HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 10th June, 2021

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 10th June, 2021, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Kay Goldsmith**
Telephone: **03000 416512**

Membership

Conservative (10):	Mr P Bartlett (Chair), Mr P V Barrington-King, Ms B Bruneau, Mr N J D Chard, Mr P Cole, Ms S Hamilton, Mr A Kennedy, Mr J Meade and Mr D Watkins
Labour (1):	Ms K Constantine
Liberal Democrat (1):	Mr D S Daley
Green and Independents (1):	Mr S Campkin
District/Borough Representatives (4):	Councillor J Howes, Councillor K Maskell, Councillor S Mochrie-Cox, and Councillor P Rolfe

UNRESTRICTED ITEMS

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

Item		Timings*
1.	Membership	10:00
2.	Apologies and substitutes	
3.	Election of Vice-Chair	
4.	Declarations of Interests by Members in items on the Agenda for this meeting.	
5.	Minutes from the meetings held on 4 March 2021 and 27 May 2021 (Pages 1 - 8)	
6.	Transforming mental health services in Kent and Medway (Pages 9 - 22)	10:10

7.	Transforming mental health services in Kent and Medway - Eradicating dormitory wards (Pages 23 - 82)	10:35
8.	Covid-19 response and vaccination update (Pages 83 - 94)	10:55
9.	Urgent Care Review programme - Swale (Pages 95 - 100)	11:20
10.	Medway Foundation Trust - CQC inspection - update (Pages 101 - 124)	11:40
11.	Healthwatch Kent and Medway - "Pharmacies and Covid: the reality" - update (Pages 125 - 138)	12:05
12.	East Kent Hospitals University NHS Foundation Trust - CQC inspection (written update) (Pages 139 - 142)	12:25
13.	Work Programme 2021 (Pages 143 - 148)	
14.	Date of next programmed meeting – Wednesday 21 July 2021 at 10:00	

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

2 June 2021

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, 4 March 2021.

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, Cllr P Rolfe, Cllr S Mochrie-Cox and Cllr K Maskell

ALSO PRESENT: Mr R Goatham

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

UNRESTRICTED ITEMS

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

(Item 2)

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

75. Minutes from the meeting held on 27 January 2021

(Item 3)

It was resolved that the minutes from the meeting held on 27 January 2021 were a correct record and they be signed by the Chairman. There were no matters arising.

76. Covid-19 and winter response 2020-21 - Update

(Item 4)

Mrs C Selkirk, Executive Director for Health Improvement, Kent & Medway CCG (KMCCG) was in attendance for this item.

1. Mrs Selkirk introduced the agenda paper and updated the Committee that since publication, a fourth vaccination centre had opened at the Saga Centre in Thanet. She drew attention to the paper's community services focus, following on from previous Member interest.

2. Mrs Selkirk noted that whilst critical care services had been under immense pressure due to the pandemic, this had begun to ease in line with the lowering infection rate. However, she warned that whilst planned elective care was beginning to get underway, staff were owed leave and therefore timescales would not return to normal immediately.

3. Community Hospitals were seeing an almost 100% occupancy rate, which was unusual for the sector, and this pressure was likely to continue for some time.

4. Discussion around vaccinations included:

    i. General staff take-up had been high, and health providers were working with hesitant staff to understand what barriers existed and how these could be overcome.
    ii. The number of people being contacted by both central and local vaccination centres (leading to confusion and duplication) was reducing as the processes became embedded.
    iii. A national database was recording details of who had received (and declined) a vaccine.
    iv. GP practices would be in contact with individuals once their vaccines were due.
    v. Generally, individuals would go to the location of their first dose in order to receive their second, but the CCG would try to redirect anomalies where people had travelled a long way.
    vi. There had been a shortage recently of vaccine in the area, but staff were utilising the downtime to contact those who had so far declined to have the vaccine.
    vii. Local health leaders were talking at least daily to the national centre to work out vaccine supply and demand.
    viii. There was no cut-off date for vaccination groups and individuals whose cohort had already been vaccinated were still able to receive it.
    ix. The local NHS was reaching out to communities with low uptake, looking for ways to reduce barriers by using mobile sites and mosques for delivery.
    x. Local health partners had been pro-actively vaccinating individuals with learning disabilities.
    xi. Councillors could play a key role in encouraging their communities to get vaccinated.

5. Responding to concerns around mental health, Mrs Selkirk explained there had been additional work undertaken in this area, particularly in relation to support for children and young people. A Mental Health Learning Disability and Autism Improvement Board had been established which looked at services offered across all age groups, from the perspectives of clinicians and system leaders.

6. Highlighting two key areas for concern, Mrs Selkirk spoke of the ongoing challenge of children and young people's mental health (an area under scrutiny by HOSC) as well as eating disorders. The Board were looking into these areas and would be happy to provide further details in due course.

7. In terms of elective surgery and working through the backlog of patients waiting for treatment, Mrs Selkirk confirmed providers were commencing elective surgery, but that staff availability was key, and many staff were owed annual leave. They were also working with the independent sector.

8. Finally, asked if staff attrition rates had been impacted by the pandemic, Mrs Selkirk confirmed absence rates were dropping and generally they had witnessed record numbers of people applying to work with the NHS.

9. RESOLVED that the Committee considered and noted the report.

77. Improving care for people living with dementia and complex needs, across Kent and Medway
(Item 5)

The following from Kent & Medway CCG were in attendance for this item: Mrs C Selkirk, Executive Director for Health Improvement, Mrs K Benbow, Director of System Commissioning, Dr Simon Lundy, GP Dementia Clinical Lead, and Mr A Oldfield, Deputy Director Mental Health and Dementia Commissioning

1. Mrs Selkirk introduced the paper and explained that since the CCG's last visit to HOSC to discuss individuals living with dementia and complex needs, they had been gathering stakeholder views and she thanked those families that had met with her and the Chief Nurse to describe their experiences.

2. She explained that whilst the national model was one of community-based services, the CCG recognised that there were periods of time when individuals needed an inpatient service along with the specialist staff that supported it.

3. Mrs Selkirk referred again to the establishment of the Mental Health Learning Disability and Autism Improvement Board and stated that there were unprecedented levels of funding available to support the delivery of mental health services over the coming 5 years. To transform local mental health services, KMPT and the Kent and Medway CCG were focussing on 5 key workstreams:

    i. Reducing the need for people to be inappropriately admitted to an acute ward (because of no suitable alternative) by improving community-based support.
    ii. Improving psychiatric intensive care for women, by developing and providing this specialist service in Kent and Medway, where currently women needing this very high level of care have to be treated out of county.
    iii. Developing specialist dementia services for people with complex needs.
    iv. Eradicating outdated and unsafe dormitory wards.
    v. Redesigning community mental health services.

4. In terms of timescales, Mrs Benbow confirmed pre-consultation engagement had been carried out (as per the agenda report) and demand and capacity modelling was due to complete by the end of March 2021. Mrs Selkirk added a note of caution around the risks created by the pandemic and the impact these have on

planned timescales. The CCG continued to work alongside NHS England/ Improvement for the assurance process. They were hopeful an update could be presented to HOSC in June.

5. In terms of the impact of the pandemic on dementia diagnosis, Mrs Benbow confirmed that the target for dementia diagnosis had not been met locally but the health system was working to improve this. Whilst demand for mental health services had dropped during April/ May 2020 (the first lockdown), it was rising and services were forecasting increased demand going forward and were planning appropriately. Mrs Selkirk explained that the provision of dementia services had not stopped during the pandemic.

6. Robbie Goatham from Healthwatch Kent commented that he had been pleased to read about the support in place for unpaid family carers as this was a concern that had been repeatedly raised throughout the pandemic.

7. The Committee was introduced to Dr Simon Lundy. As a practising GP, his role (along with three other GPs) was to provide clinical input to the KMCCG's dementia pathway for improving care for individuals suspected of having dementia as well as their carers. He supported a comprehensive package of support with sufficient capacity and continuity of provision.

8. Mr Andy Oldfield had the responsibility within KMCCG to ensure the five mental health workstreams were being delivered proactively. He did this by working collaboratively with other as well as closely with the Mental Health Learning Disability and Autism Improvement Board.

9. Responding to a question about the ongoing viability of community groups in providing early intervention services, Mrs Selkirk confirmed the CCG was looking into how they could continue working best with the third sector. She was hoping to get third representation on the Mental Health Learning Disability and Autism Improvement Board.

10. The Committee did not feel there was enough information available to determine if the proposals constituted a substantial variation of service.

11. RESOLVED that the report be noted, and the Kent and Medway CCG return in June provided further information is available.

78. Urgent Care Review Programme - Swale
(Item 6)

Justin Chisnall, Director of Integrated Care Commissioning Medway and Swale from Kent and Medway CCG was in attendance for this item

1. Mr Chisnall provided a verbal update on the Swale Urgent Care programme. He explained the project was still in its early stages and had not progressed much

since the Committee's last update in 2019. He explained that the response to the pandemic had become the primary priority, and that KMCCG needed to reconsider earlier proposals in light of the changed healthcare environment. They would be engaging with all health partners in the area to plan the best approach for successor services. KMCCG remained confident that the best option for the local population was an integrated urgent care treatment centre.

2. He confirmed that an extension had been granted to the GP walk in centre (provided by DMC Healthcare) until June 2021.

3. He offered to return to the Committee in June 2020 with a further update.

4. A Member of the Committee raised concerns around the length of time the project had been underway (since 2014). Also, they questioned the clinical literacy of the local population in understanding which facility to use for which medical issue. Finally, they questioned if the provision of a major trauma centre (currently provided out of county) in the county should be decided upon prior to any decision around urgent treatment centres. Mr Chisnall accepted the points and elected to raise the issue of a major trauma centre with colleagues from the local Integrated Care System (ICS). He recognised the need to move forward with pace, and agreed clarity was needed within the public of which health facility to use.

5. The Chair welcomed an update on the provision of a major trauma centre in Kent and asked that it be included in the workplan under the "implementation of the Integrated Care System".

6. RESOLVED that the update be noted and the Kent and Medway CCG return to update the Committee in June, if appropriate.

79. Medway Foundation Trust - CQC inspection (written item)
(Item 7)

1. The Chairman explained that the agenda report provided a summary of the events that had happened during a CQC inspection carried out in December, along with the Trust's response to the since published report.

2. Members of the Committee expressed disappointment that a senior representative from the Trust was not present to speak. The Chair noted the concern and explained that a Trust management day had been taking place at the same time. He proposed the Trust attend the next meeting to be able to answer the Committee's questions.

3. A Member noted there may be a justified reason why a senior officer from the Trust could not be present and acknowledged the pressure providers had been under.

4. Members asked the Chair to write to the Trust to voice the strength of feeling among the Committee that no one had been available to discuss the serious issues raised in the CQC report, and request that a senior representative present the Trust's action plan at the next meeting.

5. RESOLVED that the Committee was disappointed that representatives from the Medway Foundation Trust had not been in attendance at the meeting, and that whilst the written report was noted it asked the Trust to attend the next meeting in order to present their action plan.

Post-meeting note: *Medway NHS Foundation Trust subsequently confirmed to the Committee that a representative was unable to attend due to a statutory Board meeting taking place at the same time.*

80. Work Programme
(Item 8)

1. Further to discussion at the meeting, Members agreed that the following items be added to the next agenda:

    a. Medway Foundation Trust – CQC inspection update
    b. Improving care for people living with dementia and complex health needs, across Kent and Medway
    c. Urgent Care review programme – Swale
    d. The provision of a major trauma centre in Kent be addressed during the "Implementation of the Integrated Care System" item

2. It was RESOLVED that the Committee's future work programmed be noted.

81. Date of next programmed meeting - Tuesday 8 June 2021
(Item 9)

It was noted that the next meeting of the Committee would be on Tuesday 8 June 2021, commencing at 10.00am.

(a) **FIELD**
(b) **FIELD_TITLE**

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Mote Hall Leisure Centre, Maidstone, Kent ME15 7RN on Thursday, 27 May 2021.

PRESENT: Mr P V Barrington-King, Mr P Bartlett, Ms B Bruneau, Mr N J D Chard, Mr P Cole, Ms S Hamilton, Mr A Kennedy, Mr J Meade and Mr D Watkins

IN ATTENDANCE: Mr J Cook (Democratic Services Manager)

UNRESTRICTED ITEMS

1. Election of Chair
(Item 3)

1) It was duly proposed and seconded that Mr P Bartlett be elected Chair of the Committee.

2) RESOLVED that Mr P Bartlett be elected Chair of the Committee.

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Item 6: Transforming Mental Health and Dementia Services in Kent and Medway

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 10 June 2021

Subject: Transforming Mental Health and Dementia Services in Kent and Medway

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

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1) Introduction

a) The Kent and Medway CCG has asked to update the Committee on its mental health and dementia services transformation.

b) During previous HOSC meetings, the Kent and Medway CCG have referenced the transformation, which includes five workstreams:

i. Reducing the need for people to be inappropriately admitted to an acute ward (because of no suitable alternative) by improving community-based support.

ii. Improving psychiatric intensive care for women, by developing and providing this specialist service in Kent and Medway, where currently women needing this very high level of care have to be treated out of county.

iii. Developing specialist dementia services for people with complex needs.

iv. Eradicating outdated and unsafe dormitory wards.

v. Redesigning community mental health services.

2) Previous monitoring by HOSC

a) HOSC received information about the third workstream, “developing specialist dementia services for people with complex needs” at its meeting in March 2021. Following discussion, the Committee were unable to determine if the proposals constituted a substantial variation of service and invited the CCG back once there was more information available.

b) HOSC will receive information about the fourth workstream above, “eradicating outdated and unsafe dormitory wards”, at today’s meeting.

3) Substantial variation of service

a) This agenda item provides an overview of the mental health transformation, which is an overarching programme containing a number of individual but related, workstreams. It is expected that these workstreams will run as separate pieces of work with their own consultations, if required.

b) In light of this, it is proposed that HOSC note this report and agree to receive updates on the programme's progression, whilst accepting individual reports on each of the workstreams at the appropriate time. This will allow the Committee to determine if each item is a substantial variation of service and proceed accordingly.

4) Recommendation

RECOMMENDED that the Committee

i. note the report
ii. agree to receive regular updates on Kent and Medway's mental health and dementia improvement programme
iii. agree to determine on an individual basis if the workstreams constitute a substantial variation of service

Background Documents

Kent County Council (2021) 'Health Overview and Scrutiny Committee (04/03/21)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8500&Ver=4

Contact Details

Kay Goldsmith
Scrutiny Research Officer
kay.goldsmith@kent.gov.uk
03000 416512

KENT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

10TH JUNE 2021

Transforming Mental Health and Dementia Services in Kent and Medway

Report from: Karen Benbow, Director of System Commissioning
Author: Andy Oldfield, Deputy Director Mental Health and Dementia Commissioning

1. Introduction

Following the presentations to the Kent HOSC in March 2021, this paper provides an update on the following areas:

- The impact of COVID-19 on the demand for mental health services.
- The transformation of the wider mental health services, in particular the transformation of community mental health services and urgent and emergency care mental health services.
- The transformation of dementia services, including the redesign of dementia services for people with complex needs.

2. What People are Telling us.

To help to shape the future design of mental health services, the NHS has been having conversations with local people. Service users, their carers and loved ones have told Kent and Medway NHS and Social Care Partnership Trust (KMPT) that we need to:

- Find ways to drive up the quality of mental health care and improve the way care is organised, including the communications between different services and with patients
- Make it as easy as possible to access mental health care, including training all NHS staff to recognise mental health problems and having more mental health staff in A&E and urgent care centres and primary care
- Ensure health and social care support is joined up

- Work with organisations such as schools, employers, and councils, and with communities to raise awareness and understanding of mental health problems and ways to improve mental health and wellbeing.

3. Local Initiatives

There are some great programmes and initiatives to improve mental health already up and running across our area with more planned for the coming months and years. These include:

- Support and signposting services
- Crisis resolution and home treatment team
- A dedicated crisis telephone line to help provide a more seamless experience
- Mental health liaison in general hospitals, for example, mental health specialists working side by side with doctors and nurses in A&E
- Reducing the number of out of county placements, so that if people do need to be admitted to hospital, they are as close to home as possible
- 'Safe havens' in five locations where people can get support, advice and help out-of-hours, 6 pm -11pm, 365 days a year
- Working with social care on the support provided to help people remain in their own homes.

This paper provides an update on how we are progressing some important strands of the work to help us realise our ambitions.

4. Impact of COVID-19

COVID-19 has shone a spotlight on the importance of mental health services and mental health and wellbeing support for each and every one of us. Big changes to the way we live, work, and interact have made conversations about mental health and emotional wellbeing centre stage.

More people are aware of, and seeking help for, mental health problems. Since April 2020, KMPT has experienced increased demand for services. Phone contacts via their open access crisis line have increased by 65.1 per cent, community mental health team contacts have increased by 13.6 per cent and community mental health service for older people (CMHSOP) contacts have increased by 10.7 per cent. Furthermore, the levels of people admitted to hospital under a Section of the Mental Health Act have increased overall, highlighting an increase in the acuity of mental health problems people are facing. There has been a surge of people needing crisis care who are autistic alongside an increase in people who have had, up until COVID-19, a well-managed psychosis illness. There has also been an increase in admissions to hospital for people with complex emotional disorders.

It is also important to recognise the positive changes to services that have happened in response to the pandemic that we want to build on, including greater use of technology, more flexible working patterns for staff so that they can better deliver the care people need, and more collaborative working between and across organisations.

In recognition of the impact of COVID-19 on individuals' mental health and wellbeing, Kent and Medway CCG and local authorities have produced a booklet entitled 'How are you feeling?' which has been sent to every household in Kent and Medway. The booklet contains details of range of services to help people look after their mental health. A website has also been developed to support the booklet.

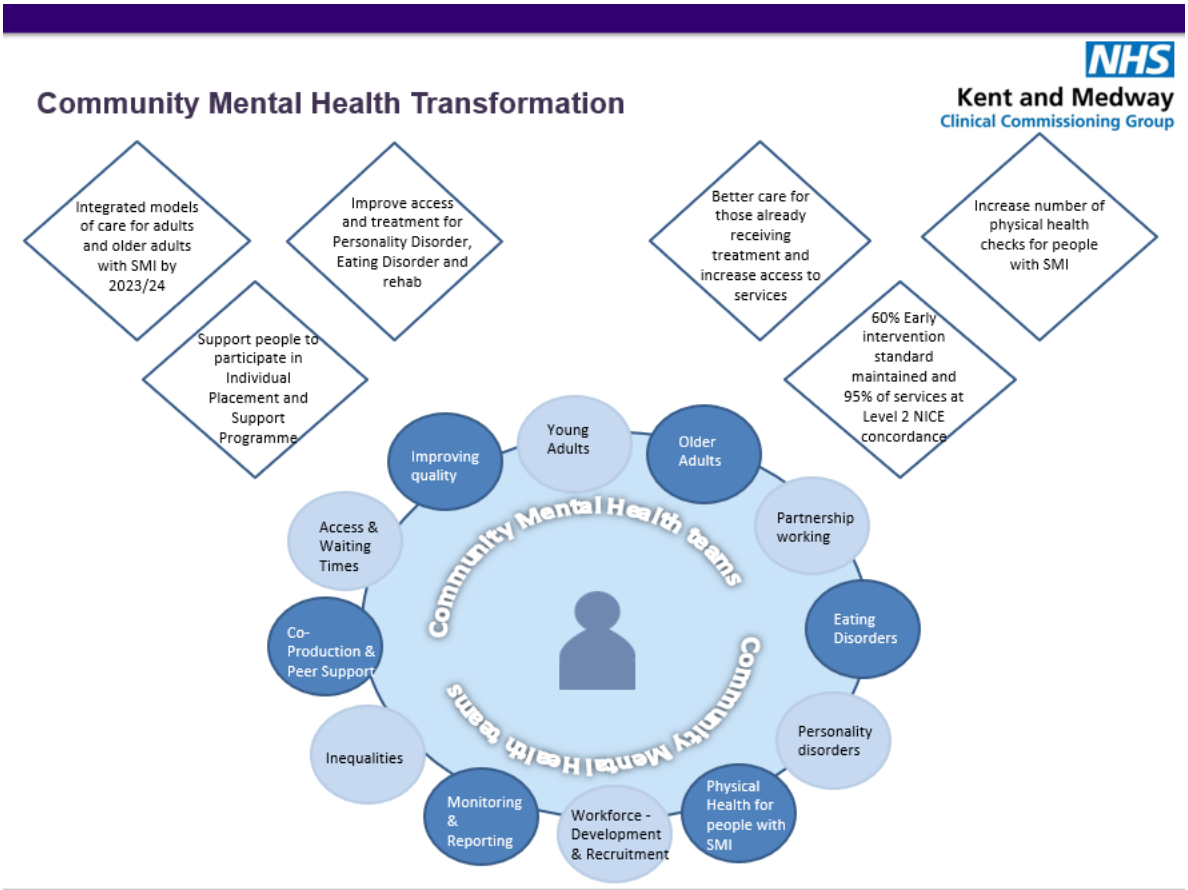
5. Community Mental Health Transformation

Aligned to the NHS Long Term Plan and the Community Mental Health Transformation Framework for Adults and Older Adults, we are working to improve clinical care pathways for adults and older people with severe and serious mental illness, including mood disorders, psychotic disorders and complex emotional difficulties. Involving all aspects of community support through the voluntary and community sector, social care, primary and secondary health care services, this is a major opportunity to enhance and improve the quality and experience of care for some of the most vulnerable people in our communities.

People want to access the care, advice and support they need no matter where they first try to seek it, whether that is from 111, their GP, from a community service, through online self-referral, self-help or another route. In other words, there should be a 'no wrong door' approach to accessing advice, care and treatment when it is needed.

We want to achieve radical change in the design of community mental health care by moving away from siloed, difficult-to-access services to joined-up care and establishing a revitalised purpose and identity for traditional community mental health services serving those most in need with serious mental illnesses. The programme will link to the four integrated care partnerships across Kent and Medway with the aim of responding to population health priorities and ensuring that national standards are met and embedded at a system level.

The diagram below provides an overview of the proposed transformation, which very much keeps the patient at the centre.



Significant investment has been made available nationally to support this programme and for Kent and Medway, £10.5 million has been made available over 3 years, with £3.4m allocated for 2021/22.

Implementation will be on a phased basis, i.e.

- Medway/Swale 2020/21.
- East Kent 2022/23
- DGS/West Kent 2023/24

6. Improving Mental Health Urgent and Emergency Care

The mental health urgent and emergency care system is dynamic and complex.

The Mental Health Urgent and Emergency Care (MHUEC) Programme is the Kent and Medway system's programme of work addressing both the NHS Long Term Plan and locally agreed system wide mental health urgent and emergency care priorities. Projects are all-age and are multi-agency; input is required from all parties involved. There are a number of programmes of work/projects that are improving access and outcomes.

Of particular importance is the focus of work with Acute Trusts, Police and NHS 111 colleagues to ensure mental health presentations at emergency departments are only made when necessary.

There is also significant investment attached to these projects. The current MHUEC programmes/projects and associated investment are shown below.

Programme/Project	Plan	Investment (21/22) – not MHIS*
Open Access Crisis (NHS 111 and 24/7 Mental Health Triage)	For NHS111 to be the first point of contact for anyone in a mental health crisis. The Mental Health Clinical Assessment Service (MHCAS) will direct callers to the appropriate crisis service. Transformation work includes: • review of resources in Single Point of Access, 836 line, MHCAS, Community and Voluntary Sector helplines • direct bookings for secondary care assessment • Directory of service (DOS) reviews. Clinical model agreed.	£987k
Open Access Crisis (NHS 111 and 24/7 Mental Health Triage)	Demand and capacity modelling underway. Soft launch planned January 2022, Go Live planned July 2022.	
Crisis Resolution Home Treatment (CRHT)	To provide a community based crisis alternative to admission to hospital that meets the nationally defined fidelity standard. A review of current provision against the standards was completed April/May 2021. This will inform priority areas of development this year. Additional funding has been allocated to ensure workforce development can progress across the 5 CRHT teams.	£1.2m
Community Crisis Alternatives:	To expand community Crisis Alternative services. In addition to the 5 safe havens operating across Kent and Medway during 2021/22 additional investment has been secured from NHSEI to sustain and develop: • Staying Alive App • SHOUT Text Service	£895k

Programme/Project	Plan	Investment (21/22) – not MHIS*
	• 24/7 Mental Health Matters Helpline (additional 10,000 calls) • Participation Workers • Peer Support Service for people with Autistic Spectrum Conditions in mental health crisis • Peer support service for people recently in crisis • Safe Havens (review and procurement). Safe havens are currently available in: ° Canterbury ° Maidstone ° Medway ° Thanet ° Folkestone	
Liaison Mental Health Service (LMHS)	All acute hospitals now have 24/7 Liaison Mental Health Services in place. Audits are taking place to identify compliance with CORE 24 service standards; target to achieve 50% coverage at CORE 24 standard by 31/03/2022.	£2.8m
Liaison Mental Health Services	Partnership working between acute, police and LMHS teams has resulted in speedy resolution of issues around several complex cases presenting in A&Es.	
Ambulance Mental Health Response	Delivering tailored MH training for Ambulance call centre staff. Development of a Mental Health Emergency Response Vehicle	£599k
Therapeutic Acute Mental Health Inpatient Care	The therapeutic offer from inpatient mental health services is being improved by increasing investment in interventions and activities. A workforce plan is being developed to deliver this. As a result patient outcomes and experience in hospital will improve. This will contribute to a: • a reduction in length of stay in adult acute inpatient mental health settings • fewer out of area (acute) placements	£493k

<table>
<tr><th>Programme//Project</th><th>Plan</th><th>Investment (21/22) – not MHIS*</th></tr>
<tr><td>Section 136 (local priority)
Section 136 (local priority)</td><td>COVID 19 and Lockdown may have had an impact on the wider services for s136 detentions, as we have seen a high increase in s136 detentions being taken to Emergency Departments; this is largely due to beds being unavailable in the wider systems to move people out of the s136 suites. This is a key area that the S136 Improvement Programme Group is focusing on and we are working closely with acute colleagues to improve this.
April 2021 saw s136 detentions move to double figures for the first time in several years:
<table>
<tr><td>Month</td><td>S136</td></tr>
<tr><td>January 2021</td><td>110</td></tr>
<tr><td>February 2021</td><td>144</td></tr>
<tr><td>March 2021</td><td>132</td></tr>
<tr><td>April 2021</td><td>98</td></tr>
</table>
The s136 Improvement Plan Group (IPG) has now completed 9 of the 18 Deep Dive Recommendations (DDRs) with positive outcomes.
Phase 4 of the DDRs will be completed by July 2021.
Once all phases have been completed the s136 IPG will formally continue and will replace the old s136 countywide group; it will continue to monitor the DDRs.</td><td></td></tr>
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* Mental Health Investment Standard

7. Transforming Dementia Services

Dementia Strategy.

The previous paper which was presented to the Kent HOSC was focussed on improving services for people with dementia and complex needs. However, this development needs to be seen in the context of an overall dementia pathway and work is currently in progress to develop a Kent and Medway Dementia Strategy which will be completed by July 2021. An initial workshop to take forward the development of the strategy took place in April 2021 and a further workshop is planned for June 2021.

The chapter headings for the strategy are below and these are based around the NHSE Wellbeing Pathway for Dementia.

- Raising Awareness and Reducing Risk Factors
- Improving Diagnosis
- Support After Diagnosis
- Supporting Carers
- Care at Home
- Care in Hospitals and Care Homes
- End of Life Care

However, there already a number of projects in place to support the transformation of dementia services.

Transforming the Diagnostic Pathway.
Kent and Medway's dementia diagnosis rate (DDR) in April 2021 was an outlier at 55.6% compared to performance across the South East (59.6%) and England (61.6%). Currently, the vast majority of diagnosis is made by KMPT, which means that people sometimes do not receive their diagnosis in a timely manner. Some GPs will undertake a diagnosis, but the majority will not, in part, because they do not feel confident to do so.

Some of the projects which are currently in place aim to increase diagnostic capacity and therefore increase the dementia diagnosis rate. These include:

- Transformation of KMPT's memory assessment pathway to enable the majority of people to receive a diagnosis within six weeks of referral. Currently, it can be as long as 18 weeks.
- Increasing the number of people who can undertake a diagnosis which will include Advanced Care Practitioners (ACPs), GPs with an enhanced role (GPwER) who have a special interest in dementia to undertake memory assessment in primary care and geriatricians.
- Using the Enhanced Health in Care Home service specification proposed for Kent and Medway to increase the number of people in care homes with a dementia diagnosis, since cognitive issues should be identified as part of the comprehensive geriatric assessment process (it is estimated that 70-80% of people in care homes have dementia).

Most of these projects will not produce an immediate, significant increase in dementia diagnosis rates as they will be dependent on the recruitment and training of personal.

However, the Government recently announced a Mental Health Recovery Plan, allocating £17m nationally for investment into the dementia pathway to improve

memory assessment services and recover the dementia diagnosis rate in 2021/22. In Kent and Medway this equates to £592k. It is intended to use this funding to increase the number of memory assessments, both face to face and virtual and to ensure access to a programme of post diagnostic support, such as cognitive stimulation therapy.

Dementia Co-ordination.

Recent engagement with people with dementia and their carers has indicated that once a diagnosis has been received, it is often very difficult to access the right services at the right time, partly due to lack of knowledge of local services.

It is therefore proposed to commission a dementia coordinator role for each PCN. A named coordinator will be allocated at the point of referral to provide consistency of support throughout the dementia journey. There a number of similar services across the country which have support an increase in dementia diagnosis rates, as well as demonstrating potential savings by avoiding acute hospital attendances and a potential reduction in GP consultations. The majority of such services are provided by various voluntary sector organisations.

A business case has been developed to support this proposal, and confirmation with regard to funding is currently awaited from the CCG.

Post Diagnostic and Carers Support

There is now greater awareness about the importance of support after diagnosis of dementia, often termed 'post-diagnostic support', both for improving the individual's and their family's quality of life and for the potential to reduce more costly crisis care, particularly emergency hospital admissions. Whilst it is anticipated that the dementia coordinator role will help to avoid crisis situations, it is also recognised that there needs to be a range of other services in place as well.

KMPT Memory Assessment Services provide an initial post-diagnostic support offer over a six week period as well as a Living Well Group, following a dementia diagnosis and there is also a variety of support for those living with dementia and their carers/loved ones commissioned by Kent and Medway CCG, Kent County Council, and Medway Council and delivered independently in the voluntary sector. This includes dementia cafes, peer support, COGs clubs, plus many other services.

KCC is currently in the process of re-procuring dementia post-diagnostic support services from the voluntary sector as part of the overall wellbeing offer and initial conversations have also taken place with Medway Council about this approach. This is to ensure that there is a consistent offer which meets the needs of all areas of Kent. It is proposed to tender for the dementia coordinator service as part of the KCC procurement (this will be a Kent and Medway service) as this role is seen to be crucial to both the pre and post diagnostic support offer.

Admiral Nurses work alongside people living with dementia and their families to provide specialist support and expert guidance and, in Kent and Medway, the majority are employed by KMPT. There is Admiral Nurse provision in all areas of Kent and Medway. However, the level of provision across the Kent and Medway is mixed. As part of the post diagnostic project, it is proposed to review the provision and model of delivery of Admiral nurses to ensure a consistent offer across Kent and Medway.

There is currently no specific contracts for carers of people with dementia. However, the general carers contracts which are commissioned by KCC and Medway Council do provide support for this group of carers.

Services for People with Dementia and Complex Needs

The demand modelling, based on underlying population health needs, has now been completed. The work has identified four key components to the proposed new model of care, i.e.

1. Proactive case finding and planning to anticipate and reduce risk of escalation or crisis.
2. Rapid assessment and treatment planning in all settings.
3. The delivery of treatment plans.
4. Admission avoidance and improved transfer of care from both acute and mental health beds.

The proposed new model will essentially have two elements:

1. A community crisis service which will support people in their own homes or in care homes. Further work is need to determine how this will align with other community services and what the hours of access will be. However, this will need to be in line with the requirements of the Ageing Well programme as outlined in the NHS Long Term Plan, 2019, which requires a two hour crisis response, where this is determined clinically appropriate.
2. A number of locally (ICP based) delivered, step up/step down beds, i.e.
    a. Short-term beds, (up to four weeks) for crisis support relating to either the patient or their carers needs or to stabilize a physical condition which does not require hospital admission.
    b. Medium term beds (approximately six months) for assessment of longer-term needs following hospital admission for those people with more challenging behaviours who require further treatment before being transferred to a permanent placement.

Work is also in progress to complete the options appraisal process to identify the service options which will be used as part of the formal public consultation process which is currently planned for late summer/early autumn

The case for change and pre-consultation business case is also in development and will be share with HOSC at a later date.

8. Conclusion

All areas of work described in this paper are ongoing, and we will continue to keep HOSC updated on our progress.

9. Recommendations

The HOSC is asked to:

- **Note** the progress update in this report
- **Agree** for regular updates on Kent and Medway's mental health and dementia improvement programme to continue to be brought for information and discussion to this committee.

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Item 7: Mental health transformation - Eradication of mental health dormitory wards

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 10 June 2021

Subject: Mental health transformation - Eradication of mental health dormitory wards

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Summary: This report falls under the transformation of mental health services in Kent and Medway.

The Committee has yet to determine if this workstreams' proposals constitute a substantial variation of service.

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1) Introduction

a) As part of a £650m government pledge to replace outdated mental health dormitories,[1] Kent and Medway NHS and Social Care Partnership Trust (KMPT) have been allocated £12.56m of capital funding to replace dormitory wards used by older adults with mental health issues, including dementia, with purpose-built accommodation.

b) KMPT are seeking to use the funding to support the construction of a new facility on the KMPT Maidstone site, which will increase overall capacity by two beds. This facility will replace the Ruby ward at Medway Maritime Hospital.

c) Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC) considered the item on 11 March 2021 and determined that the proposal was a substantial variation of service for their residents. The work undertaken by the CCG since that meeting is included in their report and appendices.

2) Potential Substantial Variation of Service

a) The Committee is asked to review whether the proposal to replace the Ruby ward at Medway Maritime Hospital with a new purpose-built facility on the KMPT Maidstone site constitutes a substantial variation of service.

b) Where the Committee deems the proposed changes as not being substantial, this shall not prevent the HOSC from reviewing the proposed changes at its discretion and making reports and recommendations to the NHS.

[1] Department of Health and Social Care (10 October 2020) Over £400 million pledged to remove dormitories from mental health facilities https://www.gov.uk/government/news/over-400-million-pledged-to-remove-dormitories-from-mental-health-facilities

2) Recommendation

If the proposed change to adult mental health services is *substantial*:

RECOMMENDED that:

(a) the Committee deems the proposed reprovision of services from Ruby ward, Medway Maritime Hospital to the Maidstone Hospital site to be a substantial variation of service.

(b) Kent and Medway CCG be invited to attend this Committee and present an update at the earliest opportunity.

If the proposed change to adult mental health services is *not substantial*:

RECOMMENDED that:

(a) the Committee does not deem the proposed reprovision of services from Ruby ward, Medway Maritime Hospital to the Maidstone Hospital site to be a substantial variation of service.

(b) the report be noted.

Background Documents

None

Contact Details

Kay Goldsmith
Scrutiny Research Officer
kay.goldsmith@kent.gov.uk
03000 416512

KENT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

10TH JUNE 2021

TRANSFORMING MENTAL HEALTH SERVICES IN KENT AND MEDWAY - ERADICATING DORMITORY WARDS

Report from: Karen Benbow, Director of System Commissioning
Author: Andy Oldfield, Deputy Director Mental Health and Dementia Commissioning

Summary

The NHS in Kent and Medway is working in partnership to improve mental health services. This includes planning for a new facility for older adults with mental health issues, including dementia. Providing high-quality and safe accommodation for patients is an integral part of the therapeutic process and has a significant bearing on the experience of patients, their families and loved ones. Outdated and old-fashioned dormitory wards compromise safety, dignity, and privacy and have no place in a 21st century mental health system.

Following a successful bid for £12.65m of government funding as part of the national drive to eradicate outdated dormitory wards, it is proposed to build a new facility for older adults including single ensuite bedrooms for 16 patients (rising from 14) at Kent and Medway Health and Social Care Partnership NHS Trust's (KPMT) Maidstone site. To access this government funding, work must begin in October 2021 to be scheduled for completion in November 2022, to meet the national deadline for eradicating dormitory wards.

The new, purpose-built facility will be available to anyone who needs it wherever they live in Kent and Medway and will replace the single last remaining mental health dormitory ward, Ruby Ward, which is currently operating at Medway Maritime Hospital. It will offer greater privacy, access to outside space and improved infection control measures, which is an increasingly important concern in light of the COVID-19 pandemic. This proposal is part of local ambitions to provide high-quality and safe accommodation for patients who need it, within the context of a programme of wider mental health transformation and services delivered in the community as well as in a hospital setting.

KMPT provides inpatient beds on a Kent and Medway-wide basis, with different specialist facilities and different specialist teams caring for patients in different places. There is not a concept of 'local' specialist inpatient beds designated for particular communities – all inpatient services are provided for all Kent and Medway residents. This means that patients requiring admission may not be admitted to a unit closest to their home, but they will be admitted to the most appropriate facility to meet their needs.

Whilst Ruby Ward is located in the former Medway CCG catchment area, it takes patients from across Kent and Medway, approximately a third of patients are from Medway and two thirds from elsewhere in Kent.

A comprehensive review of potential site options for the redevelopment of Ruby Ward has been undertaken in Medway according to an agreed set of criteria.

This paper has been developed to:

1. give HOSC an overview of the national policy context and the local 'case for change' for this work;
2. update HOSC on our proposals for relocating Ruby Ward from Medway Maritime Hospital to a purpose-built facility in Maidstone including the size and scale of this new capital investment;
3. describe the timescales and dependencies attached to accessing capital funding for the project;
4. outline our discussions with Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC) about the proposal;
5. outline our plans for a 6-week period of public consultation with Medway HASC and Medway residents including patients, families and carers who have used the Ruby ward service; and,
6. seek feedback from HOSC on how they would like to be involved as our work progresses, and specifically if HOSC view the proposed change of location of Ruby Ward services as substantial variation.

1. National policy context and local 'case for change'

Implementing national policy

We know that good quality buildings improve patient care and patient experience, as well as providing a better environment for staff to work in. There are also guidelines about how hospitals should be designed to support people with dementia and those with disabilities and to support effective infection control.

Outdated and old-fashioned dormitory wards in mental health facilities compromise the safety, dignity, and privacy of patients. It has been well documented – in the review of the Mental Health Act 2018, the NHS Long Term Plan and by the Care Quality Commission - that dormitory wards compromise mental health patients' privacy, dignity, and safety, and increase the risk of infection (particularly in COVID-19 times). NHS England and the Government have pledged £650million in national funding to replace out-of-date mental health dormitories with single ensuite rooms, to help improve care for mental health inpatients across the country.

Our local 'case for change'

Across Kent and Medway, we have been making good progress in improving the safety and quality of our mental health sites and facilities. We are delighted to have successfully secured Government capital funding to help us eradicate dormitory accommodation by 2022 and replace it with modern, purpose-built/converted accommodation with single ensuite rooms.

The investment in a new purpose-built building for these inpatient mental health services provides the opportunity to release Ruby ward, Kent and Medway Health and Social Care Partnership NHS Trust's (KPMT) only remaining dormitory ward (at

Medway Maritime Hospital in Gillingham) meaning that older adult patients would no longer need to be cared for in an outdated ward which compromises their privacy, dignity and safety and is not suitable for their needs.

Ruby Ward is the single remaining mental health dormitory ward in the area, catering for older people with acute mental health difficulties. The current ward is arranged in three bays of four beds, with two additional side-rooms with shared bathroom facilities.

The unit was not designed as a mental health ward and the environment has long been recognised as not fit for purpose. It does not deliver the safety, privacy, and dignity that our mental health patients have every right to expect. It has limited space for the additional therapeutic activities that can significantly contribute to the successful recovery and rehabilitation of patients. A small, shared lounge area also doubles up as a visitors' lounge.

Ruby ward is on the first floor and is harder to access (KMPT has a preference for ground floor facilities mainly for fire and safety reasons). There is no immediate access to outdoor space and access to fresh air and a garden area is some distance away through the main hospital. Developing a new, purpose-built facility for inpatient mental health services to the new agreed specification will improve patient care and experience.

Current challenges vs potential benefits

	Ruby Ward		Purpose built unit
✗	14 beds on an outdated dormitory style ward – lacking privacy and dignity	✓	16 beds in modern, purpose-built accommodation for older adults, with single ensuite bedrooms, designed specially around care needs
✗	First floor location	✓	Ground floor, single storey accommodation
✗	No easy access to outside space	✓	Attractive, easily accessible garden areas designed to provide patients with places for relaxation, socialising and games.
✗	Ward not designed for providing care and support for mental health patients – no additional space to offer therapeutic activities and support	✓	Light, airy, calm environment with rooms and areas for therapeutic and rehabilitation activities
✗	Shared bathroom	✓	Ensuite bathrooms ensuring privacy and dignity as well as larger assisted bathroom areas for more complex patients and presentations

✕	Small lounge area doubles as a visitor space	✓	Dedicated indoor and outdoor space for visitors, and lounge and outdoor space for patients
✕	Ward set up makes it difficult to ensure infection control for this cohort of patients	✓	Designed to ensure infection control measures can be put in place with ease
✕	Discharges into the community/back home are slower because of limited opportunities for rehabilitative activities	✓	Faster discharges as staff have the opportunity to work with patients on rehabilitation to get them ready to go home/back into the community
✕	Will not meet national guidelines for mental health facilities	✓	Adheres to national policy to eradicate dormitory accommodation for mental health patients, and national guidelines on single, ensuite rooms to improve mental health care for patients

Releasing Ruby Ward would also allow Medway NHS Foundation Trust (MFT) to work with commissioners to repatriate other NHS services to the Medway Maritime Hospital site. This includes plans to bring some general surgical and diagnostic activity currently provided by independent providers back to Medway, benefiting local residents. This has become increasingly important with the impact of COVID-19 on waiting times for people waiting for planned operations and other elective procedures. Currently Medway patients can access treatment in the independent sector, and whilst this option will still be available to support patient choice of provider, the release of Ruby ward will enable more acute activity to be delivered on the MFT site.

2. Relocating Ruby ward – our proposal

Size and scale of capital funding opportunity

Following the successful bid for £12.65m of government funding as part of the national drive to eradicate outdated dormitory wards, it is proposed to build a new facility including single ensuite bedrooms for 16 patients (rising from 14) at Kent and Medway KMPT's Maidstone site.

The new, purpose-built facility will be available to anyone who needs it wherever they live in Kent and Medway. The table below shows admissions to Ruby ward according to former CCG areas during 2019/20, demonstrating that while Ruby ward is located in the former Medway CCG catchment area, it takes patients from across Kent and Medway.

Admissions to Ruby ward

CCG area	2019/20	
	Inpatient numbers	Percent of inpatients
NHS ASHFORD CCG	1	1.9%
NHS CANTERBURY AND COASTAL CCG	2	3.8%
NHS DARTFORD, GRAVESHAM AND SWANLEY CCG	9	17.3%
NHS MEDWAY CCG	16	30.8%
NHS SOUTH KENT COAST CCG	1	1.9%
NHS SWALE CCG	7	13.5%
NHS THANET CCG	2	3.8%
NHS WEST KENT CCG	13	25.0%
OUTSIDE KENT	1	1.9%
Total	52	99.9%*

*not 100% due to rounding

About the proposed new facility

Our proposals are for a modern, purpose-built, dedicated facility that will address the challenges currently experienced by patients and staff on Ruby ward and bring about significant benefits in the way that care and support are provided. The opportunity to design a facility from scratch, using the latest research, evidence, technological and architectural innovations will help fulfil local ambitions to provide high-quality and safe accommodation for patients.

The patient cohort affected by these proposals are older female adults with acute mental health difficulties who require admission to a hospital bed for a limited period. Older adults are more likely to have physical health conditions and requirements. A purpose-built unit will provide an environment that is supportive to their recovery, maintains their dignity and privacy and ensures that their physical needs (medical and nursing) are met. The new unit is being designed so that it may cater safely for either gender or as a mixed gender unit.

We are not proposing to change the clinical model of care, but to offer two additional beds and opportunities for more therapeutic activity in support of rehabilitation. Being able to access good outside space, the opportunity to work with staff and other patients on therapeutic activities, such as cooking and self-care skills, will support their recovery and rehabilitation and enable faster discharge back home or into the community.

These considerations are most closely reflected in three criteria that have been used to evaluate potential site options and are informing the design and development of the new purpose-built unit.

- Scale – to ensure there is sufficient scope to develop a unit with space for individual ensuite bedroom, dedicated therapeutic areas and facilities including a visitor lounge

- Location with other mental health services – easier access to other mental health staff and teams on the wider site will ensure sharing of expertise and support and enable cover during peak times.
- Location with general acute hospital services – reflecting the fact that older adults are more likely to have additional physical care needs and that these must be met.

Early design concepts and ideas for the new unit are in development and patients, carers and staff are already involved in the design of the proposed new purpose-built facility. We have commissioned Ryder Architecture to work with us on these concepts, recognising their work within the mental health sector to develop facilities that provide a holistic, caring environment for patients and staff. A selection of architects' images are set out below and additional images can be found in the slide deck attached as Appendix A.

Example bedroom in the new facility

Example bedroom in the new facility

Example dining room

Example visitors lounge

Example garden area

Appendix A [slide deck] includes early architectural visuals of a proposed new purpose-built older adults facility contrasted with the current challenges of providing care on Ruby ward.

3. Accessing capital funding – timescales and dependencies

To access this government funding, work must begin in October 2021 to be scheduled for completion in November 2022, to meet the national deadline for eradicating dormitory wards.

Capital funding allocation – bid requirements and submission process

The process to access national funding required a bid to be submitted within five days of being notified of the available capital, not months as is usual for major programmes. The limited number of days available meant a desktop exercise was required to consider site options and register a bid. The challenging timescale meant that KMPT – as provider of the service - was only able to engage with stakeholders in a limited way, engaging with MFT and CCG commissioners in advance of submitting the bid to ensure their support and endorsement, and with senior local authority partners immediately after submission and indication of likely success.

It was made clear that capital funding would be allocated to provider trusts and the criteria also specified that any capital funding received by the Trust must be invested in their estate portfolio, owned by the Trust, and declared a Trust asset. In other words, any potential site for redevelopment with these monies either needs to be already owned or acquired by the Trust. Incidentally, there is no additional funding available from the national programme to support the acquisition of assets.

The criteria used for the initial search for a suitable location for a new capital build or redevelopment was for sufficiently sized KMPT owned or leased building space/land, available within the short-term, and ideally located with other mental health and general acute hospital support. The initial search was undertaken in Medway and was widened to other Trust sites across Kent and Medway when a suitable site in Medway could not be found.

Once awarded the funding, KMPT worked with health and care system partners to comprehensively re-assess the potential for local Medway site solutions. The following search criteria was used:

- **Scale:** Sufficient space, whether existing buildings for adaptation or for a new build including external space for a garden, parking etc. KMPT also prefers ground floor options for all inpatient services as it better suits patients' physical needs.

- **Availability:** Given the urgency of the national timetable, driven by both COVID-19-related concerns and the unacceptability of dormitory accommodation in terms of patient safety, privacy and dignity, the building or land must be available in the short term. The timescale set by regulators for awarding capital funds is for commencement of construction of a new-build or major conversion by October 2021 to meet a November 2022 deadline for eradicating dormitory mental health wards.

- **Location alongside other mental health services:** KMPT's strategy for locating new mental health inpatient units, in common with all other mental health trusts, is to ensure the support of other medical, psychological, therapeutic, and most importantly, nursing staff to the ward team. It is easier to ensure this access if a number of wards are located together which also provides economies of scale.

- **Location alongside general acute hospitals**: It is beneficial for mental health inpatient facilities to be located close to general hospitals so that medical emergencies are more easily managed. This is significantly more important for older people with mental health problems, whose physical health care needs are usually higher, as in the general population, but further exacerbated by their mental health problems, which can make diagnosis of serious physical health problems more difficult.

- **Site ownership**: The capital investment that the Trust will receive needs to be invested in KMPT estate, owned by the Trust and declared as an asset on the Trust's balance sheet. If the relocation is to be within Medway this would require the Trust having to acquire a site there. The Trust has had this position confirmed by its regulator. NHSEI also confirmed there is no additional funding available from the national programme to support acquisition of assets.

Initial assessment to meet timescales for the bid

The immediate challenge was to identify where a new-build or refurbished ward could be sited. Adaptation of the existing Ruby ward was ruled out as it is too small and did not support the strategic ambition to deliver more acute treatment on the MFT site. The only other inpatient facility owned or leased by KMPT in the Medway area, Newhaven Lodge, was also ruled out as inadequate in terms of space. The Trust's other service occupying a building on the Medway Hospital site is the Disablement Services Centre, which is fully operational, and in addition, standalone units are not considered good practice as they can be more difficult to staff and can lead to patient safety issues.

Having established that there were no KMPT estate options within Medway, the Trust reviewed whether it owned other sites on which to realistically base the bid.

The only available KMPT site meeting the criteria is the Maidstone site, which is also KMPT's closest nearby, and most easily accessible, site for Medway residents. Whilst acknowledging that people want as short a journey time as possible to access healthcare facilities, KMPT provides inpatient beds on a Kent and Medway-wide basis, with different specialist facilities and different specialist teams caring for patients in different places. There is not a concept of 'local' specialist inpatient beds designated for particular communities – all inpatient services are provided for all Kent and Medway residents. This means that patients requiring admission may not be admitted to a unit closest to their home, but they will be admitted to the most appropriate facility to meet their needs.

The bid which was therefore submitted is based on the proposed development of a new purpose-built facility on the Maidstone site.

Assessment undertaken following successful bid outcome

Delighted to have been awarded the funding, KMPT worked with health and care system partners to comprehensively assess the potential for local Medway site solutions which were not currently owned by the Trust, to try and retain immediate access in a Medway location. Details of this review are attached as Appendix B.

Conclusion

A comprehensive multi-agency review of accommodation options for a specialist mental health unit for older people has not identified a suitable location in Medway which meets the identified criteria, including - critically - the timescale requirements for eradication of dormitory wards and accessing capital funding. This means the option which formed the basis of the original bid to DHSC, development of a new purpose-built facility on the Maidstone site, meets all the identified criteria and remains the recommended way forward.

While the national and local strategic priority is to continue to enhance mental health community services, support people in their own homes and avoid hospital admission wherever possible, admission to an inpatient ward will be necessary for some people.

The release of Ruby ward will realise our goal to eradicate outdated dormitory style accommodation for mental health patients in Kent and Medway. The construction of a new, purpose-built facility for older adults with acute mental health difficulties will significantly improve the way that care and support are provided for this cohort of patients. The opportunity to design and construct a new unit will help fulfil local ambitions to provide the high-quality and safe accommodation that our patients, their families and loved ones have every right to expect.

4. Discussions with Medway HASC

The proposal to relocate services currently provided on Ruby ward and construct a new older adults unit in Maidstone was presented to Medway HASC at its meeting on Wednesday 17th March 2021. This included the information outlined within this report and a recommendation for public and stakeholder engagement. HASC members voiced concerns about the proposal and agreed the following:

a) that the reprovision of services from Ruby ward at Medway Maritime Hospital to the Maidstone Hospital site is a substantial variation to services.
b) recommended that a 6-week period of public consultation takes place with HASC and local people including patients, families and carers who have used the Ruby ward service, to urgently eradicate the Trust's remaining dormitory ward by 2022.
c) requested that KMCCG and KMPT investigate further potential sites within Medway (Harmony House, Canada House, the Medway ambulance site and Elizabeth House) as possible alternative sites for the new facility and also explore further with the Medway NHS Foundation Trust whether a suitable site can be found at Medway Maritime Hospital.
d) agreed that the outcomes of these investigations and discussions be discussed with a small Member Working Group.

We are in the process of planning for a six-week formal public consultation as requested by HASC and our current working timetable is that this would commence in late summer/early autumn 2021. This would enable commissioners to make a final decision on the future of the service that has to date been provided on Ruby ward and meet the deadlines for starting the construction of the new unit in October 2021.

The additional site recommendations from HASC members were reviewed against the agreed criteria and the results of this review were discussed with the HASC member

working group on Wednesday 19th May 2021. **The report is attached as Appendix C** and this includes the additional assurance that there is no available space for the unit at Medway Maritime Hospital.

5. Inviting feedback from HOSC/recommendations

The eradication of outdated dormitory wards must be a priority for the Kent and Medway health and care system. We are delighted that capital funding is available to enable us to achieve this goal in the best interest of patients. We are therefore **recommending** that a purpose-built facility for older people's mental health services is developed on the Maidstone hospital site to replace the current Ruby Ward on the Medway Maritime Hospital site.

In addition to planning for formal public consultation, we are working with our regulator to take our proposals through the national assurance process for service change. Aligned to that process, we are now seeking HOSC's views on the relocation of Ruby ward services to a proposed new facility in Maidstone and the subsequent increase in bed numbers from 14-16, taking into account:

- the clear rationale for repurposing Ruby Ward because of the poor physical environment and the risks to safety and unacceptably poor privacy and dignity it provides for mental health patients
- the short timescales to respond to the NHSE capital bid and start the build/ refurbishment, alongside requirements for the capital investment that the Trust will receive to be invested in KMPT estate, owned by the Trust and declared as an asset on the Trust's balance sheet
- MFT's need for re-purposing Ruby ward back into acute service estate, in supporting the response to the current pandemic, and in repatriation of NHS acute activity in Medway.

HOSC members are asked to:

- **Note** the national policy and support the case for eradicating outdated dormitory accommodation for mental health inpatients in Kent and Medway
- **Note** that Ruby ward, on the Medway Maritime Hospital site, is the only remaining dormitory ward for mental health patients in Kent and Medway
- **Note** KMPT's successful bid for capital funding to support the eradication of such wards through redevelopment or new build of fit-for-purpose accommodation with a requirement to commence construction of a new-build or major conversion by October 2021
- **Note** the process and progress to date in working to identify an appropriate and suitable site for reprovision of services previously provided on Ruby ward
- **Note** the current number of beds for Ruby ward is 14 and the proposed reprovision would be for 16 beds in the proposed new location
- **Determine** whether they consider the reprovision/relocation of services from Ruby ward at Medway Maritime Hospital to the Maidstone Hospital site is a substantial variation to services for Kent residents
- **Consider and advise** on appropriate and proportionate engagement on the proposed change

- **Continue to work closely and engage** with commissioners and KMPT as they seek to successfully eradicate dormitory accommodation for mental health patients in Kent and Medway.

Lead officer contacts:

Karen Benbow, Director of System Commissioning NHS Kent and Medway Clinical Commissioning Group
E-mail: karenbenbow@nhs.net
Phone number: 07545 934434

Andy Oldfield, Deputy Director Mental Health and Dementia Commissioning NHS Kent and Medway Clinical Commissioning Group.
E-mail: a.oldfield@nhs.net
Phone number: 07766 472128

Appendix A
Slide deck – images of Ruby ward and still from the architect's walkthrough

Appendix B
Review of potential sites in Medway

The following agencies were approached to provide information and suggestions on potential sites in the Medway area which might meet the criteria set out above:

- **Medway Foundation NHS Trust (MFT)** The site has some very old wards which are not fully fit for purpose, many having very cramped conditions which have become even more compromised by the impact of the pandemic and the need to socially distance, which has resulted in a reduction in bed numbers. Also, the ambition of the local health system is to repatriate Medway surgical and diagnostic activity which is currently outsourced to private providers which will require access to more estate. The opportunity to have Ruby ward back (which due to its location and comparatively modern build, compared to some of the MFT Victorian estate, is regarded as a prime asset for MFT) makes a significant contribution to tackling some of the issues above and will benefit patients using Medway Maritime Hospital.

  MFT is clear that there are no facilities available or appropriate in the main building and have plans for the various buildings sited around the periphery, including the potential for an onsite GP or healthy living centre and/or step-down facility.

- **Medway Community Healthcare Trust (MCH)** KMPT has worked with MCH and has reviewed the properties it uses in Medway against the five criteria. Of these only three meet the scale criteria, but none are available as all are patient-facing

operational services with no plans to change them in the short-term. They are owned by NHS Property Services.

- **Independent nursing and care home sector** The CCG has considered whether there might be potential within the independent nursing and care home sector. Only one site emerged with potential, but in discussions with the provider concerned they confirmed that the land they did have available is already allocated for their own purposes.

- **Medway Council estates division** A list of five potential sites was provided by the Council. The Trust has undertaken a review of each of these sites against the five criteria set out in the background section above, but none met the criteria, most being too small or not available within the necessary timescale and none are located alongside a mental health unit or general hospital.

  A full list of the sites considered is set out below.

- **NHS Property Services** provided a list showing the NHS land and property which fit the scale criteria. Unfortunately, with the exception of the Clover Street land, they have confirmed that they are all operational properties and would not be available in the short or medium term.

  The Clover Street site is vacant and remains the preferred option for the Chatham Healthy Living Centre development. The site would not meet either of the co-location criteria nor the site ownership criteria. In addition, its location in a commercial part of the town is not ideal for an inpatient unit.

  One property, **Darland House**, has been closely considered, given there is already a dementia care home service on site. However, to develop the new unit would result in loss of all garden/amenity space to the existing unit, as the site is not large enough. Ownership and co-location with general hospital services are two further criteria which Darland House does not meet. The Trust has also explored the land next to Darland, which is owned by the council and is part-occupied by football/hockey pitches. However, council officers confirmed this was not available.

Evaluation of potential sites from Medway Council estates division

Evaluation details of sites considered were as follows:

a) **St Marks**. This site does not meet any of the criteria, although it is very close to the Britton House community mental health unit. However, the site is:
   - not located alongside a general hospital
   - too small
   - currently not available and unlikely to become so in the time available
   - not a KMPT asset.

b) **57 Marlborough Road**. The site might meet scale criteria (further specialist review/survey would be required), and could potentially meet availability, but is:
   - not located alongside either a mental health unit or general hospital

- not a KMPT asset.

On inspection, work appears to have already started to redevelop the site.

c) **Marlborough Road Annex.** The site is potentially available but:
   - does not meet the scale criteria
   - is not located alongside a mental health unit or a general hospital
   - is privately owned and, therefore, unlikely to be available for transfer within the successful funding allocation.

d) **Kingsley House**. The site meets none of the criteria.

e) **Tintagel Manor**. The site could meet the scale criteria (further specialist review/survey would be required) but:
   - is currently not available and unlikely to be in the time available
   - is not near a general hospital
   - is not a KMPT asset
   - it is across a busy road from Britton House, and would still take staff several minutes to respond from there. Britton House is not a 24/7 facility so there would be no additional staff support/response out-of-hours.

Appendix C
Discussion paper 'Review of sites proposed by HASC members' – May 2021

NHS
Kent and Medway
Clinical Commissioning Group

Eradicating dormitory wards

Developing a new Older Adults Unit
for the people of Kent and Medway

NHS
Kent and Medway
Clinical Commissioning Group

Current situation

- Ruby Ward at Medway Maritime Hospital is the last remaining dormitory ward in K&M
- Outdated and old-fashioned dormitory ward - compromising safety, dignity, and privacy of patients
- Infection control issues – highlighted by challenges of COVID-19
- Very difficult for patients to access outside space
- Limited areas for visitors
- Shared bathroom

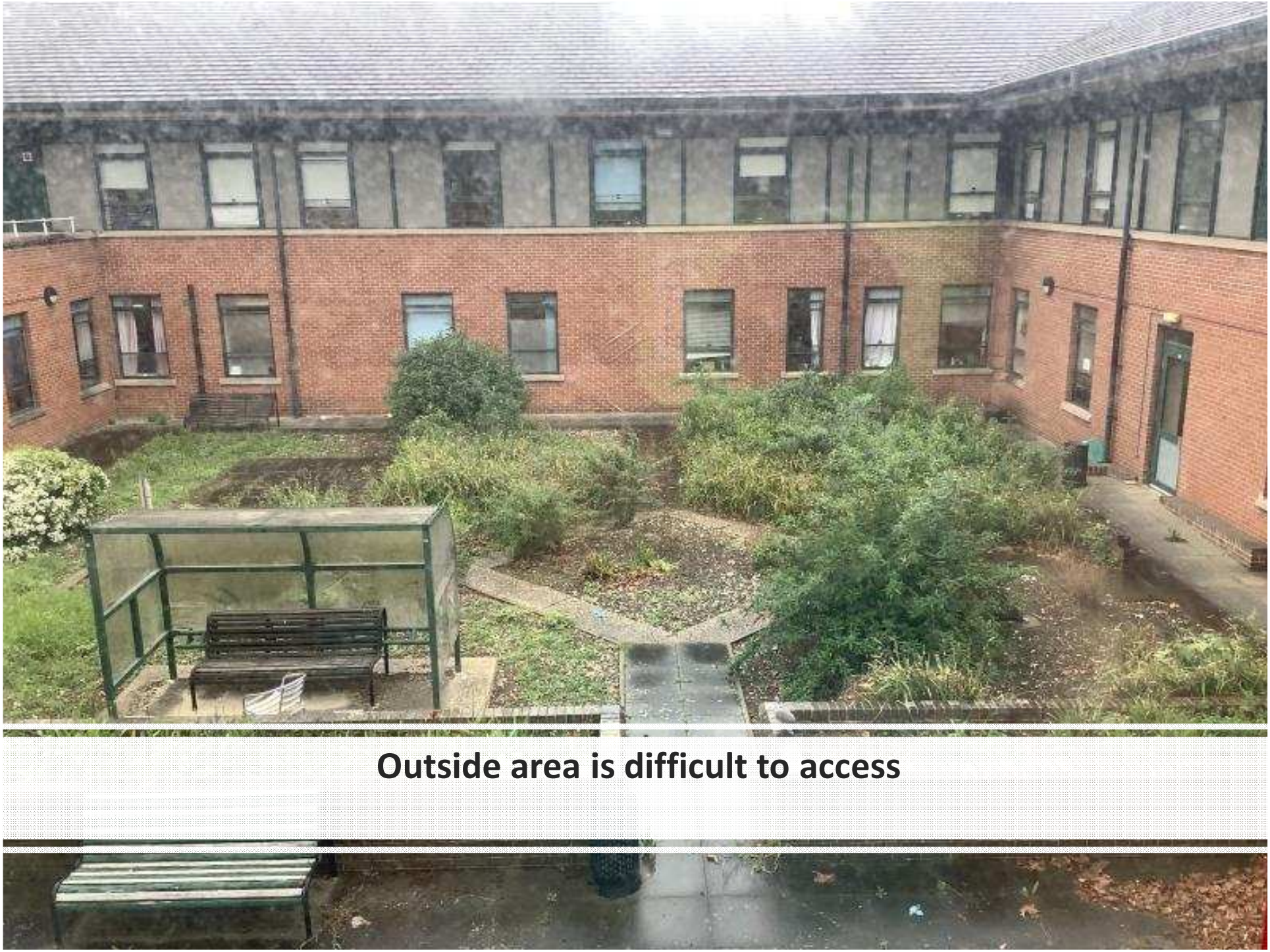
Ruby Ward – bed bay

Ruby Ward – bed bay

Ruby Ward – bed bay

Ruby Ward – bed bay

Shared bathroom in Ruby Ward



Outside area is difficult to access

Ruby ward’s small lounge doubles as a visitor area

NHS
Kent and Medway
Clinical Commissioning Group

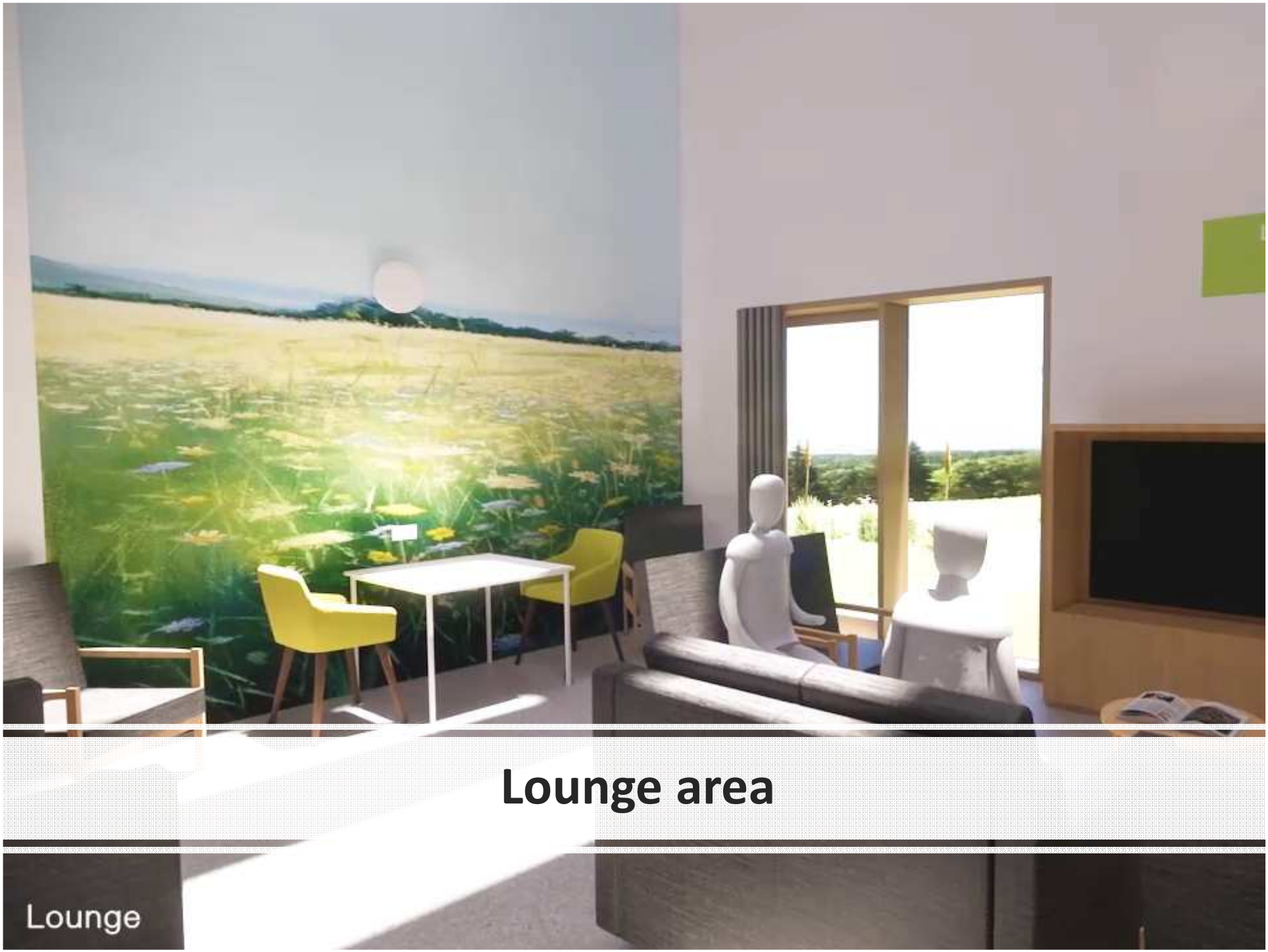
A new purpose-built facility

- £12.65m of government funding - an unprecedented opportunity to build a new facility
- Single ensuite bedrooms for 16 patients (rising from 14)
- Available to anyone who needs it wherever they live in Kent and Medway
- High-quality, safe accommodation is an integral part of the therapeutic process and has a significant bearing on the experience of patients, their families and loved ones
- A new purpose-built facility will offer greater privacy, access to outside space and improved infection control measures.

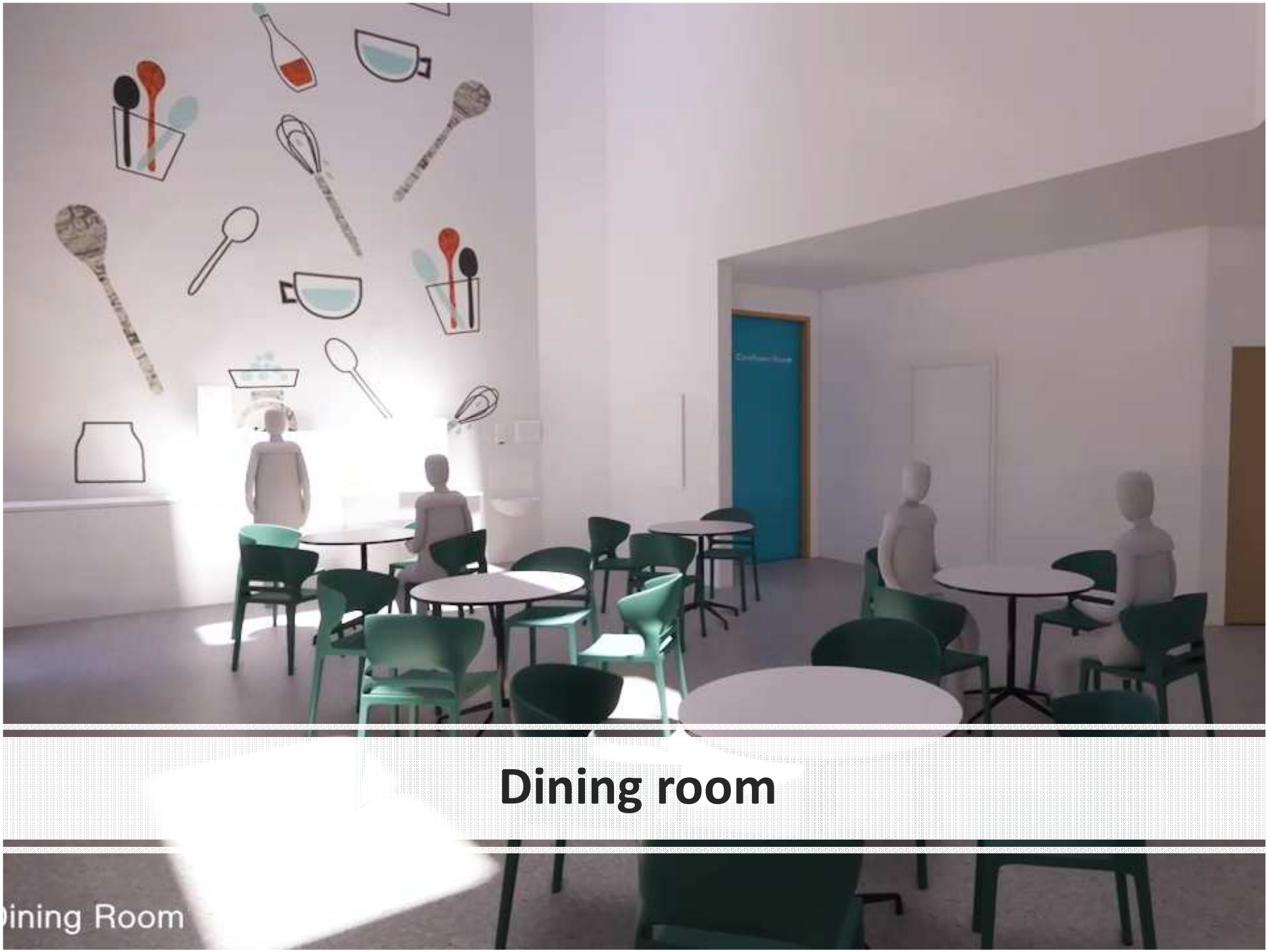
Example ensuite bedroom

Example ensuite bedroom

Assisted bathroom



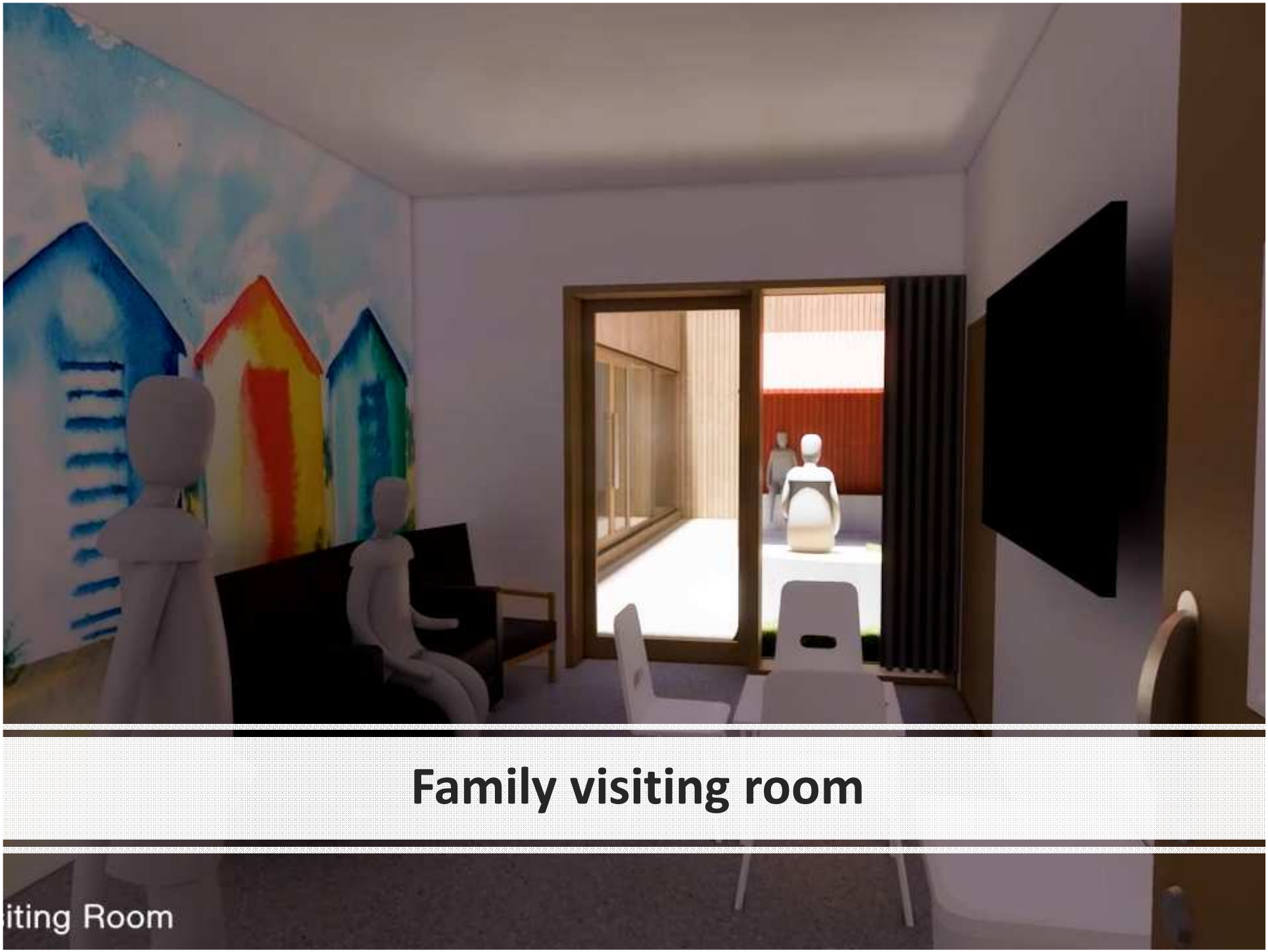
Lounge area



Dining room

Garden area

Group activity room

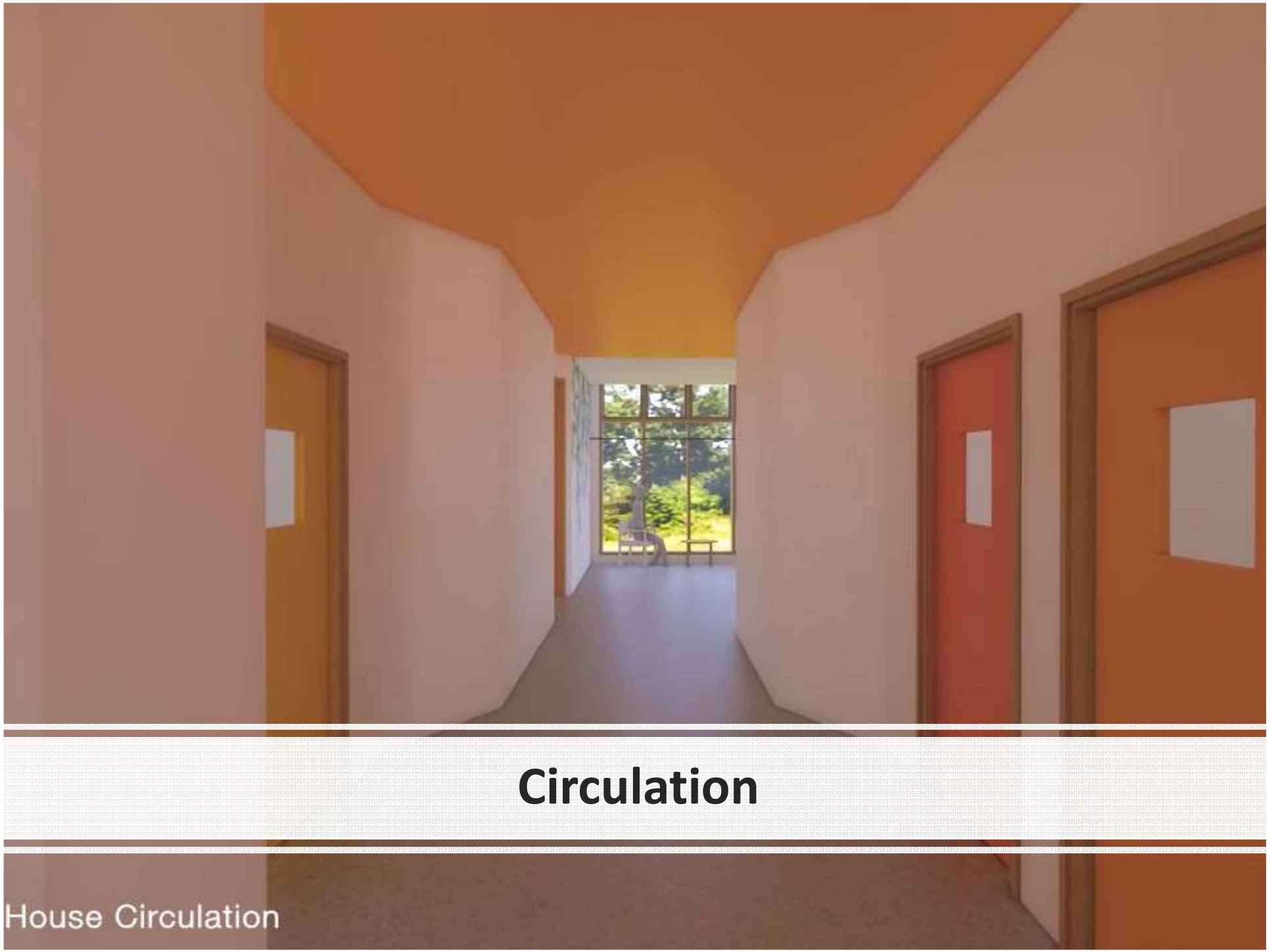


Family visiting room

Family visiting outdoor space

Activities for Daily Living (ADL) kitchen area

Complex client room



Circulation

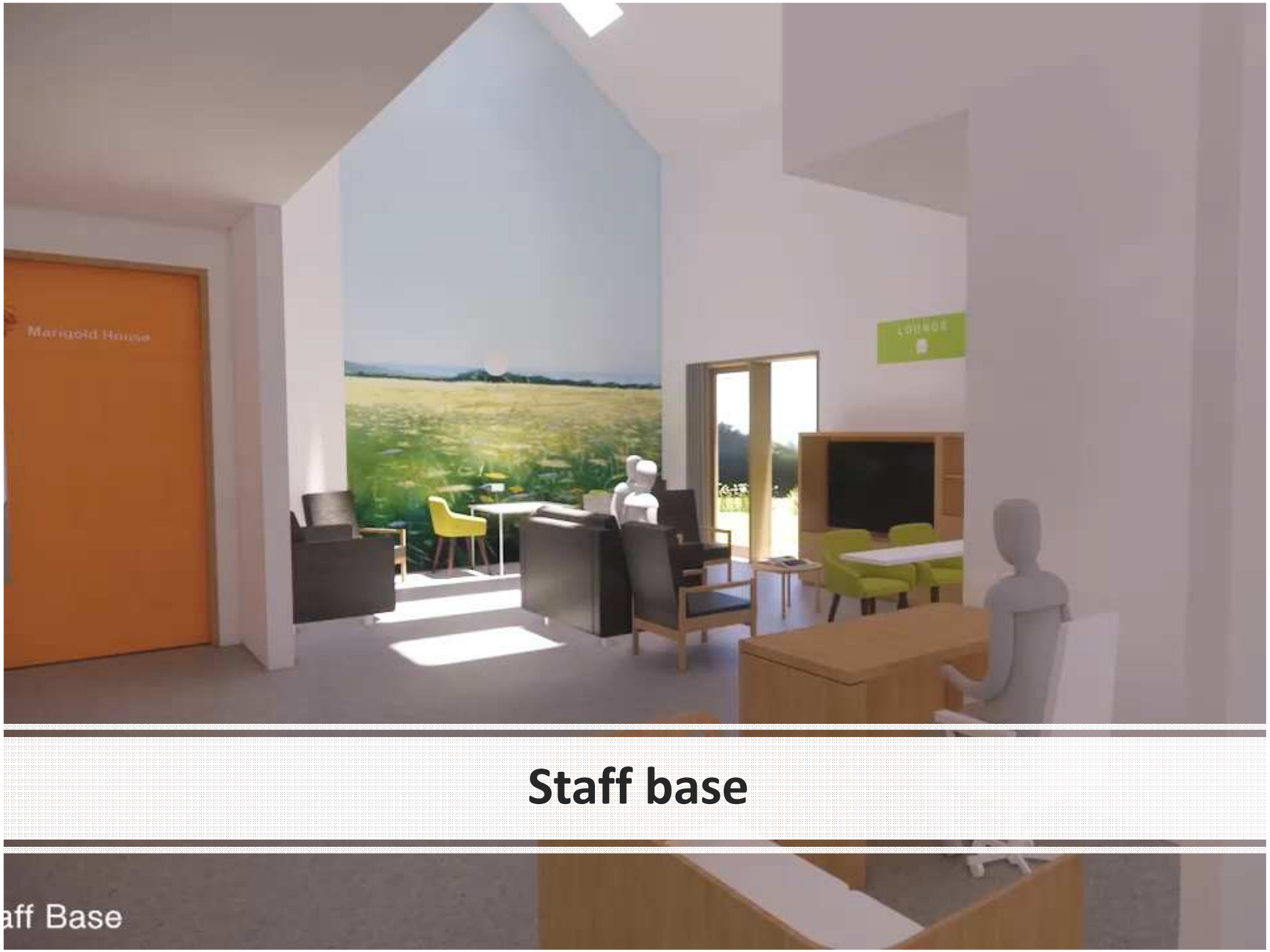
House Circulation

Seating by window

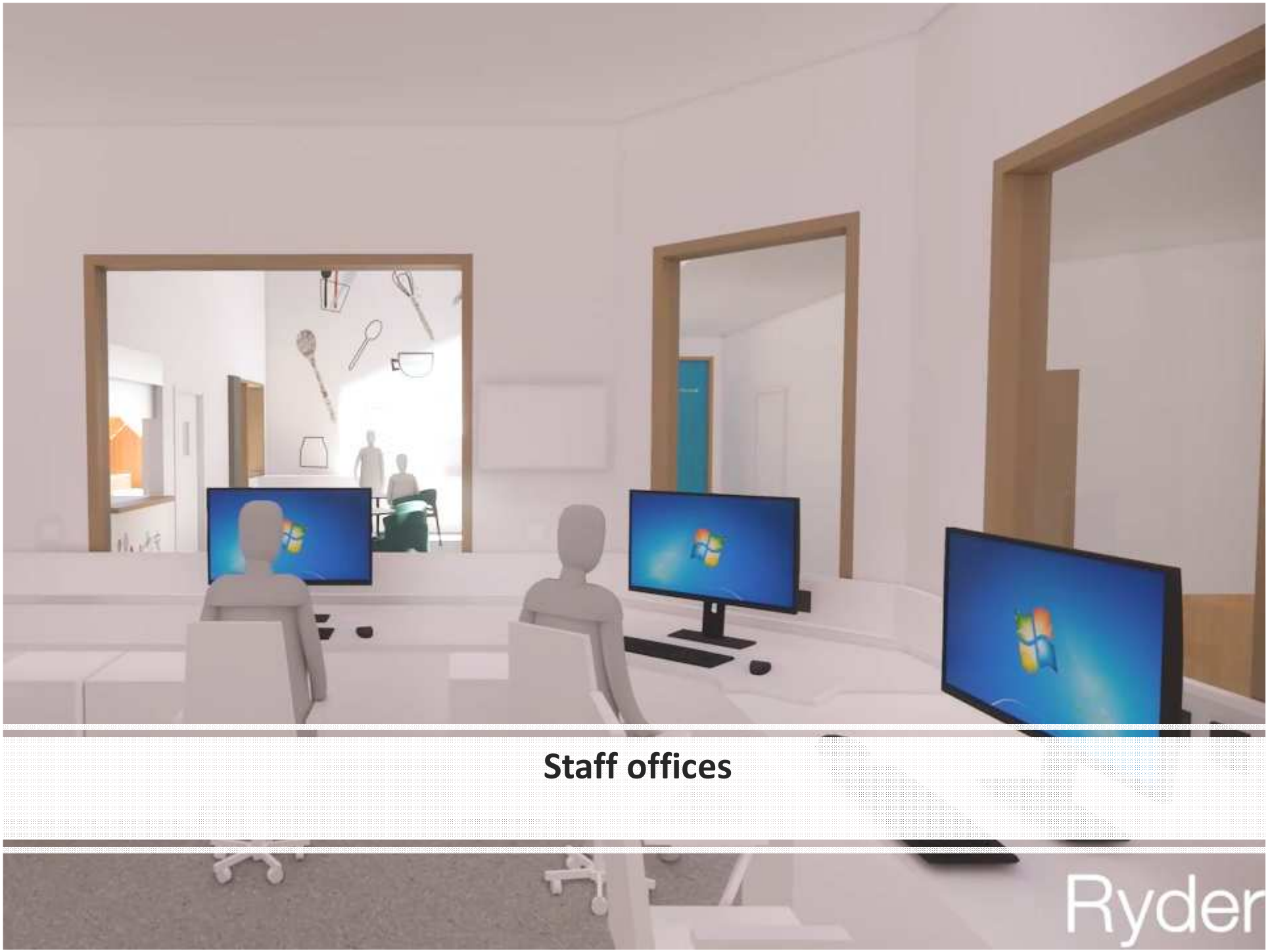
Quiet room

De-escalation outdoor space

De-escalation room



Staff base


Staff offices
Ryder

Eradicating dormitory wards – a new older adults unit for Kent and Medway

NHS
Kent and Medway
Clinical Commissioning Group

Care provided on outdated dormitory style ward – lacking privacy and dignity	Modern, purpose-built accommodation for older adults with mental health issues, including dementia.
No easy access to outside space	Holistic caring, working environment for patients and staff
Shared bathrooms	Ensuite bathrooms ensuring privacy and dignity
Lack of dedicated visiting space	Light, airy, calm environment with easy access to outside spaces to ensure optimum levels of wellbeing
Ward set up makes it difficult to ensure infection control for this cohort of patients	Designed to ensure infection control measures can be put in place with ease

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Eradicating dormitory wards – a new older adults unit for Kent and Medway

Review of sites proposed by Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC) members

Working group meeting – 19th May 2021

Introduction

The NHS in Kent and Medway is working in partnership to improve mental health services. This includes planning for a new facility for older adults with mental health issues, including dementia. Providing high-quality and safe accommodation for patients is an integral part of the therapeutic process and has a significant bearing on the experience of patients, their families and loved ones. Outdated and old-fashioned dormitory wards compromise safety, dignity, and privacy and have no place in a 21st century mental health system.

Following a successful bid for £12.65m of government funding as part of the national drive to eradicate outdated dormitory wards, it is proposed to build a new facility including single ensuite bedrooms for 16 patients (rising from 14) at Kent and Medway Health and Social Care Partnership NHS Trust's (KPMT) Maidstone site. To access this government funding, work must begin in October 2021 to be scheduled for completion in November 2022, to meet the national deadline for eradicating dormitory wards.

The new, purpose-built facility will be available to anyone who needs it wherever they live in Kent and Medway and will replace the single last remaining dormitory ward, Ruby Ward, which is currently operating at Medway Maritime Hospital. It will offer greater privacy, access to outside space and improved infection control measures, which is an increasingly important concern in light of the COVID-19 pandemic. This proposal is part of local ambitions to provide high-quality and safe accommodation for patients within the context of a programme of wider mental health transformation.

KMPT provides inpatient beds on a Kent and Medway-wide basis, with different specialist facilities and different specialist teams caring for patients in different places. There is not a concept of 'local' specialist inpatient beds designated for particular communities – all inpatient services are provided for all Kent and Medway residents. This means that patients requiring admission may not be admitted to a unit closest to their home, but they will be admitted to the most appropriate facility to meet their needs. Whilst Ruby Ward is located in the former Medway CCG catchment area, it takes patients from across Kent and Medway.

Feedback from HASC members

Representatives from KMPT and Kent and Medway Clinical Commissioning Group (KMCCG) were pleased to present the proposals to Medway councillors at the Health and Adult Social Care Overview and Scrutiny Committee meeting on Thursday 11th March 2021. This included an update on this new capital investment, the process by which this was secured, and timescale requirements for accessing funding as well as early progress in reviewing locations for a new, updated facility for Kent and Medway residents. It was helpful to discuss the issues and hear the concerns and views of committee members.

At the meeting, HASC members asked for:

1. evidence of assurance from the Medway NHS Foundation Trust's (MFT) Chief Executive that there are no options on the Medway Maritime Hospital (MMH) site which would be suitable for the new, older adults unit; and,
2. four additional sites to be reviewed for their potential to provide a Medway location for the new older adult acute mental health unit.

This paper outlines the response to these requests. Attached to this paper (Annex A) for reference is the previous report on potential sites for the new unit which was carried out in autumn of 2020 following confirmation of the capital funding award by the Department of Health and Social Care (DHSC). In that report the option of using space at MMH was reviewed in detail with MFT, and the conclusion was that there was no available space which was not required by MFT for its own healthcare development purposes which include, notably, repatriation of acute surgical and diagnostic activity for the Medway population. The Medway CEO has confirmed this remains the case (see Annex B).

1. Assurance from Medway Foundation Trust's Chief Executive

The option of using space at Medway Maritime Hospital was explored with Medway Foundation Trust shortly after KMPT's successful bid for capital funding for a new older adults unit was confirmed. This review found that there was no available space which was not required by MFT for its own healthcare development purposes which include the repatriation of acute surgical and diagnostic activity for the Medway population.

MFT's site has some very old wards which are not regarded as fully fit for purpose, many having cramped conditions which have become even more compromised by the impact of the COVID-19 pandemic, including the need to socially distance. The Trust's strategic ambition, and that of the wider health economy, is to repatriate as much as possible of the £18m of Medway and Swale surgical and diagnostic activity which is currently outsourced to private providers. To achieve this, MFT needs a further three wards of bed capacity alongside additional diagnostic on-site services. The opportunity to have the area currently known as Ruby Ward back will make a significant contribution to tackling some of these issues.

At the time of the initial review, MFT was clear that there are no facilities available or appropriate in the main building and plans are in development for buildings sited

around the periphery, including the potential for an on-site GP or Healthy Living Centre and/or step-down facility.

As part of MFT's application for university hospital status they will be taking on 75 more junior doctors over the next four years and so are currently working through options for increasing their staff accommodation units on site from 172 to 250.

It was therefore concluded that there are no alternative premises on the MFT site for an older adults' mental health unit. MFT's Chief Executive has confirmed this remains the case and the letter confirming this is attached as Annex A. In addition to the lack of availability, one of the key criteria for the government funding for a new unit is that the site should be owned by the provider trust (in this case KMPT) and therefore any move to use estate owned by MFT would not meet that part of the criteria.

2. Review of additional sites suggested by HASC members

HASC members recommended that KMPT and KMCCG review four additional sites within Medway which were not part of the original review of potential sites in autumn 2020. We were pleased to receive these suggestions and have conducted a thorough review of the following sites:

- Canada House in Gillingham
- Elizabeth House in Rainham
- Medway Ambulance Station, Star Mill Lane, Chatham
- Harmony House in Rochester

Criteria

As with the original review of potential sites undertaken in autumn 2021, the following search criteria were used to assess the potential for these four sites.

- **Scale:** Sufficient space, whether existing buildings for adaptation or for a new build including external space for a garden, parking etc. KMPT also prefers ground floor options for all inpatient services as it better suits patients' physical needs.

- **Availability:** Given the urgency of the national timetable, driven by both COVID-19-related concerns and the unacceptability of dormitory accommodation in terms of patient safety, privacy and dignity, the building or land must be available in the short term. The timescale set by regulators for eradicating dormitory wards is November 2022 which means that construction must start by October 2021.

- **Location alongside other mental health services:** KMPT's strategy for locating new mental health inpatient units, in common with all other mental health trusts, is to ensure the support of other medical, psychological, therapeutic, and most importantly, nursing staff to the ward team. It is easier to ensure this access if a number of wards are located together which also provides economies of scale.

- **Location alongside general acute hospitals**: It is beneficial for mental health inpatient facilities to be located close to general hospitals so that medical emergencies are more easily managed. This is significantly more important for older people with mental health problems, whose physical health care needs are usually higher, as in the general population, but further exacerbated by their mental health problems, which can make diagnosis of serious physical health problems more difficult.

- **Site ownership**: The capital investment that the Trust will receive needs to be invested in KMPT estate, owned by the Trust and declared as an asset on the Trust's balance sheet. The Trust has had this position confirmed by its regulator. NHSEI also confirmed there is no additional funding available from the national programme to support acquisition of assets. The Trust was prepared to consider any and all buildings and to explore potential site transfer options if all other criteria were met and the cost was token. If the relocation is to be within Medway this would require the Trust having to acquire a site there.

The following table gives a high-level overview of how each site scored against the criteria and includes Medway Maritime Hospital estate as HASC members requested further assurance on this point.

Site	Scale	Availability	Location alongside other mental health services	Location alongside general acute hospitals	Site ownership
Canada House	Y	N	N	N	N
Elizabeth House	N	N	N	N	N
Ambulance station at Star Lane, Chatham	Borderline /potential impact on parking	N	N	N	N
Harmony House	N	N	N	N	N
Medway Maritime Hospital estate	Y	N	N	Y	N

Detailed review of sites

Canada House

This former servicemen and maternity hospital building was sold at auction on 28 July 2020, having been declared surplus to requirements by KMPT after informing other NHS bodies to establish if there were alternative uses for the site. No alternative use was identified. Its most recent purpose had been as a community mental health centre, which was replaced by the new Britton House centre initiative which is run by KMPT in partnership with Medway Council. The Canada House building was approaching 120 years old and had long since passed the point of fitness for purpose, despite considerable investment over a number of years. Although the building would meet the scale criteria, it does not meet the other four key criteria – co-location with other mental health services, co-location with the general acute hospital, ownership or availability.

Canada House was not considered a viable option as part of the initial review because the building was unsuitable for conversion to inpatient use, was also considerably larger than required and would have needed a range of other activities co-located there to make the proposal viable. Multi-component developments take much longer to plan and commission than was available for this scheme, which also impacts on the availability criteria.

Elizabeth House

This site, at just under 1300m2, was too small to be considered and was returned to the landlord, NHS Property Services in August 2020**.** The new older adults unit requires approximately 1200m2 for the building itself and approximately twice as much space again for landscaping, parking and external facilities – in total around 0.4 hectares. In addition to not meeting the scale criteria the site did not meet any of the other four criteria at the time of the business case submission.

Medway Ambulance Station

South East Coast Ambulance Service (SECAmb) has recently had approval for a business case for funding for the new Make Ready Centre in Gillingham and will vacate their current ambulance station in Star Mill Lane on completion of the new site. While the site is up for sale, full vacant possession of the site can only be given around Spring 2022. This is too late to meet the timescales for the construction of the new older adults unit which requires construction work to start at the end of October 2021 so that it is fully operational in November 2022, thus meeting national timescales for the eradication of dormitory wards. The site does not meet the criteria for co-location with other mental health services or co-location with the general acute hospital. The site is about 2,500m2 which might be big enough but would require significant design consideration around parking or necessitate off-site parking which would bring significant challenges for both staff and visitors. The site cost of £1m is not available within the funding envelope for this proposal.

Harmony House

Medway Community Healthcare owns this building, which was capital-funded by European research funding. It is currently in use as respite care accommodation. It does not meet any of the criteria, being too small, not owned by KMPT and not co-located with either of the other clinical services identified in the criteria. In addition, its design does not in any way meet the requirements of an older adult's acute mental health unit, with bedrooms being split over two floors and without any ensuite bathrooms.

Conclusion

We are grateful to HASC members for their recommendations and appreciated the opportunity to explore these additional sites within the context of the agreed search criteria. Whilst there is an expectation that the replacement facility, at £12.65m, will meet

all criteria fully, a comprehensive, multi-agency review of potential options for a Medway-based facility was undertaken (as outlined in the original paper to HASC in March 2021), recognising that solutions are rarely perfect in all respects. Some latitude on one or other of the co-location criteria might be possible if a proposed solution meets all other criteria fully, and an acceptable 'work-around' can be identified.

Unfortunately, no suitable site in Medway has been identified which meets all, or indeed many, of these criteria including the critical factor of the timescale requirements for accessing the capital funding. This means that the option which formed the basis of the original bid for capital funding – the relocation of the older adult in-patient unit to a new facility on the KMPT Maidstone site - meets all of the identified criteria and remains the recommended way forward.

The Maidstone site is KMPT's closest nearby and is the most easily accessible site for Medway residents. Whilst acknowledging that people want as short a journey time as possible to access healthcare facilities, inpatient beds are provided on a Kent and Medway-wide basis, with the current Ruby Ward facility taking patients from across the Kent and Medway area. Medway residents made up approximately 30 percent of admissions during 2019/2020, demonstrating how admissions are made on a 'needs-led' basis, rather than based on geographic locality.

Next steps

As part of the wider development of proposals for the construction of a new older adults unit for the residents of Kent and Medway, we will be engaging on the range of community-based services and support that are currently available or are in development to support older adults, their families, carers and loved ones outside of a hospital or inpatient environment.

While there will always be a need for inpatient beds, a modern mental health service can and should be judged on its ability to ensure that people have access to a comprehensive range of community-based services to support the majority of mental health needs. Our plans for Medway are based on ensuring that the clinical pathway for each individual patient or service user meets their care and treatment needs.

A three-year programme to deliver transformation to community services for adults and older people with serious mental illness including rehabilitation services, complex emotional disorders and eating disorder services, underpinned by £10.5million of investment across Kent and Medway, will start in Medway in 2021. Aimed at prioritising needs that are specific to Medway residents, this work will identify and address gaps in support and will see the NHS, social services, and the voluntary and community sector integrate services and support so there is a seamless single process into the mental health pathway with a single support/care plan. Initiatives including a 'Safe Haven' in Medway and embedded mental health practitioner roles in local primary care teams, will support this community effort.

We look forward to engaging with HASC members further on the breadth of support available and demonstrating how a modern mental health service can bring significant benefits to local residents, whatever their needs, circumstances, or stage of life. We propose to update HASC members at the scheduled meeting on 15th June 2021. This will include:

- Further information on the programme timeline to meet the requirements of the capital allocations as set out by DHSC including the assurance process required by NHSEI, plans for the six week formal public consultation requested by HASC
- More detail on the process of building design for the new unit, involving service users, and their carers, in the design of the new facilities
- An outline of work to transform the wider mental health service offer across Medway including the development of community services for adults and older people.

ENDS

Annex A - Initial review of site options

The process to access national funding required a bid to be submitted within five days of being notified of the available capital, not months as is usual for major programmes. It should be noted that it was made clear that capital funding would be allocated to provider trusts and the criteria also specified that any capital funding received by the Trust must be invested in their estate portfolio, owned by the Trust, and declared a Trust asset. In other words, any potential site for redevelopment with these monies either needs to be already owned or acquired by the Trust. Incidentally, there is no additional funding available from the national programme to support the acquisition of assets.

The limited number of days available meant a desktop exercise was required to consider site options and register a bid. The challenging timescale meant that KMPT – as provider of the service - was only able to engage with stakeholders in a limited way, engaging with MFT and CCG commissioners in advance of submitting the bid to ensure their support and endorsement, and with senior local authority partners immediately after submission and indication of likely success.

The criteria used for the initial search for a suitable location for a new capital build or redevelopment was for sufficiently sized KMPT owned or leased building space/land, available within the short-term, and ideally located with other mental health and general acute hospital support. The initial search was undertaken in Medway and was widened to other Trust sites across Kent and Medway when a suitable site in Medway could not be found.

Once awarded the funding, KMPT worked with health and care system partners to comprehensively re-assess the potential for local Medway solutions, to try and retain immediate access in a Medway location. The following search criteria was used:

- **Scale:** Sufficient space, whether existing buildings for adaptation or for a new build including external space for a garden, parking etc. KMPT also prefers ground floor options for all inpatient services as it better suits patients' physical needs.

- **Availability:** Given the urgency of the national timetable, driven by both COVID-19-related concerns and the unacceptability of dormitory accommodation in terms of patient safety, privacy and dignity, the building or land must be available in the short term. The timescale set by regulators for awarding capital funds is for commencement of construction of a new-build or major conversion by October 2021.

- **Location alongside other mental health services:** KMPT's strategy for locating new mental health inpatient units, in common with all other mental health trusts, is to ensure the support of other medical, psychological, therapeutic, and most importantly, nursing staff to the ward team. It is easier to ensure this access if a number of wards are located together which also provides economies of scale.

- **Location alongside general acute hospitals**: It is beneficial for mental health inpatient facilities to be located close to general hospitals so that medical emergencies are more easily managed. This is significantly more important for older people with mental health problems, whose physical health care needs are usually higher, as in the general population, but further exacerbated by their mental health problems, which can make diagnosis of serious physical health problems more difficult.

- **Site ownership**: The capital investment that the Trust will receive needs to be invested in KMPT estate, owned by the Trust and declared as an asset on the Trust's balance sheet. If the relocation is to be within Medway this would require the Trust having to acquire a site there. The Trust has had this position confirmed by its regulator. NHSEI also confirmed there is no additional funding available from the national programme to support acquisition of assets.

Initial assessment to meet timescales for the bid

The immediate challenge was to identify where a new-build or refurbished ward could be sited. Adaptation of the existing Ruby ward was ruled out as it is too small and did not support the strategic ambition to deliver more acute treatment on the MFT site. The only other inpatient facility owned or leased by KMPT in the Medway area, Newhaven Lodge, was also ruled out as inadequate in terms of space. The Trust's other service occupying a building on the Medway Hospital site is the Disablement Services Centre, which is fully operational, and in addition, standalone units are not considered good practice as they can be more difficult to staff and can lead to patient safety issues.

Having established that there were no KMPT estate options within Medway, the Trust reviewed whether it owned other sites on which to realistically base the bid.

The only available KMPT site meeting the criteria is the Maidstone site, which is also KMPT's closest nearby, and most easily accessible, site for Medway residents. Whilst acknowledging that people want as short a journey time as possible to access healthcare facilities, KMPT provides inpatient beds on a Kent and Medway-wide basis, with different specialist facilities and different specialist teams caring for patients in different places. There is not a concept of 'local' specialist inpatient beds designated for particular communities – all inpatient services are provided for all Kent and Medway residents. This means that patients requiring admission may not be admitted to a unit closest to their home, but they will be admitted to the most appropriate facility to meet their needs. This is demonstrated in the table above, showing that whilst Ruby Ward is located in the Medway CCG catchment area, it takes patients from across Kent and Medway.

The bid which was therefore submitted is based on the development of a new purpose-built facility on the Maidstone site.

Assessment undertaken following successful bid outcome

KMPT worked with health and care system partners to comprehensively assess the potential for local Medway solutions which were not owned by the Trust, to try and retain immediate access in a Medway location. The following agencies were approached to provide information and suggestions on potential sites in the Medway area which might meet the criteria set out above:

- **Medway Foundation NHS Trust (MFT)** The site has some very old wards which are not fully fit for purpose, many having very cramped conditions which have become even more compromised by the impact of the pandemic and the need to socially distance, which has resulted in a reduction in bed numbers. Also, the ambition of the local health system is to repatriate Medway surgical and diagnostic activity which is currently outsourced to private providers which will require access to more estate. The opportunity to have Ruby Ward back (which due to its location and comparatively modern build, compared to some of the MFT Victorian estate, is regarded as a prime asset for MFT) makes a significant contribution to tackling some of the issues above and will benefit patients using Medway Maritime Hospital.

MFT is clear that there are no facilities available or appropriate in the main building, and have plans for the various buildings sited around the periphery, including the potential for an onsite GP or healthy living centre and/or step down facility.

- **Medway Community Healthcare Trust (MCH)** KMPT has worked with MCH and has reviewed the properties it uses in Medway against the five criteria. Of these only three meet the scale criteria, but none are available as all are patient-facing operational services with no plans to change them in the short-term. They are owned by NHS Property Services.

- **Independent nursing and care home sector** The CCG has considered whether there might be potential within the independent nursing and care home sector. Only one site emerged with potential, but in discussions with the provider concerned they confirmed that the land they did have available is already allocated for their own purposes.

- **Medway Council estates division** A list of five potential sites was provided by the Council. The Trust has undertaken a review of each of these sites against the five criteria set out in the background section above, but none met the criteria, most being too small or not available within the necessary timescale and none are located alongside a mental health unit or general hospital.

A full list of the sites considered is below.

Evaluation details of sites considered were as follows:

a) **St Marks**. This site does not meet any of the criteria, although it is very close to the Britton House community mental health unit. However, the site is:
   - not located alongside a general hospital
   - too small
   - currently not available and unlikely to become so in the time available
   - not a KMPT asset.

b) **57 Marlborough Road**. The site might meet scale criteria (further specialist review/survey would be required), and could potentially meet availability, but is:
   - not located alongside either a mental health unit or general hospital
   - not a KMPT asset.

   On inspection, work appears to have already started to redevelop the site.

c) **Marlborough Road Annex.** The site is potentially available but:
   - does not meet the scale criteria
   - is not located alongside a mental health unit or a general hospital
   - is privately owned and, therefore, unlikely to be available for transfer within the successful funding allocation.

d) **Kingsley House**. The site meets none of the criteria.

e) **Tintagel Manor**. The site could meet the scale criteria (further specialist review/survey would be required) but:
   - is currently not available and unlikely to be in the time available
   - is not near a general hospital
   - is not a KMPT asset
   - it is across a busy road from Britton House and would still take staff several minutes to respond from there. Britton House is not a 24/7 facility so there would be no additional staff support/response out-of-hours.

NHS Property Services provided a list showing the NHS land and property which fit the scale criteria. Unfortunately, with the exception of the Clover Street land, they have

confirmed that they are all operational properties and would not be available in the short or medium term.

The Clover Street site is vacant and remains the preferred option for the Chatham Healthy Living Centre development. The site would not meet either of the co-location criteria nor the site ownership criteria. In addition, its location in a commercial part of the town is not ideal for an inpatient unit.

One property, **Darland House**, has been closely considered, given there is already a dementia care home service on site. However, to develop the new unit would result in loss of all garden/amenity space to the existing unit, as the site is not large enough. Ownership and co-location with general hospital services are two further criteria which Darland House does not meet. The Trust has also explored the land next to Darland, which is owned by the council and is part-occupied by football/hockey pitches. However, council officers confirmed this was not available.

Annex B: Medway Foundation Trust CEO Letter of Assurance

NHS
Medway
NHS Foundation Trust

OFFICE OF THE CHIEF EXECUTIVE

Medway Maritime Hospital
Windmill Road
Gillingham
Kent
ME7 5NY

01634 830000

12 April 2021

Helen Greatorex

Chief Executive

Kent & Medway NHS & Social Care Partnership Trust (KMPT)

Dear Helen

I am writing further to our dialogue over the past few months in relation to Ruby Ward and the cohort of service users who currently receive their care on that ward, on the Medway Maritime Hospital site.

As you will know, Ruby Ward is an old dormitory ward, and it is therefore encouraging to see capital investment across the county in upgrading the facilities to single en-suite rooms, in order to help improve care for mental health service users.

We know that the eradication of dormitories will improve individual care, reduce length of stay; it will also have benefits in respect of infection control, and reducing the risk of incidents involving staff or service users/patients. These benefits have been widely talked about by both Nadine Dorries, Minister for Mental Health & Suicide Prevention, and Claire Murdoch, Mental Health Director at NHS England.

Since our first meeting with Medway Council colleagues, our respective teams have worked together to review the options for the services to continue either on the hospital site, or in another location in Medway which satisfies the criteria. I understand that we have now exhausted these options, and I can confirm that there are no other options to explore on the hospital site. The option therefore is to invest the capital monies at the identified Maidstone location.

Whilst I appreciate it will be disappointing that we could not identify a suitable location in Medway or on the hospital site, the overriding concern must be that any location must be well placed to offer the level of support that this patient cohort require and deserve to receive.

Lastly, I would like to register my thanks to your team for the collaborative way they have worked with our estates team in robustly reviewing the options we discussed with Medway Council colleagues.

Best wishes,

James Devine

Chief Executive

Item 8: Covid-19 - update

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 10 June 2021

Subject: Covid-19 - update

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

It provides background information which may prove useful to Members.

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1) Introduction

a) The Committee has received updates on the local response to Covid-19 since their July 2020 meeting.

b) The Kent and Medway CCG has been invited to attend today's meeting to update the Committee on the response of local services to the continuing covid-19 pandemic as well as the progress of the vaccination rollout locally.

2) Previous monitoring by HOSC

a) HOSC received its most recent update in March 2021. The main areas of discussion were:

- The reducing pressure on critical care as infection rates reduced.
- The unusually high occupancy rates in community hospitals.
- Progress of the local vaccination rollout.
- Elective care and related timescales, including the impact of honouring staff leave owed.
- Two key areas of concern were children and young people's mental health and eating disorders. The Mental Health Learning Disability and Autism Improvement Board were looking into these areas and updates would be provided to HOSC as part of the ongoing monitoring in this area.

b) Following the discussion, the Committee resolved to note the report.

3) 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

Kent County Council (2020) 'Health Overview and Scrutiny Committee (24/11/20)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8498&Ver=4

Kent County Council (2021) 'Health Overview and Scrutiny Committee (27/01/21)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8499&Ver=4

Kent County Council (2021) 'Health Overview and Scrutiny Committee (4/03/21)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8500&Ver=4

Contact Details

Kay Goldsmith
Scrutiny Research Officer
kay.goldsmith@kent.gov.uk
03000 416512

Covid-19 update for Kent Health Overview and Scrutiny Committee – June 2021

Content of this report is accurate for the deadline of paper submissions. Verbal updates will be provided at the committee meeting.

The report is provided by the Kent and Medway Clinical Commissioning Group (KMCCG) on behalf of the Integrated Care System. It is an overview to the NHS response to the pandemic and includes work being delivered by a wide range of NHS partners.

Vaccination programme

The Covid-19 vaccination programme across Kent and Medway has progressed well since the last HOSC update in March 2021. More than one million people have now had their first dose and over half a million completed their second dose.

Figures on vaccine progress are published nationally each Thursday, as of 20 May, the position in Kent and Medway was:

Total vaccinations given

- 1,593,304 vaccines in total
- 579,271 second doses completed

Percentage uptake across the priority groups:

Cohorts	First dose uptake	Second dose uptake
1 (Care home residents and carers)	100%*	86%
2 (80 years and over and health and care frontline staff)	94%	92%
3 (75-79 year olds)	96%	97%
4 (70-74 year olds and clinically extremely vulnerable)	94%	94%
Total 1 – 4	**95%**	**94%**
5 (65-69 year olds)	93%	85%
6 (clinically vulnerable aged 16-64)	84%	51%
7 (60-74 year olds)	91%	41%
8 (55-59 year olds)	89%	21%
9 (50-54 year olds)	86%	19%
Total 1 – 9	**90%**	**66%**
10 (40-49 year olds)	71%	16%
11 (30-39 year olds)	21%	38%
12 (18-29 year olds)	12%	50%
Total 10 – 12	**33%**	**25%**
All cohorts	**67%**	**57%**

* Data is from national reporting against an estimated denominator, with actual first dose vaccinations exceeding the denominator.

KMCCG publish a regular update on vaccine progress where you can see the latest figures https://www.kentandmedwayccg.nhs.uk/your-health/coronavirus/covid19vaccine/covid-19-vaccine-updates

The full data sets published by NHS England include details at CCG/Integrated Care System level (Kent and Medway) as well as council level information. https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/

Vaccination services across Kent and Medway

The vaccine programme continues to be a partnership response with a broad range of frontline services involved. Vaccinations are currently being provided by GP-led services, large vaccination centres run by Kent Community Health NHS Foundation Trusts, and pharmacies. The four hospital trusts also ran vaccination hubs for health and care staff and some patients; these hospital hubs have now completed their work. Prison health services have also vaccinated eligible people detained in custody. The table below shows rounded figures for how the different services are contributing to the overall programme.

Vaccine services	First doses	Second doses	Total
Hospital hubs	78,000	72,500	150,500
Large vaccination Centres	234,100	55,600	289,700
Primary Care Networks	584,100	419,200	1,003,300
Pharmacies	106,800	28,400	135,200
Detained	1,200	170	1,370

Vaccine equality

Within the high overall levels of vaccine uptake shown above we are analysing uptake within different communities and working to increase vaccination levels where it remains lowest. We have a dedicated vaccine equalities working group involving partners across NHS, public health and district councils; working closely with community groups and leaders.

Groups we are delivering dedicated support plans for are:

- Black African
- Eastern European
- Gypsy/Roma/Traveller
- Migrants
- Homeless

The vaccine equalities group is also producing data for individual General Practices with less than 85% uptake to support local actions to boost uptake.

Future of the vaccination programme

We expect to have offered all eligible people a first dose of the vaccine by the end of July (subject to supply being maintained); which will mean second doses complete by mid-October assuming a 12 week gap between doses remains for cohorts 10-12.

We are awaiting further national detail on how the Covid-19 vaccine programme will continue into a booster dose and the potential of vaccinating children. Initial planning is underway to design a robust vaccination service which can operate along-side routine health services returning to normal activity. Although much of the detailed planning will need to wait until there is clarity on how further Covid-19 vaccinations will align with the annual flu vaccination programme.

We will provide more detail on this in a future update to HOSC.

Covid-19 cases and deaths

Pressure on NHS hospitals due to treating Covid-19 positive patients is now greatly reduced; in line with the overall infection rates in the community and the vaccination programme.

In March, when the Governing Body last met, there were approximately 500 hospital beds occupied with Covid-19 positive patients. As of 20 May there were less than 10 Covid-19 positive patients in hospital beds of any type across all trusts; and no Covid-19 positive patients in Intensive Care Units.

Deaths from Covid-19 have also dropped significantly. There are unfortunately still a small number of deaths on a weekly basis however there are regularly days when no deaths are recorded in any Kent and Medway hospitals or community sites.

As of 20 May in Kent there have been:

- 3,997 deaths within 28 days of a positive test
- 4,566 deaths with Covid-19 recorded on the death certificate

In Medway there have been:

- 746 deaths within 28 days of a positive test
- 791 deaths with Covid-19 recorded on the death certificate

Post-Covid Assessment Services (Long Covid Services)

On 14 May the Kent and Medway Post-Covid Assessment Service opened. The service is for patients who continue to experience effects of a Covid-19 infection for more than 12 weeks. Up to 12 weeks support would be provided through GP services and a national offer including a website with detailed information to help people self-manage their recovery from Covid-19.

Where symptoms persist for more than 12 weeks patients should contact their GP practice so any alternative diagnosis can be ruled out and to decide if the Post Covid Assessment Service would be suitable.

Following a GP referral the Post Covid Assessment Service will make contact with the patient and an expert team of professionals will assess their condition and then provide support in accessing services that can help with their recovery.

As this is a new condition, the NHS is also collecting the experiences of people with Long Covid to find out more about how it affects people and their families to make sure the patient voice shapes the development of the service. Almost 500 people either completed a survey or attended an online meeting with more interviews being arranged.

The service is provided by Maidstone and Tunbridge Wells NHS Trust working in partnership with West Kent Primary Care GP Federation. It is for patients across Kent and Medway. As an assessment rather than treatment service the majority of appointments can happen through phone and video appointments to limit travel required.

Hospital waiting lists

The NHS across Kent and Medway has worked hard to maintain as much planned/elective non-Covid treatment as possible through the two waves of the pandemic. Good progress was also made to reschedule routine treatments in the period after the first wave and before infections rose again in the second wave.

However, there is now a significant back-log of delayed treatments which will take time for the NHS to work through. Based on verified published data up to February 2021 there were a total of 133,670 people waiting for elective care across Kent and Medway. Of these, 8,055 patients had been waiting over 52 weeks.

The work on elective care recovery is being led by a system level Elective Care Board chaired by Miles Scott, Chief Executive of the Maidstone and Tunbridge Wells NHS Trust.

All trusts have restarted elective care. Rescheduling treatment will prioritise those with the highest clinical need and those who have been waiting longest. The number of people waiting over 52 weeks is reducing on a weekly basis.

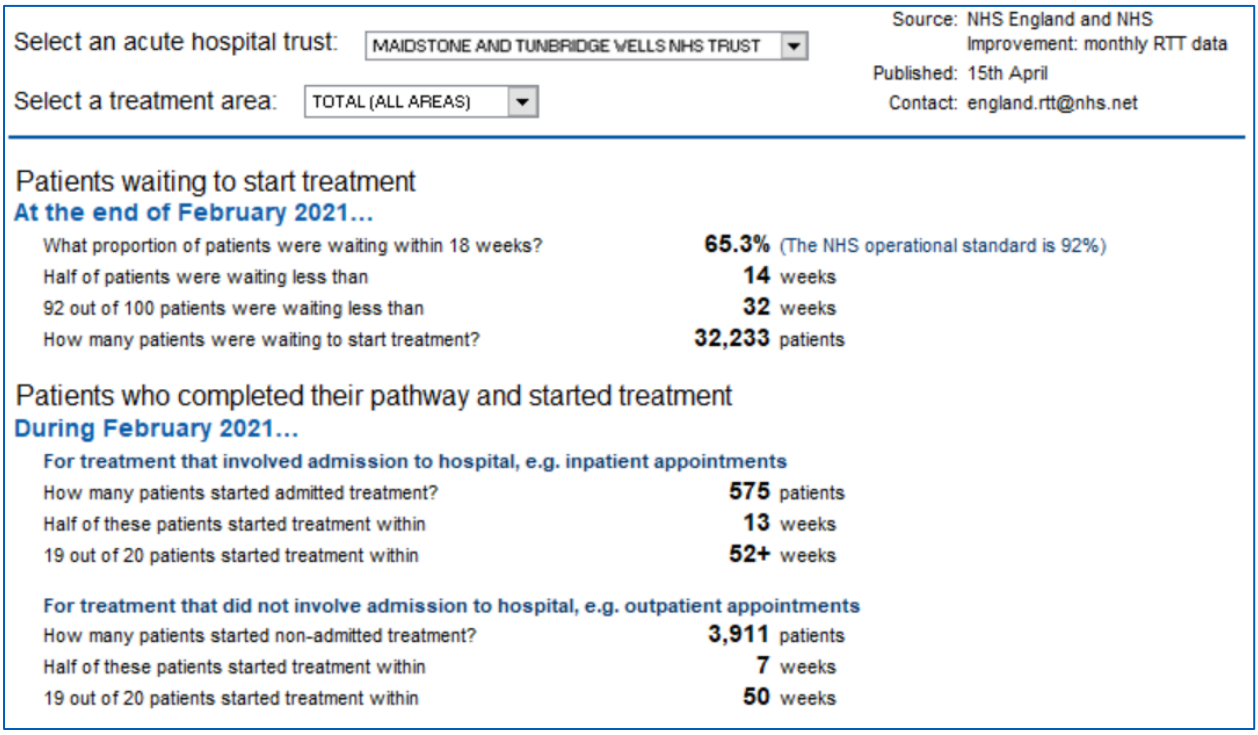
With the need to maintain Covid-secure environments both before, during and post-surgery the total capacity for elective care is lower than it was before the pandemic. We continue to use Independent Sector hospitals to add capacity and are maximising activity within our available theatre space and workforce. NHS England / NHS Improvement expectations are that the NHS recovers monthly elective care activity to 80% of pre pandemic levels by June and 85% in July to September. The Kent and Medway system is on track to exceed these expectations.

With new referrals adding to waiting lists it is recognised that this is a major challenge for the NHS. As a system Kent and Medway is working across hospitals, community, primary care services to maximise care that can be offered in community settings; this includes care that would prevent the need for elective treatment and identifying routine procedures that could be carried out in community settings.

As one example of the work to boost capacity, a new surgical centre will open at Kent and Canterbury Hospital this summer, with four operating theatres dedicated to patients needing planned inpatient orthopaedic surgery. This includes hip and knee replacements which are among many routine procedures significantly delayed by the Covid pandemic. The new surgical centre will enable the East Kent Hospitals University NHS Foundation Trust to treat approximately 3,500 orthopaedic patients a year in a brand new centre of excellence for orthopaedic surgery in east Kent, as well as freeing up theatres and beds at QEQM and William Harvey for trauma and cancer surgery.

The tables on the pages below are taken from the national published data on waiting times across NHS hospitals; reporting February data. It should be noted that the data includes patients from all areas, so includes non-Kent and Medway residents. For the Dartford and Gravesham NHS Trust in particular there are a significant number of patients from outside of Kent.

Maidstone and Tunbridge Wells NHS Trust



Select an acute hospital trust: MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Select a treatment area: TOTAL (ALL AREAS)

Source: NHS England and NHS Improvement: monthly RTT data
Published: 15th April
Contact: england.rtt@nhs.net

Patients waiting to start treatment
At the end of February 2021…

What proportion of patients were waiting within 18 weeks?	**65.3%** (The NHS operational standard is 92%)
Half of patients were waiting less than	**14** weeks
92 out of 100 patients were waiting less than	**32** weeks
How many patients were waiting to start treatment?	**32,233** patients

Patients who completed their pathway and started treatment
During February 2021…

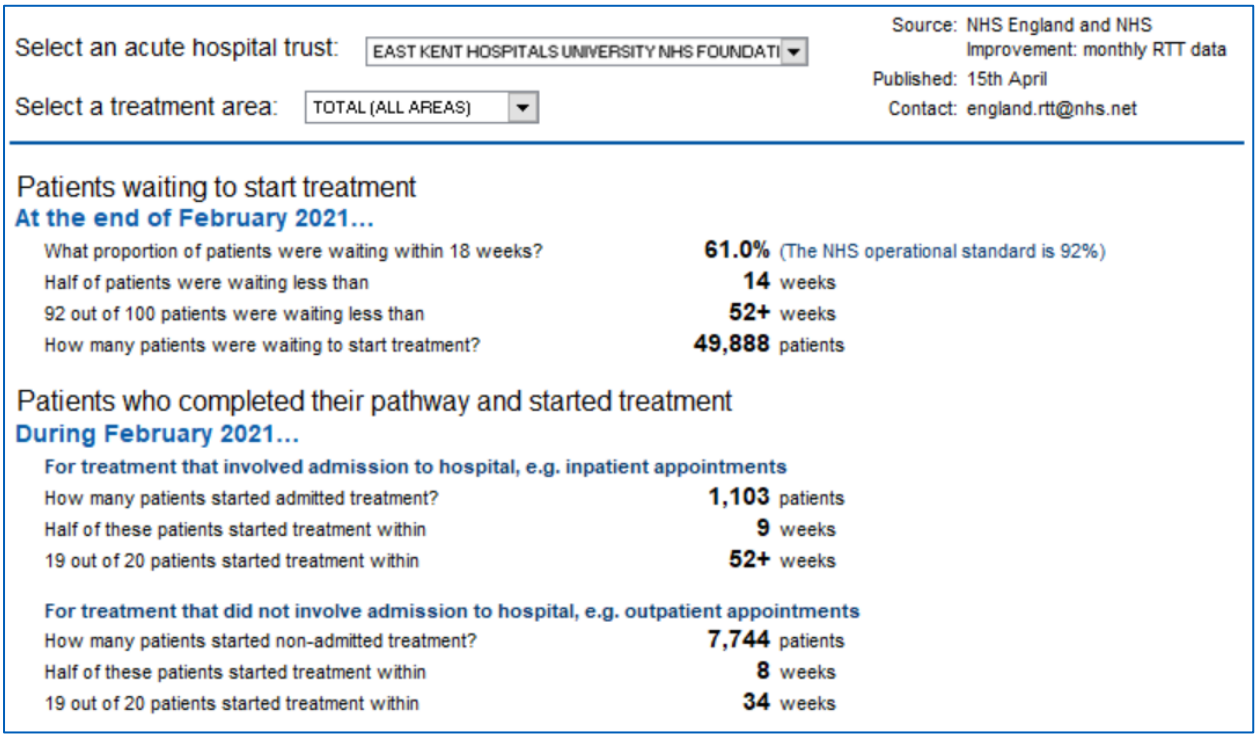
For treatment that involved admission to hospital, e.g. inpatient appointments

How many patients started admitted treatment?	**575** patients
Half of these patients started treatment within	**13** weeks
19 out of 20 patients started treatment within	**52+** weeks

For treatment that did not involve admission to hospital, e.g. outpatient appointments

How many patients started non-admitted treatment?	**3,911** patients
Half of these patients started treatment within	**7** weeks
19 out of 20 patients started treatment within	**50** weeks

East Kent Hospitals University NHS Foundation Trust



Select an acute hospital trust: EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATI

Select a treatment area: TOTAL (ALL AREAS)

Source: NHS England and NHS Improvement: monthly RTT data
Published: 15th April
Contact: england.rtt@nhs.net

Patients waiting to start treatment
At the end of February 2021…

What proportion of patients were waiting within 18 weeks?	**61.0%** (The NHS operational standard is 92%)
Half of patients were waiting less than	**14** weeks
92 out of 100 patients were waiting less than	**52+** weeks
How many patients were waiting to start treatment?	**49,888** patients

Patients who completed their pathway and started treatment
During February 2021…

For treatment that involved admission to hospital, e.g. inpatient appointments

How many patients started admitted treatment?	**1,103** patients
Half of these patients started treatment within	**9** weeks
19 out of 20 patients started treatment within	**52+** weeks

For treatment that did not involve admission to hospital, e.g. outpatient appointments

How many patients started non-admitted treatment?	**7,744** patients
Half of these patients started treatment within	**8** weeks
19 out of 20 patients started treatment within	**34** weeks

East Kent Hospitals University NHS Foundation Trust (our largest local trust with three main hospitals) has the most significant challenges. We are working as a system across Kent and Medway to plan how waiting lists can be managed in an equitable way so as to reduce health inequalities and limit the issue of how long people wait being linked to where they live in Kent and Medway.

Dartford and Gravesham NHS Trust

Select an acute hospital trust: DARTFORD AND GRAVESHAM NHS TRUST

Select a treatment area: TOTAL (ALL AREAS)

Source: NHS England and NHS Improvement: monthly RTT data
Published: 15th April
Contact: england.rtt@nhs.net

Patients waiting to start treatment
At the end of February 2021…

What proportion of patients were waiting within 18 weeks?	**68.5%** (The NHS operational standard is 92%)
Half of patients were waiting less than	**12** weeks
92 out of 100 patients were waiting less than	**42** weeks
How many patients were waiting to start treatment?	**15,835** patients

Patients who completed their pathway and started treatment
During February 2021…

For treatment that involved admission to hospital, e.g. inpatient appointments

How many patients started admitted treatment?	**355** patients
Half of these patients started treatment within	**7** weeks
19 out of 20 patients started treatment within	**35** weeks

For treatment that did not involve admission to hospital, e.g. outpatient appointments

How many patients started non-admitted treatment?	**1,886** patients
Half of these patients started treatment within	**5** weeks
19 out of 20 patients started treatment within	**25** weeks

Approximately 10,300 Kent residents are on the Dartford and Gravesham NHS Trust's waiting list.

Medway NHS Foundation Trust

Select an acute hospital trust: MEDWAY NHS FOUNDATION TRUST

Select a treatment area: TOTAL (ALL AREAS)

Source: NHS England and NHS Improvement: monthly RTT data
Published: 15th April
Contact: england.rtt@nhs.net

Patients waiting to start treatment
At the end of February 2021…

What proportion of patients were waiting within 18 weeks?	**61.5%** (The NHS operational standard is 92%)
Half of patients were waiting less than	**14** weeks
92 out of 100 patients were waiting less than	**36** weeks
How many patients were waiting to start treatment?	**21,627** patients

Patients who completed their pathway and started treatment
During February 2021…

For treatment that involved admission to hospital, e.g. inpatient appointments

How many patients started admitted treatment?	**327** patients
Half of these patients started treatment within	**12** weeks
19 out of 20 patients started treatment within	**48** weeks

For treatment that did not involve admission to hospital, e.g. outpatient appointments

How many patients started non-admitted treatment?	**3,784** patients
Half of these patients started treatment within	**9** weeks
19 out of 20 patients started treatment within	**41** weeks

Kent and Medway residents on other providers' waiting lists

Provider	Total	0-18 Weeks	18-26 Weeks	26-52 Weeks	52+ Weeks
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	3,247	2,015	341	441	450
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	4,000	2,607	488	584	321
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	2,151	1,383	244	273	251
BENENDEN HOSPITAL	577	255	95	86	141
LEWISHAM AND GREENWICH NHS TRUST	643	405	68	99	71
UNIVERSITY COLLEGE LONDON HOSPITALS NHS TRUST	572	341	69	93	69
BARTS HEALTH NHS TRUST	242	117	31	48	46
SPIRE ALEXANDRA HOSPITAL	1,328	983	213	97	35
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	303	184	50	38	31
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	237	139	34	37	27
PPG (WILL ADAMS) GILLINGHAM	1,452	1,193	78	155	26
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	492	333	83	56	20
BMI - THE CHAUCER HOSPITAL	521	430	47	32	12
BMI - CHELSFIELD PARK HOSPITAL	208	163	26	11	8
KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	3,411	3,408	3	0	0
SUSSEX COMMUNITY DERMATOLOGY SERVICE	2,649	2,463	151	35	0
KIMS HOSPITAL (NEWNHAM COURT)	1,033	735	221	77	0
Other - under 200 incompletes	2,326	1,525	279	344	178

Cancer care

Access to urgent cancer diagnostics and treatments continued throughout Wave 2 across all of our acute providers. Some of these services were running at a slightly reduced capacity due to wider system pressures. Cancer screening has also continued throughout Wave 2 for breast, bowel and cervical programmes. Figures for March 2021 show:

- 97.7% of urgent suspected cancers are seen within 2 weeks *(expected standard = 93%)*
- 93.1% of symptomatic breast referrals are seen within 2 weeks *(expected standard = 93%)*
- 94% of patients receive first treatment within 31 days *(expected standard = 96%)*
- 85.6% of patients receive subsequent surgery with 31 days *(expected standard = 94%)*
- 99.4% of patients receive subsequent drug therapy with 31 days *(expected standard = 98%)*
- 97.4% of patients receive subsequent radiotherapy with 31 days *(expected standard = 94%)*
- 80.9% of urgent GP referrals treated within 62 day *(expected standard = 85%)*
- 75.4% of urgent screening referrals treated within 62 days *(expected standard = 90%)*

Two week wait referrals

K&M met the 93% standard for the first half of the year. Referrals dropped to 42% of expected levels in April 2020 (due to the national lockdown) but cancer services maintained a steady recovery following the initial dip. The number of referrals exceeded pre-pandemic levels from September through to December which led to the two week wait standard being just missed during this time. Kent and Medway have maintained relatively high levels of two week wait compliance with many trusts triaging patients in 3-7 days rather than the 14. The development of 'straight to test' pathways as well as patient navigators has also help to shorten the initial phase of investigation. From the latest published data Kent and Medway is the best performing Cancer Alliance in the country against this standard.

The number of referrals has not been evenly spread across tumour groups and Breast and Colorectal services have been particularly pressured with the volume of patients. An Endoscopy working group has been supporting colorectal recovery and the implementation of low and high risk FIT testing to reduce the burden on the number of Endoscopies required and therefore the speed to first seen status.

GP referral to treatment within 62 days (85% target)

Nationally, we have been one of the top performing Alliances at this target for 2020/21. Kent and Medway last met 85% in October and much of the Alliance success is thanks to the continued target-beating performance of Maidstone and Tunbridge Wells over the last year. East Kent last met the target in October, Dartford in July and Medway haven't met the target this year. A Cancer Improvement Group is in place and plans are being developed with all stakeholders to support recovery. Performance is overseen by the governance of the Cancer Alliance Delivery Board. For March 2021, Kent and Medway is the second best performing Cancer Alliance against this standard nationally.

Trusts have been successful securing green operating pathways to continue operating through the second wave, although at times High Dependency Units have been pressurise due to Covid-19 patients. The successful rollout of vaccinations to diagnosed cancer patients and a series of patient focussed messaging have contributed to reassuring patients it is safe to attend for treatment.

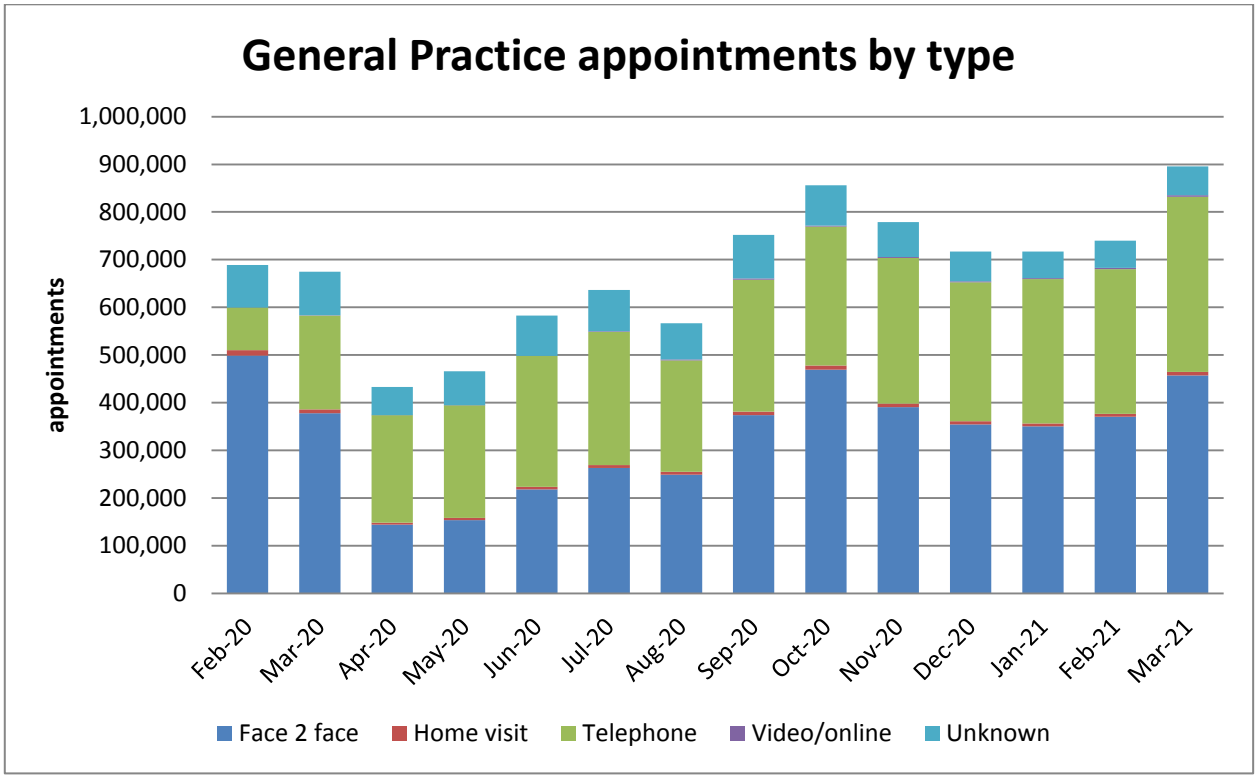
In terms of patients waiting more than 63 days for treatment, we are aiming to reduce from 500 current to 280 (Feb 2020 levels) in our recovery plans. The total number over 63 days is reducing at a greater rate than the number rolling over due to increased operating capacity, shorter pre-surgery isolation requirements, and improved patient engagement with their pathways. Mutual aid and support is available to support this within Kent and through our links to South London.

General Practice appointments

The latest monthly appointment data for general practice has shown a major increase in the numbers of face-to-face appointments happening in GP surgeries across Kent and Medway. Over 86,500 more face to face appointments took place in March 2021 compared to February 2021, with the total extra appointments of all types exceeding 155,000.

The 198 General Practice teams across Kent and Medway have continued working throughout the pandemic; albeit in different ways to what patients have been used to. Total appointments have actually been higher than pre-pandemic levels in each month since September 2020. This shows general practice adapted well to the new ways of working required at the start of the pandemic and was able to sustain the recovery made after the first wave through the much larger second wave.

These figures exclude the Covid-19 vaccine clinics run by Primary Care Networks which now total over one million vaccinations since mid-December 2020.



The table below provides some specific data across the different appointment types for comparison at key points through the pandemic including:

- February 2020 as the pre-pandemic baseline
- April 2020 as the local peak of the first wave
- January 2020 as the local peak of the second wave

Month	Total appointments	Face to face	Home visit	Telephone	Video/online	Unknown
Feb 2020 (pre-pandemic)	**689,019**	498,719	11,361	89,687	0	89,252
April 2020 (Wave 1 peak)	**432,985**	144,410	4,031	225,525	45	58,974
Jan 2021 (Wave 2 peak)	**717,175**	350,101	6,471	302,543	2,485	55,575
Feb 2021	**739,623**	370,458	6,184	303,650	2,605	56,726
Mar 2021	**895,505**	457,025	7,365	367,496	3,419	60,200

We recognise that access to general practice from the patient's perspective is not just about the actual appointments. It also covers the wider ability to drop in to a surgery for a range of queries, and the experience of getting through to the surgery on the phone for booking appointment, getting test results and other queries.

The open door access has undoubtedly been restricted through the pandemic, and for the right reasons of keeping patients and staff safe. Going forward, we will see access to surgeries increase again as the wider restrictions on social distancing are eased. Like other small businesses the physical limitations of some smaller surgeries will present continued challenges in adapting to covid-secure requirements. With increased demand, as shown in the figures above, practices will remain busy and pressure on appointment slots and phone lines will remain high. The CCG continues to work with General Practice and NHS England to address the wider workforce challenges within primary care which are needed to meet demand.

Information campaigns to support public understanding are being developed by the CCG in discussion with clinical leads and the Kent Local Medical Committee and we will be supporting local practices to make sure they have clear positive messages about how people can access different types of appointments with the whole clinical team - so that people are seen by the most appropriate person through the most effective channel for their needs.

Caroline Selkirk
Director of Health Improvement and Chief Operating Officer
Kent and Medway NHS Clinical Commissioning Group

Item 9: Urgent Care Review Programme - Swale

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 10 June 2021

Subject: Urgent Care Review Programme - Swale

Summary: This report provides the background to the agenda item and attached information provided by the Kent and Medway CCG.

The Committee has yet to determine if the proposals constitute a substantial variation of service.

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1) Introduction

a) The Local Urgent Care Programme review was first presented to HOSC in 2014. It was in response to an NHS England requirement for all areas to have an Urgent Treatment Centre (UTC) to try and reduce the pressure on A&E departments.

b) The review refers to face-to-face urgent care services, as opposed to telephony services which have been procured separately. Urgent care relates to injuries or illnesses that are not life-threatening but that require urgent clinical assessment or treatment on the same day.[1]

c) In September 2019, provision for urgent care to Swale residents included: [2]

i) A GP out of hours service with bases at Sheppey Community Hospital and Sittingbourne Memorial Hospital as well as a home-visiting service.
ii) A nurse-led minor injuries unit at Sheppey Community Hospital and Sittingbourne Memorial Hospital.
iii) A GP operated walk-in-centre from Sheppey Community Hospital, Sittingbourne Memorial Hospital and a mobile unit.
iv) A 24/7 GP led urgent treatment centre at Medway Maritime Hospital.

2) Previous visits to HOSC

a) HOSC has received updates about the urgent care review programme since 2014. Its last update was on 4 March 2021.

b) Swale CCG had initially considered a “minimal change” clinical model, but this was discontinued in November 2018 after it was deemed unaffordable. It was decided a full-service specification/ clinical model review was necessary, which would involve working alongside Medway CCG whose facilities were used by Swale residents.

[1] Kent County Council (2019) Health Overview and Scrutiny Committee, Swale CCG Urgent Care update (19/09/19)
[2] ibid

c) At its 19 September 2019 meeting, HOSC received an update from Swale CCG and was notified the clinical model options had not yet been identified. The CCG was undertaking a detailed clinical review of data from their urgent and emergency care services and findings were expected in September/ October 2019. Quantitative and qualitative data analysis that had been carried out to date was presented to the Committee.

d) Swale CCG informed the Committee that the NHS Long Term Plan required that their urgent care proposals be in place by autumn 2020.

e) The Committee received a verbal update at its meeting on 4 March 2021. The project was still in its early stages with little progression since the previous update in 2019, in part due to the onset of the pandemic.

f) Following the above discussion, the Committee agreed:

RESOLVED that the update be noted and the Kent and Medway CCG return to update the Committee in June, if appropriate.

g) The CCG has been requested to provide an update at this meeting.

4) Recommendation

RECOMMENDED that the update be noted and the Kent and Medway CCG return to update the Committee at an appropriate time.

Background Documents

Kent County Council (2014) 'Health Overview and Scrutiny Committee (10/10/2014)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5400&Ver=4

Kent County Council (2016) 'Health Overview and Scrutiny Committee (26/01/2016)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6256&Ver=4

Kent County Council (2017) 'Health Overview and Scrutiny Committee (27/01/2017)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7507&Ver=4

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

Kent County Council (2018) 'Health Overview and Scrutiny Committee (23/11/2018)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7923&Ver=4

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

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

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

Kent County Council (2021) 'Health Overview and Scrutiny Committee (4/03/2021) https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8500&Ver=4

Contact Details

Kay Goldsmith
Scrutiny Research Officer
kay.goldsmith@kent.gov.uk
03000 416512

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Kent Health Overview and Scrutiny Committee

Briefing Note: Swale Urgent Treatment Centre (UTC) Model

Introduction and Background

Currently within Swale there are two Minor Injury Units (MIUs), one based at each community hospital (Sheppey Community Hospital and Sittingbourne Memorial Hospital) that is provided by Kent Community Health NHS Trust (KCHFT) and a Walk In Centre (WIC) provided by DMC Healthcare. The WIC is combined within the primary care APMS contract held by primary care and was due to end in March 2021.

This contract has been subsequently extended to June 2021 and now to September 2021 by the CCG's Primary Care Commissioning Committee to allow time for engagement to decide the outcome of the contract. However, they are clear that the contract will not be extended beyond September 2021 and this includes the WIC element. Therefore there is a need to commission a replacement service for the WIC provision.

The UTC national guidance was published in July 2017 which set out a core set of standards for UTCs to establish as much commonality as possible.

The UTC standards require that the public will:

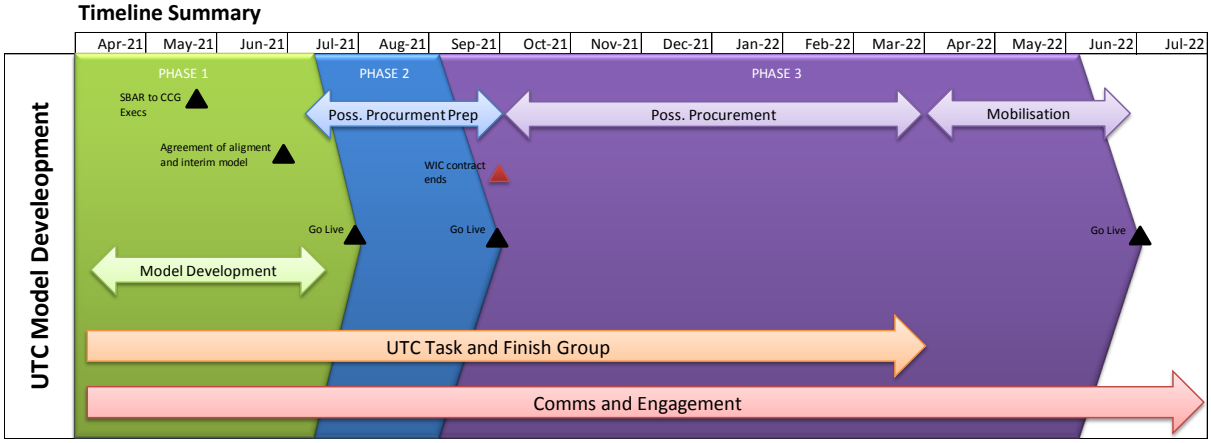
- Be able to access urgent treatment centres that are open at least 12 hours a day, GP-led, staffed by GPs, nurses and other clinicians, with access to simple diagnostics, e.g. urinalysis, ECG and in some cases X-ray.
- Have a consistent route to access urgent appointments offered within 4hrs and booked through NHS 111, ambulance services and general practice. A walk-in access option will also be retained.
- Increasingly be able to access routine and same-day appointments, and out-of-hours general practice, for both urgent and routine appointments, at the same facility, where geographically appropriate.
- Know that the urgent treatment centre is part of locally integrated urgent and emergency care services working in conjunction with the ambulance service, NHS111, local GPs, hospital A&E services and other local providers.

During the pandemic, elements of work that were not critical were put on hold. Both the MIU and WIC functioned during the pandemic therefore it was not critical to align the services given the unprecedented pressure within the system. This work is now being prioritised by the CCG to ensure that Swale residents will benefit from the UTC model. A full UTC service is planned for July 2022, with an interim service in place by October 2021.

Approach

The timeline of the project is divided into three phases as detailed below:

Phase	Description	Development Period	Go Live
Phase 1	The alignment of the existing MIU and WIC services, this could result in some minor contractual changes	Apr 21 – Sep 21*	TBC / ongoing
Phase 2	The provision of an interim service that will 'replace' the current WIC element of the service when the WIC contract expires at the end of September 2021	Apr 21 – Sep 21*	1 Oct 21
Phase 3	This is the final UTC model that is required for the Medway and Swale system. This element is likely to include to procurement hence time has been built in to allow for the right engagement, time for procurement and mobilisation. If a risk is taken and procurement option not selected time may reduce	Apr 21 – Jun 22* (incl. procurement)	1 Jul 2022



Next Steps:

- Data and costings will be further analysed and used to build the service model
- Publication of Communication and Engagement plan (currently being drafted)
- Further updates will be provided to HOSC as the model is developed

Item 10: CQC inspection update for Medway Foundation Trust

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 10 June 2021

Subject: CQC inspection update for Medway Foundation Trust

Summary: This report provides the Committee with background to the agenda item.

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1) Introduction

a) The Care Quality Commission (CQC) carried out an unannounced inspection of Medway Maritime Hospital's emergency care pathway and emergency department on 14 December 2020. Subsequently the regulator has issued a Section 31 notice (possible urgent enforcement actions) and a Section 29A (letter of intent).

b) The Care Quality Commission published their findings 25 February 2021, and the report is attached to this paper.

c) The CQC can serve a warning notice under section 29A of the Health and Social Care Act 2008 when it identifies concerns across either the whole or part of an NHS Trust or NHS Foundation Trust and it determines there is a need for significant improvements in the quality of healthcare.

d) If the CQC has reasonable cause to believe that unless it acts a person may or will be exposed to harm, they may give notice in writing under Section 31 of the Health and Social Care Act 2008 to the provider.

e) A written update was provided for the Committee at its last meeting. The Provider has been invited to attend today's meeting and update the Committee on its action plan following the issuing of the notices.

2) Recommendation

RECOMMENDED that the Committee consider and note the report.

Background Documents

Kent County Council (2021) '*Health Overview and Scrutiny Committee 4/03/21'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8500&Ver=4

Contact Details

Kay Goldsmith
Scrutiny Research Officer
kay.goldsmith@kent.gov.uk
03000 416512

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Medway NHS Foundation Trust – update

1. BACKGROUND

1.1 Medway NHS Foundation Trust was inspected by the Care Quality Commission in April and June this year.

1.2 The inspection took the form of announced and unannounced reviews of core services, an inspection related to Infection Prevention and Control, and a review under the CQC's 'Well Led' domain.

1.3 The Trust received high level feedback, with a formal report expected in late June or early July.

1.4 These inspections followed an unannounced visit in December following which the CQC highlighted the need for urgent improvements in care for patients attending the Emergency Department.

1.5 In response the Trust has implemented a number of actions.

1.6 The Trust's Our Medway Improvement Plan covers these, as well as a wide programme of improvements across the Trust.

1.7 In February the Trust received a report from the Care Quality Commission following an unannounced inspection of the hospital's Emergency Department in December 2020.

1.8 At the same time, the Trust has been managing demand in the context of the COVID-19, with a current focus on restoring services to reduce the backlog of elective, outpatient and diagnostic appointments which has arisen due to the pandemic.

2. CQC VISITS IN APRIL AND MAY

2.1 In April the CQC notified the Trust that they would be carrying out unannounced inspections, a review of Infection Prevention and Control (IPC), and an inspection under the 'Well Led' domain. This was in line with our expectations about the timescale for future inspections.

2.2 On 28 April they carried out their first unannounced inspection, looking at medical services including and old people's care. During the day, they visited a number of wards and clinical areas and spoke to staff and patients.

2.3 They returned on 5 May for the IPC inspection, visiting clinical areas, and observing staff behaviours and processes.

2.4 On 12 May they returned to inspect Children's and Young People's Services, reviewing paediatrics and our neo-natal unit.

2.5 On 12 and 13 May the team also held a focus group for junior doctors, received a presentation from our older people's team, and visited our Coronary Care Unit.

2.6 The final part of the inspection was the Well Led review during the week beginning 24 May, which involved interviews with Board members and Governors, and assessments of our governance and leadership.

3. FEEDBACK

3.1 We are currently awaiting a formal CQC report following the recent visits, with publication expected in late June or early July.

3.2 Following the visits the Chief Executive, Dr George Findlay, received high level feedback from the inspection team, which was largely positive.

3.3 They praised staff, describing them as welcoming, open and willing to talk about their achievements with pride, as well as how they approach the challenges they face.

3.4 Inspectors acknowledged good practice and said they had seen improvements.

3.5 However, as we would expect, they also noted areas for improvement, although these were mainly minor, and where there were concerns we already had plans for improvements.

4. INSPECTION OF URGENT AND EMERGENCY CARE

4.1 On 14 December 2020 the CQC carried out an unannounced inspection of the adult Emergency Department and the paediatric (children's) ED.

4.2 They provided feedback which led to some immediate improvements, and their formal report was published on 25 February 2021.

4.3 At the time of the inspection, the hospital was in the grip of the second wave, with 213 COVID-19 inpatients, more than 50% higher than at the height of the first wave in April 2020.

4.4 Bed occupancy was high in December, at 93%, leading to challenges with the flow of patients through the hospital, while the number of ambulances was far higher than normal, and higher than in other parts of Kent.

4.5 Around this time the Kent variant was acknowledged as being responsible for the surge in cases.

4.6 Inspectors noted concerns about patients experiencing lengthy waits in ambulances, and while waiting to be admitted to wards.

4.7 They also highlighted areas for improvement in the way records of patients' care were kept, the escalation of deteriorating patients, and some aspects of IPC.

4.8 The report also noted that there was poor flow out of the department at times, with some patients experiencing substantial delays before being admitted or discharged.

4.9 The team felt the department leadership, governance and culture did not always support the delivery of high-quality person-centred care for patients, although they praised the compassionate care provided by our staff and made other positive observations.

4.10 The CQC subsequently issued a letter of intent relating to a Section 31 notice, which was followed by the issuing of a Section 29a notice. A warning notice under Section 29a is served when the CQC identifies issues across either the whole or part of an NHS Trust and decide there is a need for significant improvement. The Trust produced an action plan to address the concerns raised.

4.11 Unfortunately, following publication of the report the rating for the Emergency Department was lowered to Inadequate.

4.12 The department was rated Good for 'caring' and 'effective'. Unfortunately 'responsive', 'safe' and 'well-led' were rated Inadequate.

4.13 The change in ratings did not affect the rating for the whole hospital, which remained as Requires Improvement.

5. IMPROVEMENTS SINCE THE DECEMBER INSPECTION

5.1 The Trust introduced a Patient FIRST project with support from the national Emergency Care Improvement Support Team (ECIST) to improve emergency care pathways and support the themes that emerged from the December 2020 CQC inspection.

5.2 The project began planning in January 2021 and now includes three workstreams:

- Acute Care Transformation (ED, Acute Medicine, Frailty Assessment)
- Flow and Discharge
- Site Management

5.3 Patient FIRST has the following aims:

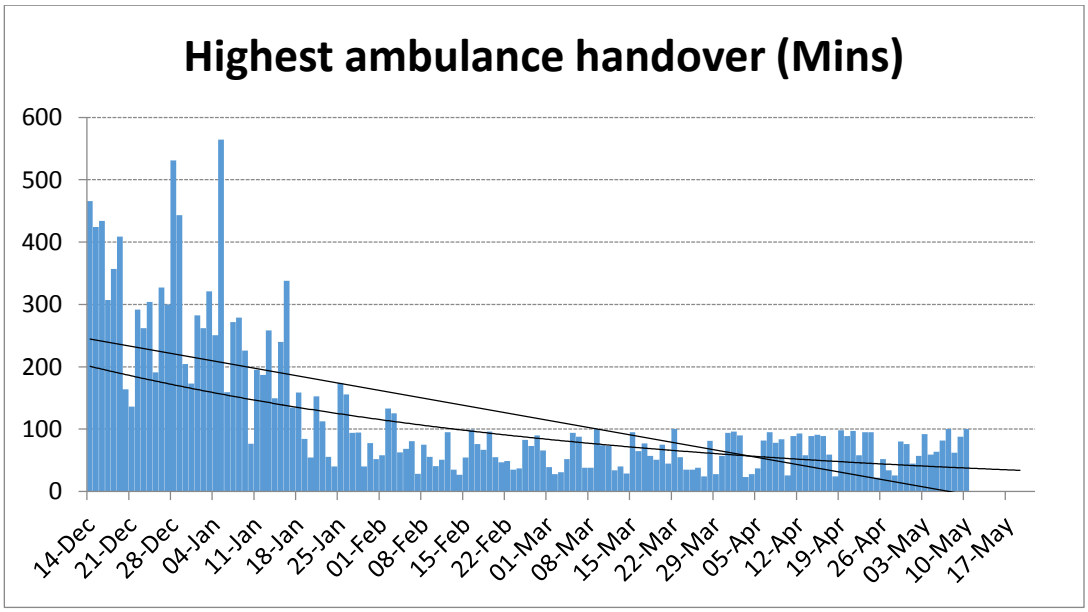
- Improving the patient safety, care quality and experience for all emergency patients

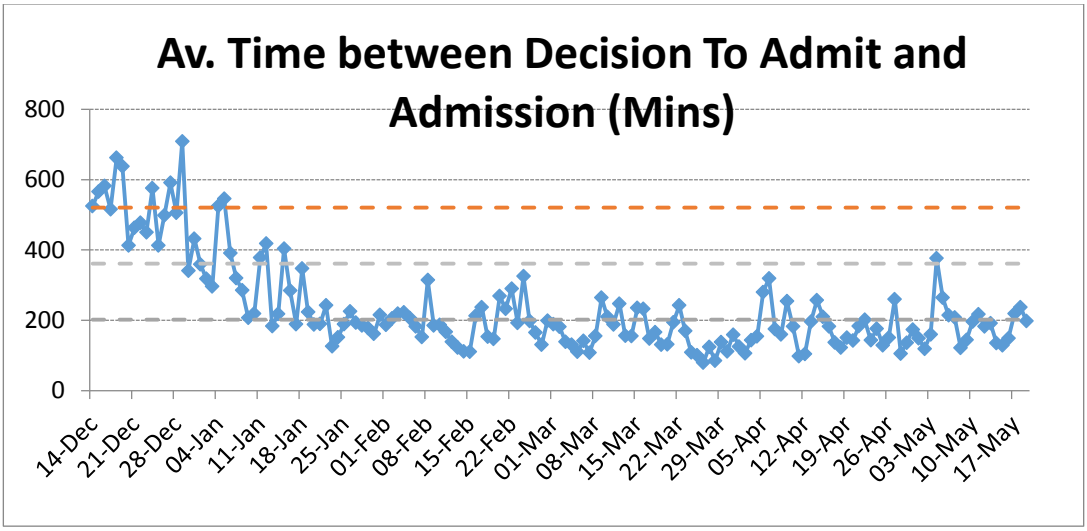
- Reducing the ambulance handover delays and Decisions To Admit in the ED, thereby improving the currently poor patient experience and long and unsafe waiting times we are providing
- Supporting safe and effective discharge of patients to maintain a safe, flowing hospital and reduce avoidable harm to patients
- Embedding professional standards within the ED and throughout the non-elective pathway to improve the working day of our teams
- Improving the visibility and capability of our clinical and operational leadership – during this period of pressure and in the long-term

5.4 A number of key metrics measure the effectives of the project, including ambulance handover times and the time patients wait to be admitted to a ward after being seen by a specialist.

5.5 I am pleased to say that in both cases these have improved significantly. This is in spite of the fact that attendances at our Emergency Department have continued to be high; although we now have very low numbers of COVID-19 patients, there has been an increase in the number of patients with non-Covid related illness.

5.6 The graphs below show progress since December:





5.7 We are now also embedding 'SAFER' and Home First principles into ward practice, resulting in an increase in discharges before noon since mid-February. A new electronic form will also aid flow and timely discharge and replace the existing paper-based system.

5.8 The Trust continues to receive support from the national support team, and has an Improvement Director from NHS Improvement working alongside senior leaders.

6. NEXT STEPS

6.1 The Trust has had a number of challenges exacerbated by the high level of COVID-19 experienced during the second wave.

6.2 The Patient FIRST programme, along with other improvements such as a Surgical Assessment Unit opened in April 2021, and improvements in our frailty pathway, have seen notable improvements in care for our patients.

6.3 Ambulance waits have been reduced, we have reduced waits for admissions from the Emergency Department, and flow through the hospital has been improved, with delays to discharge reduced.

6.4 As well as continuing to embed these improvements, we are working hard to reduce the backlog of appointments for elective surgery, outpatients and diagnostics.

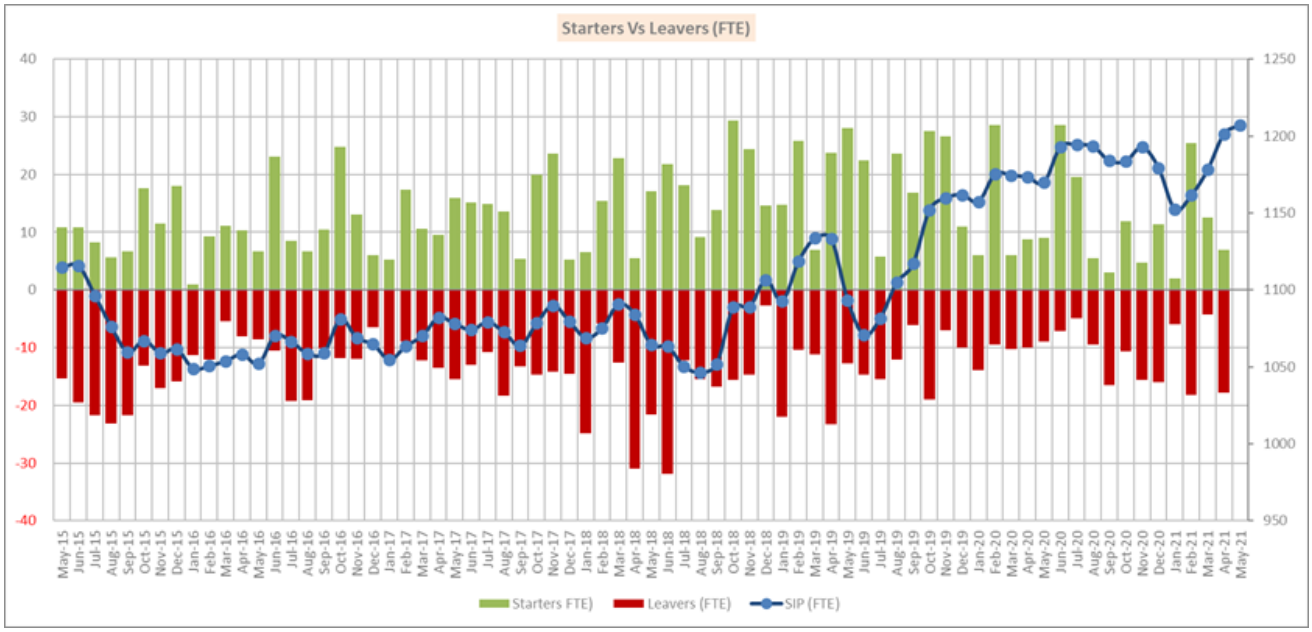
6.5 Importantly, we also have plans in place to manage any future wave of COVID-19, and to prepare for winter.

7. STAFFING

7.1 The Trust has previously reported to the committee about its staffing position. In the past there were high vacancy levels across the hospital, especially in nursing, however, the position is now much improved.

7.2 The Trust continues its three-stranded approach to recruitment, in particular to address nurse vacancies, through local, national and international routes. The international campaign continues with more than 100 hires in the last 12 months, and over 130 in the pipeline.

7.3 We have 39 nurses from local recruitment commencing in the next two months. Our overall nursing position is currently at its highest position in six years.



7.4 The Trust remains on trajectory to reach zero band five, ward-based, registered nursing vacancies by the end of June/start of July 2021 and is similarly on target to reach zero clinical support worker vacancies in the same period.

7.5 The Trust is actively appointing to seven consultant positions across critical care, medicine, emergency medicine, radiology and elderly care in the pipeline; along with 12 specialty doctors across emergency medicine, paediatrics, internal medicine, anaesthetics and frailty. Particularly hard to recruit areas remain Ear, Nose and Throat (otolaryngology) with international recruitment actively being pursued.

7.6 The Trust's workforce profile demonstrates a sustained substantive staffing position, as percentage of paybill (85 per cent of the total paybill), as the Trust works to reduce and manage its temporary staffing expenditure.

Medway NHS Foundation Trust

Medway Maritime Hospital

Inspection report

Windmill Road
Gillingham
ME7 5NY
Tel: 01634833824
www.medway.nhs.uk

Date of inspection visit: 14 December 2020
Date of publication: 25/02/2021

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Inadequate**

Our findings

Overall summary of services at Medway Maritime Hospital

Requires Improvement 

We found:

- Staff did not always keep detailed records of patients' care and treatment when completing records for urgent and emergency care patients. This included the completion of nursing, falls and skin risk assessments.
- Care for patients showing signs of deteriorating were not consistently escalated placing patients at risk.
- The department did not always control infection risk well increasing the risk of cross infection.
- There was poor flow out of the department, patients experienced substantial delays before being admitted or discharged.
- The leadership, governance and culture did not always support the delivery of high-quality person-centred care for patients.

However:

- The service had suitable equipment which was easy to access and ready for use.
- Generally, staff told us they enjoyed working in the department and spoke of positive working relationships within the team.
- Patients had access to a psychiatric liaison 24 hours a day. Staff told us although the team were increasingly busy, they were responsive and would see patients within two hours or initial referral.

Urgent and emergency services

Inadequate

We carried out an unannounced focused inspection of urgent and emergency care provided by this trust on 14 December 2020. This was in response to continued concerns of poor performance in meeting national targets and affecting patient's safety. The service was rated required improvement at our last inspection in December 2019.

Our rating of the service went down. We rated urgent and emergency care as inadequate.

- During the inspection, we spoke with over 15 members of staff, from various disciplines and the leadership team for the department. We reviewed six sets of patient records.
- To help maintain patient and staff safety during the COVID-19 restrictions, we followed all relevant guidance and visited selected areas of the department only.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Is the service safe?

Inadequate

Assessing and responding to patient risk

Staff did not consistently complete risk assessments for each patient swiftly. They did not minimise risks and updated the assessments. Staff did not identify or quickly acted upon patients at risk of deterioration.

Patients arrived in the department through the main entrance or the ambulance entrance. The main entrance had a streaming nurse responsible for assessing all patients for risk and for COVID-19 symptoms before streaming (directing) them to the relevant areas of the department depending on their needs. The ambulance entrance had an ambulance control nurse, who took handover of patients from ambulance staff.

Staff told us they used local knowledge or their own judgement to assess patients. Similarly, in the children's emergency department, staff said they did not use a streaming tool to assess patients. We raised this as a concern with the managers who said there was a risk stratification tool used. We were told 43 members of staff had completed the initial assessment skills- prioritisation and patient management competencies. During our inspection we found staff were unable to demonstrate and were not aware of a standardised risk stratification tool to ensure consistency of care for patients arriving in the department.

The department used the national early warning system (NEWS) for adults and the paediatric observation priority score for children. The scoring systems enabled staff to identify patients who were becoming increasing unwell, to provide them with increased support and improve patient outcomes.

The trust had a standard operating procedure for recognising and responding to unwell patients which was last reviewed in September 2019. The guidance advised staff to monitor patients at least every 12 hours, however the

frequency could be increased as stated by the early warning score escalation process or as advised by the consultant. We reviewed six patient care records and found although the national early warning system scores had been calculated accurately and repeated at various intervals, high NEWS scores were not escalated in a timely manner. For example, in one patient's notes we saw NEWS scores of six, nine and nine recorded at different intervals, yet there was no further documentation of increased care or escalation.

At peak times staff said offloading ambulance patients compromised patient care. Due to the demand, medical and nursing staff were not able to ensure patients waiting in the ambulances always received timely clinical intervention. We observed one patient who had been waiting on an ambulance with a NEWS score above 7. We highlighted this to the streaming staff who immediately acted to escalate and admit the patient into the emergency department.

The trust provided us with a sepsis audit from April 2020. There were no further recordings of performance from April 2020 to the time of our inspection, therefore we were not assured the department was consistently recording and monitoring their performance to support clinical decision making and patient safety.

Not all nursing risk assessments were completed. Records reviewed showed incomplete documentation for skin and falls assessments. This was a risk, especially for patients who were admitted with a fall or were frail with an increased risk of skin damage.

We reviewed the urgent and emergency care group governance board report for October and November 2020. All patients that had fallen during their time in the department were reviewed by a member of the falls team. Themes from these reviews include neurological observations not being completed in line with NICE guidelines, partially completed post falls checklist and lying/standing blood pressure not completed.

Records

Records of patient care and treatment were not kept up to date and did not contain all the information required.

The emergency department carried out a departmental documentation audit twice a month which showed the department was performing well against the standards. For example, out of the 9296 attendances in November 2020, 100% of patients received a pain assessment, had a plan of care documented at initial assessment and safeguarding information completed.

However, on the day of our inspection we saw patient care records were not completed. We reviewed six patient records and could not determine what care was being provided to patients in emergency department due to the lack of complete documentation. Patient risk assessments were not always completed or there were minimal care entries. In four of the six patient records we found skin integrity, patient repositioning and/or falls assessments had not been completed. Some patient records were not updated to state the outcome of diagnostic tests.

This was raised with the trust leaders and following the inspection the trust provided us with their action plan to address this concern. The trust told us nursing staff were to be informed of the standards for undertaking and recording clinical observations at each handover and reinforced via email and staff meeting's until embedded in practice. The department were to carry out daily audits to assess compliance with documentation.

Environment and equipment

Urgent and emergency services

The service had suitable equipment which was easy to access. However, staff were not always supported by the environment to protect their patient and themselves from infections.

During our inspection the main emergency department was undergoing building works and the paediatric emergency department had been moved to a ward next to the children's ward due to the Covid-19 pandemic.

National guidance recommends designated areas for the treatment and care of patients with Covid-19 should have signage displayed warning of the segregated area to control entry. The department had created hot, cold and warm pathways in response to the COVID-19 pandemic. Areas were clearly marked to identify which pathway they were in. Staff had a good understanding of the zoning system and the level of personal protective equipment required for each zone. The hot pathway was for patients who tested positive for COVID-19. The cold pathway was for patients who did not exhibit COVID-19 symptoms. The 'warm' pathway was for those patients with symptoms associated with COVID-19 but had not had this confirmed or were waiting for a COVID-19 test result. This pathway was also used in the paediatric emergency department where children with symptoms normally associated with the winter months but had not had a COVID test or were waiting for their Covid-19 test results were looked after. Staff told us rapid testing for Covid-19 had begun recently however, only three tests could be completed per hour with an average wait for results of four hours. This increased the risk of non COVID-19 patients being exposed to the virus.

In the main emergency department, there were two entrances into the department, one for ambulances and the other for patients walking in. There was a one-way system for entering and exiting the main reception however, once in the department there was no segregation of traffic. We also noted patients exiting through the entrance. Staff told us this was not well policed, and they relied on the posters displayed throughout the department to remind visitors on how to exit the building.

The children's emergency department which based in a ward, did not have a one-way system of traffic flow because of the environment. Corridors were too narrow to allow for adequate social distancing. We saw a hot toilet for Covid-19 patients in a cold area increasing the risk of exposure to infection.

National guidance recommended emergency departments should map patient journeys both within and outside of the department to determine likelihood of cross contamination and any need for additional precautions. There should be practical measures to control people's movement within the emergency department (patients, visiting team etc.) and where possible, try to ensure patients with and without infections, visitors and suppliers take different routes.

There was signage throughout the department reminding people to keep a safe distance.

We did not see any signs in non-clinical areas such as offices and storage rooms or staff rooms to indicate the maximum capacity of that room. This meant staff did not always know how many people could be in a room at any one time to safely maintain social distancing. Following the inspection, the trust told us the health and safety, and PPE officers would revisit clinical areas to check signs in offices and rest rooms.

There were two side rooms in resus for aerosol generating procedures. These were staffed by dedicated nurses for aerosol generating procedures to prevent staff from moving between hot and cold pathways.

Cleanliness, infection control and hygiene

The environment was generally clean and dirt free. Cleaning wipes were available throughout the department.

Various areas in the department changed from hot areas to cold areas depending on the number of COVID-19 positive patients present in the department. Staff reported hot areas were deep cleaned before changing to cold areas. We spoke to a member of the housekeeping staff who was responsible for cleaning to the department. They told us they there were usually two housekeepers in the department throughout that day, but this had not been the case recently. They explained that when an urgent deep clean was required they escalated concerns and received timely support from the trust's response team.

Staff and patients had access to enough hand decontamination gel or handwashing facilities within the emergency department. We saw hand gel dispensers were available at key points throughout the department for patients, staff and visitors to use. For example, there was a hand gel dispenser when entering the department, at the reception desk and as you moved from one area of the department to another. We saw staff using these throughout our inspection.

As well as traditional sinks, the department had portable handwashing facilities in corridors and the reception area to enable staff and visitors to wash their hands with easy access. All sinks had signs to prompt staff and inform patients of the correct steps for effective handwashing.

All staff we observed during the inspection were 'bare below the elbows' and dressed in accordance with trust policy. We saw ample supplies of personal protective equipment such as aprons, gloves and face masks and we saw these items being used. Gloves, in the full range of sizes, and various types face masks were readily available. Staff had convenient access to the correct personal protective equipment to keep themselves and their patients safe.

Personal protective equipment (PPE) such as disposable aprons, eye protection, face masks and gloves were easily accessible for staff. We observed staff wearing them when delivering personal care.

Staff had access to the updated donning (putting on) and doffing (removing) guidance on the trust intranet which also directed them to the latest national guidance on the government's website. Managers told us when changes were made, this was communicated to staff through the intranet, a mobile messaging application and information was placed in staff rooms. However, the trust did not provide us with evidence of how they monitored that staff had read and understood refreshed guidance.

We noted that donning and doffing stations were clearly marked out. Prompts on how to put on and remove PPE were displayed directly above the stations for staff to follow. The prompts were tailored to the area staff were about to enter or exit for example, there was a poster for putting on PPE when entering and exiting an area dedicated to aerosol generating procedures.

Staff were observed donning and doffing personal protective equipment. However, this was not always consistently done in line with national guidance. Staff did not always change PPE when entering and exiting patient bays. For example, in the children's emergency department we saw a registrar exiting a hot area wearing their full PPE to speak to a nurse in the main corridor. This was not in line with the trust policy and was in line with findings reported in the urgent and emergency care group governance board report for November and December 2020. Key findings from both reports for the infection control audit stated staff were not using PPE in line with the policy. Staff did not remove gloves and aprons when leaving the point of care and staff were not compliant with donning and doffing.

We raised concerns around the safety of having donning stations within busy corridors of the department used by staff and staff transferring both COVID-19 and non COVID-19 patients. Trust leaders told us an IPC advisor had been to the department to review the donning and doffing areas and remind staff to doff PPE before leaving the hot area.

We checked various pieces of equipment and furniture including chairs and ECG machines. These all appeared clean and dust free. The department made use of 'I am clean' stickers to ensure staff knew that equipment was clean and ready for use. However, we noted most stickers had been placed in the morning and had not been updated throughout the day and after use. Stickers are a useful indication of the date and time the article was cleaned along with the name of the person who cleaned it. More consistent and frequent use of these stickers would help staff to identify items that were cleaned and ready for use and assist managers in detecting any shortfalls in equipment hygiene. Following our inspection, trust leaders told us all staff had been reminded of the importance of cleaning equipment between patients. Additional housekeeping staff had been identified to attend emergency department, to regularly clean furniture and equipment This was to be monitored through quality assurance visits.

Nursing staffing

The service did not have enough nursing and support staff available with the right qualifications, skills, training and experience to provide the right care and treatment.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. However, due to high levels of staff sickness caused in the main by the coronavirus pandemic, it was increasingly difficult to ensure all shifts were filled. Nursing fill rates reviewed for 1 December to 14 December 2020 showed staffing deficits on most days. Managers told us they were often three or four qualified nursing staff short on each shift.

On the day of our inspection we saw that the actual count of nursing staff in the emergency department did not match the planned staffing count. Safe staffing levels for the whole day required 39 registered staff however, 31 staff were available. Similarly, the planned unregistered staffing was 19 compared to an actual count of 12. The department was supported by emergency nurse practitioners whose shifts were staggered throughout the day. Data showed the department had four emergency nurse practitioners rostered throughout the day which was one practitioner less than planned.

In the children's emergency department data showed 98% of registered nursing shifts and 100% of unregistered nursing shifts were filled. On the day of our inspection data showed there were enough registered and unregistered nursing staff during the day. The night shift had one less paediatric nurse than planned. Staff told us due to the proximity to the children's ward, they received supported from the ward if they required more staffing.

All nursing staff in the children's emergency department were registered children's nurses. This was in line with guidance set out in the Royal College of Paediatrics and Child Care: Facing the Future: Standards for Children in Emergency Care Settings.

Managers regularly reviewed and adjusted staffing levels and skill mix where able. Emergency department staffing levels were under scrutiny at various meetings held throughout the day including at regular site meetings and trust-wide huddles. The workforce resourcing manager and the 'safe care wheel' provided intelligence about staffing and acuity that was shared directorate wide. Sickness data revealed high numbers of staff were absent due to stress and anxiety. Staff told us there were times when sourcing extra staff was difficult. It was believed people were struggling with the demands of the work in the pressurised emergency department. Managers tried to fill shifts using bank staff, offering extra hours and by deploying specialist nurses or those with clinical skills employed in other roles to the frontline.

In the last 12 months the trust reported an average sickness rate of 3% for nursing staff in the both the emergency department and the children's emergency department. Around the period of our inspection (1 December 2020 to 18

December 2020) the trust reported a sickness rate of 7% in the emergency department for nurses, and 6% for paediatric nurses compared to the trust target of 4%. Managers told us although the sickness rate was currently higher than they would like, it was more manageable compared to September 2020 when the sickness a sickness rate had risen to 36% for nursing staff in the main emergency department.

Medical staffing

The service did not have had enough medical staff with the right qualifications, skills, training and experience.

At our last inspection, the emergency department did not meet the recommendations of the Royal College of Emergency Medicine guidelines of consultant cover within the department. This was still the same at this inspection. The recommendations state consultant cover must be provided a minimum of 16 hours a day. Where there is an insufficient number of consultants to meet this, risks should be mitigated by the provision of senior doctor (ST4 or above) presence 24 hours a day, seven days per week. During our inspection, we found consultants in the emergency department provided 15.5 hours of cover a day which was lower than recommended. However senior doctors were available 24 hours a day.

Rotas provided by the trust for the week of our inspection (14 to 20 December 2020) showed that there was a consultant rostered to provide on call cover. On call cover consisted of 7.5 hours on site and a further 7.5 hours remote cover.

During the week of our inspection consultant cover for the children's emergency department did not meet national guidance. Consultant cover averaged four hours during daytime and on 16 December there was no consultant cover for the day. Data showed there was one foundation year two doctor who provided cover for children's emergency department and the minors area between 8am and 5pm with support from the on-call doctor.

Data submitted by the trust showed eight out of 19 consultant shifts between 1 December and 14 December 2020 were covered by on call doctors, with 37% (seven) of these consultants being bank staff. During the same period data. Medical staffing was worst affected on nights and at weekends.

From 1 December 2020 to 14 December 2020 data showed 71% of shifts in the emergency department were filled and 18% of these were filled by bank staff. Data showed of the 29% of medical shifts that were unfilled, only 3% were offered to and covered by bank staff. In the children's emergency department 75% of medical shifts were filled and 25% were covered by bank staff. The department did not use any locum staff during this period.

From 1 December 2020 to 18 December 2020, the trust reported a sickness rate of 1% for medical staff and the average sickness rate for the last 12 months was 2%. This was lower than the trust target of 4%.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

The trust provided staff with a mandatory training programme. Compliance was recorded and monitored using a computerised system maintained by the trust.

Urgent and emergency services

Subjects covered included child and adult safeguarding, information governance and data security, infection prevention and control, health, safety and welfare and equality diversity and human right. Some training topics were offered 'on-line' through an internet-based learning management system, which could be accessed by staff from any computer connected to the internet.

Staff we interviewed said they received training to ensure they had the skills to do their jobs. Staff reported having adequate time allowed to completed training and attend trust courses.

The trust set a target of 85% for completion of mandatory training. At the time of our inspection compliance for mandatory training for administrative and medical staff met the trust target with a completion rate of 85% and 89% respectively. Nursing staff were shy of meeting the target with a completion rate of 84%.

However, all staff groups including medical, nursing and administrative staff did not meet the trust training target of 85% for resuscitation in adult basic and immediate life support, new born basic life support and paediatric basic life support. Compliance varied from 55% to 79%.

Is the service responsive?

Inadequate 

Access and flow

People could generally access the service when they needed it, although this was not always timely.

The nurse in charge was responsible for managing flow in the emergency department with the support of an emergency physician in charge. Patient flow out of the department was monitored though three daily site meetings.

At the last inspection in December 2019, we found adult patients experienced significant delays whilst waiting to be admitted, which was consistent with our findings during this inspection. We found decisions of onward care were not made in a timely way or there were lengthy delays once a decision to admit had been made.

For example, one patient had arrived in the emergency department at 10.30am with chest pains and was still in the department at 7pm without a decision of onward care.

Another patient had attended emergency department at 4.37am and was still in the department at 18.55pm. A decision to admit had been made in the morning but the patient was still in the emergency department eight hours later.

We saw one patient who was intubated and remained in the department for 24-hours. A decision for onward care into an appropriate care setting, where the patient could be cared for by staff with the relevant skills had not being made.

We spoke with one patient who was brought in by ambulance the night before our inspection following an episode of paranoia. The patient had been reviewed by the psychiatric liaison within two hours of initial referral. As onward care

provisions were being arranged, staff had placed the patient in the dedicated mental health room but would move them into the empty clinical decision unit when the patient became agitated due to the lengthy wait. Staff indicated the waiting time for a crisis bed and travel arrangements to be made for mental health patients took between two hours to three days.

Staff told us there were frequent closures of assessment areas, often due to staff shortages which contributed to increased delays in the emergency department. Managers told us surgical assessment unit was frequently blocked and at the time of the inspection, the clinical decision unit was taking no patients due to a lack of staff.

Patients arriving by ambulance were assessed immediately and had an initial assessment completed. Evidence received from the trust of the November 2020 departmental documentation audit showed patients arriving by ambulance waited on average three minutes before having an initial assessment while those walking in, waited seven minutes to have an initial assessment.

However, due to lack capacity in the emergency department, ambulance patients were left in the care of ambulance staff. On the day of our inspection, the department reported 24, 60-minute handover breaches. The highest ambulance handover delay was 7 hours and 40 minutes.

We spoke with four ambulance crews waiting to handover patients who said they often felt vulnerable caring for elderly and frail patients for extended periods which caused patients to become distressed. They also voiced their frustrations of having to extend their shifts while waiting to handover, which impacted their rest periods between shifts.

At the time of our inspection the average time between a decision to admit and admission was 8 hours and 45 minutes.

From 1 December 2020 to 14 December 2020, an average of 202 patients attended the department per day. On the day of our inspection between 12pm and 9pm, there was an average of 62 patients an hour in the department.

From 1 December 2020 to 14 December 2020, 635 patients experienced delayed decision to admit and a further 264 patients waited over six hours for a bed to be available. In the same period 62 patients waited over 12 hours in emergency department.

From June 2020 to December 2020, the emergency department reported 166 incidents of 12-hour breaches from decision to admit as part of their serious incidents. The department acknowledged there were lessons to be learnt from incidents of 12-hour breaches.

We raised concerns about the substantial emergency department waits. The trust leaders provided us with an action plan of changes they were to implement to improve this. Actions included but were not limited to; immediate escalation to the nurse in charge of any patients not seen by a specialist team within one hour, effective bed management meetings with escalation of any emergency department delays with executive director leadership and oversight and re-introducing planned care divisional leadership team to the surgical pathway co-ordinator post to facilitate a speedier transfer of patients out of the department.

There were a variety of pathways to enable patient flow, including same day emergency care for non-frail acute medicine, surgical assessment unit, gynaecology assessment unit, and a primary care service, depending on the need to reduce admissions and support earlier discharges.

Urgent and emergency services

Patients were able to book an appointment in the emergency department and same day emergency care through a direct access booking service. However, managers told us this service had been launched a few weeks before our inspection and was currently underutilised. Other initiatives were being developed or soon to be introduced such as the frailty pathway to reduce all emergency department attendance.

Is the service well-led?

Inadequate 

Leadership

There was a triumvirate leadership team consisting of a general manager, a head of nursing and an emergency department consultant.

Leaders generally understood the challenges the department faced and made attempts to address these difficulties. Staff spoke highly of the local leadership and described them as approachable, knowledgeable and supportive.

Most staff told us they did not feel the executive team supported the department to make improvements to reduce the impact of risk. They said concerns escalated to the executive team were not routinely discussed at strategic meetings and were not acted upon in a timely way.

Staff told us the chief operating officer and chief nursing and quality officer were visible in the department, but they felt disappointed with the lack of presence of other executive members especially during a pandemic.

Culture within the service

Staff and managers, we spoke with told us morale in the department was very low and lower than at our last inspection in December 2019. The main issues attributed to the low morale were, not enough staff to provide sufficiently timed care to the number of patients attending the service, feeling unsupported by other departments and the executive team. We were told the escalation of concerns was not listened to or acted upon.

Managers told us the chief executive and chief operating officer had held three Q&A sessions with the department to engage with staff. These sessions were poorly attended and at one of the meetings the executive team did not attend.

We attended a site meeting on the day of our inspection where we observed impolite and unsupportive challenges between attendees. The emergency department managers told us such interactions had greatly affected senior staff who now refused to attend the meetings.

Staff shared with the inspection team an email they had received from a member of the executive team following a couple of incidents. We spoke with nine members of staff of all levels, who told us the email was personally addressed to each staff member in the department. They said the tone and content of the email had contributed to the team's low morale and came at a time when staff were already feeling the pressures of Covid-19. Staff said they did not feel valued and felt their efforts through the pandemic were not recognised by the executive team.

Staff told us they tried to boost morale within the department by holding activities and events such as a bake off and advent calendar raffles. Staff within the department spoke of positive working relationship with their colleagues and managers and described themselves as having a strong team unit. Staff felt they were respected and valued by their local managers. Staff were positive about their roles.

Following our inspection, we had a meeting with the freedom to speak up guardian who told us there were recurring concerns around poor culture within the emergency department.

Governance, risk management and quality measurement

There was a lack of clear and consistent governance arrangements in place. The arrangements were not adequate to ensure high standards of care and oversight could be maintained.

During our inspection we noted there was no clear governance structure. The managers told us governance meetings lacked consistency. We were told many processes had stopped due to Covid-19. For example, the monthly care group meeting was last held in October 2020.

We raised the lack of a robust governance structure as a concern to the trust leads, who told us a review of the process was being carried out and they planned to reinstate the care group governance meetings as of 4 January 2021.

The department was not assured they were robustly assessing and mitigating the risks relating to the health and safety and welfare of patients. Managers were able to describe the three biggest risks to the department. However, the team did not include recurring delayed handovers of patients from ambulance crews as one of their biggest risks. Although they were aware of the issue, there did not appear to take ownership of the risk or have a system to mitigate it.

The trust held three site meetings a day, attended by representatives from various departments including but not limited to surgery, planned care, emergency department and diagnostic imaging. We observed a virtual site meeting at 4.30pm and were concerned about the lack of action taken particularly for patients who had been in the department for more than 12 hours. Furthermore, the meeting lacked order and structure. We noted actions from earlier meetings were not reviewed for progress. We witnessed a lack of accountability to provide patients with the necessary care and environment conducive to better patient outcomes.

The department had an emergency department quality and safety daily checklist used to record concerns throughout the day. It was not clear what purpose the quality and safety checklist served. The logbook had numerous entries of general and quality issues. We noted there were escalation of concerns to the site team however, it was unclear how often these were reviewed by senior staff, if escalations had been acknowledged or whether any action had been taken to mitigate risks.

The department held regular huddles which included governance updates. We reviewed seven of the most recent reports from the huddles. These highlighted incident reporting trends, serious incidents and complaints.

Areas for improvement

We took enforcement action to issue a section 29A Warning Notice because the quality of healthcare required significant improvement. In summary the reasons we issued this notice were:

Urgent and emergency services

MUSTS

- The trust must ensure patients are effectively monitored for deterioration and receive timely support to stay safe. Regulation 12.
- The trust must ensure patients have timely access to urgent and emergency care through improved flow in and out of the department. Regulation 12.
- The trust must ensure risks are adequately assessed and maintain good governance and oversight within the department to ensure patients are protected from potential harm. Regulation 17.
- The trust must ensure detailed and up to date records are kept in relation to provision of care and treatment and it is reflective of each patient's full clinical pathway, and include decisions taken in relation to the care and treatment provided. Regulation 17.
- The department must ensure there are always enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care. Regulation 18.

SHOULDS

- The trust should continue working to improve Covid-19 testing and waiting times for results.
- The trust should review the environment, ensuring there are segregated routes within the department to reduce the risk of cross contamination.
- The trust should work with external mental health providers to improve waiting times for crisis beds and travel arrangements.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two specialist advisors with expertise in urgent and emergency care. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Section 29A HSCA Warning notice: quality of health care

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Item 11: Healthwatch Kent & Medway – “Pharmacies and Covid: the reality” - update

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 10 June 2021

Subject: Healthwatch Kent and Medway – “Pharmacies and Covid: the reality” - update

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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) Representatives from Healthwatch Kent and the Kent Pharmaceutical Committee attended HOSC in November 2020 to introduce the report to HOSC members.

c) Key points raised included:

i) The staffing and financing of pharmacies had been particularly negatively affected by the pandemic.
ii) An initial shortage of PPE had been resolved.
iii) Uncertainty around the impact on operating capacity of any vaccination rollout.
iv) The total number of pharmacies in Kent had decreased, with the delay between spending on pharmaceuticals and renumeration and the cost of delivery services being given as contributing factors.

d) Following discussion, the Committee RESOLVED that they:

i. note the report;

ii. support the achievement of community pharmacies during the pandemic and express its appreciation for the work undertaken to keep the residents of Kent safe; and

iii. request a further update on the work of local pharmacies after the roll-out of the NHS 111 First service.

e) Representatives from Healthwatch Kent and the Kent Pharmaceutical Committee have been invited to attend today’s HOSC to provide an update on the work of community pharmacies in combatting the pandemic.

2) Recommendation

RECOMMENDED that the Committee consider and note the report.

Background Documents

Kent County Council (2020) Health Overview and Scrutiny Committee (24/11/20) https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8498&Ver=4

Healthwatch Kent and Medway (2020) Pharmacies & Covid: the reality, https://www.healthwatchmedway.com/sites/healthwatchmedway.com/files/Healthwatch%20Pharmacies%20%26%20Covid%20the%20reality.pdf

Contact Details

Kay Goldsmith
Scrutiny Research Officer
kay.goldsmith@kent.gov.uk
03000 416512

healthwatch Kent

healthwatch Medway

Pharmacies & Covid: lessons learned

A report by Healthwatch Kent & Healthwatch Medway

May 2021

What is it like being a Community Pharmacist during a pandemic?

That's the question we asked pharmacists last year. Over 100 got in touch to tell us their stories about working during the first lockdown and how it had affected them.

We published everything they told us in a report and made a number of recommendations to ensure lessons were learned, and the system could be better prepared for the months ahead.

As we emerge from another lockdown, we wanted to hear how community pharmacists are feeling now and what progress has been made.

40 community pharmacists from across Kent & Medway got in touch. This report details what they told us.

The Headlines

55% — **of pharmacies said staff morale has improved since the first wave of the pandemic, but 32.5% told us it hadn't.**

87.5% — **told us the response to equipment and PPE requests has improved since the first wave of the pandemic.**

80% — **told us they do not feel access to primary care has improved for them.**

52.5% — **could identify areas of the community which they felt are still digitally excluded from accessing services.**

35% — **said the rollout of the NHS111 first service had impacted their team and 55% told us it hadn't had any effect.**

What change do we want to see?

We hope to build some recommendations, in collaboration with service providers, which address the key issues that have been highlighted within our pharmacy reports. These recommendations will focus around workforce wellbeing, communication between pharmacies and GP practices, and NHS 111 referrals to community pharmacies.

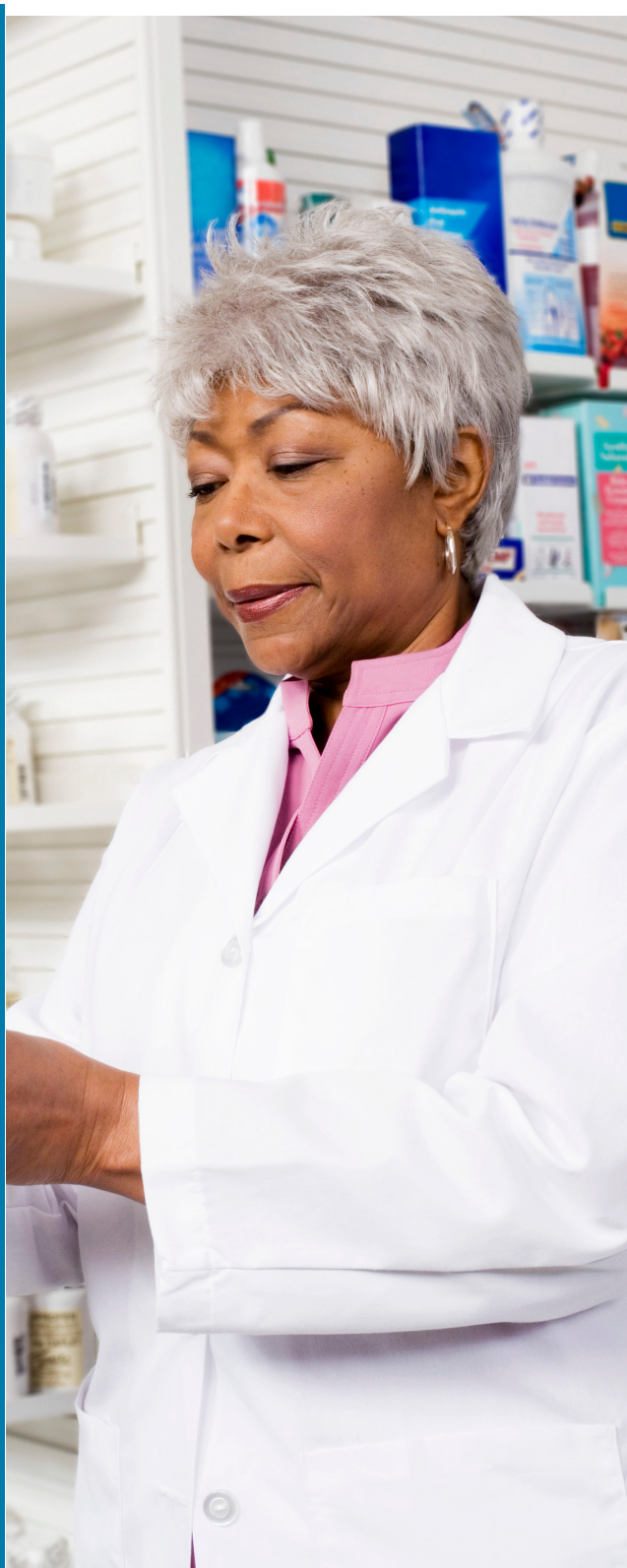
Key themes

We've identified clear themes which provide an insight into the issues reported by community pharmacists across Kent & Medway.

Difficult communication with GPs

80% of pharmacies we heard from told us they had not experienced any improvement with access to primary care, since the first wave of the pandemic and in many cases they told us it had deteriorated. Comments included:

- ***"GP services are less accessible, it's difficult to communicate with GPs"***
- ***"There is a huge problem contacting GP surgeries to resolve prescription enquiries"***
- ***"Communicating with GPs via telephone has been a challenge"***
- ***"GP just expects us to do emergency supplies if they haven't done a prescription. They direct telephone medication requests to us, resulting in 100s of phone calls. We are effectively managing their repeat service, free of charge"***
- ***"Our team is under more pressure due to local GP practices. There are delays in prescribing not working to full capacity causing an increase of emergency supplies. We are dealing with a closed-door surgery and the backlash from this."***
- ***"There is virtually no collaborative working between pharmacy and GP surgeries. The worse it has ever been in decades of my experience."***



Increased workload from GPs

A number of pharmacies told us that their workload has increased because GPs are signposting people to pharmacies. Comments included:

- ***"We are providing services for patients that would be better served by GPs"***
- ***"Challenges stemming from GPs still severely restricting face to face appointments, hence lots of enquiries regarding things like rashes and minor ailments. Although we have the knowledge, we are struggling with the workload"***
- ***"GPs are making inappropriate referrals to us. For example patients being told we can look inside their ears, down their throats and sending patients over with UTI's saying we can treat it"***
- ***"Patients who can't be offered a GP appointment are being signposted to the pharmacy instead. They are coming to us with problems that we can't resolve which is adding to their distress as well as taking our time"***
- ***"Lots of patients coming to us for blood pressure monitoring sent from GP's"***

Better understanding of the pharmacists' role

Pharmacists told us that patients often aren't aware of what they can offer and the services they provide. Often they believe pharmacists can offer services which aren't available within a community setting. This can, at times, lead to frustrations and 'abusive' behaviour.

- *"Patients don't understand the pressures we face"*
- *"Patients chasing up prescriptions before the due date, patients not waiting for the app to update and show collection is ready.*
- *"Our workload has increased due to peoples' anxieties"*
- *"Peoples' attitudes have become difficult when they don't get the service that they expected"*
- *"Patient attitudes are becoming challenging; they become annoyed and angry when asked to wear face masks or keep social distancing"*
- *"Occasional challenging behaviour from customers not wearing masks, or refusing to leave home and wanting everything delivered"*
- *"There seems to be a lack of understanding by patients, and other healthcare professionals, about non NHS funded services such as emergency supplies, deliveries and pharmacy filling of blister packs."*
- *"I feel that better patient education is required to ensure people don't contact health professionals unnecessarily. Our job is important - mistakes can lead to fatal errors"*

What has changed since our last report?

Morale and wellbeing

In our last report, community pharmacies identified mental health support as one of the top three areas where they felt their staff needed support most, as morale was extremely low.

55% of pharmacies felt morale has improved. However, the need for mental health support has still been raised as a concern by some pharmacies. We can see that whilst overall morale has improved, in many cases individual wellbeing has not.

- *“I’m working under pressure to cover people who are off”*
- *“Stress of the workload”*
- *“My workload is huge”*
- *“Mental Health is an issue”*
- *“We are physically and mentally exhausted”*
- *“We are short staffed. They are all on anti-depressant/anti-anxiety tablets”*
- *“Morale has improved as the end of the pandemic is in sight”*
- *“All our staff have had their vaccine now which has improved our morale”*
- *“Morale has decreased massively due to low staffing levels and increased demand”*
- *“The increase in rude and abusive customers has had an impact on our morale and wellbeing”*
- *“I feel like we are running on empty”*
- *“We feel like we have been forgotten, we do not come under the NHS so even though we have worked so hard during the pandemic we have not had the recognition we feel we deserve, Scotland and Wales pharmacy workers have been given £500 (tax free) each as a thank you for their hard work, what about us!!!! did we not work as hard?”*
- *“It is frustrating being a community pharmacist. We are forgotten with constant funding cuts”*
- *“We are having more and more unpaid work dumped on us”*
- *“Pharmacies have been overlooked seen rather as contractors than NHS workers. We've been open and under a lot of pressure during whole of the pandemic with no recognition from either government or general public. There was no pay improvement despite increased workload (which we took off GP surgeries and emergency services such as 111)”*

PPE for pharmacy staff

In our last report, access to PPE was identified as one of the top three areas where pharmacies felt their staff needed support. 87.5% of pharmacies told us this had now improved since the first lockdown.

- *"We have had a little more support as we are able to order PPE that wasn't available during the first wave of the pandemic"*
- *"The online portal is easy to access and the equipment is delivered the next day"*
- *"Response to PPE has improved and supplies are coming in no problem but there is no improvement in the support for our well being"*

Working with primary care

In our last report, 78% of the pharmacies we spoke to told us that communication and working with GP surgeries had been difficult and slow. We wanted to find out if this had improved.

80% of pharmacists told us that they hadn't seen any improvement with access to GPs since their first wave of the pandemic.

Whilst there were 8 pharmacists that told us access to GPs has improved, three of these said it had improved since the first wave of the pandemic but was still not back to pre-pandemic levels.

We heard some positive stories:

- *"We have direct contact with our PCN pharmacist who told us they are happy to help with issues regarding contact with GPs. They are also working on getting us a direct line for calls from pharmacies only"*
- *"A few surgeries now have direct email access which we can send queries to, this has made a massive difference in communication"*

Further comments include:

• "It stiller seems to be impossible for patients to access GPs"
• "We are having a lot of backlash from patients as they are not able to get through on the phone to book GP appointments"
• "We struggle to discuss issues with prescriptions with some surgeries. We do not have a direct line and we have to contact them through the main line just like everyone else."
• "It is difficult to speak to primary care because they do not have a direct line for pharmacies"
• "If anything, the doctors have got worse. We are constantly having to chase prescriptions and enquire where prescriptions are. Surgeries still have their doors shut and do not pick up the phone to answer queries"

Digital exclusion

In our previous report, 73% of community pharmacies identified that sections of their communities were in a greater need of support, particularly elderly people. Over 50% of pharmacies felt that parts of the community remain digitally excluded today. Comments included:

- *"I believe the elderly are at a disadvantage as they still need community support"*
- *"For patients who are not online, ordering and access to medical services can be challenging"*
- *"I think older people really struggle with apps etc"*
- *"The GP surgery won't answer their phones so patients without internet cannot put their repeats in via app or email"*
- *"A lot of our customers are elderly so they are unable to use the e-consult system"*
- *"Our village is of an older generation where patients do not have access to smart phones and must call the POD. If there is a queue of multiple people, then they tend to give up. This is the same issue when they call the GP"*
- *"No face-to-face services have resumed yet, and some GPs are still expecting customers to email photographs and this is not an option for many elderly patients"*

Vaccine roll out

The majority of pharmacies told us that the vaccine programme has had a positive impact on community pharmacy teams. Staff told us they feel safer and more confident now that they have been vaccinated.

- *"We are much more positive now that we have been vaccinated"*
- *"We were all able to access vaccines early which made the staff a lot more relaxed during the final lockdown"*
- *"At the beginning there were so many queries about whether or not we would be doing the vaccine which once again increased our workload. Now patients are aware and there has been a positive rollout of the vaccine it has helped significantly"*
- *"We feel safer"*
- *"The vaccine programme has improved the confidence and morale of team"*
- *"We've had an increased in queries and phone calls about the vaccine"*
- *Staff feel more protected"*

Impact of NHS 111 service

Over a third (35%) of pharmacies told us that their workload had been impacted by the roll out of the new NHS 111 First service. Whereas over half (55% told us they had seen no change. Comments included:

- *"We've had more referrals, but on some occasions these are unnecessary and could have been signposted in a better manner"*
- *"We do get a few NHS111 requests and they are actioned a soon as possible. It hasn't impacted our workload a great deal, although we do have to appoint members of staff to routinely check the email for referrals"*
- *"We receive more referrals on Saturdays which has a big impact"*
- *"Referrals have increased but not excessively"*
- *"Workload has increased. It has added to the pressure"*
- *"It has created more work as the 111 staff have not been properly trained. We get bad referrals every week that we should not get.*
- *"We do receive quite a few referrals which as a pharmacy we cannot deal with, as more often than not the patient's need antibiotics which we cannot supply"*
- *"This has generally impacted staff working on a Saturday - it has slightly increased their workload"*

From these insights, it seems pharmacists who feel their workload has been increased due to the rollout of the NHS111 First service, see the effects of this most on Saturdays. Some pharmacists told us they had not seen an impact on their workload, as they are closed on Saturdays.

Other challenges facing pharmacies

Pharmacists shared a number of other issues with us including:

- *"Demand for pharmacy services is high as patients find us more accessible"*
- *"More patients are talking to us about their mental health issues which is stretching our resources"*
- *"Obtaining prescriptions on time for patients is a challenge"*
- *"Increased workload with minimal staffing levels"*
- *"Obtaining certain medications is proving difficult"*
- *"We are seeing increased deliveries and we're having problems reducing this demand"*
- *"The workload has increased but the number of trained staff has not"*
- *"Pressure with quality care payments for compulsory training, in order for us to meet the QCP criteria"*
- *"Lack of clear communication between healthcare teams causes problems"*
- *"We have concerns around how to deliver services safely and keep both ourselves and customers safe"*
- *"There is Increasing demands for new services but no increase in support"*
- *"Demand on home deliveries has also increased ending in patients being disappointed and an increase in complaints. We had already reached full capacity before the pandemic"*
- *"There has been increased demand for emergency supplies caused by delays in getting prescriptions from GP surgeries"*

What do we hope to achieve?

We want to give community pharmacists a voice.

We want to ensure decision makers within Kent & Medway hear their experiences and make changes as a result.

Some of the feedback relates to specific services and in these instances we have taken the feedback to them directly to initiate change.

We are always looking to drive positive change to health and social care services.

We will keep you posted on our progress.

Thank you

Thanks to all the pharmacies that took the time to contribute feedback to our report. Without your input and insights we wouldn't have been able to build a picture of the issues you, and the wider healthcare system, is facing.

Thanks to Oaks Pharmacy (Delmergate), MD Moores Pharmacy, Knights Pharmacy, Paydens pharmacies, Ryders Pharmacy, G Currie Chemist, Thompsons, Fenns, Eckersley, Baxters Pharmacy, Courts Pharmacies, Eakins Chemist, Clarke and Coleman Pharmacy, Cairns chemist, Darnley pharmacy, and all others that contributed.

healthwatch Kent

Healthwatch Kent
Church Road, Seabrooke House
Ashford TN23 1RD

info@healthwatchkent.co.uk
@hwkent
@HealthwatchKent
@healthwatch_kent
0808 801 0102

healthwatch Medway

Healthwatch Medway
5A New Rd Ave,
Chatham ME4 6BB

enquiries@healthwatchmedway.com
@healthwmedway
@HWMedway
@HealthwatchMedway
0800 136 656

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Item 12: East Kent Hospitals University NHS Foundation Trust – update following CQC publications

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 10 June 2021

Subject: East Kent Hospitals University NHS Foundation Trust – update following CQC publications

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

It is a written item, and no representatives will be present at the meeting.

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1) Introduction

a) The Trust has provided a written update for the Committee on two areas of Care Quality Commission (CQC) inspection:

i) Infection Prevention and Control.

Report: William Harvey Hospital, 7/10/20.
This report was a focussed inspection in the area of safety and followed a core inspection on 11 August 2020 which recorded examples of poor practice in infection prevention and control (IPC) practices and led to the issuing of Section 29A and Section 31 notices.
Source: https://api.cqc.org.uk/public/v1/reports/3b1a0d80-f9e0-4828-839a-312049321304?20210507150006

Report: EKHUFT Quality Report, 23/04/21.
This was an inspection of infection prevention and control across the Trust and follows the report from 7 October 2021. The report recognises significant improvements as well as areas of outstanding practice and led to the lifting of the previous two notices. No ratings were given and the Trust remains "Requires Improvement" overall.
Source: https://api.cqc.org.uk/public/v1/reports/1b55b552-35a3-4b28-881a-fc71be226bdd?20210423064006

ii) Urgent and Emergency Care Services.

QEQM and William Harvey Hospital each had an Inspection Report published on 7/05/21. The focussed inspection of each hospital's urgent and emergency care services was undertaken as part of the Resilience 5 Plus process.[1] The services were inspected but not rated.

QEQM - https://api.cqc.org.uk/public/v1/reports/f726c44e-46bd-4d51-8d8c-7abebfc7b763?20210507070040

[1] The 'Resilience 5 Plus' process is used to support focused inspections of urgent and emergency care services which may be under pressure due to winter demands or concerns in relation to patient flow and COVID-19. The inspection framework focused on five key lines of enquiry relating to critical care, infection prevention and control, patient flow, workforce and leadership and culture.

William Harvey - https://api.cqc.org.uk/public/v1/reports/6aa49fde-80d1-4e11-bc8e-aaa7ebc06563?20210512124735

2) Previous Monitoring by HOSC

a) Following the August CQC visit and subsequent Section 31 notice, HOSC received a report from the Trust in September 2020. At that time, the CQC report had not been published, but the Trust had begun implementing the recommendations made by the CQC. HOSC requested that an update be provided to the Committee at the appropriate time.

b) The Chair of HOSC has invited the Trust to provide a written update following the CQC's recent publications.

3) Recommendation

RECOMMENDED that the Committee consider and note the report.

Background Documents

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

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

Contact Details

Kay Goldsmith
Scrutiny Research Officer
kay.goldsmith@kent.gov.uk
03000 416512

NHS
East Kent
Hospitals University
NHS Foundation Trust

East Kent Hospitals Update for Health Overview and Scrutiny Committee Care Quality Commission Inspections

Introduction

This report summarises feedback from two Care Quality Commission (CQC) inspections of William Harvey Hospital in Ashford and Queen Elizabeth The Queen Mother Hospital (QEQM) in Margate. Both inspections took place in March 2021.

1. Infection Prevention and Control (IPC)

1.1 The CQC undertook a focussed inspection in March 2021 to look at IPC practices at both hospitals. This followed enforcement action taken by the regulator in August 2020 following an inspection in August 2020.

1.2 The inspection team found the departments controlled infection risk well, with staff using equipment and control measures to protect patients, themselves and others from infection. Equipment and the premises were visibly clean.

1.3 Several areas of outstanding practice were identified by inspectors, including how staff were protecting clinically extremely vulnerable patients from infection, and changes to resuscitation areas in the emergency departments to help keep staff and patients safe.

1.4 Inspectors found that staff felt respected, supported and valued and were focused on the IPC needs of patients. The report praised the Trust's culture, where staff could raise concerns about IPC without fear and were supported to do so.

1.5 It recognised that the Trust has structures, processes and accountability to support IPC standards, with a comprehensive assurance system in place, enabling performance issues and risks to be monitored and addressed.

1.6 The report also recognised that staff were committed to continually learning and improving IPC performance.

1.7 Areas identified where improvements could be made included changing the layout of the doctors' mess to allow for social distancing, adding more staff changing rooms to wards, and increasing the IPC leadership team to ensure they have the resources to support all staff. There were no "must do" actions.

1.8 These areas are being addressed by the Trust's Integrated IPC Working Group, a multi-disciplinary group that meets weekly to ensure progress against any outstanding actions.

1.9 Dr Neil Wigglesworth, Director of IPC joined the Trust in March to lead the Trust's recently expanded IPC team. Further appointments are underway, including a Deputy Director of IPC starting in June and additional Lead Nurse roles to strengthen site-based IPC leadership.

1.10 As a result of the inspection, the conditions previously imposed by the CQC were lifted in March. The CQC's report is available here.

2. Inspection of Emergency Departments at QEQM and William Harvey Hospitals

2.1 Inspectors undertook a second focussed inspection in March to assess whether the urgent and emergency care services were experiencing pressure due to winter demands or as a result of COVID-19.

2.2 The CQC report, published earlier this month, showed improvements to the performance of both emergency departments.

2.3 The inspection team found the departments controlled infection risk well, with staff using equipment and control measures to protect patients, themselves and others from infection. Equipment and the premises were visibly clean.

2.4 Inspectors reported that staff were focused on the needs of patients receiving care and the departments had an open culture where patients, their families and staff could raise concerns without fear.

2.5 We are taking action on the areas for further improvement and have completed renovations of the mental health room at William Harvey Hospital."

2.6 Areas identified by the CQC for improvement included waiting times, consultant cover at QEQM Hospital, and suitable facilities in place to care for patients with mental health problems and processes for monitoring the health of waiting patients at William Harvey Hospital.

2.7 Reducing waiting times for patients in the emergency departments and improving bed availability is a key focus of the Trust's quality improvement programme, *We Care*. Frailty Assessment Units and Same Day Emergency Care units, specialist areas aimed at treating patients quickly so that they do not need to be admitted, have recently been established at both hospitals.

2.8 Coupled with work to increase the number of patients discharged at the weekend and earlier in the day, the Trust has already seen an improvement in bed availability, a significant reduction in medical patients outlying on surgical wards and a reduced waiting times for emergency patients with serious illness and injury (majors).

2.9 As a result of the inspection, William Harvey Hospital's rating for safety has improved from inadequate to requires improvement. QEQM Hospital's rating remains at requires improvement.

2.10 The CQC produced an inspection report for each William Harvey Hospital and QEQM Hospital.

Ends.

Item 13: Work Programme 2021

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 10 June 2021

Subject: Work Programme 2021

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) HOSC is responsible for setting its own work programme, giving due regard to the requests of commissioners and providers of health services, as well as 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

Contact Details

Kay Goldsmith
Scrutiny Research Officer
kay.goldsmith@kent.gov.uk
03000 416512

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Work Programme - Health Overview and Scrutiny Committee

1. Items scheduled for upcoming meetings

21 July 2021		
Item	**Item background**	**Substantial Variation?**
Covid-19 update	To receive an update on the response of local health services to the ongoing pandemic.	No
Major Trauma Centre and access for Kent residents (written paper)	At their meeting on 4 Mar 2021, the Committee asked to understand if there were plans for Kent to have its own Major Trauma Centre.	-
Maidstone & Tunbridge Wells NHS Trust - Clinical Strategy Overview	An introduction to the reconfiguration of clinical services across the Trust.	

16 September 2021		
Item	**Item background**	**Substantial Variation?**
Covid-19 update	To receive an update on the response of local health services to the ongoing pandemic.	No
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.	-
Maidstone & Tunbridge Wells NHS Trust - Clinical Strategy - Gastroenterology Service Development	As part of the wider reconfiguration of clinical services, this item will update the Committee on the gastroenterology workstream.	

2. Items yet to be scheduled

Item	Item Background	Substantial Variation?
Single Pathology Service in Kent and Medway	Members requested an update at the “appropriate time” during their meeting on 22 July 2020.	No
Ophthalmology services	To receive an update on the potential proposal to move ophthalmology services from Moorfields Eye Hospital, London to an existing provider in Maidstone.	-
East Kent Maternity Services	Following the discussion on 17 September 2020, Members requested the item return once the Kirkup report has been published (expected 2022).	-
Children and Young People’s Emotional Wellbeing and Mental Health Service - update	Members requested an update at the “appropriate time” during their meeting on 24 November 2020.	-
Orthotic Services and Neurological Rehabilitation	To receive information on the provision of these services in Kent for adolescents.	-
Update on the implementation of an integrated Care System across Kent & Medway	To receive an update on the implementation of ICSs, including Integrated Care Partnerships and Primary Care Networks. Also an opportunity to review how the establishment of a single CCG has gone. Expected in late Autumn 2021.	-
Provider updates	To receive general performance updates from each of the main local providers.	-
Update on the implementation of hyper-acute stroke units	Following a discussion at their meeting on 22 September 2020, HOSC asked for an update “at the appropriate time”. Currently waiting on decision from Secretary of State following a referral from Medway Council on the CCG’s final decision.	-

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

Kent and Medway Joint Health Overview and Scrutiny Committee NEXT MEETING: TBC		
Item	**Item Background**	**Substantial Variation?**
Transforming Health and Care in East Kent	Re-configuration of acute services in the East Kent area	Yes
Specialist vascular services	A new service for East Kent and Medway residents	Yes

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