HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 24th November, 2020

10.00 am

Online

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 24th November, 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
Liberal Democrat (1):	Mr D S Daley
Labour (1):	Ms K Constantine
District/Borough Representatives (4):	Councillor K Maskell, Councillor S Mochrie-Cox, Councillor J Howes, and Councillor P Rolfe

UNRESTRICTED ITEMS

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

Item		Timings*
1.	Substitutes and apologies	10:00
2.	Declarations of Interests by Members in items on the Agenda for this meeting.	
3.	Minutes from the meeting held on 17th September 2020 (Pages 1 - 6)	
4.	Healthwatch Kent and Medway – "Pharmacies and Covid: the reality" (Pages 7 - 28)	10:05
5.	Covid-19 response and winter planning 2020-21 (Pages 29 - 54)	10:20
6.	South East Coast Ambulance Service NHS Foundation Trust - provider update	11:00

Please note that given the size of appendix E, the Staff Survey, it has been published on the County Council's website alongside the agenda and is available via the modern.gov app.

7. Children and Young People's Mental Health Service - update (Pages 115 - 124) 11:25

8. Work Programme 2020-21 (Pages 125 - 130) 12:00

9. Date of next programmed meeting - 27 January 2021

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

16 November 2020

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Online on Thursday, 17 September 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, Ms S Hamilton, Mr P W A Lake, Mr K Pugh (Vice-Chairman), Mr D L Brazier, Mr A R Hills, Cllr J Howes, Patricia Rolfe, Cllr S Mochrie-Cox and Cllr K Maskell

ALSO PRESENT: Dr J Allingham and Ms L Gallimore

IN ATTENDANCE: Mrs K Goldsmith (Research Officer - Overview and Scrutiny), Mr M Dentten (Democratic Services Officer) and Dr A Duggal (Deputy Director of Public Health)

UNRESTRICTED ITEMS

48. Membership
(Item 1)

It was NOTED that Cllr Carol Mackonochie and Cllr Mark Rhodes had stepped down from the Committee. Cllr Shane Mochrie-Cox and Cllr Kevin Maskell had joined the Committee.

49. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 3)

The Chair declared a non-pecuniary interest in Assura PLC.

Mr N J D Chard declared that he was a Director of Engaging Kent.

50. Minutes from the meeting held on 22 July 2020
(Item 4)

It was RESOLVED that the minutes of the meeting held on 22 July 2020 were a correct record and they be signed by the Chairman. There were no matters arising.

51. Covid-19 update and restart of NHS services
(Item 5)

Ms C Selkirk, Executive Director for Health Improvement; Mr J Lowell, Covid-19 Kent and Medway Restart and Recover Programme Director; Mr S Jeffery, K&M NHS Tactical Commander from the Kent and Medway Clinical Commissioning Group were in attendance for this item at the invitation of the committee.

1. The Kent and Medway CCG had provided a paper with an update on the local response to Covid-19 as well as the restart of local elective services that had been put on hold as a result of the pandemic.

2. Mr S Jeffery began by addressing Member concerns related to the capacity in Emergency Departments. He highlighted the winter preparation undertaken with the adoption of a central control centre and noted cooperation with the Kent Resilience Forum. He confirmed that Kent and Medway were well prepared for the adoption of the 111 First initiative and stated that the impact had been projected to reduce Emergency Department use by 10%. Regarding critical care capacity he confirmed that 33 additional beds would be utilised during the winter, a capacity increase of a quarter.

3. Mr Lowell updated the committee regarding screening services, he emphasised that screening was a multi-agency operation, commissioned by Public Health England and integrated with the CCG. In relation to bowel screening he confirmed that additional mobile endoscopy units had been used to increase capacity, subsequently the bowel screening backlog was expected to be cleared by September 2020. Mr Lowell confirmed that mobile breast screening units underwent refurbishment to adhere to infection prevention and control measures, though this had not been fully completed. He stated that no time indicator existed concerning the breast screening backlog and agreed to provide an indicator at a future meeting.

4. Ms Selkirk, Mr Lowell, Mr Jeffery and Dr Allingham responded to comments and questions from the committee, including the following:-

a) Dr J Allingham was asked to outline when practices across Kent would have flu vaccinations. He confirmed that initial vaccination deliveries had been received by practices from August, with the last initial deliveries expected by 27 September. Dr Allingham confirmed that delays were due in part to the multitude of vaccine suppliers;

b) asked to confirm whether there had been significant changes in the mammogram backlog, Ms Selkirk agreed to circulate written figures with the committee following the meeting;

c) the impact a future national or local lockdown would have on service use and delivery was raised. Ms Selkirk confirmed that multimedia engagement had been utilised to encourage service use, whilst each individual service had their own delivery plan factoring in social restrictions;

d) Ms Selkirk was asked how mental health assistance would be provided in the event of a future national or local lockdown. She assured the committee that the Mental Health Improvement Board had led the multi-partner response across Kent and created a 24/7 open access crisis line, which had not existed prior to the original national lockdown. Ms Selkirk added that a 15% increase in the home treatment of mental health patients was planned;

e) asked how Covid-19 response efforts involving independent care providers had been funded, Mr Lowell confirmed that all Covid-19 related contracts with independent care providers had been managed and funded on a national level by NHS England; and

f) Ms Selkirk was asked how service data had been used to inform patient engagement, she confirmed that population data had proved useful in identifying individuals who were members of vulnerable age and ethnic groups. She stressed that more could be done to engage young people and cited work with other agencies, including KCC, as a future necessity when broadening the use of qualitative data.

5. It was RESOLVED that the report be noted and the following action be taken:
i. Ms Selkirk to circulate written mammogram backlog figures with the committee.
ii. Mr Lowell to provide the committee with a time indication of when the mammogram backlog will be cleared.

52. East Kent Hospitals University NHS Foundation Trust - Covid-19 update *(Item 6)*

Mrs L Shutler, Deputy Chief Executive and Dr S Mumford, Interim Director of Infection Prevention and Control from East Kent Hospitals University NHS Foundation Trust (EKHUFT) were in attendance for this item at the invitation of the committee.

1. EKHUFT had provided the committee with a report on their response to the on-going pandemic, with a particular emphasis on a recent CQC inspection that had resulted in enforcement action against the Trust. Mrs L Shutler emphasised that a reduction in inpatients across East Kent hospitals reflected the overall trend of lower Covid-19 rates in the region. She confirmed that video consultations and follow-ups had increased significantly across the Trust's operations. Regarding capital investment Mrs Shutler notified the committee that £23m had been received, with the funding facilitating ICU expansions at the William Harvey and QEQM hospitals as well as critical and mammography infrastructure.

2. Dr S Mumford outlined the Trust's short-term infection control plan, she confirmed that staff training had been undertaken to reinforce standards and Trust board members had conducted ward visits to ensure that changes had been implemented.

3. Mrs Shutler and Dr Mumford responded to comments and questions from the committee, including the following:-

a) concerns were raised regarding the lack of hand basins and sanitiser as highlighted by the CQC's inspection of the William Harvey hospital. Mrs Shutler assured the committee that a central programme monitoring hand sanitiser levels now existed, and that the placement of hand basins had been factored into the infrastructure investment plans;

b) asked whether there were a sufficient number of infection control nurses operating in the Trust, Dr Mumford confirmed that the Trust had begun the recruitment of a Deputy Director of Infection Prevention and Control as well as the recruitment of two senior infection control nurses. She further confirmed that the recruitment of a Director of Infection Prevention and Control was planned. Mrs Shutler agreed to provide the committee with a written update following the filling of the posts;

c) Mrs Shutler was asked who within the Trust should be held accountable for the shortcomings highlighted by the CQC, she affirmed that the Trust's board bore ultimate responsibility and endeavoured to improve board-ward communication; and

d) when asked by the committee, Mrs Shutler confirmed that once published the CQC's inspection report and the Trust's response to the inspection would be available in the public domain.

4. It was RESOLVED that:
i. the report be noted and that the Trust be invited to attend a future meeting at the appropriate time, and
ii. Mrs Shutler would provide the committee with a written update on Infection Prevention and Control recruitment.

53. Acute Stroke Services Update
(Item 7)

Mrs R Jones, Executive Director of Strategy and Population Health at Kent and Medway CCG was in attendance for this item at the invitation of the committee.

1. The Kent and Medway CCG had been requested to update the committee on the temporary closure of two stroke wards in Kent. Mrs Jones introduced the report and assured the committee that there had been no changes since the report was published.

2. Providing an update on the wider Stroke Services Review and implementation of HASUs, Mrs Jones confirmed that two appeals against the outcome of the review had been declined and no further legal appeals had been lodged. A decision from the Secretary of State for Health and Social Care following a referral in 2019 was still pending.

3. Mrs Jones drew the transfer of acute care patients to the attention of the committee and remarked that overall patient experiences had been positive.

4. Mrs Jones responded to comments and questions from the committee, including the following:-

a) asked how best the continued concerns of Thanet residents could be addressed, Mrs Jones highlighted the importance of engaging the local community, both to convey the improved level of service and address any negative feedback. She agreed to provide an update to the committee regarding public engagement during the implementation of the service; and

b) asked for confirmation on which stroke unit residents of the County's Sevenoaks Rural South division should use, Mrs Jones confirmed that with the exception of residents close to the Surrey border, who should utilise the Redhill service, all residents of the division should be advised to use services in Maidstone.

5. It was RESOLVED that the report be noted, and that the CCG return to the committee with an update once implementation of the HASUs was underway, with a particular focus on how public trust was being rebuilt following the consultation.

54. East Kent Hospitals University NHS Foundation Trust - Maternity Services *(Item 8)*

Mrs L Shutler, Deputy Chief Executive; Mr J Seaton, Clinical Director Women's Health and Consultant Obstetrician and Gynaecologist and Mrs S Curtis, Deputy Head of Midwifery from EKHUFT were in attendance for this item at the invitation of the committee.

1. Mrs Shutler introduced the report which provided an update on the performance of maternity services across the Trust's hospitals. She was pleased to report that the CQC had recently graded the "responsiveness" of the QEQM's maternity service as "good", though highlighted antenatal triage at QEQM and day care services at the William Harvey as areas which required further improvement. Mrs Shutler confirmed that an action plan had been implemented to tackle the issues highlighted in the CQC inspection report.

2. Mrs Shutler and Mr Seaton responded to comments and questions from the committee, including the following:-

a) asked when the Dr Bill Kirkup report into East Kent Maternity Services would be completed, Mrs Shutler confirmed that no timeline, deadline or date of publication had been confirmed;

b) asked how recent recruitment into the service had been achieved, Mr Seaton confirmed that the increase in the number of consultants in both the QEQM and William Harvey had come largely from trainees and junior doctors returning to the Trust, he stressed that the consultant recruitment process would continue until the end of the year. Mrs Curtis substantiated that within midwifery the majority of recruitment had been from internal students, with external recruits contributing to a lesser but still significant extent;

c) Mr Seaton was asked how qualitative data had been used to highlight patient experience and develop a patient focused service. He confirmed that the views and personal experiences of women who had used the service had been considered in the formulation of the maternity service's five year strategy. Members recommended that partner and family experiences be factored into the strategy as an addition (to which Mr Seaton confirmed they were already taken into account); and

d) asked to clarify the meaning of 'complete but awaiting formal provision of evidence' in Section 2.7 of the report, Mrs Shutler explained that whilst the change had been implemented, evidence had yet to be formally submitted to the CQC. In terms of the timescale for implementing outstanding changes, Mrs Curtis updated the committee on the progress of actions, confirming an 89% completion rate. The end of the calendar year was cited as the action implementation deadline.

3. It was RESOLVED that the report be noted and that the Trust provide an update once the final report from the Dr Bill Kirkup review had been published.

55. Edenbridge Primary and Community Care

(Item 9)

It was RESOLVED that the report be noted.

56. Work Programme 2020-21

(Item 10)

1. Members requested that an item providing an update on Kent and Medway's Covid-19 response, including winter planning, restart and rehabilitation be added for the next meeting.

2. The Chair noted that the following items had yet to be scheduled:-

- an update on East Kent Maternity Services' response to the Dr Bill Kirkup Report, following its publication;
- an update on stroke services during the implementation of HASUs, with a partial focus on rebuilding public trust in local communities; and
- an update on the East Kent response to the CQC inspection on Covid-19.

57. Date of next programmed meeting – 24 November 2020

(Item 11)

It was NOTED that the next meeting of the Committee would be on Tuesday 24 November 2020, commencing at 10.00 am.

Item 4: Healthwatch Kent and Medway – "Pharmacies and Covid: the reality"

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 24 November 2020

Subject: Healthwatch Kent and Medway – "Pharmacies and Covid: the reality"

Summary: This report invites the Health Overview and Scrutiny Committee to consider the report written by Healthwatch Kent and Medway.

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1) Introduction

a) In November 2020, Healthwatch Kent and Medway published a report about the lessons learnt by local community pharmacies during the first wave of the Covid-19 pandemic.

b) Healthwatch have been invited to introduce the report to HOSC members today. There will also be a representative from the Kent Pharmaceutical Committee present.

2) Recommendation

RECOMMENDED that the Committee consider and note the report.

Background Documents

None

Contact Details

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healthwatch Kent

healthwatch Medway

Pharmacies & Covid : the reality

A report by Healthwatch Kent & Healthwatch Medway

November 2020

Executive summary

During the early months of the pandemic Healthwatch Kent and Healthwatch Medway heard from hundreds of people about a whole range of issues such as isolation, mental health and delays to operations. We heard a significant amount of feedback relating to community pharmacies. Now that lockdown measures have eased, we wanted to find out more about how community pharmacies experienced the' first wave' of the pandemic, how they innovated and what lessons they feel should be learnt in order to inform planning for a possible 'second wave' of the pandemic.

We sent a survey to 335 community pharmacies and 101 responded across Kent & Medway.

This is what they told us:

72% of community pharmacies don't feel that systems have been improved in preparation for a second wave.

92% didn't receive the information, support and equipment they needed to respond to the first wave of the pandemic.

95% of community pharmacies said that their staffing levels had been affected in the first wave, the majority reporting that the impact had been significant.

73% of community pharmacies report that morale is low and what staff need most at the moment is recognition from fellow NHS professionals and for the public to be made more aware of the work they do.

95% of community pharmacies told us that their workload has changed as a result of the pandemic.

78% of community pharmacies reporting that communication and working with GP surgeries had been difficult and slow.

73% of community pharmacies were able to identify parts of the community that they felt were in need of greater support.

Recommendations

Many of the issues we have highlighted in this report require a system wide approach to improvements. Our recommendation is therefore to facilitate a multi stakeholder discussion of the report with the aim of:

- Building on the work that is already underway to address the challenges and difficulties experienced in the first wave.
- Increasing awareness of the interdependences and impacts of working practice between different contact points of community pharmacies and other NHS services to encourage collaborative action plans to address issues.

Issue to be discussed will include:

- Exploration of further adoption of electronic Repeat Dispensing across more GP surgeries.
- Mechanisms to acknowledge the work of community pharmacies and address the reported low morale.
- Ensure robust communication systems are in place to enable efficient information sharing with community pharmacies

Statement from Kent and Medway Local Pharmaceutical Committee

Kent LPC (Local Pharmaceutical Committee) would like to thank both Healthwatch for this recent survey which has given our community pharmacies a platform to voice their opinions on the effect of COVID on community pharmacy across Kent and Medway.

Poor communication early on during the pandemic led to confusion and panic for patients. We were the only healthcare provider that did not have the opportunity to fully work behind closed doors and this led to a huge influx of patients as they did not understand the different ways of working that other healthcare professionals were able to and had put in place.

Lack of PPE was of major concern as we were seeing hundreds of patients face to face daily, after the first supply community pharmacy was told that they have to purchase their own but many wholesalers had no stock and this is an additional cost that along with many other COVID costs had not been factored into at the beginning of the year and to date they have still not been reimbursed for. Whilst they were given a very small amount to fix screens in their pharmacy the money given in the majority of cases did not cover the cost of the screens being bought and fitted. We now have access to free PPE which has been helpful.

There is a common misconception that the NHS pays for delivery of medication to patients, however many pharmacies were offering this for free to help patients, taking on the cost burden themselves. Few businesses offer free delivery to their customers, yet patients expect this from pharmacy. Whilst NHS England put measures into place for payment of deliveries this was short term and many patients were not covered under this service. Voluntary groups were brilliant and the offers of support we were getting locally was phenomenal in particular from KCHFT who redeployed 50 staff members to help community pharmacy with their deliveries. Other voluntary groups were very supportive but this was not straight forward to implement as there were concerns around training of the volunteer and whether the pharmacy was insured if something went wrong.

Due to an increase in prescribed medication as patients were panicking and stockpiling, the burden again fell to community pharmacy to buy the medication upfront before being reimbursed months later by the NHS. This over ordering was also leading to out of stocks which has been a concern in Community Pharmacy pre COVID and this was further compounded. Measures were put into place very quickly at a system level and we are confident that this will not happen again with the second lockdown, though there does need to be better communication to patients nationally.

Statement from Kent and Medway Local Pharmaceutical Committee

Whilst having to work through all this, pharmacists were worried for the health of themselves and their staff. As fears among the public grew, we saw an increase in aggression and violence towards pharmacists and their teams, with one pharmacist being physically assaulted.

Locally Kent LPC worked with the whole system and has felt very much involved from day 1. We have been listened to and many local measures have been put in place. Both the CCG and Local Authorities supported with continued payments for services that could not be delivered so that this was not adding to the financial burden placed upon community pharmacy. We've worked closely with all commissioners to support each other and ensure that the patient is supported at all times in particular One You, CGL, Forward Trust and Turning Point as well as others. The LMC have worked closely with us putting measures in to stop practices prescribing large volumes of medication. These measures will remain in place which is pertinent now that we are heading into our second lockdown.

The government have assured us that there are enough flu vaccinations to vaccinate all those that are vulnerable and community pharmacy will be given access to the stock, which we have just received guidance about. The relationship between GP's and community pharmacy this year is the best it's ever been in terms of ensuring that we collaborate together to vaccinate as many vulnerable patients as we can. Locally the LPC have been heavily involved in any system work around flu vaccinations.

Concerns for this second lockdown are managing patient expectations around free deliveries, supporting patients trying to get them to maintain other health related appointments, supporting patients who don't have access to technology, managing workload with the worry of staff being off either with symptoms of COVID or with the test and trace process and supporting the mental health of pharmacists and healthcare staff.

Locally it would be great to see the system using pharmacists to make minor alterations to prescriptions via Independent Prescribers, it would really take the pressure off of the GP practices with respect to out of stock medications. The common ailments scheme is a great help in West Kent, it really takes the pressure off of GP practices and as people are furloughed and being made redundant it really helps, we would like to see this rolled out across the county.

We really appreciate how we have been involved at system level and I hope that this continues.

Shilpa Shah
CEO Kent LPC
3rd November 2020

Background

During the early months of the pandemic Healthwatch Kent and Healthwatch Medway heard a significant volume of feedback from the public about queuing at community pharmacies and the difficulties people had in collecting their complete prescriptions.

When we took this feedback to the Kent and Medway Local Pharmaceutical Committee, we had the opportunity to hear about the challenges from the pharmacy perspective. Community pharmacies were one of the few places that people could access during the early stages of the pandemic. This meant that community pharmacies found themselves facing unprecedented challenges during the months of lockdown.

Now that lockdown measures have eased, we wanted to find out more about how community pharmacies felt about their experience in lockdown, how they innovated and what lessons they feel should be learnt in order to inform planning for the second wave of the pandemic.

What were we trying to achieve?

- Offer community pharmacies an opportunity to have their voice heard alongside the recent experiences from the public by decision makers and commissioners within Kent and Medway.
- To influence and inform NHS decision makers and commissioners about how best to support community pharmacies in respect of Covid 19
- To influence and inform planning for the second Covid wave

Methodology

We worked closely with Kent and Medway Local Pharmaceutical Committee (LPC) to design a survey to enable community pharmacy staff to share their experiences.
A link to an online survey was promoted via the LPC networks. The Kent & Medway Clinical Commissioning Group and Public Health both promoted the survey as well. The survey ran from 17th September to 19th October 2020.

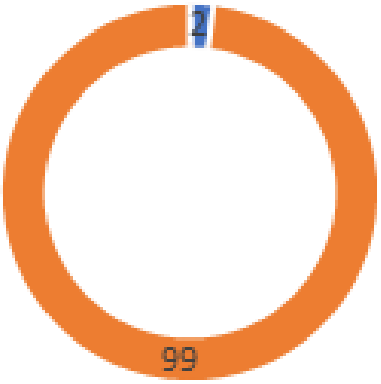
The survey captured some quantitative information, but the majority of questions generated qualitative responses. These responses were entered directly into a database, via a webform, by the respondents. This data was then analysed, within a pragmatic framework using a form of thematic content analysis. This approach assumes little or no predetermined theory, structure or framework and uses the actual data, to inform the structure of analysis. The process involves analysing the responses, identifying themes within the data and gathering together examples of those themes from the text.

30% (101 of 335) of the community pharmacies in Kent and Medway responded to the survey. The Paydens group offered feedback on behalf of 66 individual pharmacies and the Lloyds group completed on behalf of 17 pharmacies. However, we have not necessarily weighted these responses within each area of analysis to enable us to consider each response equally.

Paydens and Lloyds both have independent pharmacies across Kent and Medway. We also heard from seven pharmacies in Medway and 11 from across Kent (3 in west Kent, 4 in east Kent, 4 in north Kent).

We analysed the findings by those that identified as part of a national chain and those that did not, in order to enable us to explore any similarities or differences in experiences between groups of pharmacies.

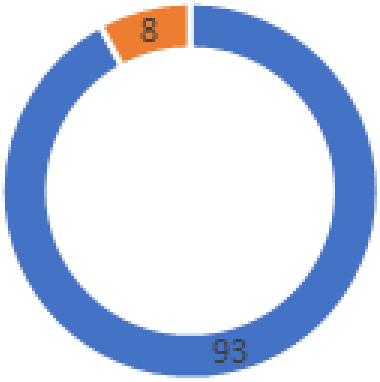
Buisness premises



Operate with in supermarket / health centre

Operate from own permises

Trading status



Independent local pharmacy

Part of national chain

Community pharmacies experience of the first wave

92% of those that completed the survey told us that they didn't receive the information, support and equipment they needed to respond to the first wave of the pandemic.

The top three themes within this were:

Lack of acknowledgement and appreciation

56% of community pharmacies talked about a feeling of *'being on our own, having to cope and manage with little appreciation and support from the NHS'*

- *'Politicians did not fully appreciate the contribution pharmacies made during the pandemic whilst all other healthcare providers were working (or not) behind closed doors, leaving pharmacy to bear the pressure of healthcare advice to patients.'*
- *'A large issue that was faced by community pharmacy included GP's closing their doors completely… leaving pharmacy staff to deal with patients with symptoms face to face.'*
- *'Remember the only part of the NHS that has remained "doors open" throughout the pandemic is community pharmacy'*
- *'We even had a couple of incidents of NHS111 directing suspected Covid patients to our branches.'*

Lack of PPE

56% of pharmacies talked about difficulties in accessing PPE and testing for staff.

- *'PPE was not provided, which was essential during the early stages, a few pharmacist colleagues have lost their lives as a result'*
- *'No support for PPE, we couldn't obtain it. Staff were forced to work in conditions that were potentially dangerous'*
- *'I feel support came too slowly, especially PPE which was extremely expensive for us to purchase and difficult to source early on and also what we initially secured from the NHS was out of date with new expiry date stickers placed over the top, which did not inspire us with much confidence!!!'*
- *'Access to Covid tests for staff was problematic in the early days of the pandemic'*

Community pharmacies experience of the first wave

Financial impacts

45% of pharmacies told us that the financial impact of the first wave had a significant impact.

- *'All the additional costs of the pandemic fell on us to sustain'*
- *'Not enough funding was provided by the government to help with additional costs associated with the pandemic'*
- *'Drugs rocketed in price (we buy them on behalf of the NHS)'*

Other issues, ranked in order of frequency of mention were:

- Difficulties related to the volume of prescriptions received and supply chains of medication. *'I also felt the government compounded our issues by advertising on the media about visiting your pharmacy and also about getting deliveries from us, when deliveries have never been part of our contract or funded other than by ourselves, putting us at greater risk of exposure and workload burden at a time when we were already working beyond capacity as patients panicked and were stocking up supplies'.*
- Issues related to staffing challenges during the first wave
- A lack of effective communication between the NHS and community pharmacies

Of the eight community pharmacies that said they did receive the support needed, six of them belonged to national chains. The Local Pharmaceutical Committee were mentioned positively in terms of their support, in particular around home delivery services.

With hindsight, the community pharmacies felt that there were three key areas that could have been improved:

Communication between GPs and the wider NHS (61%)

- *'Greater use of pharmacies to deliver messages about the pandemic to the public'*
- *'Surgeries talking to pharmacies about what their plans were rather than finding out on social media or from patients'*
- *'Information coming from one central source, not many different sources. We had no time to read most of it'*
- *'More consultation with pharmacies if they want to add additional services and/or to increase our workloads and better training of the NHS111 teams'.*

Community pharmacies experience of the first wave

Prescription processes and supply chains for medication (33%)

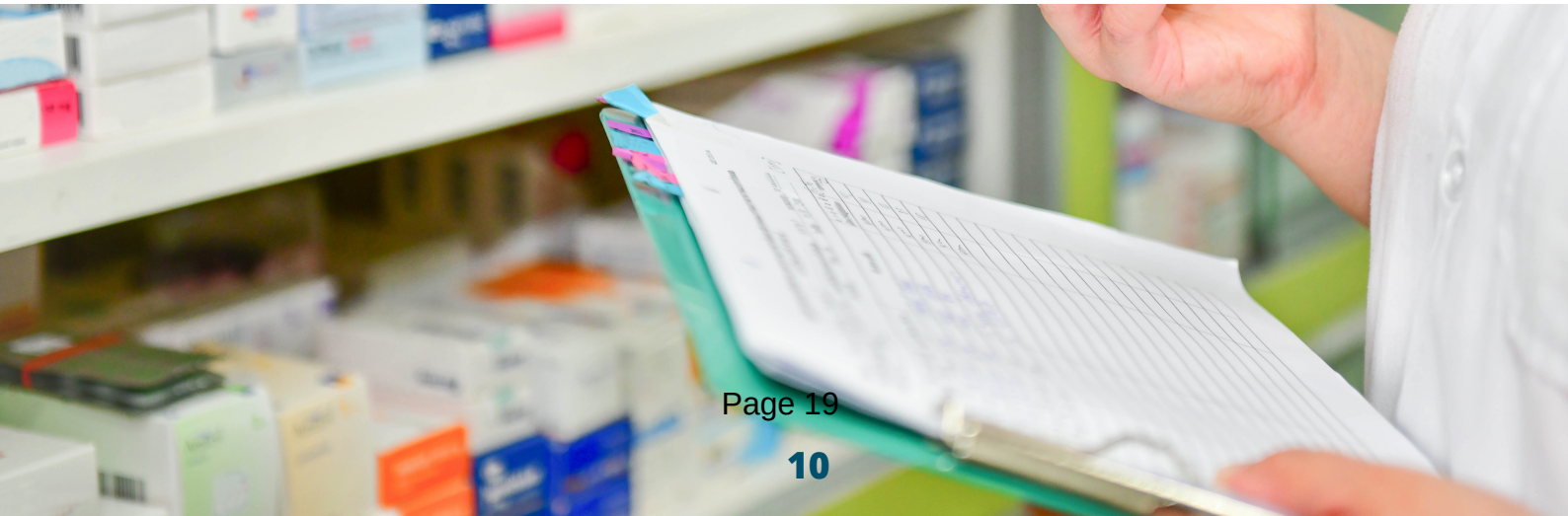
- *'Allowing pharmacists to make minor changes to prescriptions - like hospital pharmacists'*
- *'GPs should have liaised more with community pharmacies. GPs panic prescribed and put 3 months worth of medication on each scripts and sent it down in high volumes. The way they changed their prescribing actually made it harder. The removal of signed consent was too late for services and the approval of telephone MUR (Medicines Use Review) should have come in a lot sooner'*
- *'Dr surgery did not communicate with patients well and as we are next door, we became the administration team for the Drs surgery. They stopped taking paper repeat prescriptions but didn't communicate how patients should order their prescriptions, this was left up to us in the pharmacy to communicate'.*
- *'The surgery sent all prescriptions via EPS (electronic prescription service) to any pharmacy and patients didn't know where to collect prescriptions. Pharmacy did the prescriptions in good faith and many scripts went uncollected after a month. Even after contacting the surgery to contact patients many scripts had to be undispensed as not collected'*

Greater awareness and recognition of the role community pharmacies played as a key accessible public facing service during the first wave (33%)

- *'Greater recognition of the hard work done'*
- *'More information to patients on what pharmacy was going through and to inform their expectations around the pharmacy service. There was a significant increase in abuse to pharmacy staff during the pandemic mainly over having to wait for a prescription or around medication supply issues, when the staff were working hard to cope with the increased demands'*

Other areas community pharmacies reflected could have been improved in the first wave were:

- *Financial support for the addition costs incurred in medication, staffing time and equipment (23%).*
    - *'Much more financial support (even today we are being reimbursed at a lower price than what we are paying for drugs). Realistic reimbursement to extremely high operating costs we incurred.'*
- *PPE and testing (17%)*



Preparing for a second wave

During the first lockdown period (March – May) Healthwatch heard significant amounts of feedback from the public about challenges in getting mediation. When asked if community pharmacies felt that systems had been improved in preparation for a second wave, 72% said '*No*'. However the collective response of the Paydens group indicated that they do think that systems are now in place to mitigate concerns around medication in a second lockdown.

Prescriptions and medication supplies

Prescription processes and the medication supply chain are the most frequently raised current concerns for community pharmacies which thinking about preparing for a second wave. This also included accessibly of this seasons Flu vaccine, mentioned by 22% of pharmacies.

- *'We are experiencing a lot of phone calls regarding POD (Prescription Ordering Direct, an online service for patients to order prescriptions used by some surgeries in DGS and West Kent). They are constantly short staffed and not processing prescriptions on time, which is taking up a lot of staff time and resources from the pharmacy. We have no control of how quickly prescriptions are generated. Customers are expecting deliveries on demand, we need support and awareness that the medicine delivery service is not regarded as an essential service by the NHS and pharmacies will delivery when possible'.*
- *'Increased number of referrals and GPs not processing patients' prescriptions within the given time frame'.*
- *'Supplies are controlled by suppliers and manufacturers, so the shortages we have experienced are likely to continue *(I suspect they are manipulations of the market for profit). Add Brexit into that and who knows what could happen'.*
- *'If surgeries increase the number of days prescribing which happened in some cases across the locality this leads to medication shortages. There was also an increase in patients requesting asthma and other regular medication as a stock piling precaution which led to shortages'.*
- *'I don't feel that much has changed or improved, especially regarding stock, and my main concern is that the next wave is coming and at the same time we are preparing for Brexit, I anticipate further shortages and more instances of us using additional time to source products and also incurring losses due to re-imbursement shortfalls'.*

Preparing for a second wave

Flu Vaccine

- *'We are unable to order any from suppliers as they are more available to multiple's rather than independent pharmacies'*
- *'Flu vaccines are in very short supply. Government should help pharmacies distribute evenly and not to stockpile'.*
- *'There is not enough vaccines for patient demand'.*
- *'We are getting hundreds of phone calls every day re flu vaccines.'*
- *'Increase in flu vaccination demand has outstripped previous years leading to shortages in flu vaccination stocks. Flu vaccines were ordered around December 2019 before the pandemic hit and the manufacturers make flu vaccines each year according to orders - the demand is outstripping the orders placed by pharmacies as customers who would not normally have one are getting vaccinated this year.'*

Financial impacts

The second most frequently mentioned concerns were grouped around funding issues, (39%).

- *'Operating costs and reimbursement for the services we provide. Staff costs have escalated since lockdown and are still at a high level'.*
- *'Income from services have reduced considerably... Lost business to online pharmacies'*
- *'The NHS policy of closing 3000 local pharmacies remains. We were forced to close one of our own just before covid hit. Despite the warm words from politicians, community pharmacy hasn't had a single penny of additional funding .. and covid has driven up our costs massively'*
- *'Our figures show that we were on a net loss whilst providing valuable service to patients. The funding has to be improved considerably if pharmacy was going to face a second round of spike'.*

Other issues currently concerning community pharmacies included:

Meeting the needs of the public (22%)

- *'Patients coming into the pharmacy with symptoms, or not social-distancing, or those that are supposed to quarantine are coming into store'.*
- *'People are signposted by the GP a lot. Expecting us to offer blood tests, health check, blood pressure checks which we do not physically have time to offer. GP surgeries should start to offer blood tests at least so that patients do not have to travel far or book appointments for blood tests'.*
- *'Managing the queues of patients if Covid increases during the winter months, particularly where this means patients queuing outside in the rain or cold'.*
- *'Staff shortages due to lack of testing, increased mental health that pharmacies will need to support without adequate funding for extra staff to deal with queries whilst still providing a safe pharmaceutical service'.*
- *'I believe patients will find it difficult to distinguish between flu and coronavirus and therefore will come into pharmacies which can increase risk due to contact, despite PPE being in place'*

Preparing for a second wave

Ongoing impact on staffing (17%)

- *'Keeping the pharmacies running when losing staff members through Covid infection or quarantine'*
- *'The workload/staffing situation earlier this year was unsustainable, if we do not get more funding for staff and services immediately, I think it is more likely the service will collapse this winter. We only got through the first wave on the goodwill of staff, how much more can they be expected to give?'*

PPE (11%)

- *'Safety of our staff and availability of PPE'*
- *'Most patients and staff have symptoms of COVID but unable to get tested. No access to testing so staff have to isolate until the symptoms are eased'*

Improvement of communication with other healthcare professionals (6%)

How have community pharmacy staff coped?

95% of community pharmacies told us that their staffing levels had been affected, the majority reporting that the impact had been significant, with reports of loosing 'up to 50% of staff on the counter' in the first wave.

- *'It was hard to maintain optimum staff levels due to the self-isolating conditions that several members needed to undertake to decrease risk and therefore causing pressure on the pharmacy to complete normal tasks on top of the additional GP workload'.*
- *'Staff had to self-isolate; our workload literally doubled. The remaining staff were left under intolerable pressure; some then went off with stress'*
- *'Staff were isolating due to family members having suspected covid but not able to get a test, early in the pandemic'.*

30% of community pharmacies told us how staff had been flexible and they had got through the first wave 'on the efforts and goodwill of staff'.

- *'Staff had to work extended hours and without breaks on occasions'*
- *'Other staff came in on days they were not rostered to work (for free) to keep on top of the work'*
- *'Last minute notification of requirements to cover bank holidays was unacceptable given staff had foregone time off and worked longer hours in order to meet demands. Employer has had to foot the bill to fund overtime pay and make up hours owing which the NHS providers do not seem to appreciate other than with hot air and rhetoric.'*

What do staff need now?

73% of community pharmacies felt that what staff needed most was recognition from fellow NHS professionals and for the public to be made more aware of the work they do.

- *'They need a pay rise to recognise the efforts they made but there is no money in the contractors pot'*
- *'Staff are totally exhausted, and morale is on the floor because of the way we were treated'*
- *'Public are increasingly demanding and aggressive; we are not getting any support to deal with this. Often we are responding to problems that have not been created at our end, but nobody else will see patients or answer the phone'.*
- *'They are currently feeling under protected (compared to Surgery staff) and undervalued'.*
- *'Support with patient expectations; with the surgeries closed the pharmacies are busier than ever and some patients expect that if the surgery have issued a prescription 10 minutes ago it will be ready for collection at the pharmacy already dispensed. There are no allowances made for time for the pharmacy to dispense and complete the prescription.'*

There were two equally clear secondary needs that pharmacies felt their staff now needed.

- Mental health support (22%) as they dealt with the impact of the first wave.
- Access to PPE (22%) and 'more signage and display to control patients' safety and movements within the pharmacy'.

Innovation and changes in working practice

67% of pharmacies told us that they had made physical changes to their premises and how the public can access them in a covid secure way.

- *'We had to check body temperature of patients coming into the pharmacy. An automatic monitoring station by the entrance would help but needs to be funded'*
- *'Information leaflets were distributed as the pandemic developed. Electronic screens would have helped to give continuous information whilst patients were waiting to be served in a queue'*
- *'Closing the door and only allowing a certain number of people at a time'*
- *'Call and collect; patients can park in the car park and call and we bring out their prescription to them saving them being exposed in store'*
- *'Drive through INR clinics' (INR stands for International Normalized Ratio, a test result from the prothrombin time test monitoring people on warfarin or other blood thinning medication.)*

Some pharmacies (22%) mentioned that they had used social media and other digital apps to help disseminate information to the public and continue delivering their services.

- *'Increased use of social media especially local community pages to give out information about opening hours etc'*
- *'Greater use of App prescription ordering platforms'*

Innovation and changes in working practice

Impact of changes on workload

95% of community pharmacies told us that their workload has changed as a result of the pandemic. 50% told us that the profile of the work they undertake has changed and demand has increased:

- *'The profile of work has changed and a greater burden of compliance and handling of prescriptions.'*
- *'Increased significantly due to more clinical advice (positive) supporting patients mentally, however the prescription queries and delivery service has been a negative increase in workload'*
- *'Queries/problems with scripts increased massively. Spent more time dealing with queries than anything else'.*
- *'Signposting/counselling/reassuring patients greatly increased'*
- *'A greater number of consultations around minor ailments where the patient would normally have seen the GP'*
- *'Workload has been very unpredictable. We have gone from an unprecedented workload to virtually nothing some days and then very busy again. It is very difficult to plan ahead'*
- *'We will need to deal with more queries and counselling opportunities. With current staffing levels this will not be possible to sustain'*

33% told us that some areas of demand on their service had decreased due to the impact of reduced customer numbers.

- *'It was very busy the first month of lockdown but now because the surgery is still not seeing walk in patients, our walk in business has more or less dried up'.*
- *'Services related to travel are not in demand any longer'.*
- *'Business was lost to online pharmacies primarily Pharmacy2u'*
- *'Our counter sales have reduced markedly after the first 6 weeks of lock down and have not returned to normal, but the extra time available is being used with managing patient flow and extra cleaning'*

Innovation and changes in working practice

Impact of changes in primary care and GP working practice

In addition to their own changes, pharmacies told us about their experience of working with GPs and primary care services during this time, with 78% reporting that communication and working with GP surgeries had been difficult and slow.

- *'Access to GPs has been much more difficult. We have borne the brunt of the fall out'*
- *'Telephone contact with GPs is time consuming and sometimes impossible'*
- *'A small number of surgeries have a direct number for pharmacists to use which is very helpful. For others we have to join a queue system or other to try to sort out issues. Would be very helpful for our workload and time if all surgeries had a direct number for pharmacists to use.'*
- *'Found that surgeries were telling patients not to come to us as we were a supermarket with long queues to get in, when in fact pharmacy patients were let in immediately by security.'*
- *'It's been very poor, still not functioning as normal. Today a patient arrived for an appointment at the GP surgery an hour early. He was not allowed to wait in the surgery , so asked if he could wait in the pharmacy. We allowed him to wait as it was a very windy day and he was elderly'*

We also heard that:

- *'ETP (electronic transfer of prescriptions service) was slower than usual prior to the pandemic'*
- *'Dental prescription service was very cumbersome and inefficient and for the level of payment was not viable. Had to spend considerable time to resolve issues when patients came in for their medication. We then had to chase up the original prescriptions in the post.'*
- *'More use of EPS (electronic prescription service) has been easier'.*

Are community pharmacies concerned about particular groups within the community?

73% of community pharmacies felt that they were able to identify parts of the community that they felt were in need of greater support.

The most frequently mentioned group were the elderly. The need to consider people, particularly the 'older population who are not good at, or able to use, technology for remote appointments' or people without access to computers was mentioned by a number of community pharmacies

- *'The increased reliance on online services and information has isolated many elderly people who do not have a computer'*
- *'It's all very well for Matt Hancock to say every GP consultation should be remote. I can tell you it doesn't work for people who are frightened, elderly, don't have a smart phone or PC and don't use the internet. These people are being treated like second class citizens'*

Other groups within the wider community that were mentioned were:

- Children
- *'Shielded and vulnerable groups who are still reluctant to go out of their homes'.*
- *'Mental health patients who had no access to services and were left alone, vulnerable and scared'.*

What have we recommended?

The nature of public feedback Healthwatch heard during the early stages of the pandemic triangulates with issues that community pharmacies have told us they experienced.

Addressing the issues around prescriptions and medication in preparation for lockdown restrictions on patients should be a priority.

However, due to the role and function of community pharmacies, many of the issues we have highlighted in this report require a system wide approach to improvements.

Our recommendation is therefore to facilitate a multi stakeholder discussion of the report and its findings with the aim of:

- Building on the work that is already underway to address the challenges and difficulties experienced in the first wave.
- Increasing awareness of the interdependences and impacts of working practice between different contact points of community pharmacies and other NHS services to encourage collaborative action plans to address issues.

Issue to be discussed will include:

- Exploration of further adoption of electronic Repeat Dispensing across more GP surgeries.
- Mechanisms to acknowledge the work of community pharmacies and address the reported low morale.
- Ensure robust communication systems are in place to enable efficient information sharing with community pharmacies

Acknowledgements

We would like to acknowledge all the dedication and hard work undertaken by staff working within community pharmacies to support the public across Kent and Medway during this pandemic.

We would like to give our thanks to all those that took the time to talk to us and contributed to this report:

- **A E Hobbs Ltd**
- **Asda Pharmacy**
- **Boots**
- **Delmergate Limited**
- **Graham Phillips Newington Pharmacy/Pierremont Pharmacy**
- **Lloyds Pharmacy**
- **M.D.Moore**
- **Paydens**
- **Pender Pharmacy**
- **Spires Pharmacy**
- **Williams Chemist**

And others who didn't wish to have their name shared.

Thank You

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Item 5: Covid-19 response and winter preparedness 2020-21

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 24 November 2020

Subject: Covid-19 response and winter planning 2020-21

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

It provides background information which may prove useful to Members.

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1) Introduction

a) The Committee has received updates on the local response to covid-19 at its two previous meetings (22 July 2020 and 17 September 2020).

b) Members have been particularly keen to understand the impact of the pandemic on the waiting lists for services that were stopped during the height of the first wave.

c) At the last meeting, the Committee asked for backlog figures for mammograms as well as an indication of when that backlog would be cleared. This service is commissioned by NHS England who have provided the attached update:

- **Update on the English National Breast Screening Programme in Kent and Medway**

d) The CCG has been asked to provide an overview of local preparations for the 2020-21 winter period. The CCG has provided the attached papers:

- **System Winter and Escalation Planning 2020-21** (provides the committee with an understanding of how the NHS across Kent and Medway has worked to plan for this winter in the context of winter pressures, Covid and Euro exit planning)

- **Capital Resource Allocation during Covid** (setting out the resources that have been made available to the Kent and Medway system as part of the response to Covid including resources that will support winter management)

e) The Kent and Medway CCG will be in attendance at today's meeting to run through their reports, provide a verbal update on the local response to covid-19 and answer questions from the committee.

2) Recommendation

RECOMMENDED that the Committee consider and note the report.

Background Documents

Kent County Council (2020) *'Health Overview and Scrutiny Committee (22/07/20)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8496&Ver=4

Kent County Council (2020) *'Health Overview and Scrutiny Committee (17/09/20)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8497&Ver=4

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Update on the English National Breast Screening Programme in Kent and Medway,

David Selling Head of Public Health

NHS England and NHS Improvement - South East Region

5 November 2020

Breast screening is undertaken every three years for women aged 50 to 71 and mainly operates from eight mobile screening units (vans) which move around Kent and Medway. Screening is also carried out at Medway Maritime Hospital (which also covers the Dartford area), the Kent and Canterbury Hospital and Maidstone Hospital.

Services were operating routinely until March 2020 when the NHS was asked to conduct routine and diagnostic appointments remotely, where possible, to protect both staff and patients. Breast screening involves direct contact with women and cannot be conducted remotely, so a decision was taken to pause until patients could be seen in a COVID secure way with the exception of high risk women who continued to be screened at our hospital sites.

The changes involved refurbishing mobile units and adjusting appointment times to accommodate social distancing and increased cleaning. Prior to COVID we had around 2,000 appointment slots a week where women could be screened. The COVID secure changes mean appointment slots are currently reduced to 1,300 a week. In addition, as a result of the pause, there has been an increase in the numbers of women waiting to be called for the first time and in those due to be recalled for follow-up appointments.

We are working hard to reduce the number of women waiting for appointments and expect this to happen by May 2021 in Canterbury, June 2021 in Medway and with further intensive work required in Maidstone.

Screening for those re-scheduled during lockdown restarted at all three hospital sites by the end of July 2020 in line with advice in our national Phase three letter to restart all cancer screening programmes. From mid-August six of the eight vans came back into operation following refurbishment. A further refurbished mobile unit will come back on stream on Monday 9 November and a new replacement van for Medway will be operational from January. The service at Medway Hospital has also been expanded.

In addition, women are now asked to make contact to book an appointment rather than being given a fixed time. This increases the numbers attending, reduces the risk of missed appointments and maximises the capacity we have available – with 97% of women who have booked attending their appointment.

Patient safety remains our priority whilst at the same time exploring ways, working with Cancer Alliances, Clinical Directors, regional and national teams to seek innovative solutions to provide high quality cancer screening services that can meet future demands while the NHS responds to further surges of Covid.

The restoration of NHS screening services is a priority for NHS England. We will continue to monitor attendance and uptake of services and use interventions to ensure a maximum number of women are seen.

To encourage attendance for cancer screening the NHS ran a campaign in May. A further publicity campaign, 'Help Us Help You', was launched nationally and regionally to run throughout November to again encourage patients to seek help if they have concerns and build confidence in the safety of NHS services.

With the dynamic way in which we are working, the number of patients we are able to see and the number who are waiting does frequently change and so it is not possible to give an exact number until data has been verified and published by NHS Digital. We will gladly return to discuss progress with members at a future meeting.

Transforming health and social care in Kent and Medway

System Winter and Escalation Planning 2020-21 (winter planning)

Kent Health Overview & Scrutiny Committee

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

Overview and Aims for Winter 2020-2021

A. The Kent and Medway Winter Operating Model is an operational document to articulate the whole system, multi-agency surge management and escalation plans for the Kent and Medway system during the winter period, specifically Monday 2nd December to Monday 5th April.

B. This winter will be unlike any other as we face the challenges of normal winter pressures, Covid-19 and Euro-Exit. NHSE/I have been clear in their expectations, which we share, that as much as possible we should avoid any suspensions of service (including elective care), keeping the range of services provided by the NHS open for the public. The degree to which we achieve this through this unique winter will be affected to a great degree by our arrangements for mutual aid across Kent and Medway.

C. In this context the Winter Operating Model must be a dynamic, shared model which seeks to:

   a. Harmonise planning, reporting and performance management across the Kent & Medway health system

   b. Align escalation (and de-escalation) triggers and processes across the system, built around the OPEL framework

   c. Empower local winter plans around the 4 acute Trusts (through the 4 Local A&E Delivery Boards) to ensure local collaborative work and mutual support, whilst ensuring these local arrangements are consistent with the Kent & Medway model

This paper outlines key elements of the Winter Operating Model and the Operating Model established across the system. Attached as Appendix A is a paper outlining the Capital Resource Allocation during the Covid-19 pandemic, some of which addresses winter management.

Winter plan summary

Kent & Medway Key Points

- K&M Winter Operating Model supported by 4 LAEDB Winter Plans and other plans
- 111 First and DAB rollout out pre-winter
- Increased Adult Critical Care capacity
- Maintenance of community capacity and no patients waiting for discharge overnight.
- Virtual Seacole model for post Covid rehab, resourced and monitored
- Support for care homes increased with aligned GPs for each
- Flu Vaccination campaign
- Primary care – seven day access
- Single Point of Access for mental health extended to 10pm Monday to Friday
- Mental health suite at DVH
- Five MIUs/WICs upgraded to Urgent Treatment Centres
- Ambulance handover plans agreed and used, Secamb Divert policy in place
- K&M wide Discharge to Assess and Trusted Assessor process in place
- Increased UTC and ED physical capacity
- EU-Transition plan in place

Projected Impacts

- 8% net reduction in ED attendances against 19/20 baseline
- 10% net increase in UTC attendances
- Maintenance of >21 and >14 day patient numbers through winter
- Maintenance of elective activity through the winter
- Flu vaccinations delivered to 100% of staff and 75% of designated population
- Maintain K&M aggregate ED performance >90%

Funding to support the NHS this winter

In previous years the NHS has been provided with designated **winter funding** but in 2020/21 and in the context of the Covid-19 pandemic, there is a revised financial framework for the NHS. Some key elements of this are identified below, which include sources of funding available to STPs that can support a range of work relevant to winter and to the maintenance of the full range of NHS services.

1. There is now no specific RESTART funding stream that can be deployed to support priority schemes
2. The Elective Incentive Scheme is available to support increases in activity over baseline. There is an accompanying risk should providers/K&M system deliver below the baseline level. Whilst it is more likely that the EIS is a cost to the system, if we do deliver over last years activity only 75% of tariff will be available to cover costs. The baseline and process for calculation and levy of fines/incentives is still to be resolved
3. The Hospital Discharge Programme is available to support programmes that meet the criteria set out in the Hospital Discharge Policy (21st August 2020).
4. COVID funds will now be constrained to within notified limits within the CCG allocation, but to be deployed on a system wide basis
5. Any other priority investments must be funded from within baseline resources – either from the CCG envelope, additional SDF allocations or the block allocations available to providers. Progressing schemes in this way may necessitate curtailing investment in other areas.

Appendix A describes the Capital Resource Allocation for Kent & Medway some of which also supports our management of winter.

Escalation Protocol and Mutual Aid

- Partners across the NHS have agreed triggers (based on the OPEL framework) for escalations in the event that a hospital or Trust faces excessive activity pressure (or pressures caused by other factors such as workforce issues).
- Acute Trusts, working with their local partners in the 4 ICP areas, will seek to maximise mitigations through local support and the use of Independent Sector provision before escalating to seek mutual aid (support from another K&M Trust). Mutual aid can support non-elective care or elective care or both.
- Only once the above measures have been exhausted will Trusts consider applying to temporarily suspend any services. Any such suspensions would have to be agreed by the Regional team of NHSE/I.

Flu Vaccination

A major flu campaign has been undertaken this year with so far better outcomes than in previous years.

- The staff uptake this year is between 40% and 60% across all of our NHS Providers, better than at this point in previous years (details will be available by the beginning of December)

- As at 25th October, for patient aged 65 and over, uptake across the Kent & Medway system delivered by GP Practices is much better than in previous years at this stage:

Integrated Care System	PCNs Uptake
East Kent ICP	60.80%
West Kent ICP	61.60%
Medway Swale ICP	54.70%
DGS ICP	56.30%

Care Homes

Plans

- Continue with EOL support in OOH service
- SECAmb to fully adopt use of MIG to access care plans
- Review frailty and specialist resource
- Use of digital platform to support access tp specialist review /OPD alternative
- Review response team required to manage outbreaks

Planned Outcomes

- Reduced conveyances to secondary care
- Increase number of EOL within own home
- Reduced impact of outbreaks

111 First

Plans

- Mobilise new 111 service and new CAS
- Revise DOS and agree protocols in line with 111 First principles
- Ensure interoperability is established with receiving services
- Go live with 111 First once the system is assured by Region
- Undertake patient engagement
- Implement communication strategy

Planned Outcomes

- 20% of unheralded ED patients to be manged through 111First
- Reduction of 10% in ED attendances
- Improved social distancing in EDs and UTCs
- Correct care setting based on patients' needs

Mental Health

Plans

- DVH - An upgrade of the mental health assessment room
- Mental Health Safe Havens have gone live, face to face. Four sites to ensure geographical coverage.
- MH Single Point of Access extended from 6m to 10pm Monday to Friday
- Discharge to Assess for Pathways 1 and 3 to be rolled out across K&M

Planned Outcomes

- To ensure that observation and safety is inline with Core 24 and social distancing requirements.
- All NHS staff can access enhanced psychological support
- 24/7 crisis support
- 7 day community services offering support by phone, SMS or video

Workforce

Plans

- Recruitment, development and retention of staff within Kent & Medway
- Mutual aid plan
- BAME risk assessments
- Consolidate services where able to maximise use of resource
- Develop shared competencies
- Review and possible enhancement of mental health support arrangements for front line NHS staff

Planned Outcomes

- Develop a system that is able to utilise staff to support resilient system

Dartford and Gravesham ICP Specific Plans

Plans

- To establish a unit at DVH able to treat the population's surgical ED patients similar to medical ED patients within the AEC framework, part of SDEC.
- Major Emergency Floor reconfiguration to meet demands of a 'covid winter'.
- Support Care Home relationships
- Medically Fit calls to continue every day to review patients for discharge including weekends
- GP out of hours streaming at front door
- Littlestone & Ellenor additional bed capacity
- Ellenor Care Home Support Team –extension
- Extend Virgincare - MDT Co-ordinators, Rapid Response service (therapy) and Community Geriatrician
- DGS Health - Primary Care Home Visiting Service to be extended
- DGS Health – Wound care to be extended

Planned Outcomes

- Home first to keep residents and patients safe and healthy at home, care homes and support
- Flu vaccination programme – work with primary care and Virgin Care for Housebound
- Safe care
- Reduction in ED attendances
- Maintenance of social distancing in all provider areas
- 14+ and 21+ stays minimised and DH discharge policy principles met
- Ability to respond to peak surge periods
- ED performance maintained >90%
- Ambulance HO delays minimised
- No corridor care
- No 12 hour breaches
- No EU-T disruption

East Kent ICP Specific Plans

Plans

- Investment into community UTC sites
- Predictive analysis and jt demand and capacity planning across system
- Review discharge pathways capacity and align to need; maximise Home First
- Finalise the delivery of Think111 First for 1st December 2020
- Review ED staffing to align to peak times of activity
- Increase Social care capacity to meet 2.5% uplift in demand
- Reduction in Respiratory admissions and LOS
- Reduction in rehabilitation LOS for Stroke and #NOF
- Implement assessment unit use against criteria
- Increase support to care homes
- Maximise acute and community frailty pathways and open FAUs on both acute sites
- Maintain > 21 days at no more than 60
- Capital investment into QE and QHH Eds
- Capital investment/refurb of respiratory wards on QE and WHH sites
- review hot floor flow on acute sites into 3 discreet areas

Planned Outcomes

- Safe care
- 30% overall capacity of UTC increase
- Maximise Home First Pathway diverting capacity from unsuitable bed placements
- Ability to respond to peak surge periods ie Mondays and late afternoons maintaining flow
- Reduction in LOS
- Reduction in number of super stranded
- Reduction in ED attendances
- Maintenance of social distancing in all provider areas
- 14+ and 21+ stays minimised and DH discharge policy principles met
- Ability to respond to peak surge periods
- ED performance maintained >90%
- Ambulance HO delays minimised
- No corridor care
- No 12 hour breaches
- No EU-T disruption

Medway and Swale ICP Specific Plans

Plans

- Reviewing the system OPEL status to improve system recovery time
- Redefine the senior lead escalation calls.
- Agree actions and triggers that will enable earlier escalation and support swifter system recovery
- Agreeing extraordinary actions & mutual aid arrangements
- Use of SHREWD for escalation
- Embed phase 1 Think 111 First & implement phase 2
- ED Phase 3 build
- Expand SDEC
- Revised site management
- Proactive management of medically optimised patients and transfers of care
- Increase in community / social care capacity
- Swale rapid response redesign
- Trusted assessor
- Increase in home from hospital support
- Launch the Frailty Unit within MFT
- Sustaining the system MFFD/IDS model
- Increase flow to SDEC, Swale MIU and MedOCC
- Active monitoring of use of alternative pathways
- Ensuring senior clinical oversight in ED
- Continued focus on DToCs and MMFD
- Communication and escalation review.

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Planned Outcomes

- Safe care
- Reduction in ED attendances
- Maintenance of social distancing in all provider areas
- 14+ and 21+ stays minimised and DH discharge policy principles met
- Ability to respond to peak surge periods
- ED performance maintained >90%
- Ambulance HO delays minimised
- No corridor care
- No 12 hour breaches
- No EU-T disruption
- Patients streamed to the most appropriate urgent care service
- Improved utilisation of acute and community services

West Kent ICP Specific Plans

Plans

- Joint MTW and west Kent KCHFT demand and capacity planning
- From October, two UTCs at the front door of the local EDs at Maidstone and Pembury sites
- Sevenoaks MIU transition to UTC, whilst maintaining Covid-19 compliancy requirements.
- Capital for UTC appointments booking system
- Direct booking from 111 into UTC, SDEC and ED
- Direct booking from 111 to Community Urgent Care services, including Home Treatment and Rapid Response services
- Further strengthening of the Home First Programme, including social care
- Increased space for AFU Hot Clinic at MGH, IT Equipment including Medic Spot for Triage at both sites
- Staffing to meet 7 day working, including Therapies
- Opening a winter escalation ward
- Improvements to oxygen infrastructure pipework

Planned Outcomes

- Further improved or maintain current good ED performance
- Improved integration and collaboration of services
- A safe and quality urgent care offering in west Kent
- Increase in the numbers of patients treated at home or closer to home
- Further reduction of ambulance conveyances and handover delays
- Reducing delays to treatment by patients seeing right person first time
- Increased proportion of patients who are placed on planned ambulatory care pathways
- Decreased overall length of stay for patients who have had an emergency admission
- Reduction in ED attendances
- Maintenance of social distancing in all provider areas
- 14+ and 21+ stays minimised and DH discharge policy principles met
- Ability to respond to peak surge periods
- No corridor care
- No 12 hour breaches
- No EU-T disruption

EU Transition Plans

Plans

- Shared operational readiness structure and multi-agency planning at local, regional and national level
- Exercise strategy (Lundy) and Bi-national planning
- System and operational plans developed, linked to joint risk and threat assessment
- National assurance on supply chain
- Impact modelling

Planned Outcomes

- Reduced adverse impact on health and care system, workforce and patient care
- Reduced adverse impact on availability of critical supplies (both from within EU and deliveries from elsewhere in UK in to Kent)

OPERATIONAL MODEL

Surge and Escalation Framework - Roles

Winter and surge

Winter Director

- Responsible for planning and implementation of the winter operational response
- Attends all LADBs
- Not responsible for day to day operational direction / or non-surge related issues pertaining to Covid or EU-Exit

Operational Commander

- Responsible for overseeing and directing the LHEs and service team response on a day-to-day basis
- Co-ordination of all winter/surge and seasonal flu related reporting

ICP Facing Commissioning Teams & LADBs

- All queries and performance challenges relating to winter pressures, surge, seasonal flu, weather or routine Covid response
- Coordination with ICP providers

COVID and EU Exit incidents

Strategic Commander

- Responsible for Covid and EU-Exit planning and implementation and leadership of other unplanned incidents
- Not responsible for winter operational response or surge

Incident Commander

- Responsible for managing unplanned issues that require the CCG major incident plan or business continuity plan to be invoked; as well as responding to multi-agency issues through TCG and SCG

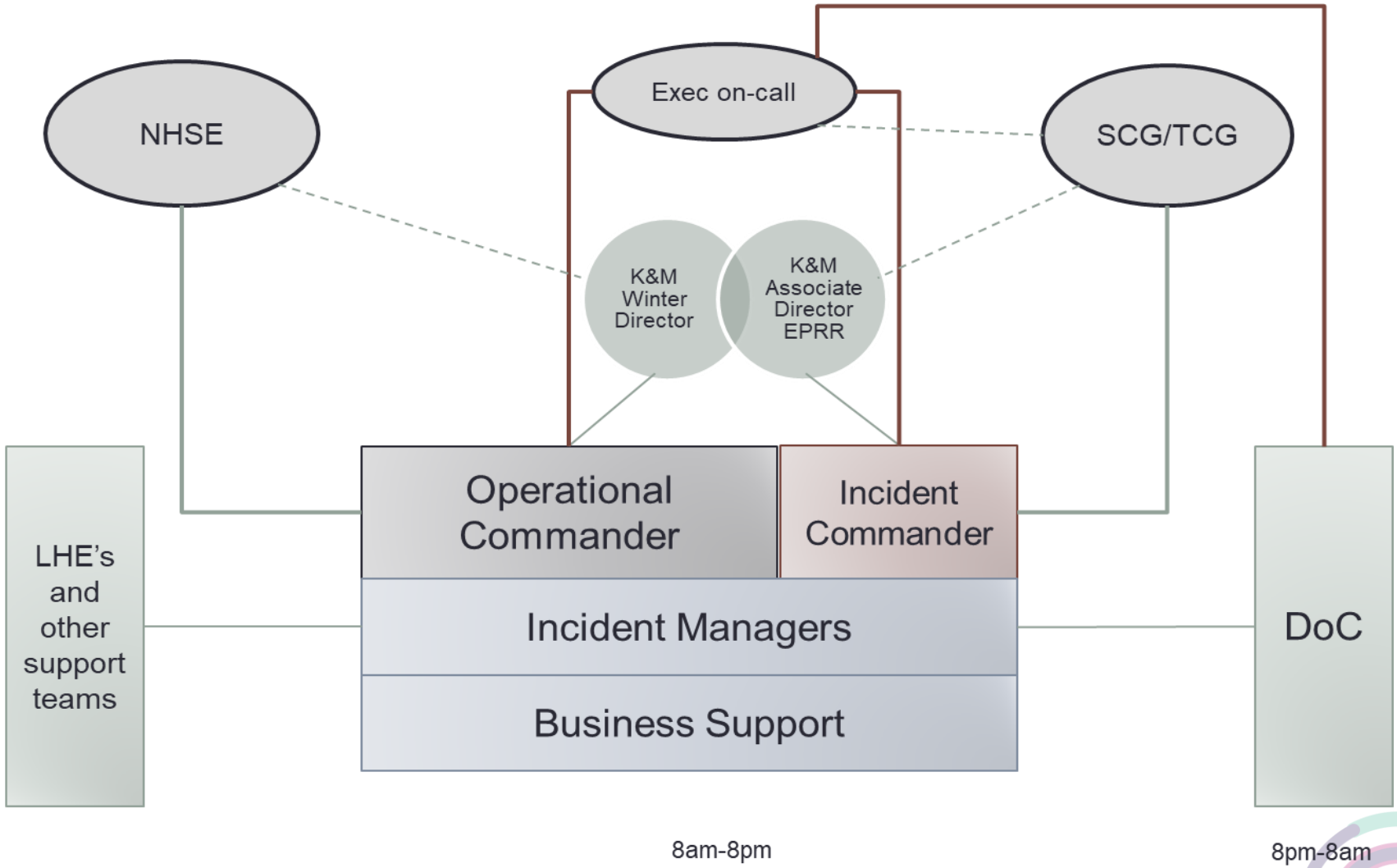
Incident Managers

- Provide central co-ordination, support and reporting for Covid, EU Exit and any other incidents

Operational Control Centre

- Oversees both the planned winter/surge programme and any incident response
- Jointly led by an Operational Commander and an Incident Commander

Operating Model



TITLE: Capital Resource Allocation during COVID

COVID Phase 3 response

2020/21 will continue to be a challenging year for the Kent and Medway STP/ICS system. Phase 3 plans for September to March 2021 build upon actual performance from April to August 2020, utilising current capacity that has been significantly impacted by the Covid-19 pandemic. It also reflects the improvement in performance for the period September to March 2021 that is considered deliverable both within the current financial framework and includes a number of bridging schemes which will require **additional revenue and capital investment.**

The system has placed significant emphasis on safely reconfiguring current resources to increase capacity and productivity to aim to meet the updated NHS priorities and increased performance standards outlined by NHSE/I in July for the rest of 2020/21. The focus for clinical services has been to identify and lead the implementation of changes to current clinical capacity to safely treat those patients whose treatment timelines have been affected by the pandemic and to meet the now increasing emergency demand.

There is recognition by the system that deliverable and affordable expansion in clinical capacity is required in some clinical services in order to achieve the required performance improvements and to support sustainable services into the future, incorporating a collaborative system focus on the integrated care agenda.

Capital restart

During June/July, those involved within the Restart workstreams undertook an exercise to identify the potential **CAPITAL** schemes that could be progressed in order to achieve progress in Kent & Medway toward the following national objectives:

- 50% increase in adult critical care beds from Q4 2019/20 numbers
- An increase in theatre capacity to improve throughput
- £500m increase in diagnostic capital investment (for equipment and associated infrastructure)
- Increase in A&E and same day emergency care capacity

It is important to highlight at this stage, there is no national process whereby the Kent & Medway system may access revenue resources associated with the specific consequences of capital schemes. These costs must be managed within the financial framework provided by NHSE to the CCG and providers during the remainder of 2020/21, and beyond.

Thereafter, NHSE/I has invited the K&M system to put forward its prioritised requirement against some of these priorities, as and when national funds were identified to be deployed. Thus far, the programmes that have been taken forward through the provision of capital funds from NHSE/I are A&E and Diagnostics. East Kent Hospitals University Foundation Trust (EKHUFT) has also been the recipient of targeted capital funds from NHSE/I, and therefore capital scheme proposals have been secured through this route

Additionally, the K&M system has identified funds to invest in priority schemes through the identification and release of funds where slippage has occurred against other capital schemes. This has enabled significant investment in schemes aimed at increasing critical care capacity.

The position for each of the key priority areas at this stage are as follows. It is important to note that these reflect additional funding sources that have been made available during the year, and are in addition to the base Capital Resource Limit available to all NHS providers in 2020/21.

A&E

The K&M system has received confirmation of £15.5m of capital relating to A&E schemes. These reflect many of the original prioritised capital schemes together with targeted resources relating to the first phase of investment in expanding A&E capacity at QEQM and William Harvey hospitals in East Kent. A further £23m is available for the second phase of this expansion in 2021/22. The table below, identifies the range of expected capital investments towards strengthening the resilience of urgent care services.

Row Labels	Sum of 2020/21 (£'000)
DARTFORD AND GRAVESHAM NHS TRUST	**2,553**
Darent Valley Hospital	**2,553**
Mental Health assessment in ED	200
Surgical Assessment Unit	150
ED floor	2,203
East Kent Hospitals University NHS Foundation Trust	**7,000**
Queen Elizabeth The Queen Mother Hospital	**4,000**
A&E Expansion	4,000
William Harvey Hospital	**3,000**
A&E Expansion	3,000
Kent & Medway System	**750**
(blank)	**250**
Primary Care - Urgent and Emergency Care (hosted by EKHUFT)	250
Various	**500**
Think 111 First (hosted at MTW)	500
KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	**1,500**
Sevenoaks Deal & Folkestone	**1,500**
Urgent Treatment Centres	1,500
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	**2,817**
MGH and TWH	**2,817**
1. ED Performance2. Paediatric A&E3. UTC4. 7 Day Services5. Winter planning	2,817
MEDWAY NHS FOUNDATION TRUST	**857**
Medway Hospital	**857**
ED final phase works to speed up work programme from 5 day to 7 day working.	250
Childrens Emergency Department.	309
IT Enhancements to the ED system.	34
The provision of End-User Devices.	64
Direct Access Booking dashboards.	50
Replacement of all PC's in ED.	70
Electronic order communications.	80
Grand Total	**15,477**

This funding is for immediate and necessary changes to prevent nosocomial infection, and to improve flow through emergency departments by increasing the capacity of EDs, urgent treatment centres and same day emergency care facilities.

In addition the capital investment is supporting developments to help prevent patients being seen at A&E Departments and possibly admitted in circumstances when they could access to the right care pathways through other points of access. Primary Care sites, the new model of 111 and new Urgent Treatment Centres are key examples.

A&E Expansion at EKHUFT represents a substantial capital investment of £30m over two financial years. Design and survey works have commenced.

The 111 First capital funding has and is being used to purchase digital systems that enable direct appointment booking as part of the 111 First workstream. Mobilisation of this digital integration is well underway and it is anticipated to be completed by the end of November 2020

Diagnostics

The K&M system has received an indicative allocation of £4.3m of capital relating to Diagnostic schemes. Members of the system will be looking to respond quickly to the emergence of any further announcements of capital funding taking place on a national or regional basis.

Row Labels	Sum of 2020/21 (£'000)
DARTFORD AND GRAVESHAM NHS TRUST	**1,978**
Endoscopy recovery capacity	1,500
CT scanner at QMH. Funding for 'base scanner' – essential extras and estates works Trust has to fund.	478
East Kent Hospitals University NHS Foundation Trust	**2,049**
Mammography	1,161
EKHUFT Diagnostics Pathways & Increased Capacity (Mobile x-ray/Ultrasound machines)	600
Pathology Testing equipment to improve turnaround times (TAT)	288
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	**1,980**
Endoscopy	1,700
Radiology working at home	280
MEDWAY NHS FOUNDATION TRUST	**1,673**
Lung function room	500
Diagnostic Equipment - Breast Screening	1,173
Grand Total	**7,680**

The expected impact of capital investment in Endoscopy equipment is to increase capacity in North and West Kent to clear waiting list backlogs by March 2021 and support future service provision delivered as part of a community diagnostic hub. The purchase of additional scopes and the commissioning of a modular Endoscopy build at Dartford & Gravesham NHS Trust will deliver up to an additional 168 endoscopy (treatment) units per week (subject to confirmation). Options are currently being worked up to consider how a modular unit can be optimised to offer maximum benefit to all parts of the system, with an expectation that the preferred option will be in place by March 2021.

EKHUFT have a significant backlog and rising demand in MSK and cancer referrals, and are in the process of securing funding with a view to increasing capacity. There is a particular focus on x ray mobile to support the fracture clinic and Ultrasound mobiles.

EKHUFT are currently experiencing issues with MRI backlogs and are in the process of planning for additional capacity through an upgraded MRI scanner at QEQM hospital. K&M have recently seen the impact of fully staffed CT mobile scanners have made at DGT and MTW, who are currently able to see an additional 30 patients a day which has dramatically impacted on the CT backlog. K&M continue to have Non Obstetric Ultrasound & MRI backlogs.

Critical Care

The K&M system has received substantial funds to support investment in critical care at EKHUFT, and in addition, the system has managed to identify internal resources to invest in capital at MTW and DGT – a grand total of £23.3m.

Row Labels	Sum of 2020/21 (£'000)
DARTFORD AND GRAVESHAM NHS TRUST	**4,450**
Darent Valley Hospital	**4,450**
Upgrade of ITU equipment and facilitate potential suge capacity requirement	1,150
Decant ward facility to facilitate longer term increase in bed capacity (2 year scheme)	3,300
East Kent Hospitals University NHS Foundation Trust	**16,793**
William Harvey Hospital	**16,793**
24 beds ITU	14,000
8 bed COVID ITU	1,481
24 beds ITU - clinical equipment	1,312
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	**2,000**
(blank)	**2,000**
Critical Care reconfiguration	2,000
Grand Total	**23,243**

Overall, through a range of funding mechanisms including this capital, the Kent & Medway system is aiming to increase the number of ventilated critical care beds by 84, a 108% increase.

These increases in capacity are vital to enable Trusts to keep Covid-19 patients separate from other patients, to be as well-equipped as possible to manage the projected increase in Covid-19 patients and to maintain as much as possible the full range of other health care services for other patients, including elective surgery.

Theatres

The following items have been made available to EKHUFT in order to facilitate the restart of planned care services in the area.

Row Labels	Sum of 2020/21 (£'000)
East Kent Hospitals University NHS Foundation Trust	**537**
William Harvey Hospital	**537**
Closed circuit smoke evacuation system to enable restart of Lapryoscopic surgery	208
Nasoendoscopies to restart the ENT service	329
Grand Total	**537**

Investment in the closed circuit smoke evacuation system have been of benefit in restarting colorectal and general surgery services, and will enable key hole surgery to be undertaken without patients having to have major open cancer surgery (laparoscopic cholecystectomy as an example).

Due to Covid-19 infection prevention and control requirements for Aerosol Generating Procedures (AGP), ENT services at EKHUFT and across the country had to cease the use of fibre scopes and rigid telescopes for staff safety reasons. The provision of funding for new equipment allows the department to use video technology, rather than fibre-optic technology, to assess patients in a way that is compliant with infection prevention and control requirements. It also allows photos and videos to be stored, which will reduce the number of repeat hospital attendances and examinations, enabling remote working and improved diagnostic capabilities.

Summary

Thus far, the K&M system are working with confirmed and potential allocations of £47m, with a further £23m notified for EKHUFT in 2021/22.

It is possible that there may be further announcements of funding available for capital investment in Kent & Medway, in which case the system will be in a good place to implement schemes as appropriate. However, there is an inherent level of risk that funds may not be capable of being deployed in this financial year, if confirmation of such funds are notified at a later point in the financial year.

Notwithstanding this, the notified allocations to date already represent a considerable sum of capital investment, in addition to baseline allocations. It is important that schemes are progressed in a way that ensures that the changes to infrastructure are made on time and within budget. The system meets on a regular basis to oversee progress towards deliverables.

Item 6: South East Coast Ambulance Service – provider update

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 24 November 2020

Subject: South East Coast Ambulance Service – provider update

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by South East Coast Ambulance Service.

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1. Introduction

(a) South East Coast Ambulance Service NHS Foundation Trust (SECAmb) receive and respond to 999 calls from the public, urgent calls from healthcare professionals and receive and respond to calls to NHS 111 as well as providing the regional Hazardous Area Response Team (HART).

(b) The Care Quality Commission (CQC) published an inspection report on 13 August 2019 which rated the Trust "Good". Prior to this inspection, the Trust had been in Special Measures.

2. Previous reports to HOSC

(a) The Committee received an update from the Trust in March 2020. Key points from that discussion included:

- An operational restructure had seen the appointment of a number of new colleagues.
- The 2019 CQC rating of the Trust was "Good".
- The Trust was working hard to mobilise the new 111 Clinical Assessment Service, commencing in April 2020.
- Alternative care pathways were being worked on in order to reduce the pressure on A&E services.
- The implementation of a Clinical Education Transformation Project was underway in response to a poor Ofsted visit in 2019.
- A targeted effort was underway to improve the response time for Category 3 patients.
- A number of "new" ambulances had been introduced in areas of high demand.

(b) The South East Coast Ambulance Service (SECAmb) have been invited to attend today's HOSC meeting to update the committee on their performance.

3. Recommendation

RECOMMENDED that the Committee consider and note the report.

Background Documents

Kent County Council (2018) *'Health Overview and Scrutiny Committee (27/04/2018)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7846&Ver=4

Kent County Council (2018) *'Health Overview and Scrutiny Committee (23/11/18)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7923&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

Care Quality Commission, 13 August 2019, https://www.cqc.org.uk/location/RYD6A

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HEALTH
OVERVIEW AND SCRUTINY COMMITTEE

24 NOVEMBER 2020

SOUTH EAST COAST AMBULANCE SERVICE UPDATE

Report from: Bethan Eaton-Haskins, Executive Director of Nursing and Quality, SECAmb
Author: Ray Savage, Strategy & Partnerships Manager, SECAmb

Summary

This report updates the committee on the South East Coast Ambulance Service Foundation Trust, with a focus on key developments since the Committee was last updated in March 2020. These key areas include: Performance and Performance Recovery, Go live of NHS 111 CAS contract, Staff Wellbeing, Estate developments, the Joint Response Unit, and Winter Framework.

1. Background

1.1. Since the last update in March 2020 the Trust has been responding to the COVID-19 pandemic. However, this has not stopped the Trust continuing to progress in a number of key areas.

- The NHS 111 Contract went live on the 1st October
- NHS 111 First was launched in Medway on the 16 September 2020

1.2. The Joint Response Unit was expanded to 7 days a week across the north of Kent, following a very successful 2 days a week scheme across Medway and Swale.

1.3. The Trust's Wellbeing Hub continues to support all staff with access to a wide range of services supporting a promoting physical and emotional wellbeing.

1.4. The Trust is investing in its estate with a significant development in Gillingham to provide a modern ambulance Make Ready Centre as well as modern office facilities for both the 999 Emergency Operations Centre and the 111 Operations Centre, investment in modernising the ambulance station at Sheppey has recently finished with staff now reoccupying and responding from the station.

1.5. The Trust has developed a winter framework and is currently reviewing is EU Transition plans.

2. Performance and Performance Recovery

2.1. During 2018, the Trust announced its transformation programme to improve care for patients across Kent and Medway, Surrey, Sussex, and North East Hampshire.

2.2. This followed the independent review undertaken by Deloitte, jointly commissioned by South East Coast Ambulance Service NHSFT (SECAmb) and the CCG's. It looked specifically at the demand and capacity to deliver ambulance services and led to an initial

investment of £10m during 2018/19, with a further commitment by the CCG's to provide further investment during 2019/20 and 2020/21.

2.3. The additional investment focused on two key areas; a) the recruitment of front-line ambulance staff on the road, with the right skills and in its Emergency Operations Centres (EOCs), b) to improve its fleet, to ensure the Trust has the right number and type of vehicles available to respond to all categories of call.

2.4. As a result of the ongoing recruitment programme in the Emergency Operations Centres, the Trust has continued to make significant improvements in its call answering time for emergency calls and has continued to achieve the 5 second (mean) standard throughout 2020.

2.5. The continued recruitment of patient facing staff (ambulance personnel) is an ongoing programme.

2.6. September's call answering performance achieved 3 seconds (mean) against a national (England) average of 4 seconds. The 95th centile performance for the month was 2 seconds against a national (England) average of 16 seconds. This year, the Trust is currently one of the best performers for 999 call answering amongst ambulance services in England. Appendix A.

2.7. 999 ambulance performance has remained challenging, however, due to the pandemic 999 activity reduced and during March the Trust achieved a Category 1 performance of 07:52 minutes mean against an England performance of 08:07 minutes mean. For April the Trust achieved a Category 1 performance of 07:05 minutes against an England performance of 07:08 minutes. This was against a national performance standard of 07:00 minutes mean. Appendix A.

2.8. Category 2 performance for April, May and June was 14:50 minutes, 14:28 minutes and 16:43 minutes respectively. This was against a national performance standard of 18:00 minutes.

2.9. The Trust also experienced a reduction in its 999 activity for the months of April and May due to the pandemic, however during June activity levels increased and have now returned to the expected seasonal levels. During May the Trust was able to deploy 99% of its targeted front-line ambulance hours despite having approximately 400 staff absent from the workplace for COVID-19 related absence.

2.10. For the month of May the Trust achieved all its Ambulance Response Programme performance indicators.

2.11. Year to date performance, highlights the legacy clinical commissioning group areas of Dartford Gravesham & Swanley, Medway, and Thanet, achieving both category 1 and category 2 ARP standards.

2.12. The Trust recognises that category 3 and 4 ARP standards also remain challenged with some patients experiencing exceptionally long waits as illustrated in appendix A.

2.13. The Trust has developed a detailed 999 Performance Improvement Plan. A key focus of the plan is to maximise the resources available on the road to respond to patients. The key aspects of this plan are:

2.13.1 Managing our abstractions closely, ensuring that we can safely return as many staff as possible to the workplace.

2.13.2 Maximising support to the front-line from other areas of the Trust. It looks to gain support from all disciplines and Directorates of the Trust where clinically capable staff are asked to mobilise to support operational delivery where this will not compromise their primary role.

2.13.3 A refocus of the daily operational 08:30 call to improve productivity and efficiency.

2.12.4 Continued focus on 999 telephone triage (Hear and Treat) for patients who do not require a face to face response.

2.12.5 Operations working with the Wellbeing Hub team to support clinical staff who are unable to be fully operational but can provide valuable support to operations from a support role position e.g. Covid track and trace.

2.12.6 Incentivised shifts offered to maintain the required number of operational hours.

2.12.7 Working with the Private Ambulance Providers that the Trust has on its framework for continuous supply of additional ambulance hours.

2.13. The Trust's 111 service experienced unprecedented levels of activity during February and March and despite a decrease during April and May, activity during the summer months remained higher than the seasonal expected levels. This is a trend that has continued into the autumn.

2.14. 111, since August 2019 has maintained good performance for 'call abandonment' apart from February, March and April of this year when call volumes significantly exceeded predicted levels.

2.15. The 'service level' (calls answered within 60 seconds) has improved since June this year and has been aligned with the national figures.

2.16. The 111 service continues to be sensitive to pressures in the wider system.

2.17. The Trust is working closely with commissioners since the launch of the Clinical Assessment Service (CAS) and the developing NHS 111 Frist programme.

3. COVID-19 Response

3.1. A robust governance framework was established to support the Trust's response to the pandemic, including the establishment of the COVID Response Management Group (CRMG). This was an executive led group that supported and directed the Trust's response and ensured that all COVID related decisions and actions were considered appropriately. This group was meeting 7 days a week.

3.2. This group also had the responsibility to receive the latest government advice and guidance, produce 'COVID action cards' to ensure that staff were as well informed as they could be in relation to a range of scenarios that meant they were likely to absent from work as a result of COVID e.g. a family member in an at risk group, staff in an at risk group, staff developing symptoms of COVID, a family member developing COVID symptoms etc. These action cards were regularly updated to reflect the most up to date government guidance.

3.3. This group also took on the role of monitoring the Trust's stocks of personal protective equipment (PPE) and ensuring that the latest Public Health England (PHE) guidance on the appropriate level of PPE to be worn in different clinical scenarios was communicated to all

front-line staff. If staff, following a risk assessment, decided to wear the next level up of PPE then the Trust's guidance allowed this.

3.4. During March all staff who could work from home were asked to do so, enabling the Emergency Operations Centre to commandeer the majority of the first floor at the Trust Head Quarters so that staff responsible for answering 999 calls could socially distance and still be in an supportive environment, in effect doubling the area that the EOC would normally occupy.

3.5. The EOC staff who were asked to shield at home were provided with laptops to they could continue to support their colleagues in the EOC through remote working.

3.6. As the Trust progressed through the pandemic the COVID Recovery, Learning & Improvement Group was established to ensure that experiences and learning were captured to inform and improve how the Trust conducts its business in the future.

3.7. The CRMG has become the Operational Response Management Group to provide review and decision making in the new way of working.

3.8. To support the communication of key actions and learning to all managers a 16:00 Executive led briefing took place every day and has continued to date.

3.9. From the outset and following the 16:00 call, the Trust agreed to produce, on a daily basis, a Common Operating Picture, as a means of communicating to system partners, MP's etc. the latest Trust position on activity, PPE, staffing levels etc. This has been well received by the system a key point of information regarding the Trust's response to the pandemic.

3.10. Welfare vehicles were also set up to support frontline staff. Ford UK kindly loaned the Trust 6 vehicles to provide welfare support to crews following their arrival at hospitals. This gave crews an opportunity in-between responding to emergency calls to grab a hot or cold drink and a snack. These vehicles were staffed by the Trust's Community First Responders (CFRs) who because of the pandemic were unable to respond to patients. This support service has recently come to an end with the CFRs now supporting frontline operations by responding to patients.

3.11. The Trust has recently established its Test and Trace Cell to give staff a single point of contact for the reporting and monitoring of all Covid-19 positive cases.

3.12. The Cell will also act as the single point of contact for Public Health England to advise of confirmed Covid-19 cases and be the conduit for all communication regarding any incidents or outbreaks within the Trust.

4. Mutual Aid to London Ambulance Service

4.1 In late March 2020 we received a request via the National Ambulance Coordination Centre to provide mutual aid support to our colleagues at London Ambulance Service for a two-week period, as they were under pressure at that time and needed to significantly increase the number of crews, they had available each day.

4.2 Despite the very short deadlines involved, we had many staff volunteer to be part of the mutual aid team and so were able to send a 'cell' of ten ambulances and staff to support LAS from 6 April 2020 onwards. This has now come to an end but is an excellent example of mutual aid.

5. Critical Care Transfer

5.1. The Trust agreed with commissioners to support the region in a strategic transport coordination role covering both 999 and Patient Transport Services. Patient Transport is currently provided by G4S in Kent and South-Central Ambulance Service across Surrey and Sussex during the first period of Covid pressures.

5.2. In this role the Trust would act as a conduit for escalation to the regional team.

5.3. The Trust would also provide an enhanced critical care transfer team to support the management of bed capacity.

5.4. In the event of high numbers of critical care patients requiring transferring, the Trust teamed up with the charity 'the Jumbulance Trust' to adapt a vehicle to assist with the transfer of multiple patients simultaneously.

5.5. The Jumbulance, a medically equipped coach type vehicle containing stretchers would be crewed by Critical Care Paramedics and has the capacity to transfer up to 5 stretcher patients at the same time.

6. 111 Clinical Assessment Service

On the 1st October 2020, the new enhanced NHS111 service went live across Kent, Medway and Sussex, providing patients with a more robust response from expert advice delivered by a wider range of healthcare professionals then previously.

6.1. GPs, paramedics, nurses, mental health professionals, dental nurses and pharmacists will be a part of the new enhanced NHS111 clinical assessment service (CAS).

6.2. People who call 111 – free from mobiles or landlines 24/7 – or access the service via www.111.nhs.uk will speak to Health Care Advisors or healthcare professionals who will be able to assess symptoms over the phone, issue prescriptions and directly book people into onward care appointments if they need one.

6.3. SECAmb as the lead provider, is working in conjunction with the not-for-profit social enterprise Integrated Care 24 (IC24) to deliver the enhanced service.

6.4. The new five-year contract, awarded in August 2019 by NHS commissioners across Kent, Medway, and Sussex, and is valued at £90.5m. The Trust and IC24 had previously provided NHS111 to parts of Kent and Medway, Sussex, and Surrey but will now work in a joined-up way with SECAmb providing resourcing to deliver 80% of the activity and IC24 20%.

6.5. The original go-live date of the 1st April 2020 was delayed due to the pandemic with both SECAmb and IC24's NHS111 services handling up to 4 times more daily calls than forecast.

6.6. The launch of this contract and the CAS is the first of several enhancements via the 111 service for patients across Kent and Medway, and Sussex.

6.7. NHS111 will integrate more closely with the Trust's 999 service and existing out of hours care, including providing access to evening and weekend GP appointments, home visiting

services, minor injury units, urgent treatment centres, Accident and Emergency Departments.

6.8. Stuart Jeffery as the Senior Responsible Officer for NHS111 across Kent and Medway at the time of the contract award commented “We are confident by working with the ambulance service and IC24, we will be in a good position to build the foundations for integrating urgent care across our regions……to help people receive the right care in the fright place at the right time.”

7. NHS 111 First

7.1. NHS 111 First is a national concept to reduce the undifferentiated (walk-in) patient activity that would traditionally self-present at an Accident and Emergency Department (ED). This is achieved through the patient call 111 first and receiving a telephone triage to reach an outcome disposition.

7.2. A key feature of NHS 111 First is the ability for 111 to directly book an appointment for the patient. This is called Direct Access Booking (DAB).

7.3. Medway was the first system to go live with NHS 111 First across the counties of Kent and Sussex and was ‘soft’ launched on the 16th September.

7.4. Under phase 1, appointments can be booked into ED, Urgent Treatment Centre (UTC) and Same Day Emergency Care (SDEC).

7.5. Phase 2 will expand on this appointment bookings will be enabled into community services, surgical assessment unit, gynaecology unit, paediatric unit, frailty assessment, ear nose and throat, and mental health.

7.6. All appointment bookings that are directly to ED will have had a further clinical review in the 111 CAS.

8.0. Handover Programme

8.1 In February 2018, the Trust, and commissioners, jointly established a handover steering group to specifically focus on ambulance handover delays. A programme director was appointed, and the steering group was chaired by the Chief Executive Officer of the Royal Surrey County Hospital NHS Foundation Trust.

8.2 This group has spent the last two years reviewing key areas such as the processes and procedures for crews on arrival at the hospital, patient flows through the department and crew wrap up time.

8.3 During the two years’, time lost due to handover delays has reduced and improvements made to the handover process across the Trust’s area through the sharing and adopting of best practice.

8.4 Handover delays less than 15 minutes (the NHSE standard) have improved from 44.1% during October 2019 to 51.1% October 2020. Appendix B.

8.5 Handover delays greater than 60 minutes had also improved with May, June and July having the lowest number for the 12-month period. October has seen an increase and there are ongoing reviews taking place with senior managers at the trusts most affected.

8.6 September 2020 saw Maidstone and Kent and Canterbury Hospitals with the lowest average handover times,13.97 and 14.03 minutes respectively, followed by the Queen Elizabeth the Queen Mother with 15.12 minutes and Tunbridge Wells with 15.36 minutes.

8.7 The hours lost over 30 minutes for the Trust is in currently below the level of October 2019, which has been a continuing pattern since April.

8.8 Kent's lost hours are slightly below the same period last year however they have been on an upward trend since July.

8.9 This group also initiated the live ambulance conveyance reviews which were a multidisciplinary team approach to review conveyances into emergency departments in 'real time'. A key learning forms these reviews was the identification of new community referral pathways.

8.10 As a result of this ongoing work this programme of work has developed into the pathways development programme, with an emphasis on community pathways available to ambulance crews to avoid unnecessary conveyances into the acute setting.

9.0. Live Ambulance Conveyance Review

9.1. As a part of the improving Handover Delays programme, the Trust has been carrying out live reviews across the area with the latest one in Kent being at Medway Maritime Hospital during January 2020.

9.2. During January 2020, SECAmb along with system partners, conducted a live front door review at Medway Maritime Hospital (Appendix c).

9.3. The aim of this review was to build on the actions that were already being taken to reduce the number of ambulance handover delays at the hospital and by conducting the live review it was anticipated that insight in to the increasing number of ambulance conveyances could be achieved as well as identifying gaps/opportunities in community pathways.

9.4. Key system partners involved in the review included MFT, MCH, Primary Care, CCG, and SECAmb with the objective of capturing the prehospital reasoning for the conveyance (crew assessment), the ED assessment, and the post ED outcome e.g. discharged or admitted.

9.5. The review took place on 4 days over a 7-day period, for 4 hours each time,

9.6. Each session was conducted at a different time to enable a broader range of conveyances to be captured and avoid any bias e.g. Monday mornings traditionally see a higher proportion of Primary Care referrals.

9.7. Those supporting the review, situated themselves at the entrance of ED and the UTC (2 teams) and using the agreed template, asked the conveying crews (post-handover) key questions.

9.8. The outcome of the review was that ambulance crews are making appropriate and informed conveyancing decisions based on existing appropriate and available community services. See appendix C for the full report.

10. Combined Ambulance Make Ready Centre, 999 Emergency Operations Centre and 111 Operations Centre

10.1. Following the green light from planners and in a first for the Trust, a new and exciting development at Bredgar Road, Gillingham, will comprise of a new Make Ready Centre for the Medway region, as well as the 999 and NHS 111 operations centres. The 999 Emergency Operations Centre (EOC) and NHS 111 Operations Centre will relocate from Coxheath and Ashford respectively.

10.2. Building work is expected to start early in 2021 with a view to being fully operational in 2022.

10.3. £6.52 million of Government capital will support the funding of the new building which was announced by the Secretary of State for Health during his visit to Medway in November 2018.

10.4. The Trust's Make Ready System (MRC), which is already in place across much of SECAmb's region, is a vehicle preparation system with specialist teams of staff employed to clean, restock and maintain the Trust's fleet.

10.5. Ambulance crews currently starting their shifts at Medway, Sittingbourne ambulance stations will instead, start and finish at the new MRC. They will then respond from the Trust's ambulance community response posts (ACRP) strategically located across the region with suitable rest facilities for crews between responding to emergency calls and when on a break.

10.6. Staff based on the Isle of Sheppey will continue to start and finish their shifts from the ambulance station on the island that has recently been refurbished. The major refurbishment and station upgrade have also provided new educational and training facilities.

10.7. The MRC will comprise a modern open plan 999 Emergency Operations Centre (EOC) and 111 Operations Centre. This replicates the current layout of the EOC for the West of the Trust's area, situated in Crawley.

10.8. Bringing both the 999 and 111 services together under one roof, allows greater support between the services and aids the development of the synergies between both services which is a key part of the Trust's Strategic Plan to deliver new integrated services over a wider area. In addition, having both services housed in the same building will facilitate the sharing of best practice especially as both are on the same computer system, Cleric, and use NHS Pathways as the triage tool. This is a key feature for both services as it allows the training and development of staff to undertake both 999 and 111 calls.

10.9. Also, having an integrated region-wide approach will provide clearer pathways for patients and a more efficient and resilient emergency and urgent care response service.

10.10. Medway will be the 9th MRC that the Trust has rolled out across its area delivering the key benefits of the Make Ready initiative:

- Make Ready uses specially trained operatives who regularly deep clean and restock the vehicles, minimising the risk of cross infection, freeing up front-line staff who would have traditionally been responsible for the cleaning and restocking of their ambulance for the duration of their shift, allowing them instead to spend more time focusing on the care and treatment of patients'.
- Working alongside the Make Ready operatives are the Trust's mechanics who check and carry out a wide range of mechanical repairs to the fleet to ensure that all vehicles are fully operational.

- The design of the MRC and the operational management structure enable crews to have managerial support 24 hours a day and 7 days a week.

- Should a crew either develop a mechanical fault with their vehicle or require a major restock following a period of activity, they can return to the MRC and simply swap onto a vehicle that has already been fully prepared and continue to be available to respond to emergency calls.

10.11. The centres also host the Trust's Urgent Care Hubs, staffed by Specialist Paramedics who provide clinical support to crews on scene and as a part of the design have training facilities for the training of new staff and the ongoing training of existing staff.

11. Sheppey Ambulance Station

11.1. The Trust's ambulance station on the Island of Sheppey has recently reopened following a 6-month major refurbishment project to turn the existing site into a MRC.

11.2. The improvement work at the Main Road site in Queensborough means that the developed site not only operates as a MRC but also boasts modern rest, educational and training facilities.

11.3. Both of these developments are a part of the ongoing Trust review of its estate and Brighton in East Sussex will also open a new Make Rady Centre early in 2021 and the recent planning permission received to enable the redevelopment of the legacy Trust head office in Banstead, Surrey, for a Maker Rady Centre with training facilities.

12. Joint Response Unit

12.1. The Joint Response Unit (JRU) is a combined unit of officers from the Kent Special Constabulary and paramedics from the Trust responding to incidents when both services are required.

12.2. The JRU was launched in March 2018 and until recently covered the areas of Medway and Swale for 2 days a week, however after proving to be so successful, it has been extended to run across the north Kent area with the addition of a second car.

12.3. The unit will now be operational for 7 days a week during peak times and cover the areas of Dartford, Gravesend, Medway and Swale.

12.4. Since its launch, the JRU has attended over 2,750 incidents including road traffic and medical incidents as well as assaults and mental health concerns.

12.5. Another key part of the success of the unit is the prevention of drug and alcohol-fuelled incidents from escalating into disorder, allowing the paramedics to safely treat patients.

12.6. The Care Quality Commission (CQC) highlighted, in their review, the unit as an area of outstanding practice following their inspection of SECAmb and recognised the successful reduction in calls to both the Police and SECAmb.

12.7. The vehicle used carries all the necessary medical equipment required by the paramedics as well as other equipment to support the police offices to tackle crime.

12.8. Recently a third car has been added in east Kent as a pilot for the next three months (November, December, and January), initially working on a Friday and Saturday.

13. Staff Wellbeing

13.1. The Trust continues to put staff welfare at the heart of all it does and recognises that to deliver a great service to the public, staff need to feel motivated and supported. The SECAmb Wellbeing Hub continues to offer staff a range of support options to help them both physically and emotionally.

13.2. It provides advice and guidance as well as face to face options dependant on the requirement of the staff member. It also supports managers and has in place the 'mangers support helpline'.

13.3. Some of the key areas offered by the hub are:

- Mental Wellbeing: encouraging staff to recognise that their mental health is as important as their physical health and that their needs to be balance between the work environment and the home environment. On the Trust's Intranet there are factsheets and simple tools that help staff, as well as the opportunity to have face to face support with wellbeing advocates and trained professionals.

- Stress Resilience: recognises that the way we deal and manager stress in the workplace can have a significant impact on our general wellbeing. There is guidance for both staff and managers to help recognise the signs and symptoms of stress and ways in which to get help. The also offers a free counselling service which is fully confidential.

- Chaplaincy: the chaplaincy service offers, friendship, emotional and spiritual support as well as listening ear whenever staff require it. Any member of staff can book a face to face appointment with one of the Trust's chaplains. There is also the 24-help line.

- Bereavement: practical advice and guidance on recognition of 'grieving'.

- Physical Wellbeing: via the hub there is a wide range of advice and support on some key topics such as sleeping, stop smoking, managing back pain, and physical activity.

- Work-related Wellbeing: The Trust offers occupational therapy support to all staff, including physiotherapy. The occupational health service recognises, that at times, staff (including managers) require additional support with both physical and advice available.

13.4. The Trust also offers advice and assistance on how to work safely, including workstation set up and assessments, manual handling, lone working, hand and skin care, vaccinations, conflict resolution etc.

13.5. Freedom to Speak Up: in 2018 the Trust appointed its dedicated Freedom to Speak Up Guardian. This role enables staff to have a point of contact where they feel that the regular avenues for raising concerns have been exhausted, including staff who 'whistle-blow' as well as ensuring that staff who raise concerns do not face detriment.

13.6. These concerns could include both patient safety concerns as well as staff issues of bullying and harassment.

13.7. The Freedom to Speak Up Guardian is supported by a team of advocates across the Trust.

13.8. The Trust has been working on improving the timeliness of the feedback given to staff when a compliment has been received.

13.9. While there is not a standard for determining how long it should take for staff to receive this feedback, the Trust recognises the positive experience of receiving a compliment and has made a commitment to process compliments received within a week of receipt.

13.10. The feedback to staff is accompanied by a letter from the Trust's Chief Executive acknowledging and thanking them for the work they do.

13.11. During 2019/20, 1,884 compliments were received.

13.12. The Trust recognises that the investigations into Serious Incidents are an opportunity to improve both professional practice and patient care/experience.

13.13. Throughout 2019 the Trust has improved the way in which it investigates Serious Incidents (SI).

13.14. This was achieved through the process mapping of the investigation process leading to improvements in the quality of report and the roll out of root cause analysis training as well as collaborative working between the Trust's corporate patient safety teams and field operations.

13.15. This way of working enables the Trust to ensure that SIs are being declared more appropriately, learning is identified, shared and embedded more quickly.

13.16. The NHS Staff Survey of 2018 indicated a number of key areas that the Trust requirement in e.g. staff appraisals. This was an area that the CQC had also identified for improvement.

13.17. The results of the 2019 NHS Staff Survey confirmed the Trust had made improvements across the board and were in line with the national average. Appendix E.

13.18. The 2020 NHS Staff Survey is currently underway and to date 52% of staff have responded with 3 weeks remaining.

14. Care Quality Commission (CQC) and the Professor Duncan Lewes Report

14.1. Since 2017, when both the CQC and the commissioned Professor Duncan Lewes reports identified that the Trust had a culture of bullying and harassment, as well as a 'blame culture', the Trust has worked tirelessly to improve its management and employee relations and change the culture of the organisation.

14.2. Since this time the Trust has launched:

- The 'Community Facebook Group' enabling staff from across the whole organisation to feel connected and hear of a wide range of experiences and activities from their colleagues.
- The Freedom to Speak Up guardian position was established, and the Trust now has Freedom to Speak Up advocates across the organisation giving staff the confidence to raise concerns confidentially.

- A 'Zero' tolerance to any form of bullying or harassment.

- The Wellbeing Hub offering a wide range of support to staff.

- An improved Intranet enabling staff to keep up to date with the latest news, updated policies and procedures, links to access support, as well as a wide range of helpful and informative topics relating to trust life.

- An Operational Directorate restructure enabling first line management support for frontline staff 24/7.

- The Senior Leadership Cultural Change Programme, which included cultural change workshops, 360^{o} feedback sessions.

- Monthly staff 1:1's with their line manager and annual appraisals.

14.3. The CQC during their visits in 2019, recognised the work that been done over the previous 2 years and their report, published in August 2019, highlighted:

- Staff told inspectors they felt respected, supported, and valued. They were focused on the needs of patients receiving care.

- Staff treating patients with compassion and kindness, respecting their privacy and dignity, and taking account of individual needs.

- A strong visible person-centred culture and that staff were highly motivated.

- Staff were supported following traumatic experiences and events.

- The service promoted equality and diversity in daily work and provided opportunities for career development.

14.4. The Trust has embedded in its strategy its commitment not only to the public, patients but also the staff that work within the Trust.

15.0. Equality and Inclusion

15.1. The Trust recently achieved a gold award from 'Employers Network for Equality and Inclusion'. The 'Talent Inclusion and Diversity Evaluation' gold award followed the previous 2 years when the Trust achieved the sliver awards.

15.2. This award recognises an organisations response to how diversity and inclusion is embedded in is culture.

16.0. Innovation

15.1. SECAmb is the first ambulance service in the country to introduce new pioneering guidance aimed at improving the treatment of spinal injury patients.

15.2. The guidance includes the ending the use of neck braces or semi-rigid collars on spinal injury patients. While collars are often seen as synonymous with spinal care but there is growing evidence that they could cause further harm while providing little or no benefit.

15.3. The new approach follows a working group being established at SECAmb with the remit of re-examining the Trust's approach towards spinal care to ensure the guidelines were fit for modern pre-hospital practice. Headed by SECAmb Critical Care Paramedic, Alan Cowley, the group worked closely with the region's trauma networks to develop a new set of guidelines to benefit patients.

15.4. A decision tool that separates vulnerable, frail patients from those considered healthy and fit has also been developed

16. Winter Planning Framework 2020 - 21

16.1. The Trust has developed its winter planning framework which is designed to enable the Trust to meet the challenges of the winter period and takes into consideration the historical seasonal increase in ambulance activity but also the impact of the current Covid pandemic and the forthcoming EU Transition on the 31st December 2020. Appendix D.

16.2. The framework draws on past experiences of planning for a winter period and the Trust's recent and continued response to the pandemic, as well as the potential service delivery impacts because of the end of EU Exit transition.

16.3. In addition to the overarching Trust framework each Operating Unit has devised a local tactical plan to consider the nuances of the local health and social care systems.

16.4. The overarching intent of the framework is to ensure that patient safety is at the centre of all the trust's actions

16.5. In preparation for this period the Trust has based its plan on the following assumptions:

- Process to monitor anticipated activity and the required levels of resourcing to meet activity demands.
- Internal escalation triggers which work to mitigate the risks posed by activity surges.
- Provision of additional resources to meet surges in demand.

16.6. Trust operates a 24/7 Command and Control Structure to maintain core services through the escalatory framework and to monitor staff welfare during periods of high demand.

16.7. The Covid response has been covered earlier in this report and will continue throughout the winter period and for the duration of the pandemic.

16.8. The Trust has recently initiated an Executive led priority review of its EU Exit Transition plans, through a number or workstreams, meeting weekly and feeding into a programme board.

16.9. This review will encompass the previous EU Exit plans the Trust has as well as reviewing any new considerations.

16.10. The Trust is linking in with system resilience forums in preparation for the 31st December and will work with system partners to ensure patient safety is as the centre of all planning assumptions and actions taken.

16.11. The Flu vaccination programme is already underway, on a phased basis with frontline staff in phase one, followed by phases two which will account for non-patient facing staff in the

999 Emergency Operations Centre and 111 Operations Centre. Phase three convers the remaining workforce.

16.12. To date 65.4% of patient facing staff have received their vaccine with some of the Kent Operating Units leading the way i.e. Dartford and Medway OU, and Thanet OU achieving 70.9% and 74.1% respectively.

17. Income and Expenditure (I&E) Performance Summary

17.1. Year to September 2020**:** The Trust continues to report a break-even position after 6 months, in line with national expectations. The additional costs incurred in response to COVID-19 and any other excess costs are funded through the 'Top-Up' arrangement as set out in the 'Revised arrangements for NHS contracting and payment during the COVID-19 pandemic' publication issued 26 March 2020 by NHS England.

17.2. Plan for October 2020 to March 2021: New contracting and payment guidance October 2020 – March 2021 was issued on 15 September 2020.

17.3. The revised framework will retain simplified arrangements for payment and contracting but with a greater focus on system partnership and the restoration of elective services. Systems have been issued with funding envelopes comprising funding for NHS providers equivalent in nature to the current block and prospective top-up payments and a system-wide COVID-19 funding envelope.

17.4. The Trust has submitted a revised 2020/21 plan in partnership with the ICS on 17 October 2020, with clear and transparent triangulation between commissioner and provider activity and performance plans.

18. Recommendations

18.1. The Committee is asked to note and comment on the update provided.

Lead Officer Contact

Ray Savage, Strategy and Partnerships Manager, Secamb

Appendices

Appendix A – Ambulance Response Programme
Appendix B – Ambulance Handover
Appendix C - Live Ambulance Conveyance Review
Appendix D – Winter Planning Framework

Background papers

None

Appendix A: Ambulance Response Programme

England, SECAmb, Kent Performance 2020

Ambulance Response Programme								
	Category 1		Category 2		Category 3		Category 4	
2020	Mean	90th Perc	Mean	90th Perc	Mean	90th Perc	Mean	90th Perc
Standard	00:07:00	00:15:00	00:18:00	00:40:00	NA	02:00:00	NA	03:00:00
April								
Kent	00:07:07	00:13:37	00:15:28	00:28:35	00:53:47	02:09:29	01:16:12	02:51:52
SECAmb	00:07:05	00:13:32	0014:50	00:27:32	00:49:14	01:54:57	01:08:29	02:42:46
England	00:07:08	00:12:27	00:18:28	00:38:24	00:39:40	01:29:20	01:06:57	02:25:18
May								
Kent	00:06:52	00:13:26	00:14:33	00:26:57	00:42:31	01:32:57	00:57:32	01:52:08
SECAmb	00:07:00	00:13:10	00:14:28	00:26:58	00:45:06	01:40:20	00:59:14	02:14:44
England	00:06:34	00:11:27	00:13:28	00:25:14	00:28:50	01:03:07	00:51:05	01:45:42
June								
Kent	00:07:44	00:14:45	00:17:37	00:32:26	01:24:09	02:53:48	01:44:08	03:48:02
SECAmb	00:07:31	00:14:01	00:16:43	00:31:02	01:09:54	02:38:05	00:59:09	02:01:54
England	00:06:38	00:11:35	00:14:53	00:28:24	00:36:16	01:21:30	01:35:43	03:30:44
July								
Kent	00:07:57	00:15:19	00:19:16	00:36:00	01:31:31	03:25:49	01:43:16	04:11:35
SECAmb	00:07:38	00:14:34	00:18:31	00:34:56	01:25:48	03:19:04	01:50:59	04:40:05
England	00:06:47	00:12:02	00:16:39	00:32:56	00:43:19	01:38:58	01:09:19	02:27:08
August								
Kent	00:08:04	00:15:26	00:19:27	00:35:24	01:41:42	03:44:11	02:04:08	04:56:07
SECAmb	00:07:53	00:14:50	00:18:57	00:34:57	01:34:11	03:31:37	02:05:27	05:01:24
England	00:07:06	00:12:40	00:20:03	00:40:34	00:56:42	02:11:40	01:25:01	02:59:06
September								
Kent	00:07:51	00:15:14	00:19:37	00:36:30	01:39:06	03:34:25	02:18:11	05:52:16
SECAmb	00:07:42	00:14:22	00:18:55	00:35:28	01:28:43	03:15:36	02:08:04	04:50:26

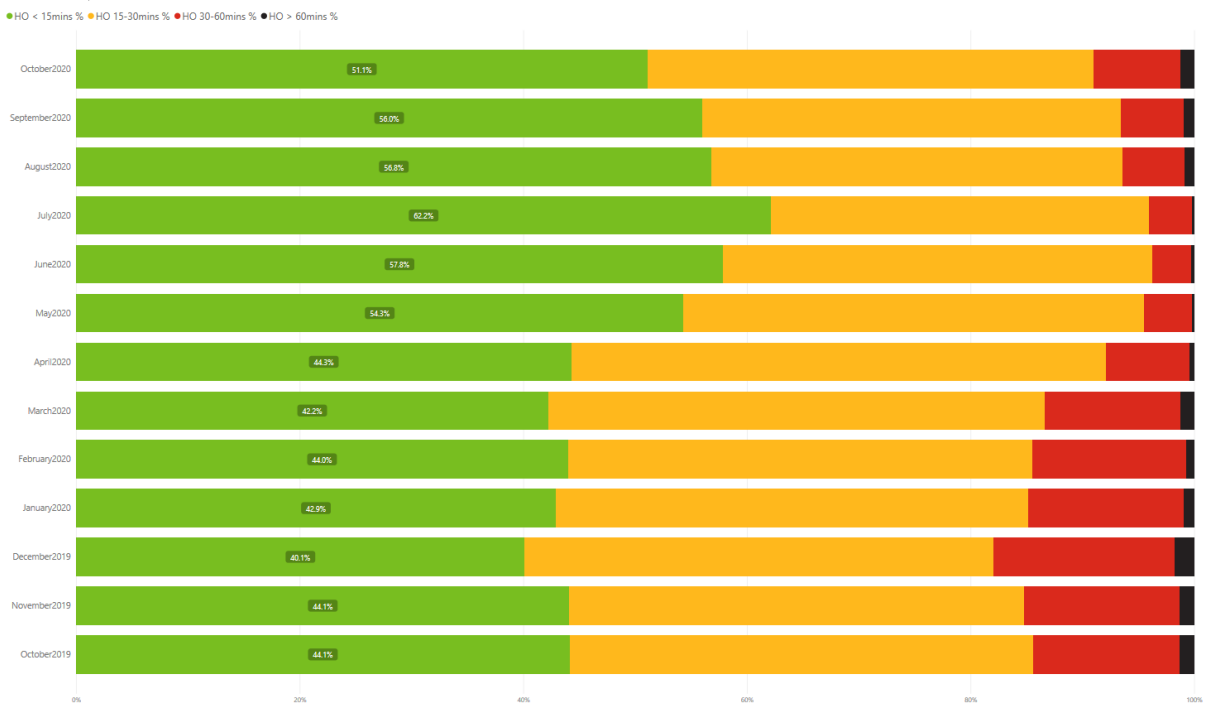
Emergency Operations Centre Call Answering Performance 2020

Call Answer Times (seconds)						
	April	May	June	July	August	September
SECAmb						
Mean	1	1	2	2	3	3
90th percentile	1	1	1	1	2	1
England						
Mean	*11	2	na	2	3	4
90th percentile	*38	2	na	2	3	6
*London Ambulance Service experienced high levels of activity						

April 2020 to September 2020 (YTD)						
Ambulance Response Programme Standards	Category 1			Category 2		
	Incidents	Mean	90th	Incidents	Mean	90th
		00:07:00	00:15:00		00:18:00	00:40:00
Ashford CCG	530	00:07:40	00:15:21	4787	00:16:51	00:31:56
Canterbury and Coastal CCG	977	00:09:04	00:16:35	7897	00:21:33	00:37:58
Dartford, Gravesham and Swanley CCG	1254	00:06:50	00:11:48	10134	00:15:50	00:29:15
Medway CCG	1599	00:05:58	00:09:47	11696	00:14:46	00:27:09
South Kent Coast CCG	1129	00:09:33	00:17:50	9368	00:20:54	00:37:40
Swale CCG	636	00:09:23	00:17:46	5238	00:21:18	00:37:35
Thanet CCG	1035	00:05:26	00:09:00	7339	00:14:13	00:28:49
West Kent CCG	2047	00:08:19	00:15:34	15775	00:18:29	00:33:12
Kent & Medway STP	9207	00:07:39	00:14:38	72234	00:17:49	00:33:08
Ambulance Response Programme Standards	Category 3			Category 4		
	Incidents	Mean	90th	Incidents	Mean	90th
		na	00:02:00		na	00:03:00
Ashford CCG	3058	01:24:49	02:52:15	81	01:34:23	03:30:44
Canterbury and Coastal CCG	5441	01:21:54	03:02:55	94	01:53:02	04:00:49
Dartford, Gravesham and Swanley CCG	6491	01:05:49	02:44:29	162	01:16:13	02:57:46
Medway CCG	6984	01:17:56	03:05:13	184	01:20:34	03:23:31
South Kent Coast CCG	6837	01:23:28	03:12:11	128	01:43:41	04:20:22
Swale CCG	3082	01:27:26	03:23:05	55	02:10:13	05:18:34
Thanet CCG	5192	01:03:50	02:36:13	113	01:33:09	03:30:14
West Kent CCG	10443	01:19:26	02:58:27	208	01:41:48	04:06:51
Kent & Medway STP	47528	01:17:23	02:59:00	1025	01:35:12	03:53:59

Appendix B – Ambulance Handover

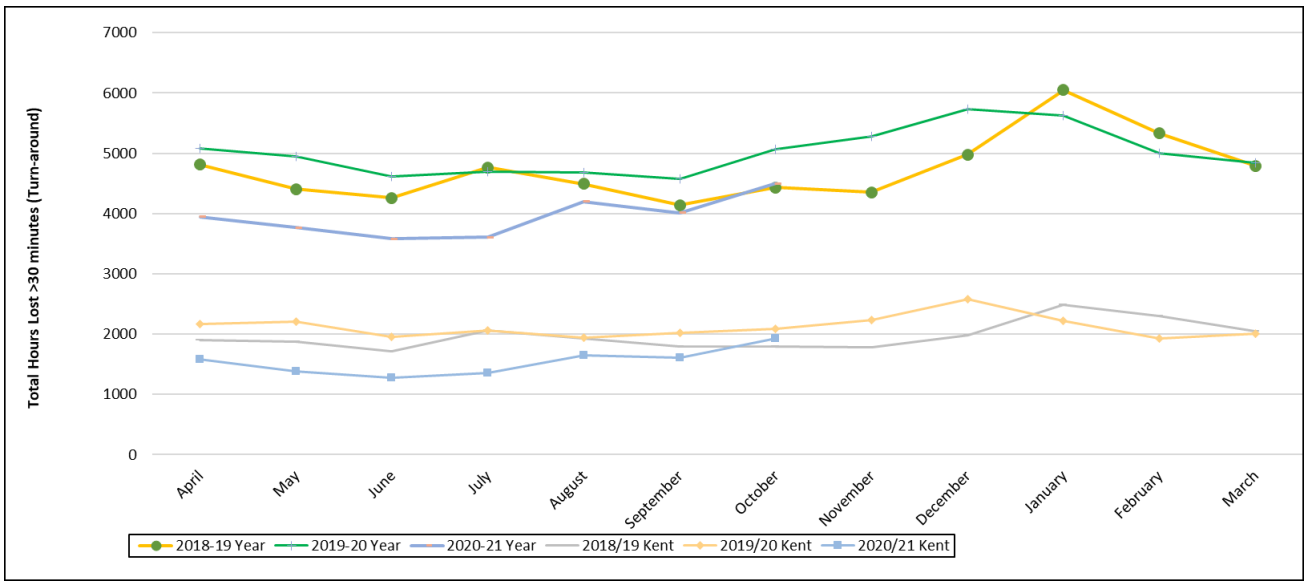
Ambulance Handover October 2019 to October 2020



Ambulance Handover - September 2020 Ambulance Turnaround

September 2020	Ambulance Turnaround				
Hospital	**Total Patient Transports**	**Total Turnaround Hrs Lost (over 30min) hh.h**	**Average Handover Time (mins)**	**Average Wrap up Time (mins)**	**Total Amb Hrs Lost (over 30min) per journey h.hh**
Medway Maritime Hospital	3334	430.8	17.72	16.75	0.129
William Harvey Hospital	2880	348.4	17.54	17.57	0.121
Tunbridge Wells Hospital	2186	240.9	15.36	18.75	0.110
Darent Valley Hospital	2058	229.8	17.89	16.76	0.112
Queen Elizabeth Queen Mother Hospital	2675	172.4	15.12	15.92	0.064
Maidstone Hospital	1540	157.6	13.97	19.18	0.102
Kent And Canterbury Hospital	275	16.9	14.03	15.72	0.061

SECAmb/County of Kent Hours Lost >30 Minutes



Appendix C – Medway Maritime Hospital Live Ambulance Conveyance Review

Medway live conveyance review Ja

Appendix D – Winter Planning Framework

Winter 2020 Planning Framework '

Appendix E – NHS Staff Survey 2019 (Ambulance Sector)

NHS Staff Survey 2019.pdf

South East Coast Ambulance Service NHS
NHS Foundation Trust

Medway Maritime Hospital
Live Ambulance Conveyance Review

Version	Author	Title and Organisation	Review/ Change	Date
V1.0	Gillian Wieck	Programme Director	Initial draft	16/02/2020
V 1.1	Gillian Wieck	Programme Director	Revised version	12/03/2020
V 1.2	Gillian Wieck	Programme Director	Final Version	17/03/2020

This review and report has been supported by the system partners below

Supporting Organisations:

Medway Maritime Hospital Foundation Trust (MFT)

South East Coast Ambulance Service NHS Foundation Trust (SECAmb)

Medway Community Healthcare MCH

Medway and Swale CCG

MedOCC - Medway Community Healthcare

Medway Practices Alliances Ltd

Review Team:

SECAmb: Laurence Sopp , Emma Milburn , Andrew Pearson , Angela Cavalier, Maria Picozzi, Mark Wright, Darren Dzialowski

MFT Tim Godsen

Medway Community Healthcare Sarah West, Lisa Mills

MedOCC Jo Cumes

Primary Care (Medway Practices Alliance Ltd) Dr Jane Jonny and Dr Oluwaseun Arokodare

1 Introduction

The local Medway ambulance liaison group (operational meeting between SECAmb and MFT) was established to undertake a joint piece of work to reduce ambulance handover delays. Handover delays are a long-standing issue at Medway Hospital. High numbers of patients have previously waited >60 minutes before a handover takes place This impacts both on the safety and experience of patients waiting in ED ,but also impacts on SECAmb's ability to respond to patients awaiting a 999 response in the community.

Joint working has recently enabled positive progress to be made, with a significant improvement in handover delays since the beginning of the year. It should be acknowledged however, that the numbers of conveyances to Medway hospital has increased significantly which has contributed to the pressure experienced in ED/UTC and impacted on patient flow which in turn impacts on handover times.

To gain an understanding of the reasons for the increase in the numbers of conveyances, the group agreed to undertake a live front door conveyance review. The review aims to capture the demographics and case mix of patients being conveyed by the ambulance service, and to consider the clinical rationale for conveyance to hospital, including if available appropriate community pathways were considered before deciding to convey.

This report will consider the review of ambulance conveyances with a focus on identifying any barriers that crews experienced on the day in accessing available and appropriate community pathways. The review hopes to highlight these barriers so that opportunities may be identified to address them. The review also is an opportunity to identify any gaps /inconsistencies in the availability of community pathways or to identify any opportunities for the development of community pathways.

2 Methodology

Live ambulance conveyance reviews have previously been conducted at a number of EDs within SECAmb's catchment area. Most recently, a review was conducted at St Richards Hospital in Chichester West Sussex in October 2019, and one at Conquest Hospital East Sussex in February 2020. The methodology for these reviews has been broadly similar; and this review followed a similar approach

In order to target a variety of conveyance and demand times the review was conducted over four 4-hour sessions during one week. This staggered approach ensured there was appropriate representation from in hours, out of hours, weekdays and weekend conveyance times. The review sessions were:

Monday 13/01/2020	10:00- 14:00
Wednesday 15/01/2020	18:00 – 22:00
Friday 17/01/2020	14:00 – 18:00
Sunday 19/01/2020	11:00 – 15:00

Each review session was supported by clinical representation from SECAmb and Medway Community Healthcare (including two sessions from MedOCC) and for two sessions there was representation from a GP. Data collection was conducted through the completion of a review tool, examples of the questions asked can be found in Appendix 1.

Members of the review team were situated next to the ambulance entrance at ED and next to the entrance of the collocated UTC (where the majority of ambulance arrivals are received). When an ambulance crew arrived, they were approached by a member of the review team to gain consent to be involved in the review

Once the crew had completed clinical handover and the patient transferred, the attending clinicians were interviewed by the SECAmb members of the review team for the data collection tool to be completed. Additional questions were asked by the community services /MedOCC /GP colleagues where appropriate to draw conclusions about any appropriate community pathway that could have been considered. Post review, MFT staff retrospectively reported the diagnosis, treatment and outcome of each patient captured in the review. Finally, the data was collated together and analysed to consider if any of the patients in the review could have been referred to an existing non-Medway ED/UTC pathway.

3 Conveyances Reviewed and Outcomes

In total 75 conveyances were captured during the review It should be noted that within the review period, 107 ambulances arrived at the hospital in total. It was not possible for the team to review every single ambulance conveyance and for the purpose of the review (looking at access to appropriate community pathways before deciding to convey) the team focused primarily on patients going through UTC and RAT (Rapid , Assessment and Triage) area , rather than patients going into resus or direct to other units e.g. maternity .

3.1 Source of Call

In this review, the majority of the conveyances originated from 999 calls, with calls direct from Health Care Professionals (HCP) and transfers from 111 making up a smaller percentage. It should be noted that none of the HCP requests for conveyance were expected by the hospital

Source of call	Numbers of Patient	Percentage
111	18	24%
999	47	63%
HCP (9 local GPs and one prison HCP referral)	10	13%
Total	75	100%

3.2 Age of Patient

Patient age groups were split into paediatrics (under 16), working age (16-64) and older age adults (65+). The majority of patients (48 %) were 65 or older, with paediatrics and younger adults accounting for 16% and 36% respectively.

Age Range	Number of Patients	%
Pead 0-15	12	16%
Adult 16-64	27	36%
Older Adult 65+	36	48%
Total	75	100%

3.3 Outcomes

Following the initial data collection and live review of conveyances, each of the patients captured were followed up in order to understand the outcome of their conveyance to ED/UTC.

Outcome		Percentage	Comments
Admitted	11	15%	2 went to SAU and 5 to AMU
Discharged	61	81%	3 went to SDEC and 14 to MedOCC
Not known	3	4%	Details not recorded

Of the 75 conveyances, the review team identified 10 conveyances for consideration and where the rationale for conveyance should be highlighted. Of the 10 highlighted there are 5 conveyances where crews had shown evidence of considering other appropriate pathways before conveying to ED/UTC and 5 HCP requests for conveyances where conversations between primary care /community services and or Medway hospital **may** have resulted in a safe alternative to a conveyance by ambulance to the ED/UTC

4 Community pathways and collaborative decision making

Collaborative decision making for this review involves the review team identifying any conveyance where the Ambulance crew attempted to contact/consider an appropriate community service, in order to discuss the patient's condition and/or to explore any potential community pathway. It does not include conveyances where the crew were conveying the patient under the direction of another HCP.

The review team highlighted the 5 cases below where there was evidence of crews considering community /alternative pathways (where appropriate) before conveying

Source of call	Age	Grade of Crew	Presenting complaint	Collaborative decision making	Comments	Outcome
999	65+	AP/APP	Chest Pain	Yes – SECAmb PP hub	Patient and son wanted crew to take patient to Lewisham hospital (or to self-convey) where patient is cared for normally PP desk advised conveyance to Medway as nearest hospital	ECG and monitoring in MedOCC discharged home
999	65+	AP/APP	#NOF	Attempted to access the # NOF pathway at Medway Hospital – no capacity	Received IV and Meds in ED transferred to SAU	Admitted
999	65+	Paramedic	Mental Health patient presenting with acute confusion Had undergone medical assessment today as part of dementia screening	Contacted Social Services direct to discuss alternative care pathway (out of hours call)	Social services consulted and advised crew that patient needed medical assessment even though patient had already been assessed that day , so crew conveyed to ED	Observation and bloods – "social problem" patient admitted
111	0-15	Paramedic	URTI and chest pain	Advised patient could be seen by GP/MedOCC Parent declined and insisted on being conveyed	Mother declined offer to access primary care and to stay in the community (Background of safeguarding concerns and parent highly anxious)	No treatment given, seen by MedOCC and discharged home
999	65+	Technician /Advanced Technician	Bronchitis	Attempted to refer to Virgin Local Referral Unit	Patient not suitable Antibiotic service available in Medway but not in Swale where this patient lived	COPD – IV Monitoring and Meds Discharged home

The review team highlighted 5 HCP requests to convey a patient to ED , where an additional conversation with community services and or a clinician at Medway hospital **may** have led to either a different pathway being accessed , or where the patient could have made their own way to ED rather than an ambulance conveying

Source of Call	Age of Patient	Presenting condition	Comments by the review team	Outcome
HCP	65+	Septic Arthritis?	Patient in nursing home discharged yesterday from Medway hospital following treatment for knee injury . Following results of blood tests today received at GP surgery (taken when patient was an inpatient in Medway) the GP queried septic arthritis and queried why the patient had been discharged A request was made for a conveyance based on high CRP blood results Review team thought there was no need for conveyance at that point based on the results of the blood test results and thought that the GP could have repeated bloods and then prescribed Abx if abnormal (for community management.)	Obs , meds and discharged back to nursing home
HCP	65+	? CaudiaEquina syndrome	Patient drove to surgery. Following assessment HCP requested an ambulance to convey to ED Review team queried if ambulance was necessary (could have got to hospital himself /friend transported) and if the patient could have been directly referred to AMU (patient not expected)	Caudiaequina syndrome Clinical obs and neuro obs undertaken in ED transferred to Lister (AMU)
HCP	65+	Heart Failure	Review team thought that Medway Community Health ACP and Heart Failure Team could have been considered for this patient	IV Frusomide given in ED and discharged home
HCP	65+	Heamaturia referral from Sheppey Hospital	Patient originally an inpatient at Medway but transferred to Sheppey for rehab .Was referred to SDEC and accepted by urology however 4-5 hour wait and due to tissue viability patient was unable to sit that long and so came in via ED. Review team thought no clinical need to be sent to Medway Catheter patent , no haematuria very good urine output IDT contacted by review team to repatriate patient to community hospital	Bloods , obs and discharged back to Sheppey Hospital
HCP	65+	6/7 D&V symptoms. GP home visits x 2, feels that home treatment options now exhausted.	Review team thought that Rapid Access Outreach Team could have been considered by the GP (team are able to review patients at home) Can do urgent bloods and also can have access to consultant review The team also queried if patients relatives could have transported the patient to hospital rather than the HCP call for an ambulance	Gastroenteritis Obs and IV fluids given in ED Admitted to Arethusa

The Review Team included colleagues from Medway Community Services/MedOCC who provided insight in order to identify whether any patients that were conveyed to ED/UTC, may have been considered suitable for referral to the new "Community Urgent Response Team " (if it were in place) taking into consideration the presenting condition . Five possible patients were identified.

Source of call	Age	Clinical grade of crew	Presenting complaint and comments	Hospital diagnosis and outcome
111	65+	Paramedic	Arrythmia and palpitations known to GP but not medicated as yet Awaiting Echo/ECG before initiating Treatment. Family concerned as patient more confused crew found Pt in fast AF and conveyed to ED	AF/Flutter. IV and Meds given. Obs and ECG. Patient admitted
999	65+	Paramedic	Head injury (patient on blood thinners) Would be suitable for Urgent response providing exclusion of certain blood thinners (Clopidogrel not currently required to convey)	Bruise /contusion neck abrasion Taken to streaming but redirected to RAU Obs CT head and spine – discharged home
999	65+	Paramedic	COPD and heart failure diagnosis Presenting with shortness of breath, no recent meds review ?? Bradycardic	Obs , bloods ECG – discharged home
999	65+	Paramedic	? LRTI	COPD Obs , meds and admitted
111	16-64	AP/AAP	Acute confusion elderly female lives alone no poc new onset of confusion for? 3 days. Patient denies fall but small laceration to head Crew concerned confusion related to head injury. Did not consider SECAmb PP hub as felt needed hospital review	Outcome not known Unable to trace on hospital system

In addition to the conveyances that have already been outlined, the following ones are also noteworthy

- A patient under the care of MCH respiratory service, contacted the team as his condition had deteriorated. The team had no capacity and advised the patient to call 999. The patient was subsequently conveyed to ED received IV fluids and meds and was admitted
- A patient with a similar presenting condition to the one above, would also have been suitable for the MCH community respiratory service but patient lived in the Swale area (where service is not commissioned) This patient received IV fluids and Meds in ED and was discharged home.
- Two patients were conveyed from prison with the reason for both conveyances being trauma (assault and self-harm). Neither patients were suitable for treatment at an MIU
- Out of area crew conveyed patient to ED rather conveying direct to the UTC as the crew were unaware of acceptance criteria at UTC

5 Discussion

The review of the ambulance conveyances to Medway set out to understand if there had been a shift in clinical decision behaviour that had led to an increase in conveyance activity In addition the review also sought to explore opportunities to improve the utilisation of appropriate available clinical pathways and to identify opportunities for new pathways to be considered.

The outcome of the review is that ambulance crews are making appropriate and informed conveyancing decisions based on existing appropriate and available community services It is positive to note that ambulance clinicians are attempting to utilise available non ED pathways for patients, as well as seeking additional support for clinical decision making from other health care professionals The review has however highlighted some issues around accessing pathways that were around lack of capacity or gaps in the community services currently available. It would be worth establishing a way of routinely capturing this information to inform future development opportunities

In particular the review has highlighted a cohort of patients that would be suitable for the new Community Urgent Response Team if it was in place and the review has therefore identified opportunities in the future to reduce conveyances when this team is up and running .

The review has highlighted a need for some focussed work around HCP requests to convey patients to ED. This will need to include raising awareness of existing community services that can support HCPs in keeping patients in the community wherever possible. It will also need to consider how best HCPs can liaise with Medway hospital before requesting a conveyance so that the patient is already expected/accepted and wherever possible conveyed direct to AMU/SDEC instead of ED in order to reduce congestion.

It should be noted that the review also provided an opportunity to talk to crews , community services , ED staff and GPs in order to gain a better view of the availability of community pathways A common theme in particular that came up was the lack of “alternative pathways” for patients presenting with mental health needs. It wasn’t necessarily that crews were unable to access existing pathways but rather that alternatives to conveying to ED were limited and therefore patients were often conveyed to ED because there was no choice (e.g. place of safety or where acceptance criteria needed a medical assessment) Within the review 4 patients were conveyed who had mental health needs. 2 were known to mental health services and 2 were not. All 4 were unable to access a community mental health pathway as all needed medical assessment prior to accessing suitable mental health services. Of those 4 patients one was admitted and the 3 received treatment/monitoring and discharged home.

There were also comments around the variance in services provide by GPs/primary care e.g. some services that were provided by some GP practices but not others e.g. Arrythmia service advice line meaning that patients in certain areas were more likely to be conveyed to ED than in others.

There was also some concern raised from crews about the length of time they sometimes experienced waiting for call backs from GP surgeries (in hours) e.g. when crews were wanting to refer patients to primary care , or when requesting for prescription of antibiotics In these circumstances there is a risk that patients are more likely to be conveyed to hospital.

6 Recommendations

- HCP- when requesting an emergency ambulance to transport a patient for a non-life or limb threatening condition , the patient should have had a clinical assessment by the referrer and a clinical discussion should have taken place with the receiving team at the hospital before a request is made to convey i.e. the patient should be expected by the hospital
- Crews and referring HCPs to consider if the patient could make their own way to hospital rather than being conveyed by ambulance as a default
- HCP awareness raising exercise about the availability of community services /pathways and how to access
- SECAmb to ensure all crews are aware of service finder so that crews have access to up to date information relating to available community pathways. This is particularly important where “out of area “crews are responding
- Development of a clinical referral criteria for direct GP and ambulance crew referrals to hospital non-ED destinations e.g. SDEC to reduce congestion in ED (already in progress) and also to consider direct referrals to AMU/SAU/Frailty service for GP expected patients
- Consideration of “We tried “ email or similar feedback process to capture barriers for crews accessing community pathways or to identify any gaps (including where referrals have been declined due to lack of capacity) General themes to be regularly presented at system level discussions i.e. Local A&E delivery board
- Review of the difference in availability of community services between Medway and Swale to see how they may be resolved e.g. access to MedOCC (in hours) and availability of service providing IV antibiotics
- Although this review focused on the live reasons for conveyance there may be benefit in some retrospective work to see what could have been effectively provided in the community, based on what interventions were provided at Medway. This may help to direct some decision making related to community service and identify possible opportunities. This may be particularly relevant for patients with mental health needs
- Repeat of the review in 6 months

Appendix 1

Questions to be asked on review tool

To be completed by the attending Ambulance Crew	
Patient ID	Was there an electronic patient record / care plan available on IBIS?
Hospital number	Who was the patient record / care plan (IBIS) from?
At Hospital Time (HH:MM)	Did you access the patient record / care plan (IBIS)?
Source of incident	If no (did not access patient record / care plan) why?
Were you providing transport under the instruction of another clinician?	Did the patient record / care plan (IBIS) influence your clinical decision making?
Presenting Complaint / Impression - Crew	Is the patient EOL?
Type of transporting vehicle	Was there collaborative decision making?
Clinical grade of crew	If yes (collaborative decision making), was there a reason for conveyance?
Age of patient	Is there a community service / pathway available that could have provided same assessment and/or treatment that was considered?
Was the patient time-critical?	What community service / pathway?
Was the patient clinically 'fit to sit'?	Did crew attempt to access community service / pathway?
If no, why were they not fit to sit?	Comments around community pathway
Could the patient have made their own way to A&E?	How did you attempt to contact community service / alternative pathway?
If Yes, what was the reason for ambulance conveyance?	Did you use any clinical guidelines / assessment tools to support conveyance decision? (select dropdown)
	Did the patient 'want' to go hospital, despite ambulance clinician recommendation for
	Other additional comments

To be completed by ED Staff
Diagnosis - Hospital
Did the patient receive treatment / intervention in A&E?
Briefly outline the treatment given
Time/duration in department (HH:MM)
Other additional comments

To be completed by Audit Team
Is there a community service / pathway available that could have provided same assessment and/or treatment that was considered?
What community service / pathway?
Comments around community pathway
Other additional comments

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NHS
South East Coast Ambulance Service
NHS Foundation Trust

Winter 2020
Planning Framework

Aspiring to be *better today*
and even *better tomorrow*

Document Sign Off

Version:	V2.0
Name of originator/ author:	Anne Harvey
Responsible management group:	Organisational Response Management Group
Directorate/team accountable:	Operations/EPRR Team
Winter 2020 Planning Framework:	
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Document Control

Review/comments:

Person/ Committee	Comments	Version	Date
Anne Harvey	Initial review and development of plan.	V0.1	July/Aug 2020
Resilience Forum Winter Planning Group.	Input from key stakeholders to review and update or provide narrative to respective sections of the plan.	V0.1	July/Aug 2020
EPRR Team	Winter 2020Risk Assessment completed	V0.1	11/08/2020
Resilience Forum Winter Planning Group and EPRR Team	Circulated for review and comment	V0.1	17/08/2020
EPRR Team	Document reviewed and updated	V0.2	18/08/2020
Anne Harvey	Updated with review of feedback from Resilience Forum Winter Planning Group.	V0.3	20/08/2020
Covid Management Group	Submitted for approval	V0.3	21/08/2020
Covid Management Group	Plan approved	V1.0	21/08/2020
Teams A	For information	V1.0	24/08/2020
Executive Management Board	For ratification	V1.0	02/09/2020
EPRR Team	Plan reviewed and amended to reflect change to Leadership group/name, C2 flowchart removed as no longer correct, risk assessment updated to reflect Trust Risk Register. Key Contacts included	V1.1	15/10/2020
Organisational Response Management Group	Submitted for approval	V1.1	21/10/2020
Organisational Response Management Group	Plan approved	V2.0	21/10/2020

This is a Live Document and will be subject to review and update in a dynamic operating context.
The latest version will be updated onto the Trust website

Contents

1. Introduction

This plan is designed so that the South East Coast Ambulance Service NHS Foundation Trust (SECAmb) can meet the challenges a winter period brings, whilst maintaining a sustainable service throughout the winter period.

Historically increased activity during the winter period has presented significant challenges to the Trust, it is recognised that these demands are not always those placed directly onto the Trust but can be those affecting the wider health and social care system.

Winter 2020 is anticipated to be no exception, set against the impacts of the Covid19 pandemic and possible Covid 19 resurgence, along with service delivery impacts which may be the result of EU Exit transition arrangements. The difficulties presented by these factors when combined with similar situations in partner organisations across the wider health community, may make the challenges of this winter even more acute and unpredictable.

This document is intended to draw on the experiences of past winters and of the Covid19 response and integrates recommendations, guidance and criteria for winter 2020 planning.

1.1. Planning Assumptions

This plan has been developed based on the following planning assumptions;

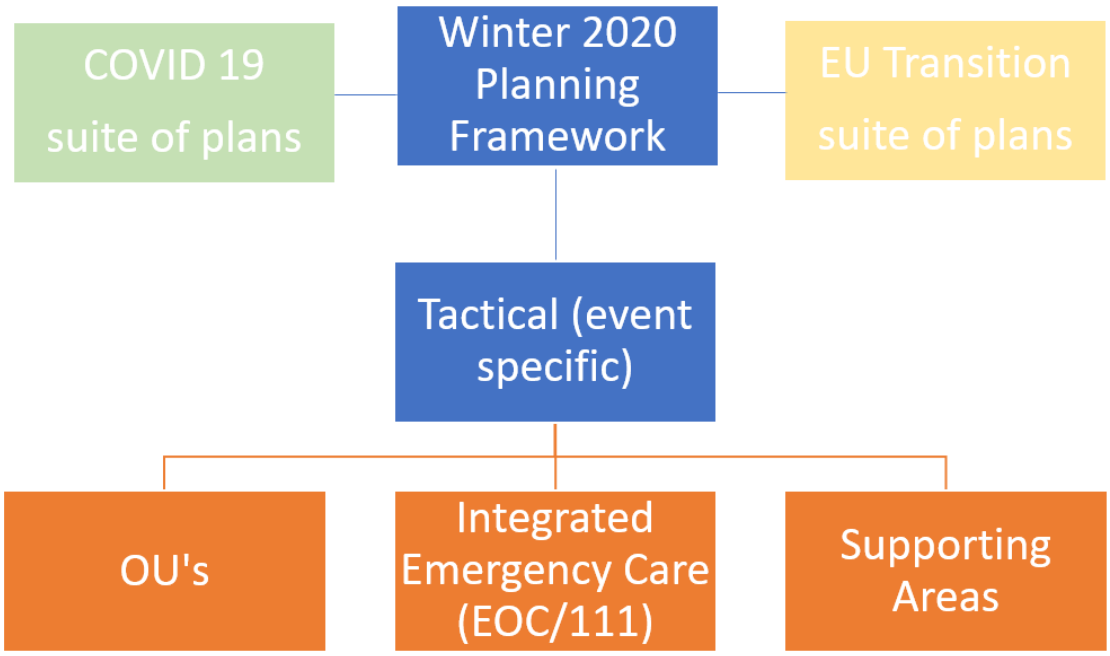
- The trust has in place a process to monitor anticipated activity and deliver the required resource to meet this anticipated activity.
- The Trust has in place a set of internal escalation triggers, which are effective and work to mitigate the risk posed by surge conditions.
- The Trust will be able to provide the additional resources required to meet surge conditions.
- The trust will, when necessary provide support for other priority areas to ensure delivery of trust objectives.

Should the above conditions not be met, the mitigation provided by this winter plan will be lessened. With the above conditions adequately met this plan should provide sufficient mitigation to ensure a manageable winter period.

The document concentrates on several year-round processes and key seasonal initiatives that will deliver robust resilience during the winter period and ensure engagement with local health systems. It is designed to offer assurance at a strategic level that the levels of preparedness for winter in SECAmb is high and that this will contribute to the resilience of the whole system. It also serves as an overarching plan to bring together the arrangements detailed in the individual Operating Unit, Emergency Operations Centre and SECAmb 111 winter plans.

This is a live document and will be subject to review and updated accordingly throughout the Winter planning period.

Plan Structure



1.2. Associated Documents

This plan is not intended to replicate or replace existing Trust plans or guidance and should be used in conjunction with the following associated documents**:**

- Operating Unit Winter Plan(s)
- Contact Centre Winter Plan(s)
- Resourcing Escalatory Action Plan (REAP)
- Surge Management Plan (SMP)
- Clinical Handover and Transfer of Care Procedure
- Major Incident Plan & Additional Contingencies
- Business Continuity Management Policy
- Business Continuity Management Plan & Associated Documents
- Command & Control Procedure
- COVID-19 Strategic Plan
- COVID-19 Incident Operating Model
- COVID-19 Pandemic Test and Trace Cell SECAmb Staff Procedure
- COVID-19 Outbreak Control Management Framework
- SECAmb EU Transition Plan(s)
- Infection Prevention Ready Procedure
- Infection Prevention and Control Manual
- Winter Period Communications Plan 2020/21
- NHS England Operational Pressures Escalation Level Framework (OPEL)

2. Intent

The intention of this plan is to provide sufficient arrangements and options to manage this anticipated demand and mitigate the associated risks in accordance with the visions and values of South East Coast Ambulance Service NHS Foundation Trust.

2.1. Strategic Intention

- Maintain a clinically safe and effective service that meets the clinical needs of all our patients
- Mitigate and minimise the impact to the wider NHS
- Inform the public and maintain public confidence
- Ensure sufficient assets are available to manage the event to maintain service delivery to national standards
- Ensure a swift return to normality in the event of an incident

2.2. Tactical Intention

- To ensure patient safety is at the centre of our actions
- To have a predefined Command and Control Structure in place to ensure the operational demand is managed effectively
- To maintain core services through the effective use of escalatory framework
- To ensure that staff welfare is considered by providing refreshments and adequate breaks within the constraints of the demands being placed on the service.
- To ensure staff safety through continuity of supply of Personal Protective Equipment in respect of PHE/NHS guidance.
- To work with partners to mitigate demands and limit the impact on the wider NHS

3. Scope

This plan covers the winter period, normally defined as being from 1st November to 31st March with specific emphasis on the critical period, historically, this is the festive period from early December to mid-January., However given the additional challenges of Winter 2020, this critical period may begin earlier or be extended further.

Analysis of historical data for this period will be utilised to predict potential periods of increased demand, however it is important to recognise that the other impacts (Covid, EU Exit etc) brings a high level of uncertainty to this period. Therefore, any plans produced will be required to maintain a high level of adaptability.

3.1. Christmas and New Year

There will be specific arrangements for the key dates over the Christmas and New Year period, which include provision of additional operational resources and appropriate, focused managerial support. These arrangements may be extended in response to challenges posed by prolonged increased activity, system pressures, seasonal flu and other challenges.

This year, there are the additional challenges of the Christmas public holidays going into a weekend, where there may be long periods of people off of work and limited access to primary care during this time and the EU transition period due to end on 31st December.

3.2. Trust Response to Covid 19

The Trust's response to COVID-19 has evolved over time to reflect the needs of staff and patients and to ensure that the Trust is meeting the specific actions, outlined by NHSEI that all NHS organisations should take. Throughout the Covid-19 response, maintaining staff and patient safety as well as delivering a safe service has been a key objective of the Trust. As we move into the next phase of the response a further objective is to ensure that robust governance and processes are in place to support the timely reporting and management of COVID-19 outbreaks, hospital acquired infection and associated staff absence.

It is still unclear how the COVID-19 virus will progress throughout the approaching months, with a high likelihood of a 'second peak'. The Trust's response to COVID-19 will continue to be closely monitored by the Organisational Response Management Group (ORMG) and inevitably may be revised in order to ensure we continue to best service our staff and our patients.

3.3. EU Transition Arrangements

The UK left the EU on 31 January 2020 and entered a transition period which is due to end on 31st December 2020. The Trust had a number of plans and mitigation measures in place for EU Exit. Ensuring cognisance of potential issues and dependencies, the Trust continues to engage with Local Resilience Forums (LRF)and NHS partners in planning for EU transition.

Building on learning identified from EU Exit debriefing and considering new arrangements for EU transition we will continue to develop the plans and arrangements required for the end of the transition period.

4. Review of Winter 2019

A review of arrangements put into place for Winter 2019 has been undertaken, with areas of good practice to be fed into the planning for this year. The Trust has also engaged with local systems to review the challenges of Winter 2019, key themes around areas that worked well and areas for improvement have been identified and will support system Winter 2020 preparedness planning.

Concerns/ areas for improvement include:

- Daily management calls were stood down in order to focus on the call volume and patient response, it was identified that this may have contributed to a lack of focus on wider system issues including hospital handover delays and system capacity.
- A main challenge for the trust was an increase in short term sickness over the Christmas period. Specifically, Christmas day and Boxing day.

Actions taken include:

- Additional Clinicians in EOC and Urgent Care Hub set up where workforce allows,
- Band 7 Paramedic Practitioner rotational models developed,
- Longest one waiting vehicle (LOWV) and Joint Response Unit (JRU) have been further developed and rolled out.
- Acute pathways support - ongoing work to improve and establish acute pathways.
- Improved Hear & Treat and direct referrals focus

5. Risks

Risks are multifactorial and involve internal and external factors. Whilst planning is completed on the basis of what is known or can reasonably be expected to happen, factors may impact on planning outside of that process. Delivery risks are based on predicted and actual demand, patient facing vehicle hours available, hospital handover delays, sickness, significant disruption of service or major incidents and other external factors such as events or weather issues.

Key risks identified in respect of Winter 2020 include:

- Potential Covid 19 resurgence in conjunction with known winter pressures
- Winter Flu pandemic
- Increased Activity
- EU transition ends during critical winter period
- Adverse Weather
- Potential for Public Disorder

While the full health sector picture is not fully known, the report “Preparing for a Challenging Winter 2020-21”[1] provides an in-depth analysis of the risks and challenges to the NHS in the coming months. It is anticipated that the challenges identified will add to the winter pressure challenges normally experienced by the wider NHS & social care system and in turn will likely impact on ambulance service activity.

A risk assessment for the Winter period is provided at Appendix A

6. Method

[1] https://www.gov.uk/government/publications/covid-19-preparing-for-a-challenging-winter-202021-7-july-2020

The delivery of this plan will be achieved through comprehensive operational and organisational arrangements, which are designed to provide a quality service to meet the needs of our local communities. The overall strategy will be delivered through the supporting plans, as detailed in the Plan Structure Framework so that the arrangements remain sufficiently flexible to match more local workloads.

The operational arrangements include the identification of 'key dates' of anticipated high demand which are derived from analysis of historical data. Such predictions will be subject to adjustment based on shorter-term impacts such as forecasts of severe weather, high seasonal flu levels, fuel shortages or other Business Continuity challenges including industrial action within or outside of the NHS.

This section of the Plan describes the processes to predict, monitor and mitigate the demands that are likely to be placed upon the Trust over the winter period, and looks to ensure delivery of service is maintained during surges in demand or reduced capacity.

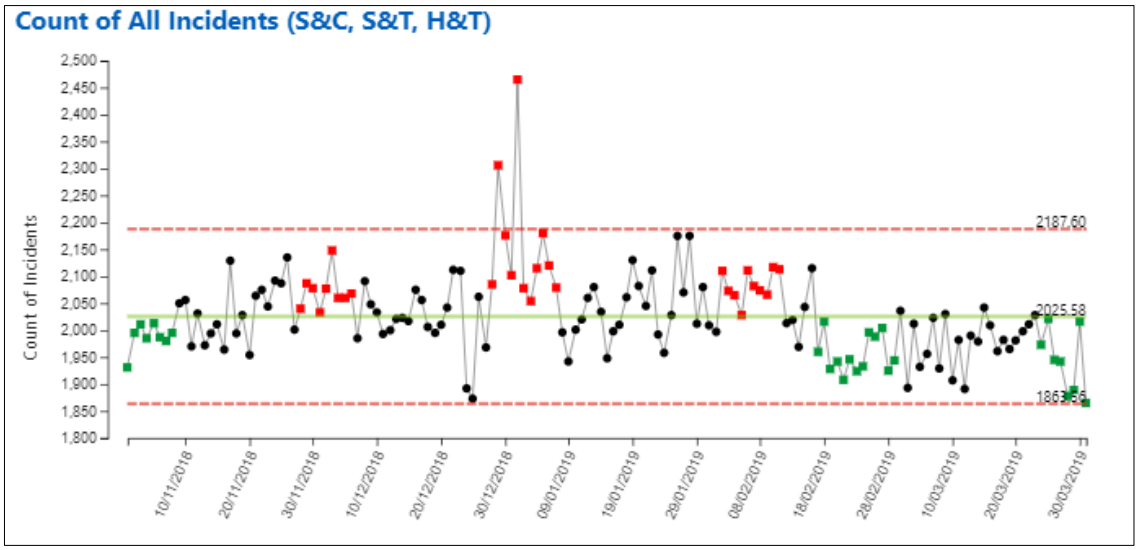
6.1. Activity Profiling

Activity profiling is based on demand and capacity review assessment. Analysis of past activity, present performance and growing demand produces a view of the levels of activity anticipated over the winter period and gives us an indication of when we might see demand peaks this winter.

However, this is not an exact science and it is recognised that the Trust may experience unplanned short-term/sustained periods of increased activity, therefore, demand and capacity is reviewed on a regular basis by Teams A, the Trust's senior operational leaders to consider factors which may change predictions, in order to manage resourcing and provision of operational hours.

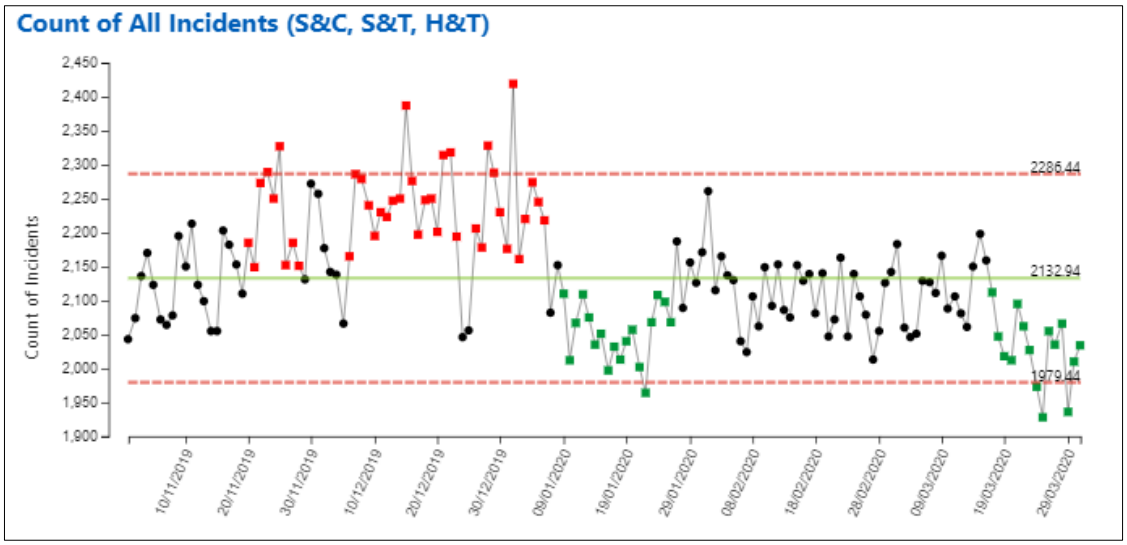
The following graphs show the activity over the winter period (November to March) for the previous two years.

Winter 2018



The trajectory for 2018 -19 reflects the implementation of the Ambulance Response Programme (Nov 2018) and the improved quality of data reporting due to the new CAD.

Winter 2019

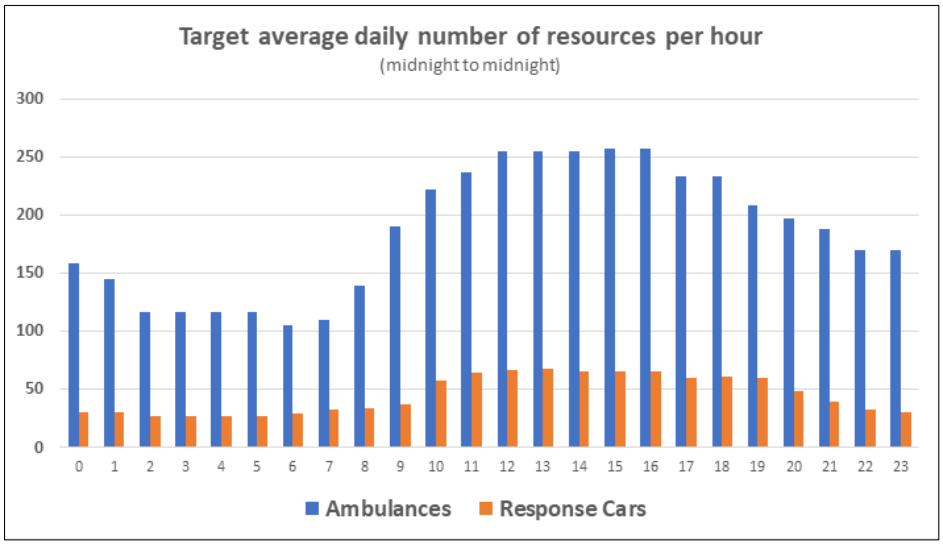


- indicates sustained period of average normal variation.
- indicates sustained period above average normal variation.
- indicates sustained period below average normal variation.

6.2. Operational Resource Planning

The Trust's scheduling teams, in conjunction with the OU leadership are responsible for providing operational resources in line with the Demand and Capacity Review. This also applies to the Contact Centres (Emergency Operations Centre & 111) with regard to call handling, clinical advisory and dispatch functions.

The scheduling teams role is to populate staff rotas up to six weeks in advance, with an objective of meeting the daily target hours per day, per week. The planned/target provision of operational staff hours is 65,150[2] hrs per week, these are then broken down per day to reflect demand. The average daily picture for the pattern of resourcing is represented in the graph below, however, as there is little to differentiate from day to day this provides a high-level view.



[2] Commencing September 1st, 2020

As we move towards the winter period a more accurate picture of the available resource against the predicted demands will emerge. This will be kept under constant review by Teams A to ensure that risk periods are identified, and mitigating actions are put in place.

6.3. Staff Abstraction

The Trust's Annual Leave Policy details the arrangements for annual leave over the Christmas period, which limits annual leave abstraction at 50% of normal levels. All short notice leave will be authorised at Operational Unit Manager level or above.

In addition to the above arrangement it is proposed that there are no abstractions other than pre-booked annual leave.

6.4. Financial Incentives for Targeted shifts

To incentivise and maximise overtime uptake, consideration will be given to provide overtime rates outside those available under Agenda for Change but only for specific days/shifts as required. The Trust's Operations Team will work in collaboration with both the Trust's Financial Directorate and staff-side to ensure a uniformity of approach to the issuing of incentives.

6.5. Surge Demand Mitigation

The Trust maintains a comprehensive surge escalation framework to augment service delivery during periods of increased activity:

Resource Escalatory Action Plan (REAP)

The Trust's REAP identifies rising trends in operational and organisational demands and facilitates escalation/de-escalation through the nationally set REAP levels.

Trigger mechanisms have been established through REAP arrangements that allow the Trust to respond to substantial increases in demand, in either specific areas or Trust wide. The Trust's REAP status is formally reviewed every week by the Director of Operations at the Teams A meeting, change to Reap Level is authorised by the Executive Management Board

REAP arrangements remain active at all times.

Surge Management Plan (SMP)

The SMP is utilised by the Trust from its EOC's in situations of surges in call volume, which result in the supply of ambulance service resources being insufficient to meet the clinical demand of patients. The more flexible and immediate nature of this plan will often mean that it provides a more effective and expedient response to surges in demand that are likely to be for short durations**.**

6.6. Increasing Operational Capacity and Effectiveness

6.6.1. Emergency Services Collaboration

The Trust has well established links with the other emergency services and is constantly seeking new ways of collaborative working with partners in order to increase efficiency or reduce demand on one or more emergency services. Examples of these activities are:

Co-Responding- Kent Fire and Rescue Service (KFRS) are our only FRS service colleagues that undertake this activity. However, each Fire and Rescue Service will consider other methods of assistance such as assisting crews with manual handling and deploying Liaison Officers to EOC on a case by case basis.

Forced Entry – All partner FRSs carry out this activity on behalf of SECAmb, unless time critical, crews must be on scene and make reasonable efforts to safely gain entry prior to requesting FRS support.

Joint Response Units (JRU) - The JRU is a Trust vehicle crewed with a Band 6 Paramedic and 1 or 2 Police Officers. This crew will attend a range of incidents for both services where a combined response may be required. These units generally operate to the night-time economy and are currently available in North Kent, Guildford, Brighton and Worthing. Operating hours vary in each location.

In hours the Emergency Services Collaboration Manager (ESCM) can facilitate this and out of hours the Trust Tactical Advisers can provide a link to other emergency services as the need arises.

6.6.2. Community First Responders

During the period of this plan Operating Units will highlight to the Community Resilience team where community first responder (CFR) schemes may support resourcing gaps. CFRs and Fire and Rescue responders (Kent FRS only) can respond to all category of calls. All have appropriate PPE to be patient facing and support the Trust during Covid-19 pandemic along with clear supporting guidance. Only CFRs those that have been fit tested and trained in appropriate PPE have their call sign available on the CAD to book on.

Requests for additional community first responders in hours will come through the Community Resilience Team in the first instance. During the Out of Hours (OOH's) period, EOC will cascade a message through the Response Desk targeted at local OUs that require operational support. The Community Resilience Team (in conjunction with the SECAmb communication team) will consider the use of social media to cascade messages where appropriate to CFRs. Again, during the OOH's period, this will be led through the SECAmb communications team.

During high periods of demand where conference calls are held to ascertain situational awareness and review resource against demand, consideration must be given to the use of CFRs and Fire and Rescue responders to assist the Trust in providing a timely response to our patients.

6.6.3. Response Capable Managers

During periods of severe pressure on service delivery, response capable mangers may be redeployed from their normal duties to support the delivery of operational

service as required. Teams A will work with Departmental Heads and managers to ensure that they are targeted effectively to support operational response when required, as it is recognised that there are a number of key work areas, which if not maintained and continued may cause additional problems and issues.

To ensure that the Trust maintains the capability to respond to a range of issues/incidents that may arise, on-call Strategic and Tactical Commanders and the Tactical Advisors should not be tasked to operational shifts, they can, however be called upon to provide support within the Command Hub(s) as required.

6.6.4. Private Ambulance Provision (PAP)

PAP is used throughout the year to support gaps in establishment and is currently provided under Direct Award Contracts. We also have the ability to request additional hours above the direct award contract level where PAP is eligible through the NHS framework.

6.6.5. Additional Funding Initiatives

The Trust may have to respond to ad hoc funding bids for winter initiatives, where short notice funding has been made available as experienced in previous years.

6.6.6. Paramedic Practitioner (PP) Urgent Care Hubs.

The PP Urgent Care Hubs have been introduced as an initiative to improve operational effectiveness. The function of the PP urgent Care hubs is to support operational staff in providing Emergency Clinical Advice Line call backs at a local Operating Unit level and providing supported clinical decision making with the aim to increase See & Treat, reduce Job Cycle Time and See & Convey to Emergency Departments especially for the Cat 3 / 4 Frailty cohort.

6.7. Maintaining Key Management Priorities

It has been identified that the following management duties will continue to be prioritised in addition to maintaining an operational response to patients.

- Focused HR Attendance Management support
- Return to work interviews
- SI’s
- Incident investigations
- Complaints
- Patient Experience Team support
- Appraisals

In order to maintain these key functions, support may be requested from other Directorates and work areas within the Trust. Directors and functional Heads will identify staff within support functions/alternative duties who could undertake identified tasks under the guidance of senior/operational managers.

7. Command and Control

The Trust's recognised strategic, tactical, and operational command structure will be in place throughout the winter period, details of which can be found on the on-call rota, accessible on the Trust's intranet and rostering system.

In the event that external partner organisations need to contact the Trust on-call commander(s), initial contact will be made via the respective EOC Managers West & East who will escalate as required.

During the period of this plan day to day responsibility of operations remains with the Director of Operations (or their nominated deputy). They are responsible for triggering a Trust wide response if the demands are outside the scope of normal procedures.

In addition, the Trust has implemented a dedicated Covid 19 management team to manage the Covid 19 response. Command capacity will be reviewed and flexed as necessary, in respect of EU transition arrangements.

The Organisational Response Management Group (ORMG), a multi-disciplinary management group (morphed from the Covid Management Group (CMG)) will provide senior leadership, oversight and governance in respect of the contingency arrangements put in place for the anticipated challenges that have been identified for the winter 2020/21 period.

The following table outlines additional measures to be considered to support an extended command structure in the event of increased pressure on Operations.

Item	Details
Winter Pressures	Additional teleconferences may be implemented to supplement the existing programme of oversight and control.
Strategic Suite	The Director of Operations (or their nominated deputy) may consider establishing a Strategic Command Hub within the Strategic Suite to support the Trust's normal management and command structures.
Tactical Command Hub	A tactical operations and performance hub is currently operational, providing 24/7 cover. Tactical oversight may be increased through the provision of 24/7 cover at both East and West hubs. There may also be a need to supplement this with additional resource capacity to enable additional functions and duties.
Clinical Oversight	The Senior Medical Advisor will provide clinical oversight to review risks and impacts to patients and provide senior level clinical support and advice.

8. NHS Winter Resilience Planning

Recognising the continued increase in pressures on the wider health system over the winter period, NHS England and NHS Improvement has circulated guidance to all Clinical Commissioning Groups and NHS providers regarding planning for winter. For Winter 2020, the NHS Winter Operating Model has been expanded to address the challenges of Covid 19 2nd wave and EU Transition.

In line with this guidance and the operational priorities set out the Trust will continue to engage with the wider NHS through A&E Delivery Boards and Collaborative ICP/ICS/STP sessions in order to influence and shape local initiatives, whilst continuing to focus on delivering 999 and 111 core services safely and timely. Additionally, the Trust Strategy and Partnership will continue to engage with and seek assurance from the systems that their plans have sufficient capacity to manage surges in demand, any concerns will be escalated through established processes.

8.1. Hospital Handover Delays

System wide pressures can result in significant ambulance handover and turnaround delays at acute hospitals across the Trust region, with delays having an impact on the Trust's ability to deliver a safe service to patients wating for a 999 response in the community. Hospital handover delays increase during the winter when there is an increased need for urgent and emergency care services. This leads to a mismatch between capacity and demand and is associated with poor patient flow.

This winter will see this effect compounded by the already pressurised system. There is a risk that due to the need for social distancing to be implemented in Emergency Departments (EDs) and the wider hospital, handover delays will increase, particularly at sites where there are challenges around hospital estates.

Locally SECAmb continues to work closely with hospital colleagues and other partners across the region as part of system wide programme of work to reduce handover delays. The focus is on streamlining processes and embedding best practice at Emergency Departments (EDs) to improve handover and flow. The programme also focuses on raising awareness and improving crews' ability to access existing community pathways to safely reduce the number of avoidable conveyances to hospital. Work with system partners also focuses on developing new pathways both in the community and at hospital sites including direct conveyance to non-ED destinations e.g. same day emergency care units (SDEC). Direct conveyance to non-ED destinations supports the NHS111 First delivery and helps reduces congestion in EDs, improves patient experience and safety, and reduces handover delays in EDs

At times of increased pressure and when handover delays create significant problems, the trust will continue to work closely with hospital colleagues to seek early resolution using established locally agreed escalation processes .The trust's Clinical Handover and Transfer of Care Procedure (which replaces the Immediate Handover Standard Operating Procedure and the Conveyance Handover and Transfer of Care Procedure) supports operational and clinical staff in managing handover delays with actions to be taken and points of escalation.

8.2. Hospital Diverts

A system wide SOP for hospitals requesting an ambulance divert is in place and ensures requests are managed in a consistent way supported by an appropriate governance framework. The SOP has recently been reviewed with input from commissioners and hospital colleagues across Kent, Surrey and Sussex. The final agreed version will be sent out to all A&E delivery boards (AEDB) ahead of winter.

8.3. NHS Operational Pressures Escalation Levels (OPEL)

NHS England has distinct escalation levels in the management of surge pressures as set out in OPEL, which standardised local, regional and national escalation levels to respond to severe pressures on the NHS. These levels are used by the wider health community. To ensure a consistent approach the Trust's REAP has adopted the same system of escalation over four levels with related triggers and actions.

Adverse Weather

As part of business as normal procedures it is the responsibility of the Emergency Preparedness, Response and Resilience Team to monitor any approaching adverse weather via Met Office and Local Resilience Forum (LRF) alerts. The Trust's Tactical Advisors provide a 24/7 on call arrangements and act as a single point of contact for external agencies to alert for incidents or significant events.

Tactical Advisor SPOC: 0330 332 6231

Warnings of any potential adverse weather are communicated through the daily Team E calls and to on-call commanders, relevant managers and functional heads.

At times of severe weather during the winter period or access via difficult terrain, the Trust needs to be able to deploy four-wheel drive (4x4) resources to provide access to patients and retrieval to road-based resources.

The Trust operates a variety of vehicles with 4x4 capability across its geography and a range of operational staff across the organisation are trained to drive these vehicles. All the Trust's ambulances/response cars have all-weather tyres fitted in readiness for adverse weather conditions.

The Trust also maintains a contract to hire in additional 4x4 vehicles to support with staff movement. These will be deployed under the direction of Tactical Commanders in preparation for or during any adverse weather.

The Trust also has Memorandum of Understandings (MOU's) in place with Voluntary Aid Societies (VAS) who can also mobilise 4x4 vehicles and ambulances as required to support operations. In addition, Memorandum of Understandings (MOU's) are in place with volunteer 4x4 groups to provide assistance at times of severe weather.

Around 40 Community First Responders have their own 4X4 vehicles. A contact list is held by production and during an emergency or BCI situation, for example inclement weather, the CFR volunteers can be called upon to support the Trust in either responding to patients within their communities or moving Trust staff from A to B such as EOC staff.

The Logistics department robustly plans for the distribution of supplies of winter stock to Trust estate in advance of and throughout periods of adverse weather.

The Trust's Major Incident Plan, Additional Contingencies provides further guidance and information specific to adverse weather.

9. Major Incident

In the event of a Major Incident being declared during this period, procedures as detailed in the Trust's Major Incident Plan will be followed. Please refer to the Trust's Major Incident Plan and Additional Contingencies and EOC Action Cards for further information.

10. Business Continuity

In the event of a (further) Business Continuity Incident being declared during this period, procedures as detailed in the Trust's Business Continuity Plan(s) will be followed. All service areas have been asked to review their business continuity arrangements in light of the risks identified in this framework.

11. Key Support Services

11.1. Fleet Resource Planning

Fleet services are responsible for ensuring that the Trust's vehicles are available to operations when required to meet their peak demand. However, this must be based on an effective working relationship between operational managers and vehicle maintenance staff. This will ensure that vehicles are presented for scheduled maintenance and MOTs when requested without affecting performance and that vehicle utilisation is maximised by robust monitoring and implementation of driving standards and vehicle damage.

There are a number of measures for the Fleet Department to take to ensure that vehicle availability is maximised and particularly through Q3 and Q4; these include:

- All MOTs being rescheduled to avoid November and December
- Damage repairs will be 'bundled' to be undertaken in batches (unless it requires to be done for safety / road worthiness).
- All decommissioning of old vehicles will be slowed down so we can utilise these additional resources where possible.
- The Fleet Department has an escalatory Plan which ensure that additional maintenance capacity can be applied during periods of higher demand.
- The Fleet Department will support and work alongside the Make Ready and Vehicle Preparation Programme (VPP) to ensure efficient turnaround of vehicles within the system.

There are risks associated with being able to provide sufficient vehicles to meet peak demands, however we are currently refreshing our fleet to increase vehicle numbers.

11.2. **Make Ready**

The Make Ready system is responsible for cleaning, restocking and checking equipment on ambulances and SRVs in readiness for operational shifts.

The Make Ready system has an escalatory plan, that may be implemented during periods of increased pressure, which extends the Make Ready programme, and allows for vehicles to be “hot loaded”, in that they are not put through the full Make Ready system to ensure that sufficient vehicles are available for operational response.

Contractual arrangements are in place with the Make Ready provider to enable optimal staffing levels over the Christmas period.

11.3. **Logistics Resource Planning**

The Logistics Support Department are responsible for ensuring that all Trust locations have the availability of medical consumables, gases, medical paperwork and sundry items to ensure that the Operational vehicles can be maintained to the required stock levels for effective patient treatment and care.

There are a number of measures which can be taken by the Logistics Support Department to ensure that stock levels are pre-positioned and maintained to ensure maximum availability, particularly in the lead up to and through Q3 & Q4, and may factor in the following;

- Medical equipment servicing is not planned during the Q3/Q4 period.
- Medical consumables stock is uplifted to account for the increase in demand.
- Medical gas supplies are uplifted and pre-positioned in certain Trust areas to allow for increase in demand.

The Logistics Support Department will support and work alongside the Make Ready and Vehicle Preparation Programme (VPP) to ensure efficient turnaround of equipment and consumable requests required to support the vehicles within the system.

11.4. **IT/EOC Systems**

The Head of Information Management and Technology is responsible for ensuring 24-hour IT support which is delivered through an on-call system.

Dedicated support is provided to the EOCs by the EOC Systems team, again through an on-call system.

Additional arrangements for the provision of on-site support for key dates such as New Year’s Eve will be in place

12. Infection Prevention and Control

12.1. **Flu Vaccination Programme**

The Executive Director of Nursing and Quality is responsible for the delivery of the seasonal influenza vaccination programme for Trust staff. Staff communications processes will be run prior to and throughout the winter period to encourage uptake.

Following an established model, specially trained Trust clinicians will be available at workplaces across the Trust to undertake vaccinations. We anticipate that the vaccination programme will start as soon as the vaccine has been produced and distributed to areas. Last year the Trust was one of the leading Ambulance Trusts with a 77% uptake, this year NHSE/I directive is for 100% of staff to be offered flu vaccination therefore the aim is to get as close to 100% as possible.

12.2. Seasonal Influenza and Norovirus Outbreaks

Any flu or norovirus outbreaks in the community are monitored by the IPC Team via the Public Health England Daily Outbreaks reporting system (these reports are also shared on a daily basis with 111). Local IPC Alerts will be sent out as and when required as well as regular updates on procedural compliance to IPC Universal Standard Precautions for staff to maintain.

Any flu or norovirus outbreaks within the Trust will be investigated and managed by the IPC Team with all necessary actions put in place. This will include local IPC Champions supporting the team and occupational health support from Optima.

The IPC Team will also liaise with EOCs, Make Ready Teams and Production Desk to provide advice on the decontamination requirements for vehicles and staff involved in any possible post treatment / transportation contamination issues.

The Trust's Pandemic Influenza Plan has been maintained in line with national guidance. Due to the variables associated with pandemic flu there are no specific triggers for implementing pandemic specific arrangements, therefore the Trust response to a pandemic influenza outbreak will be guided by the NHS response.

12.3. Personal Protective Equipment (PPE)

Covid-19 and changes to how the NHS Supply Chain works will mean challenges around the supply of many key items of PPE that ensure operations are maintained. The following items are some examples of stock that can no longer be ordered through NHS Supply Chain (a full list can be found at https://www.ppe-dedicated-supply-channel.co.uk/ppe-product-listing/) :

- Type llR surgical Masks
- FFP3 masks for use in level 3 settings
- Coveralls
- Clinical Waste bags
- Gloves

These items rely on a "push pallet" delivery system which Trusts currently have very little influence over. Any adverse weather such as flooding or significant snow that affects the distribution element of the supply chain may have a profound effect on the ability to resupply key items. This is made more challenging as many items of PPE are not currently held in enough numbers to provide prolonged reserves.

There is a possibility that worst case scenario EU Exit impacts disrupting UK ports of entry could also disrupt the acquisition and distribution of stock as described above.

The Trust continues to look at alternative PPE in place of FFP masks for staff use, and will work with procurement and operations to determine requirement for a strategic reserve of PPE to reduce reliance on NHS Supply Chain.

13. Staff Welfare

The Trust understands that the health and wellbeing of all our staff is of paramount importance and recognises the extraordinary challenges being faced by staff, more so during this Covid-19 pandemic.

The Wellbeing Hub provides an entry point for employees to obtain emotional and wellbeing support, signposting and access to appropriate services in a timely manner can provide to staff where necessary.

The Wellbeing hub has collated a wide range of self-help resources and information on support services that have been made available for all staff, on The Zone. Guidance is also available to managers on how to support their staff and the wellbeing services available.

14. Communication

During this period the Trust's internal and external communications will include general and specific communications which support the delivery of this plan. Led by the Trust's Communications team this will include internal and external messages some of which will be prepared based on foreseeable issues including the following:

- Adverse weather
- Stay Safe messages
- Extended periods of excess demands or in advance of known key dates
- Staff communications

The team will continue to engage with Local Resilience Forum and NHS communications teams to ensure co-ordinated messaging.

Operating Unit Managers, Operations Managers and Operational Team Leaders will be responsible for liaison with operational staff within their Operational areas, as well as engaging with key stakeholders such as hospitals, CCGs and A&E Delivery Boards/Integrated Care Systems.

The Trust Business Account Managers will act as commissioner liaison and provider through engagement with the Lead CCGs and A&E Delivery Boards/Integrated Care Systems.

15. Review

The Executive Director of Operations has overall responsibility for this plan.

This is a living plan and will be subject to review through the Trust Resilience Forum, as we continue to develop this plan prior to implementation, and throughout the Q3/Q4 period as required.

During periods of extended escalation, the Executive Director of Operations will report to the Executive, who will review the on-going impact of escalation on the Trust.

An exercise will be undertaken as part of winter preparation in the preceding period to ensure readiness. In addition, testing of the plan will be undertaken through attendance at NHS winter capacity exercises across the Trust's region.

16. Distribution

16.1. Internal Distribution

- Teams A
- Senior Leadership Team
- Executive Management Board
- Communications Team (for publication on Staff Zone)
- Operational Manager
- Strategy and Partnerships Managers
- EPRR Team
- ORMT

16.2. External Distribution

- NHS England and NHS Improvement -South East
- Lead Commissioners
- Integrated Care Systems

Appendix A: Risk Assessment

No	Description of Hazard	Existing Controls/Actions in Place	Risk Level		
			initial	current	target
1	**Covid-19, Second wave resurgence** The worst-case scenario is that infections reach epidemic levels again, putting serious strain on the Trust and the wider NHS due increased operational demand, staff absence and supply chain interruption.	• Covid-19 Strategic Plan • Covid-19 Operating Framework • COVID-19 Pandemic Test and Trace Cell SECAmb Staff Procedure. • COVID-19 Outbreak Control Management Framework. • Executive Oversight by the CMG • Dedicated Covid Management Team in place • Multi-Agency Response Plans via the LRFs	25	15	10
2a	**Winter flu and other winter related illnesses** There is a risk that COVID 19 cases may be conflated with traditional flu cases and winter illnesses. Symptoms are similar and it will be difficult to discern which is which. This may lead to the continued job cycle time increase seen due to donning and doffing of appropriate PPE for potential COVID 19 cases and may also impact on PPE burn rates.	• Covid-19 Response Plans • Executive Oversight by the CMG • Tactical Hub dynamically monitoring hospital performance • PPE management group oversight	16	12	12
2b	**Serious winter flu outbreak and other winter related illnesses - System Pressures** Each winter the wider NHS and Social Care sees and increase in influenza and other seasonal infectious diseases that will impact on urgent activities in the health and social care systems. A compound risk is that patient flow issues will be exacerbated, and some pathways	• The Trust continues to engage in system wide Winter Planning • There are a number of contingency plans in place to mitigate surges in activity including: SMP, REAP and BC Plan • Tactical Hub dynamically monitoring hospital performance • Operational Commanders available and low threshold to	16	12	12

	disrupted due to procedures put in place for Covid 19 protection. In turn this can result in significant ambulance handover and turnaround delays at acute hospitals across the Trust region, with delays having an impact on the Trust's operations and affect our ability to respond to demand.	deploy to provide on-site supervision and liaison including implementation of the Trust's Clinical Handover and Transfer of Care Procedure.			
3	**EU Exit Transition** The UK left the EU on 31 January 2020 and entered a transition period until 31 December 2020. If the UK does not reach an agreement with the EU before 31 December 2020, this will likely create a similar scenario the 'Day 1 No Deal' situation that the Trust was previously planning for. As a result of this there may be significant impact on several areas of SECAmb as an organisation.	• All EU Exit identified risks are recorded on the Trust Risk Register and will be reviewed in light of EU Exit Transition. • The Trust continues to engage with LRFs and wider NHS partners across the region in planning and exercising. • The Trust is continuing to plan and put contingencies in place for EU-TE,	16	12	6
4	**Adverse Weather** There is a potential for adverse weather during this period which could further exacerbate the challenges faced at this time, when resources are under pressure.	• Adverse weather preparation and planning arrangements • Trust 4x4 fleet and authorised drivers • MOUs with 4x4 volunteers and multi-agency response with LRF partners	12	9	9
5	**Supply Chain** There is a potential for Supply Chain shortages including PPE, uniform and fleet. This may be due to increased use of PPE, delays in production of items; the impact on the ability to import goods and internal and external distribution impact due to staffing.	• Covid 19 planning considered elements (specific to PPE) • EU Exit Transition planning considered elements • PPE management group oversight • Contact being made with suppliers re key products. • Maintenance of stock levels. • Effective planning of supply requirements e.g. uniform, PPE etc. • Effective procurement process to understand delivery and supply implications.	20	12	9

6	**Staff absence** Staff absence above the expected norm. This may be due to a range of causes such as; influenza and other winter respiratory illnesses, Covid-19, self-isolation (awaiting results for/still symptomatic), adverse weather etc.	• Flu vaccination programme rolled out • Planning assumption alignment/workforce planning • SMP • REAP • COVID-19 Plans /action cards • Business Continuity Management plan • Departmental business continuity plans • HR BC Plan • Wellbeing Hub	16	15	12
7a	**Public Disorder** There is a risk of increased criminal activity against staff including physical assault, verbal assault and theft of personal and trust property.	• Trust security management policy/procedures and support.	6	6	6
7b	**Public Disorder** There is a risk that trust staff, vehicles and property may become embroiled at public order events. However, staff are not equipped or trained to attend public order events and may unwittingly as a result of moral pressure commit to an area that is unsafe and as a result may suffer injury, fear, stress and fatigue. If there are multiple public order events occurring and trust staff are required to attend several, without a break, due to the unavailability or lack of resources then these factors maybe further exacerbated. Public disorder and planning for this may be exacerbated by the uncontrolled nature and unknown or unexpected hazards that may occur.	• Multi-agency information sharing • Use of JESIP principles to plan for known and unknown events.	9	9	9
8	**Organisation Reputation** Failure to plan for, mitigate and manage the forecast increase demand over the winter period	• Engagement with CCG's, NHSE&I, PHE and system partners throughout planning, preparedness and	6	6	6

	and provide a safe service to our patients could lead to damage to the Trust's reputation.	response to maintain confidence across the system of robust arrangements within SECAmb • Patient Survey Responses • Friends and Family Test • Communications activity reports to EMB • Communications and Engagement Plan			
9	**Activity flow from SECAmb111** Previously throughout this period 999 has seen an increased activity flow from SECAmb111	• The SECAmb111 Escalation Plan is in place to mitigate pressure on the 999 service. • Additional recruitment for 111/CAS	20	12	4
10	**PTS Provision** The Trust is not commissioned to provide PTS, if the PTS providers do not maintain robust resourcing over this period, this could impact on A&E departments when hospitals booked discharges are required to enable capacity.	• This risk will need to be addressed through continued engagement with 999 commissioners and the Local Delivery Boards and links into wider NHS/system Winter Resilience Planning.	6	6	6
11	**High Dependency Intermediate Care Transfers** The Trust is not commissioned to provide high dependency intermediate care transfers, except when this is shown to be an escalation of care.	• This risk will need to be addressed through continued engagement with 999 commissioners and the Local Delivery Boards and links into wider NHS/system Winter Resilience Planning.	6	6	6
12	**Access to Primary Care** The Christmas and New Year bank holidays result in an extended weekend. There is limited access to primary care throughout this period adding to Ambulance/NHS111 activity.	• This risk will need to be addressed through continued engagement with 999 commissioners and the Local Delivery Boards and links into wider NHS/system Winter Resilience Planning.	6	6	6

The risk assessment reflects risks/rating as detailed on the Trust Risk register and includes additional risks identified in the planning for winter 2020. The assessment takes account of the SECAmb regional footprint and it is recognised that there may be local county/ICS variances.

Appendix B: Key Contacts

External Partner Trust On call contact

Systems on OPEL 1 & 2 should maintain contact through the local Operational Commander who will escalate to Tactical Support Hub and Strategic on call as required. Any additional external on call contact access is via the Emergency Operations Centre Manager.

Emergency Operations Centre Manager

EOC	Area	Number
EOC West	Surrey, West Sussex, Brighton & Hove	**0300 123 9883**
EOC East	Kent & Medway & East Sussex	**0300 123 5818**

Tactical Support Hub

Location	Area	Number
WEST	Surrey, West Sussex, Brighton & Hove	Due remote working – initial contact via EOC Manager WEST **0300 123 9883**
EAST	Kent & Medway & East Sussex	Due remote working – initial contact via EOC Manager EAST **0300 123 5818**

Tactical Advisor/National Inter-agency Liaison Officer (NILO)[3] Single Point of Contact - **0330 332 6231** Option 1 West /Option 2 East

Tactical Advisors provide a 24/7 on call arrangement and act as a single point of contact for external agencies to alert for incidents or significant events.

Covid Management Team - 0300 123 9198

Media On Call - **01622 740562** and then option 1

[3] Tactical Advisors provide a 24/7 on call arrangement and act as a single point of contact for external agencies to alert for incidents or significant events.

Item 7: Children and Young People's Emotional Wellbeing and Mental Health Service - update

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 24 November 2020

Subject: Children and Young People's Emotional Wellbeing and Mental Health Service - update

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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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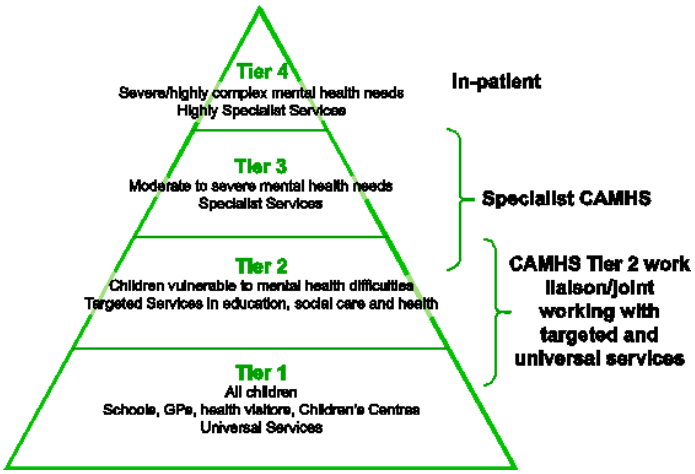
1) Introduction

a) Children and young people's mental health services (CYPMHS) is an umbrella term covering a wide range of services commissioned by the NHS and local Government. The diagram below helps to explain the tiered provision of the overall service.

Diagram: How CAMHS is structured[1]



b) Locally, specialist CYPMHS (Tier 3) is commissioned by Kent & Medway CCG and provided by North East London NHS Foundation Trust (NELFT).

2) Previous visits to Kent's HOSC

a) HOSC have raised a number of concerns about the CYPMHS over recent years. These concerns have centred around waiting times; service provision because of capacity issues; and communication during waiting times.

b) The commissioner and provider last attended HOSC in March 2020. Key points from that update include:

[1] Parliament (2014) CAMHS as a whole system https://publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/34206.htm#note29

- The service was experiencing a rise in demand and also difficulty in recruiting staff (they had a 22-26% vacancy rate).
- For general mental health conditions, NELFT were meeting the Referral to Treatment (RTT) standard (18 weeks) by about 82%.
- There were between 6,000 – 7,000 children on the Neurodevelopmental (ND) waiting list, mainly for diagnostics.
- A new ND pathway was to be implemented in July 2020 – there would be a period of transition between the two pathways.
- The Looked After Children (LAC) caseload remained high.
- A new initiative had been piloted in Canterbury, showing the importance of early information which was offered via a handbook. The pilot had been well received and it was intended to roll this out across the county.
- NELFT had been awarded the contract for Kent Tier 4 inpatient mental health beds for children and young people. They were due to take over the management of the Woodland House unit (near Staplehurst) on 1 April 2020.

c) Following the discussion, the Chair requested that the following updates be provided when the item returned to HOSC:

i. the implementation of the new pathway
ii. the rollout of the Canterbury pilot
iii. the changes to the Woodlands Unit
iv. the new care model, and
v. demand and financial projections

d) Representatives from the CCG have been invited to attend today's HOSC meeting to provide an update.

3) CAMHS Tier 4 provision at Cygnet Hospital, Godden Green

a) Specialist in-patient provision for CAMHS (Tier 4) is commissioned by NHS England. The Chair of HOSC was notified on 26 October 2020 that two CAMHS wards at Cygnet Hospital in Godden Green near Sevenoaks had been closed. A recent Care Quality Commission (CQC) inspection did not provide assurance that the service met the standards expected or that the provider could implement and sustain the improvements required. Cygnet advised NHS England of its intention to close the two wards as a result of this inspection and this closure happened on Monday 26th October.

b) The small number of patients cared for on the CAMHS wards have been transferred or discharged. Additional services provided at the Hospital remain unaffected.

c) There remains one inpatient unit in Kent, which is the Kent and Medway Adolescent Hospital (formerly known as the Woodlands Unit) provided by NELFT.

d) An investigation is currently underway led by NHS England into a serious incident that took place at Cygnet Hospital prior to its closure and it is proposed the item be brought to HOSC for scrutiny once that investigation has concluded.

Item 7: Children and Young People's Emotional Wellbeing and Mental Health Service - update

e) Kent and Medway CCG are not responsible for commissioning in-patient Tier 4 services and therefore will be unable to answer questions about the closure at today's meeting.

4. Recommendation

RECOMMENDED that

i. the report on Children & Young People's Emotional Wellbeing & Mental Health Service (Tier 3) be noted and Kent & Medway CCG be invited to provide an update at the appropriate time.

ii. The closure of the inpatient unit at Cygnet Hospital in Godden Green is brought to HOSC once the investigation has concluded.

Background Documents

Kent County Council (2016) *'Health Overview and Scrutiny Committee (04/03/16)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6257&Ver=4

Kent County Council (2016) *'Health Overview and Scrutiny Committee (02/09/16)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6261&Ver=4

Kent County Council (2017) *'Health Overview and Scrutiny Committee (20/09/17)'*, *https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7788&Ver=4*

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 (01/03/19)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7926&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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Kent MP quarterly briefing note:
Quarter one
April to June 2020

Children, young people and young adults' emotional wellbeing and mental health in Kent

(This quarterly briefing note provides a regular update for all MPs in Kent. Please note this is not for media use or for use in any other publication.)

Commissioner update

Children's System Covid-19 response

NHS Kent and Medway Clinical Commissioning Group (K&MCCG), in partnership with Kent County Council (KCC) developed a Covid-19 response system within the first quarter of this year. All providers, commissioners and partners engaged in meetings three times a week to keep a real-time track of issues relating to children and families during this time. Providers have been required to attend and report on issues relating to service provision, workforce capacity and welfare and risk. All issues had a direct escalation route to the Kent and Medway Covid Response mechanism.

Children's mental health Covid-19 response

During quarter one, the commissioners and NELFT focussed on maintaining service levels where possible and where safe to do so. The key points, relating to quarter one, are as follows:

- Workforce arrangements to work from home with appropriate equipment was achieved quickly and a virtual appointment system was set up within the first two weeks
- Children and young people with high clinical risk were prioritised and face-to-face appointments were continued (where safe to do so)
- Referrals into the service for mental health interventions dropped significantly in quarter one, while referrals for the Neurodevelopment and Learning Difficulties Service (NLDS) were maintained
- Clinical harm reviews of over 4,000 cases were undertaken by NELFT across both the mental health service and NLDS during this time, as part of a multi-provider response to serious incidents (this was aligned with KCC social care and other partners undertaking a similar approach to children identified as vulnerable)
- All children on caseload were contacted by NELFT to make them aware that help and interventions were still available to them.

With regards to the wider commissioner and partner system response during this time, actions were undertaken to ensure that there was a consistent approach to messaging and support. These included:

- 'Here for You' - a joint CCG and NELFT social media campaign, which was created for and shared with schools to promote via their own social media channels, sharing eight key messages about services in Kent supporting young people's mental health needs, these were: the Single Point of Access, Kooth, Shout, Moodspark, Release the Pressure, ChatHealth, Big White Wall and information on domestic abuse
- A 'central hub' for information regarding mental wellbeing during the coronavirus pandemic hosted on the KCC website, regularly updated with the latest partner information and information for families and children
- Distribution of over 3,000 copies of the Handbook for Families to those waiting for an autism or ADHD assessment
- Funded the roll out of Kooth (online counselling service) across the whole of Kent so all children can access support online
- The CCG and KCC have also jointly commissioned the production of 'crisis cards' for frontline workers to give to families and individuals detailing the mental health support and services available. These are currently being designed but will be shared with SECAMB, the Police, pharmacies, GP surgeries and partner organisations

Covid-19 recovery response for children and young people's mental health

During quarter one, commissioners have developed a Covid-19 'recovery response' for children and young people's mental health. The current focus of 'recovery' is to establish evidence-based modelling regarding the impact of Covid-19 and to plan accordingly to meet the demand. The recovery work is cross-sector with all partners involved and is currently focussed on the following:

- **Autism and ADHD pressures:** the rate of referrals into services did not drop during Covid-19, however the rate of diagnostic assessments did due to the clinical licence for some assessments being invalidated if used virtually or with personal protective equipment (PPE). There are five providers across Kent and Medway that are commissioned to deliver diagnostic assessments and they have been working with commissioners to put recovery plans in place.
- **Supressed/latent demand:** these are the children and young people who did not access NELFT's services during quarter one that are likely to do so over the coming months. Work is under way to model that demand, prepare for any surge and seek additional funding for increased capacity.
- **New demand:** this is the demand that is expected to have been 'created' by the lockdown itself. Specific focus is being given to children and young people experiencing anxiety and/or trauma (including traumatic bereavement).

Mental Health Support Teams (MHSTs) in schools

In May 2020, the Medway and Thanet areas were informed that they had both been successful in a bid to receive NHSE/I funding to develop Mental Health Support Teams (MHSTs). Each locality will host two teams under the management of NELFT. This builds on the two North Kent Trailblazer teams and Canterbury and Maidstone's 'Wave Two' teams (a total of six teams in all). Recruitment is under way for the staff needed, and they will begin a year-long training programme in November 2020.

NELFT update

COVID-19 update

To manage our response to Covid-19, we maintained a Gold/Silver/Bronze control and command approach, with local daily management meetings to ensure key messages and arising issues were discussed and resolved.

Throughout the pandemic, our children and young people's mental health services (CYMHS) across Kent remained open and ran as business as usual, in line with national guidance for critical health services. To support our patients and keep our staff safe, we utilised technology with telephone and video consultations for one-to-one and group therapy. We continued to deliver face-to-face consultations based on clinical risk and need and maintained the safety and staff and patients by ensuring our settings were compliant with PPE and Covid-19 regulations.

Although we saw a decrease in referrals to the service at the start of lockdown, this has steadily increased as schools have re-opened and lockdown measures have eased. We are prioritising and supporting the in-depth, system-wide work following the unfortunate increase of serious incidents in Kent since the start of lockdown. We are now focussing on the recovery and restoration phase of our Covid-19 response and have established our priorities and begun work on key areas. Formal monthly performance scrutiny has remained in place with our commissioners.

Inpatient mental health unit update

NELFT successfully took over the provision of in-patient mental health services for children and young people at the Kent and Medway Adolescent Hospital (KMAH), formerly provided by South London and Maudsley NHS Foundation Trust (SLAM), in Staplehurst, on 1 April 2020.

KMAH is our first mental health inpatient unit in Kent and means we can provide more comprehensive care for some of our patients, who we are already treating as outpatients or in the community. We have started building work on a Section 136 suite, which will be used as a place of safety for patients who are brought to our unit by the police. We will update you on the progress in our next quarterly briefing.

NELFT CYPMHS performance activity data – April to June 2020 (Q1)

This briefing is accompanied by two key appendices.

- **Appendix 1** provides a full detailed breakdown of referral and caseload activity for the quarter period from April to June 2020 by CCG locality
- **Appendix 2** focuses on the length of waiting times for assessment and treatment by week and CCG locality area over the same period.

The data within both appendices is provided in line with MP specification and has been shared quarterly since October 2018.

Access, referrals and caseload management

The service continues to manage a significantly high patient caseload of over 11,600 children and young people. Close caseload monitoring, continual review of individual clinical risk on the waiting list and local data cleansing initiatives have contributed to the reduction in the overall caseload.

The number waiting for the first assessment has increased as referral to the service remained high and a number of patients did not attend their appointments due to Covid-19 and families' reluctance to meet face to face.

We reviewed all the caseloads in Q1 as part of our risk stratification process during Covid-19 which resulted in discharges of appropriate cases. Services remain business as usual, with service users being contacted regularly and/or seen face-to-face, based on clinical need and escalation.

Table 1 summarises key activity across the service over the last six months.

Kent CYPMHS & Neurodevelopmental and Learning Disability Service
Jan 20 - Jun 20

	Q4 2019/20	Q1 2020/21
Total Caseload (NLDS & CYPMHS)	12,373	11,670
Caseload - NEURO ONLY	7,467	7,077
Caseload - CYPMHS ONLY	3,907	4,593
Referrals received - CYPMHS	5,467	3,696
Referrals received - Neuro	607	885
Number waiting for first assessment - CYPMHS	406	1,031
Number waiting for routine treatment - CYPMHS	1,586	1,756
Number waiting for treatment - Neuro	3,504	3,237
Number of discharges (inc Neuro)	4,396	5,383

Appendix 2 – Key notes

- Improved position for service users waiting over 18 weeks for NLDS due to the implementation of a Neurodevelopmental SPA function to include early screening and triage for ASD/ADHD. Referral volume remains high throughout the period, which has impacted on less than 18-week waits across the service.
- Both ADHD and ASD face-to-face diagnostic assessments continued but were limited to high risk cases due to COVID-19 during the quarter. Locality mental health teams and neurodevelopmental services offered virtual assessments but were unable to complete some of these assessments due to schools not being open and not being able to supply additional information required to support the assessments.

Table 2 below is a summary of Appendix 2 and compares performance against the previous quarter.

Children & Young Peoples Mental Health Service (CYPMHS) - Waiting Times

East Kent: Referral to Assessment (RTA)				
	Under 18 weeks	Over 18 weeks	Over 52 weeks	Total
Q4 (Jan 19 - Mar 20)	141	12	1	154
Q1 (Apr 20 - Jun 20)	494	9	35	538
	⬆	⬇	⬆	⬆

West Kent: Referral to Assessment (RTA)				
	Under 18 weeks	Over 18 weeks	Over 52 weeks	Total
Q4 (Jan 19 - Mar 20)	213	38	1	252
Q1 (Apr 20 - Jun 20)	453	39	1	493
	⬆	⬆		⬆

East Kent: Referral to Treatment (RTT)				
	Under 18 weeks	Over 18 weeks	Over 52 weeks	Total
Q4 (Jan 19 - Mar 20)	534	102	9	645
Q1 (Apr 20 - Jun 20)	731	57	60	848
	⬆	⬇	⬆	⬆

West Kent: Referral to Treatment (RTT)				
	Under 18 weeks	Over 18 weeks	Over 52 weeks	Total
Q4 (Jan 19 - Mar 20)	683	230	28	941
Q1 (Apr 20 - Jun 20)	688	191	29	908
	⬆	⬇	⬆	⬇

Neurodevelopmental and Learning Disability Service (NLDS) - Waiting Times

East Kent: Referral to First Assessment & Treatment				
	Under 18 weeks	Over 18 weeks	Over 52 weeks	Total
Q4 (Jan 19 - Mar 20)	332	494	1936	2762
Q1 (Apr 20 - Jun 20)	517	341	1643	2501
	⬆	⬇	⬇	⬇

West Kent: Referral to First Assessment & Treatment				
	Under 18 weeks	Over 18 weeks	Over 52 weeks	Total
Q4 (Jan 19 - Mar 20)	117	182	443	742
Q1 (Apr 20 - Jun 20)	232	103	401	736
	⬆	⬇	⬇	⬇

A significant increase in Did Not Attends (DNAs) over the reporting quarter has impacted waiting times for children and young people waiting to be seen within 18 weeks. This is due to families' reluctance to engage during the pandemic, however the service has since fully embedded digital offers for assessment and treatment by telephone and video.

The service was able to reduce waits for those waiting between 18 and 52 weeks however, due to non-engagement from families and new ways of reporting since COVID-19 (i.e. virtual treatment based activity) not being reflective within data, those waiting over 52 weeks have increased within the locality.

Key highlights on Referral to Treatment and Referral to Assessment

- Referral volume increases year on year
- Trajectories in place since September 2018 to monitor waiting times
- Overall reduction in long waiting times since transfer
- Improved position on NLDS waiters
- Weekly review of longest-waiters caseload, which is monitored through clinical harm review and clinical risk assessment contact with families/service users
- Continual data cleanse and review in place
- This quarter has seen a decrease in those waiting between 18-52 weeks.

For further information on the CCG content, please contact:

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Item 9: Work Programme 2020

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 24 November 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

27 January 2021		
Item	**Item background**	**Substantial Variation?**
Wheelchair Services	Members requested an update on the performance of the Wheelchair Service in 9-12 months following their meeting on 29 January 2020.	-
Ophthalmology Services	To discuss a possible change in provider for the service.	To be determined
Dermatology Services	To receive an update on provision of the service following the contract termination with DMC Healthcare.	-

4 March 2021		
Item	**Item background**	**Substantial Variation?**
New model of care for dementia patients with complex needs	To receive an update on the proposed new model (follows on from Frank Lloyd Unit closure)	To be determined

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	To be

	provision in Swale	determined
Single Pathology Service in Kent and Medway	Members requested an update at the “appropriate time” during their meeting on 22 July 2020	No
Update on the implementation of Primary Care Networks across Kent		
Update on the implementation of the integrated Care System across Kent & Medway		
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	-
The Kent & Medway CCG – 18 months on	An opportunity to review how the first 18 months of the new single CCG has gone.	-
Provider updates	To receive general performance updates from each of the main local providers.	-
Provision of Child and Adolescent Mental Health Services at the Cygnet Hospital in Godden Green	To receive an update on the closure of the Tier 4 CAMHS service following the internal investigation by NHS England	-

3. Items to be considered for scheduling

Item	Item Background	Substantial Variation?
Orthotic Services	Information into provision of service requested by the Chair	No
Neurological Rehabilitation	Information into provision of service requested by the Chair	No

4. 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
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
Dermatology Services	To scrutinise the situation unfolding in relation to DMC Healthcare and provision of Dermatology Services across Kent and Medway	No

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