HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 22nd July, 2020

10.00 am

Online via Microsoft Teams Live

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 22nd July, 2020, at 10.00 am	Ask for:	**Kay Goldsmith**
Online	Telephone:	**03000 416512**

Membership

Conservative (11):	Mr P Bartlett (Chairman), Mrs P M Beresford, Mr A H T Bowles, Mr N J D Chard, Mrs L Game, Ms S Hamilton, Mr P W A Lake, Mr K Pugh (Vice-Chairman), Mr D L Brazier and Mr A R Hills, [vacancy]
Liberal Democrat (1)	Mr D S Daley
Labour (1):	Ms K Constantine
District/Borough Representatives (4):	Councillor C Mackonochie, Councillor J Howes, Councillor M Rhodes and Councillor P Rolfe

In response to COVID-19, the Government has legislated to permit remote attendance by Elected Members at formal meetings. This is conditional on other Elected Members and the public being able to hear those participating in the meeting. This meeting will be streamed live and can be watched via the media link on the webpage for this meeting here.

County Councillors who are not Members of the Committee but who wish to speak at the meeting are asked to notify the Chairman of their question(s) in advance.

UNRESTRICTED ITEMS
(During these items the meeting is likely to be open to the public)

Item | Timings*

1. Membership

Members are asked to note that Mr David Brazier and Mr Tony Hills have joined the Committee.

There is a Conservative vacancy following the passing of Mr Ian Thomas.

2. Substitutes

3. Declarations of Interests by Members in items on the Agenda for this meeting.

4. Protocol for virtual meetings (Pages 1 - 6)

5. Minutes of the meeting held on 5 March 2020 (Pages 7 - 20)

6. Local Covid-19 response and restart of NHS services (Pages 21 - 28) 10:10

7. Dermatology Services (Pages 29 - 32) 10:40

8. Review of Frank Lloyd Unit, Sittingbourne (Pages 33 - 50) 11:00

9. Medway NHS Foundation Trust - Performance Update (Pages 51 - 60) 11:50

10. Single Pathology Service for Kent and Medway (Pages 61 - 70) 12:15

11. East Kent Financial Recovery Plan & Financial Performance for Kent and Medway CCGs 2019-20 (written item) (Pages 71 - 76) 12:40

12. East Kent Hospitals University NHS Foundation Trust - Maternity Services (written item) (Pages 77 - 82) 12:50

13. Edenbridge Primary and Community Care (written item) (Pages 83 - 88) 13:00

14. Work Programme (Pages 89 - 92) 13:10

15. Date of next programmed meeting – 17 September 2020

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

**Timings are approximate*

Benjamin Watts
General Counsel
03000 416814

14 July 2020

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

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Item 4: Protocols for Virtual Meetings

From: Ben Watts, General Counsel

To: Health Overview and Scrutiny Committee – 22 July 2020

Subject: Protocols for Virtual Meetings

Classification: Unrestricted

1. Introduction

a) In line with provisions in the Coronavirus Act, regulations have come into force giving local authorities the ability to take a more flexible approach to holding meetings.

b) However, the core governance requirements for meetings remain. Notice still needs to be given for meetings and the Agendas need to be made available online. The public's right to observe meetings remains the same and so provision needs to be made for the public to hear the discussion and see it where possible as well.

c) The regulations are written so that each local authority can tailor their ability to hold virtual meetings to the technology they are able to put into place. Use of the technology needs to ensure the business of the Council can be conducted fairly and without any participant or observer being unduly disadvantaged.

d) Formal meetings held virtually are still formal meetings, and while the procedures and rules remain the same as when all Members are present in the same room, it will be a different way of working.

2. Protocols for Virtual Meetings

a) Each Committee is being asked to adopt a set of supplementary protocols to guide how virtual meetings will be run. These are geared to explaining how the requirements of the Constitution will be put into effect in a virtual setting.

b) Adopting these Protocols will enable Members to have a common point of reference and to understand how business will be conducted. For members of the public observing our virtual meetings, this will improve transparency and understanding of the democratic process.

c) A set of Protocols for this Committee are attached as an Appendix to this report.

3. Recommendation:

That in order to facilitate the smooth working of its virtual meetings, the Committee agrees to adopt the appended Protocols.

Background Documents

The Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority and Police and Crime Panel Meetings) England and Wales) Regulations 2020 - SI 2020 392, http://www.legislation.gov.uk/uksi/2020/392/contents/made

Contact details

Report Author and Relevant Director:

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Draft – Protocol for Meetings of the Health Overview and Scrutiny Committee held under SI 2020 392

General

1. Part Three of the Constitution (Standing Orders) shall continue to apply for all virtual meetings except where there is a requirement, implied or otherwise, for Members to be physically present in the same location.
2. These Protocols supplement but do not replace the Standing Orders in the Constitution and exist to make meetings held under SI 2020 392 more effective and efficient.
3. Reference to Chair or Clerk relate to the Chair or Clerk of the specific virtual meeting.
4. The Monitoring Officer or his deputies are available to assist and advise the Chair and the Clerk as necessary.
5. Members are respectfully reminded to ensure that the electronic device through which they are attending the virtual meeting has sufficient battery charge.

Rules of Conduct

6. The Chair's ruling on the meaning or application of these Protocols or any other aspect of the proceedings of a meeting held virtually cannot be challenged.
7. The Chair may give any direction, or vary these Protocols, when they consider it appropriate to do so in order to allow for the effective and democratic management of the meeting but must take advice from the Clerk before so doing.
8. Immediately before the commencement of the virtual meeting, all participants must switch the video and microphone settings to "off" and only turn them on when invited to speak by the Chair.
9. Members are reminded that any member of the public may observe the meeting.
10. The conversation function referred to in the Protocols is also known as the 'meeting chat'. Members should proceed as if the content can be viewed by participants and the wider public and only use the function for procedural matters as set out below. It should not be used to discuss the substantive issue – this should be done verbally.

Attendance

11. Members must affirm their presence by typing the word 'Present' in the conversation function of the meeting. This shall be accepted by the Clerk as the equivalent of the Member having signed the attendance list.
12. Where a Member is leaving the meeting permanently or temporarily, the word 'Absent' shall be typed in the conversation function. Where the Member joins the meeting once more, 'Present' shall be typed once more.
13. Where a Member has declared a DPI or other interest which means they need to absent themselves for part of the meeting, the Member shall leave

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the meeting completely at the appropriate time. The Clerk shall email the Member when they are able to re-join. The Clerk will confirm the absence by checking the meeting attendees and confirming the same to the Chair.

14. The standard quorum of one third of the total voting membership applies and this number must have indicated they are 'Present' for the meeting to commence or continue. The Clerk will conduct electronic checks on quoracy periodically throughout the meeting.

Substitutes

15. In order to ensure that Members have access to the virtual meeting, it is requested that formal notification of substitutes to the Clerk be made at least 48 hours prior to the start of the meeting. The start time of the meeting will be affected if this is not done.

Speaking

16. Members and other participants in the meeting must wait to be called on by the Chair before speaking.
17. Attendees may indicate a desire to speak through use of the conversation function. The Clerk will ensure these are brought to the attention of the Chair in the order received.
18. Members not part of the Committee wishing to speak shall request permission from the Chair in advance so that the Clerk is informed 24-hours ahead of the meeting.

Motions and Amendments

19. Except where the motion before the Committee is set out in the Agenda, any Member is entitled to request that a motion or amendment before the Committee be typed out in the conversation function by the proposer. Where this is done, the Clerk shall read out the motion/amendment.
20. All proposed motions/amendments will need to be seconded by a Committee Member present in line with usual practice.
21. The Chair shall ask for Members' views on the motion/amendment. Where the view of the Committee is unclear, the Chair shall call for a vote.

Voting

22. Voting will be through a rollcall of all Members taken in alphabetical order, or through a poll overseen by the Clerk through the conversation function, with the Clerk announcing whether the motion/amendment was agreed or not agreed once this has concluded. The Chair will announce at the start of the meeting which of these methods is to be used.
23. Where a poll is the chosen method but is not able to take place, the Chair shall ask Members to record whether they are for, against, or abstaining in the conversation function. No response shall be taken as an abstention.
24. No votes shall be recorded in the Minutes unless sections 16.31 or 16.32 of the Constitution apply.

Clerking

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25. There will normally be a minimum of two Officers supporting the Chair and Committee during a virtual meeting. One will act as a facilitator to support the Chair. The other will be taking minutes.

Other Provisions

26. Where the minimum legal requirements apply and Members are only able to hear each other and be heard, the Chair shall be responsible for identifying speakers etc., and will be supported in this by the Clerk as facilitator. A rollcall shall be held at the start of the meeting, and at other times as deemed necessary by the Chair, to establish quoracy in these circumstances.

Part Two Meetings

27. At the start of any formal meeting, or part of any formal meeting, from which the press and public have been excluded in accordance with section 15.17 of the Constitution, Members shall type the words ‘Present - Alone’ to verify that no unauthorised person is able to hear, see, or otherwise participate in the meeting.
28. A Part Two meeting will normally be anticipated and will be scheduled in advance as a separate virtual meeting. Where the need to move into a Part Two meeting only becomes apparent during the meeting, the item affected should be adjourned to a later date.

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KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Thursday, 5 March 2020.

PRESENT: Mr P Bartlett (Chairman), Mrs P M Beresford, Mr A H T Bowles, Mr N J D Chard, Ms K Constantine, Mr D S Daley, Mrs L Game, Mr P W A Lake, Mr K Pugh (Vice-Chairman), Cllr J Howes, Cllr M Rhodes, Patricia Rolfe and Mr J Wright

ALSO PRESENT: Mr S Inett and Ms L Gallimore

IN ATTENDANCE: Mr T Godfrey (Scrutiny Research Officer) and Mrs K Goldsmith (Research Officer - Overview and Scrutiny)

UNRESTRICTED ITEMS

23. Declarations of Interests by Members in items on the Agenda for this meeting.

(Item 2)

1. Mr Wright declared an interest as he was a Governor at Medway Hospital Trust.

2. Mr Chard declared an interest as a Director of Engaging Kent.

24. Minutes from the meeting held on 29 January 2020

(Item 3)

1. The Chair raised a question relating to item 9 “General Surgery reconfiguration at Maidstone and Tunbridge Wells NHS Trust”. The agenda papers stated that around 600 patients per year were directed to Maidstone Hospital for complex elective gastrointestinal surgery. However, at the HOSC meeting, Dr Lawton expressed that there were 230 such patients.

2. The Clerk confirmed she had sought clarification with the Trust, who have provided the following explanation:

   “There are currently 600 inpatients per year receiving upper and lower gastrointestinal surgery at Maidstone Hospital. Half of these will live nearer Tunbridge Wells than Maidstone and therefore not have to travel further as a result of the change. Of the 300 patients living nearer to Maidstone, around 70 will be intermediate cases some of which will be day case patients who will continue to be treated at Maidstone Hospital. The remaining 230 are the number of patients requiring complex gastrointestinal surgery that will have to travel further as a result of the change.”

3. RESOLVED that the Committee agreed that the minutes from 29 January 2020 were correctly recorded and that they be signed by the Chair.

25. Children and Young People's Emotional Wellbeing and Mental Health Service
(Item 4)

In attendance: Dave Holman (Associate Director of Mental Health, Children's and Maternity Commissioning, West Kent CCG) and Gill Burns (Director Children's Services, NELFT).

1. The Chair welcomed the guests to the meeting and thanked them for the informal briefing that had been held the previous week for HOSC and Children, Young People & Education (CYPE) Cabinet Committee Members. The briefing provided an opportunity for Members to hear about the Children and Young People's Mental Health Services as a whole. He reminded HOSC that the Committee would only be scrutinising NHS elements of the contract at today's meeting.

2. Mr Holman explained that the report was similar to a new quarterly report that was sent to Kent MPs, an arrangement that had been well received. Overall, the report showed a picture of continued rising service demand against recruitment difficulties. A Single Point of Access (SPA) had been procured two years previously and the CCG budgeted over £2m a year for that to help reduce the waiting times for general mental health conditions.

3. For general mental health conditions, NELFT were meeting the Referral to Treatment (RTT) standard (18 weeks) by about 82% which compared favourably to other counties. Figures in relation to Neurodevelopmental (ND) referrals were less positive. The recent CQC SEND inspection had provided an opportunity for partners to carry out a deep dive and achieve greater clarity around what the issues were.

4. There were between 6,000 – 7,000 children on the ND waiting list, mainly for diagnostics. He explained that a key driver for that was parents wanting their child to have an Education, Health and Care (EHC) Plan in school. In order to meet the demand, the following action was being taken:

    a. A new ND pathway was being led by Dr Chesover to collate a whole new way of improving access to information for children as part of their universal offer in schools. A draft pathway was scheduled for April 2020 with implementation by the end of July 2020.

    b. In relation to the waiting time for current patients, there would be a period of crossover whilst dealing with those waiting under the current system and those under the new system (as per 4a). There had been an initiative piloted in Canterbury which had been well received.

5. The Canterbury pilot saw families and professionals coming together to discuss options for co-production and modelling of the service. It demonstrated the importance of early information in order to reduce the number of parents requesting a diagnosis. A key element to this was a handbook which would continue to be developed as well as shared with all

those on the waiting list. The intention was for the Canterbury pilot to be rolled out across the county.

6. Mr Holman felt the system needed to change its culture, away from diagnostics to meeting need.

7. The current ND waiting list was being prioritised in order to meet the needs of the most vulnerable first. At the same time, the CCG Board were being approached for more funding to get the whole waiting list down.

8. Mr Holman drew attention to the Contract Performance Framework in the report. It showed that for Apr-Oct 2019 Kent and Medway were above the national average for the percentage of children and young people with a diagnosable mental health condition that were able to access treatment. In addition, all urgent cases were being seen within contract timeframes. Mr Holman said this was testament to the hard work of NELFT.

9. Members were informed that NELFT were taking over the operation of the Woodlands Unit from South London and Maudsley NHS Foundation Trust (SLAM). The Unit provided 14 short-term inpatient beds. Currently children were placed outside of Kent or at the Adult unit "Littlebrook" run by KMPT. NELFT were proposing to build a 136-bed suite specifically for children at the Woodlands site before the end of the year. Whilst there would always be a requirement for inpatient units and out of county placements for some complex cases, the preference was for home-based intensive support.

10. Ms Burns echoed the success highlighted by Mr Holman, and updated the Committee that between January 2020 to date, the service had received the highest number of presentations to their crisis team they had ever seen.

11. Ms Burns explained that sustained demand for the service had been challenging. NELFT had embellished their offer at the front door and those requesting ADHD diagnosis would be spoken to straight away to ensure that that pathway was right for them. Where children did not meet the criteria for a diagnosis the service would offer parents and carers Positive Behaviour Support.

12. In terms of workforce, Ms Burns explained NELFT were operating with a 22 – 26% vacancy rate. Agency and bank staff provided cover. However, internal performance reports demonstrated that more staff had been staying than leaving over recent time. She felt the key was attracting the right skilled people for the job.

13. Ms Burns said she was proud of the joint work between NELFT, the CCG and KCC and that each partner recognised the service required a collaborative model.

14. The Committee discussed the underlying causes of the sustained high demand for children and young people's mental health services. Whilst a changing society was expected to have played a part, it was unknown what national studies had been undertaken into the area.

15. Ms Burns said the removal of stigma around mental health was a positive change. But the language (such as depression, anxiety and self-harm) was becoming normalised from an early age and its use was socially acceptable. Social media was a contributing factor, as was the "need" for a diagnosis from parents and carers. Looked After Children, who could be placed in countless homes over a small number of years, faced particular challenges.

16. A Member questioned the use of the phrase "national standards" for waiting times. He stated the NICE standards were 13 weeks. Ms Burns confirmed the 18-week national standard they worked to was based upon the standard NHS contract.

17. Looking at the figures used on page 22 of the report, Members questioned the worsening performance in terms of time between Referral and First Assessment for NLDS, and also the variation between east and west Kent. It was explained that the figures were a mixture of those coming into the service and those that were on the historic waiting list and that there was a concerted effort to get the latter cohort treated.

18. The data demonstrated an increase in the Looked after Children caseload. A proportion of those were from London Boroughs. Mr Holman was unsure on the number of asylum seekers included in the figures, but this information would be circulated to the Committee.

19. In terms of combatting the rising demand, Mr Holman explained that this was a system wide issue and that one action was for Mental Health Teams to go into schools. He offered to bring demand and financial projections the next time they visited the Committee.

20. The Chair thanked the guests for attending, and was keen they return to the Committee with an update on the various planned activities for 2020 (the draft pathway being implemented, the rollout of the Canterbury pilots, the changes to the Woodlands Unit, as well as the new care model). He was keen for the Committee to be updated on the outcome of those interventions, though accepted Woodlands may not have had sufficient time to fully establish itself by that point.

21. RESOLVED that the report be noted and the CCG and NELFT are requested to return to the Committee with an update at an appropriate time.

26. South East Coast Ambulance Service NHS Foundation Trust (SECAmb) - update
(Item 5)

In attendance: Ray Savage (Strategy and Partnerships Manager, Kent & Medway, East Sussex), Tracy Stocker (Associate Director of Operations) and Steve Emerton (Executive Director for Strategy and Business Development) from South East Coast Ambulance Service NHS Foundation Trust.

1. The Chair welcomed representatives from the Trust to the Committee. He invited them to introduce themselves and provide a short summary of the paper.

2. Mr Emerton highlighted the following from the report:

    a. There had been a number of staff changes since the last report to the Committee, including a new Chief Executive Officer and Director of HR & Organisational Development. An operational restructure had also seen the appointment of a number of new colleagues.

    b. The 2019 CQC rating of the Trust was "Good", with Outstanding service in Urgent and Emergency Care.

    c. The Trust continued to work hard to mobilise the new 111 Clinical Assessment Service, commencing in April 2020.

    d. Alternative care pathways were being worked on in order to reduce the pressure on A&E services.

    e. The implementation of a Clinical Education Transformation Project in response to a poor Ofsted visit in 2019.

    f. A targeted effort was underway to improve the response time for Category 3 patients.

3. In terms of handover delays, Mr Emerton explained that the Trust understood what worked well to reduce them and more work was needed to share that best practice.

4. The Trust was seeing increased demand for their service (in particular due to the Covid-19 virus). Key to managing that was close partnership working in terms of working out the most suitable clinical pathway for a patient and knowing which hospitals had capacity.

5. A Member asked how many of the "new" ambulances were located in Kent. Mr Emerton offered to bring those details back to the Committee but confirmed they were all located where the demand capacity review showed additional resource was required.

6. A Member asked where stroke patients would be sent to as the Pembury Stroke Ward had temporarily closed. Mr Savage explained that the Kent & Medway stroke review had provided good insight into this area. Depending on their location, patients would be taken to hospital in East Surrey, Eastbourne, Maidstone or Darent Valley – wherever their nearest receiving appropriate hospital was.

7. In response to a question about rurality, Mr Emerton explained that it was an area of challenge in terms of response times because of the prohibitive cost associated with serving the area. There was some quality work underway which would look to optimise response times in those areas. He also highlighted that this was a national challenge, not just applicable to Kent.

8. A Member drew upon a Freedom of Information (FOI) request they had submitted to SECAmb in relation to the length of time taken for Thanet

residents to get to the William Harvey Hospital after calling 999. The Member believed the figures were worrying and demonstrated a poor response time. Mr Emerton explained that all calls were categorised and responded to accordingly. Each call had a context which may explain the cause of the perceived delay. Reasons may have included, though not be limited to, additional treatment at home; consultant input into the most appropriate pathway; volume of road traffic. He was happy to address individual cases for concern outside of the meeting. Overall, Mr Savage explained that Thanet produced some of the best response times across the Trust area.

9. The Member felt it would be useful for all Members to see response times for their district. They also requested that the data around response times on blue lights from Thanet to William Harvey Hospital be circulated to the Committee.

10. A Member asked a question around managing the expectation of patients whilst they waited for an ambulance, particularly those that were vulnerable or elderly. Mr Emerton explained 999 responders regularly assessed the risk to a patient whilst they were waiting, and if they were deemed to be at risk of harm then the call would be escalated. The NHS Pathways platform, which was used to categorise patients, was continually updated to ensure conditions were categorised appropriately and tended to be risk averse in terms of acuity. But Mr Emerton did offer to look into cases where the Trust had got it wrong in the past and see if there were lessons that could be learnt.

11. Ms Stocker informed HOSC of the falls work the Trust was involved in. They were working with partners to consider how falls could be prevented but also what the right course of action was for those that did fall. A pilot was underway in Thanet and the Trust and its partners would seek to learn from that.

12. The Chair thanked the guests for attending and welcomed the good progress that had been reported.

13. RESOLVED that the report be noted.

27. Review of Frank Lloyd Unit, Sittingbourne
(Item 6)

In attendance: Adam Wickings (Deputy Managing Director, West Kent CCG), Janet Manuel (Clinical Head Specialist Assessments and Placements Team, DGS, Medway & Swale CCG) and Andy Lang (Lead Nurse for Continuing Healthcare, NEL).

1. The Chair welcomed the guests and referenced the informal briefing for HOSC Members that had taken place a few weeks previously.

2. Mr Wickings referred to a wider piece of work around developing a clear clinical model for patients with complex dementia, including quantifying future demand.

3. In terms of the Frank Lloyd Unit, he explained that affected patients had been supported by Continuing Health Care to find a suitable alternative placement. There were currently no patients in the Unit.

4. Ms Manuel explained that North Kent CCGs had assisted in the repatriation of five former Frank Lloyd patients. That unit had never been intended for long-term stays. By supporting and engaging partners, they were able to find suitable placements for each of the five patients.

5. Mr Lang confirmed NEL had assisted in repatriating four Frank Lloyd patients. They were able to do this by looking for suitable placements as well as working alongside the patients and their families.

6. Mr Bowles stated that nothing he had heard from the CCG over the course of the previous two years had convinced him that closing the unit was the right thing to do at that time.

7. A proposal from Mr Bowles was moved and seconded by Mr Wright:

   The Committee is asked to agree to refer the closure of the Frank Lloyd unit to the Secretary of State on the grounds that it was not in the interests of the local population.

8. The Chair explained that the Committee were unable to refer the item at this meeting because Members were required by law to set out their concerns and give the CCG adequate time to consider and respond to those concerns. Members were informed that the motion proposed would therefore not be valid in this form.

9. Members had the following concerns around the de-commissioning of the Frank Lloyd Unit:

   a. the new care model for complex dementia patients had not been fully developed nor implemented;

   b. it was unclear if there was suitable, alternative local provision for those with complex dementia. Whilst Members agreed care within the home was appropriate for some, they felt there would always be a small number requiring dedicated facilities;

   c. the proposed care model had dementia patients supported within existing care homes, but it was unclear if those care homes were ready or had the right staff to deal with complex behaviour;

   d. there had been a lack of openness around the closure of the Frank Lloyd unit, which Members understood had not been accepting referrals for a substantial period;

   e. there had not been suitable clinical evidence that the closure of the Unit was in the interests of the local population; and

   f. it was unclear what would happen to the staff employed at Frank Lloyd, but Members felt there was a real risk their professional skills would be lost.

10. In relation to point 9d, Mr Wickings responded that the Unit was empty, not closed, and the CCG were committed to reopening the beds if there was a future need to do so.

11. Following their discussion, the Chair proposed the following motion:

That this Committee considers that the decision of the Kent & Medway CCGs to de-commission the Frank Lloyd Unit will not be in the best interests of the local population for the following reasons:

a) The decision to close was premature without sufficient alternate provision being available in Kent and Medway.
b) Insufficient consultation had been carried out.
c) There was a lack of proper clinical evidence that the closure was in the best interests of patients.
d) There would be workforce implications that needed to be taken into account in light of the closure.

Therefore the Committee asks that the Kent & Medway CCGs consider and respond to these comments and report these back to the Committee ahead of a final determination as to whether or not to refer their decision to the Secretary of State on the grounds that the proposal is not considered to be in the best interests of the health service in the area.

12. The recommendation was agreed.

13. RESOLVED that this Committee considers that the decision of the Kent & Medway CCGs to de-commission the Frank Lloyd Unit will not be in the best interests of the local population for the following reasons:

a) The decision to close was premature without sufficient alternate provision being available in Kent and Medway.
b) Insufficient consultation had been carried out.
c) There was a lack of proper clinical evidence that the closure was in the best interests of patients.
d) There would be workforce implications that needed to be taken into account in light of the closure.

Therefore the Committee asks that the Kent & Medway CCGs consider and respond to these comments and report these back to the Committee ahead of a final determination as to whether or not to refer their decision to the Secretary of State on the grounds that the proposal is not considered to be in the best interests of the health service in the area.

28. East Kent Transformation Programme (written item)
(Item 7)

1. Members were asked to note the update on the East Kent Transformation programme. It was a similar report to that which had been shared at the Kent and Medway NHS Joint Overview and Scrutiny Committee – the Committee exercising the formal scrutiny powers over this issue.

2. RESOLVED that the report be noted.

29. East Kent Hospitals University NHS Foundation Trust - General Update
(Item 8)

In attendance: Liz Shutler (Deputy Chief Executive), Dr Paul Stevens (Medical Director) and Dr Abigail Price (Consultant Paediatrician) from East Kent Hospitals University Foundation Trust.

1. The Chair welcomed guests from the Trust and invited them to highlight any key points from the report. Ms Shutler emphasised the following:

    a. The performance of cancer care had improved markedly since the last update to HOSC.

    b. The staff vacancy rate had reduced compared to the previous year. Also, the ratio of substantive staff to agency workers had improved, which reflected an increased use of bank staff.

    c. Over 2,000 patients had received their planned lower limb operation sooner because of the orthopaedic pilot. The Trust had secured £15m capital investment to build four new operating theatres.

2. In relation to paragraph 1.4 of the report in the agenda a Member questioned the opening hours of Buckland Hospital. Ms Shutler believed it was open 8am – 8pm but offered to confirm outside of the meeting.

3. A Member asked how the Trust had managed to reduce the vacancy rate. Ms Shutler explained that they had recruited staff both in this country and abroad, with particular focus on typically hard to recruit areas. Brexit had not led to any staff losses but continued to be an area of risk. One of the keys to retaining staff was to have a comprehensive training package in place. For instance, the Trust had in place the CESR pathway (Certificate of Eligibility for Specialist Registration).

4. Finally, Ms Shutler spoke of the improvements made to children and young people's hospital services following the CQC inspection rating of "inadequate". In particular, she highlighted the investment in the physical surroundings as well as increasing staffing at both QEQM and William Harvey. The Trust had invested in middle grades as well as improving the on-call rota and providing additional training for all staff. Daily safety checks had been introduced with the aim of giving assurance that the fundamentals of care were being delivered.

5. The Chair thanked the guests for their update.

6. RESOLVED that the report be noted.

30. East Kent Hospitals University NHS Foundation Trust - Maternity Services
(Item 9)

In attendance: Liz Shutler (Deputy Chief Executive), Dr Paul Stevens (Medical Director), Dr Ciaran Crowe (Consultant Obstetrician), Dr Abigail Price (Consultant Paediatrician) and Hannah Horne (Deputy Head of Midwifery) from East Kent Hospitals University Foundation Trust.

1. The Chair welcomed the guests to the meeting and invited them to introduce themselves.

2. Ms Shutler began by saying that in 2015 the Trust recognised that it needed to improve care under its maternity services. They commissioned the Royal College of Obstetricians and Gynaecologists to review the service and following that a number of improvements were put in place. However, the Trust recognised that those improvements were not put into place quick enough or at the scale required.

3. Around 7,000 babies were born under the Trust's care in any one year and Ms Shutler asserted that one preventable death was one too many. The Trust recognised it had not always provided the standard of care it should have for every woman and baby, and Ms Shutler wholeheartedly apologised on behalf of the Trust to the families who should have received a different experience whilst in their care.

4. The Trust fully accepted the coroner's conclusions and recommendations from the January 2020 inquest. To address those recommendations the Trust had established an externally chaired Board (a sub-committee of the main Board) which in turn had seven task and finish groups each with its own area of focus.

5. The Minister for Patient Safety had also announced an independent review being led by Dr Bill Kirkup. The Trust were committed to participating in that review and taking on board any recommendations.

6. Mr Inett explained that Healthwatch had attended one of the review meetings and would continue to be involved. He said the Trust appeared to be clear on the action required from the Royal College report and the coroner's recommendations. He did not feel the Trust were sidestepping the issues or trying to come up with excuses. He also pointed out that some actions were required by the Trust as a whole, not just the maternity services.

7. A Member asked why things had gone so wrong despite there being a Royal College review in 2015. Dr Stevens explained that themes from that report had been repeated in subsequent reports which suggested any changes that were made failed to be embedded. The seven task and finish groups would be reviewing all the recommendations in a bid to understand where actions had not been strong enough.

8. Asked how East Kent residents could be assured that the Trust's Board was adequately monitoring the implementation of best practice, when they failed to do so in 2015, Ms Shutler explained that the chair of the new Board was independent in order to provide external opinion as well as assurance. The seven workstreams were overseen by clinicians which Dr Price felt demonstrated a real shift. Ms Shutler also felt it was important that the Trust accepted the additional clinical support on offer. Dr Stevens also pointed out

that each of those present was an East Kent resident and therefore had a vested interest in making the services the best they could be. Dr Crowe felt, as a relatively new employee of the Trust, that the employer was recruiting different skillsets in order to build their workforce and that they were being open about the challenges being faced.

9. A Member questioned why QEQM did not use the workforce planning system Birthrate Plus. Ms Horne responded that a tabletop exercise of the tool was undertaken in 2018 and it was decided it was not as sensitive as they would like for East Kent. Instead, they had appointed an external senior midwife who used the Birthrate Plus methodology.

10. A Member asked for a staffing update on the appointment of Speak Up Guardians and the Duty of Candour. Dr Stevens explained that three Speak Up Guardians had been formally appointed as well as a number of champions on each site, and their feedback would feed directly to the Director of HR. For the Duty of Candour, which all Trusts as well as the CQC were trying to drive forward, Dr Stevens explained that women and children were the core care group in terms of this and he understood that the service was completely up to date with initial letters sent to that cohort.

11. In response to a question about any public communications regarding where families could go for advice, Ms Shutler said that a helpline had been set up and publicised but the take up was low. Instead, she felt the most effective method for communication was between a woman and her lead midwife. They were encouraging women to contact the service directly and those calls would be triaged by a midwife.

12. In terms of timescales, Ms Shutler explained that no reorganisation would take place in the next 12-18 months and it would likely be 4-5 years until changes were implemented after consultation and any capital investment secured. However, Ms Shutler also recognised that the Trust didn't move quickly enough in 2015 and that whilst a number of reviews were underway, they would not be waiting for the recommendations before implementing necessary changes.

13. Dr Crowe acknowledged that there were lots of things to be done, and they were having to be prioritised. Examples of actions that had been, or were being, taken included:

    a. remote foetal monitoring (where consultants could monitor a foetus from any location).
    b. further investment in training and development for both technical and non-technical skills;
    c. implementing controls to ensure increased consultant presence on the wards;
    d. appointment of three specialist midwives (one specialising in the Better Births agenda and two in foetal wellbeing);
    e. a piece of work to scope out continuing care and what that means for women and families in East Kent;
    f. Out of hour safety huddles to ensure ward leads had a helicopter view of the service at that time;

g. investing in and expanding the Getting it Right First Time (GIRFT) programme; and
h. the Chief Nurse holding “floor to board” meetings to gather intelligence and ensure staff feel listened to.

14. In terms of measuring service satisfaction, Ms Horne explained that all women were offered the “Friends and Family” test in order to provide feedback, as well as the “birth after thought” service. Feedback was triangulated and lessons learnt shared – both positive and negative. Dr Crowe added that Healthwatch sat on the oversight committee, as does the MVP Chair. It was important that the woman and family voice be part of every decision the Trust made.

15. A Member asked if a midwife sat on the Trust’s Board of Directors. Ms Shutler responded that nursing and midwifery representatives were on the Board as well as relevant sub-committees. The Director of Nursing was also an ex-midwife.

16. The Chair thanked the guests for attending, and on behalf of the Committee he offered his deepest sympathies to the families affected. He summarised the three key pieces of work that HOSC would want to receive updates on, and what the timescales were:

    a. Healthcare Safety Investigation Brach (HSIB) which looked into certain categories of incidents in maternity units across the country. The Trust received quarterly reports and met with HSIB to review the findings and themes.
    b. NHS England independent review led by Dr Bill Kirkup. The timescales were unclear at that point in time.
    c. The Trust’s sub-committee with its seven workstreams. The Trust’s Chief Executive had set an expectation that initial conclusions would be available by the end of April.

17. RESOLVED that the report be noted and that the Trust be requested to provide an update at the appropriate time.

31. Work Programme
(Item 10)

1. In light of today’s meeting, the following would be added to the work programme:

    a. Frank Lloyd Unit – decision around any possible referral to the Secretary of State to come to the next HOSC meeting.

    b. EKHUFT maternity services.

2. RESOLVED that the work programme be noted and updated.

32. Date of next programmed meeting – Wednesday 29 April 2020

(Item 11)

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Item 6: Local Covid-19 response and restart of NHS services

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 22 July 2020

Subject: Local Covid-19 response and restart of NHS services

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Kent and Medway CCG.

It provides background information which may prove useful to Members.

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1) Introduction

a) The Covid-19 pandemic has required an unprecedented response from public bodies, including the NHS.

b) During the height of the pandemic, the Kent and Medway CCG provided a written update for HOSC Members regarding the temporary changes which had been necessary to meet need during the pandemic. In light of their urgent nature, there was no time to consult HOSC but the NHS England/ NHS Improvement made it clear health scrutiny committees should still be engaged.

c) This written update (dated 29 April 2020) was discussed by HOSC Members on 5 May with follow up questions sent to the Accountable Officer at the K&M CCG.

d) The CCG has been invited to attend HOSC today to update Members on how the local NHS plans to move forward after the height of the pandemic.

2. Recommendation

RECOMMENDED that the Committee consider and note the report.

Background Documents

None

Contact Details

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Covid-19 response and restart of NHS services

1 Introduction

The NHS across Kent and Medway is working as one to respond to the pandemic and will continue to do so through the restart phase of work. The NHS is also a key partner on the Kent Resilience Forum response for Covid-19 and continues to be actively involved in the recovery cells of the KRF.

The impact of Covid-19 on the people of Kent and Medway is a tragedy. At the time of writing this report, deaths from Covid-19 were 1319 in Kent and 188 in Medway. This is the figure using ONS data published on 7 July for deaths in all settings including care homes. Whilst there has been a downward trend in the number of infections and deaths since May 2020 local people are still getting seriously ill and dying from Covid-19.

The number of people affected by Covid-19, in terms of physical and mental wellbeing, is also far greater than those who have needed hospital treatment and those who have sadly died.

- The isolation of lockdown and the impact of unemployment means we expect more people to need support from mental health services in the months ahead.

- The physical health of people who have been unable or unwilling to access NHS services during the April/May peak of the pandemic will have worsened.

The local NHS is now focussed on three overarching issues:

- Ensuring there is sufficient capacity to care for people who continue to be infected with Covid-19
- Restart non-Covid-19 services
- Meet the increased demand across rehabilitation and mental health services for those affected by Covid-19 either directly or indirectly

In addressing all three of these areas we must consider the evidence of health inequalities and how specific groups within our local population have been disproportionately affected by the virus.

2 Recovery of NHS services – national priorities

On 29 April 2020, NHS England and NHS Improvement (NHSE/I) set out priority issues that the NHS needed to address as part of continuing to provide an effective response to the pandemic and restoring wider NHS services that were temporarily suspended or reduced whilst the April/May peak was managed.

There are 34 specific requirements across hospital, primary care, community and mental health services. The scope of the individual requirements varies considerably.

Key requirements include:

- Return urgent and routine referrals to secondary care to pre-Covid-19 levels
- Return urgent and time critical treatment to pre-Covid-19 levels
- Restart routine elective care services

- Catch-up on backlogs in screening programmes
- Introduce increased clinical support in care homes
- Establish open-access crisis services for mental health
- Maintain delivery of telephone/online consultations

Kent and Medway's NHS is progressing well against the requirements and there is intensive work across all parts of the NHS to restart services. Challenging areas at present include screening programmes where capacity for bowel screening is limited for clearing backlogs and refurbishment work is needed to make mobile breast screening units Covid-19 safe.

Cancer diagnostics have all restarted and work is underway to clear backlogs. Treatment for cancers including chemotherapy, radiotherapy and surgery are expected to be back to pre-covid levels by September 2020.

Care homes continue to receive extra clinical support. There are arrangements in place for 100% of all care homes that includes for each care home a weekly ward round, a named clinician, a named coordinator, a process for medication reviews and a process for anticipatory care plans. Further work is underway to improve digital solutions to giving care homes access to clinical advice through video and online consultations.

A summary of the 34 requirements is included as appendix 1 of this report.

3 Restarting services whilst Covid-19 is still circulating

Covid-19 has not gone away and two key areas of focus for the NHS are to:

- ensure we keep sufficient capacity across Kent and Medway to support those patients who continue to need specialist care to treat the virus
- be ready to respond if infection rates start to rise again.

If a second peak does happen we must tackle it without the same disruption to other services that occurred in preparing for and managing the April/May peak.

This does mean that clinical staff and beds will continue to be dedicated to Covid-19 care and therefore impacts on our ability to fully restore other services.

In addition to continuing to provide services for Covid-19 patient, like other employers and organisations, the NHS must implement a range of social distancing national requirement to help limit the spread of the virus and protect our staff and people visiting our services. The key requirements are:

- greater distancing between people in waiting areas, wards, communal space and offices
- more frequent and in-depth cleaning of sites

The impact of these requirements varies across different locations, with our older and smaller premises most affected. It reduces both the number of patients we can accommodate and the speed people can be seen; and therefore also impacts on our ability to fully restore services.

Covid-19 is likely to remain a health problem until an effective vaccine is developed and administered to a significant proportion of the population.

4 Potential timeline for full recovery

The restoration of all health services to pre-pandemic levels is complex and constrained by the issues noted above. It will take time and we must ask the people of Kent and Medway and HOSC to bear with us and work with us. Our restart work will be phased and prioritised but we expect it to take into 2021/22 to fully recover for all non-urgent services. The speed of the recovery will also critically depend on whether we see further peaks in infections; which is to a large extent dependent on how everyone living and working in Kent and Medway behaves in terms of respecting the rules on social distancing and maintaining good hygiene practices.

5 Maintaining benefits from new ways of working

Whilst the pandemic has had a terrible impact on so many people, we believe that a range of new ways of working which the NHS had to introduced in response to the pandemic have benefitted patients and our teams. Where this benefit can be maintained we will be looking to retain these new ways of working as normal practice in the future. The clearest example has been the rapid increase in the use of telephone and video consultations across primary, community, hospital and mental health services. Maintaining high levels of phone and video consultation are specific requirements set out in the national priorities for NHS recovery.

However, we recognise that telephone/video consultations will not be right for some people and some types of appointment. They would not replace the ability to see a clinician face to face but they are offering more convenience and flexibility for people and reducing the need for people to travel to healthcare settings.

With any plans for restart that may involve adopting new ways of working we will be considering patient and public engagement requirements to ensure the views of local people have shaped our plans.

6 Informing and involving patient and the public in our restart programme

Making sure that we keep patients and the public informed about progress and involved in any services change that is proposed as part of the restart programme is important to us. The restart programme includes a dedicated communications and engagement workstream which will ensure:

- a broad and diverse range of stakeholders are informed about progress to restart services
- where changes are being considered there is active patient and public involvement in designing/reviewing those changes
- statutory requirements to engage and consult are met where required
- targeted communications and engagement campaigns are delivered to help local people continue to protect themselves and the NHS from Covid-19.

During June we ran public and staff surveys and conducted a series of interviews and discussions to capture experiences during the lockdown and peak of infections. We asked for feedback both on the experience of using NHS services during the pandemic and where people were unable to or chose not to use NHS services.

Over 2,100 people responded to our public survey and nearly 700 NHS staff responded to a separate survey. 45 focused interviews were also carried out. The feedback is being analysed during July and will be used to support the restart programme to:

- understand levels of support for the new ways of working such as telephone/online consultations

- plan communications campaigns and further engagement work with local people to help them protect themselves and support the NHS in restoring services safely and effectively
- identify way that we could better support local people if infection rates start to rise again.

7 Continuing to engage HOSC

We welcome HOSC's view on how frequently the committee would like to receive general updates on the NHS restart programme.

Where any restart plans are proposing permanent variations to how services are provided we will seek your advice on whether they are significant variations requiring public consultation and whether Kent HOSC or the Kent and Medway Joint HOSC is the appropriate committee to review the proposals.

We will share, through the HOSC chair/secretariat, stakeholder briefings and formal progress reports which are presented to the KMCCG Governing Body and local Trust Board meetings.

Wilf Williams
Accountable Officer - Kent & Medway CCG
SRO for Transforming Health and Social Care in Kent & Medway

Appendix 1 – progress against urgent/critical care priorities

Priority milestone	Service area
Regional cancer SROs must provide assurance that cancer surgery hubs are fully operational everywhere	Cancer
Referrals, diagnostics and treatment must be brought back to pre-pandemic levels ASAP to minimise potential harm, and to reduce the scale of the post-pandemic surge in demand.	All services
Create plan to support the increase in patients who have recovered from Covid and need ongoing community health support	Community based services
Make full use of available hospice care - K&M	Community based services
Extend testing capacity to include regular testing of asymptomatic NHS staff	Swabbing and Testing
Encourage GP practices to triage patients using online consultations and maintain current rates of remote appointments (85%)	Primary Care
As far as practicable, video or telephone appointments should be offered by default for all outpatient activity without a procedure. Ensure trusts should use remote appointments - including video consultations - as a default to triage their elective backlog. They should implement a 'patient initiated follow up' approach for suitable appointments - providing patients the means of self-accessing services if required	All services
Maintain mutual aid working arrangements between LGAs and LRFs - discharge planning, flexible staffing.	Incident Control
Ensure obstetric units have appropriate staffing levels including anaesthetic cover	Maternity / Workforce
Ensure providers make direct and regular contact with all women receiving antenatal and postnatal care, explaining how to access maternity services for scheduled and unscheduled care, emphasising the importance of sharing any concerns so that the maternity team can advise and reassure women of the best and safest place to receive care	Acute / Maternity / Workforce
Establish all-age open access crisis services and helplines and promote them locally working with partners such as local authorities, voluntary and community sector and 111 services	Mental health and Learning Disability / Autism services
Proactively contact and support existing mental health service patients, especially those recently discharged from inpatient services	Mental health and Learning Disability / Autism services
Liaise with local partners to ensure referral routes for children and young people are understood to ensure they have access to mental health services	Mental health and Learning Disability / Autism services
Create plan for a possible longer-term increase in demand as a consequence of the pandemic, including by actively recruiting in line with the NHS Long Term Plan	Mental health and Learning Disability / Autism services
PPE availability for all staff	PPE
Provide clear information on how to access primary care services and that patients are confident about making appointments (virtual or if appropriate, face-to-face)	Primary care
Complete work on implementing digital and video consultations, so that all patients and practices can benefit	Primary care
Stratify and proactively contact high-risk patients with ongoing care needs, to ensure appropriate ongoing care and support plans are delivered through multidisciplinary teams	Primary care

Introduce a weekly virtual ‘care home round’ of residents needing clinical support	Primary care
Make two-week wait cancer, urgent and routine referrals to secondary care as normal, using ‘advice and guidance’ options where appropriate	Primary care
Catch-up on backlog of those already in an active screening pathway and reschedule deferred appointments	Screening and immunisations
Make screening services are available for the recognised highest risk groups (as identified in individual screening programmes)	Screening and immunisations
Build a plan for each STP/ICS for the service type and activity volumes required beyond the end of June to inform discussions during May about independent sector contract extensions	Urgent and routine surgery and care
Work with systems to make judgement on, and plans for, further capacity for routine non-urgent elective care	Urgent and routine surgery and care
Strengthen 111 capacity and sustain appropriate ambulance services ‘hear and treat’ and see and treat’ models. Increase availability of booked appointments and open up new secondary care dispositions, allowing patients to bypass ED’s, where appropriate	Urgent care
Provide local support to the new national NHS communications campaign, encouraging those seeking emergency or urgent care to contact their GP, go online to NHS 111 or call 999	Comms
Provide urgent outpatient and diagnostic appointments at pre-Covid19 levels - K&M	Outpatients and diagnostics
Provide urgent and time-critical surgery and non-surgical procedures at pre-Covid 19 levels of capacity	Urgent and routine surgery and care
Stratify and proactively contact high risk patients to educate on specific symptoms/circumstance needing urgent hospital care, and ensure appropriate ongoing care plans are delivered	Shielded patients
Restart routine electives, where capacity is available, prioritising long waiters	Elective care
Ensure all NHS acute and community hospitals assess all admitted patients daily for discharge, against each of the Reasons to Reside; and ensure timely completion of a Hospital Discharge List, enabling the community Discharge Service to achieve safe and appropriate same day discharge	Discharging
Ensure there are: Daily reviews of all patients in a hospital bed on the Hospital Discharge List and Prompt and safe discharges	Discharging
Employers should complete the process of employment offers, induction and any necessary top-up training for all prospective ‘returners’ who have been notified to them.	Workforce
Ensure education material, training and appropriate PPE is available for the whole workforce, inc. non-clinical staff	Workforce

Item 7: Dermatology Services in North Kent

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 22 July 2020

Subject: Dermatology Services in North Kent

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the Kent and Medway CCG.

It provides background information that may be useful to Members.

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1. Introduction

a) Dermatologists are specialist physicians who diagnose and treat diseases of the skin, hair and nails.[1]

b) DMC Healthcare was awarded the contract to deliver this service to residents of Medway, Dartford, Gravesham, Swanley and Swale from 1st April 2019.

2. Previous monitoring by the Kent HOSC

a) HOSC last received a performance update on Dermatology Services in North Kent under DMC Healthcare on 16 December 2019. During the meeting, the Deputy Managing Director at Medway CCG highlighted 4 key points:

i. DMC Healthcare took over the running of Dermatology Services from Medway Foundation Trust (MFT) in April 2019. The previous service had been failing and needed significant work put into it.

ii. The initial backlog focus had been on cancer services and cancer patients, and this appeared to have been sorted.

iii. The second focus was on dealing with the backlog transferred from MFT, which had also been rectified.

iv. The final focus was on the waiting times being experienced by current patients which the CCG recognised were too high.

b) Healthwatch Kent had been involved with monitoring performance, and they were expecting to commence a piece of work to evaluate the Service around March 2020.

c) At the end of the discussion, HOSC Members made the following recommendation:

[1] British Association of Dermatologists, What is a dermatologist? www.bad.org.uk

RESOLVED that the report be noted, and Medway CCG return to HOSC after summer 2020 with an update on performance, accompanied by the service evaluation by Healthwatch Kent and Healthwatch Medway.

d) On 23 June 2020, the Chair of HOSC received notification that the CCG had suspended the contract with DMC Healthcare following new data which indicated there were risks with continuing with it.

e) The CCG has prepared the attached report, which HOSC are invited to debate.

3. Recommendation

RECOMMENDED that the Committee note the report and the Kent and Medway CCG be invited to update HOSC at the appropriate time.

Background Documents

Kent County Council (2019) 'Health Overview and Scrutiny Committee (25/01/19)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7924&Ver=4

Kent County Council (2019) 'Health Overview and Scrutiny Committee (06/06/19)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8281&Ver=4

Kent County Council (2019) 'Health Overview and Scrutiny Committee (23/07/19)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8282&Ver=4

Kent County Council (2019) 'Health Overview and Scrutiny Committee (16/12/19)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8483&Ver=4

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NHS
Kent and Medway
Clinical Commissioning Group

Statement re: North Kent Dermatology Service

9 July 2020

NHS Kent and Medway Clinical Commissioning Group (CCG) suspended DMC Healthcare's contract to provide dermatology services in Medway, Swale, Dartford, Gravesham and Swanley on 19 June 2020. This decision was taken to ensure patient safety after the CCG identified concerns about the provider's ability to meet NHS standard contract requirements.

Dermatology is the medical term for the treatment or management of skin conditions which can include rashes, lesions, lumps on the skin, changes to moles and skin cancer.

Wilf Williams, Accountable Officer at NHS Kent and Medway CCG, said: "Since we took the decision to suspend DMC Healthcare's contract for dermatology services, we have been working hard to put alternative provision in place to best meet patient needs.

"There are 1,855 patients who need procedures and these patients are being contacted and booked into clinics which will begin on Friday 10 July. The 18 Week Support team, which specialises in seeing a high volume of patients in a short space of time, will be running the clinics with support from West Kent Dermatology Service.

"West Kent Dermatology Service will also see new routine patients once the priority patients have been treated. The service is already receiving referrals and has the capacity to see more than 500 new patients per week. Services will be led by expert consultant dermatologists with a team of more than 20 consultants available to deliver services.

"Patients with newly diagnosed cancer and inflammatory skin disease will be seen and linked to other specialist services as required. This will include skin cancer support services provided at Queen Victoria Hospital and oncology services provided by Maidstone Hospital. Multidisciplinary clinics – which bring a range of clinicians from different specialities together – have already begun to ensure these patients are seen as quickly as possible.

"Both West Kent Dermatology Service and the temporary service being delivered in North Kent are fully supported by parent provider Sussex Community Dermatology Service

(SCDS). SCDS provides dermatology services across Sussex, Surrey and Kent with a proven track record of service delivery for more than 10 years, working in acute hospital trust and community locations.

“Although we are still in the process of clinically triaging and validating data provided by DMC Healthcare, we know there is a large waiting list of patients who need to be assessed so we are planning provision for them. Once we have clearer data, we will put plans in place to treat patients as quickly as possible. It has been important to prioritise the high risk patients which is what we have been concentrating on.”

Clinics will take place at Rainham Healthy Living Centre, High St, Rainham and Fleet Health Campus, Vale Rd, Northfleet.

The CCG has asked clinicians who see patients that have been waiting a long time to consider whether they believe any delays to their treatment may have caused harm.

As the situation develops, www.bit.ly/NorthKentDerm will be kept updated so please check for the latest information.

For more press information, please contact kmccg.comms@nhs.net or call 07825 844666.

Caroline Selkirk
Director of Health Improvement

Item 8: Review of the Frank Lloyd Unit, Sittingbourne

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 22 July 2020

Subject: Review of the Frank Lloyd Unit, Sittingbourne

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the Kent & Medway CCG and make a final determination with regard the proposals on the future of the Frank Lloyd Unit.

It provides additional background information which may prove useful to Members.

The proposed change to the Frank Lloyd Unit has been deemed a **substantial variation of service**.

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1) Introduction

a) The Frank Lloyd Unit has been an inpatient unit for individuals with complex dementia needs and challenging behaviour.[1] It is accessed by patients across Kent and Medway.

b) The service is provided by Kent and Medway NHS and Social Care Partnership Trust (KMPT).

c) Due to the falling number of patients receiving care at the Unit, the Trust has deemed its operation as unviable. In April 2019, the CCG's served notice on the Frank Lloyd Unit and the site has been decommissioned since 31 March 2020.

2) Previous monitoring by the Kent HOSC

a) HOSC received notification at their meeting on 21 September 2018 that the Frank Lloyd Unit was under review. The Committee received further written updates at its June and July 2019 meetings, when the CCG acknowledged that work had progressed slower than anticipated.

b) At its 19 September 2019 meeting, HOSC deemed the proposed changes to the Unit to be a substantial variation of service.

c) A confidential briefing was held for HOSC members in January 2020 to discuss the onward pathway for current Frank Lloyd Unit patients.

d) At its last meeting on 5 March 2020, the Committee made the following resolution:

[1] KMPT (2019) Frank Lloyd Unit, https://www.kmpt.nhs.uk/our-services/frank-lloyd-unit/

RESOLVED that this Committee considers that the decision of the Kent & Medway CCGs to de-commission the Frank Lloyd Unit will not be in the best interests of the local population for the following reasons:

a) The decision to close was premature without sufficient alternate provision being available in Kent and Medway.
b) Insufficient consultation had been carried out.
c) There was a lack of proper clinical evidence that the closure was in the best interests of patients.
d) There would be workforce implications that needed to be taken into account in light of the closure.

Therefore the Committee asks that the Kent & Medway CCGs consider and respond to these comments and report these back to the Committee ahead of a final determination as to whether or not to refer their decision to the Secretary of State on the grounds that the proposal is not considered to be in the best interests of the health service in the area.

e) Members of the Committee had the following specific concerns around the de-commissioning of the Frank Lloyd Unit:

i. the new care model for complex dementia patients had not been fully developed nor implemented;

ii. it was unclear if there was suitable, alternative local provision for those with complex dementia. Whilst Members agreed care within the home was appropriate for some, they felt there would always be a small number requiring dedicated facilities;

iii. the proposed care model had dementia patients supported within existing care homes, but it was unclear if those care homes were ready or had the right staff to deal with complex behaviour;

iv. there had been a lack of openness around the closure of the Frank Lloyd unit, which Members understood had not been accepting referrals for a substantial period;

v. there had not been suitable clinical evidence that the closure of the Unit was in the interests of the local population; and

vi. it was unclear what would happen to the staff employed at Frank Lloyd, but Members felt there was a real risk their professional skills would be lost.

3. The Next Steps

a) As per the recommendation from its meeting on 5 March 2020, HOSC must decide at this meeting if they are going to refer the decommissioning of the Frank Lloyd Unit to the Secretary of State for Health and Social Care.

b) The NHS have had an opportunity to hear Members concerns and questions and respond to them.

c) As set out in the recommendation for this meeting, HOSC Members must consider the evidence presented by the NHS and the responses to the comments and questions made at the last meeting. The full range of legal options remains available to the HOSC as to the final decision and none is excluded by the recommendation agreed on 5 March. These options include:

- endorsing the proposal; or
- making a formal referral on the grounds that the proposal is not considered to be in the best interests of the health service in the area; or
- making any other comment(s) on the proposal that the HOSC deems appropriate.

d) If the Committee considers a motion of formal referral to the Secretary of State, Members would need to be assured that the full legal requirements could be complied with. Any referral would need to include:

i. An explanation of the proposal being referred.
ii. An explanation of the reasons for making the referral.
iii. Evidence in support of these reasons.
iv. A summary of the evidence that the proposals are not in the best interests of the health service in the area, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area.
v. An explanation of the steps taken by the HOSC to try to reach agreement with the relevant NHS bodies.
vi. Evidence that the HOSC has complied with all the legal requirements of a referral.

e) Where a formal referral under the terms of The Local Authority (Public health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013 has been made, and the Department of Health and Social Care agrees it meets the legal requirements, the Secretary of State may ask for advice from the Independent Reconfiguration Panel (IRP).

f) The IRP is an advisory non-departmental public body. Where requested by the Secretary of State, the IRP will undertake an initial assessment of the referral. In exceptional circumstances, it may advise that further evidence is required before reporting back. The IRP offers advice only. The Secretary of State makes the final decision on any contested proposal.

g) If the Committee feels that the NHS has adequately responded to their specific concerns, and that the above grounds no longer apply, it will still be able to monitor the implementation of the service and make comments and recommendations directly to KMPT or the CCG.

h) The Committee has not yet made a decision whether the continuing model of care for dementia patients with complex needs is a substantial variation of service. The CCG will return to the Committee with an update as soon as further information is available.

4) Recommendation

The Committee is asked to consider the decision of the Kent and Medway CCGs to decommission the Frank Lloyd Unit and take one of the following actions:

a) Endorse the decision of the Kent and Medway CCGs to decommission the Frank Lloyd Unit; or

b) Refer the decision to the Secretary of State on the basis that it is not considered to be in the best interests of the health service of the area.

c) Agree to make any other comments the Committee deems appropriate.

Background Documents

Kent County Council (2018) *'Health Overview and Scrutiny Committee (21/09/18)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7921&Ver=4

Kent County Council (2019) *'Health Overview and Scrutiny Committee (06/06/19)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8281&Ver=4

Kent County Council (2019) *'Health Overview and Scrutiny Committee (23/07/19)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8282&Ver=4

Kent County Council (2020) *'Health Overview and Scrutiny Committee (05/03/20)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8286&Ver=4

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NHS
Kent and Medway
Clinical Commissioning Group

Transforming mental health care services in Kent and Medway – proposed changes at the Frank Lloyd Unit in Sittingbourne

Update for the Kent Health Overview and Scrutiny Committee (HOSC)

1. Introduction

Before the merger of Kent and Medway clinical commissioning groups (CCGs) into a single Kent and Medway CCG in April 2020, work was underway (headed by the former West Kent CCG) to review and improve the clinical model of care for dementia patients across the county, of which the use of the Frank Lloyd Unit in Sittingbourne is an integral part. The cohort of patients affected are those with complex needs requiring highly specialist care and support. This includes patients who receive funding from Continuing Health Care.

An update on the future of the Frank Lloyd Unit, including proposals for its de-commissioning in place of different, more personalised and better value for money care settings, was presented to the Kent Health Overview and Scrutiny Committee (HOSC) in March 2020. Committee members raised concerns about these plans and considered that the decision of the Kent and Medway CCGs to de-commission the Unit was not in the best interests of the local population for the following reasons:

a) The decision to close is premature without sufficient alternative provision being available in Kent and Medway
b) Insufficient consultation has been carried out
c) There is a lack of proper clinical evidence that the closure is in the best interest of patients
d) There will be workforce implications that will need to be taken into account in light of the closure.

The Committee asked that the Kent and Medway CCGs (now the newly constituted Kent and Medway CCG) consider and respond to these comments and report these back to the Committee ahead of a final determination as to whether or not to refer their decision to the Secretary of State on the grounds that the proposal is not considered to be in the best interests of the health service in the area.

The new Kent and Medway CCG has made it a priority to conduct an internal review of the process leading to the proposal to de-commission the Frank Lloyd Unit and the development of a case for change and new clinical model of care for the cohort of patients affected.

This paper has been developed to:

- update HOSC members on the findings of this internal review;
- respond to the comments and recommendations from HOSC members;

- outline the steps that the CCG is intending to take to reassess and re-start this work; and,
- seek HOSC's input and support to continue to develop a robust case for change and model of care for this cohort of complex dementia patients across Kent and Medway.

2. Current status of the Frank Lloyd Unit

The Frank Lloyd Unit is a Care Quality Commission (CQC) registered mental health unit of two wards, in a self-contained unit on the Sittingbourne Memorial Hospital site. The unit only supports patients who are in receipt of NHS Continuing Healthcare (CHC) funding. Each ward has a bed capacity of 20. For the past 12 months only one of the two wards has been in operation as the number of referrals reduced. Since January 2018, there have been eighteen successful discharges from the Frank Lloyd Unit to a range of care homes and nursing homes within Kent and Medway that care for individuals with dementia and complex needs. These discharges were subject to discussions and care planning between clinicians and patients' families to ensure that more appropriate long term care could be found for their loved ones. The last person on the ward successfully moved to their new care setting in March 2020. Since that time the unit has been closed although it is available to care for individuals if needed. More information about the unit is included as **Appendix A**.

As previous updates to HOSC have described, the issue of underutilisation and appropriateness of the Frank Lloyd Unit in caring for vulnerable CHC patients on a long-term basis has been long-standing. Discussions with Kent and Medway NHS and Social Care Partnership Trust (KMPT) about potentially closing the unit and using the associated funding in different ways to better care for this cohort of patients closer to home have been ongoing for several years. The unit has not been fully used for some time due to it being a hospital environment and considered by clinicians and commissioners as not ideal as a long-term placement that can be considered "home". Subsequently, as the last cohort of patients' wellbeing improved, it allowed for placements to be sourced that can focus on the person's long-term care.

3. Internal review of the proposed de-commissioning of the Frank Lloyd Unit and development of a new model of care for Kent and Medway

The eight Kent and Medway clinical commissioning groups merged into a single Kent and Medway CCG (KMCCG) on 1st April 2020. KMCCG now has responsibility for the programme of work around the Frank Lloyd Unit and developing a new model of care for this patient cohort.

KMCCG has undertaken an internal review of the work connected with the Frank Lloyd Unit. This was driven by concerns raised by HOSC members as well as a review of ongoing work programmes and processes under new leadership arrangements. Key

findings from the internal review as well as responses to the comments made by HOSC are set out below.

Key findings from the internal review and actions taken

- **Kent and Medway CCGs did not adequately follow due process around proposed service changes at the Frank Lloyd Unit**

  KMCCG's internal review has demonstrated that the eight Kent and Medway CCG's did not adequately follow due process when changes were made to the model of care for this cohort of patients with dementia and complex needs, including plans to de-commission the Frank Lloyd Unit and provide more care within a community setting.

  NHS England (NHSE) Guidance *'Planning, assuring and delivering service change for patients'* first published in 2013, outlines the requirements for health service reconfiguration, including the Secretary of State's 'four tests' which are designed to build confidence within the service, with patients and communities. KMCCG acknowledge that the previous work undertaken by Kent and Medway CCGs did not meet the four test areas, namely: 1) support from GP commissioners, 2) strengthened public and patient engagement, 3) clarity on the clinical evidence base, and 4) consistency with current and prospective patient choice. An additional test to ensure that patients will continue to receive high quality care should bed numbers be reduced was introduced in 2017 and is a key area for commissioners to consider as they seek to assure their plans. KMCCG apologises unreservedly for these omissions and accepts that Kent and Medway scrutiny committees should have been formally consulted. The CCG further acknowledges that their service reconfiguration process was not applied in full.

  Action taken: KMCCG is working hard to rectify these shortcomings with a refreshed programme of work with the five tests as its guiding principles. The CCG will ensure it works closely with NHSE/I in this programme going forwards, to strengthen internal assurance and checks and balances as the programme of work progresses over the next period. KMCCG will work hard to ensure there is sufficient engagement, consultation and clinical leadership of the development of any new approach to dementia care, to involve and assure stakeholders and regulators (including HOSC members, NHSE/I), patients and carers and the wider public about the future shape of dementia services for this patient cohort.

- **The need for a robust case for change, a Kent and Medway 'model of care' for dementia patients with complex care needs, and options for delivering that care**

While we believe that the community-based model of care provided for many of the patients previously at the Frank Lloyd Unit is in line with national objectives for improving dementia services and appropriate and will bring benefits in terms of patient outcomes and experience, we acknowledge that insufficient work has been undertaken at a Kent and Medway level to develop a robust local 'case for change' and new clinical model of care for dementia patients in this complex care cohort. Any such case for change, model of care and options for delivering that model of care, requires thorough testing and involvement of a wide variety of stakeholders (in light of the five tests set out above), including HOSC members, patients, families, carers, staff and the general public, before any proposed changes are made to the way services are organised. Despite the best of intentions to deliver better experiences and outcomes for patients, the Kent and Medway CCGs did not do this.

The former Kent and Medway CCGs took the view that the £4m currently being spent on a block contract for a unit operating at significant under capacity would be better spent on more community care and support for this cohort of dementia patients. This would be in line with national policy and would represent better value for money and improve patient experience and clinical outcomes. We recognise that this was a decision made with the best of intentions but without due process and involvement. The new CCG is committed to confirming service specifications prior to consultation on options for the future.

Action taken: The refreshed programme of work for patients in this complex care cohort will build on current work and undertake full demand and capacity modelling based on demographic and clinical data, robust clinical engagement to design an effective and improved new clinical model of care, review and analysis of locally-held data relating to dementia patients (including admission and readmission to hospitals from community care), patients, carer and staff experience data and feedback, to inform the development of a thorough case for change and options for the future.

A programme of engagement, involvement and consultation will be undertaken as necessary to test these options with HOSC, stakeholders, staff, patients and their carers, and the public before any changes are made to services. In the interim, we will continue to monitor and review the use of inpatient and community services for dementia patients in this complex care cohort across Kent and Medway to ensure that care is provided that is both clinically appropriate and responsive to the needs of patients, carers and families.

Responses to comments from HOSC:

- ***The decision to close is premature without sufficient alternate provision being available in Kent and Medway***

  We acknowledge that insufficient work has been undertaken to thoroughly develop a suitable model of care for this cohort of dementia patients across Kent and Medway and are working to rectify this as a matter of urgency.

  It was agreed by commissioners and KMPT that whilst notice was served by the CCGs, this would be dependent on any patients still in the Frank Lloyd Unit being successfully and appropriately found alternative placements. The unit could not be closed whilst there were still patients in residence. Patients have only been moved from the unit when more appropriate placements for their care have been found, a process that would have happened in the interests of their clinical and personal interests even if the unit remained fully open.

  While we acknowledge that due process has not been followed, it is clear that the intentions of commissioners was to move from a service where people were admitted into the Frank Lloyd Unit and remained there until the end of their life; to a service which enabled patients to have a period of assessment and then be discharged to a less intensive environment at an appropriate time via delivery of tailored care and support. However, in a number of cases it was appropriate for patients to remain within the Frank Lloyd Unit as the clinical assessment of their needs indicated that the Frank Lloyd Unit was the most appropriate environment. Inevitably some patients remained there until the end of their lives, rather than being moved.

- ***Insufficient consultation has been carried out***

  We acknowledge and apologise that we have failed to follow due process within this regard. We will develop robust plans to consult on a clear case for change and a proposed new model of care.

  We will build on the programme of pre-consultation stakeholder engagement around the proposed de-commissioning of the unit undertaken in 2019 (see section below for more information).

  Work is underway to plan for consultation on the clinical model of care for this cohort of patients with complex needs and dementia. We will aim to complete this by 31st March 2021 subject to COVID-19-related requirements.

- ***There is a lack of proper clinical evidence that the closure is in the best interest of patients.***

  We believe that there is a compelling body of national clinical evidence to support the move to more community based care; however, we acknowledge that insufficient work has been undertaken at a local level to understand the

demand and capacity of the Kent and Medway population for highly specialist dementia services now and in the future.

In Kent and Medway, commissioners made the decision to focus on putting in place the support to keep people in their usual place of residence, avoiding any unnecessary hospital admissions to minimise disruption to both patients and their carers. Guidelines from the National Institute for Health and Care Excellence (NICE)[1] and national policy set out in the NHS Long Term Plan published in 2019, set out a clinically-evidenced ambition to increase the capacity and responsiveness of community and intermediate care services for dementia in the next five years to enable people to remain in the community for as long as possible[2].

While this move was based on national policy and best practice, we acknowledge that a robust Kent and Medway-focussed case for change should have been developed to ensure that the current and future needs of the local population were taken into account and that this should have been subject to consultation. It is our intention to build on existing work, best practice guidance and national best practice and develop a Kent and Medway 'case for change' for this cohort of patients that reflects the needs, priorities and preferences of patients, families and carers.

While we will base our future work on the national profile to provide services for patients as close to their home as possible, we will also take into account local needs and requirements through in-depth demand and capacity modelling and clinical leadership. We will review how patients who have been moved to a domestic setting, or nursing or residential home, have adapted and whether these moves have impacted on readmission rates. We will develop a proposed model of care that ensures that services are available to all patients who need them, focused on high-quality, personally-tailored services.

We will also consider people with dementia who do not meet the Continuing Health Care criteria as part of the new clinical model development. We also recognise that for a very small cohort of patients, an inpatient unit will be clinically appropriate, and the new service model will take this into consideration.

- ***There will be workforce implications that will need to be taken into account in light of the closure.***

We will look again at workforce considerations as part of the development of a robust clinical model for dementia patients. In terms of staff working at the Frank

[1] NICE Guideline NG97 Dementia: assessment, management and support for people living with dementia and their carers, 20th June 2018

[2] NHS Long Term Plan, Section 1.20. We will go further in improving the care we provide to people with dementia and delirium, whether they are in hospital or at home. 7th January 2019

Lloyd Unit, KMPT has confirmed that staff involvement has been a high priority during this period, in recognition of the fact that retaining staff across all service areas is a priority for the Kent and Medway system. We are aware that the trust formally consulted with staff to start an internal redeployment process to safeguard clinical skills and expertise as referral numbers and bed occupancy rates reduced.

A phased release of staff into new roles started in September 2019 and was completed in March 2020 when the last patient in the Frank Lloyd Unit was found a suitable alternative placement. Nine qualified and 20 unqualified staff were successfully deployed into suitable vacant roles across the trust. This included the ward manager and two deputies. KMPT had seen staffing levels significantly reduce prior to the formal staff job role consultation process as staff had already started to find themselves other roles both internally and externally.

Additional clinical leadership and management support from KMPT's Older People's Services has remained in place throughout the period of change to ensure good levels of care quality were maintained alongside support to safely transfer patients, their families and staff.

4. Next steps

Using the Secretary of State's 'Four Tests' and the additional 'Fifth Test' as guiding principles for this work, we will:

- Undertake a full review of current dementia services being provided to this cohort of patients with complex needs.
- Undertake demand and capacity modelling to better understand the requirements of the Kent and Medway population both now and in the future.
- Develop a robust 'case for change' for Kent and Medway.
- Develop options for the future clinical model for this cohort of dementia patients with complex needs, their families and carers, considering a range of factors including clinical quality and outcomes, patient experience, access, workforce, and value for money.
- Develop options for how and where the new clinical model could be delivered, aligned to national policy and clinical best practice.
- Ensure public and stakeholder involvement in developing the case for change, the proposed model of care and the options; and consulting on this as appropriate.
- Continue to engage with HOSC, NHSEI assurances panel, patients, carers, the public, staff and stakeholders before, during and after consultation.

5. Work to date

We believe that while the former CCGs have not followed due process, much of the work already undertaken to inform a Kent and Medway case for change and new model of care has value and is a sound foundation to build upon over the coming months. Previous work proposed to develop a new model of care for this cohort of dementia patients across Kent and Medway, based on the principle of providing the right support at the right time to enable patients to remain independent for as long as possible as well as providing support to their families and carers. Early thinking has suggested that the development of an enhanced community model in partnership with local providers should focus on:

1. Reducing unnecessary admissions to hospital (both acute and mental health)
2. Reducing the length of stay in hospital
3. Providing an increase in supported discharges to appropriate care settings
4. Providing an increase in people with dementia (or suspected dementia) who are supported to return home following hospital discharge
5. Providing an increase in support for carers in the community to enable them to continue with their caring role
6. Providing an increase in assessments for continuing healthcare conducted outside a hospital setting.

A workshop involving clinicians from a variety of backgrounds and specialisms relating to dementia care, was held in December 2019. It identified an additional two elements to the proposed model of care for Kent and Medway:

- **A community service**, a dementia intensive support service, to support people with dementia in their own homes and care homes at a time of crisis, or urgent need, with the aim of avoiding hospital admission and supporting people to remain in their usual environment wherever possible. The assumptions supporting the model are that a number of individuals with dementia and/or delirium and challenging behaviours:

  a. can be supported in their own home and have a hospital attendance or admission avoided
  b. can be supported in a care home and avoid hospital admission

- **A small number of specialist beds** for those complex individuals with dementia and behaviours that challenge and who are not able to be managed in most care or nursing homes. We will test this as part of our demand and capacity work to establish if this is the case and, if so, how many beds are required across Kent and Medway.

6. Engagement with patients, families and carers

There has been a significant programme of engagement with Frank Lloyd Unit patients, families and carers. We will build on this approach and extend our engagement to cover the wider cohort of dementia patients with complex needs and their families and carers, the general public and stakeholders as we develop a case for change, clinical model of care and options for the future, in advance of consultation.

An overview of the engagement undertaken with Frank Lloyd Unit patients is set out as **Appendix B**.

7. Clinical leadership and oversight

A clinical reference group meeting which consisted of primary care and secondary care clinicians has been set up to provide clinical recommendations on the proposed new model of care. Clinical model scoping work has been undertaken on the proposed new Dementia Intensive Support service for this cohort of patients.

8. Summary/conclusion

KMCCG have undertaken a thorough review of the process to propose the de-commissioning of the Frank Lloyd Unit and the development of a supporting model of care to benefit this cohort of dementia patients with complex needs across Kent and Medway. We have found this process to be lacking in terms of assurance, clinical engagement and consultation. We unreservedly apologise for this and the new CCG is committed to putting this right. Commissioners now want to continue development of a robust case for change, and a proposed new model of care in line with statutory duties, aiming to consult on our plans by the end of March 2021 (subject to COVID-19-related requirements). The CCG is committed to regular engagement with HOSC as part of this process and will ensure that regular updates are presented to Committee members as well as consultation with NHSEI in line with statutory duties and good practice.

9. Recommendation

The Kent HOSC is asked to:

- Note the results of KMCCG's internal review described in this paper
- Consider and discuss responses to the Committee's recommendations in light of the next steps and actions set out in this paper.
- Note and comment on the next steps outlined within the paper.
- Agree an appropriate date for the Kent and Medway CCG to return to HOSC to give a further update on progress on this programme.

Caroline Selkirk
Director of Health Improvement

Appendix A – About the Frank Lloyd Unit

When operating, the unit provides inpatient care and treatment for people who are in receipt of NHS Continuing Healthcare (CHC) funding and have a diagnosis of dementia with related complex behaviours that would be difficult provide care for in more general settings. The ward is not an acute psychiatric admission ward and people who have used the service require long term health care and are unlikely to significantly recover.

The ward was assessed as outstanding by CQC in 2017 however it has been acknowledged the ward should not be considered a home for life; it is very much a therapeutic environment to provide assessment, treatment and expertise in terms of the care needed to reduce the behavioural impact of having a dementia. KMPT also recognises the organisation is not a specialist in providing continuing health care services per se. It is a specialist in providing care to people with complexity in presentation relating to dementia.

The unit was accessed by all former eight CCGs in Kent and Medway within the NHS Standard Contract. The unit was originally made up of two wards of 20 beds, 30 of which were commissioned on a block basis at a cost of circa £3.029m per annum. The remaining 10 beds were purchased on a cost per case basis at £405 per day; however, the unit ceased taking cost per case patients in 2016 in response to a reduced demand spot purchased capacity was no longer required.

The service provided at the unit was originally commissioned as a short term inpatient service (admission was generally intended to be for six months) for people with dementia and complex needs, which aimed to settle patients with the use of behaviour care plans and dementia mapping and then discharge them back to a community home or care/nursing home. However historic data shows that when CHC patients were admitted to the Frank Lloyd Unit they were unlikely to be discharged again, even when they became physically frail and at the end of life. This means that the unit was operating out of scope and at significant cost, providing a prolonged service for patients whose physical needs has greatly surpassed their mental health needs and who could have been more suitably looked after in the community.

Appendix B - Frank Lloyd Unit – patient, family and carer engagement

Families of patients previously in the unit were invited to meet with representatives from the CCG and KMPT on 28th August 2019 to hear about the proposed changes, ask questions, explore potential implications of the broader changes generally and the issues that might impact on their loved ones more specifically. Healthwatch representatives also attended to hear from and support the families.

Eleven family members took part in the discussion and the independent engagement facilitator explained that this was an opportunity to:

- provide families with some background and context for the proposed changes that may take place over the next few months; and,
- talk through potential implications, and mitigations, for their family members who are currently on the unit.

The discussion covered both the broader proposed changes for older people living with dementia and the implications for the current patients and their families. Feedback covered the following areas:

- Ensuring that existing patients and their families were supported through the transition process
- Understanding and responding to the needs of each individual patient
- Involving families and carers in the decision-making processes.

More generally families expressed concern about this service "being lost" and that patients in similar positions in the future would not be able to access the Frank Lloyd Unit.

A number of actions were identified as a result of the feedback provided during the meeting. The Continuing Healthcare Assessors, along with key clinical staff from Kent and Medway Partnership Trust (KMPT) and Clinical Commissioning Group (CCG) commissioning leads, would work closely with patients and their families to ensure that appropriate safe placements could be made by the end of March 2020. The commissioners would continue to assess progress for each of the patients and their families and put resources into ensuring that appropriate, safe, personalised care is put into place for everyone currently in the unit. Each individual would have a tailored package of care, reflecting the detailed plans that are already in place. This would include one-to one input, as needed, once transferred.

The CCGs and KMPT would work with each family to ensure the package is appropriate and that additional funding is made available as deemed necessary through transition and beyond.

External, independent, facilitative support will be offered to individual families to help them through transition. This support may be from a range of people/organisations – for example, advocates, Healthwatch, staff from the unit, independent agencies – who could provide support for some or all of the following areas (examples only):

- Act as a point of contact/liaison with the various agencies
- Look at individual plans
- Facilitate meetings
- Find the best available options, as near to the families as possible
- Be involved in individual discussions with Continuing Health Care assessors, to discuss people's individual requirements
- Go with the family to check potential venues
- Continue to liaise with the family and the new residence to ensure care provided continues to be safe, appropriate and responsive to individual needs and wishes
- Support families to write an outline (checklist) of what's needed, that could be sent to homes to find out whether they can match the needs
- Ensure detailed plans are read and followed at every stage of transition.

Commissioners agreed to meet with Continuing Health Care managers to:

- explore different ways of working with individual families, to ensure a detailed, personalised plan for safe and successful transition is developed, including assessors studying existing individual plans in detail before meeting with families
- consider approaches to supporting this group of patients, other than the current list of homes, and whether a scoping exercise of other facilities and homes could be conducted
- ask that assessors visit the homes on their lists, to understand what they offer and assure themselves of the quality of care, staff ratio, skills
- ask staff from prospective homes to visit the unit, to understand each patient and their needs and whether their home can accommodate those needs, before any visits from the family.

Due to some of the feedback from the families, it was noted that there may be a need to follow up patients who have been discharged over the last 6 months, to ensure they are receiving the most appropriate care for their needs.

Some of the family members shared their concerns about how future services would provide high quality care for the next generation. It was proposed that family members be involved in ongoing discussions about the emerging model of care, so that their experiences and ideas could inform and help shape future services.

Commissioners agreed that resources will need to be allocated to training and transferring skills and experience into community settings/residences, as part of the new care model.

A briefing paper was given to each family member at the end of the session. This included contact details, if there were any further issues or questions.

Families were advised that this was only the start of the conversation and that the commissioners and providers were committed to supporting them and their loved ones through this transition phase and beyond.

Over the next two weeks, commissioners and KMPT representative fed back to their leadership teams and agreed next steps.

Healthwatch representatives reported back and obtained a commitment to follow up on the reported standard of homes being offered.

Participants were advised that a period of pre-consultation engagement would take place in forthcoming months, where a range of methods (for example, survey, public meetings, social media) will be used to share the emerging plans with people across Kent and Medway and gain their feedback to inform the design of future services.

The families were thanked for coming and sharing their very personal and sometimes difficult experiences so openly. It was agreed that NHS staff and Healthwatch would stay in touch with family members to support them through transition and also to gain their views on the future plans as they develop.

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Item 9: Medway NHS Foundation Trust – Performance Update

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 22 July 2020

Subject: Medway NHS Foundation Trust – Performance Update

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Medway NHS Foundation Trust.

It provides background information which may prove useful to Members.

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1) Introduction

a) Medway NHS Foundation Trust have asked to provide a performance update to HOSC.

b) Their latest CQC inspection was published on 30 April 2020, and the Trust was rated “Requires Improvement”.

c) The Trust’s previous inspection was published in July 2018 and the rating was also “Requires Improvement”.

2. Recommendation

RECOMMENDED that the Committee consider and note the report.

Background Documents

Care Quality Commission (2020) Medway NHS Foundation Trust – Overview and CQC inspection ratings (30 April 2020), https://www.cqc.org.uk/provider/RPA

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Trust performance report

1. COVID-19

1.1. The Trust reached the peak of coronavirus admissions around the first week of April, at which time we were caring for more than 100 patients with COVID-19, with a high number of patients in critical care. There was another peak on 16 April, which mirrored figures elsewhere in the region.

1.2. Since that time we have seen a steady decline in the number of patients who have had a positive test for the virus, and of admissions to critical care, and at the time of writing this continues to be the case.

1.3. At all times the hospital has been able to manage the demand from COVID-19, both on our wards and in critical care, as a result of careful planning in the early stages.

1.4. We saw higher than usual levels of staff sickness, and staff absence due to self-isolation during the busiest weeks, but were able to maintain safe staffing levels in all areas throughout. Many of our staff showed extraordinary levels of dedication, and a number chose not to go home to their families for periods of time so that they could continue to do their jobs without exposing their relative to increased risk of infection.

1.5. To ensure we would be able to support the increase in patient with respiratory issues, and the increased need for intensive treatment capacity, we took steps to rearrange our bed base.

1.6. This involved creating a triage model to identify coronavirus patients, increasing the number of critical beds, and converting 250 beds for COVID-19 patients.

1.7. At the same time we need to maintain other wards for patients who did not have COVID-19, maternity services, our emergency access pathway, and stroke and cardiac care wards.

1.8. In line with national guidance we sadly had to cancel planning non-urgent operations outpatients and diagnostic appointments. Urgent surgery and cancer treatments have continued throughout.

1.9. However, we made use of technology which has benefited many patients, for example through telephone consultations.

1.10. During this time we saw a drop-off in general attendances, although we experienced considerably higher attendances than in our neighbouring trusts.

1.11. Like most trusts, maintaining levels of PPE such as masks, gloves, visors and gowns, has, at times, been challenging but at no stage have we run out.

1.12. We have been conscious of the impact of not being able to allow visitors on-site (except for a birthing partner for women in labour, the parents of children, and end-of-life patients). Our staff have done their best to connect very unwell patients with their loved ones by using iPads, and by helping relatives leave messages online with special postcards, which are given to or read out to patients.

1.13. Our local community – members of the public and businesses – have been incredibly generous, donating food and toiletries for our staff, as well as money which has been used to benefit staff during this difficult and stressful time. We have greatly appreciated the support shown, including the weekly Clap for Carers.

1.14. Both inside and outside the hospital, we have truly seen the best of people.

2. RESTORE, RECOVER, RETURN

2.1. We are now in the process of restarting services to care for patients in this next phase, with the number of COVID-19 patients at a reduced level.

2.2. Our Board is very conscious of how upsetting it can be to have operations and appointments cancelled, especially for those who are worried or in pain. We therefore want to reinstate appointments as soon as possible, while maintaining the safety of patients and staff as our number one priority.

2.3. Our plans to restart our core business is well advanced, as we work to recover our performance both for urgent and cancer care, but also elective patients.

2.4. This includes working with our partners in the healthcare system, and considering the potential use of the independent sector.

2.5. As we return to a more familiar model for the hospital we will also ensure we reflect and learn, so we can prepare for any future waves of COVID-19 and for winter.

3. OUR CQC REPORT

3.1. During December 2019 the Care Quality Commission (CQC) undertook a planned and unannounced inspection of the Trust in six Core Services.

3.2. In addition the Trust underwent Use of Resource and Well-Led inspections.

3.3. In response to feedback from the December visits the Trust immediately developed an action plan. Actions included ensuring hazardous to health were kept in locked cupboards at all times, and improvements to hand hygiene.

3.4. We also brought forward the closure of Dickens ward, an escalation ward primarily for patients deemed 'medically fit for discharge' (patients who no longer required acute hospital care but may have required additional care, such as rehabilitation, before

being safely discharged), ensuring that patients were safely transferred to an alternative ward or discharged from the hospital.

3.5. The Trust worked together with the support of our partners in the community and our commissioners to ensure patients who were fit to go home or to a community setting were able to do so in a timely way.

3.6. The CQC's report was published on 30 April, having been delayed by a few weeks due to the coronavirus outbreak.

3.7. The Trust maintained its rating at 'requires improvement' overall. The report highlighted improvements in a number of areas, with the rating for Critical Care raised to Outstanding. The rating for End of Life Care was lifted to Good.

3.8. Inspectors highlighted the highly individualised care to support treatment in Critical Care. They also noted that the hospital's End of Life service truly respected and valued patients as individuals. The report also singled out the hospital's Prehabilitation programme for praise.

3.9. The Trust was also praised for the progress it has made in its 'use of resources', with the report noting improved productivity in clinical services, a significant reduction in its reliance on agency staff, and a reduction in the underlying financial deficit. The rating for 'use of resources' was raised from 'inadequate' to 'requires improvement'.

3.10. However, we were disappointed that the rating for medical care (including older person's care) was lowered to 'Inadequate'. It is worth noting that the findings in this area largely related to the comments inspectors made following their visit to Dickens Ward rather in relation to a wider inspection.

3.11. We were also disappointed that the 'well-led' domain was also rated 'Inadequate', and have been working hard to address the improvements needed in this area. Much work has already taken place and we are grateful for the support received from regulators including NHS Improvement.

3.12. It is clear that there is much more to do to provide the high quality care we strive to deliver for all patients, every single day. While we would have liked to have seen improvements across all areas, we realise that there are many challenges for this hospital, many of which are taking longer to address.

3.13. We have developed an action plan and are already working to quickly to deliver the improvements needed, including the 'most dos' and 'should dos' identified by the CQC.

3.14. The CQC action plan sits under the umbrella of the Trust-wide Improvement Plan which is linked to the Trust's five strategic objectives:

- High quality care
- Integrated health care
- Innovation

- Financial stability
- Our people.

3.15. Key to success will be implementing a model based on clinical leadership, comprehensive staff engagement, and improving culture throughout the organisation. A comprehensive engagement and involvement programme is already underway.

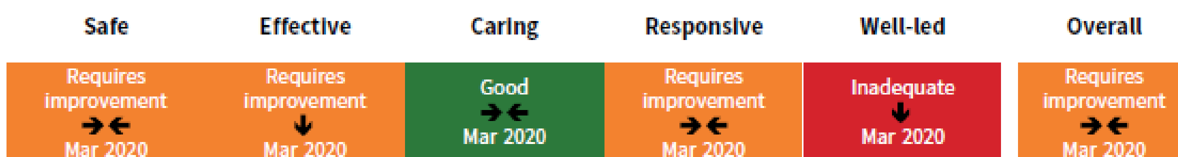
3.16. The Improvement Plan is due to be approved by our Board in August 2020.

3.17. The grids below show the Trust's ratings following the CQC inspection:

Our ratings for Medway NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency care Services	Requires improvement →← Mar 2020	Good →← Mar 2020	Good →← Mar 2020	Requires improvement →← Mar 2020	Good →← Mar 2020	Requires improvement →← Mar 2020
Medical Care (Including older peoples care)	Requires improvement ↓ Mar 2020	Requires improvement ↓ Mar 2020	Requires improvement ↓ Mar 2020	Inadequate ↓ Mar 2020	Inadequate ↓↓ Mar 2020	Inadequate ↓↓ Mar 2020
Surgery	Requires improvement →← Mar 2020	Good →← Mar 2020	Good →← Mar 2020	Requires improvement →← Mar 2020	Requires improvement →← Mar 2020	Requires improvement →← Mar 2020
Critical Care	Good ↑ Mar 2020	Good →← Mar 2020	Outstanding ↑ Mar 2020	Good ↑ Mar 2020	Outstanding ↑↑ Mar 2020	Outstanding ↑↑ Mar 2020
Maternity and Gynaecology	Good Mar 2017	Good Mar 2017	Outstanding Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Services for Children and Young People	Requires improvement →← Mar 2020	Requires improvement ↓ Mar 2020	Good →← Mar 2020	Requires improvement ↓ Mar 2020	Good →← Mar 2020	Requires improvement ↓ Mar 2020
End of Life Care	Good →← Mar 2020	Good →← Mar 2020	Good →← Mar 2020	Good ↑ Mar 2020	Good ↑ Mar 2020	Good ↑ Mar 2020
Outpatients	Good Jul 2018	N/A	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Diagnostic Imaging	Requires improvement Jul 2018	N/A	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Overall trust	Requires improvement →← Mar 2020	Requires improvement ↓ Mar 2020	Good →← Mar 2020	Requires improvement →← Mar 2020	Requires improvement →← Mar 2020	Requires improvement →← Mar 2020

Our overall rating for Medway Foundation Trust



4. STAFF SURVEY 2019

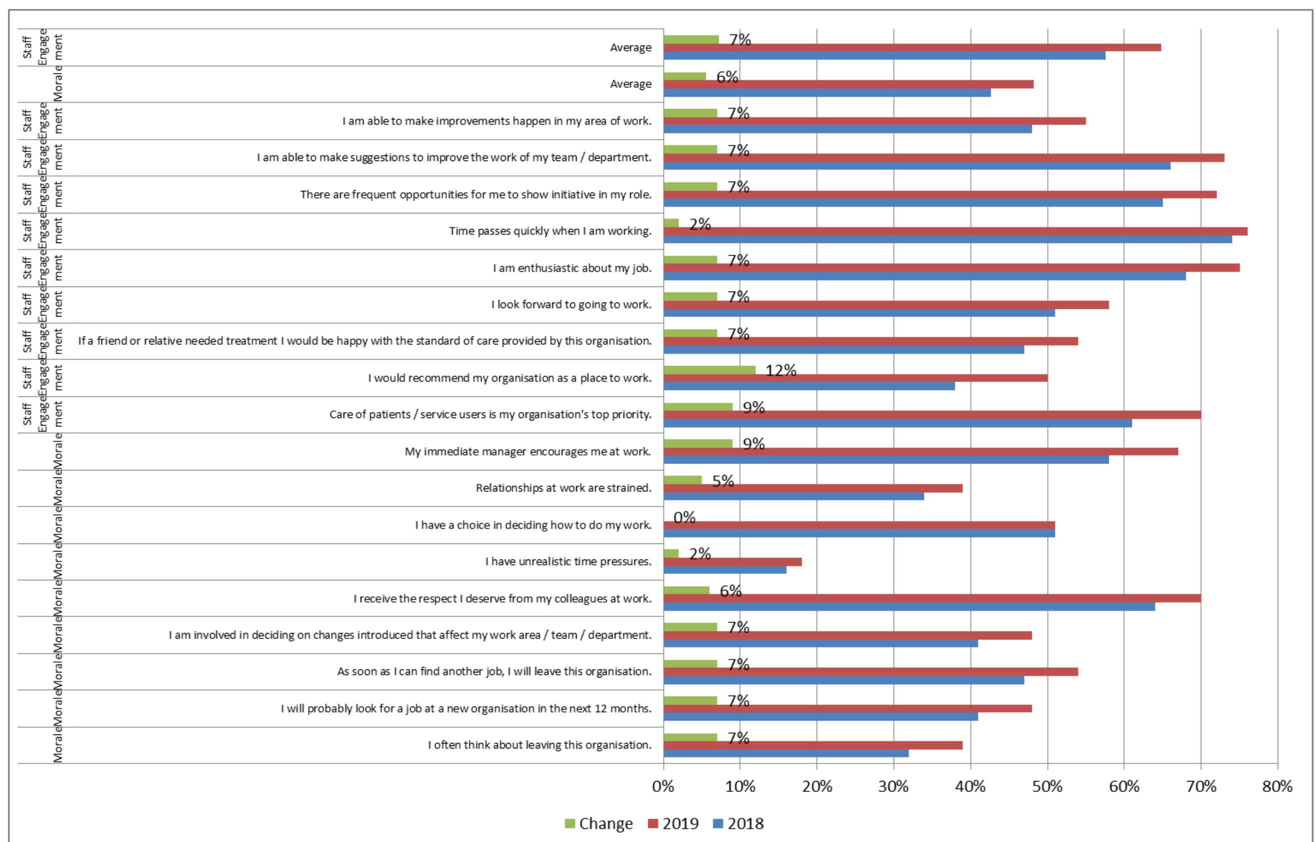
4.1. The Trust carried out its staff survey in Q3 2019/20 in line with national processes and requirements. A third party provider runs the survey on behalf of the Trust and reports through a national reporting centre.

4.2. The Trust's response rate for the national staff survey 2019 increased (+3%) to 43% and reflected the opinions of 1,828 employees – against an average national response for acute Trusts at 47%.

4.3. Across the staff survey themes – for the entire Trust, 10 of 11 scores improved (of which eight were statistically significant improvements), one remained the same and none deteriorated. The results are shown below:

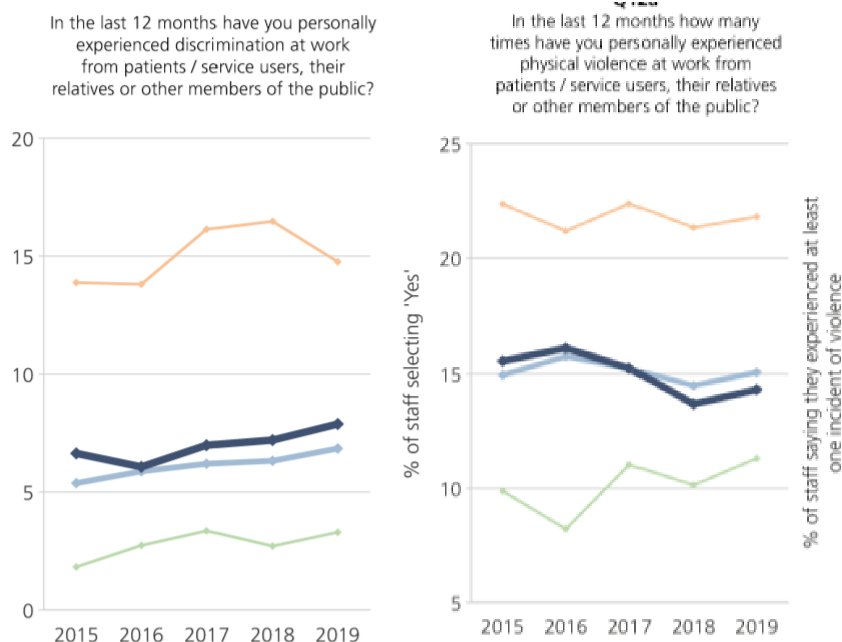
Theme	2018 score	2018 respondents	2019 score	2019 respondents	Statistically significant change?
Equality, diversity & inclusion	**8.8**	1573	**8.9**	1792	Not significant
Health & wellbeing	**5.3**	1591	**5.6**	1809	↑
Immediate managers	**6.2**	1596	**6.6**	1810	↑
Morale	**5.4**	1584	**5.8**	1789	↑
Quality of appraisals	**5.5**	1248	**5.7**	1518	Not significant
Quality of care	**7.0**	1342	**7.4**	1580	↑
Safe environment - Bullying & harassment	**7.4**	1584	**7.8**	1797	↑
Safe environment - Violence	**9.4**	1581	**9.4**	1788	Not significant
Safety culture	**6.1**	1577	**6.4**	1800	↑
Staff engagement	**6.4**	1609	**6.8**	1821	↑
Team working	**6.1**	1573	**6.6**	1799	↑

4.4. There was a significant increase in Morale (4% thematic swing/6% improvement on positive scores) and Staff engagement (4% thematic swing/7% improvement on positive scores), which were target areas for improvement across the Trust following the 2018 staff survey (having both reported as some of the lowest scores in the NHS), between 2018 and 2019 with the greatest improvement being 12%. The results are shown below:



4.5. There has been a statistically significant improvement in reducing harassment and bullying compared to 2018 staff survey (+4% improvement to score) which is corresponding to improvement across line management relationship scores, working as a team and improvement communication with senior management.

4.6. Four questions deteriorated (as positive score), two were directly related to experiencing physical violence or experiencing discrimination from patients/service users or their relatives (2% decrease across both questions). In August 2019, the Trust launched a zero tolerance campaign to tackle treats of violence, abuse or harassment against staff – this was to raise awareness to the public, and also to help staff understand that violence and abuse against them or colleagues is not tolerated – a review of incidents will be carried out to understand the impact. There was a 1% increase in the numbers of staff witnessing errors, near misses or incidents that could have hurt staff in the last month. There was a 2% increase in the number of staff reporting they were working additional paid hours beyond their contracted; however this is not mirrored across bank/overtime reports.



4.7. The 2019 staff survey results improved significantly compared to 2018. The next steps reflect the need for continual organisational spotlight on actions aligned to engaging and supporting our staff over a period of time where change management is increasing, and financial pressures continue.

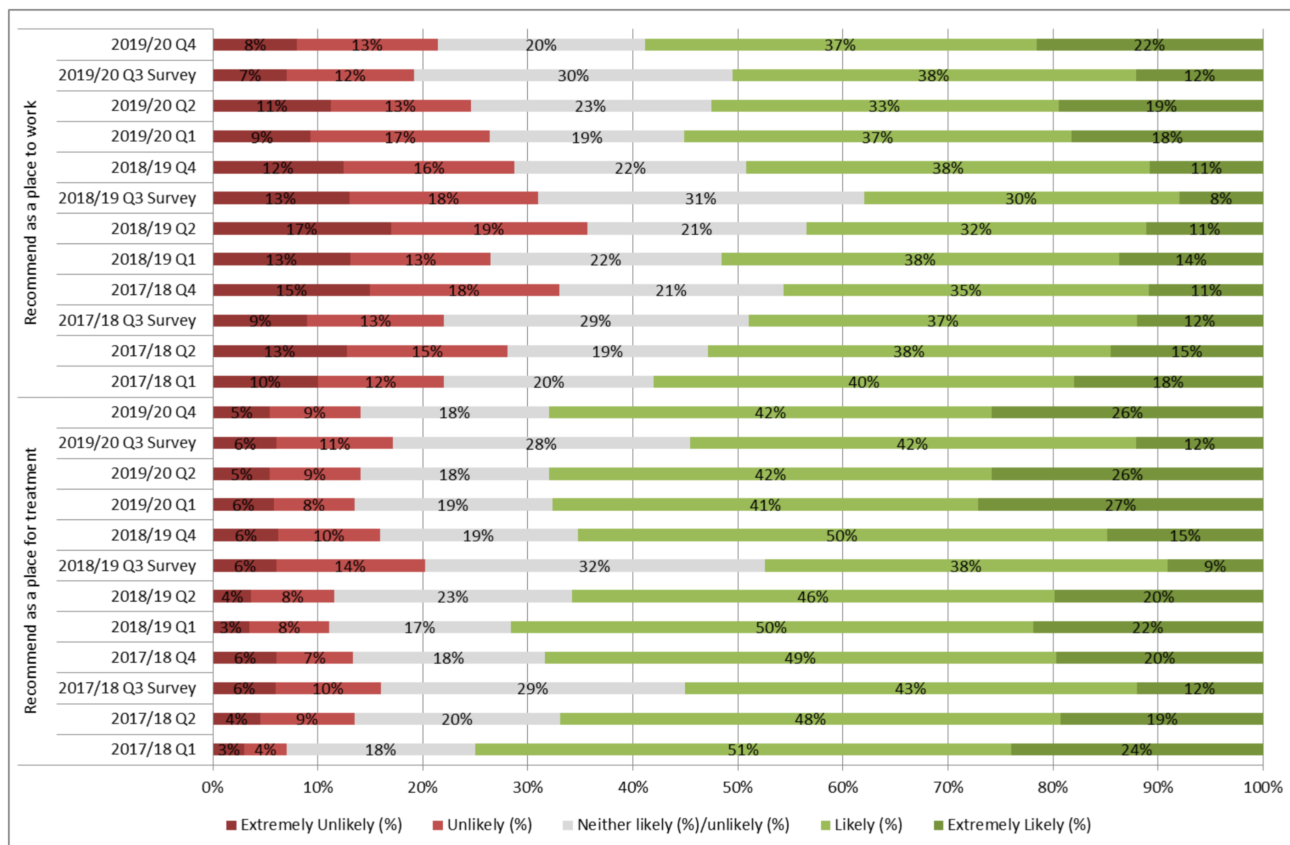
5. FRIENDS AND FAMILY TEST

5.1. The Trust carries out its staff Family and Friends test across three quarters of the year, with the full staff survey in the final quarter.

5.2. The staff's response to recommending the Trust as a place to work has seen a nine per cent increase (to 59 per cent) for those extremely likely or likely to recommend. This represents the highest score in three years.

5.3. There has been a similar improvement to staff recommending the Trust as a place for treatment with a 14 per cent increase (to 68 per cent) for those extremely likely or likely to recommend. This is in line with the last two years.

1.1. The graph below shows the results of the most recent survey.


Recommend as a place to work
2019/20 Q4 8% 13% 20% 37% 22%
2019/20 Q3 Survey 7% 12% 30% 38% 12%
2019/20 Q2 11% 13% 23% 33% 19%
2019/20 Q1 9% 17% 19% 37% 18%
2018/19 Q4 12% 16% 22% 38% 11%
2018/19 Q3 Survey 13% 18% 31% 30% 8%
2018/19 Q2 17% 19% 21% 32% 11%
2018/19 Q1 13% 13% 22% 38% 14%
2017/18 Q4 15% 18% 21% 35% 11%
2017/18 Q3 Survey 9% 13% 29% 37% 12%
2017/18 Q2 13% 15% 19% 38% 15%
2017/18 Q1 10% 12% 20% 40% 18%
Recommend as a place for treatment
2019/20 Q4 5% 9% 18% 42% 26%
2019/20 Q3 Survey 6% 11% 28% 42% 12%
2019/20 Q2 5% 9% 18% 42% 26%
2019/20 Q1 6% 8% 19% 41% 27%
2018/19 Q4 6% 10% 19% 50% 15%
2018/19 Q3 Survey 6% 14% 32% 38% 9%
2018/19 Q2 4% 8% 23% 46% 20%
2018/19 Q1 3% 8% 17% 50% 22%
2017/18 Q4 6% 7% 18% 49% 20%
2017/18 Q3 Survey 6% 10% 29% 43% 12%
2017/18 Q2 4% 9% 20% 48% 19%
2017/18 Q1 3% 4% 18% 51% 24%
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Extremely Unlikely (%)
Unlikely (%)
Neither likely (%)/unlikely (%)
Likely (%)
Extremely Likely (%)

Item 10: Single Pathology Service for Kent and Medway

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 22 July 2020

Subject: Single Pathology Service for Kent and Medway

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the Kent and Medway STP.

It provides background information which may prove useful to Members.

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1) Introduction

a) "Pathology is the study of disease. It is the bridge between science and medicine. It underpins every aspect of patient care, from diagnostic testing and treatment advice to using cutting-edge genetic technologies and preventing disease."[1]

b) In September 2017, NHS Improvement set out its intention for all acute hospital trusts in England to enter pathology networks. The aim of the pathology networks is to provide more responsive, high quality and efficient services. It would also reduce the unwarranted variation in pathology services. All networks were to be fully operational by 2021.[2]

c) NHS Improvement set out plans for 29 pathology networks. The "Kent Pathology Services" network was to cover:

i) Dartford and Gravesham NHS Trust
ii) East Kent Hospitals University NHS Foundation Trust
iii) Maidstone and Tunbridge Wells NHS Trust
iv) Medway NHS Foundation Trust

2) Previous engagement with HOSC

a) The Kent and Medway STP provided updates to HOSC in September 2018 and January 2019.

b) In September 2018, Medway Foundation Trust set out 7 options for future service delivery. Trusts were invited to return in January 2019 with a full business case (which was to be developed by December 2018).

c) The Kent and Medway STP returned in January 2019, and updated the Committee that:

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[1] The Royal College of Pathologists (online) What is pathology? https://www.rcpath.org/discover-pathology/what-is-pathology.html

[2] NHS Improvement (2018) NHS Improvement pathology networking in England: the state of the nation

i) the Strategic Outline Case was with Trust Boards for consideration;

ii) The Outline Business Case was to be with Boards for approval during summer 2019;

iii) A Final Business Case would be written for approval towards the end of 2019.

iv) Subject to approval, implementation would take place between 2020 and 2024.

d) The CCG subsequently update HOSC on 25 January and 19 September 2019. At the latter meeting, HOSC Members recommended the following:

AGREED that:

i. the Committee deems that proposed changes to Pathology Services in Kent and Medway are not a substantial variation of service, and

ii. NHS representatives be invited to attend this Committee and present an update at an appropriate time.

e) Members are asked to consider the attached update from the NHS.

3) Recommendation

HOSC note the report and the Kent and Medway CCG be invited to attend and present an update at the appropriate time.

Background Documents

Kent County Council (2019) *'Health Overview and Scrutiny Committee (19/09/19)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8283&Ver=4

Kent County Council (2019) *'Health Overview and Scrutiny Committee (25/01/19)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MID=7924

Kent County Council (2018) *'Health Overview and Scrutiny Committee (21/09/18)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7921&Ver=4

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Single Pathology Service for Kent and Medway – update for Kent Health Overview and Scrutiny Committee July 22nd 2020

SINGLE PATHOLOGY SERVICE FOR KENT AND MEDWAY

Report from:	Amanda Price, Kent and Medway Pathology Programme Lead
	Supriya Joshi, Pathology Clinical Director, MTW
Author:	Amanda Price, Kent and Medway Pathology Programme Lead

Summary
The report informs the Committee of progress in the Kent and Medway Pathology Programme since the update in September 2019.

1 Background

1.1 The report to the Committee in September 2019 provided details of the review of pathology services undertaken by provider NHS trusts across Kent and Medway on the creation of a single service in response to the National Pathology Network Strategy. Twenty nine networks are in development in England.

1.2 The September report stated the four acute provider trusts in Kent and Medway – Medway NHS Foundation Trust (MFT), East Kent Hospitals University NHS Foundation Trust (EKHUFT), Maidstone and Tunbridge Wells NHS Trust (MTW), and Dartford and Gravesham NHS Trust (DGT); and the Kent and Medway Sustainability and Transformation Partnership signed off the strategic outline case (SOC) in April 2019. It then outlined the initiation of the outline business case (OBC) phase which would develop OBCs in service change, a laboratory information management system (LIMS) and managed service contracts (MSC).

2. Outline business cases

2.1 The OBCs were developed through working groups reporting to the project team which in turn reported to the programme board, chaired by Miles Scott, CEO, Maidstone and Tunbridge Wells NHS Trust.

2.2 The service change OBC is concerned with service configuration, service delivery, and management. For service configuration, nine options were considered which were: Do nothing; do minimum - where services operate independently but help each other out as required; single hub laboratory at Ashford, Maidstone or Dartford and six smaller essential services laboratories (ESLs); two hubs (from the three hubs listed above) and five ESLs; and three hubs with four ESLs. The option put forward in the OBC was to retain the current configuration of three hubs and four ESLs as there was insufficient evidence for a two hub model at this time; and

serious risks regarding resilience and sustainability with a one hub model, do nothing and do minimum.

The OBC also outlines commercial options including outsourcing and working with a major strategic partner. There was little appetite for either of these options and no successful evidence of this working well elsewhere in the country. Therefore the single service will be an NHS-owned and managed contractual joint venture.

The service change OBC outlines a range of workforce opportunities based on a number of external and internal benchmarks relating to productivity. As pathology demand is growing we have been able to commit to no planned redundancies as a result of the programme.

2.3 The LIMS OBC details the scoping, procurement and implementation of a single IT solution for the single pathology service. The preferred option in the OBC is a single LIMS for the whole county. This is presented as two options – one capital option where the IT hardware is hosted by one trust; and a cloud based revenue solution. The final option will be selected ahead of the best and final offer stage of procurement. LIMS is the clinical priority for pathology transformation in Kent as the current systems are up to 25 years old and will soon be no longer supported by suppliers.

2.4 The MSC OBC details the scoping, procurement and implementation of a core contract for equipment; plus a range of potential additional services including business intelligence and logistics (transport). The preferred option for MSC is to tender by pathology discipline and to select an overall lead supplier to manage the contracts.

2.5 The LIMS and MSC are enablers for the service change OBC. The order of deployment is LIMS followed by MSC followed by service change. In reality, there are likely to be service changes in advance of the completion of LIMS and MSC rollout. The whole programme timeline is 13 years with LIMS from year three, MSC from year five and service change from year six/seven.

3. OBC approval

3.1 The three OBCs went through a comprehensive appraisal and approvals process including programme team, programme board, senior peer appraisal, check and challenge with deputy finance directors, back to programme board and finally a gateway review of trust CEOs and CFOs before going through individual trust board approvals. The three OBCs were all approved up to and including the gateway review. The OBCs have been approved by MTW Board, EKHUFT Strategic Investment Committee and MFT Finance Committee. The trusts managing North Kent Pathology Services (NKPS) have, since the gateway review in March, proposed a hybrid option – joining in the single LIMS and MSC but not at this time joining a single service with single management. They do not want their pathology services to go through more major change following the merger of their two trusts' pathology services at this time.

3.2 The feasibility of the NKPS hybrid model was considered by the programme board on 7 July 2020. Five considerations were explored: 1) Feasibility of single LIMS without a single management; 2) the content of the service change full business

case and impact to the target operating mode of a single service; 3) financial impact including phasing on all trusts and the system as a whole; 4) lessons learnt from the NKPS merger; and 5) the requirements of NHSE/I. The paper concluded the hybrid model is possible but would be more complex and difficult to manage; would result in lower savings across the system and the service change FBC would need to demonstrate commitment for working towards a single service to meet NHSEI requirements.

The programme board did not conclude discussions on this issue. MTW and EKHUFT CEOs are meeting urgently to understand and agree the contractual vehicle they wish to adopt should the hybrid model be agreed.

4. Full business cases (FBC)

The programme governance structure has been refreshed from June 2020 to include four new steering groups – one each to manage the FBC process for LMS, MSC and service change; and a governance and legal steering group to work through the detail of agreements which will be required by the joint venture and partner organisations.

The full business cases are in development pending OBC board approval. The service change FBC development includes development of the target operating model and the workforce and ways of working to deliver it. It will also describe the governance and legal arrangements needed to operate the joint venture.

The priority for LIMS is to launch the tender as the process of planning and implementation with the selected supplier is significant for such a complex project. The priority for MSC is to agree baseline activity with which to go out for a market testing exercise to seek robust indicative prices for the required service to include in the FBC.
A tender cannot be undertaken at this time due to the time lag required to implement LIMS first before a new MSC.

5. Timeline

PROJECT	Milestone	Current scheduled Date
LIMS	Tender launched (stage 1),	15/07/2020
	Launch Stage 2	31/07/2020
	End stage 2 to confirm which option	20/11/2020
	End of stage 3	11/12/2020
	End of stage 4	11/01/2021
	Preferred Bidder identified	15/02/2021
	FBC complete	18/03/2021
MSC	Activity validation	30/09/2020
	Market testing launch,	31/10/2020
	Market testing closed	30/11/2020
	FBC complete	18/03/2021
	Tender launched	01/01/2022
	Tender complete	31/10/2022
	Contract award	31/01/2024
SERVICE CHANGE	TOM developed	03/07/2020
	Issue Strategic Case for review	15/05/2020
	Issue Economic Case for review	04/09/2020
	Issue Commercial Case for review	17/07/2020
	Issue Financial Case for review	09/10/2020
	Issue Management Case for review	18/09/2020
	FBC complete	15/11/2020
APPROVALS GOVERNANCE	SC FBC approved by Programme Board	28/02/2021
	Gateway review of SC FBC	15/03/2021
	LIMS FBC approved by Programme Board	15/04/2021
	MES (MSC) FBC approved by Programme Board	15/04/2021
	Gateway review of LIMS FBC	21/04/2021
	Gateway Review of MSC (MES) FBC	21/04/2021
	FBCs approved by Trust Boards	30/06/2021

IMPLEMENTATION	Go live site 1 LIMS	30/08/2023
	Go live sites 2 and 3 LIMS	31/01/2024
	Commence MES (MSC) – MTW	30/04/2024
	LIMS Project Closed	30/06/2024
	Complete MES (MSC) MTW	28/02/2025
	Commence MES (MSC) – EKHUFT	30/11/2025
	Commence MES (MSC) – NKPS	31/05/2026
	Complete MES (MSC) EKHUFT	31/08/2026
	Complete MES (MSC) NKPS	31/08/2027
	Commence service change	31/08/2027
	Programme Complete	31/08/2033

6. Risk management

Description	Action to avoid or mitigate risk
There is insufficient management and clinical capacity to support the delivery of the plans	Resource plan in OBC approved, prioritise the input of clinical and managerial staff and project team. Involve the departmental teams more across the county
The recruitment and retention of staff deteriorates, impacting on the service capacity and capability to deliver the change	Develop an effective recruitment and retention strategy for pathology, identify and implement the skill mix and technological solutions to maintain or improve service delivery, involve staff in the development and creation of the new service. Deliver on the FBC revised timetable to minimise further staff anxiety.
The impact on quality of the pathology service on patients, GP's, acute hospitals and commissioners as the integration occurs	Ensure robust transitional plan is in place for creating the new service, implement changes in a timely and scalable manner, maintain laboratory accreditation, quality impact assessment of each option. Involvement of primary care in option appraisal.
The potential failure of current pathology partnerships in Kent and Medway due to quality and safety concerns	Ensure issues are addressed they arise, develop a clear contingency plan and look to share management expertise to resolve issues
Not all Trusts agree to a single model	Assess feasibility of alternative models and present to Programme Board
The failure to have access to data required for modelling and option appraisal	Ensure timescales for data request are reasonable; escalate where data is not provided
Delays in procurement process due to supplier and pathology capacity	Ensure timescales for work needed is reasonable and escalate where project slips Ensure timescales for data request are reasonable; escalate where data is not provided
Impact of Covid-19 on pathology services	Ensure pathology included in break even bids to NHS E/I. Ensure TOM flexibility to prepare for surges and continuous antigen and antibody testing

7. Engagement and consultation

7.1 The programme governance includes a patient and public engagement assurance group. The group includes representatives from Healthwatch; patient groups representing those with medical conditions requiring regular pathology input; STP patient representatives; foundation trust governor; point of care coordinators from pathology; and members of the project team. The purpose of the group is:

- the engagement of key public and patient stakeholders in understanding the goal, methods and outcome of the OBC
- the use of the group as a sounding board for input into the project
- awareness of the progress of the project
- internal communication to their organisations
- equality impact assessment of options on groups and individuals.

7.2 A continued programmed of internal communication and engagement has been taking place, including monthly staff forum meetings at each hospital site, made virtual since Covid-19, which pathology colleagues are given time to attend to feed in their experiences and questions to the project team.

A monthly newsletter is sent directly to all colleagues and has included an anonymous feedback survey to temperature check how colleagues are feeling about the progress of the programme. Pathology colleagues and union representatives have been encouraged to join the sub-groups to ensure staff concerns and suggestions are fed into the change process.

8. Recommendations

The Committee is asked to note and comment on the progress of the Kent and Medway Pathology Programme.

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Item 11: East Kent Financial Recovery Plan & Financial Performance in 2019/20 for Kent & Medway CCGs

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 22 July 2020

Subject: East Kent Financial Recovery Plan & Financial Performance in 2019/20 for Kent & Medway CCGs

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the Kent & Medway CCG.

It provides background information which may prove useful to Members.

It is a written briefing only and no guests will be present to speak on this item.

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1) Introduction and Background

a) HOSC received periodic updates on the financial position of the former East Kent CCGs[1], following their placement into Special Measures by NHS England CCG Assessment Delivery Group in July 2018. One of the areas of concern was the "deterioration of the CCGs financial positions and non-delivery of agreed surplus".[2]

b) On 6 June 2019, HOSC received an update on the East Kent CCG's financial recovery plan. One point of note was that any final deficit would not be written off when the 8 Kent and Medway CCGs merged into one.

c) At the end of the item, HOSC asked the East Kent CCGs to provide an update at the appropriate time.

d) Whilst the 2019-20 accounts have now closed, the East Kent CCGs no longer exist in their previous form following the creation of a single Kent and Medway CCG. Therefore, HOSC is invited to consider the attached written report covering the year end positions for the former 8 CCGs, along with information about the East Kent Special Measures being lifted and some context around how funding within the single CCG will be distributed across the whole of Kent and Medway.

2. Recommendation

RECOMMENDED that the Committee consider and note the report.

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[1] A partnership of the following CCGs: Ashford, Canterbury & Coastal, South Kent Coast and Thanet.
[2] Kent County Council (2018) 'Health Overview and Scrutiny Committee (21/09/2018)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7921&Ver=4

Acronyms

CHC - Continuing Healthcare

CIP - Cost Improvement Programme

FOT – Forecast Outturn

PMO – Programme Management Office

QIPP - Quality, Innovation, Productivity and Prevention programme.

RTT - Referral to Treatment time

Background Documents

Kent County Council (2019) *'Health Overview and Scrutiny Committee (06/06/19)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8281&Ver=4

Kent County Council (2019) 'Health Overview and Scrutiny Committee (25/01/2019)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7924&Ver=4

Kent County Council (2018) 'Health Overview and Scrutiny Committee (21/09/2018)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7921&Ver=4

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Kent and Medway
Clinical Commissioning Group

Briefing for Kent Health Overview and Scrutiny Committee (HOSC)
East Kent Financial Recovery Plan July 2020

Background

In April 2018 the east Kent Clinical Commissioning Groups (CCGs) produced a financial plan for 2018/19 that generated a £24m deficit, assuming a £19.5m Quality, Innovation, Productivity and Prevention (QIPP) programme. This financial plan was approved by the Governing Bodies of the CCGs and NHS England (NHSE). The £24m deficit was matched by £24m Commissioning Support Funding of £24m, resulting in a control total of break-even. However, at that time the financial plan also identified unmitigated risk of £16m. By reporting this unmitigated risk, the east Kent CCGs were highlighting the high possibility of overspending by £16m

During July and August ‘18 there was further analysis of the risks facing the CCGs in 2018/19 resulting in an increase in risk value from the original £16m to £41m with a high probability of materialising. This shift in risk of £25m was due to a number of factors including:

- “Optimistic accruals” in ‘17/18 accounts have resulted in an accumulating deterioration in the underlying financial position of the CCGs in 18/19.
- The Expert Determination regarding the service-level agreement (SLA) with the CCGs’ main provider has been taken fully on the “downside”.
- The main acute contract in 2018/19 was agreed with an activity level below that necessary to achieve referral to treatment (RTT) maximum waiting times.
- The main acute contract was set at a value with a built-in over-performance highly likely.

Also, during July and August ’18, the 2018/19 QIPP plan was assessed independently as part of the national “QIPP4 programme”. This review identified potential material slippage of £10m in the QIPP programme unless action was taken.

As an immediate response the east Kent CCGs commissioned additional financial turnaround and senior PMO capacity. This additional capacity and capability existed through-out 2018 and into 2019 improving the internal system and process, increasing organisational grip and facilitating the period of stabilisation and recovery.

Financial performance in 2018/19

In summary, a revised Financial Plan was submitted to NHSE that moved the control total deficit for 2018/19 from £24m to £49m, recognising that there was a further £8m of unmitigated risk that could materialise, before Commissioning Support Funding. The delivery of this recovery plan is based on the foundation of stabilisation in 2018/19, led by the Managing Director and Clinical Chairs, driven by the Executive Directors and owned by the four CCGs in east Kent. It also identified a number of risks that were increasingly difficult to

mitigate; in particular potential over-performance by the acute providers and increasing demand for continuing healthcare (CHC) assessments.

Unfortunately, despite the CCGs over-performing in QIPP delivery and managing further in year additional risk (see the following table), the above unmitigated risk of acute activity performance and increased demand for CHC assessments materialised, resulting in the east Kent CCGs generating a £57m deficit.

Financial Performance in 2019/20 for east Kent System

The east Kent system out turned 2018/19 with a deficit of £99.5m, and a recurrent deficit of £100.7m, a deterioration on the deficits of the previous year.

The system is being asked to deliver a £30m improvement in the recurrent deficit in 2019/20 – see the following table.

East Kent Financial Position	Amount £000s
2018/19 Forecast Outturn - Trust	(42,155)
2018/19 Final Outturn - CCGs	(57,368)
2018/19 Combined FOT	**(99,523)**
2018/19 Recurrent Deficit carry forward - Trust	(52,250)
2018/19 Recurrent Deficit carry forward - CCGs	(48,452)
2018/19 Combined Recurrent Deficit carry forward	**(100,702)**
2019/20 Control Total - Trust*	(36,569)
2019/20 Control Total - CCGs*	(33,900)
2019/20 Combined Control Total*	**(70,469)**

**Excluding PSF/FRF/CSF payments.*

To achieve this the CCG was required to deliver QIPP of £35m (4.1 per cent of non-hypothecated spend) and the Trust cost improvement programme (CIP) requirement is £30m (6 per cent of influence-able spend), this is against a backdrop of three years of 5 per cent savings targets but increasing deficits.

The CCGs and Trust signed an aligned incentive contract based around £440m.

By signing the aligned incentive contract with a fixed value, the system was able to:

- increase certainty of income and expenditure for both parties
- release contingency held to reduce the overall system control total gap by £6m
- align focus to deliver transformation of services and drive cost from the system.
- implement a single system PMO, reporting system and reports
- implement joint system management of contingencies to manage total system risk.

In 2019/20 the CCGs and Trust all hit their control totals at year end.

East Kent CCGs Financial Performance in 2019/20

The CCG's in East Kent have completed the year with a small surplus of £0.587m against their control total (the CCG receive additional funds through the Financial Recovery Fund to

bridge the difference between a deficit control total and delivering a break even position which is predicated on delivery on the control total).

This is mainly as a result of planned measures that were put in place mid-year to cover emergent and subsequent materialisation of risks and to cover the shortfall in planned QIPP savings targets.

At Month 12 QIPP delivery amounted to £32.954m, 94.2% of the plan of £35.0m, as shown in the table below. A number of the additional actions (£10.1m) that were required to bring the position back into line are non-recurrent, and will need to be accounted for in planning through 20/21.

Programme	Target Savings	Full Year Original Plan	YTD Actuals	Variance v Original Plan	Variance v Target
Local Care	£ 6,000,000	£ 7,281,992	£ 6,458,000	-£ 823,993	£ 458,000
CHC	£ 4,000,000	£ 3,674,541	£ 3,494,352	-£ 180,189	-£ 505,648
Medicines optimisation	£ 8,000,000	£ 5,192,996	£ 4,954,218	-£ 238,778	-£ 3,045,782
Planned Care inc Right Care	£ 6,000,000	£ 5,534,379	£ 4,005,082	- £ 1,529,298	-£ 1,994,918
Children's Services	£ 1,000,000	£ 1,003,998	£ 250,000	-£ 753,998	-£ 750,000
Mental Health	£ 3,000,000	£ 2,431,992	£ 2,930,083	£ 498,091	-£ 69,917
Contracts	£ 7,000,000	£ 6,828,000	£ 716,806	- £ 6,111,194	-£ 6,283,194
Additional QIPP Action	£ -	£ -	£ 10,145,873	£ 10,145,873	£ 10,145,873
TOTALS	**£ 35,000,000**	**£ 31,947,898**	**£ 32,954,413**	**£ 1,006,515**	**-£ 2,045,587**
					94.2%

As a result of the financial performance in 2019/20, CCG Directions were lifted at the end of February 2020 and the CCGs ended the year with a clear unqualified set of accounts and value for money opinion.

Financial Performance in 2019/20 for Kent & Medway CCGs

All eight CCGs within Kent & Medway achieved a breakeven or small surplus position, and ended the year with clear unqualified sets of accounts and value for money opinions.

K&M CCGs' Month 12 Position (£m) - 2019/20				
		Excluding CSF		
	Actual Position (inc CSF)	Plan	Actual	Variance
NHS Ashford CCG	0.1	-11.1	-11.0	0.1
NHS Canterbury & Coastal CCG	0.2	-10.1	-9.9	0.2
NHS South Kent Coast CCG	0.3	-9.5	-9.2	0.3
NHS Thanet CCG	0.1	-3.2	-3.1	0.1
NHS Dartford, Gravesham and Swanley CCG	0.0	-5.0	-5.0	0.0
NHS West Kent CCG	0.0	0.0	0.0	0.0
NHS Medway CCG	0.0	0.0	0.0	0.0
NHS Swale CCG	0.0	0.0	0.0	0.0
Total CCG Position	0.6	-38.9	-38.3	0.6

Ivor Duffy
Chief Finance Officer

Item 12: Maternity Services at East Kent Hospitals University NHS Foundation Trust – written update

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 22 July 2020

Subject: Maternity Services at East Kent Hospitals University NHS Foundation Trust (written update)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by East Kent Hospitals University NHS Foundation Trust (EKHUFT).

It provides background information which may prove useful to Members.

It is a written briefing only and no guests will be present to speak on this item.

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1) Introduction

a) EKHUFT is currently subject to increased scrutiny following the performance of its Maternity Services.

b) In January 2020, a coroner ruled that the death of baby Harry Richford in the Queen Elizabeth the Queen Mother Hospital (QEQM) in November 2017 was “wholly avoidable”. Since then, several families have raised concerns in relation to the care given by the Trust’s maternity services.

2) Previous visits to HOSC

a) On 5 March 2020, EKHUFT attended HOSC to update Members on their action plan for improving maternity services in East Kent.

b) Following discussion, the Chair summarised the three key pieces of work that HOSC would want to receive further updates on, as well as expected timescales:

i. Healthcare Safety Investigation Branch (HSIB) which looks into certain categories of incidents in maternity units across the country. The Trust receives quarterly reports and meets with HSIB to review the findings and themes.

ii. NHS England independent review led by Dr Bill Kirkup. The timescales were unclear at that point in time.

iii. The Trust’s sub-committee with its seven workstreams. The Trust’s Chief Executive had set an expectation that initial conclusions would be available by the end of April.

c) Members agreed the following:

RESOLVED that the report be noted and that the Trust be requested to provide an update at the appropriate time.

3) Latest Developments

a) Following a CQC inspection in January and February 2020, the Trust's maternity services have been rated "Requires Improvement". Services are rated Good for being effective, caring and responsive to people's needs and Requires Improvement for being safe and well-led.[1]

b) Following the announcement of the CQC rating on 28 May 2020, EKHUFT held a confidential briefing for HOSC Members on 2 June.

c) Today's written update will be followed in due course with Trust representatives attending HOSC to discuss developments in the three key pieces of work (paragraph 2b).

4. Recommendation

RECOMMENDED that the Committee consider and note the report, and that the Trust be requested to provide an update at the appropriate time.

Background Documents

Kent County Council (2020) *'Health Overview and Scrutiny Committee (05/03/20)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8286&Ver=4

Care Quality Commission, East Kent Hospitals University NHS Foundation Trust, Overview and CQC inspection ratings, https://www.cqc.org.uk/provider/RVV

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[1] CQC (2020) East Kent Hospitals University NHS Foundation Trust maternity services rated Requires Improvement, https://www.cqc.org.uk/news/releases/east-kent-hospitals-university-nhs-foundation-trust-maternity-services-rated-requires

East Kent Hospitals Update for Health Overview and Scrutiny Committee

Maternity Services Update

1. Care Quality Commission Inspection

1.1 The Care Quality Commission carried out an unannounced inspection of maternity services at Queen Elizabeth The Queen Mother Hospital, Margate, and William Harvey Hospital, Ashford, on 22 and 23 January 2020, along with a further unannounced visit to the hospitals on 4 and 5 February 2020.

1.2 The CQC rated East Kent Hospitals' maternity service as 'good' for effectiveness, care and responsiveness and 'requires improvement' for leadership and safety.

1.3 The maternity service retained its rating as 'requires improvement' overall, while the service at Queen Elizabeth The Queen Mother Hospital, Margate, was upgraded to 'good' for 'Responsive', which means services are organised in a way that meets women's needs.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

1.4 The CQC inspections took place after concerns were raised about the safety of maternity services at the Trust, including the inquest this January into the death of baby Harry Richford, who died at Queen Elizabeth The Queen Mother Hospital in 2017, and a number of families coming forward.

1.5 The CQC's said the Trust:

- Implemented processes to make sure patient safety was at the centre of women's care.
- Provided care and treatment based on national guidance and evidence-based practice.
- Following the investigations into serious incidents found the maternity service implemented learning to improve safety for women and babies.
- And the head of midwifery and senior maternity leadership had strengthened the way in which they communicated incidents with families following serious incidents.

1.6 However, the CQC cited a number of areas requiring improvement and issued two Requirement Notices, relating to improvements needed with regard to the governance and the provision of the safe care and treatment.

1.7 The areas requiring improvement were primarily in the hospital's new antenatal triage and day care services used to assess and monitor women experiencing pain or symptoms from 16 weeks of pregnancy.

2. Action taken

2.1 The CQC gives immediate feedback following inspections, so that areas needing improvement can be addressed without delay. Action the Trust has taken against specific areas in the CQC's findings include:

2.2 Standard operating procedures within the new antenatal triage service, including guidelines for risk assessment and escalation - the CQC found these were not always followed within the triage service, which meant the necessary care and treatment were not always identified quickly. The CQC found these guidelines were being followed on the hospitals' labour and post-labour wards. The CQC found staff in day care did not always report incidents, which meant managers could be unaware of avoidable events on the unit.

- Since the CQC's inspection, the service has begun using the nationally-recommended safety communication system called 'Situation, Background, Assessment and Recommendation' (SBAR) for all women presenting to triage. The Trust has also recently appointed a Maternity Governance Lead to co-ordinate the review and improvement of the service's internal governance processes and improve reporting of incidents.

2.3 Antenatal documentation – this was not always clear or up-to-date, because 50% of records were stored digitally and 50% were hand written. The CQC found documentation was well kept and detailed on the labour and post-labour wards.

- The Trust is investing in the Maternity Information System, which is supplied by an external provider, so the Trust can begin using further digital recording throughout pregnancy and birth as soon as the technology becomes available.

2.4 Long waits and limited senior doctor cover in the hospitals' antenatal day care service.

- The Trust has since changed the midwifery rota to improve midwifery staffing levels in the antenatal triage and day care service and has increased the senior doctor presence throughout the day. Additional consultants have been recruited, which will ensure continued senior doctor presence.
- Since the CQC's inspection, the service has included all waiting times on the electronic patient records, reported them in the care group quality and risk report, and introduced a weekly review by a senior midwife.

2.5 At William Harvey Hospital, the inspection team found cleaning checks were out of date on some equipment in the antenatal and day care service. The cleaning checks are now being monitored regularly.

- Since 2017, many changes had been put in place within the maternity service, including a new leadership team, a staff training programme and new equipment. Following its inspection, the CQC recognised that leaders had improved the governance processes throughout the service with support from partner organisations. It found 'effective structures, systems and processes to support delivery of the maternity service'.

3. Areas highlighted as improvements, good or outstanding practice

3.1 The CQC found:

- Staff monitored the effectiveness of care and treatment and used their findings to make improvements and achieve good outcomes for women.

- Staff worked well together for the benefit of women.
- The Trust had reviewed its escalation process and implemented processes to make sure patient safety was at the centre of women's care, and safety huddles, on-call medics, and the centralised fetal monitoring system would ensure that escalation processes were strengthened.
- The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

3.2 Improvements noted by the CQC following their previous inspection in 2018 included:

- Scanning all women at 36 weeks of pregnancy to reduce the incidence of birth complications, caesarean sections, breech birth and pre-term babies, in line with best practice
- Women receive one-to-one care during childbirth
- Midwifery staffing levels had improved and were safe and in line with national guidance
- Strengthened clinical leadership.

3.3 Inspectors also found areas of 'outstanding practice', including the Trust's state-of-the-art simulation training equipment, which allows all staff exposure to simulated 'real life' emergency situations for life-saving training, and providing wraps to help new mums give 'skin to skin' care when breastfeeding their babies.

You can read the reports in full on the Care Quality Commission website

4. Maternity Services Independent Investigation

4.1 In February 2020 the government health minister, Nadine Dorries MP, announced that NHS England and NHS Improvement were commissioning an independent investigation into the maternity and neonatal services provided by East Kent University NHS Foundation Trust. The investigation is being led by Dr Bill Kirkup and is expected to cover the period since 2009. Dr Kirkup expects to report in 2021.

4.2 A panel of clinical experts has been appointed to assist Dr Kirkup and an investigation support team is being put in place. The support team is being led by Mr Ken Sutton, Secretary to the investigation, and his assistant, Ann Ridley, both of whom have worked with Dr Kirkup previously.

4.3 Full details of the panel and support team are available on the investigation's website. Dr Bill Kirkup has started his investigation by meeting with families and a panel of experts. The panel is working with families to agree its terms of reference.

4.4 The Trust has welcomed this independent investigation and is doing everything it can to assist Dr Kirkup and his panel.

5. Learning and Review Committee

5.1 A Trust board sub-committee, chaired by consultant in Obstetrics and Gynaecology Mr Des Holden, was set up by the Trust in February to oversee a

number of task and finish groups. These included reviewing the Royal College of Obstetricians and Gynaecologists report undertaken in 2015; the Trust's maternity improvement programme "BESTT"; to implement, embed and assure the Coroner's recommendations following the inquest of baby Harry Richford and reviewing data available on maternity services in east Kent.

5.2 The Learning and Review Committee has been reporting to the Trust Board on a monthly basis and will produce its final report to the Board in July. The close down of the current 'discovery phase' of the work of the committee will enable the Trust to move to further implementation and embedding of the changes resulting from the task and finish groups.

5.3 The Chair of the committee has commissioned an integrated action plan to address the remaining tasks, themes and actions that require implementation. The implementation of this plan will be overseen by a working group chaired by a Non-Executive Director of the Trust as a demonstration of the Trust board's commitment to maternity improvement. Implementation will be monitored by the Trust's Quality Committee which reports in public to the Board of Directors.

5.4 The Trust Board is determined to ensure continuous improvement in maternity services and that it must and will ensure the delivery of a maternity service that our local residents and our local representatives can all be truly proud of.

July 2020

Item 13: Edenbridge Primary and Community Care

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 22 July 2020

Subject: Edenbridge Primary and Community Care

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the Kent and Medway CCG.

It provides background information which may prove useful to Members.

It is a written briefing only and no guests will be present to speak on this item.

---

1) Introduction

a) Historically, health services in Edenbridge have been provided by a GP Practice ("Edenbridge Medical Practice"), an at home service through Kent Community Health NHS Foundation Trust (KCHFT) and the Edenbridge and District War Memorial Hospital.

b) The GP surgery and Hospital were both deemed unsuitable for modern healthcare needs, therefore the NHS West Kent CCG carried out a consultation in 2017 to develop a vision for a more modern and integrated service in new facilities.

2) Previous visits to HOSC

a) HOSC were first made aware of emerging proposals for primary and community care in Edenbridge as part of a wider item on local care in West Kent in November 2016.

b) On 27 January 2017 the Committee considered an update about the proposals to co-locate the GP surgery and community services in Edenbridge. The Committee decided the proposed changes did not constitute a substantial variation of service but would re-consider this position following the next update.

c) On 14 July 2017 the Committee considered the proposals following the public consultation around plans. The CCG reported that there was strong support for bringing the GP practice and community hospital together on a new site.

d) At that meeting, the Committee again determined that the changes did not constitute a substantial variation of service and asked to be updated once the CCG Governing Body had made their decision on 25 July 2017.

e) The CCG's preferred option for the future of Edenbridge health services was to build a new integrated surgery/hospital on a new site without inpatient beds, but with a wide range of other services including daybeds.

f) The minutes from the 25 July 2017 West Kent CCG Governing Body meeting show that the above preferred option was approved. Implementation would be progressed by the parties involved.[1]

g) HOSC received a written update on 21 September 2018. The report highlighted areas of progress in relation to the clinical model workstream, communications and engagement, site identification (dependant on the Local Plan) and financing (the outcome of a capital bid to NHS England was due in late 2018). The Committee resolved to note the report.

h) The CCG has provided the attached update for the Committee on the progress made.

3. Recommendation

RECOMMENDED that the Committee consider and note the report.

Background Documents

Kent County Council (2016) *'Health Overview and Scrutiny Committee (25/11/2016)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=42582

Kent County Council (2017) *'Health Overview and Scrutiny Committee (27/01/2017)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=43321

Kent County Council (2017) '*Health Overview and Scrutiny Committee (14/07/2017)',*
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7530&Ver=4

Kent County Council (2018) '*Health Overview and Scrutiny Committee (21/09/2018)',*
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7921&Ver=4

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[1] West Kent CCG (2017) NHS West Kent Clinical Commissioning Group Governing Body Meeting (22 August 2017)
https://www.westkentccg.nhs.uk/EasysiteWeb/getresource.axd?AssetID=453819&type=Full&servicetype=Attachment

Kent and Medway
Clinical Commissioning Group

Kent Health Overview and Scrutiny Committee
Written Update on Edenbridge Programme HOSC

July 2020

1. Introduction and Summary of Progress

1.1 For the last four years, NHS West Kent CCG (Now Kent & Medway CCG) has been working with two key partners in the Edenbridge area on proposals for developing a new site and new service models, in view of the challenges facing the Edenbridge Medical Practice and the War Memorial Hospital. The two key partners in this work are the GP Practice and Kent Community Health NHS Foundation Trust (henceforth "KCHFT"): KCHFT is by far the main provider of services from the hospital, which is owned (freehold) by NHS Property Services.

1.2 The local population is expected to grow due to planned housing developments in the South East. Both buildings suffer from limited parking and give very poor disabled access. The GP Practice building needs to grow to meet new demand but cannot physically be enlarged to enable the practice to grow. The fabric and infrastructure of Edenbridge Hospital has aged and requires modernisation.

1.3 An Outline Business Case (OBC) was completed in December 2016, agreed by NHS England, endorsed at the West Kent CCG Governing Body in January 2017. After a formal public consultation in July 2017, the CCG Governing Body agreed to proceed with the two key partners towards the building of a new health facility in Edenbridge that would bring together the GP Practice and the Hospital services, without any inpatient beds. The outcome of the public consultation was decisive support for this model:

a) *94 per cent (1,089) of the 1,159 people (1,089) responding to a survey carried out as part of a three-month public consultation backed a combined hospital/surgery*
b) *79 per cent (915) supported the preferred option – for services to be provided in a new building, on a new site, with additional day services (such as intravenous drips) and no inpatient beds.*

1.4 On 24 September 2018 an Options Paper re site selection was considered by the Edenbridge Programme Board. A long-list of 15 potential sites was explored by the Programme Board and that assessment brought the long-list down to two short-listed sites, adjacent to one another. The Programme Board recommended one site and the Trust indicated agreement to purchase the land directly. That purchase of the land has been completed.

1.5 The Programme Team has accomplished much including the consultation and public support for the works, design, planning permission and purchasing the land for the preferred site. Further permissions and approvals are now required from the newly established Kent and Medway CCG and NHS England and NHS Improvement (NHSE/I) around clarity of primary care business case approval and procurement of finance and construction.

1.6 This paper provides the Health Overview and Scrutiny Committee with an update on the Edenbridge associated workstreams and overall progress of the Programme for the benefit of patients and citizens in Kent and Medway. The table at the end of the paper highlights key milestones.

2. **Strategic and Economic Case Update:** A Strategic, Economic and Commercial Case exercise was commissioned from Avison Young in 2019. Their report recommended that ‘‘formal procurement advice is sought, using as a framework the discussion on procurement from a market sounding event’’ which was held on 3 December 2019. The focus of the Avison Young work, in terms of affordability, has been on the third party funding variant where third party investor provides lifecycle and hard facilities management services with soft facilities management services provided by KCH. The economic case reconfirmed the decision to pursue a **’’new build’’** option over maintaining the existing Edenbridge Practice and Edenbridge War Memorial Hospital.

3. **Commercial Case Update:** a number of existing commercial models were discussed with KCC and WKCCG and a market sounding event held on December 3 2019. The event allowed the opportunity to share with potential investors including Sevenoaks District Council, Kent KCC and Assura plc. KCC were flexible in terms of a delivery solution, referencing other early stage discussions across Kent with NHS partners including the Southborough Hub. Procurement lead time will have a key bearing upon delivery timescales and formal procurement advice is being sought from the newly constituted Kent and Medway CCG, using the discussion document from December 2019.

4. **Financial Case Update:** In the Base Case, Edenbridge offers cash savings overall in steady state, albeit affordability implications differ for KCH, WKCCG and the GPs. This is subject to further investigation in light of the application of IFRS16 to public sector organisations from April 2020. Approval will also be needed from the newly created Kent and Medway CCG and NHSE/I in the next three months as restart continues.

5. **Clinical Update:** The clinical case for change for community and primary care in Edenbridge has been developed collaboratively with input from Edenbridge GPs, Kent Community Health NHS partners and other stakeholder agencies. The case takes into account local and national NHS clinical strategy, as well as local public health population data.

   5.1 The original clinical principles still hold true, in light of the changes instigated by the NHSE Ten Year Plan, in that work has proceeded continuously on the Operating Model for a new combined facility and the incorporated clinical model. Key objectives (from the original OBC) that have informed this work are:

   - To introduce place-based health and social care support wrapped around the local community (a key tenet of the 10 Year Plan)
   - provide more preventative services so people can stay well for longer
   - Integrate services so patients do not have to see lots of different professionals, in different places at different times
   - Access more services seven days a week
   - Provide as much care as possible in the community, not in an Acute Trust
   - Use technology better

   5.2 A review is now commencing to assess how the impact of the national Covid-19 crisis may impact on the clinical and operating model for the planned new facility.

5.3 In practice that the principles adopted at Edenbridge are:

a) **Maximising integration** - almost all areas of the new facility would be used by both practice and KCHFT staff, clinical spaces all being designed flexibly for use by a range of clinicians, shared reception and administrative facilities.

b) **Incorporating Local Care "mini hubs"** - continuous interface has been ensured with the team developing the west Kent Local Care model, and the development at Edenbridge has accordingly been built into the emerging West Kent Hubs strategy as it develops. Work around the hubs is ongoing with a SOC produced in June 2020.

c) **Incorporating Health and Social Care Integration** - the Councils in west Kent are all involved in Local Care design through the Local Care Development Board (and West Kent Improvement Board). All are involved in co-designing the Hubs Strategy. In Edenbridge directly, Kent County Council are working with the Practice and the Trust on an innovative model for integrated services (Buurtzorg) and the programme team are in discussion about what range of social care services will be made available from the new Edenbridge facility.

6. Stakeholder Management Update:

6.1 Local public support is at the heart of the Edenbridge Programme. The results of the formal consultation in 2017 have been built upon by the Edenbridge team. At its meeting on 25 July 2018, NHS West Kent Clinical Commissioning Group's Governing Body agreed to proceed with the preferred option after hearing that:

- *94 per cent (1,089) of the 1,159 people (1,089) responding to a survey carried out as part of a three-month public consultation backed a combined hospital/surgery*
- *79 per cent (915) supported the preferred option – for services to be provided in a new building, on a new site, with additional day services (such as intravenous drips) and no inpatient beds.*

6.2 A number of large public events in Edenbridge have been held, the most recent in February 2020. The Edenbridge Programme has a comprehensive communications plan in place and are planning restart process currently paused due to Covid-19.

Next Steps

6.3 The Edenbridge Project Team is now well established and has a detailed plan for delivery. The table below outlines these milestones and their progress to completion. However, the Covid-19 crisis has caused a postponement of all non-Coronavirus-related work within the CCG. The Project Plan below therefore is subject to update as the crisis lessens across Kent and Medway.

Date	Item	Comments
29/01/20	Land Purchased	Achieved
13/02/20	Planning Permission Granted	Achieved
18/02/20	Plans Signed Off	Achieved
17/02/20	Procurement Process	Process Started

Date	Item	Comments
30/03/20	Finance Appraisals to be Presented	Meeting were in place for 26 March with SDC to discuss funding further but on hold due to Covid-19
06/04/20	Tender to go Live	Process in planning – delayed due to Covid -19
01/04/20	Land Clearance	Asbestos clearance is currently underway
30/04/20	Additional Wildlife Surveys Carried Out	Awaiting a fee proposal
30/04/20	Landscape Consultant Start	Currently looking into this and aiming to have them appointed by the 30 April – *Delayed due to Covid -19*
01/09/20	Design & Building Contract Awarded	In plan – *subject to restart post Covid-19*
01/10/20	Pre-build Design Off	In plan – *subject to restart post Covid-19*
01/11/20	Construction Starts	In plan – *subject to restart post Covid-19*
01/12/21	Completion Date	In plan – *subject to restart post Covid-19*

Figure 1 – Edenbridge Programme Plan for Delivery*

Recommendation(s)

1. HOSC is asked to **note** the continued progress of the Edenbridge Programme

Caroline Selkirk
Director of Health Improvement

Item 14: Work Programme 2020

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 22 July 2020

Subject: Work Programme 2020

Summary: This report gives details of the proposed work programme for the Health Overview and Scrutiny Committee (HOSC).

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1. Introduction

a) The proposed Work Programme has been compiled from actions arising from previous meetings and from topics identified by Committee Members and the NHS.

b) The HOSC is responsible for setting its own work programme, giving due regard to the requests of commissioners and providers of health services to bring an item to the HOSC's attention, as well as taking into account the referral of issues by Healthwatch and other third parties.

c) The HOSC will not consider individual complaints relating to health services. All individual complaints about a service provided by the NHS should be directed to the NHS body concerned.

d) The HOSC is requested to consider and note the items within the proposed Work Programme and to suggest any additional topics to be considered for inclusion on the agenda of future meetings.

2. Recommendation

The Health Overview and Scrutiny Committee is asked to consider and note the report.

Background Documents

None

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Work Programme - Health Overview and Scrutiny Committee

1. Items scheduled for upcoming meetings

17 September 2020		
Item	**Item background**	**Substantial Variation?**
The Maidstone and Tunbridge Wells Stroke Service, and Medway Stroke Service	To receive an update following the temporary closures of the Tunbridge Wells and Medway stroke units	-

2. Items yet to be scheduled

Item	Item Background	Substantial Variation?
Urgent Care provision in Swale	To receive greater clarity around the plans for Urgent Care provision in Swale	To be determined
Children and Young People's Emotional Wellbeing and Mental Health Service	To receive an update on performance from provider NELFT.	-
Publication of the Kent & Medway Primary Care & Workforce strategies	For information, following publication of the strategies.	No
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	Members requested an update at the “appropriate time” during their meeting on 1 March 2019	-
Wheelchair Services	Members requested an update in 9-12 months following their meeting on 29 January 2020	-
New model of care for dementia patients with complex needs	To receive information about the new model of care to be put in place.	To be determined

3. Items that have been declared a substantial variation of service and are under consideration by a joint committee

Kent and Medway Joint Health Overview and Scrutiny Committee **NEXT MEETING: TBC**		
Item	**Item Background**	**Substantial Variation?**
Transforming Health and Care in East Kent	Re-configuration of acute services in the East Kent area	Yes
Assistive Reproductive Technologies	Consideration of proposed changes to fertility services	Yes
Specialist vascular services	A new service for East Kent and Medway residents	Yes
Changes to mental health provision (St Martin's Hospital)	KMPT's plans for the St Martin's (west) former hospital site, under their Clinical Care Pathways Programme	Yes