HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 21st July, 2021

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 21st July, 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, Mrs B Bruneau, Mr N J D Chard, Mr P Cole, Ms S Hamilton (Vice-Chairman), Mr A Kennedy, Mr J Meade, Mr D Watkins and Mr A R Hills
Liberal Democrat (1)	Mr D S Daley
Labour (1):	Ms K Constantine
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
	The Committee is asked to note the re-appointment of Mr Tony Hills.	
2.	Apologies and Substitutes	
3.	Declarations of Interests by Members in items on the Agenda for this meeting.	
4.	Minutes from the meeting held on Thursday 10 June 2021 (Pages 1 - 8)	
5.	Covid-19 response and vaccination update (Pages 9 - 16)	
6.	Provision of Ophthalmology Services (Dartford, Gravesham and Swanley) (Pages 17 - 24)	10:20

7. Maidstone & Tunbridge Wells NHS Trust - Clinical Strategy Overview (Pages 25 - 34) 10:40

8. Maidstone & Tunbridge Wells NHS Trust - Clinical Strategy Overview - Cardiology reconfiguration (Pages 35 - 58)

9. Maidstone & Tunbridge Wells NHS Trust - Clinical Strategy Overview - Digestive Diseases Unit (Pages 59 - 76)

10. Dental Services in Kent (written item) (Pages 77 - 84) 11:20

11. Major Trauma Centre provision in Kent (written item) (Pages 85 - 88)

12. Follow up from previous meeting - the funding of community pharmacies (Pages 89 - 94)

13. Work Programme 2021 (Pages 95 - 100)

14. Date of next programmed meeting – 16 September 2021 at 10am

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

13 July 2021

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Thursday, 10 June 2021.

PRESENT: Mr P Bartlett (Chair), Mr P V Barrington-King, Mrs B Bruneau, Mr P Cole, Ms S Hamilton (Vice-Chairman), Mr A Kennedy, Mr J Meade, Mr S R Campkin, Ms K Constantine, Cllr S Mochrie-Cox, Mr H Rayner and Mr D Ross

ALSO PRESENT: Mr R Goatham and Dr C Rickard

IN ATTENDANCE: Mrs K Goldsmith (Research Officer - Overview and Scrutiny) and Mr M Dentten (Democratic Services Officer)

UNRESTRICTED ITEMS

2. Membership

(Item 1)

1. The Committee noted the change in membership, owing to the recent elections.

2. The Chair noted 1 Conservative vacancy remained.

3. Election of Vice-Chair

(Item 3)

1. Paul Bartlett proposed and Andrew Kennedy seconded that Sarah Hamilton be elected vice-chair of the Committee. There were no other nominations.

2. AGREED that Sarah Hamilton be elected Vice-Chair of the Committee.

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

(Item 4)

No interests were declared.

5. Minutes from the meetings held on 4 March 2021 and 27 May 2021

(Item 5)

1. A Member questioned the late notification to Borough and District representatives of the meeting held on 27 May 2021 (when the Chair of the Committee was elected). The Chair noted that the process of electing KCC Committee chairs (on the rise of the KCC Annual General Meeting after an election had taken place) had been in place since 2008. However, he

understood the concern and offered to raise with relevant officers outside of the meeting.

2. Agreed that the minutes from 4 March and 27 May 2021 were correctly recorded that they be signed by the Chair.

6. Transforming mental health services in Kent and Medway

(Item 6)

In virtual attendance: Karen Benbow, Director of System Commissioning (K&M CCG), Andy Oldfield, Deputy Director Mental Health and Dementia Commissioning (K&M CCG), Vincent Badu, Deputy Chief Executive/ Executive Director Partnerships & Strategy (KMPT) and Dr Rosarii Harte, Deputy Medical Director (KMPT).

1. The Chair welcomed the NHS attendees and invited Karen Benbow to provide an overview of the report. Key points included:

    i. The impact of covid-19 and subsequent increase in demand.
    ii. An increase in patients held under the Mental Health Act section 13.
    iii. New investment in memory services for dementia care.

2. A Member welcomed the update on the provision of Safe Havens but asked if there were plans to expand the service in terms of its hours of operation and provision in North/West Kent. Mr Oldfield explained further analysis was underway before such decisions were made and noted that HOSC would like to be kept informed.

3. Members questioned the role of NHS 111 in the triaging of mental health patients. It was explained that KMPT worked jointly with the 111 provider (SECAmb) and their staff had received appropriate training from KMPT. Since the pandemic, virtual and telephone assessments were being offered, as well as face to face when it was deemed appropriate and necessary. Dr Harte noted the improved joint working across the system over the last year.

4. Members also questioned the role of GPs in providing mental health support, particularly drawing on the low percentage of physical consultations (29%) since the pandemic began. As this was an area of particular concern, HOSC requested a paper on the provision of GP services at a future meeting.

5. In relation to specific concerns around children's mental health, Ms Benbow offered to bring a paper to a future HOSC meeting which the Chair welcomed. This was to include in school support services.

6. Vincent Badu noted the important role of the community in supporting mental health issues and explained that as part of a programme of improvement KMPT had been working on the Prevention Concordat – a programme of community engagement projects that aimed to increase awareness of mental health and encourage discussion (for example, Webbs Garden in St Martins Hospital, Canterbury).

7. The Committee agreed to:

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

7. Transforming mental health services in Kent and Medway - Eradicating dormitory wards

(Item 7)

In virtual attendance: Karen Benbow, Director of System Commissioning (K&M CCG), Andy Oldfield, Deputy Director Mental Health and Dementia Commissioning (K&M CCG), Vincent Badu, Deputy Chief Executive/ Executive Director Partnerships & Strategy (KMPT) and Dr Rosarii Harte, Deputy Medical Director (KMPT).

1. Karen Benbow introduced the paper, which was a workstream under the previous, Mental Health Transformation, paper. The CCG wanted to remove the final dormitory ward (Ruby Ward at Medway Hospital) and had been successful in a capital funding bid. The proposal was to build a new facility on the Maidstone Hospital site. She noted that patient admissions to Ruby Ward were from across Kent, with just 30% resident in Medway and Swale. The proposal would also result in an increase in overall mental health bed numbers.

2. In response to a question from the Chair, Mr Badu assured the Committee the new facility would be accessible to all Kent residents. He confirmed there were four other adult wards in Kent, and the Patient Flow team were responsible for assessing the needs of the patient and allocating them to the most suitable site (with need taking priority over location, as some wards had specialised support).

3. Robbie Goatham from Healthwatch commented that a 6-week consultation would take place following Medway HASC's declaration of a substantial variation of service.

4. RESOLVED that:

    i. 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.
    ii. the report be noted.

8. Covid-19 response and vaccination update

(Item 8)

In virtual attendance: Caroline Selkirk, Executive Director for Health Improvement, K&M CCG, and Lee Martin, Recovery Director, Kent and Medway CCG.

1. Caroline Selkirk introduced the report and provided an update since the report had been published.

    - There had been 1.8 million vaccines in Kent – 1.1m first doses and 700,000 second as of Thursday 3 June.
    - Uptake of vaccines had been 91%.
    - The 24-29 age group were being invited for vaccination.
    - There would be a pop-up vaccine centre in Ashford next week.*
    - ¾ of vaccines had been delivered by primary care, and she thanked volunteers for their work in supporting the vaccine programme.
    - Noted close work with Public Health.
    - Awaiting guidance on vaccinating children and boosters.
    - The number of patients in hospital with covid was low.
    - A post covid assessment service had opened.
    - Primary care was seeing an increase in demand. Rollout of the vaccination programme was on top of their usual workload.

2. A member noted the reduced number of face-to-face GP appointments and asked if this would increase. Ms Selkirk acknowledged the reduction and explained that a working group had been established. She explained there were a number of patients contacting their GP surgery regarding non-primary care matters, and this put a strain on services.

3. A member questioned the impact on staff from the increased pressures, noting that they had heard there were 44 clinical vacancies at QEQM hospital. Ms Selkirk explained work/ life balance had been returning to normal following the use of staff rotas at vaccine centres as well as needing less staff now routines were more embedded. KMPT were offering support services to struggling staff. Staff recruitment was challenging but Trusts were advertising locally, nationally and internationally. Bed modelling was used to monitor capacity and demand and more work was being undertaken in this area. Mr Martin offered to provide a response specific to QEQM outside of the meeting if required.

4. The representative from the Local Medical Committee (LMC) and GP in East Kent, Dr Rickard, provided a summary of primary care's response to the pandemic. She explained:

    - Primary care was under-resourced before the pandemic.
    - When the pandemic hit, GP surgeries followed government advice and moved to a telephone triage system. Patients were invited to a face-to-face meeting if it was deemed necessary.
    - Some frontline clinicians had themselves been required to shield.
    - Hot hubs were established for acutely unwell people, as well as assistance to stay at home.

- Primary Care Networks, and the GPs within them, have led the vaccination programme roll out on top of their usual workload.
- There had been an increase in demand across the entire health system.
- GP surgeries were experiencing a high number of call from patients wanting an update on their secondary care appointments (that they were unable to help with).
- Moving forward, more face-to-face appointments were taking place, working alongside a telephone triage system.

5. In response to a question around demands on the primary care system, Ms Selkirk confirmed a national redesign programme was underway, which would look at what had worked well and not worked well and building on these. Triaging had benefits, though there had been different experiences across surgeries. Triaging had its limits, mainly due to staffing numbers, so leaders needed to consider how the demand on that service could be reduced – how could non GP enquiries be managed? One member cited the importance of keeping website and social media updated so patients would not need to phone up. Ms Selkirk recognised the need to utilise other methods of communication to reduce the strain on GPs. Dr Rickard gave the example of a pilot underway in East Kent where a patient access line was in use to support GP phonelines.

6. A member questioned the effectiveness of telephone triage on mental health patients, as the first point of contact was often vital, especially if they were in crisis.

7. A member highlighted the importance of equal access to services, citing a stalled life expectancy rate amongst women.

8. The Chair mentioned the “My GP” app, which he had personally used and found effective, though he noted it may not be used by all Kent surgeries. Another Member acknowledged the app but noted that not all necessary information was available on it. Ms Selkirk believed the utilisation of apps would improve over time but that this was not within the control of the CCG.

9. A Member asked if there was a dedicated phone number for mental health patients, to which Ms Selkirk said NHS 111 was the first point of call for all patients regardless of symptoms. She acknowledged work needed to be done to provide easier and more direct access to mental health lines.

10. Members expressed their thanks to all NHS staff for their work and support during the pandemic.

11. RESOLVED that the Committee note the report.

**Post meeting note – the pop-up vaccine centre was in Canterbury, not Ashford.*

9. Urgent Care Review programme - Swale

(Item 9)

In virtual attendance: Justin Chisnall, Director of Integrated Care Commissioning Medway and Swale, Kent and Medway CCG.

1. Justin Chisnall provided an overview of report, following on from the discussion that had taken place at the previous meeting. The expectation was to introduce an Urgent Treatment Centre model, where the UTC would be GP-led and offer an integrated service.

2. It was proposed the move be implemented over two stages – the first centring on engagement around the current GP surgery and walk-in unit (provided by DMC Healthcare) whose contract would end in Autumn. The expectation was that the GP surgery would move into the MIU whilst a specification was developed around provision of a UTC.

3. Mr Chisnall advised it was too soon to state where the final location(s) would be, though it was recognised there was need for provision on the Isle of Sheppey.

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

10. Medway Foundation Trust - CQC inspection - update

(Item 10)

In virtual attendance: George Findlay, Chief Executive, Medway Foundation Trust

1. George Findlay, the new Chief Executive of the Medway Foundation Trust provided a verbal overview of the report and highlighted the progress made since the published CQC inspection, whilst noting that more needed to be done. The Trust had received high level verbal feedback on subsequent CQC inspections which had taken place, with the final reports anticipated at the end of June/ early July.

2. Mr Findlay addressed concerns around staffing numbers, explaining that the Trust had seen a rapid increase in nursing numbers. He recognised recruitment needed to be supported by a higher retention rate.

3. A Member drew attention to the CQC inspection report's negative comments about governance and culture. Mr Findlay said it was his priority to understand the behaviours of governance and culture across the whole Trust as he recognised the link between culture and an effective service. He acknowledged improvements were needed and felt his background from different NHS trusts would help.

4. A Member asked if international recruitment (as cited in the report) was a sustainable method. Mr Findlay noted the historic reliance on international recruitment in UK, perhaps more than was healthy. He believed that

encouraging training in the UK was important as well as making MFT an employer of choice.

5. A Member asked for assurance that the skills base of staff was stable. Mr Findlay confirmed that there was a variety of experience across services, noting that experienced (as well as less-experienced) nurses had been recruited, with new recruits carefully selected and developed through a practice education department. A talent management strategy was discussed at Board level.

6. The Chair noted the role of affordable housing in attracting key workers.
7. A Member asked if analysis was carried out to understand why staff left and where they went. Mr Findlay confirmed that exit interviews were conducted, though it was down to the employees to disclose what job they were moving into. He cited career advancement and culture as key reasons people had left the Trust, and noted that staff turnover had increased since beginning of the pandemic.

8. RESOLVED that the report be noted.

11. Healthwatch Kent and Medway - "Pharmacies and Covid: the reality" - update
(Item 11)

In virtual attendance: Robbie Goatham, Manager at Healthwatch Kent, Lucie Price, Healthwatch Kent, Shilpa Shah, CEO at Kent Local Pharmacy Committee (LPC).

1. Lucie Price introduced the report, highlighting that:

    - 55% of pharmacies said morale had improved since first wave.
    - Communication between pharmacies and GPs has worsened.
    - Pharmacy workload continued to increase, in part due to signposting from GP surgeries.
    - Many patients were unaware of the service offer from pharmacies.

2. Shilpa Shah raised the issue around funding or pharmacies, noting that the impact may result in pharmacies closing. A £370m covid support loan was likely to need paying back. A key issue was around displaced patients, whereby pharmacies were a fallback for those patients unable to access other healthcare services.

3. A Member asked how the presence and role of community pharmacies was promoted. Ms Shah explained the difficulty in this because of the way services were provided by private companies but said the NHS Voice website showed where residents nearest pharmacies were located.

4. In terms of funding, the Chair asked if the £370m loan given to pharmacies was ever portrayed by the Government as a loan or was it set out as a grant/to be written off. Ms Shah explained it had been given as loan, but the implication

was that it wouldn't need to be paid back. A year on and it was still being negotiated. She invited Members to lobby their local MPs and offered to send the clerk further information after the meeting.

5. RESOLVED that the Committee note the update, and the chair undertook to consult with officers as to the best way to show support for pharmacies on this issue. Members agreed to this suggestion.

12. East Kent Hospitals University NHS Foundation Trust - CQC inspection (written update)
(Item 12)

1. AGREED that the report be noted.

13. Work Programme 2021
(Item 13)

1. Following discussion during the meeting, the Committee agreed to add the following items to the work programme:

    a. NHS first 111 - service update (including mental health)
    b. Children and young people's mental health services

2. AGREED that the work programme be noted.

14. Date of next programmed meeting – Wednesday 21 July 2021 at 10:00
(Item 14)

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

Item 5: Covid-19 response and vaccination update

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 21 July 2021

Subject: Covid-19 response and vaccination 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.

---

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 June 2021. During the discussion, members of the Committee raised concerns about the impact of the pandemic on access the GP services. A separate paper will be brought to the Committee in September.

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

Kent County Council (2021) 'Health Overview and Scrutiny Committee (10/06/21)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8501&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 – July 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 continues to progressed well. Since the last HOSC update we have passed the two million vaccines milestone. The programme has been delivered across three distinct phases:

- Phase 1 – vaccination of extremely vulnerable (cohorts 1-4)
- Phase 2 – vaccination of all eligible adults aged 18+
- Phase 3 – autumn/winter boosters and possible extension to under 18s

Within Kent and Medway:

- **Phase 1 is complete** in terms of having offered the vaccine to all eligible groups and achieved high uptake levels. Vaccination remains available to anyone who has not yet taken up the offer.
- **Phase 2 is nearing completion** in terms of having offered a first dose to all adults by 19 July 2021 and completing second doses by September/October 2021.
- **Phase 3 is in planning** but reliant on additional national decisions before local implementation plans can be fully developed. We will provide more detail on this in a future update to HOSC.

VACCINATION PROGRESS

Figures on vaccine progress are published nationally each Thursday. As of 8 July, the position in Kent and Medway was:

- 2,174,480 vaccines in total
- 1,236,674 first doses
- 937,806 second doses completed
- 88% of the top 9 at-risk cohorts are now vaccinated with both doses. This equates to 96% of those who have had a first dose.

There has been significant progress in vaccinating younger people in the last month. In our update to the June HOSC we reported:

- 12% of 18-29 year olds had received a first dose. **This is now at 51%**
- 21% of 30-39 year olds had received a first dose. **This is now at 65%**

Uptake amongst younger groups has not been as fast as the older and more at risk groups, but steady progress is being made with significant local, regional and national publicity to promote the importance of getting vaccinated and the availability of clinics. Responding to feedback the NHS across the country has opened up walk-in options both from existing vaccination services and at pop-up sites in various locations. Details of local walk-in clinics are published on the CCG website www.kentandmedwayccg.nhs.uk/grabajab and promoted through social media and other channels.

Second doses for all age groups are now being brought forward to 8 weeks (rather than 12). Within the 40-49 year olds 47% have now had both doses (58% of those who have had a first dose). First dose take up in 40-49 year olds is 81%.

Percentage uptake across the priority groups:

Cohorts	First dose uptake	Second dose completion	Whole pop. fully vaccinated
1 (Care home residents and carers)	100%*	88%	85%
2 (80+ years and health and care frontline staff)	95%	95%	91%
3 (75-79 year olds)	97%	98%	95%
4 (70-74 year olds and extremely vulnerable)	95%	98%	93%
Total 1 – 4	**95%**	**97%**	**92%**
5 (65-69 year olds)	94%	98%	92%
6 (clinically vulnerable aged 16-64)	86%	92%	79%
7 (60-74 year olds)	92%	97%	89%
8 (55-59 year olds)	90%	95%	87%
9 (50-54 year olds)	88%	95%	83%
Total 1 – 9	**92%**	**96%**	**88%**
10 (40-49 year olds)	81%	58%	47%
11 (30-39 year olds)	65%	28%	18%
12 (18-29 year olds)	51%	22%	11%
Total 10 – 12	**65%**	**37%**	**24%**
All cohorts	**80%**	**76%**	**61%**

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

LARGE VACCINATION CENTRES

The vaccination programme has been a partnership across the whole NHS system in Kent and Medway. Kent Community Health NHS Foundation Trust (KCHFT) have run the large vaccination centres and roving services for hard to reach groups.

The five large vaccination centres have played an important part in phases 1 and 2. They have delivered approximately 20% of the vaccines given across all services in Kent and Medway.

With phase 2 nearing completion KCHFT has decided that they must now focus on restoring their core services and supporting the recovery programme of the wider NHS. We are working with them to plan their exit from the vaccination programme whilst making sure there is sufficient capacity to complete phase 2 and developing a resilient model for phase 3. As we near the completion of the vaccine programme and leisure venues are returning to normal the Angle leisure centre and Woodville Halls theatre are being handed back so the buildings can open to the public again.

We are confident that there continues to be a range of vaccination services open to local people and sufficient capacity to complete phase 2 of the vaccination programme. This is helped by increased access to appointments through the National Booking Service (NBS). There are now 13 pharmacies and 14 GP-led vaccination services across Kent and Medway taking bookings through the NBS; meaning appointments are open to anyone, not just patients registered with particular GP surgeries.

Site by site summary of large sites

- **Folca – Folkestone**
  The Folca site will remain open and run by KCHFT until the end of the adult vaccination programme (phase 2). First dose appointments are expected to end in-line with meeting the national target of 19 July.

  Five pharmacies are also running in the East Kent area including Deal, New Romney and Ashford. 13 GP-led services are running in East Kent with GP-led services on the NBS offering appointments in Dover, Canterbury, Ashford, Ramsgate, Folkestone and Faversham.

- **Pentagon – Chatham**
  The Pentagon will remain open and run by KCHFT until the end of the adult vaccination programme (phase 2). First dose appointments are expected to end in-line with meeting the national target of 19 July.

  Three pharmacies are also running in the Medway area and all of the GP-led services continue to offer vaccination to all cohorts. GP-led clinics run from Rochester and Lordswood Healthy Living Centres are in the process of moving onto the national booking service for bookings.

- **Saga – Thanet**
  The PCN service which has been running from the Saga centre has ow taken over from KCHFT. The PCN will continue to run the centre at the total capacity that both KCHFT and the PCNs have been delivering to date.

  The other PCN service based in Ramsgate and a pharmacy in Cliftonville, Margate also now take bookings through the NBS.

- **Woodville Halls – Gravesend**
  Woodville Halls will remain open until the end of August. The Theatre is opening for performances in September. First dose appointments are expected to end in-line with meeting the national target of 19 July.

  There are five PCN vaccination services still operating in the Dartford, Gravesham and Swanley area. Services now bookable through the NBS are running at the Swanley council building; Dartford football club, the Orchard practice, and a pharmacy services at Bluewater.

- **Angel Centre – Tonbridge**
  The lease to use the Angle Centre expires at the end of July 2021. KCHFT is now focussed on completing second dose vaccinations for those previously vaccinated at the centre and completing the close down process to hand the site back to the landlord in the first week of August.

  With four pharmacy-run services and three GP-run services in West Kent now available on the NBS there are vaccination services open for all residents to book with in the following towns:

  - Tunbridge Wells
  - Sevenoaks
  - East Peckham
  - Maidstone
  - Leybourne
  - Ticehurst (noted not Kent, but continues to be available)

MORE INFORMATION ON THE VACCINE PROGRAMME

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 every Thursday 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/

Covid-19 cases and deaths

Community infection rates are rising, but at this point the increase in hospitalisation has been modest. As of 8 July there were 25 Covid-19 patients in hospitals across Kent and Medway; 2 of those in critical care beds.

Deaths from Covid-19 remain low, although there are unfortunately still a small number of deaths on a weekly basis. The position remains that there are regularly days when no deaths are recorded in any Kent and Medway hospitals or community sites.

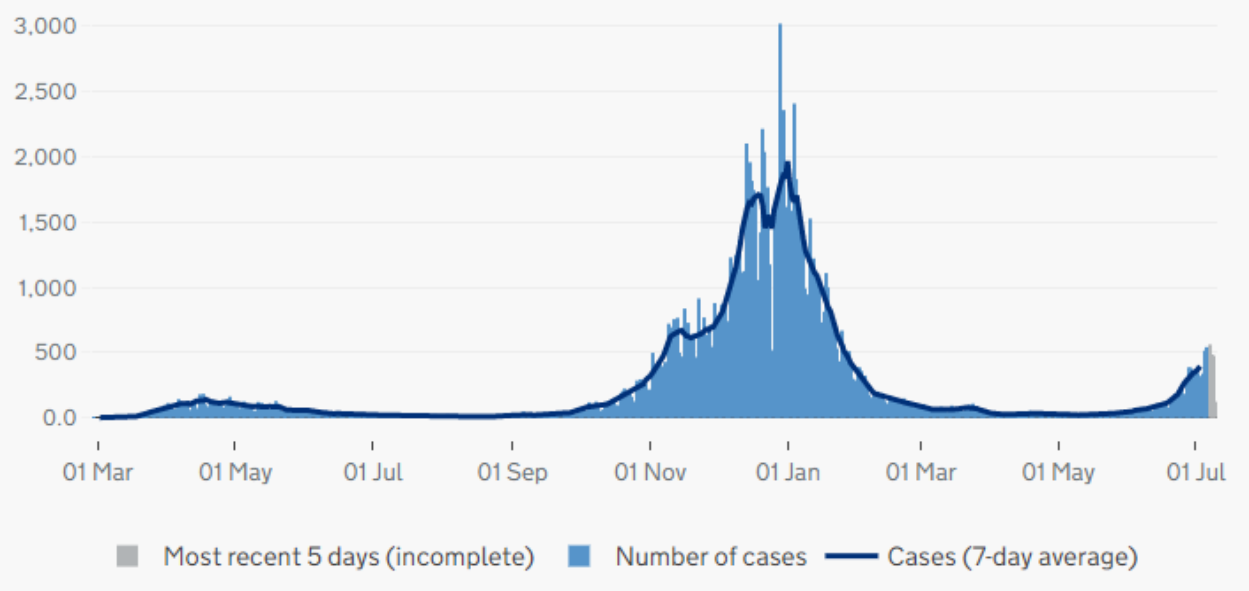
As of 11 July in Kent there have been:

- 3,994 deaths within 28 days of a positive test
- 4,583 deaths with Covid-19 recorded on the death certificate

In Medway there have been:

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

The graph below shows the **daily confirmed cases** in Kent over the duration of the pandemic:



Source: 11 July 2021 https://coronavirus.data.gov.uk/details/cases?areaType=utla&areaName=Kent

Hospital elective care treatments

The NHS across Kent and Medway continues to work hard to reschedule routine treatments and good progress is being made. 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. Latest published waiting list figures were published on 9 July, providing figures for May 2021, and show the number of people waiting over 52 weeks fell from 7,963 in April to 6,815 in May.

	April 2021	**May 2021**
Total incomplete pathways	143,974	150,752
Total within 18 weeks	92,867	103,028
% within 18 weeks	64.5%	68.3%
Average waiting time in weeks	10.7	10.5
Total 52 plus weeks	7,963	6,815

Source: National Consultant-led Referral to Treatment Waiting Times Data 2021-22, 8 July 2021
https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2021-22/

In May 2021, activity across all local NHS hospitals, NHS providers outside Kent and Medway and the independent sector included 24,488 inpatient treatments and 240,991 outpatient appointments.

General Practice pressure

The CCG continues to work with general practice, the Local Medical Committee and wider NHS partners to address pressures caused by the backlog of patients who have not been seen during the pandemic. Whilst the number of people on hospital waiting lists is relatively easy to quantify, there is also a significant backlog in demand for general practice appointments; which is harder to quantify.

The key drivers of pressure on general practice include:

1. Suboptimal use of primary care appointments
2. Backlog of GP work post-covid
3. General practice infrastructure challenges
4. Lack of sufficient and timely access to diagnostics
5. Workforce constraints

Plans are being developed to address all of these areas with a range of actions across the short, medium and long term. Some of the short-term improvement plans are given below as examples and a new primary care strategy is being prepared to address medium to long term issues. A more detailed report of the development of strategy will be brought to a future HOSC meeting.

- **Hospital waiting list queries** – people on hospital waiting lists have traditionally had to contact their general practice for updates, which then needs the practice to follow up with the hospital. We are working with all hospitals to implement direct enquiries services.

- **Medication on discharge** – people leaving hospital often require on-going medication but are routinely prescribed just 2-3 days of supply by the hospital, meaning people have to quickly contact their practice to arrange further supplies. We are reviewing options to increase the amount of medication prescribed on discharge.

- **Internal hospital referrals** – If one hospital service sees a patient and identifies a need for another appointment with another services the patient is normally directed back to general practice to make the new referral. We are reviewing options to enable internal referral directly from one hospital service to another.

- **Promoting alternative services** – 111, pharmacy and urgent treatment centres can provide the advice and care that some patients need. We continue to work with practices and the public to promote suitable alternatives to contacting general practice.

- **Telephone system capabilities** – some practices have inadequate telephone systems for the level of demand now being experienced. We are working with NHS England to pilot new systems and develop a national standard for primary care telephone systems.

- **Remote monitoring solutions** – during the pandemic we developed a successful remote monitoring service for blood oxygen levels. A similar model is now being developed for blood pressure monitoring.

- **Increased capacity for blood testing** – routine blood tests are a significant activity across general practice. We are developing plans to increase capacity both for collecting samples and analysing results.

Pressure on primary care is also related to workforce and infrastructure challenges, which existed before the pandemic, need longer-term solutions. A new primary care strategy will review work that has been on-going in these areas and identify additional options for improvement.

Conclusion

All parts of the NHS continue to work extremely hard to meet the needs of patients which have built up through the period of lockdown restrictions. With Covid-19 infections rising we maintain our attention on supporting those needing hospital care and planning for potential increased pressure on hospitals. With the vaccination programme progressing well it is hoped that the majority of new infections will lead to less serious illness with fewer people needing hospital care.

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

Item 6: Local provision of ophthalmology services (Dartford, Gravesham and Swanley area)

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 21 July 2021

Subject: Provision of Ophthalmology Services (Dartford, Gravesham and Swanley area)

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

---

1) Introduction

a) Ophthalmologists diagnose, treat and prevent disorders of the eyes and visual system.[1]

b) The Kent and Medway CCG has asked to attend today's meeting and update the Committee on its plans for the ongoing provision of ophthalmology services in Dartford, Gravesham and Swanley.

2) Potential Substantial Variation of Service

a) The Committee is asked to review whether the proposed changes to ophthalmology services constitute 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.

3) Recommendation

If the proposed changes to ophthalmology services are *substantial*:

RECOMMENDED that:

(a) the Committee deems the proposed changes to ophthalmology services to be a substantial variation of service.

(b) Kent and Medway CCG be invited to attend this Committee and present an update at an appropriate meeting once the timescale has been confirmed.

[1] NHS (2021) Ophthalmology, https://www.healthcareers.nhs.uk/explore-roles/doctors/roles-doctors/ophthalmology

Item 6: Local provision of ophthalmology services (Dartford, Gravesham and Swanley area)

If the proposed changes to ophthalmology services are *not substantial*:

RECOMMENDED that:

(a) the Committee does not deem the proposed changes to ophthalmology services 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

NHS
Kent and Medway
Clinical Commissioning Group

Update Report for Kent HOSC July 2021

Date:	21st July 2021
Title Report:	Transfer of Acute Ophthalmology Services for Dartford, Gravesham and Swanley Patients from Moorfields Eye Hospital to Maidstone and Tunbridge Wells NHS Trust
Lead Director:	Caroline Selkirk, Executive Director for Health Improvement / Chief Operating Officer
Authors:	David Peck, Director of the Dartford, Gravesham and Swanley Integrated Care Partnership, Kent and Medway CCG Neil Fisher, Commissioning Programme Manager – Planned Care (Dartford, Gravesham and Swanley), Kent and Medway CCG Debbie Pyart, Senior Programme Manager – Planned Care, (Dartford, Gravesham and Swanley), Kent and Medway CCG

Summary:

This paper outlines the actions taken by Kent and Medway Clinical Commissioning Group to ensure patients from the Dartford, Gravesham and Swanley area needing acute ophthalmology services can continue to get the treatment they need following the withdrawal of a London Provider (Moorfields) from running a satellite service at Darent Valley Hospital.

Moorfields Eye Hospital served notice in February 2020 on the Kent and Medway system of their intent to discontinue providing ophthalmology services from Darent Valley Hospital. Preparation for the pandemic and pressures from the first wave caused significant challenges in identifying a new Provider, although putting in place measures to facilitate the safe and effective transfer of patients during the this time remained of paramount importance for the CCG.

Maidstone and Tunbridge Wells (MTW) NHS Trust stepped forward to work with the CCG to ensure that patients can still receive ophthalmology treatment following Moorfields' withdrawal. Cataract surgery, which represents the majority of the treatments affected by this transfer are currently being carried out by from an Independent Sector site in Gillingham using MTW clinicians.

Overview:

The majority of ophthalmology patients within Dartford, Gravesham and Swanley (DGS) are seen within the local community service without onward referral into secondary care. In 2020/21, 83% of patients have been treated within this service through a Consultant-led "triage and treat" model, which ensures that patients are seen expediently and are triaged into the most appropriate setting of care.

The following table uses acute ophthalmology activity from DGS for the pre-COVID year of 2019/20 provides a baseline to provide context to the volume of elective activity that affected by the transfer:

Activity Type	Activity
Elective Procedures	1,021
Of which, Cataracts	985
Outpatient First Appointments (based upon Month 11 forecast outturn to mitigate impact of COVID)	1,767
Outpatient Follow Up Appointments	3,964

Moorfields raised concerns in March 2019 regarding the financial viability of continuing to provide services from the hospital site. The CCG worked with both Providers to help facilitate a solution, which included trying to find alternative locations within community settings, but these efforts were unsuccessful, despite extensive discussions and concerted efforts.

Moorfields served 6 months' notice on their contract at the end of February 2020, which is less than the 12 month notice period normally associated with acute services. The CCG worked to negotiate an extension to the 6 months' notice given by Moorfield in order to better prepare for a transfer within the context of the pandemic, but agreement could not be reached to do so.

The CCG put in place a demobilisation plan, which included identifying a new Provider and ensuring that there would be a safe, effective and expedient transfer of patients. The initial consensus view was that the vast majority of patients on Moorfields' waiting list would be treated before the end of their contract in September 2020. However, the impact of COVID led to the cessation of a considerable amount of acute activity and the residual waiting list at the point of contract expiration was higher than was originally anticipated. Nonetheless, this not inconsistent with the waiting list position for the ophthalmology departments at other hospitals.

Operational challenges caused by the pandemic were added to by a number of staff leaving the service. The priority for the CCG was to identify a new Provider and considerable engagement with potential providers was undertaken.

The overriding imperative was to ensure that patients would be able to continue with their treatment pathway without experiencing any additional delay. The CCG therefore approached the following additional Providers, to see if they would be in a position to provide a service:

- Kings College NHS Foundation Trust - unable to take on the service;
- Will Adams Treatment Centre – were at that time unable to help due to restrictions on their own site to support the COVID-19 response;
- Operose Health (community ophthalmology provider) - do not currently provide the services required to take on an acute level service, but were open to look into providing cataracts in a community setting, should this be required;
- Maidstone and Tunbridge Wells NHS Trust (MTW) - MTW was assessed as being the only realistic provider who could deliver the service and is the closest acute Trust to DVH within Kent and Medway. There are already established patient flows into the hospital for services not provided at DVH, such as Ear, Nose and Throat (ENT) and Rheumatology.

The CCG are incredibly grateful to MTW for recognising that this was a system problem for Kent and Medway and for being driven by NHS values by putting the interests of patients in the DGS area first.

Transfer Options for Patients

As part of the transfer, patients already on the service waiting list were given the choice to remain with Moorfields and be treated at one of their many sites elsewhere or to transfer to MTW. For the patients who remained on the transfer list, a robust approach to clinical prioritisation was taken to ensure that patients with the highest clinical need were seen first. The residual waiting list was further triaged in order to identify patients who could be discharged to a community Provider, which resulted in 680 patients being transferred.

The impact of the pandemic has created significant backlogs of patients waiting for all types of elective treatment and the NHS is committed to using all means possible to ensure that patients are treated expediently. For the ophthalmology service, additional theatre capacity has been commissioned from an Independent Sector site in Gillingham that allows Consultants from MTW to operate on ophthalmology patients in theatre capacity ring fenced for ophthalmology patients without having to compete with other specialties. This significantly reduces the risk of operations being cancelled as a result pressure on main acute hospitals from either a third wave of the pandemic or winter. Many of the patients who need surgery are elderly patients with cataracts and this approach will help ensure that some of the most clinically vulnerable patients are kept out of a traditional acute hospital environment.

In relation to the specific cohorts of patients, the following table highlights the solutions that have been enacted as part of the transfer of activity:

Cohort	Narrative	Solution
Cataracts Patients	This represents the largest cohort of patients. Approximately 1,250 patients per year were historically treated at DVH through the Moorfield's service.	All patients on the former MEH waiting list were offered appointments by 31/03/2021. Cataract procedures began to be undertaken from the Independent Sector site in Gillingham during June.
Paediatric Surgery	Most of this activity (85%) is commissioned by NHSE Specialised Commissioning and will continue to be undertaken at sites within London.	Discussions are ongoing with the Evelina London Children's Hospital to increase options for secondary care referrals into *tertiary Providers.*
Retinopathy of Pre-maturity Screening	This is a specialist element of the service which forms part of the neo-natal pathway. MEH provided the screening of babies on the ward at DVH where there is concern about the development of the baby's retina and eyesight generally.	Arrangements were put in place with effect from 1st October 2020 which meant that the service is provided by the same consultant who provides the service at Medway Maritime Hospital (a visiting consultant from Evelina Children's Hospital, London).
Medical Retina	This covers a number of distinct services, including Wet Age-related Macular Degeneration (WAMD), Diabetic Retinopathy and other similar services. The vast majority (95%) of WAMD activity takes place at the Queen	Processes were put in place that were agreed between MEH as the transferring provider and MTW as the receiving provider for the safe transfer of urgent patients with ongoing treatment needs. As with all patients on the MEH waiting list, patients were offered the choice to

	Mary's Sidcup site, provided by Kings College Hospital NHS Foundation Trust.	either remain with MEH at one of their other sites in London, or to be transferred to MTW.

Patient Engagement

Due to the impact of the pandemic's second wave last winter, the planned patient engagement that was anticipated to have taken place was postponed. However, engagement commenced on 14th June with the current community Provider within Dartford, Gravesham and Swanley sending out surveys on behalf of the CCG to patients who have already been triaged and / or treated by the service (including those referred into MTW) and to those who were scheduled to have an appointment before mid-July 2021 (the CCG does not have access to patient identifiable data, so cannot undertake this task themselves).

A further link to the survey has been included on the CCG website and there are scheduled posts on social media through to early August to promote the engagement exercise. The survey has also been shared with our Health Networks and stakeholders in the DGS area and it is anticipated that a good response will be received.

Analysis of the feedback will be undertaken in August, which will form part of an on-going process of engagement to help shape ophthalmology provision for DGS patients in the longer term.

Commentary:

Whilst the withdrawal of Moorfields from Kent and Medway has been less than ideal, the transfer of the service to MTW provides an opportunity for the hospital to develop as a centre of excellence for ophthalmology within Kent and Medway. The model of specialist Providers, like Moorfields, running local ophthalmology departments has happened in a number of other health care systems and is reflective of the fact that some smaller clinical specialties, like ophthalmology, often lack the critical mass to provide resilience in relation to both clinical and financial viability. The additional activity that will flow into MTW will allow them to grow their workforce and develop new models of care that can be achieved through having greater economies of scale.

The partnership with the Independent Sector is both novel and innovative and will help to ensure that ophthalmology patients can be seen in an expedient manner without the specialty having to compete for theatre space within an acute setting through ring fencing capacity at an offsite facility. This will help to ensure that some of the most clinically vulnerable patients are treated within a facility that has the potential to be more COVID-secure.

The longer-term aspiration of the CCG is to identify opportunities for MTW to provide ophthalmology services within the footprint of Dartford, Gravesham and Swanley. However, the over-riding imperative currently is for the NHS is to reduce backlogs and to treat patients based upon clinical priority. This does not currently lend itself to additional considerations being factored into the booking process, such as triaging patients into different geographical settings based upon their area of residence.

Work continues with the MTW service to evolve the model into one where there are increased opportunities for more local delivery, and we are working on the basis that the longer-term model will provide more flexibility in that regard, but the short to medium term priority for the NHS is to address the backlog of Kent and Medway patients waiting for elective procedures.

Recommendation:
The members of the HOSC are asked to note the background to the service transfer, which was on the basis that all reasonable options to identify an alternative Provider were exhausted. The concurrent operational challenges arising from the pandemic meant that it would have been unlikely that an alternative solution could have been found. These challenges also limited the CCG's ability to undertake wider patient engagement during that window. On-going patient engagement will shape services for ophthalmology patients from the Dartford, Gravesham and Swanley area moving forwards. There remains a longer term aspiration to provide more cataract treatment from within the DGS footprint and work continues to identify a site that will enable that. Having explored options to have a new Provider in place in time for the Moorfield service ending, Maidstone and Tunbridge Wells NHS Trust was the only viable option to provide a high quality and effective service. HOSC are asked to acknowledge the challenges of identifying new Providers for contract withdrawals during the pandemic and accept the provision of the service by Maidstone and Tunbridge Wells NHS Trust as the only viable option and in the best interests of patients affected.

This page is intentionally left blank

Item 7: Maidstone and Tunbridge Wells NHS Trust – Clinical Strategy Overview

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 21 July 2021

Subject: Maidstone and Tunbridge Wells NHS Trust – Clinical Strategy Overview

---

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the Maidstone and Tunbridge Wells NHS Trust.

---

1) Introduction

a) Maidstone and Tunbridge Wells NHS Trust (MTW) has asked to present the Committee with a paper on its clinical strategy and subsequent service reconfigurations.

2) Substantial variation of service

a) This agenda item provides an overview of the clinical strategy, 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 Maidstone and Tunbridge Wells NHS Trust clinical strategy.
iii. agree to determine on an individual basis if the workstreams constitute a substantial variation of service.

Background Documents

None.

Contact Details

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

MTW clinical strategy overview for HOSC

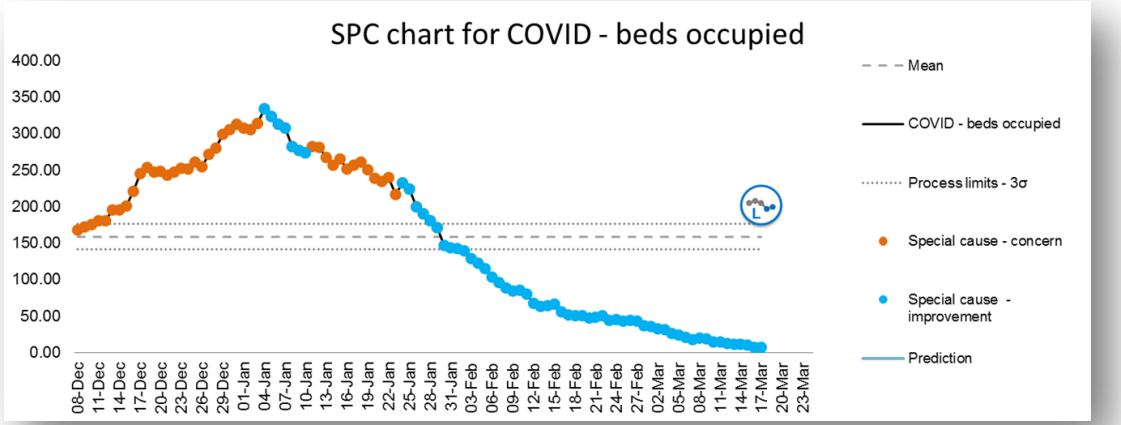
HOSC Briefing
21/07/2021

MTW
Exceptional people, outstanding care

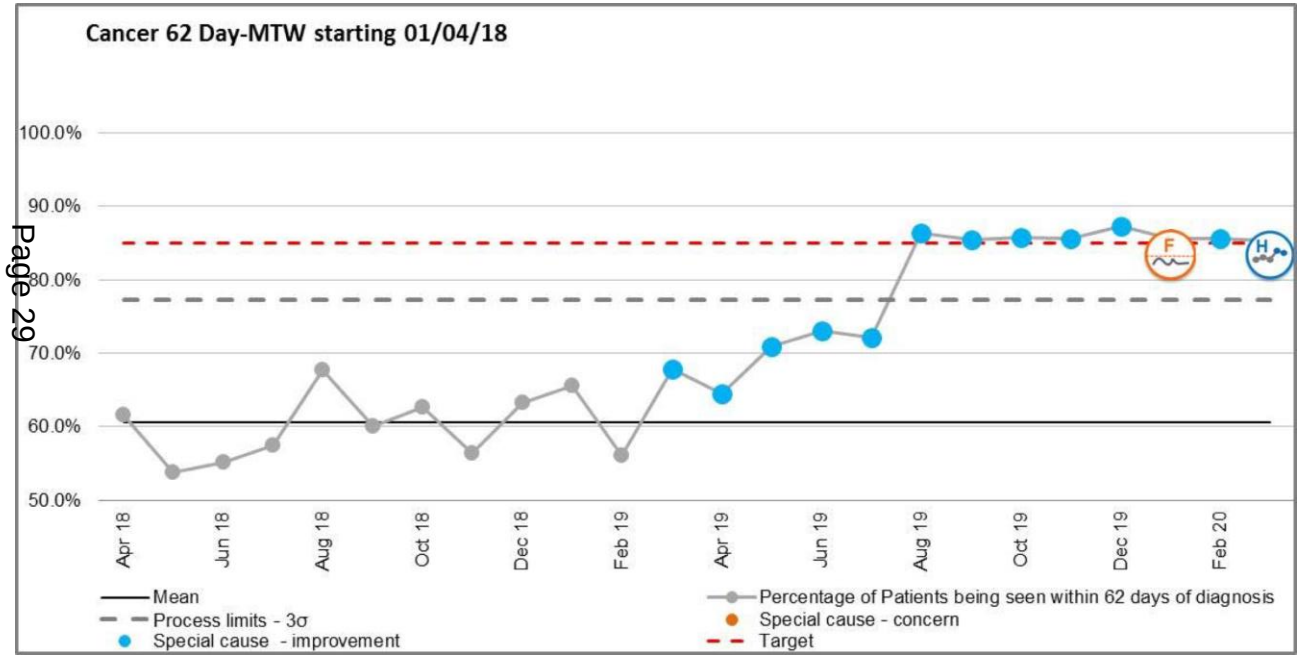
NHS
Maidstone and Tunbridge Wells NHS Trust

While 2020 was the most challenging year the NHS has ever faced MTW has come through it strongly thanks to our exceptional people

- We have worked with partners across the system to **implement new ways of working** e.g. the COVID virtual ward that have been adopted across Kent and Medway
- We have seen a **consistent decline in COVID patients** and now have 10 or less positive or suspected cases in our hospitals (from a high of over 300 in January)
- Our COVID vaccination service has served as a beacon of hope vaccinating both staff and vulnerable patients within West Kent
- We have **maintained our position as one of the best performing Trusts in the country for ED performance**
- We were also **shortlisted for the Acute Trust of the year at the recent HSJ awards** underlining the fantastic achievements of our staff during the pandemic



We continue to go from strength to strength on cancer performance and are now one of the top performing Trusts in the country



93.0%
2 week wait
Target 93%

85.9%
62d Treats
Target 85%

95.3%
31d Subs Rad
Target 94%

97.2%
31d First
Target 96%

96.7%
31d Subs Surg
Target 94%

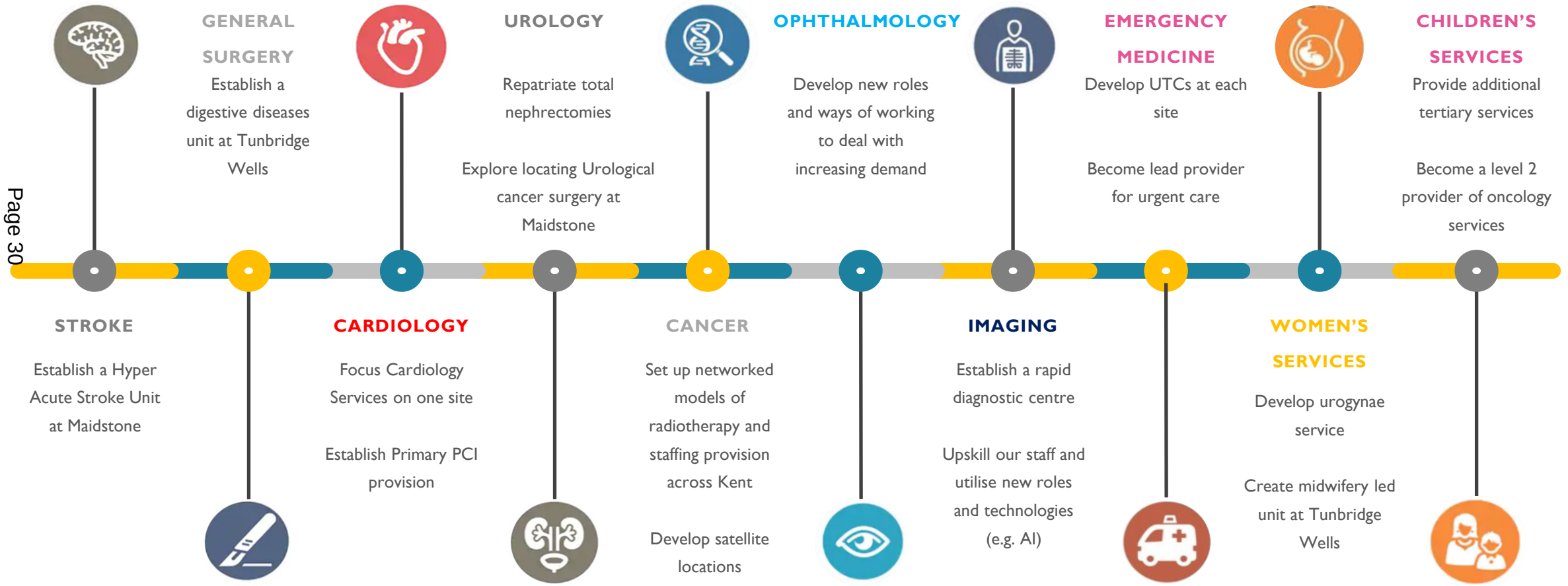
94.9%
62d Screening
Target 90%

95.2%
Sympt. Breast
Target 93%

98.1%
31d Subs Drug
Target 98%

MTW
Exceptional people, outstanding care

We are now looking to progress our ambitious clinical strategy that would see our hospitals develop deeper specialist services



All of our proposals have been developed with the patient at the centre to ensure we provide the very best of clinical quality and patient experience (1/2)

James presenting at Maidstone with Ulcerative Colitis

Before surgical reconfiguration, without a Digestive Diseases Unit

James is a **48 year old man, with ulcerative colitis**, who has been under the long term care of a consultant gastroenterologists based at Maidstone Hospital. They have established a very good relationship over the years. He experiences a **flair up of his colitis and presents to the gastroenterology clinic.** James is **admitted to Maidstone hospital** and treatment with intravenous steroids and infliximab is started. On this occasion, James **does not respond well to the treatment** and becomes increasingly weak with his bowels opening up to 12 times a day and his albumin levels falling.

There are significant **delays in the gastroenterology team being able to obtain senior colorectal surgical opinion**. James is finally **seen on a Friday by a consultant colorectal surgeon, 10 days after his admission,** and needs to be **transferred to Tunbridge Wells Hospital for emergency surgery.**

On arrival at Tunbridge Wells Hospital the **surgical team on call, who are not colorectal specialists,** feel that James should wait for the colorectal team who will be taking over on Monday. However, on Sunday James becomes increasingly unwell with severe abdominal pain. He undergoes an **emergency laparotomy and colectomy.**

After surgery, James requires intensive care. Initially, he makes a good recovery and is returned to the ward. On the 5th post-operative day however, he **develops a wound infection requiring the wound to be opened**. He has a **large wound from the emergency surgery** and requires extensive wound management, intravenous antibiotics and the placement of a VAC dressing. He is eventually **discharged with the VAC in place which remains for a further 3 weeks**. **Throughout the admission at Tunbridge Wells he has not seen the gastroenterologist he knows or the surgical consultant who operated on him** on Sunday.

DISADVANTAGES OF CURRENT MODEL

- **Delay in referral from gastroenterologists to surgical team**
- **Extended stay in hospital**
- **Gaps in specialist cover**
- **The requirement for an emergency transfer from Maidstone to TWH**
- **Emergency operation required when condition worsens**
- **Unplanned surgery delays recovery**
- **Poor continuity of care**

All of our proposals have been developed with the patient at the centre to ensure we provide the very best of clinical quality and patient experience (2/2)

James presenting at Maidstone with Ulcerative Colitis

After surgical reconfiguration with a Digestive Diseases Unit

James is a **48 year old man, with ulcerative colitis**, who has been under the long term care of one of the consultant gastroenterologists based at Maidstone Hospital. They have established a very good relationship over the years. He experiences a **flair up of his colitis and presents to the gastroenterology clinic** and is **admitted to the digestive diseases unit at Tunbridge Wells Hospital.**

He remains under the care of the gastroenterologist that he knows , who commences treatment with intravenous steroids and infliximab. After 72 hours it is clear that James is **not responding as well as would be hoped**. The **gastroenterologist promptly involves one of the colorectal specialist consultant surgeons who visits James with the gastroenterologist**. They decide to closely watch and wait for another few days to see if things improve. They both keep him under close observation but by the 7th day of his admission it is **decided to perform surgery**. The consultant **surgeon re-arranges a case from his elective operating list** and is able to promptly perform an **"urgent" laparoscopic colectomy**.

James is returned to ITU. Initially, he makes a good recovery and is returned to the ward. **On the 5th post-operative day he develops a wound infection**. As the **operation was laparoscopic the wound is small** and management is relatively simple. James is able to go **home with antibiotics the following day**.

Throughout his admission the gastroenterologist and surgical consultant that James knows have been involved in his care every day.

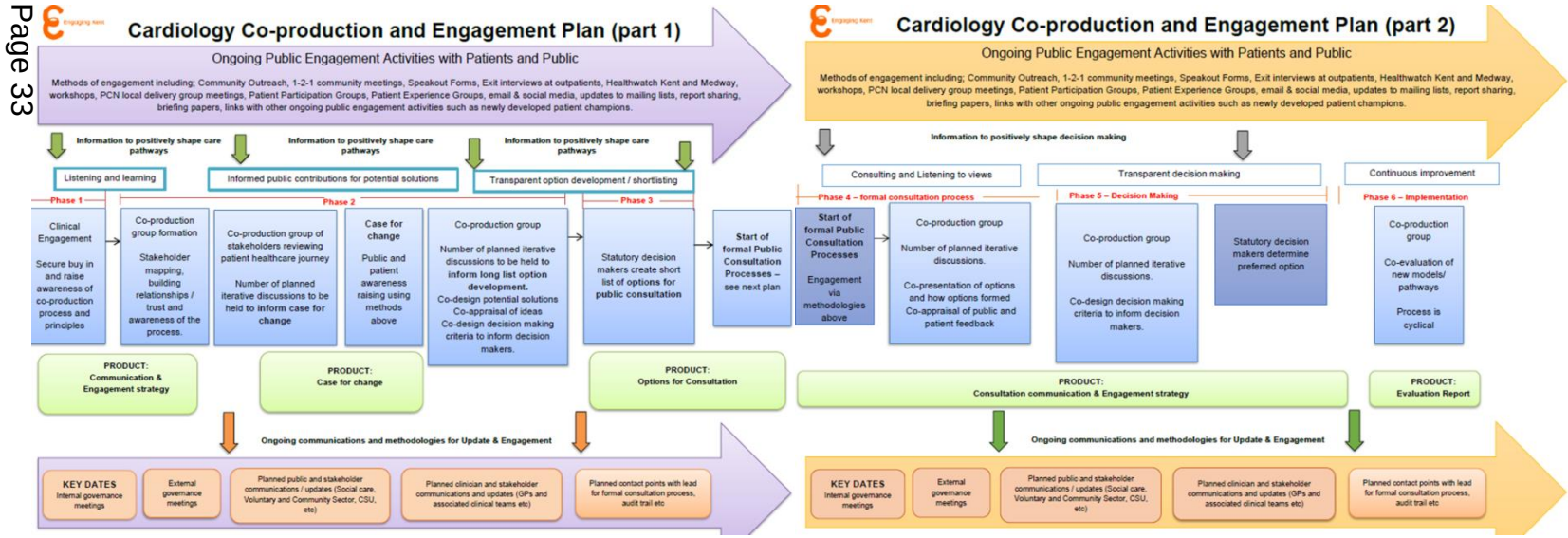
ADVANTAGES OF DIGESTIVE DISEASES UNIT

- **Continuity of care under specialist**
- **Prompt care plan**
- **Good multidisciplinary specialist cover**
- **Urgent but planned elective operation pathway available to manage urgent conditions**
- **Laparoscopic planned surgery enhances recovery**
- **Reduced stay in hospital**

Central to our plans is co-production and engagement with the public

We are **working with EK 360 (formerly Engage Kent) on the patient and public engagement for our clinical strategy**

Our Teams are working hard to ensure that we put **co-production at the heart of our plans** weaving this in from day 1




MTW

NHS Maidstone and Tunbridge Wells NHS Trust

The MTW Gastroenterology / DDU Engagement Plan

The Centralisation of the complex elements of the Medical Gastroenterology Service and formation of a Digestive Diseases Unit at MTW

This document describes our plan for engaging members of the public, patients and wider stakeholders about our service change

MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Item 8: Maidstone and Tunbridge Wells NHS Trust – Clinical Strategy – Cardiology Services

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 21 July 2021

Subject: Maidstone and Tunbridge Wells NHS Trust – Clinical Strategy – Cardiology Services

---

Summary: This report falls under the clinical strategy reconfiguration at Maidstone and Tunbridge Wells NHS Trust.

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

---

1) Introduction

a) In the previous item, the Committee received information about a clinical strategy reconfiguration that was under at Maidstone and Tunbridge Wells NHS Trust (MTW).

b) This item falls under that reconfiguration and specifically relates to cardiology services.

2) Potential Substantial variation of service

a) The Committee is asked to review whether the proposal to reconfigure cardiology services at MTW 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.

3) Recommendation

If the proposed change to cardiology services is *substantial*:

RECOMMENDED that:

(a) the Committee deems the proposed reconfiguration across Maidstone and Tunbridge Wells NHS Trust 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 cardiology services is *not substantial*:

RECOMMENDED that:

(a) the Committee does not deem the proposed reconfiguration across Maidstone and Tunbridge Wells NHS Trust 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

Cardiology Service Reconfiguration

Outline of Proposal to develop a specialist cardiology service to deliver both the GIRFT standards and MTWs clinical strategy aspirations

HOSC Briefing
21/07/2021

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Contents

Introduction and background

The current cardiology service outline

The **inpatient cardiology service at MTW is currently provided at both the Maidstone and Tunbridge Wells hospital sites**.

There is a **cardiac catheter laboratory on both sites** with the Tunbridge Wells site providing angioplasty intervention and simple pacing procedures, and the Maidstone site providing simple & complex cardiac pacing and electrophysiological intervention.

On this basis **if patients at Maidstone hospital require an angioplasty intervention they will be transferred to Tunbridge Wells Hospital**. **If patients at Tunbridge Wells Hospital require complex cardiac pacing or electrophysiological intervention they will be transferred to Maidstone Hospital.**

Both sites have a 6 bedded Coronary Care Unit (CCU), and patients' inpatient stays outside of CCU are managed in the general medical wards with some sub specialisation.

Both sites have Outpatients and other diagnostics (ECG, echocardiography)

The case for change

The case for change

Patients are having their treatment delayed due to requiring transfers between the two hospital sites for procedures during their in-patient stay

Inability to provide specialist cardiology services in a dedicated cardiology ward outside of CCU at either site

Diluted services due to necessary duplication across two sites

The **complicated clinical model** results in:

- **Difficulty in recruiting and retaining specialist staff** of all disciplines
- **Non compliance with 9 of 25 clinical standards** set out in the National GIRFT report of 2020 (Getting it Right First Time) (see opposite)

  -Seven non compliant standards relate to inpatient management and access

The Cardiology GIRFT report from 2020 sets out 25 standards for NHS Trusts to deliver to provide optimum cardiology care.

(See appendix 1 for complete list of standards)

MTW non-complaint GIRFT standards

Standard	Recommendation
1	All hospitals must deliver cardiology services as part of a defined and agreed network model
2	All hospitals receiving acute medical admissions must have a consultant cardiologist on call 24/7 that is able to return to the hospital as required. There should be a consultant job planned specifically to review newly admitted and acutely unwell inpatients 7/7 and a consultant job planned to deliver review of other inpatients ensuring continuity of care
4	All members of the wider heart team should be supported to work in extended roles and trusts should ensure that appropriate staff (including ACPs, specialist nurses and cardiac physiologists) are trained accredited and authorised to prescribe medications relevant to their role
5	Each network must ensure that there are clearly defined patient pathways covering all acute hospitals for provision of 24/7 emergency temporary pacing and 7/7 permanent pacing
7	Networks should ensure that stable chest pain pathways are consistent with the recommendations of NICE CG95. Invasive angiography should as a default be performed as '? Proceed' and must be performed in a PCI-enabled cath lab by a PCI trained operator
8	Networks must ensure that all hospitals performing PCI have a 24/7 on site rota for urgent return to the cath lab
10	For the acute chest pain pathway all networks should provide 7/7 ACS lists accessible to all hospitals in the network. Coronary angiography '? Proceed' should be performed within 72 hours for patients without high risk factors and within 24 hours for high risk patients and within 2 hours for highest risk patients. Cardiac surgery should be undertaken within 7 day of angiography
11	In each hospital there should be a specialist consultant lead for heart failure supported by a multidisciplinary HF team. Secondary care services should be integrated with community teams with regular joint MDMs
15	Networks should ensure that all hospitals admitting acute cardiology patients have 24/7 access to emergency echo including the facility for immediate remote expert review as required. Elective/urgent echo should be routinely undertaken 7/7. Urgent TOE should be available 7/7

Cardiology Activity and Dedicated Staffing

Procedure, diagnostics and outpatient activity:

Average annual Cath Lab activity:

Electrophysiology	200
Implanted Devices	712
Angiography	1049
Angioplasty	272

Annual OPA: *(as per 2021-22 demand & capacity templates)*

Grade	New Total	Follow-up Total
Consultant	3,238	2,735
Registrar	765	1,309
SHO	-	207
Nurse	2,648	13,683
Total	6,651	17,934

Annual OP diagnostics:

Echocardiography	2394
BP / ECG / Cardiac Event recorders	4620
Pacing clinics	4200

Staffing:

Consultants	8 WTE *
Associate Specilaists	2 WTE
Specialist nurses	8.97 WTE
Radiographers	2 WTE
Cardiac Physiologists	11.68 WTE
Cardiac Physiology support staff	10.64 WTE

*Current on call commitments
MH = 1 in 4
TWH = 1 in 5 (due to Associate Specialist cover)

Also:
2x6 bedded CCU's with staffing in line with national standards
Beds within the medical directorate for cardiology patients are not dedicated to cardiology

Working towards the reconfiguration of the cardiology service

Centralisation of specialist cardiology inpatient care for the provision of a cardiology specialist unit in line with the Kent Health and Wellbeing Strategy and the JSNA 2015

Proposed Changes

Inpatient cardiology services would be centralised onto one 'hot site' providing:

- 12 CCU beds
- 2 co-located cardiac catheter labs for both elective and emergency procedures
- up to 24 dedicated cardiology beds
- consolidated skills and facilities onto one site for the provision of care to the most complex cardiology conditions
- consolidation of lab staff to one site facilitates provision of 24/7 on call and weekend lab activity

A robust transfer protocol will ensure patients on the 'cold' site are managed safely, quickly and appropriately for their condition.

The 'cold' site would continue to manage less complex or serious cardiology conditions through the medical ward with support from the cardiologists

Outpatient clinics and non-invasive investigations (ECG, echocardiograms) will remain on both sites. This will provide daily (weekday) consultant cardiology presence on the 'cold' site

Provision of specialist out-patient clinics at both sites (for example heart failure and arrhythmia clinics)

Link to Kent and Medway Joint Strategic Needs Assessment (JSNA)and Health and Wellbeing Strategy (HWBS)

JSNA

"For those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery"

JSNA 2015

HWBS

"One of the key issues that we need to tackle is that of public awareness of the changes that will be taking place over the coming years, namely the move to more care being delivered in local communities and away from acute hospitals. **This will inevitably mean major changes to our big hospitals, with the creation of specialist hospitals where good quality care can be provided with specialist trained staff**, with general services provided in the community or at a local hospital as clinically appropriate. This may mean an increase in journey times to access specialist provision for some people, but conversely will allow people to access much more of the care they need in community settings"

Kent Health and Wellbeing Strategy

Outline case for change

The Challenges of current service

Fragmented care for the patient requiring cardiology intervention in the cardiac catheter lab, with CRM/EP procedures taking place at Maidstone hospital and PCI procedures taking place at Tunbridge Wells hospital. This leads to between site transfers, a fragmented care pathway and less than optimum patient experience

Managing patients with complex cardiology conditions. This is undertaken on both sites and the inpatient ward is not a dedicated cardiology ward on either site. Access to emergency intervention does result in patient transfers between site with inherent risks this presents.

Challenges with recruitment to all cardiology disciplines Fragmented systems of working lead to challenges with recruitment and retention of staff

The Benefits of new configuration

Improve ability to provide a 7 day service and emergency service with consolidated workforce, facilities and the support.

The availability of a nursing and technical teams skilled in complex diagnostics will improve access and impact on quality of care

Improved continuity of clinical personnel on one inpatient site will impact of the streamlining and efficiency of the service and improve patient experience.

Ability to provide more complex care to inpatients with the most complex cardiology conditions

Access to cardiac catheter lab facilities 7 days a week with facilities and staff available to support

Ability to develop the service to further improve access to specialist cardiology care for patients in West Kent

Our engagement plan

Jointly developing an engagement plan

The cardiology service has a robust governance and assurance structure to support the programme of work and as part of that structure a Communications Group is in place with representation from the cardiology service, Trust Patient Experience Team and EK360 (formerly Engage Kent) with the latter supporting the external communication plan with patients and the public.

The engagement plan table outlines the activities completed and being undertaken to include:-

- A preparation phase
- Staff engagement – presentations, Trust communications and staff survey
- Public engagement – survey, face to face patient interviews, focus groups
- Analysis
- Ongoing consultation
- Engagement activity with local MPs, CCG and HOSC

	14.06	21.06	28.06	05.07	12.07	19.07	26.07		Aug-Oct 2021
Phase 1: Preparation (Communications Group)									
EIA Completed									
Stakeholder mapping									
Communication and engagement plan									
Agree engagement questions									
Contacting stakeholders									
Recruit patients for focus groups									
Secure consent from outpatients									
Consent and set up focus group participants									
Phase 2: Staff Engagement (MTW Lead)									
Presentation to cardiology Governance meeting	15.06								
Briefing paper to executive directors		22.06							
Staff communication via CEO bulletin and MTW news using Survey Monkey		25.06							
CEO Stakeholder update		25.06							
Senior Leaders update via corporate Team Brief									
Paper to HSOC									
Phase 3: Public Engagement (EK 360 Lead)									
Launch public			30.06						
Cascade online survey to all channels									
Continue to promote survey on line									
Face to face interviews with MH cath lab patients				01.07					
Face to face interviews with MH cardiology inpatients				02.07					
Face to face interviews with TWH cath lab patients					05.07				
Face to face interviews with TWH cardiology inpatients					06.07				
Four focus groups							19 & 20.07		
Exit interviews with outpatients									
Visits to community/voluntary organisations									
Phase 4: Analysis and ongoing consultation									**TBC**

The level of engagement and consultation required

The MTW programme has considered the level of engagement for the change in light of engagement guidance.

Consideration has been given to both levels 2 and 3 and in light of the challenges with confirming where the programme sits with the level of engagement .

The current plan is to continue with the 12 week programme outlined in the level 3 guidance.

HOSC consideration about the positioning of the level of change will be supportive in confirming the position as level 2 or 3

Level 1 – Ongoing development
A small scale change or a new service
Affecting small numbers and/or having low impact
There is good evidence that the change will improve or enhance service provision
Often requires an information-giving exercise (2-4 weeks)
May require some low level engagement

Level 2 – Minor Change
A small/medium scale change or a new service
Affecting low numbers of people
Often requires a small engagement (4-6 weeks)

Level 3 – Significant change
A significant service change
Affecting large numbers of people and/or having a significant impact on patient experience
A significant change from the way services are currently provided
Potentially controversial with local people or key stakeholders
A service closure
Limited information about the impact of the change
Requires a significant engagement (3 months)

Level 4 – Major change
A major change that requires formal consultation and follows NHS England guidance
Affects majority of the local population and or having a significant impact on patient experience
A substantial change from the way services are currently provided
High risk of controversy with local people or key stakeholders
A service closure
Limited information about the impact of the change
Requires a significant engagement (3 months+)

Next Steps:

- **Confirm the site options** for the development of the hot and cold sites
- **Feedback from the staff, patient and public** communications to inform the ongoing engagement and consultation plan
- Complete the **Equality Impact Assessment** (EIA) to ensure all potential risks are mitigated
- Through the local governance structure **confirm the clinical pathway** from the cold to hot site
- **Engage with SECAMB** to confirm any impact on change in flows as a result of reconfiguration of the specialist cardiology inpatient and cardiac catheter lab services
- **Develop a SOC** to confirm the changes and inform a robust risk assessment
- Through the programme governance **work on the service design, clinical model and service development**
- Complete the business planning cycle to **confirm the development timeli**ne

Indicative Timeline

Patient feedback collated	Early August 2021
Ongoing engagement activity	July/August – October 2021
SOC to Cardiology Programme Board	August 2021
Medicine Divisional Board and Executive team	August 2021
MTW Trust Board	October 2021
Kent HOSC detailed update	October 2021
Timeline for completion of reconfiguration	October 2021

Appendix 1 (embedded) – MTW performance against GIRFT Standards 2020

Adobe Acrobat Document

This page is intentionally left blank

Appendix 1 (HOSC Overview Cardiology Reconfiguration July 21)

MTW GIRFT Compliance 2020

Recommendation	Current compliance	Actions required	Timescale
1. All hospitals must deliver cardiology services as part of a defined and agreed network model.	**Essential services level 1 onsite – non-compliant** 7/7 consultant ward review for all cardiology in-patients 7/7 elective/urgent echocardiography **Level 2 (onsite/network level) – non-compliant** 7/7 permanent pacing, 7/7 PCI with 24/7 on call for return to lab **Workforce** Consultant cardiologists 1 per 36,000 (currently 1 per 71,420) Heart failure nurse specialists 3.5 per 100,000 (currently 1.8 in the hospital, 4.3 for West Kent, 1.5 for ES) Chest pain & arrhythmia pathways 7.5 WTE per million (currently chest pain clinic 1.2 WTE in post, rehab 4.24 in post & 0.6 vacancy and currently ANS 1.53 WTE in post for 500,000)	Single siting cardiology and additional recruitment is required to achieve level 1 and level 2 compliance Total of 14 consultants required to achieve compliance (further 7 consultants to be recruited) Additional recruitment for specialist nurses tbc	Feb 2023
2. All hospitals receiving acute medical admissions must have a consultant cardiologist on-call 24/7 who is able to return to the hospital as required. There should be a consultant job planned specifically to review newly admitted and acutely unwell inpatients 7/7 and a consultant job planned (note this may be the same consultant) to deliver 7/7 review of other inpatients, ensuring continuity of care.	**Non-compliant** Consultant on call 24/7 is currently in place, however this is a 1 in 4 rota at each site and minimum recommended rota in the GIRFT report is a 1 in 6. Consultant to deliver 7 day review of all cardiology patients will require a change in job plan as current rotas accommodate a ward round to see CCU patients and any urgent referrals only.	Single siting required to achieve basic compliance, but additional recruitment required to staff weekend cold site cover & intervention & pacing rotas Additional PAs required on job plans to accommodate longer working hours at weekends, but this is not sustainable until at a rota frequency of at least 1 in 6	Feb 2023

3. All NHS consultant cardiologists should, by default, participate in an on-call rota for general and/or specialist cardiology.	**Compliant**	No action required	n/a
4. All members of the wider heart team should be supported to work in extended roles and trusts should ensure that appropriate staff (including ACPs, specialist nurses and cardiac physiologists) are trained, accredited and authorised to prescribe medications relevant to their role.	**Non-compliant** Current hospital based specialist nurses 3 out of 5 are prescribers. The remaining 2 have both have applied, but no guarantee that there will places available this year on the course	Ensure study leave available for specialist nurses to attend prescribers course when secure a place	Feb 2023
5. Each network must ensure that there are clearly defined patient pathways covering all acute hospitals for the provision of 24/7 emergency temporary pacing and 7/7 permanent pacing.	**Non-compliant** 24/7 emergency temporary pacing is provided at both sites, but there are safety concerns regarding the current set-up and use of emergency theatres. Permanent pacing is currently only available on weekdays during normal working hours (not including bank holidays).	Single siting to pool physiologist & radiographer rotas to staff a 24/7 temporary pacing service in the cardiac catheter lab. Single siting to pool cardiologist, physiologist & radiographer rotas to staff 7/7 permanent pacing. Additional recruitment required: Currently 3 consultants to staff 7 day pacing and 3 consultants to staff 7 day angiography. Additional numbers physiologists, radiographers tbc	Feb 2023

6. All outpatient referrals should be triaged with maximum use made of the ERS–Advice and Guidance function. Appropriate investigations should be requested so that all results are available for advice or review in clinic. Clinics should, by default, be conducted virtually unless not feasible for the patient or if 'face-to-face' is required to progress clinical decision-making.	**Partial compliance** (currently non-compliant at TW site)	Increase non-invasive CR capacity and reorganise clinics to ensure investigations are requested & performed in advance of clinics such that results are available in time for clinic.	Feb 2022
7. Networks should ensure that stable chest pain pathways are consistent with the recommendations of NICE CG95. Invasive angiography should, as a default, be performed as '?proceed' and must be performed in PCI-enabled cath lab by a PCI-trained operator.	**Non-compliant** Currently we have two lists /week (capacity 6-8 patients per list) – only at TWH scanner. 2nd list each week covered by SP doesn't occur every week. Chest pain/ACS angiography at Maidstone site is currently only performed by an interventional consultant (BM), but PCI kit is an emergency 'bail-out' kit only and cases are not ?proceed Invasive coronary angiography in advance of non-coronary cardiac surgery currently performed by non-PCI enabled operator at Maidstone lab.	Significant increase in CTCA capacity required with 2 to 3 lists each week at both sites, requiring x cardiologists Whilst Trust remains as two separate cath lab sites a substantial investment in PCI kit (including pressure wire) at Maidstone site is required to have two PCI enabled labs, or alternatively stop angiography at the Maidstone site All coronary angiography to be performed by PCI enabled operators only	Feb 2022
8. Networks must ensure that all hospitals performing PCI have a 24/7 on-site rota for urgent return to the cath lab.	**Non-compliant** Current rota is Monday to Thursday up until midnight only staffed by 3 physiologists, 4 radiographers and 3 cath lab nurses	Single siting to pool staff to provide 24/7 on call rota. Required numbers tbc: Nurses Physiologists Radiographers	Feb 2022

9. All designated PPCI centres must provide a 24/7/365 service and all PCI operators should, by default, participate in a PPCI on-call rota.	**Not currently applicable** PPCI must be carried out in designated heart attack centres, operating 24/7 and not performing PCI for limited hours	No action currently required, but intention is to bid for 2nd Kent PPCI service and need to plan bed capacity, ITU support & intervention rota	n/a
10. For the acute chest pain pathway, all networks should provide 7/7 ACS lists, accessible to all hospitals in the network. Coronary angiography '?proceed' should be performed within 72 hours for patients without high risk features, within 24 hours for high risk patients and within 2 hours for the highest risk patients. Where cardiac surgery is required, this should by default be undertaken within seven days of coronary angiography.	**Non-compliant** Coronary angiography currently available normal working weekdays and currently non-compliant with targets for ACS.	Single site plus three additional interventional consultants (or network protocol) to provide 7/7 coronary angiography ?proceed	Feb 2022
11. In each hospital there should be a specialist consultant lead for HF, supported by a multidisciplinary HF team. Secondary care services should be integrated with community teams, with regular joint multidisciplinary meetings (MDMs).	**Non-compliant** No current heart failure lead (but job currently advertised)	Recruit to heart failure lead post (funding in place for substantive post)	Feb 2022
12. All networks should ensure that rehabilitation is offered to all eligible patients, including those with HF.	**Compliant**	No action required	n/a

13. All networks should ensure pathways are in place for the diagnosis and management of patients with heart valve disease, including referral to specialist aortic and mitral/tricuspid teams at a tertiary centre.	**Compliant**	No action required	n/a
14. Arrhythmia pathways should incorporate rapid access clinics, which may be led by ACPs, specialist nurses or cardiac physiologists, for the assessment of palpitations and suspected or confirmed AF. Cardioversions should, by default, be nurse, physiologist or ACP led and undertaken outside the cath lab.	**Partial compliance** DC cardioversion is led by specialist arrhythmia nurses and performed outside of the catheter lab at Maidstone site. Valve clinics currently run by echo physiologists. Specialist nurses involved with rapid access heart failure clinics.	Compliant if single siting the service to the acute site. Explore additional advanced practitioner roles for cardiac physiologists	Feb 2022
15. Networks should ensure that all hospitals admitting acute cardiology patients have 24/7 access to emergency echo including the facility for immediate remote expert review as required. Elective/urgent echo should be routinely undertaken 7/7. Urgent TOE should be available 7/7 and delivered on a network basis).	**Non-compliant** 24/7 emergency echo is currently provided by the consultant on call (1 in 4 rota at each site) Elective/urgent echocardiography is not currently routinely available 7/7 (although there has been some additional funded weekend work to catch up lists). Currently 2 substantive consultants, 1 fixed term consultant and 1 staff grade are TOE capable	Will need echo physiologist rota for 7/7 care (this will require additional staff, number tbc), and echo specialists to contribute to network TOE rota. Will need to decide if going to provide echo cover at both sites at weekends – or whether to transfer patients to acute site if require an echo.	Feb 2022

16. Networks should ensure that all hospitals have ready access either on site or at network level to CTCA including CT-FFR, with all of the images reported by appropriately trained cardiologists and/or radiologists.	**Compliant** (although current capacity is significantly under-resourced o see recommendation 7)	See entry for recommendation 7	Feb 2022
17. Networks should ensure that all hospitals have ready access on a network basis to dedicated sessions of CMR, including stress CMR, with all of the images reported by appropriately trained cardiologists and/or radiologists.	**Compliant**	Plan to develop in-house service by recruiting an imaging consultant (post to be advertised this year) with CMR sessions at a tertiary centre	Feb 2022
18. Nuclear cardiology services, including PET and PET-CT, should be available at a regional level.	**Partially compliant**	Need to formalise PET-CT service rather than current ad-hoc provision	Feb 2022
19. All networks should ensure that: (a) there are MDMs for HF and device implantation for all relevant patients within the network; b) there are MDMs for review of patients for revascularisation, aortic valve disease, mitral/tricuspid valve disease, endocarditis and EP at network level; and (c) there are pathways to access external MDMs in ICC, ACHD, advanced HF and low volume interventions if these are not provided within the network.	**Compliant** All complex device implants are subject to MDT at Maidstone. Have access to regional valve, endocarditis, ICC and ACHD MDT.	No action required	n/a

20. All trusts should ensure that audit teams are appropriately resourced to provide weekly uploads of data to the national cardiac registries.	**Partially compliant** Regular contribution to NICOR, MINAP registries	Need funded audit staff MINAP currently 0.2 WTE in post	Feb 2022
21. Trusts must ensure that there is regular clinical validation of coded data, that all relevant clinical information is captured and readily available to coders and that clinical staff are fully aware of the importance of accurate coding, especially that of co-morbidities.	**Compliant**	No action required	n/a
22. Care pathway redesign using digital tools needs to be clinically led and patient centred. Examples of good practice can be found in the NHSX Cardiology Digital Playbook and appropriate governance standards should be adhered to.			Feb 2022
23. All networks should implement robust evidence-based prescribing guidelines which are regularly reviewed and cover both primary and secondary care, ensuring optimal outcomes for patients across the clinical interface.			Feb 2022

24. NHSX and the Department of Health and Social Care should work to ensure that there is clinical engagement with the procurement of cardiac devices and that all devices are subject to systematic surveillance to ensure their safety and efficacy.			ongoing
25. Trusts should work to reduce litigation costs by adopting the GIRFT 5-point plan.			ongoing

Item 9: Maidstone and Tunbridge Wells NHS Trust – Clinical Strategy – Developing a Specialist Digestive Diseases Unit for West Kent

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 21 July 2021

Subject: Maidstone and Tunbridge Wells NHS Trust – Clinical Strategy – Developing a Specialist Digestive Diseases Unit for West Kent

---

Summary: This report falls under the clinical strategy reconfiguration at Maidstone and Tunbridge Wells NHS Trust.

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

---

1) Introduction

a) In the previous item, the Committee received information about a clinical strategy reconfiguration that was under at Maidstone and Tunbridge Wells NHS Trust (MTW).

b) This item falls under that reconfiguration and specifically relates to gastroenterology services.

c) On 29 January 2020, HOSC received a paper relating to general surgery reconfiguration at MTW hospitals. The proposal was to move complex elective gastrointestinal surgery from the Maidstone site to the Tunbridge Wells site in order to treat patients at the same location as complex emergency inpatient surgery. Following discussion, the Committee determined the changes did not constitute a substantial variation of service. Details from that meeting can be found online: https://democracy.kent.gov.uk/mgAi.aspx?ID=53098

d) Included in the January 2020 report, MTW wrote about their aspiration to form a Digestive Diseases Unit (DDU) – a medical and surgical ward where patients with gastrointestinal conditions are looked after. At that time, a DDU had not been an option because the split site configuration of the surgical service lacked the scale and concentration of expertise that is required to set one up.

2) Potential Substantial variation of service

a) The Committee is asked to review whether the proposal to centralise gastroenterology services at MTW 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.

3) Recommendation

If the proposed change to gastroenterology services is *substantial*:

RECOMMENDED that:

(a) the Committee deems the proposed reconfiguration across Maidstone and Tunbridge Wells NHS Trust 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 gastroenterology services is *not substantial*:

RECOMMENDED that:

(a) the Committee does not deem the proposed reconfiguration across Maidstone and Tunbridge Wells NHS Trust 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

Developing a Specialist Digestive Diseases Unit for West Kent at MTW NHS Trust

Engaging on the next step: Gastroenterology Inpatient Centralisation

HOSC Briefing
21/07/2021

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Contents

Background and link to previous engagement and consultation on services for patients with digestive disease at MTW

Background

The paper on surgical centralisation presented to HOSC in January 2020

The January 2020 paper was about co locating services for ‘ complex’ patients with digestive disease if the patient needed **Planned Surgery or Emergency Surgery** .

(The data in it was only about **surgical** gastro patients – about 400 patients/year moved)

The result of that move was that all of the patents with complex digestive disease who need **surgery** now have it at the Tunbridge Wells Hospital

This paper on medical centralisation

is about co locating services for ‘ complex’ patients with digestive disease if the patient need **medical treatment**.

The result we are looking for is that for **all services for patients with ‘complex’ digestive disease, regardless of if they need surgical or medical treatment, are co-located.**

The data in this paper is only about **medical** gastroenterology patients – It is forecast to affect the location of service for 255 patients /year

The vast majority of patients with digestive disease when they need our services, whether managed by the surgical team or the medical team, are non-complex outpatients, day cases, or need endoscopy and they stayed local in the surgical change and they would stay local in the medical change . *The data in each case does not overlap.*

Introduction

Previous engagement with Kent HOSC in relation to developing Digestive Diseases Unit (DDU)

In spring 2020, following engagement and consultation with a variety of stakeholders including the Kent Commissioning Group and the Kent and Medway Health Oversight and Scrutiny Committee (HOSC), Maidstone and Tunbridge Wells Trust (MTW) centralised some complex gastrointestinal surgical services onto the Tunbridge Wells Hospital site.

An important part of the case for change for the surgical centralisation was that it was …

the first step towards formation of a Digestive Diseases Unit at MTW.

Nottingham Digestive Diseases Centre

What is a Digestive Diseases Unit?

A DDU involves a dedicated combined medical and surgical ward where specialist surgeons and physicians and a specialist team of nurses, dieticians and other professional work together to provide joined up care. This is regarded as a highly beneficial **multidisciplinary** approach to the care of patients with gastroenterological conditions.

Many hospitals in England have organised their complex gastroenterology medical and gastrointestinal surgical services into one co-located Digestive Diseases Unit (DDU).

Working towards the next step in the development of a DDU

The next step in developing a DDU for the population of West Kent

Surgical and medical treatment together
Now the emergency and routine surgery for patients with digestive disease is successfully co located, the Hospital Trust is working towards the next step, which is for **the most specialist medical service for inpatients with Digestive Disease to co locate with the surgical services at TWH**

The most specialised segment of the service - A small proportion of the entire gastroenterology service
It is important to note that it is only the most complex part of the medical gastroenterology specialist service that needs to be co located.
Approximately 255 patients a year of the 28,000 patient contacts the service manages each year

255/28,000
Less than 1% of annual patient contacts in Medical Gastroenterology are affected

The current service

The current service

Patient contacts, hospital site and disease type

MTW provides a wide range of medical gastroenterological services with two centres of expertise, one at Tunbridge Wells Hospital at Pembury (TWH) and one at Maidstone Hospital (MH). Both sites provide around 4000 outpatient consultations a year and between 8000-10,000 patients for endoscopy per year. **Both sites admit 255-369 complex gastroenterology inpatients** to hospital beds per year with the higher volume at TWH.

The inpatient service manages complex inpatient care for patients with the following conditions - decompensating liver disease, acute colitis and Crohn's, acute GI bleeds and acute jaundice

An audit of complex gastroenterology inpatients

A recent audit of complex gastroenterology in-patients:

At Maidstone Hospital

- 255 patients/y
- 0.7 admissions/d
- 8 beds
- 5.5 days average stay

At Tunbridge Wells Hospital

- 369 patients/y
- 1 admission/d
- 11 beds

Link to Kent and Medway Joint Strategic Needs Assessment (JSNA)and Health and Wellbeing Strategy (HWBS)

JSNA

"For those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery"

JSNA 2015

HWBS

"One of the key issues that we need to tackle is that of public awareness of the changes that will be taking place over the coming years, namely the move to more care being delivered in local communities and away from acute hospitals. **This will inevitably mean major changes to our big hospitals, with the creation of specialist hospitals where good quality care can be provided with specialist trained staff**, with general services provided in the community or at a local hospital as clinically appropriate. This may mean an increase in journey times to access specialist provision for some people, but conversely will allow people to access much more of the care they need in community settings"

Kent Health and Wellbeing Strategy

The case for change

The Challenges of current service

Fragmented care for the patient with digestive disease. Leading to barriers to multidisciplinary working

Managing patients with emergency presentation of gastroenterological bleeding. This service is based at The Tunbridge Wells Hospital, supported by on site emergency surgery.

Challenges with recruitment . Fragmented systems of working lead to challenges with recruitment

Requirement for specialist Dietetics and other specialist support

The Benefits of new configuration

Improve ability to provide a 7 day service and an emergency service for the patient with digestive disease that has consolidated workforce, facilities and the support.

The availability of a nursing and dietetics teams skilled in complex surgical and medical treatments for digestive diseases has synergistic improvement on quality

Improved continuity of clinical personnel . Co-location of complex medical and surgical gastroenterology will reduce the number of handovers and avoid unnecessary changes of the team in charge of patient's care. These are issues which our clinicians recognise impact upon the quality of care.

Continuity of clinical information.

Ability to provide more complex care. Patients requiring the most complex care and/or with multiple conditions are not getting the quality of service that clinicians know is possible. It is often challenging because of the configuration of services to undertake combined diagnostic and therapeutic procedures leading to a need for patients to have 2 visits and potential for pathway delay in some cancer treatments.

Our engagement plan

Jointly developing an engagement plan

The gastroenterology service has worked with the Trust **Patient Experience Team** who have linked with **Healthwatch** to help design appropriate staged approach to engagement. A three stage process has been formulated .

The three stage engagement plan

Stage one – June and July 2021
General feedback on the current service from gastroenterology patients from existing documents and from collection via bespoke form. The service have also undertaken **stakeholder analysis** and **equality impact assessment**.

Stage two – **July – October 2021** Wider stakeholder engagement and patients invited to **help co- design elements of DDU**. Developing the plans in response to feedback following engagement activity and the review of feedback

Stage three – **September 2021** Level of need for further consultation assessed after **involvement of CCG and HOSC**

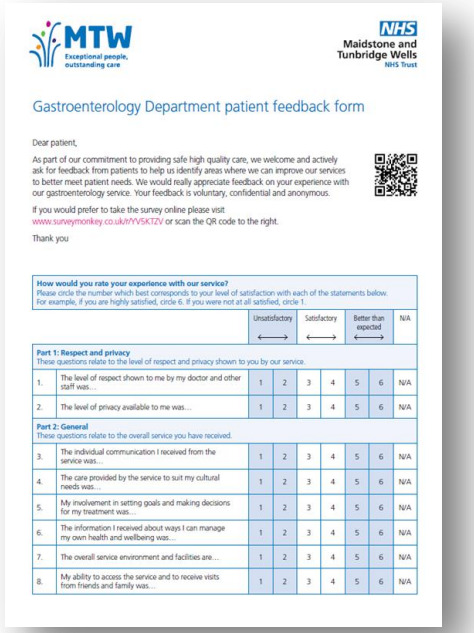
Engagement activities currently underway

Stakeholder engagement activities

- Ward Matrons and Gastroenterology Clinical Nurse Specialists included in Reconfiguration Project Work and cascade information to all staff levels
- Presentations at Departmental Speciality Meetings and Divisional Clinical Governance Meeting by Gastroenterology Clinical Lead
- Wide engagement with Trust Service Leads as required by business case form.
- Joint working with Dietetic and Diagnostics team
- The Project group reporting into a the Trust DDU Steering Group with attended by Chiefs of Service.
- CCG commissioner engagement
- Further work with primary care and ambulance service is planned

Patient feedback collection

Patients are being asked to provide their feedback on their experience of the current service via a bespoke form with collection in person, by mail or online
Form designed with input from Healthwatch
Collection planned for 4 weeks starting 17th June 2021.



MTW Exceptional people, outstanding care

NHS Maidstone and Tunbridge Wells NHS Trust

Gastroenterology Department patient feedback form

Dear patient,

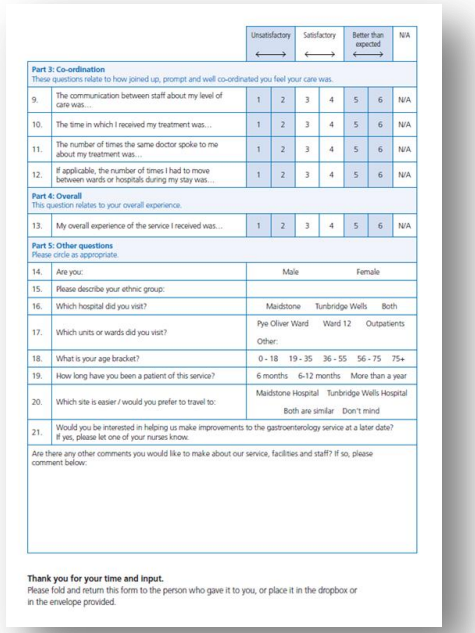
As part of our commitment to providing safe high quality care, we welcome and actively ask for feedback from patients to help us identify areas where we can improve our services to better meet patient needs. We would really appreciate feedback on your experience with our gastroenterology service. Your feedback is voluntary, confidential and anonymous.

If you would prefer to take the survey online please visit www.surveymonkey.co.uk/r/YV5KTZY or scan the QR code to the right.

Thank you

How would you rate your experience with our service?
Please circle the number which best corresponds to your level of satisfaction with each of the statements below. For example, if you are highly satisfied, circle 6. If you were not at all satisfied, circle 1.

		Unsatisfactory ⟷		Satisfactory ⟷		Better than expected ⟷		N/A
Part 1: Respect and privacy These questions relate to the level of respect and privacy shown to you by our service.								
1.	The level of respect shown to me by my doctor and other staff was…	1	2	3	4	5	6	N/A
2.	The level of privacy available to me was…	1	2	3	4	5	6	N/A
Part 2: General These questions relate to the overall service you have received.								
3.	The individual communication I received from the service was…	1	2	3	4	5	6	N/A
4.	The care provided by the service to suit my cultural needs was…	1	2	3	4	5	6	N/A
5.	My involvement in setting goals and making decisions for my treatment was…	1	2	3	4	5	6	N/A
6.	The information I received about ways I can manage my own health and wellbeing was…	1	2	3	4	5	6	N/A
7.	The overall service environment and facilities are…	1	2	3	4	5	6	N/A
8.	My ability to access the service and to receive visits from friends and family was…	1	2	3	4	5	6	N/A



		Unsatisfactory ⟷		Satisfactory ⟷		Better than expected ⟷		N/A
Part 3: Co-ordination These questions relate to how joined up, prompt and well co-ordinated you feel your care was.								
9.	The communication between staff about my level of care was…	1	2	3	4	5	6	N/A
10.	The time in which I received my treatment was…	1	2	3	4	5	6	N/A
11.	The number of times the same doctor spoke to me about my treatment was…	1	2	3	4	5	6	N/A
12.	If applicable, the number of times I had to move between wards or hospitals during my stay was…	1	2	3	4	5	6	N/A
Part 4: Overall This question relates to your overall experience.								
13.	My overall experience of the service I received was…	1	2	3	4	5	6	N/A
Part 5: Other questions Please circle as appropriate.								
14.	Are you:	Male				Female		
15.	Please describe your ethnic group:							
16.	Which hospital did you visit?	Maidstone		Tunbridge Wells		Both		
17.	Which units or wards did you visit?	Pye Oliver Ward		Ward 12		Outpatients		
		Other:						
18.	What is your age bracket?	0 - 18		19 - 35		36 - 55	56 - 75	75+
19.	How long have you been a patient of this service?	6 months		6-12 months		More than a year		
20.	Which site is easier / would you prefer to travel to:	Maidstone Hospital		Tunbridge Wells Hospital				
		Both are similar		Don't mind				
21.	Would you be interested in helping us make improvements to the gastroenterology service at a later date? If yes, please let one of your nurses know.							

Are there any other comments you would like to make about our service, facilities and staff? If so, please comment below:

Thank you for your time and input.
Please fold and return this form to the person who gave it to you, or place it in the dropbox or in the envelope provided.

Equality impact assessment and travel time

Equality impact assessment

Data on patient group characteristics has been collected to help inform planning

This includes data on:

- Ethnicity
- Age
- Sex
- Religion

The co located service will mean **patients from across West Kent, regardless of their characteristics, will have the same level of service.**

Travel time

The project group have defined that 255 patients a year will have their inpatient stay at TWH rather than at Maidstone Hospital. Approximately half of these will be admitted directly to TWH. Half are expected to be transferred after presenting to Maidstone

The proposed configuration will reduce the requirement for emergency transfers for surgery from Maidstone to TWH.

SECAMB will be given a clearer pathway to work with as all complex gastroenterology can be directed to TWH rather than the current situation where the ambulance service need to assess if the complex gastroenterology patient needs surgery or not.

The level of engagement and consultation required

Level of engagement required

The MTW project group have assessed the level of engagement for the change in light of engagement guidance. (See next slide)

However, decisions about the level of changes need to be confirmed with the support of the CCG and HOSC

The project group consider this a '**Minor Change**' because:

- The change is part of an ongoing development of a new Digestive Disease Unit service as shared with HOSC as part of the centralisation of surgery at the Trust in 2020
- Relatively small numbers of patients are affected in terms of site of service (255 patients a year) with 99% of patient contacts unaffected by the change
- There is good evidence that the change will improve or enhance service provision
- Good information about the effect of the change
- Very unlikely to be controversial with local people or key stakeholders as is intended to develop an improved specialist service
- Affects an extremely small percentage of the population

Levels of engagement – guidance

Level 1 – Ongoing development
A small scale change or a new service
Affecting small numbers and/or having low impact
There is good evidence that the change will improve or enhance service provision
Often requires an information-giving exercise (2-4 weeks)
May require some low level engagement

Level 2 – Minor Change
A small/medium scale change or a new service
Affecting low numbers of people
Often requires a small engagement (4-6 weeks)

Level 3 – Significant change
A significant service change
Affecting large numbers of people and/or having a significant impact on patient experience
A significant change from the way services are currently provided
Potentially controversial with local people or key stakeholders
A service closure
Limited information about the impact of the change
Requires a significant engagement (3 months)

Level 4 – Major change
A major change that requires formal consultation and follows NHS England guidance
Affects majority of the local population and or having a significant impact on patient experience
A substantial change from the way services are currently provided
High risk of controversy with local people or key stakeholders
A service closure
Limited information about the impact of the change
Requires a significant engagement (3 months+)

The proposed way forward

Admissions. Half of (255/y) admissions would be directed via GP or ambulance service straight to TWH before arriving at Maidstone. One patient every three days will require a transfer to TWH via established processes**.**

Medical staff. A gastroenterologist of the week rota has been planned to manage the new configuration

Nursing Staff. No change in overall nursing numbers is expected from this proposed service change .

Dietetics. Currently, there is no dedicated dietetic service to gastroenterology but an audit of requirements has been done and the service are planning the development of dietetic support

The impact on other Trusts. MTW Trust anticipates no change in overall patient flow to the Trust and no impact on neighbouring Trusts. MTW will link with SECAMB to co design emergency pathways

Vision for the Digestive Diseases Unit

The Clinical Team

Specialists in surgical and medical diagnosis and treatment of patients with Digestive Disease are developing the joint pathways and processes to improve the management of the patients on a shared unit at TWH

Patient and Clinical Co-design

As part of the engagement processes underway **patients are being invited to take part in collaborative co design the new DDU unit**

Timeline

Patient feedback collated (Potential to extend depending on response rate)	17th June – 17th July
Patient co design input into DDU	July 21- onwards
Gastroenterology Directorate board	July 21
Medicine Divisional Board	July 21
CCG	Jun – Oct 21
MTW Trust Board	29th July 21
Kent HOSC (TBC)	16th Sep 21
Go live	1st Oct 21

This page is intentionally left blank

Item 10: Dental commissioning in Kent

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 21 July 2021

Subject: Dental commissioning in Kent

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS England/ NHS Improvement South East.

It provides background information which may prove useful to Members.

---

1) Introduction

a) NHS England is responsible for commissioning primary dental care services to meet local needs and priorities, managed through local area teams.

b) Contracts are issued to independent providers based on an oral health needs assessment which identify the level of dental need for a particular community.

c) Contracted providers fulfil a certain number of “units of dental activity” (AUDs) in return for an annual amount of money.

d) NHS England South East have provided the attached paper which provides an overview of dental provision in Kent, including patient access. Unfortunately, no one from the organisation was available to attend today’s meeting, and any questions from the Committee will be relayed via the Clerk for a written response.

2. Recommendation

RECOMMENDED that the Committee consider and note the report.

Background Documents

None

Contact Details

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

This page is intentionally left blank

All dental practices were required to close for face to face care on 25 March 2020 at the beginning of the first national lockdown due to the COVID-19 pandemic. They continued to provide telephone advice to patients with an urgent need, including advice on pain relief and prescribing antibiotics where clinically appropriate.

Urgent Dental Care Hubs were set up during April with strict infection prevention control (IPC) measures in place to protect patients and staff in order to provide a referral service for those patients with the greatest urgent need. In Kent there were three practices located in Ashford, Chatham and Maidstone in phase one during the first national lockdown.

Dental services recommenced from 8 June and have remained open for face-to-face care during the current lockdown period. By 20 July all practices were required to be open for face to face treatment whether or not they carried out aerosol generating procedures (AGPs; for example fillings, root canals, crown preparations), however activity was severely restricted as only 20% of normal contracted activity was required due to the restrictions in place and fallow time required in the surgeries following all AGP treatments.

A second phase of urgent dental care hubs was introduced following the reopening of practices in June with further hubs opening in Ashford, Canterbury, Dartford, Margate, Ramsgate, Sittingbourne and Swanley.

In the national Standard Operating Procedure published in June the Office Chief Dental Officer detailed the priority order in which practices should see patients, with routine care to be provided only when urgent need had returned to pre-COVID levels.

Whilst dental services are operational, the priority remains focussed on patients who require access to urgent care, patients at higher risk of oral disease, and patients with outstanding treatment needs that cannot be delayed. All dental practices are continuing to provide remote consultations with triage and advice as necessary options.

Dental practices are also prioritising the health and safety of both patients and staff. The nature of the treatments involved means adhering to strict infection prevention control procedures between appointments, which reduces the number of patients that can be treated on a daily basis.

This has had a significant impact on those patients wishing to resume their routine dental check-ups and treatments. Patients requiring routine dental care such as check-ups and scale and polish will inevitably experience longer waiting times.

The Standard Operating Procedure (SOP) and letters from the Chief Dental Officer outlining a phased transition to the resumption of the full range of dental services are subject to regular updates.

At this stage, the patient pathway for dental care now consists of two broad stages – remote management and face-to-face management – for both urgent and routine care.

It is important to retain the initial remote stage, particularly to identify possible/confirmed COVID-19 cases (and household/bubble contacts), patients who are/were shielding, and patients at increased risk, to ensure safe care in an appropriate setting. This stage also helps to prevent inappropriate attendance, support appointment planning and maintain social distancing and patient separation.

During this phase, the baseline expectation is:

- Practices should be open for face-to-face care unless there are specific circumstances which prevent this, which should be agreed with NHS England and NHS Improvement
- Practices should prioritise urgent dental care provision, with flexibility for practices to do what is best for their patients.

NHS England and NHS Improvement has received reports that NHS dentistry is difficult to access at the moment. This is partly due to the still prevalent belief that patients register with a practice. This has not been the case since the current contractual arrangements were introduced in 2006. Under the current contract, practices' obligations extend only as far as the patient's current course of treatment; once it ends, practices do not have to see the patient again if they do not have the capacity to do so. However, most practices operate a list of patients that they consider to be theirs, and because practices can self-determine whether they accept new patients for NHS treatment this leads many to say that they are not accepting new patients.

Although many patients have historically had a dental check-up on a 6 monthly basis, NICE guidance states this is not clinically necessary in many instances and clinically appropriate recall intervals may be between 3 to 24 months dependent upon a patient's oral health, dietary and lifestyle choices. Therefore, many patients who are attempting to have a dental check-up may not clinically need this at the current time. While practices continue to prioritise patients with an urgent need, where they have the capacity to provide more than urgent care they will prioritise according to clinical need such as patients that require dental treatment before they undergo medical or surgical procedures, those that were part way through a course of treatment when practices closed, those that have received temporary urgent treatment and require completion of this, looked after children and those identified as being in a high risk category and so have been advised they should have more frequent recall intervals.

All practices have varying sizes of NHS contract which will affect how many hours per week they are funded to provide NHS treatment. This means they have varying levels of capacity to see patients on the NHS on a face to face basis. In order to assist practices to determine the amount of time that should be allocated to NHS treatment, NHS England and NHS Improvement has advised that the same amount of time should continue to be allocated now as would have been the case during a typical week pre-COVID.

If patients have concerns about this they can follow up with NHS England and NHS Improvement on england.contactus@nhs.net who can provide further advice or investigate the matter with the practice concerned.

We continue to stress that all practices should deal with any patient who calls them within their NHS capacity, whether or not they have seen that patient in the past. This means that if patient enquires to whether the practice is 'taking on' NHS patients, the practice should assess whether the patient has an urgent need, is at high risk of oral disease or has outstanding treatment that need that cannot be delayed. Practices should not be utilising capacity for routine care if they are unable to meet the urgent need presenting to them. This does not

necessarily mean that patients with an urgent need will automatically be offered a face to face appointment but if need to be seen is identified, the practice can arrange for this happen.

In December, NHS England and NHS Improvement implemented arrangements for the NHS dental contract for the period 1st January – 31st March 2021. This re-introduced activity targets for this period at a much lower level of 45% of contracted activity.

In April, the activity targets were increased to 60% of contracted activity which further increased access to NHS Dentistry. Whilst this will not mean capacity is at pre-pandemic levels it will mean more patients can be seen and that some will be able to open for routine appointments. As part of this expansion of capacity, dental practices have also been asked to do the following:

- Maximise safe throughput to meet as many prioritised needs as possible.
- Remain open throughout contracted surgery hours and prioritise care for patients who are considered at highest risk of oral disease, in line with the prevailing dental SOP and guidance.
- Use NHS funding to the full for the provision of NHS services.
- Comply with the contractual requirement that practices will not advise that NHS services are unavailable with a view to gaining their agreement to undergoing the treatment privately
- Continue preventative work and target efforts in a way that will reduce health inequalities (e.g. by agreeing to see irregular attenders as well as usual patients).
- Prioritise all known and unknown patients to the practice who require urgent dental care if contacted directly or via 111 services, as capacity allows.
- Keep contractual premises open throughout contracted surgery hours unless otherwise agreed via the regional commissioner.
- Complete and keep under review all staff risk assessments.

These arrangements will be subject to further review from 1st October 2021.

Although this gradual increase in activity has improved access to urgent dental care and is starting to deliver routine care for those with the greatest clinical need, it is still some considerable way from 100% of usual activity. It has also not addressed the backlog of care that built up during 2020/21 when practices were closed during the first quarter, when 20% of historic activity was delivered during quarters 2 and 3 and 45% of contracted activity during quarter 4. The resulting backlog is going to take some considerable time to address.

NHS England and NHS Improvement (South-East) also has 10 practices in Kent currently providing additional hours in support of patients who do not attend the dentist regularly and are in need of urgent treatment.

Urgent Dental Care hubs are still in place to see patients referred to them where practices cannot provide certain dental procedures due to safety considerations for members of the dental team or they have service continuity issues due to local outbreaks. Referrals to these hubs have fallen by 98% since resumption of services in June when general dental practices started to reopen, but they remain vital to the local dental systems.

As per other referral services there are on-going challenges with waiting times for dental referral services. This includes referrals to hospital Oral and Maxillofacial, Restorative and Orthodontic services; General Anaesthetic services for children and special care adults and tier

2 community based Oral Surgery, Restorative and Orthodontic services. NHSE/I (South-East) is working with a range of stakeholders on Restoration and Recovery plans with a focus on patients in the most urgent need of treatment. But all these services face the same challenges as others in terms of access to facilities in the NHS at this stage of the pandemic and the requirements to provide services safely.

New services

Following a procurement exercise, NHSE/I has commissioned four new dental practices in Dartford, Dover, Faversham and Sevenoaks, plus an increase to an existing practice in Margate. A new practice is in the process of being set up in Minster. Each of these is the equivalent of three whole time NHS dentists. In addition, a practice in Sandwich is being increased by the equivalent of two whole time NHS dentists.

A second round of procurement will increase provision by the equivalent of one whole time NHS dentist in the following areas: Canterbury, Swale, Sittingbourne and Tonbridge. These practices are still being set up but are expected to come online over the coming weeks.

Each of these new contracts includes a requirement for the practice to offer a set number of appointments to patients in urgent need who do not have a regular dentist. In addition, each is required to provide a number of hours outside of normal working hours to provide more choice to patients.

Information for patients

We understand that this is a confusing time for members of the public trying to access NHS dental care. Practices are communicating with their regular patients to keep them informed of services available from their practice and what they need to do to access these. Practices are also responsible for ensuring their information is up-to-date on the NHS website so that members of the public without a regular dentist can search for services local to them.

If patients do attend a dental practice on a regular basis then they should contact that practice if they believe they have an urgent need. If not, they can search for a dentist in their local area on the NHS website (https://www.nhs.uk/service-search/find-a-dentist) or they can call the Kent Dental Helpline on 0300 123 4412 who will direct them to the NHS practice closest to their home address.

We ask patients to be understanding of the current situation with regards to the prioritisation of those with urgent needs and be respectful of the clinical decision. The dentist is best placed to clinically assess their dental issue. If they are deemed non-urgent, we would ask that they don't then call the Kent Dental Helpline for a second opinion leaving the service free to deal with other patients with urgent health issues.

Figures for Kent

Local Authority	Population	Number of Contracts	UDAs	No. of Whole Time Equivalent dentists	UDAs per head of population
Ashford	129,281	13	184,933	26.4	1.43
Canterbury	175,407	23	188,173	26.9	1.07
Dartford	113,910	14	92,967	13.3	0.82
Dover	118,100	10	125,233	17.9	1.06
Gravesham	113,890	14	160,144	22.9	1.41
Maidstone	176,879	21	217,369	31.1	1.23
Medway	296,561	37	411,151	58.7	1.39
Sevenoaks	123,757	17	102,338	14.6	0.83
Shepway	112,432	14	180,403	25.8	1.60
Swale	151,953	17	156,052	22.3	1.03
Thanet	148,233	12	220,056	31.4	1.48
Tonbridge & Malling	132,579	11	94,152	13.5	0.71
Tunbridge Wells	118,134	18	130,891	18.7	1.11

Communicating with the public

Please find below a tweet/Facebook message and a digital asset for sharing on your own social media accounts:

Item 11: Major Trauma Centre provision in Kent

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 21 July 2021

Subject: Major Trauma Centre provision in Kent

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

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

---

1) Introduction

a) At its meeting on 4 March 2021, a member of the committee enquired if a Major Trauma Centre would ever be located in Kent. It was noted that Kent residents would currently be directed to London for such provision.

b) The Kent and Medway CCG has provided the attached written response.

2. Recommendation

RECOMMENDED that the Committee 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

This page is intentionally left blank

NHS
Kent and Medway
Clinical Commissioning Group

Kent Health Overview and Scrutiny Committee

Trauma Care Update

June 2021

Situation:

This paper provides an update on the current situation of trauma services for Kent and Medway residents.

Background:

The development of Major Trauma Networks was a national requirement set out in the revised NHS Operating Framework of 2010/11. The South East London, Kent and Medway (SELKaM) network went live in April 2013 and is the operational delivery network serving trauma and major trauma patients in South East London and the Kent and Medway areas. There are 27 MTCs in England.

The SELKaM Trauma Network is a hub and spoke model with Kings College Hospital in London serving as the Major Trauma Centre (MTC) supported by 7 trauma units (TU's), 3 of which are in Kent & Medway located at the William Harvey Hospital in Ashford, Medway Hospital in Medway and Tunbridge Wells Hospital in Pembury. The other A&E departments in Kent and Medway are local emergency hospitals. Kings College Hospital NHS Foundation Trust is the host for our Trauma Network and the network is responsible for ensuring standards of trauma care.

Assessment:

Seriously injured adults and children are described as having suffered from major trauma. This is measured on a scale known as the Injury Severity Score (ISS) which scores injuries from 1 to 75, the latter being the most serious. Patients who have an ISS>15 are defined as having suffered from major trauma. In addition, patients with an ISS of 9-15 have moderately severe trauma.

A MTC has all the facilities and specialties required to be able to treat patients with any type of injury in any combination. Examples of such patients, are patients who have suffered traumatic amputation of one or more limbs, patients with a serious head injury and patients who have suffered a number of injures (known as polytrauma) such as a combination of abdominal and chest injuries.

The main difference between a major trauma centre and a trauma unit is the provision of very specialist services such as neuro surgery and cardio thoracic surgery.

Update:

The Major Trauma Network arrangement is still in place. Kent and Medway will continue to have local emergency hospitals and trauma units however there are no plans to develop an MTC due to the very specialist nature of the services which must to co-located together to get the best

outcome for our patients. There are only small numbers of patients who require these very specialist services and therefore, at the moment, these services could not be sustained in Kent and Medway until we reach a minimum population of 2 million people.

Rachel Jones
Executive Director Strategy and Population Health
June 2021

Item 12: Follow up from previous meeting – the funding of community pharmacies

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 21 July 2021

Subject: Follow up from previous meeting – the funding of community pharmacies

---

Summary: This report invites the Health Overview and Scrutiny Committee to note the follow up from the previous meeting.

---

1) Introduction

a) At its last meeting on 10 June, HOSC received an update from Healthwatch Kent and the Kent Local Pharmacy Committee (LPC) about the role of community pharmacies during the pandemic.

b) During that meeting, the LPC raised an issue around the treatment of a £370m covid support loan provided to pharmacies early in the pandemic. The money had been badged as a loan, but the implication was that it would not need to be paid back. Negotiations were ongoing. Ms Shilpa Shah from the LPC invited Members to lobby their local MPs and offered to send the clerk further information after the meeting, which she did.

c) Following the discussion, Members agreed the following:

> *RESOLVED that the Committee note the update, and the chair undertook to consult with officers as to the best way to show support for pharmacies on this issue. Members agreed to this suggestion.*

d) Following the meeting, the clerk circulated the additional information received from the LPC along with a draft letter to the Secretary of State for Health and Social Care and Chancellor of the Exchequer. The letter was subsequently sent (attached as Appendix 1) and a response from HM Treasury has been received (attached as Appendix 2).

e) These letters are attached for Member's information.

2) Recommendation

RECOMMENDED that the Committee note the update.

Item 12: Follow up from previous meeting – the funding of community pharmacies

Background Documents

Kent County Council (2021) 'Health Overview and Scrutiny Committee (10/06/21)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8501&Ver=4

Contact Details

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

Rt Hon Matt Hancock MP
Rt Hon Rishi Sunak MP

Via email
matt.hancock.mp@parliament.uk
rishi.sunak.mp@parliament.uk

Members Suite
Kent County Council
Sessions House
County Hall
Maidstone
Kent
ME14 1XQ

Direct Dial: 03000 416512
Email: HOSC@kent.gov.uk
Date: 24 June 2021

Dear Matt Hancock and Rishi Sunak,

Financial pressures facing Community Pharmacies

The Kent Health Overview and Scrutiny Committee (HOSC) are writing in support of the letter sent to you from the Chair of the All-Party Pharmacy Group, Jackie-Doyle Price MP, on 20th May 2021 which calls for fairer funding for the pharmacy sector. In particular, we support the write-off of the advance payments of £370m to the sector, which if made to be re-paid could see the closure of some local providers or reduction in service levels.

Community pharmacies play a vital role in the provision of primary care services to local people, yet do not seem to be recognised for this in terms of their funding. All too often over the last year, our Committee has heard of the difficulty for some residents in accessing medical advice and support. To insist upon clawing back the emergency funding of £370m to pharmacists would seem counterintuitive, as it could lead to reduced services or closures that would in turn increase demand upon GPs and other NHS services.

My Committee would urge you to make the right decision, as soon as possible, to give local pharmacies the certainty they need and gratitude they so rightly deserve.

Kind regards

Paul Bartlett
Chair, Health Overview and Scrutiny Committee
Kent County Council

This page is intentionally left blank

POA2021/17137

HM Treasury

1 Horse Guards Road
London
SW1A 2HQ

Paul Bartlett
Chair, Health Overview and Scrutiny Committee
Kent County Council
Sessions House
County Hall
Maidstone
ME14 1XQ

1 July 2021

Dear Paul Bartlett,

Thank you for your correspondence dated 24 June regarding support for pharmacies. The Chancellor of the Exchequer has asked me to write to you directly.

The Government recognises that community pharmacies are providing a vital frontline service to patients during the pandemic. As such, they have put in place a comprehensive package of support. The Government has provided extra funding for Bank Holiday openings, a new medicines delivery service for shielding patients and a contribution to social distancing measures for every pharmacy. They have also provided non-monetary support including the removal of some administrative tasks, flexibility in opening hours, and the delayed introduction of new services.

Between April and July 2020, a total of £370 million in increased advance payments were made to support community pharmacies with cash-flow pressures due to COVID-19. The Government has also put forward firm proposals for additional funding to meet extra costs incurred by pharmacies during the pandemic, and discussions between the Department of Health and Social Care and the Pharmaceutical Services Negotiating Committee are ongoing.

Crucially, most community pharmacies can also benefit from the unprecedented financial package that has been provided to support all businesses during the pandemic, including tax deferrals and cash grants. The Government estimates community pharmacies have had access to some £82 million in grants.

The Government is grateful for the important contribution made by community pharmacy teams and thanks you for raising these important issues.

I hope this is helpful. If you have any questions about this reply, please email public.enquiries@hmtreasury.gov.uk quoting reference POA2021/17137.

Yours sincerely,

V Gallagher
Correspondence and Enquiry Unit
HM Treasury

Item 13: Work Programme 2021

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 21 July 2021

Subject: Work Programme 2021

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

---

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

This page is intentionally left blank

Work Programme - Health Overview and Scrutiny Committee

1. Items scheduled for upcoming meetings

16 September 2021		
Item	**Item background**	**Substantial Variation?**
Covid-19 response and vaccination 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.	-
Children and Young People's Emotional Wellbeing and Mental Health Service - update	To receive an update on the provision of mental health services to children and young people in Kent.	-
Provision of GP services in Kent	To receive an update on the provision of, access to and patient satisfaction in relation to GP services.	-
NHS 111 service review	At their meeting on 10 June 2021, HOSC asked for an update on the provision of the 111 service.	-

23 November 2021		
Item	**Item background**	**Substantial Variation?**
Covid-19 response and vaccination update	To receive an update on the response of local health services to the ongoing pandemic.	No
		-

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
Urgent Care review programme - Swale	Members requested an update at the “appropriate time” during their meeting on 10 June 2021.	TBC
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).	-
Orthotic Services and Neurological Rehabilitation	To receive information on the provision of these services in Kent for adolescents.	-
Transforming Mental Health and Dementia Services in Kent and Medway	To receive information about the various workstreams under this strategy.	TBC
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

This page is intentionally left blank