening Accountability – Involving patients and the Public*

3.14. Questions began to arise about the long-term sustainability of the proposals agreed in the decision of 25 March 2002 and the ability to implement them within an acceptable time-scale. Recognising these difficulties, the East Kent Hospitals Trust, in collaboration with its health partners, began to develop interim proposals that could provide a “bridge” to achieving long-term aims.

3.15. Three interim proposals have been developed. Briefly, service changes common to all three options are:

- A&E at KCH to be redesigned as a Local Emergency Centre
- Women's health on two sites (WHH and QEQM)
- Child health on two sites (WHH and QEQM)
- Trauma on two sites (WHH and QEQM)
- Colorectal surgery on two sites (WHH and QEQM)
- Vascular surgery centralised at KCH
- Urology centralised at KCH
- Clinical haematology centralised at KCH

3.16. The differences in the organisation of clinical services under the three options are:

3.17. **Option One**

- Large Elective Centre at KCH including the centralisation of Orthopaedic Surgery and Breast Surgery

**Option Two**

- Some Elective Surgery at KCH – Orthopaedic Surgery to become two site working (KCH and QEQM) with Breast Surgery centralised at QEQM

**Option Three**

- Mainly two site working with Orthopaedic Surgery at WHH and QEQM and Breast Surgery at WHH and QEQM

3.18. No formal decision on any of these proposals has been taken pending a decision by the Secretary of State for Health on the proposals referred to him in April 2002 (that is, the decision of 25 March 2002).

## **THE EVIDENCE**

### ***What we established***

4.1. A vast amount of written and oral evidence was submitted to the Panel. We are grateful to all those who have taken the time to offer their views on this important subject. The evidence put to us is summarised below.

#### **4.2. Geography, Demography, Access and Transport**

##### **4.2.1. East Kent profile**

The East Kent Hospitals Trust provides services for a geographically and demographically diverse population. The current population of East Kent is around 620,000. The area is predominantly rural with the main population concentrations in:

- Margate, Ramsgate and Broadstairs (Thanet) – 120,000
- Canterbury – 30,000 within the city boundary but a wider population of around 130,000 within the Canterbury Council boundary that incorporates Faversham, Whitstable and Herne Bay.
- Ashford – 102,000

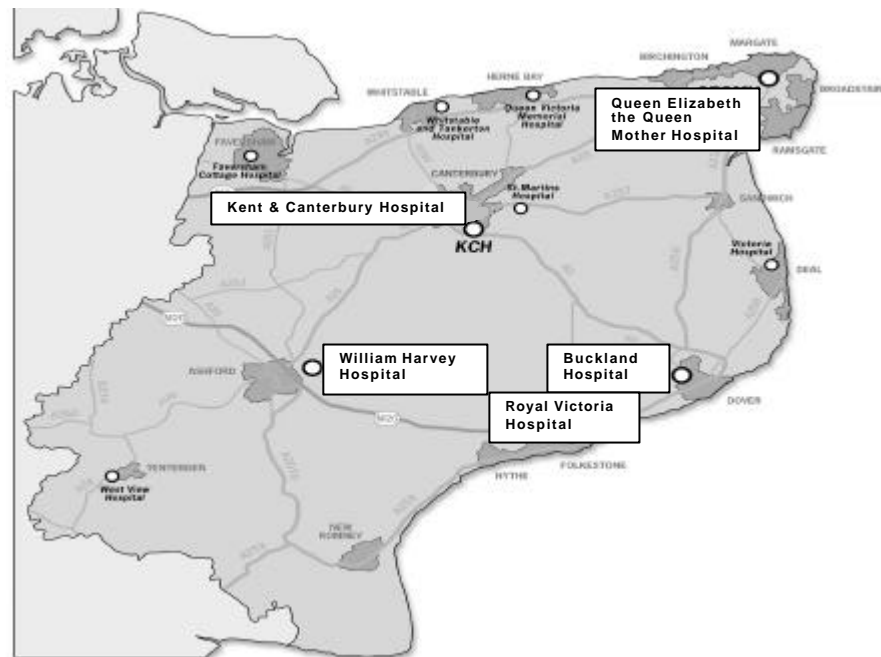
There are further population concentrations in the coastal towns of Deal, Dover and Folkestone plus numerous villages within the area.

4.2.2. Overall, the population is set to expand by 2.4% over the next ten years. However, the impact is not evenly spread throughout East Kent. The most significant increase will occur in Ashford where the population is planned to double in size to 200,000 by 2031. The Panel also heard of plans for expansion in Thanet and Canterbury though the current status of those proposals was not



clear.

*Figure 1: Current hospital sites in East Kent*



4.2.3. The average life expectancy is 78 years. The population is growing in the older age group, due in part to East Kent's popularity as a retirement area. The elderly population is concentrated in the coastal towns. Overall, the area compares favourably with the national average in terms of deprivation and health indices. There are, however, some significant pockets of deprivation notably in Thanet and in Dover.

4.2.4. The East Kent Hospitals Trust comprises three main acute sites at:

- Ashford – the William Harvey Hospital
- Canterbury – the Kent and Canterbury Hospital
- Margate – the Queen Elizabeth the Queen Mother Hospital

There are also hospitals in:

- Dover – the Buckland Hospital
- Folkestone – the Royal Victoria Hospital

There are approximately 1,600 acute beds across the Trust.

4.2.5. Other healthcare services in the area are provided by:

- The East Kent Community Trust
- Four primary care trusts – Ashford PCT, Canterbury and Coastal PCT, East Kent Coastal PCT, and Shepway PCT
- Kent Ambulance Trust
- The neighbouring Maidstone and Tunbridge Wells NHS Trust provides health services in West Kent, including the Maidstone, Pembury and Kent & Sussex Hospitals
- Cancer services are managed from the Maidstone and Tunbridge Wells NHS Trust as part of the Kent Cancer Network.

East Kent represents roughly one half of the area for which the Kent and Medway Strategic Health Authority is responsible.

4.2.6. **Access and Transport**

Transport links are heavily influenced by the area's proximity to London. While there are generally good radial links to and from London, lateral links across East Kent are less well developed. The main transport links connecting the area are arterial roads – the M2/A2 connecting London to Faversham, Canterbury and Dover, and the M20 linking Maidstone, Ashford and Folkestone. Road links running laterally across the area often get congested, notably the A28 connecting Ashford to Canterbury and Margate.

4.2.7. Similarly, rail links connect the area to London with lines through Faversham and Canterbury to Dover, along the coast to Margate and Ramsgate, and through Ashford to Folkestone. A service also operates between Ashford, Canterbury and stations in Thanet.

4.2.8. Patient transport services have been established to connect the three main sites. 200,000 patient journeys per annum are provided. A health hopper bus has been introduced to aid travel between

sites. A volunteer car scheme has also been established and is managed by the Trust's transport department.

**4.3. Services provided, their current and possible future location**

4.3.1. The three main hospital sites at Ashford, Canterbury and Margate provide a range of acute services; including a 24 hour Accident and Emergency service on each site. Inpatient and day care services, care of older people, low risk obstetric and minor injuries services are provided at the Buckland Hospital in Dover. Care of older people, stroke rehabilitation and a minor injuries unit are provided at the Royal Victoria Hospital in Folkestone. The Kent and Canterbury Hospital is part of the Kent Cancer Network.

4.3.2. A chart showing the current organisation of hospital services across East Kent and the location of services that would exist under the proposals for change set out in the decision of 25 March 2002 is included at Annex One. The location of services that would exist under each of the interim options is shown in Annex Two.

4.3.3. A substantial amount of evidence was submitted in relation to the future location and operation of clinical services, in particular on emergency care and cancer services. We have not attempted to include all of the issues raised in this document but some are of particular relevance.

**4.3.4. Emergency care**

A full Accident and Emergency service is run from each of the three main sites. The Buckland Hospital in Dover and the Royal Victoria Hospital in Folkestone both provide services for the treatment of minor injuries. Around 135,000 patients per year are treated in the Trust's main A&E departments with a further 28,000 receiving treatment in the minor injuries units.

4.3.5. Emergency care provision in East Kent has recently undergone a programme of modernisation. Changes to acute care access now mean that the Trust is consistently achieving a rate in excess of 95 per cent on the under four hour waiting time target at KCH.

4.3.6. The Kent Ambulance NHS Trust provides an emergency service, a non-emergency patient transport service and a special transport service for the 1.6 million residents in Kent. The emergency service responds to approximately 3,000 calls per week, including 999 calls, doctors' urgent requests and high dependency hospital transfers. The Trust is one of the key members of the East Kent Emergency Care Network.

4.3.7. **Cancer services**

The Kent and Canterbury Hospital is part of the Kent Cancer Network. It is currently undergoing a major programme of investment, both in equipment and staff. A replacement £1million linear accelerator for radiotherapy treatment has just begun treating patients, which is supported by new scanning and treatment planning equipment. Funding has also recently been announced for the replacement of the second linear accelerator at KCH. A new £1 million breast-screening unit at KCH is now operational.

4.3.8. **Other services**

i). Renal Services and Vascular Surgery

The Renal Unit at KCH serves a population covering East Kent, Maidstone and Medway and provides services for the three main categories of renal condition; end stage renal failure, acute renal failure and general nephrology. Transplantation services for local residents are provided from specialist centres in London. Vascular Surgery is provided at WHH, QEQM and KCH. It is widely acknowledged that vascular surgery requires a population of 600,000 to maintain viability and that it is best provided from the same location as renal medicine.

ii). Pathology

Pathology services are provided across the Trust. Development of the service has been hampered by the planning blight affecting the Trust.

iii). Women's and Children's Services

The Royal College of Obstetrics and Gynaecology and the Royal College of Paediatrics are both due to review the Trust's recognition for training posts in Summer 2003. Concern has been expressed that recognition for SHO training posts may be withdrawn unless firm plans are in place to reduce the location of services from three to two sites.

4.4. **Workforce issues**

4.4.1. The Trust has experienced particular difficulties in recruiting and retaining staff. The problem is apparent in a number of specialities and is in part linked to the uncertainty about the future shape of services. As a result, high costs have been incurred in the use of agency staff.

4.4.2. Implementation of the European Working Time Directive, which limits the number of hours staff are able to work, is also having a significant effect.

4.4.3. There are national and local negotiations with the primary care services and the consultant workforce respectively about future working arrangements in a modern NHS. The results of these negotiations will affect the way in which services are delivered in the future.

4.5. **Finance**

4.5.1. The health community of East Kent is facing a significant,

ongoing financial deficit. A financial recovery plan is being implemented with the assistance of the Kent and Medway Strategic Health Authority.

4.5.2. Linked to the proposals set out in *Modernising Hospital Services in East Kent* was a Private Finance Initiative (PFI) intended to address many of the estate issues involved.

4.5.3. The Trust recently announced that, in view of the growing costs associated with the PFI (in excess of £250m) the proposal had been suspended.

4.6. **Other issues**

4.6.1. **Localised settings**

The four PCTs are currently reviewing local provision of ambulatory care services with the intention of bringing together a range of services wherever possible. These include primary care, minor injuries, pharmacy, dental services, optical services, walk in centres, outpatients, other community clinics and day care.

4.6.2. **Estate matters**

The physical condition of the estate varies considerably across East Kent. While parts of the estate comprise modern and well maintained stock, much of the estate is old and there is a backlog of maintenance work. In the older parts, it is widely recognised that functional suitability and space utilisation is poor.

4.6.3. **Medical Teaching**

There are plans to teach pre-clinical medical students at the University of Kent at Canterbury in association with the Guy's, St Thomas' and Kings Medical School. Additionally, the Medical School has a link with the East Kent Hospitals Trust and an understanding, that from 2004, more medical students will receive part of their clinical teaching and experience in East Kent.

**4.6.4. Consultation and public involvement**

Public consultations on proposals for service change were held in 1998 and 2001. A Judicial Review of events took place in 2002. A local campaigning group, Concern for Health in East Kent (CHEK), has conducted a campaign highlighting many issues focussing on patients and their care. Equally strong views were also expressed that CHEK did not speak for the whole of East Kent but solely for residents of Canterbury.

## DISCUSSION

### *With reference to our remit*

5.1 Working through the written evidence submitted, and listening to the views expressed during our visits and meetings, a number of key themes consistently emerged. These are summarised below.

5.2. **Access and Transport**

5.2.1. Transport and access to health services is a core issue. A considerable amount of work has been undertaken to survey transport arrangements and establish accurate travelling times. Much of this data is necessarily of a complex nature. But it was also apparent to the Panel that the general public had great difficulty in fully understanding this information. The Panel sympathises with this view – we found that the best way to assess the transport and travelling situation was to undertake some of the journeys ourselves. We acknowledge that traffic conditions worsen considerably during school term time.

5.2.2. Evidently, despite the considerable amount of work undertaken by all stakeholders to improve transport links in the area, gaining access to services remains a real issue.

5.2.3. The valuable role undertaken by volunteer drivers is much appreciated. However, this role should not be taken for granted and the transport service should not depend on the goodwill of volunteers.

5.2.4. The Kent County Council NHS Overview and Scrutiny Select Committee (OSC), in its *Select Committee Topic Review of “Modernising Hospital Services in East Kent”*, stated that:

*“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”.*

Co-operation between the County Council and the Trust, PCTs and other health partners is essential to support the development of the public transport infrastructure in East Kent.

### 5.3 **Emergency Care**

- 5.3.1. The Trust operates three A&E units, one at each of the main hospital sites. The standard of the facilities on each site was variable – a fully refurbished facility at QEQM, a 1970s building at WHH, and older facilities at KCH.
- 5.3.2. There has been considerable debate over many years about the viability of maintaining accident and emergency services on three sites. General agreement appears to have been reached that this is not a sustainable option and that in future full A&E services should be concentrated on just two sites. However, the debate has continued about on which two sites future services should be concentrated.
- 5.3.3. The decision of 25 March 2002 would have altered A&E services at the Kent and Canterbury site whilst retaining A&E services at Ashford and Margate. Canterbury residents have been worried by what they see as an unjustified downgrading of their emergency services. They claim that their workload is similar if not greater than that of the other two hospitals.
- 5.3.4. The interim proposals would see emergency services at KCH developed into a Local Emergency Centre. Those with more serious injuries would receive care at well-resourced facilities at WHH or QEQM. This arrangement would enable the sustained development of major trauma centres in East Kent that would benefit the whole health community whilst continuing to provide appropriate local emergency services to those users of KCH.
- 5.3.5. The Panel heard interesting evidence about the transformation of

emergency services at KCH and its potential value as a basis for the modernisation of emergency access across all specialities in East Kent. The approach involves a shared vision for unscheduled care across the whole healthcare system. It recognises that a significant proportion of those admitted for care only need to stay in hospital for a brief period. The key element of acute assessment is to ensure that a patient is safe to return home by the exclusion of certain key diagnoses. Planning the patient pathway to provide a standardised response allows the maximum utilisation of alternatives to hospital admission. The Panel was encouraged by this initiative and supports its extension across East Kent.

- 5.3.6. The Kent County Council NHS OSC, in commenting on *Modernising Hospital Services for East Kent*, stated that the provision of safe emergency care under the proposals will be dependent on the expansion of the Kent Ambulance Trust (KAT). The same is equally true under the interim options. It is vital that expansion of the service is adequately funded, monitored and developments clearly communicated to the public.

## 5.4 Cancer Services

- 5.4.1. The Kent Cancer Network is managed by the Maidstone and Tunbridge Wells Trust and is seen, by some, as being too remote. But the concept of networks for the provision of treatment for cancer is central to national policy. Nationally, cogent arguments for the modernisation of cancer services were put forward in the policy framework for commissioning cancer services in 1995 leading to the National Cancer Plan September 2000 and the establishment of 34 cancer networks in England in 2001. The National Institute for Clinical Excellence (NICE) guidance specified the framework for the service delivery of cancer services and the evidence base for the appropriate delivery of those services. The process of Cancer Network accreditation took place in 2001 after the publication of the Manual of Cancer Services

Standards. This led to the accreditation of 34 English cancer networks and 59 cancer centres.

5.4.2. The Kent Cancer Network proposes that the East Kent service for radiotherapy and chemotherapy day attenders and outpatients should continue at KCH. This would be supported by high quality diagnostic and treatment services. Patients with rarer forms of cancer would receive their care at specialist centres in London and Maidstone.

5.4.3. Everyone we have talked to in the course of our discussions agreed that it was right for the rarer forms of cancer to be treated in specialist centres in London and Maidstone in accordance with the national guidance.

## **5.5 Other services**

### **i). Renal Services and Vascular Surgery**

The Panel notes that the Strategic Health Authority is currently undertaking a review of renal services and vascular surgery for Kent and Medway.

### **ii). Pathology**

Clearly, some services need to be centralised for recruitment and sustainability reasons whilst others, where patient attendance is involved, need to be offered locally. It is to be hoped that greater certainty about the future direction of services across the Trust will help to resolve these issues.

### **iii). Women's and Children's Services**

Again, greater certainty about the future direction of services should help to meet the concerns of the Royal Colleges and allow the development of a sustainable, high quality service.

## **5.6 Workforce issues**

5.6.1. The effects of the European Working Time Directive (EWTB) and

general problems with recruitment and retention of staff figured widely in discussions.

5.6.2. The EWTD is a common problem affecting trusts throughout the country. Innovative approaches are needed to tackle this and the re-organisation of emergency care in East Kent is already contributing and reducing the burden on medical staff.

5.6.3. Whatever the outcome of negotiations about the new contract for primary care, and attempts to agree a new consultant contract, opportunities to work in innovative ways may present themselves. These opportunities should be explored to the benefit of patients. Simply attempting to do more of the same is not a sustainable option.

5.6.4. It is clear that uncertainty about the future configuration of services in the Trust has had a major and very unsettling impact on the recruitment and retention of staff. Resolution of this uncertainty and clear messages on future direction will help to address these problems.

## 5.7. **Finance**

5.7.1. The current financial position is serious and is receiving urgent attention from the local health community.

5.7.2. The Capital Cost Summary contained in *Moving Forward: a strategic outline case for modernising hospital services in East Kent*, published in February 2001, put the cost of the proposed PFI scheme at just over £102 million. At the point at which work on the PFI scheme was suspended, the cost had grown to in excess of £250 million. The Panel notes the Trust's recognition that a scheme of this magnitude is unworkable given the underlying financial deficit.

## **5.8. Other issues**

### **5.8.1. Localised settings**

The four East Kent PCTs are developing proposals for a range of services that are now or could in the future be provided in local settings. These would centre on communities co-locating various services that at present operate from different locations and different premises. These plans are being developed in conjunction with other NHS providers and with social care providers. The Panel was impressed by the work that has been done so far and supports the PCTs and its partners in taking this work further.

### **5.8.2. Estate**

The Panel recognises that some areas of the estate are in need of urgent renewal. Other areas will be in need of attention in the future and further investment required. The potential benefits of new technology and new ways of working should be borne in mind as the Trust tackles these issues.

### **5.8.3. Medical Teaching**

The fact that more medical students may in the future be placed in East Kent has been used by some to support their case for a particular shape of clinical services to accommodate the students. However, it can also be argued that students should follow the patients and that this proposal should not be allowed to influence decisions on where services are sited.

### **5.8.4. Consultation process**

The Judicial Review of November 2002 found that the process undertaken was entirely lawful. The Judge complimented a number of parts of the process. Nevertheless, it is apparent, given the level of disquiet that has existed for so long, that sections of the general public in East Kent have been unhappy with the level of involvement and influence that they have been permitted in deciding on their

future healthcare provision. New requirements for involving patients and the public in shaping the future of the NHS are now in place through the Health and Social Care Act 2001. In February 2003, the Department of Health published good practice guidance on involving and consulting patients and the public in *Strengthening Accountability – Involving Patients and the Public*. Guidance on the operation and functions of local authority overview and scrutiny committees – *Overview and Scrutiny of Health – Guidance* - was published in May 2003. It is essential that all future action to develop services in East Kent fully meet the requirements of legislation and the Department's guidance.

## **OUR ADVICE**

### ***Adding Value***

#### **Introduction**

- 6.1. Meeting the healthcare needs for such a diverse population as that of East Kent is a major challenge. The Panel believes that greater interdependence between the William Harvey Hospital, the Kent and Canterbury Hospital and the Queen Elizabeth the Queen Mother Hospital is the key to the way forward. New linkages and cross fertilisation of skills are needed to provide patients with better access to treatments at a wider range of local settings and to a high standard of clinical care.
- 6.2. The vision is of the hospitals in Ashford, Canterbury and Margate, together with the community hospitals, combining to guarantee a robust and vibrant future. Working interdependently with the four PCTs and primary care services they should seek to offer greater choice to patients, increased capacity and improved access to services across East Kent.
- 6.3. None of the hospitals will be able to sustain specialist services in the longer term unless strong clinical networks are developed. Staff across all of the sites need to work together. By doing so, they will be better placed to attract and retain a quality workforce.

6.4.

#### **Recommendation One**

**The three main acute hospitals should work interdependently, each contributing to the provision of specialist services where it is feasible to provide such services only on one or two of those hospital sites.**

#### **Working together**

- 6.5. Providing effective acute health services is crucially dependent on the co-operation and agreement of the other elements that make up healthcare provision – primary care, community care, mental health and social care. The full participation of the Primary Care Trusts is vital to the sustainability of acute services in the future.

- 6.6. The four PCTs that cover East Kent are all relatively new bodies. As they have expanded their roles over the last twelve months, they have become increasingly involved with the East Kent Hospitals Trust, and with other stakeholders, in the future development of local health services. They are the major commissioners of care and will have a large influence on the development of services in the future. It is essential that this involvement and influence continues to grow.

6.7.

**Recommendation Two**

**The health community of East Kent, including the Acute, Community and Ambulance Trusts, PCTs, Social Services and the Strategic Health Authority, must continue to follow an inclusive process of involvement. The OSC, CHCs and all stakeholders, including patients and the public, must be fully involved in the development of services for the whole of East Kent.**

**The decision of 25 March 2002**

- 6.8. Our terms of reference asked us to consider first the decision of 25 March 2002. For a variety of reasons these proposals, as set out at the time, failed to win the hearts and minds of the many interested parties in East Kent. The Panel accepts that the Trust's situation was unsustainable and that change was necessary but time has moved on since that decision was made and circumstances have changed again.
- 6.9. The basic principles underpinning the proposals for change set out in the decision of 25 March 2002 were sound. However, it is apparent from our examination of the written evidence, from the interviews conducted and from our site visits that the proposals as set out in the decision of 25 March 2002 no longer command any significant support.
- 6.10.

**Recommendation Three**

**There is now little support for the proposals for change as set out in the decision of 25 March 2002 [by the East Kent Health Authority].**



**The interim options**

- 6.11. Our terms of reference also asked us to consider how to proceed in the speediest and most efficient manner in the interest of local people.
- 6.12. Many of the key drivers for change described in the 2001-2002 Consultation Document *Modernising Hospital Services in East Kent* continue to be relevant. Bearing in mind publication of the Department of Health guidance *Keeping Services Local – A New Direction of Travel*, the Panel considers that the three main hospital sites should each provide a general hospital service. They should work to complement each other in providing those specialised services that can only be based on one, or at most two, of the sites in the future for reasons of sustainability.
- 6.13. It is clear from our discussions that the interim proposals that have been more recently drawn up by the Trust in collaboration with its health community partners enjoy a good level of support. This support includes a wide range of stakeholders including the PCTs, the SHA, Social Services, CHCs and the OSC. Although these proposals were originally drawn up as an interim measure between the present and the ultimate configuration, there may be merit in considering their longer-term future as a point in the journey of a modern, evolving NHS. In assessing the long-term benefits, while further work will be required to ascertain their clinical and financial viability, they do offer a means of progress from the current impasse.

- 6.14. **Recommendation Four**  
**The interim proposals represent the speediest and most efficient means of proceeding in the interest of the people of East Kent.**

**Further work**

- 6.15. Future work should involve the Modernisation Agency and provide specific assurances about the impact of changes on patients. This should be demonstrated through the effect on patient care journeys or pathways through

the health care system for key conditions. Work should also take explicit account of clinical and financial sustainability issues, as well as the effects of service changes on the staff involved.

6.16.

**Recommendation Five**

**The health community should work with the NHS Modernisation Agency in the development of the interim options. Within the given parameters of financial sustainability, they should seek to develop robust clinical networks across the whole health community, demonstrate the benefit to patients through appropriate pathways, and take account of the needs of staff.**

**Localised settings**

6.17. PCTs have a lead role in commissioning the overall provision of care for their patients. As *Keeping the NHS Local – A New Direction of Travel* emphasises, patients want more, not fewer, local services. The development of clinical networks, new ways of working and advances in technology are opening up new ways to achieve this.

6.18. The interim options are intended to rationalise services across the three main hospital sites. In determining what activity takes place on those sites, the health community should give consideration to those services that could be provided in more localised, non-acute settings. This consideration should be linked to appropriate staff education and training.

6.19.

**Recommendation Six**

**A health community transformation team, led by the four PCTs, should ensure that all health services that do not need to be provided on hospital sites should be located in local settings.**

**Emergency care**

6.20. The interim proposals accept the need for rationalisation of A&E services within the Trust. Under these proposals, the emergency service at the Kent

and Canterbury Hospital will be developed into a Local Emergency Centre. Patients treated in the Local Emergency Centre will benefit from a modern, more-focussed and accessible service appropriate to their needs. For people with more serious injuries, care will be provided at major trauma centres in Ashford and Margate.

6.21.

**Recommendation Seven**

**The Panel considers that the development of a Local Emergency Centre at the Kent and Canterbury Hospital, linked to appropriate resources and training of the ambulance service, is an appropriate way to proceed.**

6.22. Innovative approaches to service delivery of emergency care need to be developed further. The Panel considers that the recent merger of medical and A&E services within the Trust and the new model of care introduced at the Kent and Canterbury site are excellent examples of such innovative approaches.

**Finance**

6.23. One of the primary concerns relating to the proposals contained in the 25 March 2002 decision was the significant underlying financial deficit affecting the Trust. A Financial Recovery Plan has now been drawn up to address this issue with the support of the Strategic Health Authority.

6.24. Achieving financial balance is a statutory requirement. The current management has made good progress in addressing this issue. Indicative reference costs suggest that there is scope to reduce costs in line with national averages. Work to reduce reference costs, as part of a package of measures for achieving financial balance, must continue.

6.25. With the deteriorating financial situation and concern expressed by the four PCTs, there has been a growing realisation that the PFI scheme developed alongside the proposals for change set out in the decision of 25 March 2002 is no longer affordable. The scheme has now been suspended. At the point at

which it was suspended, the PFI scheme had grown to an estimated cost in excess of £250 million. Whether, in fact, these proposals can ever be resurrected in their present form is a matter of some doubt to the Panel.

6.26. **Recommendation Eight**

**The Panel considers that the PFI, currently suspended, should be abandoned. The possibility of a new PFI, to address the key estate renewal and service issues, should only be considered once the Trust has reached a position of greater financial stability.**

**Estate**

6.27. Having travelled across the area and seen the NHS estate serving a population of 620,000, it is clear that some rationalisation of the estate is required to implement the concept of three interdependent sites.

6.28. Parts of the estate are out-dated and rundown. Capital expenditure will be required to implement some of the interim proposals. The Kent and Medway Strategic Health Authority has informed the Panel of its willingness to support the Trust financially with some of its capital requirements to implement these proposals. In doing so, it will be important to address the most urgent requirements in the renewal of the estate and service rationalisation.

6.29. **Recommendation Nine**

**Improvement and rationalisation of the estate should be addressed in an integrated way with the implementation of the interim proposals. A longer-term strategy will be required to meet all estate renewal requirements.**

**Elective care**

6.30. The Kent and Canterbury site is well positioned to act as an elective service in the future. It also seems well placed to host a Diagnostic and Treatment Centre. A DTC at the Kent and Canterbury Hospital formed part of the

proposals within the decision of 25 March 2002 but does not form part of the interim options.

6.31. The Panel was advised that the development of a DTC at the Kent and Canterbury Hospital was not possible within the existing “footprint” of the site. A new building would be required that could not be funded given the current financial position of the East Kent Hospitals Trust.

6.32. In the absence of a DTC, the health community should bear in mind that the private sector might also be able to contribute to the delivery of services for the NHS.

6.33. **Recommendation Ten**  
**Consideration should be given to the potential benefits of a plurality of partners in developing elective services.**

#### **Cancer services**

6.34. Cogent arguments have been put forward for the modernisation of cancer services throughout East Kent in accordance with the National Cancer Plan.

6.35. However, there is some local clinical resistance to the way in which the National Cancer Plan is being implemented on the Kent and Canterbury site. Some specialists, voicing a genuine concern for their patients, have not felt able to embrace the changes proposed. It is regrettable that this situation has occurred but it is not in the patients’ best interests to let the impasse continue.

6.36. **Recommendation Eleven**  
**The National Cancer Plan should continue to be implemented through the Kent Cancer Network. Most cancer services, being predominantly ambulatory, should be provided in East Kent. The treatment of rarer cancers should be centralised in Maidstone and London.**

- 6.37. Our terms of reference then asked us for any other observations that we might wish to make.

### **Transport**

- 6.38. The Panel heard and read a great deal about transport issues and the difficulties of travelling to and between local NHS services. Despite the considerable efforts of stakeholders to date, the accessibility of services remains a problem and needs to be addressed.

- 6.39. Whilst the Panel commends the work done so far, more radical action and a stronger partnership between the Kent County Council, Social Services, the SHA, NHS Trusts and the four PCTs, is required to implement a first class patient transport service.

- 6.40. **Recommendation Twelve**  
**Lead responsibility for transport issues lies with the local authority. In collaboration with the health community, the Kent County Council should continue their progress in addressing the problems of patient transport in East Kent.**

### **Public Involvement**

- 6.41. The interim proposals have been drawn up relatively recently. Sections 7 and 11 of the Health and Social Care Act 2001 now apply. The Panel does not consider that it would be in anyone's interest to engage in yet more protracted formal consultation on the interim proposals. Nevertheless, the requirements of the law must be borne in mind.

- 6.42. **Recommendation Thirteen**  
**In implementing the interim proposals, the health community should ensure full engagement with the OSC, CHCs and all stakeholders, including patients and the public, so that solutions that best meet the needs of the local population can be reached in the swiftest possible manner.**

**Medical Teaching**

- 6.43. The Panel heard evidence of plans to teach medical students at the University of Kent. The Guys, St Thomas' and Kings Medical School has a link with the Trust and an understanding that, from 2004, more medical students will receive part of their clinical teaching and experience in East Kent. It is important that changes in the arrangement of local services do not delay the implementation of these plans. Equally, such arrangements should not dictate the shape of local health services.

6.44.

**Recommendation Fourteen**

**Healthcare professionals need to experience up to date practices in healthcare delivery. When the proposals are implemented, all healthcare professionals undergoing training in East Kent should receive their clinical experience as services are developed. Their training and education should be organised around the new shape of services within the Trust. Patient services should not be sited for the convenience of those in training.**

## **LESSONS FOR THE FUTURE**

### ***What We Learned***

- 7.1. The managers, health professionals, patients and public that we met all cared deeply about their health service. They were frustrated by the uncertainty, indecision and length of time that the debate on the configuration of health services in their area had taken. The managers had to cope with a dynamic situation in which circumstances were constantly changing. This led to decisions either not being taken or those taken not being implemented. Ill feeling and recrimination built up which was detrimental to morale and resulted in subsequent problems with recruitment and retention of staff.
- 7.2. A clear direction and implementation of decisions when made may well have avoided this situation even if some would have felt disadvantaged by such decisions at the time. Winning the hearts and minds of the whole health community and encouraging them to think not just of their own area but of service delivery across the whole of East Kent would have helped.
- 7.3. It is heartening to see that the current management of the Trust and the SHA are working to improve this situation and we understand that their efforts have been recognised in an Audit Commission report. This bodes well for the future.
- 7.4. The divisions apparent in East Kent could well have been lessened by the genuine engagement of the community at the earliest possible stage in the process of reconfiguration. Although the consultation process was judged by the judicial review to have met all legal requirements, the formal public consultation took place after a great deal of work had already been done with the limited involvement of the public. Options were developed from which the public could then choose. This was not uncommon practice at the time. An ongoing dialogue and joint development of proposals would have helped develop a collective, inclusive approach to the modernisation of health services. It would have helped all those concerned to recognise and understand



the very real constraints on the health service whilst achieving the necessary modernisation required throughout the whole of East Kent.

- 7.5. A greater focus on the patient's progress through the health and social care system would have highlighted unacceptable or unworkable changes to service provision. It is to be hoped that the latest requirements for patient involvement and consultation will avoid a situation like that which has arisen in East Kent developing in the future.
- 7.6. In the interests of avoiding further delay, we have not been able to examine the effects of the interim proposals on patient journeys through the system to the extent that we would have liked. Those working to develop health services for East Kent from this point onwards should adopt the concept of the "patient journey" as the mainstay of their considerations.

## **Appendix One**

### **INDEPENDENT RECONFIGURATION PANEL**

#### **Terms of Reference**

1. To provide expert advice on:
  - Proposed NHS reconfigurations or significant service change;
  - Options for NHS reconfigurations or significant service change;referred to the Panel by Ministers.
2. In providing advice, the Panel will take account of:
  - patient safety, clinical and service quality
  - accessibility, service capacity and waiting times
  - other national policies, for example, national service frameworks
  - the rigour of consultation processes
  - the wider configuration of the NHS and other services locally, including likely future plans
  - any other issues Ministers direct in relation to service reconfigurations generally or specific reconfigurations in particular.
3. The advice will normally be developed by groups of experts not personally involved in the proposed reconfiguration or service change, the membership of which will be agreed formally with the Panel beforehand.
4. The advice will be delivered within time-scales agreed with the Panel by Ministers with a view to minimising delay and preventing disruption to services at local level.
5. The effectiveness and operation of the Panel will be formally reviewed one year after its establishment and annually thereafter.

## **Appendix Two**

*From the Parliamentary Under Secretary of State for Public Health  
Hazel Blears MP*



11 APR 2003

Dr Peter Barrett  
Chair  
Independent Reconfiguration Panel  
Kierran Cross  
First Floor  
11 The Strand  
London WC2N 5HR

Dear Dr Barrett

### **CONSULTATION ON SERVICE CHANGE IN EAST KENT**

As you know, I announced in the House on Monday night that the consultation on modernising hospital services in East Kent would be referred to the Independent Reconfiguration Panel for advice. This letter sets out the terms of that referral.

#### **Background**

The service changes being proposed in East Kent were decided by the then East Kent Health Authority on 25 March 2002, at the end of consultation on options presented in the document "Modernising Hospital Services in East Kent 2001-2005". Two Community Health Councils -South East Kent, and Canterbury and Thanet -subsequently referred the issue to Alan Milburn for review, citing concerns about both the consultation process and the access and clinical effects of the changes.

At the same time, a group of local people sought judicial review of the consultation process. The outcome of this review was made known in December 2002, when it was found that the consultation process had been properly undertaken.

#### **Terms of referral**

The Panel is asked to advise

- a) Whether it is of the opinion that the proposals for change set out in the decision of 25 March 2002 will ensure the provision of safe, effective and accessible health services for the people of East Kent. And if not, why not;

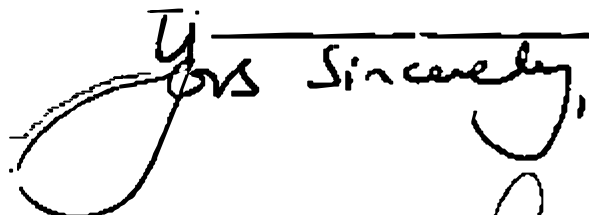
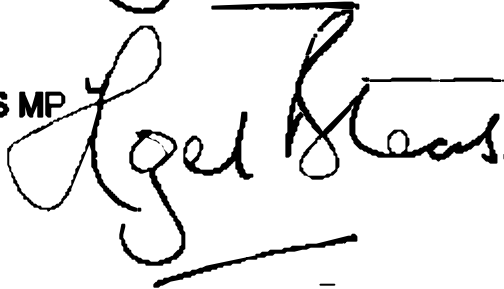
- b) Any other observations the Panel may wish to make in relation to the proposals for change; and
- c) In the light of a) and b) above, the Panel's advice as to how to proceed in the speediest and most efficient matter in the interests of local people.

and to submit its recommendations by 12 June 2003.

I know that you are aware that the people of East Kent are in urgent need of action to improve the delivery of local health services, and that the advice will focus on finding a solution to achieve that. In formulating that advice the Panel will also pay due regard to the principles set out in:-

- a) paragraph 2 of its general terms of reference; and
- b) the guidance "Keeping the NHS local- a new direction of travel",

The Chief Executive of the Strategic Health Authority, by copy of this letter, will be preparing the background information and papers to enable you to read into the issues.

  
Yrs Sincerely,  
  
**HAZEL BLEARS MP**



Kierran Cross  
First Floor  
11 The Strand  
London  
WC2N 5HR

Tel: 07867 536767

Hazel Blears  
Parliamentary Under Secretary of State  
for Public Health

16 April 2003

Dear Hazel

### **PROPOSALS FOR SERVICE CHANGE IN EAST KENT**

Thank you for your letter of 11 April requesting the Independent Reconfiguration Panel's advice on the modernisation of hospital services in East Kent.

I note the specific terms on which you have referred the case and I am happy to confirm that the Panel will offer its advice in accordance with those terms. You have asked us to provide our advice by 12 June. In normal circumstances, I would not wish the Panel to be so severely time limited in providing advice. However, I appreciate that, in this instance, time is of the essence and the Panel will, therefore, endeavour to submit its advice to you by the required deadline.

Since the Panel membership was announced in February, we have spent a good deal of time considering how best to undertake our work and defining the means by which we will assess cases referred to us. I will be writing separately to the Secretary of State to advise him more fully on this in due course.

In brief, we intend that the principles set out in *Keeping the NHS Local*, together with *Strengthening Accountability – Involving Patients and the Public*, should form the backbone of our considerations. Clearly, much if not all, of the work that has been done in East Kent pre-dates these documents so we will need to take a pragmatic approach to considering the evidence in this particular case.

The Panel will also, in future, wish to receive evidence in a common format and is developing a template to facilitate this. But, again, recognising the practicalities of this case, we will work with the evidence as it stands and look forward to receiving it as early as possible.

I will be appointing a sub-group of three Panel members to undertake the initial consideration of the case though all members will be closely involved throughout and the advice that we submit will be that of the full Panel. The sub-group will, I am sure, wish to visit East Kent and meet stakeholders from all sides of the debate. I hope that the NHS locally will be willing to assist in arranging this.

Finally, in keeping with the public commitment to openness and transparency in our working, the Panel will wish to publish its advice on the IRP website. As you state in your letter, the people of East Kent are in urgent need of action. We would, therefore, propose to publish our advice on the website no later than four weeks after its submission to you.

I am copying this letter to Alan Milburn and to John Hutton.

Yours sincerely

A handwritten signature in dark ink, appearing to read 'Peter Barrett', with a stylized flourish at the end.

Dr Peter Barrett  
Chair  
Independent Reconfiguration Panel

## **Appendix Three**

### **Independent Reconfiguration Panel Site Visits, Meetings and Conversations**

#### **Site Visit to East Kent Hospitals Trust (EKHT) 20<sup>th</sup> May 2003**

Mr Julian Brazier	Member of Parliament for Canterbury
Ms Ann Sutton	Chief Executive, Shepway PCT
Dr Sandro Limentani	Director of Public Health, East Kent Coastal PCT
Ms Marion Dinwoodie	Chief Executive, Ashford PCT
Mr Wilf Williams	Chief Executive, Canterbury and Coastal PCT
Mr John Butler	Chair, Canterbury and Coastal PCT
Mr Colin Burgess	Director of Operations and Modernisation, Kent Ambulance Trust
Dr John Ribchase	General Practitioner
Mr David Short	Chair, Concern for Health in East Kent (CHEK)
Mr Ken Rogers	Vice Chair, CHEK
Ms Pam Williams	Acting Lead for Patient Advisory Liaison Service, EKHT
Mr John Kemp	Ex-Chair, South East Kent CHC
Mr Bill Peppiat	Chair, Canterbury and Thanet CHC
Ms Betty Renz	Local campaigner
Mr Barry Coppock	Former Leader of Thanet Council
Ms Liz Cracknell	Executive Director, Kent Cancer Network
Prof. Stuart Field	Consultant Radiologist, EKHT
Mr Robert Install	Clinical Director of Surgery, EKHT
Ms Jo Yardley	General Manager, Maidstone and Canterbury Cancer Service

#### **Site Visit to East Kent Hospitals Trust 27<sup>th</sup> May 2003**

Mr David Astley	Chief Executive, EKHT
Mr Peter Hermitage	Chairman, EKHT
Mr Rupert Eggington	Director of Finance, EKHT
Dr Noel Padley	Medical Director, EKHT
Mr John Mills	Deputy Director of Facilities, EKHT
Dr Marie Beckett	Clinical Director – A&E, EKHT
Dr Ian Sturgess	Acting Clinical Director – Medicine, EKHT
Dr Ruth Lapworth	Clinical Director – Pathology, EKHT
Dr James Nash	Consultant Microbiologist and Clinical Lead, Infection Control, EKHT
Dr Andrew Johnson	Sub Dean for Undergraduates, KCH
Ms Candy Morris	Chief Executive, Kent and Medway Strategic Health Authority

Ms Marianne Griffiths	Director of Strategic Development, Kent and Medway Strategic Health Authority
Dr Anne Mackie	Director of Health Improvement, Kent and Medway Strategic Health Authority
Dr Tony Robinson	Chair, Kent County Council NHS Overview and Scrutiny Committee
Mr Steve Leidecker	Mid Kent Area Director, Kent County Council Social Services
Mr John Wale	Assistant to Chief Executive, Kent County Council
Mr Paul Wickenden	Committee Manager (Overview & Scrutiny), Kent County Council

**Meetings with Dr Peter Barrett, Chair, IRP  
3<sup>rd</sup> June 2003**

Mr Damien Green	Member of Parliament for Ashford
Mr Michael Howard	Member of Parliament for Shepway
Mr Roger Gale	Member of Parliament for Thanet North
Ms Gwyn Prosser	Member of Parliament for Dover
Prof. Roger James	Clinical Director, Kent Cancer Network
Mr Mark Outhwaite	Modernisation Agency National IT Programme Lead (former Chief Executive, East Kent Health Authority)

**Telephone conversations with Dr Peter Barrett, Chair, IRP  
27<sup>th</sup> May, 3<sup>rd</sup> June, 5<sup>th</sup> June**

Dr Stewart Coltart	Consultant Clinical Oncologist
Dr Stephen Ladyman	Member of Parliament for Thanet South
Dr Paul Stevens	Chairman of Medical Staff Committee and the Head of Renal Services, EKHT
Mr Richard Collins	Consultant General and Endocrine Surgeon
Mr R M Heddle	Consultant General Surgeon
Dr Richard Gale	Head of East Kent Haematology Service



## Appendix Four

### Supporting Papers supplied to the Independent Reconfiguration Panel by Kent and Medway Strategic Health Authority and East Kent Hospitals Trust

Paper	Title	
1	Minutes of East Kent Health Authority Meeting	29 June 1998
2	“Future of Hospital Services in East Kent” – Response to Tomorrow’s Healthcare	29 June 1998
3	The NHS Plan	July 2000
4	Kent and Medway Public Transport Map and Guide	2001/2002
5	“Moving Forward” – Strategic Outline Case for Modernising Hospital Services in East Kent	February 2001
6	Terms of Reference for the Public & Patient Involvement (PPI) Steering Group	October 2001
7	“Modernising our Hospitals” – Consultation Summary	5 Dec 2001 – 28 February 2002
8	“Modernising Hospital Services in East Kent” – Consultation	5 Dec 2001 – 28 February 2002
9	List of Groups Invited to Participate in Consultation	January 2002
10	Minutes of East Kent Hospitals Trust meeting with CHEK	7 February 2002
11	Full transcript of East Kent Hospitals Trust meeting with CHEK	7 February 2002
12	Collation of Responses to the Consultation	March 2002
13	Summary of Responses to the Consultation	March 2002
14	Responses to Consultation from Kent Country Council NHS Overview and Scrutiny Committee	March 2002
15	“Update on PFI Process” – paper for East Kent Hospitals Trust Board	18 March 2002
16	Minutes of East Kent Hospitals Trust Board Meeting	18 March 2002
17	Report to East Kent Health Authority Board Meeting	25 March 2002
18	Minutes of East Kent Health Authority Board Meeting	25 March 2002
19	Minutes of Kent and Medway Health Authority Board Meeting	16 April 2002
20	Minutes of meeting held with East Kent MPs, KCC Councillors, East Kent Hospitals Trust, Maidstone & Tunbridge Wells NHS Trust and Professor Mike Richards	31 May 2002
21	Approved Judgement on Judicial Review from The Honourable Mr Justice Silber	4 December 2002
22	“Modernising Hospital Services in East Kent” – Outline Business Case	28 February 2003
23	“Keeping the NHS Local – A New Direction of Travel”	February 2003
24	Updated Response to KCC NHS Overview and Scrutiny Committee Recommendations	March 2003
25	DRAFT Ten Year Service and Financial Strategy – Work in Progress	2003/4 – 2012/13
26	Letter from South East Kent CHC	9 April 2002
26A	Letter and attachments from Liz Cracknell to Martin Hawkins regarding Paper 26	7 August 2002
27	Letter from Canterbury and Thanet CHC	9 April 2002
28	Letter from Capsticks covering Claim Form and Accompanying Paperwork from Fisher Meredith (acting for CHEK)	25 June 2002
29	EKHT Board Paper Update on PFI Process	18 March 2002
30	EKHT Board Paper Public Consultation on Modernising	25 March 2002

	Hospital Services in East Kent, part 7	
31	Recent Press cuttings related to K&C and IRP	
32	Recent SHA briefing on Service review proposal	Jan 2003
33	Briefing from Martin Hawkins re; further information re: EK Consultation/PFI	
34	Briefing for re: K&C adjournment debate	1 April 2003
35	Briefing re: Cancer and Transport	27 Sept 2002
36	KMHA Board paper re: East Kent reconfiguration	April 2002
37	Paper from KMHA CE summarising above Board paper	
38	Briefing re: EKHT update	October 2002
39	A Sledge Hammer to Crack a Walnut	
40	Staff opinions	
41	Drive time Isochromes	2001
42	Future models of care	
43	Rural transport to Health	
44	Study briefing for Health Transport Partnership Board	
45	Computer Tabulations from Sample Surveys	February 2002
46	NHS Performance Ratings Summary Report	July 2002
47	Royal College Guidelines	
48	KAT CHI report	
49	EKHT Consultant vacancies	May 2003
50	Deprivation in East Kent Townsend Scores	
51	EKHT Inpatient Finished Consultant Episodes April 2002 – March 2003	

### Other Information and Evidence submitted to the Independent Reconfiguration Panel

Document Title	Submitted By	Date
East Kent Hospitals NHS Trust Ten Year Service and Financial Strategy 2003/4 – 2012/13	EKHT	March 03
Letter to Dr Peter Barrett	Roger Gale, MP, North Thanet	14 April 03
Letter to Dr Peter Barrett	David Short, Chairman, CHEK	14 April 03
Strategic Outline Case for Tertiary Cancer Services at Maidstone Hospital (Draft)	Professor Roger James, Clinical Director of Kent Cancer Network	May 03
Letter to Dr Peter Barrett	Mr R M Heddle, Consultant General Surgeon	8 May 03
Letter to Dr Peter Barrett	Mr Richard Collins, Consultant General & Endocrine Surgeon	12 May 03
Letter to Dr Peter Barrett	Stewart Coltart, Consultant Clinical Oncologist	15 May 03
Submission to IRP Attachment – Monthly Theatre Cases	Email from Julian Brazier, MP, Canterbury	19 May 03
Letter including Total Activity 2001-2003 figures	John R Sewell, Consultant Physician, William Harvey Hospital	19 May 03
Letter to Dr Peter Barrett	James Appleyard, Children's Physician	19 May 03
Examples of Communication of Reconfiguration issues East Kent Hospitals NHS Trust	EKHT	Site Visit 20 May 03
PEC Position Statement Canterbury & Coastal PCT	PCTs	Site Visit 20 May 03
Submission to the IRP from CHEK	CHEK	Site Visit 20 May 03

'Putting Patients First' Canterbury & Thanet CHC Response to Modernising Hospital Services in EK Consultation 2001 – 2005	Canterbury and Thanet CHC	Site Visit 20 May 03
Letter to IRP	Betty Renz	Site Visit 20 May 03
Letter to Dr Peter Barrett	Hugh Robertson, MP, Faversham and Mid Kent	20 May 03
Letter and Health Inequalities Paper	Dr Sandro Limentani, Director of Public Health, East Kent Coastal NHS PCT	21 May 03
<ul style="list-style-type: none"> <li>- CDU Impact Aug-Mar</li> <li>- Directorate of Medicine Rec 19/08/02</li> <li>- Acute Care Performance Standards</li> <li>- Acute Medical Algorithms 09/08/02</li> <li>- Algorithm Guidance Notes 21/04/02</li> <li>- KCH CDU Operational Policy</li> <li>- KCH Mews Appendix 1</li> <li>- Medical Directorate 19/08/02</li> <li>- Redesign Discussion Paper 1 (01/05/02)</li> <li>- Redesign Discussion Paper 2 (09/05/02)</li> <li>- Redesign Discussion Paper 3 (27/05/03)</li> <li>- Redesign Discussion Paper 4 (11/06/02)</li> <li>- Redesign Discussion Paper 5 (11/06/02)</li> <li>- Redesign Discussion Paper 6 (25/08/02)</li> <li>- Redesign Discussion Paper 7 (02/10/02)</li> </ul>	Dr Ian Sturgess, Acting Clinical Director – Medicine, EKHT	21 May 03
Evidence to the IRP	Professor Roger James, Clinical Director of Kent Cancer Network	21 May 03 28 May 03
Letter to Dr Peter Barrett	David Astley, Chief Executive, EKHT	22 May 03
Letter, Statement and 2 reports	Colin Burgess, Director of Operations & Modernisation, Kent Ambulance Trust	23 May 03
Letter to Dr Peter Barrett	Nicholas Graham	26 May 03
EKHT Performance Benchmarking Profile V1.1	David Blackwell/Stephen Lazell, Performance & Income Team, Finance Directorate	Site Visit 27 May 03
Report on Modernising Hospital Services in East Kent 2001 – 2005 and Response	Cathy Baker, Regional Officer, Royal College of Nursing	27 May 03
Briefing Paper on Cancer Services	Dr Stewart Coltart, Consultant, Clinical Oncologist	28 May 03
Letter to Dr Peter Barrett	Prof. Stuart Field, Consultant Radiologist	28 May 03 (& 27 April 03)
Letter to Trust Secretary, KCH	Mr & Mrs B. R. Taylor, Birchington, Kent	28 May 03
Notes of a Meeting of East Kent MPs, KCC Councillors, East Kent Hospitals Trust, Maidstone & Tunbridge Wells NHS Trust and Prof. Mike Richards	Liz Cracknell, Executive Director, Kent Cancer Network	29 May 03
Letter to Dr Peter Barrett	Mr R M Heddle, Consultant General Surgeon	29 May 03
Letter and Annex A & B to Dr Peter Barrett	Edward Leigh, MP, Chairman, Committee of Public Accounts	2 June 03
Letter to Dr Peter Barrett	Derek Wyatt, MP, Sittingbourne & Sheppey	3 June 03
Letter to Dr Peter Barrett	Edward Leigh, MP, Chairman, Committee of Public Accounts	4 June 03
Letter including report of independent review request and final report	Mrs Sarah Jowett, Kent	4 June 03
Letter to Dr Peter Barrett	Paul Stevens, Chairman of	5 June 03

	Medical Staff Committee & The Head of Renal Services	
External Review of Haemato-Oncology Services in Kent, September 2002	Richard Gale, Head of Service East Kent Haematology	6 June 03
Email to Dr Peter Barrett	Ann Francis, Director of Community Services, Canterbury City Council	9 June 03

## **Appendix Five**

### **INDEPENDENT RECONFIGURATION PANEL MEMBERSHIP**

#### **Chair**

Peter Barrett	General Practitioner former Chair Nottingham Health Authority and Trent NHS Executive
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#### **Members**

Sanjay Chadha	Trustee Multiple Sclerosis (MS) Society
Catherine Elcoat	Executive Chief Nurse University Hospital Birmingham NHS Trust
Lise Llewellyn	Chief Executive Brent PCT
Nick Naftalin	National Clinical Governance Support Team former Consultant Obstetrician and Gynaecologist, Leicester Royal Infirmary
Ray Powles	Professor and Head of Haematological Oncology The Royal Marsden Hospital
Paul Roberts	Chief Executive Plymouth Hospitals NHS Trust
Mark Santer	former Bishop of Birmingham non-executive member of University Hospital Birmingham NHS Trust Board
Malcolm Stamp	Chief Executive Addenbrookes NHS Trust

#### **Administration**

Tony Shaw	Chief Executive
Martin Houghton	Secretary